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Clinical Social Workers, Telemental Health and the COVID-19 Pandemic

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CLINICAL SOCIAL WORKERS, TELEMENTAL HEALTH, AND THE COVID-19 PANDEMIC

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ABSTRACT

As a result of the COVID-19 pandemic, and due to the shelter in place order that most states required, licensed clinical social workers (CSWs) were forced to switch from in-person services to telemental health services almost overnight. Many did so without previous training, adequate technology, a confidential office, or professional support. While there is a growing body of research regarding the increased use of telemental health in the mental health field during COVID-19, there is minimal research which narrows in on what it was like for the CSWs who made this transition.

The purpose of this study was to better understand the lived experience of CSWs who transitioned to provide telemental health services during the national shelter in place order as a response to the global COVID-19 pandemic, and how this impacted them professionally and personally. A qualitative, phenomenological mode of inquiry was used, and data analysis was guided by an adaptation of Moustakas' transcendental phenomenological method. Ten CSWs were interviewed for this study between April 2023 and August of 2023 through Zoom. The interviews were transcribed verbatim, and the data were coded, analyzed, and organized into themes and subthemes. A textural and a structural description, and a composite textural-structural for each CSW interviewed were completed. Six themes emerged from the interviews with eleven subthemes: (1) the transition to telemental health, (2) professional insecurity, (3) working from home works, (4) the shared reality is harder, (5) self-care is a priority, (6) it is going to be ok. The subthemes are (a) challenges, (b) guidance on best practices for telemental health, (c) insurance reimbursement, (d) protection from COVID-19, (e) more free time in the

day, (f) flexible work schedule, (g) telemental health is preferred for some clients, (h) fear of the unknown, (i) amplified mental health problem, (j) empathetic connections and disconnections, and (k) connections. Finding suggest that CSWs transitioned quickly to telemental health care and found they were able to provide effective therapy services for their clients, even though they initially struggled with feelings of professional insecurity due to lack of experience or training. The CSWs interviewed for this study discovered that there were many benefits to working from home. Additionally, they experienced emotional and mental hardship due to the shared reality of living through the pandemic while simultaneously providing therapeutic care for their clients. Through the efforts of regular self-care, the CSWs were able to mitigate the effects of compassion fatigue and burnout. Implications for future research in social work practice and education will be discussed, as well as suggestions for future research topics.

CHAPTER ONE

INTRODUCTION

In the early months of 2020, the United States was thrown into a global health crisis caused by a coronavirus, SARS-CoV-2. This coronavirus was named COVID-19 because it was first detected in December 2019. It spread from Wuhan, China, with unbelievable speed resulting in a world-wide pandemic (Adhikari et al., 2020; Ibáñez-Vizoso et al., 2020). Using guidelines provided by the World Health Organization (WHO), and with support from federal, state, and local governments, strict and severe measures were put in place to mitigate the harm of this novel and deadly virus. One of the most restrictive measures, generally known as shelter in place orders, was enacted in 43 states between mid-March and April 2020 which prohibited public group gatherings (https://ballotpedia.org, 2020). Employees were either terminated or sent home to work remotely. Schools scrambled to provide education to students virtually. Travel was suspended and non-emergency medical appointments or procedures were canceled (Békés & Doorn, 2020; Leite et al., 2019; Wiener et al., 2021). To keep our country functioning, the U.S. Department of Homeland Security and the U.S. Department for Health and Human Services identified certain professions and businesses as essential to the well-being of citizens. Along with many other occupations, clinical social workers (CSWs) were deemed essential workers and virtual therapy, or telemental health, was recommended as the safest option for psychotherapy services (Perle, 2022; Wiener et al., 2021).

As Americans adjusted to life sequestered at home, CSWs had to pivot almost overnight to implement telemental health services for clients while simultaneously adjusting to their new

life in the reality of the pandemic and shelter in place order. Although telemental health had been in use for many years prior to the COVID-19 pandemic, it has not been widely utilized in the field of social work (Merrill et al., 2022; Shore et al., 2014). This seems to be a result of several barriers that made it difficult for CSWs to execute telemental health effectively and ethically. These barriers include: inferior technology available to the client or social worker; rigid insurance and licensure regulations; lack of appropriate training or guidelines on best practices; problems with ensuring confidentiality and compliance with HIPPA regulations; low or no insurance reimbursement rates; and therapeutic barriers which prevent or interfere with building rapport and trust with a client (Brooks et al., 2013; Chou et al., 2016; Turner & McGee-Lennon, 2013; Wilson et al., 2017).

Despite the availability of telemental health services, it was the COVID-19 pandemic that accelerated the relaxation or removal of these barriers and allowed CSWs to provide these services (Békés & Doorn, 2020; Benudis et al., 2022; Perle, 2022). Even though this was a new way to interact with clients for many CSWs (Békés & Doorn, 2020; Perle, 2022), a small but consistent body of research had documented the effectiveness of telemental health for mental health care delivery. This was especially true during a crisis when the infrastructure of a community was compromised; and traditional, in-person sessions were not available or safe for the clinician or the client (Fried et al., 2005; Lowe et al., 2016; Saurman et al., 2011). While it is unlikely that most CSWs were familiar with this research, COVID-19 ushered in telemental health as the new occupational “normal”, and in the early months of 2020, was implemented with little or no training, support, experience, or guidelines. Professionally speaking, many CSWs were in new and uncharted territory (Doran & Lawson, 2021; Perle, 2022).

In a crisis, mental health problems can arise or be amplified and reports of depression, anxiety, substance abuse, and post-traumatic stress disorder (PTSD) increase (Hiremath et al., 2020; Javed et al., 2020; Miller, 2012; Norris et al., 2002). Consequently, therapeutic services are sought out for support and CSWs are often on the front lines providing care (Adams et al., 2008; Naturale, 2007). They are asked to absorb the trauma and loss that accompanies the disaster and its aftermath (Adams et al., 2006; Sweifach et al., 2013; Tosone et al., 2012). CSWs who provide crisis care, whether it is via telemental health or in person, often experience emotional, psychological, and relational distress from the exposure to their client's trauma. This distress can have a negative impact on their professional and personal well-being (Norris et al., 2009; Sweifach et al., 2013). The literature provides extensive documentation of the impact of this experience and uses terms such as shared trauma or reality, secondary or vicarious trauma, compassion fatigue, and burnout to describe this phenomenon (Acker, 2012; Adams et al., 2006; Aparicio et al., 2013; Hope & Edward, 2013; Kapoulitsas & Corcoran, 2015; Leiter & Harvie, 1996; Nuttman-Shwartz, 2015; Tosone et al., 2012; Waegemakers Schiff & Lane, 2019).

CSWs who provided therapy during the COVID-19 pandemic offered therapy month after month for clients who were suffering in varying degrees, but they were also personally experiencing similar, or maybe identical struggles as their clients (Banerjee et al., 2020; Rajkumar, 2020; Salazar de Pablo et al., 2020). A unique and unusual client/clinician intersection was created where both parties experienced a shared, long-term crisis that affected not only the CSWs professional world, but their personal world as well. Four years after the COVID-19 pandemic started, we are at a place where we can begin to understand how CSWs were affected by the pandemic.

Since the pandemic began, research on CSWs who switched to telemental health has begun to populate the literature. Although not robust, a recent search of psychinfo, psycharticles, social work abstracts, and social service abstract databases provided articles that focused on this unique population. Some examples of articles that were discovered include the effectiveness of specific therapeutic interventions (Thomas et al., 2021), types of difficulties that either the client or social worker experienced due to telemental health (Cwikel & Friedmann, 2020), the attitude of therapists towards telemental health (Békés & Doorn, 2020), new MSW graduates providing telemental health (Senreich et al., 2021), the ethical or competency problems encountered (Merrill et al., 2022), the need for telemental health training (Perle, 2022; Rinkel et al., 2022), the effectiveness of telemental health for clients (Thomas et al., 2021; Wosik et al., 2020) and the rise of telemental health due to COVID-19 (Wosik et al., 2020). One article which was found studied the lived experience of pediatric oncology CSWs. This lays some groundwork to understand how the switch to telemental health in the hospital environment impacted the lives of those CSWs, but not all the CSWs interviewed were fully remote workers. Many of them either stayed in the hospital setting or used a hybrid of telemental health and on-site therapy (Wiener et al., 2021). One article was found which affirmed that some CSWs experienced difficulty transitioning to telemental health but focused on their attitudes toward the use of it (Békés & Doorn, 2020; Wiener et al., 2021).

Sharing the experience of the COVID-19 pandemic with clients and the switch to telemental health care was a dramatic change for many CSWs. The professional and personal impact of this is still widely unknown. Research is just beginning to explore the immediate and long-term effects that the pandemic had on the professional and personal life of the CSW. It

would be beneficial to know how this change in care affected them and what types of professional or mental health support systems might have been supportive during the pandemic. The purpose of this study is to better understand the lived experience of CSWs who switched to provide telemental health services during a national pandemic due to COVID-19, and how this impacted them both professionally and personally.

Significance

As a result of COVID-19, and due to the shelter in place mandate that most states required, CSWs were forced to make the dramatic switch from in person services to telemental health services. Many did so without previous training, adequate technology, confidential office space, or professional support (Duden et al., 2022; Lawson et al., 2022; Liem et al., 2020a; Rinkel et al., 2022; Wosik et al., 2020). While there is a growing body of research regarding the increased use of telemental health in the mental health field, there is minimal research which narrows in on the CSW and their lived experience. Even less literature exists documenting the experience of the CSW who provided telemental health for clients while working from home during the COVID-19 pandemic shared by their clients. This gap in the literature gives space and justification to explore this phenomenon more deeply. The following section will discuss the significance this study holds for CSWs in their professional and personal lives.

Significance to the Clinical Social Worker as a Professional

CSWs are found in a variety of work environments. The type of agency or institution they work in often guides the day-to-day tasks and services provided for their clients. Prior to the COVID-19 pandemic, most of these entities relied on in-person attendance for access to services. Few agencies provided mental health care via telemental health due to a range of barriers such as

a lack of training, prohibitive insurance regulations, technology limitations, and provider uncertainty (Brooks et al., 2013; Chou et al., 2016; Rinkel et al., 2022). When the COVID-19 pandemic hit the United States, most states instituted measures to mitigate the spread of the virus. One such measure was a shelter in place order which transitioned most people to work from home (Hsieh et al., 2020; Wosik et al., 2020). This measure compelled many CSWs to transition from in-person care to telemental health with little notice. There was minimal opportunity to prepare their practice or clients for this shift. Agencies and private practice providers scrambled to find ways to take care of existing clientele, manage new clients, navigate insurance company reimbursement, use technology for mental health care services, and protect client confidentially (Rinkel et al., 2022; Torous et al., 2020).

Better understanding of this experience can provide insight into how to prepare CSWs to pivot care efficiently and competently in an emergency (e.g., such as natural disasters, war or terrorist attacks, pandemics, or other unexpected crisis events in a community or geographical area). Research can provide insight into what CSWs need or want to ensure they can continue to provide quality care despite environmental changes. The stories from this research may also provide a better understanding of the steps and interventions they can take to stay emotionally, professionally, and mentally healthy during a long term, shared crisis.

Significance to the Clinical Social Worker as a Person

CSWs who provide mental health services during or in a disaster or crisis are at risk of experiencing emotional and psychological distress, depression, anxiety, cognitive and relational hardship, and PTSD as a consequence of their job (Adams et al., 2006; Cocker & Joss, 2016; Naturale, 2007; Shamai & Ron, 2009; Shoji et al., 2014; Sweifach et al., 2013). In places with

continued stress, such as war, or an event in which they are experiencing the same crisis as their client, it becomes increasingly difficult for them to separate their personal and professional life from the trauma (Band-Winterstein & Koren, 2010; Shamai & Ron, 2009). When the clash of professional stress bleeds into one's personal life, emotional and relational erosion can occur. As a result, serious mental health problems can be an outcome of continued exposure to the constant issues clients bring to each session (Baum, 2012; Wagaman et al., 2015).

Research provides ample evidence on ways to mitigate such consequences and documents steps that clinician can take for self-care and increased emotional well-being. Examples include time with family and friends, regular exercise, engagement in leisure activities and hobbies, professional support from colleagues and supervisors, spiritual practices, and scheduled time away from daily work and life stressors (Bercier, 2013; Bercier & Maynard, 2015; Bourassa, 2012). Unfortunately, many of these options were unavailable during the COVID-19 pandemic leaving CSWs with minimal options for self-care. Understanding the experience of CSWs during the pandemic can offer a glimpse into what types of self-care and support was effective and ways they were able to sustain personal well-being, which promotes a healthier professional identity as well.

Key Definitions and Terminology

In this section, key terms are defined relative to this research. They are used in current professional literature, the practice of social work, and in reference to COVID-19.

Telehealth is a specific method of medical service delivery defined as the exchange of medical information at a distance through the use of technology platforms including the telephone, text messages, client portals, video platforms, and mobile applications (Abel et al.,

2018; El-Miedany, 2017; Newman et al., 2016). For this study the term *Telemental health* will be used to differentiate the provision of medical services from mental health services and is typically done by licensed, mental health clinicians and monitored by insurance companies (Aboujaoude, 2018; Brenes et al., 2011). Many mental health providers switched to telemental health during the pandemic, but the population to be researched for this paper will be CSWs who have a master's degree and have reached the highest licensure required by their state to provide clinical services. Typically, this is a Licensed Clinical Social Worker (LCSW), but it is possible that some areas in the United States would approve a Licensed Social Worker (LSW) based on insurance and state regulations.

Only CSWs who provide *clinical social work* services were interviewed for this study. Services are defined as the provision of direct, relationship-based practice with clients, or client groups, in respectful and collaborative partnerships to work through psychosocial concerns impacting the person's well-being (Gates et al., 2022). Often this is understood to occur in the private practice setting. It may also include school and hospital social workers, psychiatric social workers, social workers in not-for-profit or community agencies, government agencies and long-term care facilities.

The national pandemic and resulting situations that arose as an outgrowth from the global COVID-19 pandemic fit into the definition of a *communal disaster*. The term can be known as an event, or series of events, that affects a wide array of humans, communities, and institutions; and has both a public and private dimension to its suffering (Miller, 2012). It is not a static experience, but rather a process and evolving situation that is understood as being outside of one's previous template of ordinary life. The evolution is modulated and refined by the

individuals who are experiencing the disaster by the use of language, the written word, and further embellished by a shared agreement of the emotional, behavioral, and relational consequences that arose from the situation (Miller, 2012; Shamai, 2003). A communal disaster dismantles the usual coping mechanisms employed by an individual or group, disrupts social connections and interactions, and, for a time, disempowers individuals and communities from the ability to successfully move through life. This could be from a variety of factors such as a compromised infrastructure that prevents travel, closure of business used for supportive services, or unsafe conditions in the community. The experience of a communal disaster is understood through the lens of several different filters such as socio-economic, cultural, political, religious, geographical, and familial. Additionally, this filter considers the micro, mezzo, and macro impact of such disasters in which each social-ecological level processes the spectrum of experiences regardless of how small or large the impact has on each system (Hope & Edward, 2013; McTighe & Tosone, 2015; Miller, 2012).

As front-line workers, it would be expected that CSWs emotional and mental well-being would be affected over time. They are especially susceptible due to their work with traumatized groups or individuals. Research shows that prolonged exposure to a client's traumatic situation without mitigating factors can cause *secondary traumatic stress*, *vicarious trauma,* and *compassion fatigue* (Bride, 2007; Gil & Weinberg, 2015; Naturale, 2007; Pulido, 2007; Rotabi et al., 2017; Wagaman et al., 2015). These are often seen as interchangeable terms used in the literature to describe "the phenomenon of helpers experiencing posttraumatic stress-like symptoms in response to being exposed to trauma material they hear from their clients" (Bercier & Maynard, 2015, p. 81; Bride et al., 2007).

Charles R. Figley first coined the term *secondary traumatic stress*. His research highlighted the toll caretaking had on mental health providers and defined it as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (Bride, 2007, p. 63). Bride (2007) defined *vicarious trauma* as:

> The transformation in cognitive schemas and belief systems resulting from empathic engagement with clients' traumatic experiences that may result in significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory. (Bride et al., 2007, p. 155)

And finally, *compassion fatigue* is defined as the "formal caregiver's reduced capacity or interest in being empathic or bearing the suffering of client" and can be experienced by any individual, usually in a professional capacity, who has regular and consistent interaction with traumatic events and the people who are impacted by those events (Adams et al., 2008, p. 239). A key aspect of compassion fatigue is the inclusion of the empathetic engagement by the professional which is vital to the healing process for the traumatized but can amplify the emotional exhaustion experienced by the professional (Adams et al., 2008; Dekel, 2010).

Some literature indicates secondary traumatic stress, vicarious trauma, and compassion fatigue are unrelated and have unique consequences for the helper (Adams et al., 2008; Gil & Weinberg, 2015; Lee et al., 2018; Naturale, 2007). However, there is a larger body of evidence which validates that the central and clinical features of all three overlap to such a degree that it would be difficult to fully untangle one outcome from another. The research shows that all three cause similar, if not identical, emotional, behavioral, and psychological manifestations in the caregiver (Adams et al., 2008; Aparicio et al., 2013; Bercier & Maynard, 2015; Lee et al., 2018).

It is anticipated that the CSWs who are interviewed will have been impacted by the shared experience of the pandemic with their clients. This is called *shared trauma or shared reality* and refers to situations in which a therapist and client are exposed to the same communal disaster. It can be defined as "the affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience as a result of dual exposure to the same collective trauma as their clients" (Tosone et al., 2012, p. 223). These situations are characterized by two central components: (1) The helping professional and the person receiving the assistance or therapy both belong to the same community, group or geographical location that has been affected by the situation at hand; and (2) the helping professional suffers double exposure. They or their family are individually and personally affected by the crisis, and simultaneously they provide professional services or psychotherapy to persons adversely affected by the same crisis. The double exposure is an added layer of stress and distress for CSWs (Baum, 2012, p. 37; Kretsch et al., 1997; Nesbeda, 2014). The literature uses the terms shared trauma and shared reality, and the impact this phenomenon has on a social worker, interchangeably (Baum, 2012; Cohen et al., 2014; Dekel, 2010; Tosone et al., 2012). For the purposes of this paper the term shared reality will be used.

In the face of untreated compassion fatigue and/or the experience of shared trauma or shared reality, job *burnout* is very possible. This is defined as a response to prolonged exposure of demanding, highly emotional, interpersonal work situations without adequate social supports and is characterized by "emotional exhaustion, depersonalization, and reduced personal accomplishment" (Adams et al., 2008, p. 240). Mitigation factors to protect from burnout include adequate social support, a sense of accomplishment and satisfaction with the job,

professional support from colleagues or a supervisor, adequate coping skills, and psychological strengths such as resilience, a strong self-esteem, and a sense of mastery and agency in one's life (Adams et al., 2008; Harker, Pidgeon, Klaassen, & King, 2016; Schwartzhhoffer, 2009; Waegemakers Schiff & Lane, 2019). Unfortunately, the mitigating factors typically accessed were not readily available or had disappeared in the wake of the pandemic and shelter in place orders enacted by several states. This, in combination with the prolonged difficulties associated with the COVID-19 pandemic, may contribute to higher numbers of burnout in the healthcare field (Ching et al., 2021; Peinado & Anderson, 2020).

To fully understand the experience of the CSW, *phenomenology* will be the guiding method for this study. It is indicated for use in qualitative research and holds a theoretical point of view which allows for the objective study of a variety of experiences such as perception, memory, emotion, thoughts, or imagination. It is concerned with the first-person viewpoint, which is provided by the conscious experience of the person and the meaning the individual attaches to the experience (Peoples, 2020; Zalta et al., 2011). Meaning making is essential to phenomenology research and is studied within the context of a person's *lived experience* of a certain phenomenon. It is designed to capture the essence of the lived experience of a person, group, or community, adding depth and breadth to the phenomenon under investigation (Creswell, 2007; Groenewald, 2017; Krefting, 1991).

To provide a framework for understanding this shared reality, the guiding theory for this study is *social construction.* This is a philosophy that asserts the belief that humans "actively construct the world of everyday life and its constituent elements" (Witkin, 2012, p. 17). It understands that the nature of reality is discovered through the shared, active participation

humans take in how they choose to describe, explain, and understand the realities of their world (Ackermann, n.d.; Anastas, 2014; Witkin, 2017). Knowledge of the world is discovered through communal, social interchange and is further defined through the influences of history, culture, beliefs, and an understanding of language. These influences are always changing and therefore one cannot assert that a singular interpretation of reality exists (Gergen et al., 2001; Saleebey, 1996). Under this construct, it is possible that the experience of the CSW was shaped, and perhaps changed, as they spent week after week hearing about their clients' experience of the pandemic. If one is to fully understand the lived experience of the CSW, one must allow space to consider that the stories of their clients may have influenced their understanding, awareness, or beliefs of the pandemic, personally or professionally.

Dissertation Overview

In times of crisis, mental health needs in a community rise. CSWs are called on to provide clinical interventions and offer support for those suffering (Jack & Glied, 2002; Norris et al., 2002; Ruskin et al., 2018). The COVID-19 pandemic touched every community in the United States, and as such, the needs for mental health care rose (Blundell et al., 2020). Literature validates that compassion fatigue, secondary trauma, and burnout occur when mitigating factors to relieve occupational stress are not available, or when a crisis becomes long term (Adams et al., 2006; McTighe & Tosone, 2015; Tosone et al., 2012). Considering these facts, one would predict that the professional and personal life of a CSW would be impacted during this unique time in history. This dissertation research explored the experience of CSWs who provided telemental healthcare during the pandemic and shelter in place order in the United States and how this affected them professionally and personally.

The following section will discuss the general content of each chapter including the literature review, the use of phenomenology as the method of research using social construction as the guiding theory base, the methods of study, discussion of the findings, analysis of the research data, conclusions, and implications for future research in social work.

Chapter Two presents the current research in the literature regarding this study. Due to the novel nature of COVID-19, there is not a robust representation of research, especially as it pertains to CSWs. Over the past several years, articles have begun to populate the literature which document the origins of COVID-19, the resulting pandemic, the response of the social work profession, and the mental health consequences one would expect to see during this type of communal disaster. An examination of telemental health and its barriers as a method for mental health care delivery is presented to understand how the social work profession continued to provide services even as they worked from home. COVID-19 and the pandemic brought to light several social justice concerns such as access to technology, adequate health care, and needed resources or services. CSWs had upfront exposure to this which often added an additional weight to carry as they continued to provide support for their clients. The use of social construction theory has been used to explain how individuals learn about, understand, and define their reality. This is often done through the spoken or written word and is a framework to bring a sense of knowing about the reality one lives in. For this study, social construction allowed the researcher to approach the stories that emerged from the research as a compilation of experiences that were shaped through the interactions the CSWs had with family, colleagues, clients, and the world at large.

Chapter Three details the methodology for this dissertation research project. Phenomenological inquiry is a qualitative research method that allows one to study the lived experience of a person or group and the unique way in which they make meaning of that experience (Lincoln & Guba, 1985; Padgett, 2008). It is most suitable for this dissertation as it provides a framework to answer the question "*What was the lived experience of CSWs who transitioned to provide telemental health during the COVID-19 pandemic and how did this affect them personally and professionally?"*

The analytic technique that was used is Transcendental Phenomenology detailed by Moustakas (1994). This type of analysis is especially helpful when the researcher has a deep interest in or personal experience of the phenomenon under study. To protect against researcher bias, data analysis began with a personal analysis of their lived experience of the phenomenon. This attempts to protect against researcher bias and further safeguard the trustworthiness of the results. Transcendental Phenomenological analysis is a modification of the Stevick-Colaizzi-Keen method which includes the use of the Epoche, Phenomenological Reduction, Imaginative Variation, and finally, Synthesis (Moustakas, 1994).

In the tradition of phenomenology and qualitative research, in depth, semi-structured interviews were used to develop thick and rich descriptions from the CSWs (Creswell & Poth, 2018; Lincoln & Guba, 1985; Moustakas, 1994). Data analysis began by transcribing verbatim the recorded interviews of each CSW. Extended time was spent in the data to become familiar with and deeply immersed in each person's experience. Significant statements were developed and grouped into units which provide meaning of the data though emerging themes. Textural and structural descriptions were developed to offer the reader a narrative of what each CSW

experienced and how they understood their experience through the universal structures of relationship to self and others. Lastly, a composite of the textural and structural descriptions were synthesized to describe the essence of the data. Bracketing was done throughout the entire process to document the researcher's feelings, thoughts, biases, and assumptions. This is necessary to keep the researcher's ideas separate from the stories told by the subjects and creates more trustworthy results (Creswell, 2007; Creswell, John W. & Poth, 2018; Padgett, 2008).

In Chapter Four, I will discuss the findings and results which will include themes and subthemes that have emerged during the data analyses. Discussion points will highlight themes that might not have been represented in the literature review and how this new data might influence the implications for the profession of social work. I will present how CSWs experienced the transition from in-person services to telemental health and the ways in which their professional and personal lives were impacted. Additionally, I will present a composite textural/structural description for each CSW.

Chapter Five will contain a discussion section including the limitations and implications related to the findings of the study and the profession of social work. Implications for the social work practice and education will be discussed as well as ideas for future research. The results from this dissertation can be used to inform the social work profession on ways to improve the mental and physical well-being of CSWs in a shared, communal disaster such as the COVID-19 pandemic. Schools of Social Work can be better informed regarding ways to prepare and train CSWs to provide telemental health care in an ethical and competent manner.

Summary

In summary, this research is designed to better understand the experience of CSWs providing telemental health services to their clients during the COVID-19 pandemic and shelter in place order. The use of phenomenology and qualitative research is indicated to gain a deeper insight into each person's experience and allow for themes to emerge from the research. "It is a particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language, on their own terms" (Krefting, 1991, p. 214). Previous research shows that during a communal disaster, CSWs who provide services for clients as they experience trauma, distress, and despair are susceptible to secondary trauma, compassion fatigue, and burnout. Add to this the extra stress of shared reality, and the risk for these maladies rise. Without effective coping skills and support as mitigation factors, this can lead CSWs to feel exhausted, depleted, hopeless, and the potential for career burnout is a real possibility (Banerjee et al., 2020; Holmes et al., 2021; Peinado & Anderson, 2020b; Vindegaard & Benros, 2020). The results from this research can contribute to the current body of literature on what CSWs need for telemental health training, for emotional and professional support in a shared, communal disaster, and the professions preparedness for future disasters our country might face.

CHAPTER TWO

LITERATURE REVIEW

COVID-19

Origin and Background Information

Originating in Wuhan, China, the novel corona virus, now known as COVID-19, made its appearance when a multitude of people were suddenly hospitalized supposedly for pneumonia of an unknown cause. In response to this mystery, the Chinese Center for Disease Control and Prevention (China CDC) sent a rapid response team to help health authorities of Hubei province and Wuhan city to conduct epidemiological and etiological investigations. The World Health Organization (WHO) identified that the outbreak originated at the Huanan South China Seafood Marketplace and was identified as a virus belonging to the family *Coronaviridae,* which causes symptoms ranging in severity which include pneumonia, lung infections, severe cough, fevers, and respiratory complications (Adhikari et al., 2020; Ibáñez-Vizoso et al., 2020). COVID-19 is a highly contagious virus that spread quickly throughout China within weeks after its first appearance, causing massive lockdowns of whole cities and provinces. It was declared to be a public health emergency by the WHO in January of 2020, and in March of the same year, COVID-19 was officially classified a pandemic due to the international spread of the disease (Adhikari et al., 2020; Ibáñez-Vizoso et al., 2020; Rajkumar, 2020; Wiener et al., 2021).

The United States Response to the Pandemic

In response, extreme measures were put in place to stop the spread of the virus. These measures included wearing masks in public places and within groups or gatherings, social

distancing, hand washing, and a widespread shelter in place order. Local and national government officials from around the world advised that everyone who could work from home, needed to do so, leaving only essential workers to work on location (Javed et al., 2020; Wosik et al., 2020). The pandemic forced all healthcare systems, clinics, and hospitals to limit patient contact and implement telehealth for provider services (Javed et al., 2020; Lasalvia et al., 2021; Rajkumar, 2020). Many places of business were forced to close such as movie theatres, gyms, restaurants, shopping centers, amusement parks, places of worship, and many more. Schools across the world, including colleges and trade schools, had to shut down in-person attendance, forcing students and teachers alike into the world of e-learning and Zoom classes (Doran & Lawson, 2021; Duden et al., 2022; Sullivan-Tibbs et al., 2022). Essentially, this lockdown forced the world to converge work, schooling, leisure, and home life into the same space. Sequestered to their homes, many turned to technology as the primary source of connection with the rest of the world. Business meetings, education, social interactions, and medical services turned to online platforms such as Zoom, Facetime, or Skype.

Clinical social workers were asked to pivot care as well. Due to the concern over mental health needs of Americans, social workers were deemed essential workers and were expected to continue with service provision using telemental health and to discontinue in-person sessions (Wiener et al., 2021). To ensure the continuity of care for clients, providers responded by shifting to remote delivery of mental health services via telemental health (Doran & Lawson, 2021; Sullivan-Tibbs et al., 2022). This situation created a confidentiality conundrum as CSWs tried to provide a safe, confidential, and visually appropriate virtual office from the confines of their home.

Research that has been published since the pandemic began to indicate that a majority of CSWs did not use telemental health previously and faced a variety of challenges in response to the work from home mandates (Békés & Doorn, 2020; Benudis et al., 2022; Doran & Lawson, 2021). The following section outlines the history of telemental health care, situations where it has been used in the past, effectiveness, and barriers to its use.

Telehealth and Telemental Health

Background

Telehealth is a method of service delivery defined as the exchange of medical information at a distance through the use of technology platforms such telephone, text messages, on line client portals, video platforms, or mobile applications (Abel et al., 2018; El-Miedany, 2017; Newman et al., 2016). In its simplest form one can define it as "providing specialist medical services using information and communication technologies to remotely located healthcare workers and patients where such expertise is not immediately available" (Amadi-Obi et al., 2014, p. 1). This type of communication with others about healthcare has been in use for centuries, going back to African tribes who used smoke signals to alert other tribes of illness, and villages in the middle ages that lit bonfires to warn travelers of the bubonic plague infection (Amadi-Obi et al., 2014). Telemedicine has been refined and improved with advances in technology, starting with the telephone in the early nineteenth century, and then in the 1950's when television was used for video conferencing to monitor patients and offer consultations. The National Aeronautics and Space Administration (NASA) was an early adopter of this form of medical care in the 1960's as a way to monitor astronauts on space flights (Amadi-Obi et al., 2014). With the introduction of the internet, telemedicine has advanced in its efficacy and

availability. Doctors, medical professionals, and specialists from all over the world are now able to provide care, consultation, assessments, and treatment plans for patients who are unable to access in-person care (du Toit et al., 2019; El-Miedany, 2017; Myers, 2019; Turner & McGee-Lennon, 2013).

Telemental Health

As technology has improved and become more accessible, the mental health field has joined the virtual health platform to offer mental health care services (Aboujaoude, 2018; Aboujaoude et al., 2015; Doran & Lawson, 2021). Telemental health uses the same or similar technology for service provision as telehealth but provides mental health care rather than medical care. There are many situations that call for telemental health as a preferred option for services. For example, telemental health can be used for individuals in rural or medically underserved communities, or those who cannot travel due to an injury or illness. Telemental health is also useful for individuals who have barriers to in-person visits such as those with mobility problems, transportation issues, or live far away from the medical professional (Choi et al., 2014; Doarn & Merrell, 2014; du Toit et al., 2019; Kim et al., 2013; Ruskin et al., 2018). It is often a service of convenience when smaller life hassles like car trouble, an inflexible schedule, childcare problems, or bad weather would make an in-person session difficult (Hilty et al., 2013; Johnson, 2017; Neufeld & Case, 2013; Perle & Nierenberg, 2013). Telemental health can be especially helpful when individuals or whole communities have been impacted by a biological hazard; during, or in, the aftermath of a natural or man-made disaster; acts of terrorism or community violence and unrest; in times of war; or when a person has a communicable disease that makes

in-person visits dangerous (Doarn & Merrell, 2014; du Toit et al., 2019; McCarty & Clancy, 2002; Renzulli, 2019).

Research shows that telemental health care is an effective way to provide services when in-person visits are not possible or appropriate and report high levels of client satisfaction (Daker-White & Rogers, 2013; El-Miedany, 2017; Torgusen & Kosberg, 2006). Even though clients who chose telemental health report a high level of satisfaction with this type of therapy, the vast majority of mental health care and therapy before the COVID-19 pandemic was performed in person at a physical location (Brooks et al., 2013; Neufeld & Case, 2013; Perle & Nierenberg, 2013; Shore et al., 2018). This is due to a variety of barriers that were difficult for CSWs to overcome.

Barriers to Telemental Health Use

Telemental health is a relative newcomer to the virtual care delivery scene, and it provides mental health care in similar ways as telehealth. Unfortunately, this method of mental health care has not gained as much popularity as its medical counterpart due to a variety of barriers that make it difficult to successfully implement (Brooks et al., 2013; Romney & Baird, 2015; Shore et al., 2018). One barrier is the lack of leadership and direction by professional organizations. The first major efforts to support the use of telemental health were implemented by the American Psychological Association in 2011, followed by the American Psychiatric Association in 2015 (Aboujaoude, 2018), and soon after the profession of social work published a Standards for Technology in Social Work Practice in 2017 (NASW, ASWB, CSWE, & CSWA 2017a). Even with this step forward, the lack of guidance has contributed to confusion among practitioners regarding treatment best practices, insurance coverage and reimbursement,

malpractice protection, documentation, and product vetting (Aboujaoude, 2018; Liem et al., 2020b).

Another barrier to use of telemental health arises from the CSWs perspective. For example, there is often a general sense of unease felt within the social work community regarding the use of telemental health (Brooks et al., 2013; Doran & Lawson, 2021; Lawson et al., 2022). This is due to inadequate training which can cause the CSW to find difficulty in building rapport with clients. Video or phone sessions often prevent access to nonverbal cues that are important during an assessment or in case management (Békés & Doorn, 2020; Benudis et al., 2022; Doran & Lawson, 2021). Examples of cues a CSW might miss during a telemental health visit include a client who is under the influence of drugs or alcohol during a session, physical evidence of abuse, neglect, or poor hygiene.

A significant problem that prevents access to telemental health is limited or no technological skills of the client or the clinician, and limited or no access to HIPPA compliant security, or video-conferencing platforms (Aboujaoude et al., 2015; Brooks et al., 2013; Kim et al., 2013; Romney & Baird, 2015). Additionally, many insurance companies, such as Medicare and the U.S. Department of Veteran Affairs (Doran & Lawson, 2021), require CSWs to be trained specifically in telemental health by their licensing bodies before they will approve reimbursement for clinical services. Many states have local licensing boards that also require approval or specific training before allowing CSWs to provide telemental health. To do so without this approval can be seen as unethical, which could cause a clinician's license to be revoked or suspended as a consequence (Liem et al., 2020b; McCarty & Clancy, 2002; Romney & Baird, 2015).

Telemental health is shown to be an effective way to provide mental health care. These barriers have given mental health providers reason to shy away from developing a robust, online counseling practice. The COVID-19 pandemic and work from home mandates forced CSWs to utilize this method in lieu of in-person services.

The following section will discuss COVID-19 as a communal disaster, the concepts of shared reality, compassion fatigue, and burnout. Attention will be given to the use of telemental health in other communal disasters and ways CSWs are impacted by providing care in this type of shared reality.

Communal Disaster

Disasters occur all over the world. Examples include natural disasters such as floods; earthquakes or hurricanes; technological disaster such as a stock market crash; man-made disasters such as mass shootings; terrorist attacks; and health disasters like the AIDS crisis and the COVID-19 pandemic. Disasters typically occur to a specific population in a localized geographical area (Breslau, 2000; Day et al., 2017; Hamid et al., 2020; Norris et al., 2002). Communal disaster is a term used to describe an event or series of events that are characterized by specific metrics which significantly affect both the individual and the greater community. Joshua Miller (2012) outlines what elements must be present for a situation to be categorized as a disaster. One way to measure is to evaluate the footprint of the disaster. It would include loss of life and destruction of property and induces stress and trauma for anyone who experiences the disaster or the side effects of the disaster. Another element is that a disaster has a start and an end that is easily identifiable, occurs without warning, and has long lasting side effects for those affected. A disaster typically affects a large quantity of people, and more than one family or

family unit in a public arena (Miller, 2012). A unique aspect of a disaster is the unusual nature of the situation making it out of the ordinary of everyday life. This can be subjective based on culture, geographical location, beliefs and spiritual practices, local values, and morals (Baum, 2010; Miller, 2012).

There is value in isolating a definition of a communal disaster because a catastrophic event or emergency could in some ways merge into what some might define as a disaster (Miller, 2012). The nature of a disaster seems to need an individual suffering within a public context of loss. For example, while the loss of a family member or an individual home burning down is a disaster for the family, this does not affect a large enough number of people in the community to be classified as a disaster (Baum, 2010; Miller, 2012; Richardson & Maninger, 2016). Because a communal disaster is outside the ordinary realm of daily experience, those involved in it socially construct the way it is seen and experienced. "It is socially constructed as an event outside of ordinary experience that overwhelms a group's individual and collective coping capacities, destabilizing and disrupting everyday life and normal functioning" (Miller, 2012, p. 7). This definition best fits what has happened to our world resulting from the outbreak of COVID-19. What made this communal disaster unique was its global nature that affected all communities in the world. While some communities were more successful than others in mitigating the spread of the virus, the public and private effects continue to play out around the world.

Telemental Health in a Communal Disaster

Telemental health has been used in the past by CSWs and mental health providers to deliver mental health care when a disaster or crisis occurs, and those affected by it are unable to access in-person care. Following 9/11, Hurricanes Katrina, Rita, and Sandy, mental health

problems were a significant side effect of these disasters (Campbell, 2007; Hoagwood et al., 2007; Nesbeda, 2014; Ruskin et al., 2018). Traditional, in-person therapy sessions were not possible due to the displacement of the population and destruction of buildings and physical space (Ruskin et al., 2018; Weisler et al., 2006). Efforts were put in place to provide virtual mental health support and counseling for those impacted by the disaster, but even so, telemental health was not a widely used medium. Potential clients who had been displaced did not always have access to a stable internet connection, or any internet at all, did not have a confidential location for a session, might not have had a computer or phone to use for a session, or had left the area or state due to the magnitude of destruction to the area they lived in (Fried et al., 2005; Lowe et al., 2016; Norris & Bellamy, 2009; Wang et al., 2008; Weisler et al., 2006).

Typically, this type of mental health care is relatively short term and ends when the disaster or crisis has resolved. Once the community's infrastructure is stabilized, the individuals and communities impacted find a way back to normal life as quickly as possible (Fried et al., 2005; Norris et al., 2009). As a result, those who were receiving telemental health services will terminate care, return to in-person sessions, or have re-located to another geographical location resulting from the situation (Jack & Glied, 2002; Norris et al., 2009). Those touched by a disaster attempt to move forward in their lives, but often suffer from the emotional and psychological impact that can lead to PTSD, anxiety, depression, increased substance abuse, and other mental health difficulties. Due the continued mental health needs following a disaster, in-person mental health service often resume and continue without the use of telemental health (Jack & Glied, 2002; Jang & LaMendola, 2007; Lev-Wiesel et al., 2009; Norris et al., 2002; Weisler et al., 2006).

The use of on-line or virtual therapy is useful and effective for use during a crisis or communal disaster (du Toit et al., 2019; Shorey et al., 2002; Steffas, 2010). Overall, clients report a positive experience of telemental health (Benudis et al., 2022; Shore et al., 2014). Much of this research has been done with populations that have chosen this type of therapy rather than individuals forced to use it due to extenuating circumstances. Additionally, most of the studies have small sample sizes which make the results difficult to generalize to a larger population (Jenkins-Guarnieri et al., 2015).

Since COVID-19, more research has been published which investigates the effectiveness of telemental health, and the response to its use by both client and CSW. Overall, the experience of the CSW who provides the telemental health is less favorable than the client who receives it, although there is a percentage of CSWs who reported a preference for telemental health over in-person sessions (Benudis et al., 2022; Doran & Lawson, 2021; Lawson et al., 2022; Senreich et al., 2021). One aspect not widely studied is how the forced switch to telemental health, in a long term, shared communal disaster, impacted the professional and personal life of the CSW. We know that in a communal disaster, the level of trauma the CSW is exposed to goes up (Adams et al., 2006; Hsieh et al., 2020; McTighe & Tosone, 2015; Tosone et al., 2012). During the COVID-19 pandemic, CSWs endured month after month of telemental health care for clients who brought forth challenging mental health, medical, occupation, and personal issues. The experience of providing telemental health care to their clients, while facing the same types of issues of their clients, put CSWs in a unique psychological position. One which is known as a shared reality.

Shared Reality

The concept of shared reality specifically refers to the practitioner having the same effect or experience of trauma that their clients are presenting (Baum, 2010; Richardson & Maninger, 2016; Tosone et al., 2012). It is unique in that the professional provides care to clients who are experiencing effects from a shared situation in conjunction with the layer of a direct effect in their personal life (Freedman & Mashiach, 2018; Kretsch et al., 1997; Tosone et al., 2012). Some examples of a shared reality include natural disasters such as a flood, fire, or tornado; violence such as a school shooting or acts of war; and medical trauma such as SARS, the AIDS crisis, and most currently, COVID-19.

One of the more widely studied events of shared reality is when on 9/11 terrorists flew two planes into the twin towers in New York City. Research on CSWs in New York who experienced the trauma of seeing the twin towers fall, losing loving ones in the disaster, or living in New York City, created a unique juxtaposition of trying to understand their own trauma in tandem with the clients they cared for (Goin, 2002; Jack & Glied, 2002; McTighe & Tosone, 2015; Nesbeda, 2014; Seeley, 2008). It is estimated that over 409,000 people were directly affected by the 9/11 terrorist attacks. Over three-fourths of this population did not actually witness the event or lose a loved one, but they were exposed to several physical and psychological hazards at different levels of intensity and duration in their homes and workplaces. This exposure continued on for many weeks and months after the actual event (Welch et al., 2016). Shared reality has also been noted and documented with therapists in war zones or in areas where there is high conflict and terrorist attacks (Day et al., 2017; Freedman & Mashiach, 2018; Lev-Wiesel et al., 2009; Shamai & Ron, 2009).

Research shows that, unless appropriate mitigating interventions are available, CSWs who provide mental health care during a shared, communal disaster such as the COVID-19 pandemic are more likely to suffer from more complicated problems such as compassion fatigue and burnout (Adams et al., 2006; Goh et al., 2022; Tosone et al., 2011). Shared reality can elevate mental health problems for the CSW such as depression, anxiety, PTSD, compassion fatigue, and burnout (Baum, 2010; Hamid et al., 2020; Kretsch et al., 1997; Whitebird et al., 2013).

Research published since the start of the pandemic points to increases in mental health problems in the general population, and a greater prevalence in health care and mental health care workers (Duden et al., 2022; Ross et al., 2021; Sklar et al., 2021). The literature on shared experiences is limited because the case examples of 9/11 or Hurricane Katrina were confined to a relatively small set of social workers and clients. Because the COVID-19 pandemic was a global phenomenon every social worker shared the experience with their clients. As such, there is scant research which studies the experience of the CSW in the shared reality of the COVID-19 pandemic, who provided care to clients through telemental health, and the impact this has had on them in their professional life and personal life.

Compassion Fatigue

Compassion fatigue is a term used to understand the emotional experience and behavioral responses of individuals who provide care for others who have suffered some type of trauma. It can be defined “as the experience of posttraumatic stress symptoms in trauma counselors as a result of listening to the trauma material of clients or exposure to a client or a loved one’s trauma” (Naturale, 2007, p. 174). Another definition is the “formal caregiver’s reduced capacity

or interest in being empathic" or "bearing the suffering of clients" and involves "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person" (Adams et al., 2008, p. 239). Within this context, compassion fatigue is often correlated to the clinical setting or among first responders to traumatic events (Kapoulitsas & Corcoran, 2015). When discussing compassion fatigue, it is often understood as the 'cost of caring' (Kapoulitsas & Corcoran, 2015, p. 88) and alludes to the immediate, but often accumulated stress and emotional wear and tear over a period of time. Even though it is deeply rewarding, CSWs who provide direct, clinical care find it a stressful profession due to the secondary mental health consequence that arises due to the significant issues a client presents (Adams et al., 2008; Baum, 2012; Quinn et al., 2019).

Providing care for traumatized individuals can be stressful due to the intensity of what a client is sharing, and the accumulation of emotional weight. Some common symptoms of compassion fatigue can include apathy, feelings of powerless, anger, guilt, depression, and a preoccupation with trauma (Cocker & Joss, 2016; Ratzon et al., 2022; Whitebird et al., 2013). Behavioral impacts can be seen through increased moodiness, withdrawing from social situations or relationships, and increased anxiety (Adams et al., 2008; Kapoulitsas & Corcoran, 2015). Some notable ways to mitigate compassion fatigue include supportive and empowering professional relationships with colleagues or a supervisor, spending time with friends or family, physical activity such as a sport or going to the gym and having a strong sense of resilience (Kapoulitsas & Corcoran, 2015).

S*econdary Traumatic Stress and Vicarious Trauma*

As outlined above, professionals that provide mental health care during a crisis or disaster, such as clinical social workers, are not immune to the emotional, mental, relational, or physical stress that emerge in their professional and personal lives due to repeated exposure of trauma stories (Adams et al., 2006; Javed et al., 2020; Miller, 2012; Tosone et al., 2012). In addition to compassion fatigue, secondary traumatic stress and vicarious trauma are professional hazards.

Secondary traumatic stress and vicarious trauma are terms often used interchangeably in the literature and show up as an emotional and cognitive consequence for many CSWs (Adams et al., 2008; Gil & Weinberg, 2015; Kapoulitsas & Corcoran, 2015; Waegemakers Schiff & Lane, 2019). Charles R. Figley first coined the term *secondary traumatic stress*. This refers to the toll caretaking has on mental health providers and defined it as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (Bride, 2007, p. 63). In the same article, Bride (2007) defines vicarious trauma as "the transformation in cognitive schemas and belief systems resulting from empathic engagement with clients' traumatic experiences" (p.155). This state disrupts the mental health worker's sense of meaning, connection, and identity in their world. In this section, secondary traumatic stress and vicarious trauma will be talked about together and referred to as secondary traumatic stress.

There are many different types of situations that make a CSW vulnerable to the phenomenon of secondary traumatic stress. They are expected to provide care and support for

clients who have experienced many forms of abuse, neglect, torture, grief, and trauma (Naturale, 2007; Pulido, 2007; Whitebird et al., 2013). When they extend emotional support and empathy to their clients, they can incorporate the traumatized person's feelings as their own experience. A negative reaction occurs as they bond with the trauma survivor and endure the repeated, indirect exposure to the details of the trauma story (Gil & Weinberg, 2015; Waegemakers Schiff & Lane, 2019). In the face of this, CSWs report symptoms similar to PTSD such as "feeling emotionally numb; reliving their clients trauma experiences outside of work; developing panic-like symptoms when thinking about their clients; nightmares about their clients' trauma experiences; and higher irritability" (Quinn et al., 2019, p. 505). PTSD type symptoms are shown to be the hallmark symptom for secondary traumatic stress. It can cause unwanted and intrusive re-experiencing of the traumatic themes of their clients, an avoidance of trauma triggers and emotions, sleep disturbances, anxiety, and panic attacks, and increased emotional arousal. These symptoms can interfere with the CSWs ability to be effective at work, in personal relationships and with their overall sense of well-being (Badger et al., 2008; Cieslak et al., 2013; Whitebird et al., 2013). Mitigating factors include high job satisfaction, support from peers and supervisors, strong social supports, a sense of mastery in their lives, good internal copings skills, and higher levels of resiliency (Gil & Weinberg, 2015; Quinn et al., 2019; Shoji et al., 2014; Waegemakers Schiff & Lane, 2019).

The COVID-19 pandemic was traumatic for many Americans (Ross et al., 2021; Wiener et al., 2021). Past our shores, its reach impacted every single human around the world. It is difficult to underscore how dramatic and inclusive this experience was for everyone, including CSWs regardless of whether or not they transitioned to telemental health. The CSWs who

provided telemental health care or in-person services for their clients were regularly exposed to repeated stories of loss, fear, and trauma (Banerjee et al., 2020; Ratzon et al., 2022; Talarowska et al., 2020). There is some recent evidence that secondary traumatic stress was reported by CSWs resulting from the amplified mental health issues from clients and the lack of effective mitigating factors. One study reported that during the pandemic, 26.1% of CSWs met the clinical criteria for PSTD and 49.59% reported secondary trauma symptoms. These were social workers who primarily self-identified as essential workers and worked over 40 hours per week, so it is not likely they were CSWs in private practice (Holmes et al., 2021). Another study on Israeli social workers reported 26.7% expressed secondary trauma symptoms due to exposure to the stressors of COVID-19 (Ratzon et al., 2022). To date, this writer has not found any literature that directly links secondary traumatic stress with CSWs in private practice who provided telemental health care from home during the pandemic.

Burnout

For CSWs who provide mental health services in a shared, communal disaster, and in the face of untreated compassion fatigue, job burnout is very possible (Peinado & Anderson, 2020; Waegemakers Schiff & Lane, 2019; Whitebird et al., 2013). This is defined as the psychological response to long-term exposure of highly emotional, overly demanding, interpersonal work situations without adequate social supports (Acker, 2012; Peinado & Anderson, 2020). Work environments that are not perceived as supportive, are unstable or financially at risk, and have high job turn over contribute to the risk of burnout (Acker, 2012; Scarnera et al., 2009). It is characterized by "emotional exhaustion, depersonalization, and reduced personal accomplishment" (Adams et al., 2008, p. 240). Burnout is associated with higher levels of

mental and physical ailments, increased absenteeism, a lower quality of work, and job dissatisfaction (Acker, 2012; Dreison et al., 2018). Reports of PTSD are higher in CSWs who experience burnout (Dreison et al., 2018; Waegemakers Schiff & Lane, 2019).

Mitigation factors to protect from burnout include adequate social support, a sense of accomplishment and satisfaction with the job, professional support from colleagues or a supervisor, adequate coping skills, and psychological strengths such as resilience, a strong self-esteem, and a sense of mastery and agency in one's life (Adams et al., 2008; Harker et al., 2016; Schwartzhhoffer, 2009; Waegemakers Schiff & Lane, 2019). Many of the interventions researched are instigated and run by an organization rather than self-directed or implemented (Dreison et al., 2018). Burnout is widespread in the mental health field and between 21-67% of mental health providers report significant suffering from burnout (Dreison et al., 2018; Waegemakers Schiff & Lane, 2019). This results from regular exposure to the intense emotional suffering and traumatic events of their clients' lives.

Emerging research on burnout for CSWs during the COVID-19 pandemic is slow to appear. Burnout is seen as a process rather than an event or response to an event, which may be why there is limited data represented (Peinado & Anderson, 2020b). One recent study of mental health workers found that instances of burnout were higher in job sites where work changes were high and job resources were low (Sklar et al., 2021). A study of social workers in Singapore cited higher reports of depression, anxiety, health problems, and burnout during the pandemic (Goh et al., 2022). A recent systematic review of the psychological distress among health care workers in Asia reported over two-thirds expressed a fear and burnout as a result of COVID-19 (Ching et al., 2021). This report focused on health care workers only and the occupation of

social work was not mentioned. There was a percent of "allied related health care workers" included in this study, but it is unknown if this represents mental health workers.

The efforts to reduce or prevent job burnout include strong social and professional supports, work place security, robust internal and external coping mechanisms, and greater personal resiliency (Ching et al., 2021; Goh et al., 2022; Peinado & Anderson, 2020). One might expect that CSWs who provided telemental health services throughout the state mandated work from home order would be more likely to experience symptoms of burnout. This may be due to factors discussed above such as providing care in a shared reality and the mental health consequences associated with it.

Social Construction Theory

Social construction is a philosophy under the umbrella of post-positivism beliefs. It started gaining momentum in the 1950s and is characterized by questioning, critiques, and alternatives to the assumptions, beliefs, and consequences of the world (Witkin, 2017). As a theory, it offers a framework with which to the understand the nature of how people come to understand themselves and their world through interactions with others and their society or community. The basic foundation is the belief that humans actively construct the world of everyday life and its constituent elements (Patton, 2014; Turner, 2017; Witkin, 2012). This process ascribes meaning and value to the objects and events in their world and is co-created by the influences they are exposed to in relationship with people, society, and, unique to the 21st century, the communities created through technology and social media (Patton, 2014; Shamai, 2003; Turner, 2017). A person's sense of self and the thoughts surrounding that identity emerges from an aggregated weaving of all past life experiences. This could change or be modified based

on new information from their world and thus shift their known sense of reality or identity within that reality.

Social construction asserts that the way to gain knowledge of the world and an understanding of it is through the perceptions and observations an individual makes through communal interchange (Gergen, 1985; Turner, 2017). Reality is discovered through social interactions and humans are active participants in creating this reality. Along with these ideas, there is a general belief that "knowledge is historically, culturally, and socially contingent, social meanings are created through language and 'taken for granted knowledge' is a valid incorporation of defining reality" (Witkin, 2012, p. 19).

A key building block of qualitative research and social construction is the importance of language. It would be difficult to tell the stories of CSWs who provided telemental health services during the pandemic without incorporating their voice (Gergen et al., 2001; Polkinghorne, 2005a). There is an unmined wealth of knowledge to discover as one listens to the experiences and complexities of providing telemental health care during a worldwide pandemic. This fits with phenomenology due to the value placed on the experience of meaning-making between the individual and the world as a way of knowing and understanding reality (Moustakas, 1994; Polkinghorne, 2005a; Turner, 2017). Social constructionism asserts that the use of language and the meaning embedded in words is part of how we come to understand our world (Gergen et al., 2001; Shamai, 2003; Witkin, 2012). This understanding is fluid, open to change, and uniquely influenced by the culture, context, and period of time in history in which a person is situated (Gergen et al., 2001; Patton, 2014). This accumulation of meaning from language

builds on ones' knowledge of the world and helps create a working, internal model with which to understand ways to navigate relationships and interactions with ourselves, others, and the world.

Social construction theory compliments the use of phenomenology as a research method. It affirms the power of shared story, the value of lived experience, and the openness to change constructs of reality based on new information (De Santis, Hopkins, & Majolino, 2012; Hoshmand, 2005; Lincoln & Guba, 1985; Witkin, 2012). The meaning of a situation or phenomenon is neither right nor wrong. It is constructed by the individual and society, using relationships and language as the method of construction and creates the emotional and behavioral response to the reality (Groenewald, 2017; Moustakas, 1994; Peoples, 2020; Shamai, 2003). Social construction is a helpful framework to acknowledge that cultural, personal, social, economic, and community influences would have been a contributing factor to how CSWs understood their experience of the pandemic. It also gives space for their experience to have been influenced by their clients as they walked alongside them therapeutically.

Conclusion

The COVID-19 pandemic ushered in a new way of providing mental health care. The shelter in place orders that many states mandated required CSWs to move in-person care to a virtual platform known as telemental health (Liem et al., 2020a; Sullivan-Tibbs et al., 2022). Within days, clinical practice was moved to the home and a new rhythm for day-to-day life was created. Telemental health is known to be effective, but due to a multitude of barriers previously noted, it was not a wide-spread tool used by the majority of CSWs (Békés & Doorn, 2020; Brooks et al., 2013; Shore et al., 2018). By necessity, these barriers dissolved and telemental health became the preferred way to provide mental health care services (Békés & Doorn, 2020;

Lawson et al., 2022). The communal disaster of the COVID-19 pandemic affected everyone in the United States to varying degrees, but for CSWs incidents of emotional and mental stress rose. Typical mitigating factors were no longer available due to widespread lockdown of schools, businesses, and leisure activities (Banerjee et al., 2020; Salazar de Pablo et al., 2020). Higher levels of compassion fatigue, secondary traumatic stress, and burnout have been noted (Peinado & Anderson, 2020; Salazar de Pablo et al., 2020; Sklar et al., 2021).

This literature review has highlighted many aspects of the COVID-19 pandemic and the different ways it has affected mental health professionals. The use of telemental health including the barriers, its efficacy, and the use of it during COVID-19 has been presented. It has also highlighted the lack of current information on the impact on the professional and personal life of the CSW who switched to provide telemental health during a shared reality of the COVID-19 pandemic. As a CSW who provided telemental health during the COVID-19 pandemic, this gap in literature is an area of interest and will be the focus of this dissertation.

CHAPTER THREE

METHODOLOGY

The purpose of this study was to better understand the lived experience of CSWs who transitioned to provide telemental health services during the national shelter in place order as a response to the global COVID-19 pandemic, and how this impacted them professionally and personally. A qualitative, phenomenological mode of inquiry is best suited as this study explored the unique, lived experiences of a very specific population in relation to a specific concept or construct order (Creswell, 2007; Groenewald, 2017; Padgett, 2008). In this case, what it meant to be a professional caregiver and their personal experience of living through the national shelter in place. This chapter will discuss phenomenology as a philosophy and research method, the description of the methods, the rigor of design, and ways to protect the trustworthiness of the study.

Phenomenology

The origins of phenomenology can be traced to philosophers Immanuel Kant (1724-1804) and Georg Wilhelm Friedrich Hegel (1770-1831); however, the German philosopher Edmund Husserl (1859-1938) is considered to be the father of phenomenology (De Santis et al., 2012; Moustakas, 1994). Husserl believed a person arrives at knowledge through intuition, and that the essence of an experience holds greater value than the empirical knowledge of it. It can only be arrived at from the conscious awareness of one's inner evidence. Or in other words, the perception of reality of a phenomenon is based on the subjective experience a person has of it (Moustakas, 1994). Phenomenology places importance on the "value of returning to the self to

discover the nature and meaning of things as they appear in their essence" (Moustakas, 1994, p. 27). Phenomenology studies the conscious experience one has of an experience, and it is the starting point of all science (Zalta et al., 2011). Phenomenology posits that a phenomenon be described using thick, rich descriptions rather than linked to a causal relation. In a phenomenological research approach, "realities are treated as phenomena, and the objective of this methodological approach is to describe as accurately as possible the phenomenon under investigation, as experienced by the people involved" (Moustakas, 1994, p. 35).

A phenomenological study aims to illuminate the essence of the lived experience of the individual or groups being researched which adds a deeper and more robust understanding of the phenomenon under investigation (Creswell & Poth, 2018; Lincoln & Guba, 1985; Peoples, 2020). Knowledge is derived through the understanding of personal perceptions, thoughts, emotions, and lived experiences. According to Moustakas, "Only what we know from internal perception can be counted on as a basis for scientific knowledge" (Moustakas, 1994, p. 45). Therefore, phenomenology does not limit the researcher's approach to one way of attaining this knowledge. It allows for the voice of the participant to emerge and be heard through the thoughtful and intentional reflection of the researcher, synthesizing the experiences back onto the things themselves (Moustakas, 1994; Peoples, 2020). This approach reinforces the concept that truth is subjective and is known through the experiences of the individual and how they make sense of them.

Since phenomenology allows the researcher to explore a participants' subjective experience deeply, and told from their point of view, it is well suited for this dissertation. Phenomenology posits that the individuals or groups who are experiencing the phenomenon are

experts. Due to that, one would expect that they share certain essences of their experiences and those would emerge through the analysis of a phenomenological study (Groenewald, 2017; Moustakas, 1994; Peoples, 2020). One way to attain this information is through an in-depth interview, which is a common method of data collection for qualitative research. It allowed me to develop a thick description of the feelings and thoughts the CSWs had regarding their experience and the meaning they attributed to it (Padgett, 2008). The narrow scope of the topic limits the likelihood that the results will be transferrable to the general population and supports the small sample size (Groenewald, 2017; Moustakas, 1994; Patton, 2014).

Methods

Sample

This study was designed to understand the experience of a sample of CSWs who transitioned from in-person mental health services to video-based telemental health services due to the COVID-19 pandemic and shelter in place order. Prior to the pandemic, a large percentage of CSWs in private practice had never provided telemental health services for their clients (Békés & Doorn, 2020; Perle, 2022). In my private practice, COVID-19 and the pandemic amplified mental health struggles and I saw an increase in the need for psychotherapy. Conversations with colleagues in other practices echoed my experience. As such, I thought CSWs could offer a unique glimpse into what it was like to switch to telemental health, during a shelter in place order, and how this impacted them personally and professionally. As discussed above, phenomenology captures the essence of the lived experience of individuals under a specific phenomenon and is understood through the stories told from the point of view of those individuals (Creswell & Poth, 2018; Lincoln & Guba, 1985; Peoples, 2020). Therefore the

sample of individuals interviewed for this dissertation must have experienced the same phenomenon under investigation.

Inclusion and Exclusion Criteria

For this study, the inclusion criteria were CSWs who:

- lived and practiced in the state of Illinois during the shelter in place order from March 2020 to August 2020;
- provided in person, clinical therapy services, but switched to telemental health sessions due to the COVID-19 shelter in place order;
- had a master's degree in social work;
- held the highest license required by Illinois to perform private practice clinical therapy services, which is a Licensed Clinical Social Worker (LCSW);
- worked in private practice either as a solo clinician or part of a private practice group.

This criterion was to ensure the lived experience under investigation was as close to the same for each individual as possible (Creswell & Poth, 2018; Padgett, 2008; Polkinghorne, 2005b). There were several reasons for this. Since different states have different regulations for social workers in private practice, it was important that I interviewed CSWs with the same level of education and licensure. This offered a higher likelihood their training and experience were similar. Additionally, not every state enacted a shelter in place order, so staying with CSWs in Illinois ensured they were working from home. And lastly, the experience of a CSW in private practice was a way to ensure that they were performing clinical therapeutic work with clients rather than agency work which can often include case management, working in a hospital or with the court system, and onsite visits to schools or residential facilities.

Exclusions for this research included CSWs who:

- had previously worked from home using telemental health services;
- did not work in private practice during the shelter in place order;
- lived outside the state of Illinois during the shelter in place order;
- did not hold a clinical license in the state of Illinois;
- provided therapy services exclusively in a language other than English.

There were no exclusions based on age, race, sexual or gender identity, marital status, or years in practice as there was no evidence found in the literature that these factors would influence the research results.

In addition to the inclusion criteria outlined above, I also specifically sought out participants for whom those experiences might have varied which included:

- CSWs who had children living at home during the shelter in place order and those who did not;
- male and female CSWs;
- CSWs with varied ethnic identities.

This variation provided a greater possibility that a broad representation of the CSWs experience of providing telemental health from home was presented. To ensure my sample of CSWs met the criteria for this study, I engaged in purposive sampling. This type of sampling is often used with phenomenology and involves the purposeful selection of individuals based on a pre-established criteria that is of core importance to the research topic (Creswell & Poth, 2018; Padgett, 2008; Patton, 2014; Robinson, 2014; Yuksel & Yildirim, 2015). Additionally, snowball sampling was implemented as there was a need to find individuals of color and males since there

were none represented through purposive sampling. This method involved asking individuals who already agreed to be interviewed if they could recommend CSWs who I could contact directly to be interviewed (Creswell, 2007; Padgett, 2008).

Recruitment and Procedures

The CSWs for this study were recruited from a variety of sources based in Illinois. Professional groups, list-servs, peer groups, and personal relationships were used to access potential participants (Fong & Mcroy, 2016; Gill, 2014). I am a member of several list-serve groups on different social media platforms, mental health boards, and on-line professional networking groups which allowed me to post a recruitment flyer offering the opportunity for CSWs to participate in my research (Appendix A). The professional groups I belong to include the Illinois chapter of the National Association of Social Workers (NASW), the Illinois chapter of the International Association of Eating Disorder Professionals (iaedp), the Northshore Networking Group, the National Association of Christian Social Workers (NACSW), the McHenry Area Mental Health Professionals list serv and the Chicago Area Practitioners list serv. I posted my recruitment letter online in these groups and sent out a mass email to the list serve groups I belong to. The posting in the Illinois chapter of NASW was put up twice and produced no responses. I posted in iaedp and NACSW one time and this also produced no responses. I sent my recruitment flyer to the McHenry Area Mental Health Professional list serv, the Chicago Area Practitioners list serv, and the Northshore Networking Group and received 12 responses. Of those 12 only 7 met the inclusion criteria. This is typically sufficient for phenomenological research (Padgett, 2008); however, my sample had no male CSWs or CSWs of color so I sent out another round of emails to the aforementioned list serv groups. I did not receive any more

responses, so using snowball sampling (Creswell, 2007; Groenewald, 2017), I asked the CSWs that had already agreed to be interviewed if they could recommend any male CSWs or CSWs of color to be interviewed. Two participants offered to connect me with potential participants. The two CSWs sent an introductory email to the potential participants with me included on the email. Three individuals indicated an interest in an interview. I then individually emailed an introduction paragraph with my recruitment flyer attached. Each of the three agreed to participate. One of the questions on my demographic survey (Appendix B) asked the CSWs who had lived with them during the shelter in place order. I was able to determine though this method that I had enough individuals with children living at home during the shelter in place time period, and so I did not need to do any further sampling. The final 10 participants consisted of 1 male of color, 1 female of color and 8 white females. Further description of the participants is presented in Chapter Four.

Details of Confidentiality and Protection of Privacy

The consent form (Appendix C) for this study provided participants an explanation of this study, including the voluntary nature of their involvement, assurance of confidentiality of data collected, description of data storage and protection, possible threats to confidentiality, and the option to have access to my research results. Each participant gave permission to have the interview audio recorded through Zoom, have it transcribed, and used for my data analysis. Each participant was assigned a pseudonym to maintain their confidentiality. The transcribed interviews and all electronic data were stored on a password-protected computer that was only accessed by this researcher. Recordings were uploaded from Zoom to my private dropbox application and transcription was done manually by this researcher using the initial transcript that

Zoom provided of each interview. Data will be stored for seven years in a secure location to comply with the expectations set by the Institutional Review Board (IRB) of Loyola University Chicago.

Protection of Human Subjects

Adult CSWs who volunteered to be interviewed for this study do not constitute a vulnerable population. Even so, it is ethical and necessary that each participant be provided with a full explanation of this dissertation and the purpose of the information collected. As such, all the guidelines set forth by the Loyola University Chicago Institutional Review Board (IRB) were followed. Since each interview was conducted via Zoom, IRB approval was given by verbally reading the informed consent form to each participant prior to the interview. The option to have the consent form emailed to them for their records was offered, however no one desired an emailed copy of the consent. Prior to each interview, the participants were verbally informed that the interview details were confidential and that any details that would reveal their identity would be protected or removed in the research. Participants were told they had the option to stop the interview at any time or decline to answer any question if so desired with no negative consequences. No one ended their interview early or declined to answer any of the interview questions.

There was minimal risk to the participants as the nature of the questions did not inherently evoke traumatic experiences. Discussions on the personal and professional impact of telemental health service provision during the COVID-19 pandemic could potentially evoke distressing emotions, unpleasant memories, or other unknown reactions. Due to this possibility, I disclosed to participants that the interview process may cause emotional or psychological distress

and referrals for counseling or supportive services would be provided if needed or desired. At the end of each interview, no participants requested referrals. Each participant was read the potential benefits of this research and the data collected from their experience, but no other financial or beneficial compensation was provided.

Data Collection and Instrumentation

Qualitative research and phenomenology often use personal stories as a method of collecting data and are referred to as in-depth interviews (Groenewald, 2017; Padgett, 2008). In-depth interviews are an effective research tool to gain deep insight into the individual's experience and provide rich detail about who they are and the lives they lived (Creswell, 2007; Moustakas, 1994; Patton, 2014; Saldaña, 2016). Phenomenological research aims to gain a deeper understanding of the meaning of everyday experiences, and as such the questions used in the interview addressed the concept of what it was like for the individual to have lived in and during the phenomenon under investigation.

For this dissertation research, interview questions (Appendix D) were open ended, semi-structured, and probes were used if further understanding was needed (Patton, 2014; Saldaña, 2016). This allowed participants to freely share their thoughts, feelings and experiences without direction or influence from me as the researcher. The interviews were scheduled via email and done through the video platform Zoom. I sent each participant several dates and times that I could do the interviews and requested them to choose a time that best fit their schedule. All 10 interviews were completed over a period of 5 weeks. Prior to each interview, a demographic survey was read to each participant verbally and filled out by this researcher. To ensure ethical research standards were upheld, an informed consent form was read to each participant before

the interview began to receive verbal, informed consent. No second interviews were required, although each participant was asked for, and agreed to, a second interview if clarification or more information was necessary. I also asked each participant if they would be willing to review the data once my analysis was completed to ensure I had accurately captured the stories represented through the interviews. All 10 agreed to help in this way if needed. The interviews were an average of 50 minutes, the shortest one being 35 minutes and the longest one being 60 minutes. They were audio and video recorded using the Zoom recording functionality. Zoom also provides a transcript of each interview which was used for the beginning transcription process. In line with Transcendental Phenomenology, bracketing was done throughout and following each interview and during each time I listened to the interviews during transcription (Moustakas, 1994). This allowed me to document my thoughts, feelings, reactions, and biases that emerged while I listened to each participant's story. Once each interview was completed, the transcript and audio and video data were downloaded into dropbox, which is password protected, and saved to the cloud to ensure I would not lose the data. I then spent prolonged time listening to and reading through each transcription to produce a verbatim transcript which was used for data analysis.

Data Analysis

The intention for this study was to illuminate the essence of a phenomenon in its entirety without the influence or manipulation of the researcher's personal bias (Creswell, John W. & Poth, 2018; Moustakas, 1994). To do this and stay true to the process, the approach I used was Transcendental Phenomenology. This specific method of organizing and analyzing the data is Moustakas's modification of the Stevick-Colaizzi-Keen method (Moustakas, 1994). I chose this

specific modification of Transcendental Phenomenology for data analysis because it begins with the premise that the researcher has a personal connection to the topic at hand. Analysis began with my own documentation and analysis of my experiences. The objective is to protect the trustworthiness of the analysis by documenting and then setting aside the way the researcher understood their way of living though the specific phenomenon they chose to study. I am a CSW and transitioned to telemental health due to the COVID-19 pandemic and shelter in place order in March 2020. Due to my personal experience, it was important to ensure my biases, perceptions, and experiences of this phenomenon had limited power to influence the results of the research. Transcendental Phenomenological analysis is done through the use of Epoche, Phenomenological Reduction, Imaginative Variation and Synthesis. These four steps, and the journey of my analysis, will be described in detail in the following section. Table 1 gives an overview of what steps occur in each stage of the analysis process.

Table 1. Analytic Overview

Epoche	***Phenomenological Reduction***	***Imaginative Variation***	***Synthesis***
a) As I interact with the data, I journal or bracket my thoughts, biases, or assumptions to protect the trustworthiness of the analysis.	a) Using the verbatim text from each interview, consider all statements that have significance to the experiences that is being researched.	a) Reflect upon each textural description that has been developed, and using my imagination, intuition, and knowledge of the date, create a structural description for each interview.	a) From the individual textural/structural descriptions from each interview, construct a composite description of the essences and meanings of the experience to provide a universal narrative that represents the group as a whole.
b) This begins as I obtain a full description of my	b) Record all relevant statements.	c) With the use of my imagination, intuition, and the data	

own experience of the transition to telemental health and how it impacted me professionally and personally. This is done by interviewing myself		from the textural and structural descriptions, create a composite textural/structural description of the meanings and essences of the experience for each CSW I interviewed.	
c) Once this is finished, I apply Phenomenological Reduction, Imaginative Variation, and Synthesis to my verbatim text from the interview.	c) List each novel statement. These are the horizons or meaning units of the experience.		
	d) Connect and cluster the units of meaning into relevant themes.		
	e) Synthesize the meaning units and themes into the textures of the experience using verbatim examples from the interviews.		

Epoche

Epoche is a Greek word which means to stay away from or abstain. In the Epoche, the researcher strives to set aside any prejudgments or preconceived ideas about the phenomenon under study. It is designed to minimize the risk of my experience becoming an influence on the way I interpreted the stories of the individuals I interviewed (Moustakas, 1994). This is done with the intentional use of the Epoche, also called bracketing or journaling. Bracketing is a core concept of phenomenology and is used throughout data collection and analysis. The goal is to

note a bias or thought and then suspend (or bracket) it and look at it from multiple perspectives. This process allowed me to examine my thoughts, beliefs, and assumptions as I interacted with the data to reduce the influence my experience would have on the analysis (Creswell & Poth, 2018; Groenewald, 2017; Morrow, 2005; Peoples, 2020).

The Epoche began as I documented my experience as a CSW who switched to telemental health during the shelter in place order from March 2020 to August 2020. Before I started any of my interviews, I went through each of my interview questions and answered them based on what it was like for me to switch to telemental health and the ways I was personally and professionally impacted. I bracketed, or journaled, throughout the process to document my personal biases and experiences so I could set them aside and separate from the experience of the other CSWs that I interviewed (Creswell & Poth, 2018; Moustakas, 1994; Yuksel & Yildirim, 2015).

Once this process was completed, I was able to begin my interviews. Each time I interviewed a CSW, I journaled thoughts and reactions during and immediately after the interview. I noticed that the more interviews I did, the less my personal thoughts or biases were coming to mind. Even though each interviewee was different, I quickly noticed that many of the ways I experienced the phenomenon under investigation was not universal to the CSWs in my research. This ended up being very helpful for me because I found myself more fully present and attentive during the interviews rather than monitoring my thoughts or worrying about writing them down. I was able to journal less during the interview and did most of it reflectively at the completion of each one.

I used Epoche during phenomenological reduction, imaginative variation, and synthesis. Every time I listened to an interview, read through a transcription, my notes, or previous journal

entries, I strove to set aside my personal thoughts or beliefs so the voices of the CSWs could emerge. There were times I needed to engage in journaling to keep my thoughts set aside, and other times I reviewed what I had previously journaled to ensure my interpretation of the data continued to be free from bias.

Phenomenological Reduction

The next step of my analysis was Phenomenological Reduction which "takes on the character of graded pre-reflection, reflection, and reduction, with concentrated work aimed at explicating the essential nature of the phenomenon" (Moustakas, 1994, p. 91). It began with bracketing as I read through each interview and bracketed, or set aside, everything except the research topic being studied. Next, I engaged in horizonalizing which removes overlapping, irrelevant, or repetitive statements with the objective of reducing the data into clusters or units of meaning. Each cluster is then reduced further into themes which represent the overall experience. The final step was to transform the data gathered through this process into textural descriptions of each participant's experience. A textural description is an account of *what* the actual experience was like for the CSWs to transition to telemental health and work from home during the shelter in place order. These steps are described in detail below.

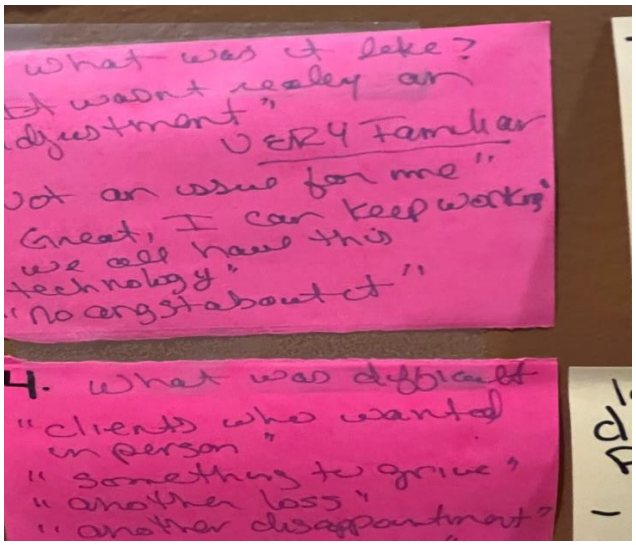
Bracketing involved reading and listening to the transcriptions several times, journaling every time I did so, to become familiar with the content, meaning, and significance of the data. The continual journaling helped me suspend my beliefs and biases about the data to focus on and find meaning of the participants' experiences. Then, I did this process again. Read the transcriptions, listened to the audio recordings, noted my perceptions, and wrote down what I was learning about the experience of each CSW (Creswell & Poth, 2018; Groenewald, 2017;

Moustakas, 1994). I then printed out each interview transcript and highlighted what I thought were significant statements as I read them. I went through this process multiple times to make sure I captured all the statements that held significance to the research. This allowed me to reduce the data to its essence and is part of process known as horizonalization (Moustakas, 1994, p. 95). The concept horizonalization is that every time I go back into the data, I use self-reflection, insight, and self-awareness to pay attention to what emerges when I am exploring the phenomenon. I go back into the data, read through it, listen to it, and pay attention to what new thoughts and perceptions would arise. Each reflection modified my conscious knowing of the data and what it meant in context of the phenomenon being studied.

Horizonalization was accomplished by creating a visual, handwritten open coding process. This stage of analysis required that the statements I pulled out were not repetitive or overlapping with similar thoughts so that each one listed represented a specific experience to be investigated (Creswell & Poth, 2018; Moustakas, 1994). First, I created a document that listed the names of each CSW with a randomly chosen correlating pseudonym next to it. Then for each CSW represented, I gathered the printed out, highlighted transcription of the interview, my handwritten journal notes, the demographic survey, and the interview guide (which also had handwritten notes on it) and labeled each document with the correlating pseudonym. I chose 10 different colors of paper and assigned a different color for each CSW. Each piece of paper was also labeled with the pseudonym. I numbered each piece of paper to correlate with the interview question number and began transferring significant statements I had highlighted from each question onto the colored paper. Figure 1 is an example of this. I did this for every interview. After this process was done for every interview, I went back and re-read all my journal notes and

looked through each transcription to ensure I had transferred all significant statements to each piece of paper.

Figure 1. Example of Horizonalizing



Then I went back one more time and reduced the statements to a handful of words or one sentence to further compress the statements into its most pure form. This process left me with only horizons, or the textural meanings of the phenomenon. These were handwritten on the colored paper and taped up on a wall so I could have a visual representation of all the data in front of me at once. Some questions had many significant statements while others had only two or three. Once this was completed, I began to group the significant statements into more cohesive units, or themes. Some of the themes were easy to see since they repeated in almost every interview with virtually the same verbiage. An example of this was from the last question in the interview. The CSWs were asked "As we end the interview, I would love to know if there is any advice you would give to your pre-pandemic self after living and working through the work from home order?" Six out of the ten CSWs responded with a version of "don't worry, everything is going to be ok" or "we are going to get through this, everything will be ok." Some

themes were more difficult to discern and required additional time thinking and reflecting about what each CSW was experiencing and describing. An example of this was the emerging theme of professional insecurity. Almost every CSW indicated somewhere through the interview that they had doubts about their ability to do telemental health effectively. There were voiced concerns about efficacy, worries about how their therapeutic skills would translate over a screen, and fears about doing it "wrong" or "messing it up" somehow. Since this theme was not a direct answer to one question, I had to continue to go back into the transcript to find where this type of statement showed up and the context in which the CSW was intending it be understood in.

As themes started emerging, I wrote them on yellow sticky notes and taped them to the correlating statements that were already taped up on the wall. If I noticed a theme represented in more than one of the interview questions (on more than one piece of paper), I would go back into the description to ascertain if I was seeing a new theme or a previous one that was popping up several times. An example of this is seen in Figure 2 and 3. This visual process was very helpful for taking in all the information at once to compare the data I was creating.

I started with over 15 different themes. A list of my initial themes can be found in Appendix E. I spent hours sitting in front of my colored papers, looking at the statements, thinking about the themes I had written up, and going back into the transcripts to make sure I was representing the voices of the CSWs accurately. Six themes and eleven subthemes began to emerge from this process.

Figure 2. Example of Theme Development

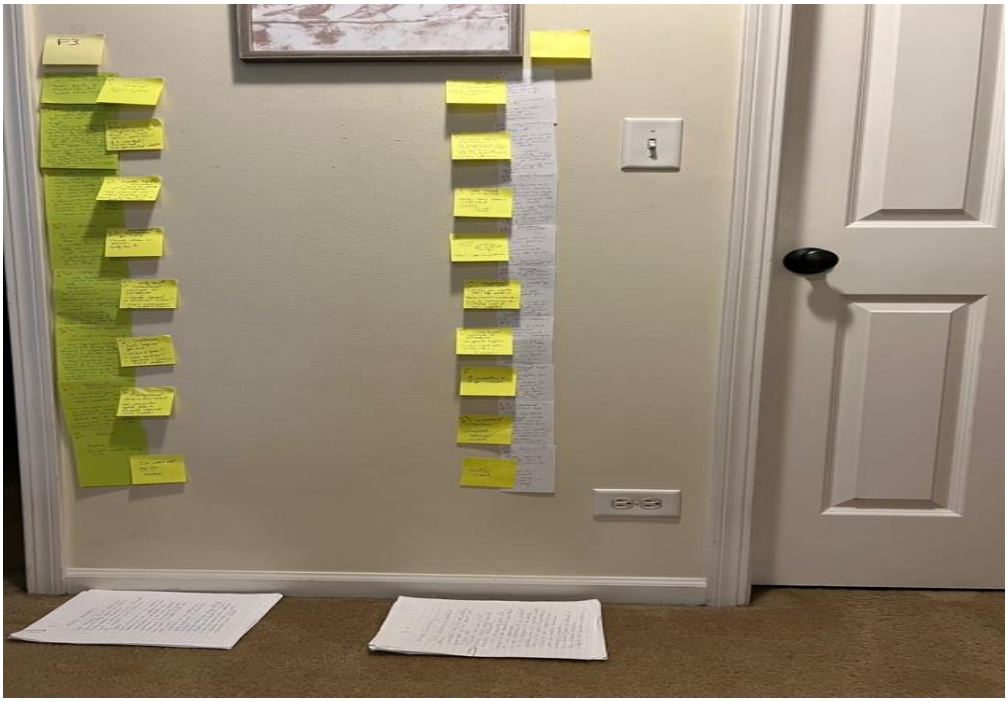
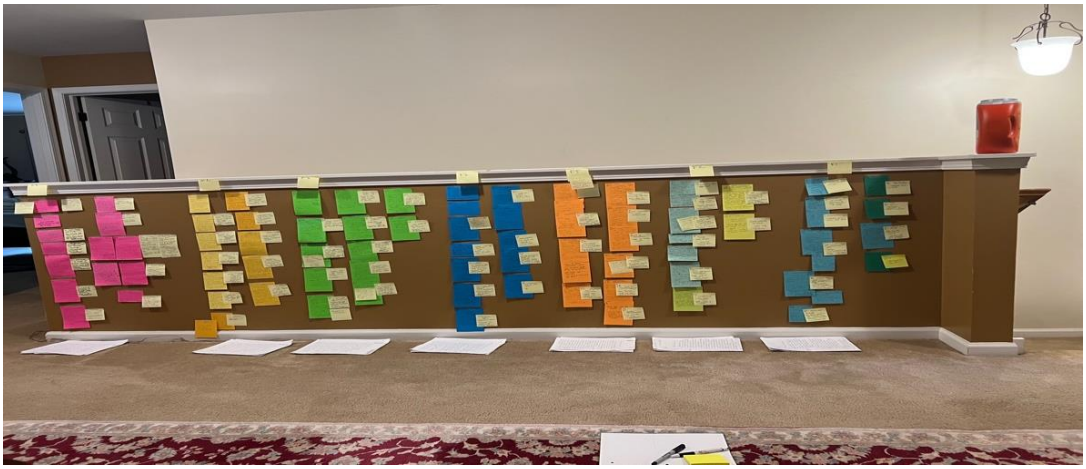


Figure 3. Example of Theme Development



The themes are: (1) the transition to telemental health, (2) professional insecurity, (3) working from home works, (4) the shared reality is harder, (5) self-care is a priority, (6) it is going to be ok. The subthemes are (a) challenges, (b) guidance on best practices for telemental health, (c) insurance reimbursement, (d) protection from COVID-19, (e) more free time in the

day, (f) flexible work schedule, (g) telemental health is preferred for some clients, (h) fear of the unknown, (i) amplified mental health problem, (j) empathetic connections and disconnections, (k) connections.

The final step of phenomenological reduction is to use the data from bracketing, horizonalizing, and theme development to create the textural descriptions. A textural description provides a thick, rich description of *what* the CSWs experience was when switching to telemental health. It is my attempt as the researcher to develop a narrative of the individual's actual experience and make meaning of it.

The creation of the textual descriptions was done one interview at a time. I went back into each transcript, reviewed the highlighted quotes, re-read the journal notes that were attached to it, and re-read the notes on the interview sheet and the open coding pages I had created for each one. I pulled out verbatim examples from each CSW to highlight, in their own words, what the experience of providing telemental health was like for them and how this experience impacted them. This process took an extensive amount of time. I wanted to make sure that the statements I pulled out were framed in the appropriate context and accurately depicted the actions, thoughts, and feelings the CSWs shared during the interview. While I was writing up the textural descriptions, I modified two of the themes. Initially I pulled out the themes "Self-Care is a Priority" and "A Better Work/Life Balance." As I wrote up the textural descriptions it became clear that these two ideas were nestled together too closely to be separated. Every time I went back into the transcripts to pull out examples for the "better work/life balance" theme, it was always talked about through the lens of self-care. Considering this, I eliminated the

previous theme and included it in examples of what the CSWs did for self-care during the shelter in place order. The full textural descriptions of all ten CSWs can be found in Appendix F.

Imaginative Variation

Once the text had been reduced and essential themes were identified, Imaginative Variation was next. This process developed the structural description. Unlike the textural description that describes *what* the experience was like, a structural description is a narrative to help understand *how* participants experience a phenomenon by making clear what the underlying structures were that influenced the way they remember experiencing it. It is a thick, rich description of the underlying components of the experience that account for the feelings and thoughts each participant had (Moustakas, 1994). Imaginative Variation has a touch of creativity embedded in the analysis process. Moustakas describes it as a reflective state in which to look at all possibilities. "Free imaginative fancy is coupled with reflective explication giving body, detail, and descriptive fullness to the search for the essences" (Moustakas, 1994, p. 99). The researcher is called to apply the use of intuition and imagination to determine what universal structures are present in each interview.

This step of analysis began with a systematic exploration of all the possible structural meanings that were found in the textural descriptions and noting any underlying themes or contexts that emerged (Moustakas, 1994). It was achieved by prolonged time reading and re-reading my interviews, my journal notes, and the textural descriptions. I had many conversations with my dissertation chair, Dr. Singer, to help process and talk through different ideas and possibilities. I journaled several thoughts and spent hours reading and re-reading the interview texts and my previous journal notes. I used my intuition, imagination, and the data to discern

how the participants felt, thought about, and understood their experience of working from home during the shelter in place order and the move to all virtual sessions. Below is an example of one of my journal entries which included an iterative process to reduce different ideas of how the CSW's understood their experience and what the underlying structures might be. This helped me condense the concepts into more defined themes or ideas with which to write up the structural descriptions.:

Journal Entry

They perceived it as **challenging**, and the CSWs communicated this by their insecurity in their ability to do telemental health, indicating their lack of training, education, and guidance on how to do it effectively. It was seen through the structure of relationship with themselves as a professional.

They perceived it as **rewarding**, and the feeling that supported that was a sense of gratitude that they could still be working, and still be present and helpful for clients. This was seen through the structure of relationship with others (their clients) and themselves (a positive feeling that they were working and helping).

They perceived it as **growth as a professional**, and the feelings or thoughts that support that include their own perception and reflection that they grew in their skill set and abilities. The underlying structures that support this seem to be their relationship with themselves. Even though this reflects a connection to their relationship with others (clients), it is better understood through how THEY see themselves and the growth they have experienced.

They perceived their experience as **being part of a bigger picture** in their awareness of what the world was going through and the common human experience of the pandemic. This

structure would be seen through the framework of their relationship with others (the macro view of the rest of the world).

They perceived it as **uncertain or fearful**, and this was understood through a fear of getting sick or dying, the unknown of the future and what COVID-19 would do to our country and our world, and many other fears of what the pandemic would bring about. The structures underneath that was relationship to self (what will happen to me?) and to others (clients, the rest of the world, friends, and family).

After several rounds of this type of journaling and imagining, I synthesized some common experiences that were significant to how the participants understood their experience. These can be labeled as: fearful, challenging, professional growth and personal growth. These are evidenced by many quotes from the CSWs I interviewed, the deep immersion I had in the data, the journaling I engaged in, and the use of my intuition and imagination of the essence of each person's experience.

In Imaginative Variation an important step is to make clear what the universal structures were that framed and informed how the CSWs understood their experience. Universal structures are defined as "the structure of time, space, bodily concerns, materiality, causality, relation to self or relation to others" (Moustakas, 1994. p. 99). Upon much reflection and significant time in the data, the structure of relation to self and relation to others was the most appropriate structure to help understand the way they felt, thought, and experienced telemental health use and the shelter in place during the pandemic. All ten of the CSWs talked about their understanding of the experience from the perspective of how it felt to them and what they thought about themselves, how they understood who they were in relation to their clients, their children and

partners, and how it felt in relation to the rest of the world. The full structural descriptions of all ten CSWs can be found in Appendix G.

Synthesis

The final step in Transcendental Phenomenological analysis was to synthesize the themes, the textural descriptions, and the structural descriptions to arrive at a composite statement that describes the essence of the experience as a whole. This is a reflective process that required me to push the limits of my imagination and intuition as I studied the data and the previous analysis I had already completed. The Covid-19 pandemic presented the CSWs in this research, and all around the world, with a unique experience that has never before happened and may never happen again. I was responsible to create a narrative which provided a deep, rich, vivid description of the experience ten CSWs had when they were forced to work from home and change from in-person services to all virtual services. The synthesis is not a final statement about the phenomenon; rather, a snapshot of the data the represents an unprecedented experience at a particular moment in time (Creswell & Poth, 2018; Moustakas, 1994).

To begin, I created a composite textural/structural description for all ten CSWs. I incorporated the details of *what* was experienced and *how* it was understood through the structure of relationship with self and with others. I started by re-reading the textural description of each CSW and captured the highlights or main points that best described what it was like for them. I did the same process with all ten of the structural descriptions. The end result are ten rich narratives that offer a guided tour for the reader to deeply understand what and how each CSW experienced during the COVID19 pandemic, the shelter in place order, and the dramatic switch from in person to all virtual sessions. These can be found in Chapter Four.

To finish the synthesizing phase of analysis, a single composite of all ten textural/structural descriptions was created. The objective was to provide a unified narrative describing the essences of the experience of the phenomenon as a whole (Moustakas, 1994). I found this to be a rather enjoyable experience. I had so much connection to the data that it felt as though some final puzzle pieces were being put in place. As I wrote, I reflected on each person I interviewed, the emotions they brought and the stories they entrusted me with. It took several attempts to complete the full composite because I wanted to ensure every important detail and experience was represented and expressed. I felt very honored to provide a platform for their voices to be heard. The full synthesis of textural/structural descriptions and the final, completed composite can be found in Chapter Four.

Support for Rigor of Design

Qualitative research studies how an individual or group experiences the world and attempts to "capture unique elements of experiences, and the lives, thoughts, and feelings of the individuals being explored" (Peck & Mummery, 2018, p. 27). The qualitative researcher walks side by side with the individuals (or experiences) they study and holds serious responsibility to represent those individuals with respect, honesty, and truth. Pure objectivity is unattainable since humans (both researcher and subjects) will respond to and interact with each other in ways that might influence subjects' responses or the researchers interpretation of the data (Krefting, 1991; Lincoln & Guba, 1985; Padgett, 2008). As a result, data collection, data interpretation and analysis are vulnerable to threats of trustworthiness. Trustworthiness can be described as the level of trust given to the investigator's findings and the confidence that the findings are accurate. The elements that define research as trustworthy are: truth value; applicability;

consistency; and neutrality (Krefting, 1991; Lincoln & Guba, 1985). Truth value refers to how confident the researcher is in the truth of the findings within the scope and context of the study. Applicability is the ability to transfer findings from the study to a larger group or population or in similar contexts. The third component of trustworthiness is consistency which looks at how predictable the results of a study would be if it was repeated using the steps outlined in the research. Lastly, neutrality is the degree to which the biases or judgments of the researcher have been removed leaving a pure representation of the experience of the individual or topic under examination (Krefting, 1991; Lincoln & Guba, 1985)

High levels of trustworthiness in the research process, data collection and analysis, interpretation and dissemination are necessary for rigor to be ensured. To protect for trustworthiness and rigor, there are four guiding metrics to integrate throughout the entire research project. These are credibility; transferability; dependability; and confirmability. The following section describes these metrics and methods to ensure they are maintained throughout the research process (Krefting, 1991; Lincoln & Guba, 1985; Padgett, 2008).

Credibility

Credibility attends to truth value in a study. It is a way to measure the degree of accuracy in the data base and can be achieved "when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognize the descriptions" (Krefting, 1991, p. 216). One cited method to support this is through prolonged engagement with the research subject/s or phenomenon which is being studied (Krefting, 1991; Lincoln & Guba, 1985; Patton, 2014). I spent hours immersed in the interview transcripts and the audio files and was deeply connected to the stories from each CSW

interviewed. I read and re-read my journal entries, notes I had taken during each interview, and the statements I had written up during the Phenomenological Reduction stage of analysis.

Reflexivity is a way to improve credibility and was achieved through the Epoche process. The practice of journaling acknowledged my personal experience and how it could influence the way I understood the CSWs experience. This process of introspection helped me recognize any assumptions or preconceptions that might threaten to shape my view of the data. Epoche documented my emerging or pre-existing assumptions and biases so that during analysis these were either set aside as personal bias or purposely incorporated as valuable data for interpretation (Morrow, 2005; Moustakas, 1994; Padgett, 2008).

Member checking is another way to protect for credibility. Research participants are asked to review the data to confirm how accurate the results have been interpreted and summarized (Padgett, 2008; Patton, 2014). Transcendental Phenomenology views interview subjects as co-researchers even though they have no formal role with the design, execution, or final analysis of the study (Moustakas, 1994). At the start of each interview, I asked each CSW if they would be willing to review my results after I had finished my analysis and each one agreed to help. I picked two CSWs randomly and sent them excerpts of some of the significant statements and themes that had been identified. I also include the pictures I had taken of the papers taped up on my wall, so they had a sense for the open coding analysis. They were also emailed a copy of the interview questions so they could have context for the statements they were reading. I followed up with an email a week later and both CSWs felt the themes were descriptive and they could see some of their experiences represented in the themes. I then asked them to read their textural and structural description as well as the synthesized one. I called them

a week later to ask for their feedback. Both reflected accuracy in how I presented their experience and thanked me for doing so. It was an emotional experience for them to read a synopsis of what they went through, but both stated that it made them proud to see how well they persevered and how much they had grown from it. This process further protected against personal bias or misinterpretation of the interview content (Padgett, 2008; Patton, 2014).

Transferability

Transferability describes how generalizable the findings of a study is to other groups and addresses the issue of applicability of trustworthiness. Transferability is difficult to control for in this study since my sample size is small and the phenomenon being studied cannot be applied to the general population. According to Krefting (1991), a research study that is designed to understand the essences of a lived experience of a person is descriptive in nature and the applicability criterion may not be relevant. However, I created an internal audit trail of journaling and have the transcribed interviews which offer a dense description of the phenomenon under study and can improve the level of transferability. This depth of description allows for another researcher make transferability judgements for themselves (Krefting, 1991; Lincoln & Guba, 1985; Patton, 2014).

Dependability

Dependability looks at the consistency aspect of trustworthiness and provides evidence that the research process, procedures, and analysis was consistent and can be repeated by another researcher (Krefting, 1991; Lincoln & Guba, 1985). Variability is expected in qualitative research and as such, dependability is more concerned with trackable variability. This is the ability to follow the journey of the researcher and how they identify the uniqueness of each

interview and situation, both of their own experience and that of the individual who is interviewed (Krefting, 1991). To provide evidence of dependability from my research methodological process, the following are available for inspection: the internal audit trail of my journals, transcribed interviews, handwritten notes, pictures of the open coding process taped onto a wall, the actual pieces of paper that were taped onto the wall, and the textural and structural descriptions that were created during the Epoche, Phenomenological Reduction, and Imaginative Variation.

Confirmability

Confirmability is the measure of how closely the results are linked with the data and addresses the concept of neutrality of trustworthiness (Krefting, 1991). While it is difficult to imagine my personal beliefs were completely absent from the analysis process, it was valuable to put as much effort into this as possible. This was achieved primarily through the dense descriptions in the Epoche, Phenomenological Reduction, and Imaginative Variation produced during the analysis phase. This is considered an internal audit trail and offers fellow researchers a map to follow if they wanted to repeat the research and expect to arrive as a similar conclusion (Krefting, 1991; Morrow, 2005; Padgett, 2008; Patton, 2014). The journaling that happened throughout my research is my second technique to protect for confirmability. It took place before, during, and after each interview, and continued throughout analysis and each time I was in the data. I documented my thoughts, feelings, and biases as an attempt to protect the results from being influenced by them (Krefting, 1991; Padgett, 2008).

Researcher Qualification

Phenomenology asserts that a researcher cannot be free from their own life experiences and the presuppositions and beliefs that they hold (Groenewald, 2017; Moustakas, 1994; Patton, 2014). As a researcher and clinical social worker, it was important to acknowledge the a priori knowledge I held based on professional experience of providing telemental health services to my clients during the COVID-19 pandemic and shelter in place order. Even though I am skilled in rapport building, and my interview skills may be naturally stronger than a non-clinical researcher, I was very aware and alert that my interview style did not cross the line to become more therapeutic or leading in nature. I stayed true to a research interviewing style which kept me on script with my interview questions and follow up probes.

Additionally, because of my positionality of a CSW who transitioned to telemental health I was intentional in my use of strategies to minimize professional bias in the research process. Through the use of Epoche, and in my rigor for design strategies, I strove to ensure that implicit biases, assumptions, beliefs, and personal experience were made explicit and I was less likely to let them influence my data analysis. (Morrow, 2005; Padgett, 2008; Patton, 2014). As a result of engaging in these processes associated with trustworthiness as well as the use of transcendental phenomenology for my analysis, the voices of the participants were given an opportunity to be heard. Their experience of working from home and the transition to telemental health is further discussed in Chapter Four below.

CHAPTER FOUR

FINDINGS

This study was designed to understand the experience of a sample of CSWs who transitioned from in-person mental health services to telemental health services due to the COVID-19 pandemic and shelter in place order. This researcher is a CSW who made the transition to telemental health and, due to my personal experience of this, I believed the novel nature of this phenomenon was worthy of exploration. A deeper understanding into what this experience was like could hold valuable information for future research in areas of education, practice, and policy. A phenomenological, qualitative design was implemented, and data analysis was transcendental phenomenology. Ten in-depth interviews were completed.

This chapter will offer a brief review of the research design and the findings. The findings will be presented through the themes that emerged and the textural and structural descriptions from each interview. A composite textural/structural description for each interview will be presented as well as a final, composite synthesis of all ten interviews.

Summary of Transcendental Phenomenology

The first stage of my analysis began with the Epoche which is also called bracketing or journaling. Bracketing is a core concept of phenomenology and is used throughout data collection and analysis. The goal is to note a bias or thought and then suspend (or bracket) it and look at it from multiple perspectives. This process allowed me to examine my experience and ensure it did not influence the interpretation of the other CSW interviews (Creswell & Poth, 2018; Groenewald, 2017; Morrow, 2005; Peoples, 2020). This was done any time I interacted

with the data such as during and after each interview, during and after each time I listened to the recordings or read the transcript, and as I was developing themes.

The following step is called Phenomenological Reduction. This was accomplished through prolonged time in the data. All data was examined with an equal level of value, and as I spent time reading through the verbatim transcripts, I pulled out repetitive, overlapping, or irrelevant statements. What remained were the horizons of the phenomenon studied such as relevant expressions, quotes, or statements from each interview (the quotes on colored paper in Chapter Three). This is called horizonalizing. The textural descriptions are developed during this stage which provided information on *what* it was like for the CSW to experience the phenomenon under study. Through the building of the textural descriptions, I continued to reduce the data until I found units of meaning that I consolidated into overarching themes, presented in Table 2.

Table 2. Themes and Subthemes

Themes	The transition to telemental health	Professional insecurity	Working from home works	The shared reality is harder	Self-care is a priority	Everything will be ok
Subthemes	*Challenges*		*Protection from Covid-19*	*Fear of the unknown*	*Connections*	
	Guidance on best practices		*More free time in the day*	*Amplified mental health problems*		
	Insurance reimbursement		*Flexible work schedule*	*Empathetic connections and disconnections*		
			Telemental health is preferred for some clients			

These will be discussed below.

After I identified the themes, I engaged in Imaginative Variation as the next step of data analysis. This process calls the researcher to use their imagination and intuition while spending

time in the data to develop a structural description of each experience. These descriptions provide an understanding of the overall essence of each experience by highlighting *how* they understood their experience through the universal structure of relation to self and relation to others. Once this was accomplished, a composite textural and structural experience for each CSW was developed. I achieved these composite textural and structural descriptions through synthesizing individual experiences of the data from each CSWs interview, the textural description, the structural description, and imaginative variation on the part of the researcher.

The final stage of my analysis was Synthesis. This process called upon my imagination, intuition, and knowledge of my data to synthesis the experience of all ten CSWs into a final composite description. It provides the reader with an overall statement of the essence of the phenomenon being studied. It unifies the experience of all into a common, integrated narrative. According to Moustakas, there are always more meanings and essences one can find when researching a particular phenomenon, but a synthesis provides a snapshot of an experience at a particular time.

> The essences of any experience are never totally exhausted. The fundamental textual-structural synthesis represents the essences at a particular time and place from the vantage point of an individual researcher following an exhaustive imaginative and reflective study of the phenomenon. (Moustakas, 1994, p.100)

Participant Demographics

This study included ten CSWs who switched to telemental health during the shelter in place order from March of 2020 through August of 2020. They all lived in the state of Illinois during those six months, worked in private practice, and had never used telemental health as a method for service delivery previously. Tables 2 and 3 provide practice and demographic information regarding each CSW. Pseudonyms were used to protect their privacy.

Table 3. Professional Data

Name	Years in private practice	Number of clients seen weekly prior to the Pandemic	Current virtual sessions per week	Current face to face sessions per week
Amy	7	15	90%	10%
Helene	18	27	60%	40%
Nancy	18	28	50%	50%
Sandy	9	6	98%	2%
Michael	5	22	2%	98%
Cindy	19	17	60%	40%
Ashley	7	10	20%	80%
Janet	6	32	60%	40%
Rhonda	18	18	25%	75%
Kate	29	18	100%	0%

Table 4. Demographic Data

Name	Age	Marital Status	Gender	Sexual Orientation	Ethnicity	Children in the home
Amy	36	Married	Female	Heterosexual	White	Yes
Helene	66	Single	Female	Heterosexual	White	No
Nancy	49	Married	Female	Heterosexual	White	Yes (teenagers)
Sandy	44	Married	Female	Bisexual	White	No
Michael	33	Single	Male	Heterosexual	Hispanic	No
Cindy	55	Married	Female	Heterosexual	White	Yes (teenagers)
Ashley	43	Married	Female	Heterosexual	Hispanic	Yes
Janet	41	Long Term Relationship	Female	Queer	White	No
Rhonda	66	Long Term Relationship	Female	Lesbian	White	No
Kate	67	Married	Female	Heterosexual	White	No

Themes

The interviews with the CSWs and the analysis that followed provided a glimpse into what it was like for them to work from home during the pandemic and how it impacted them professionally and personally. As the themes began to emerge during analysis, it was clear that the professional and personal selves of the CSWs were tightly intertwined. For example, if a CSW needed to connect with other colleagues to support their professional well-being, that effort simultaneously helped them feel healthier in their personal life and relationships as well. If they took breaks throughout their workday to spend time with family, they felt professionally stronger

and could show up better for their clients. Two themes that stayed primarily focused on the impact on the professional self was the transition to telemental health and professional insecurity. These will be discussed first. It provides insight into what the transition was like for the CSWs to provide services from home with telemental health and how it impacted them professionally. The remaining themes represent a holistic view of each CSW's experience as a fellow human living through a pandemic and what it was like to work as a CSW at the same time.

The Transition to Telemental Health

This theme emerged as the CSWs shared what it felt like for them to begin to work from home and use telemental health. Since this was a new form of service delivery for them, they all experienced an initial learning curve in the first few weeks of the pandemic. The CSWs in this study expressed that the difficulties for them included challenges with the physical transition to telemental health service from home, the need for guidance on telemental health best practices from social work organizations, and insurance reimbursement and liability worries.

Challenges

All ten of the CSWs interviewed for this study were new to providing telemental health services for their clients, but some had a harder time adjusting than others. There were challenges associated with the use of technology, how to problem solve computer glitches, and how to share data virtually. Three of them were less familiar with technology in general and struggled with the logistics of getting set up. Rhonda was one of the CSWs that needed extra support. She stated that, "tech stuff was really challenging for me. I had to hire a computer guy to come in and get me set up." Once she started though, she lost her worries, "I thought how in heavens name can this possibly work? But I was blown out of the water at how effective it

was!" Janet had some worries as well. For example, she had to figure out ways to get handouts or worksheets to clients during a session and how to get legal documents signed like consent forms and office policy forms for new clients. She was unsure if some of her therapeutic interventions that she did in office would work virtually. This concerned her, "I do think it [working from home] challenged me to think creatively. I was trying to be creative about how we would utilize different skills together and I found a lot of solutions online that I could use so that was helpful." One CSW, Cindy, had never used an electronic health records (EHR) platform in her practice, and she shared that it was a stressful process to get that set up in addition to her learning curve with telemental health.

Guidance on Best Practices

Even though this was a new mode of therapy for all ten of the CSWs, they were quick to adapt after the initial week or two. None of them shared that these challenges continued to be a factor in their experience of working from home and providing virtual therapy for their clients.

The speed in which the CSWs needed to transition offered little chance to be trained on or have access to guidelines on best practices. Three of them shared how frustrated they felt with the lack of guidance from professional organizations and worried they might be doing telemental health wrong. Nancy was one CSW that expressed how much training and guidance would have supported her professionally:

> One thing that really irritated me about our field is I wish we could have gotten guidance on rules quicker. We didn't really have rules at the beginning. Everyone was keeping their head above water, and it would have been nice to have some professional guidance. No one really had any training or rules of how to do this. I was like, Oh my god, what if something happens with them and I'm watching it with sheer panic as a professional. I did not like that, and I still don't like that.

Janet felt frustrated by this as well and did her own research as the social work profession was slow to provide structure:

> I did a bunch of research to find out what is legal and what do we need to have in place. That information was not highly accessible. I had to do a lot of work to find that stuff out. But once I had access to it, I was able to set it up. I found a lot of guidelines to make sure everything was on the up and up.

For some CSWs in this study, this was seen as a frustrating experience and challenged their professional competency. They did not want to provide services for their clients that were unethical or outside the scope of what was clinically appropriate. They looked to professional organization such as NASW for direction and did not feel there was a quick enough response to give them with the guidance that would have helped them feel more confident in the best practices and ethical guidelines for telemental health.

Insurance Reimbursement

One aspect of the transition that emerged in the interviews was the fear that insurance companies might not pay for telemental health services. It is important to note here that the only CSWs who talked about this were the two practice owners. At the beginning of the pandemic and shelter in place order, insurance companies were slow to communicate how they would handle the influx of telemental health sessions and if they would reimburse CSWs for that service. Prior to the pandemic, clinicians were required to be trained and certified by each insurance company before they were allowed to provide telemental health. It would be unethical to do so without the proper training and insurance fraud to submit without proper approval. No one knew how to submit claims or if there would be reimbursement. Amy runs a large practice, and this was deeply concerning for her:

> It was very stressful because of billing issues. For a while insurance wasn't saying whether they were going to cover telehealth and so we had to make decisions to continue seeing clients and billing despite telehealth not being officially approved. If my business goes down, I go down and then where is the money going to come from? I mean, the finances were the most traumatizing for me by far.

Sandy felt the weight of this as well. It was more than just the financial worries though. She was making decisions for her staff and their clients without any guarantee that she was doing the right thing. The shelter in place order provided some structure in that she felt compelled to send her staff home, but that did not remove the worry. This stress affected her significantly:

> I think the first thing was, I don't want to make the wrong decision. Some of the staff were more concerned than others. I was kind of afraid things were overblown, so I didn't want to, you know, make people go home and then not have sessions covered by insurance. It was just really stressful. I felt a lot of pressure on me to do the right thing, not just for me and my clients, but for the staff and their clients too.

Sandy and Amy found relief when insurance companies provided clear communication on how to submit claims and started reimbursing for sessions. The CSWs who were not practice owners did not share the same type of stress and anxiety that Sandy and Amy did. This research shows that the experience of a practice owner carried unique worries and additional responsibilities the other eight CSWs did not share. Not only did they worry about the financial stability of their practices, but they also had to make decisions about how to run their practice virtually, pay bills to keep their office space open for when the shelter in place was lifted, how to best lead and support their staff, and how to provide continued services for the clients in the practice. They remember this as a very difficult experience during the early weeks of the pandemic.

Professional Insecurity. A reoccurring theme surrounding the professional experience were profound feelings of insecurity. This encompassed doubts that they would be able to

provide effective therapy for their clients virtually, and worry surrounding how to care for clients who were not well suited for telemental health.

Typically, if a clinician decides to provide a new mode of therapeutic intervention, such as telemental health, a time for training would be expected before using it with their clients. This is to ensure that the new method or intervention is implemented correctly, and the therapist feels capable to provide it. Due to the quick nature of the shelter in place order, this did not occur for any of the CSWs. They were unsure if they would be effective online and some doubted their abilities to adequately care for their clients. Amy felt very worried at the beginning:

> I think I'm more effective in person and there were some head games of am I good enough? Am I engaging enough? I don't feel effective enough. I really started doubting my effectiveness because so much of therapy is about energy and rapport. It really challenged my sense of capacity and ability.

Nancy echoed this worry and stated, "I don't know. I don't think I'm my best online, or at least I know I really wasn't in the beginning. It was really hard to get it get adjusted to that."

The use of telemental health was not a new concept for the CSWs as this technology had been available for many years, but none of them offered it in their private practices. Prior to the pandemic, they all preferred to see clients in person for a variety of reasons and saw no reason to change that. Ashley had never desired to use telemental health and it was difficult to imagine she would be effective at it or enjoy the experience:

> Before the pandemic I had friend who had started providing telehealth services, and I really always thought I don't feel like that's something I could ever do. And I didn't see how you navigated all of that. Then obviously the pandemic happened, and you had no choice. You had to do it, you had to jump right in, and I think it exposed me to something that I probably never would have done otherwise. I think maybe in general I do better with the structure of the office and coming in, and I think, as a professional that really jarred me a little bit, not being able to.

Another professional hurdle was the worry that telemental health would not be effective for some of the clients the CSWs worked with prior to the pandemic. Without proper telemental health training or professional support in place, many felt inadequate as a therapist and struggled to find ways to provide the needed therapeutic care for those clients. Examples of this include clients who were seen as high risk, younger children, individuals with severe mental health problems, and clients who struggled with eating disorders or self-injury. Michael was one of the CSWs who had little trouble with the physical transition to telemental health from home, but he did struggle with how to care for some of his clients and this impacted his confidence as a CSW:

> I felt like some of my clients shouldn't have been virtual. One was struggling with schizophrenia and another who was stuck home with a parent who was abusing them. I thought virtual was not going to help them. They were in need of much more services. I felt helpless a little bit and like I had imposter syndrome because I didn't know how to help them.

Michael was not the only CSW who struggled to provide adequate therapy services for their clients. There were three CSWs who cited difficulty in the use of telemental health with younger children. They soon discovered that this population did not do well with telemental health sessions due to their shorter attention spans and inexperience using a phone or computer for a therapy session. Ashley stated, "I found it very, very difficult to provide telehealth to those clients because those were the clients I was getting on the floor with and doing play therapy. We were talking as we were building things and drawing pictures." She had to create new ways to connect with the children she was working with and took some continuing education classes to help support her efforts. Amy had similar worries,

> It is very difficult to be accurate with making a diagnosis or how you are helping them without seeing them. We do a lot of child and adolescent work and so much is done through body language, eye contact and human connection. We also had self-injury kids and eating disorders.

Cindy discovered she needed to be more creative in the interventions and interactions she had with clients. One of the interventions she offered clients was brain spotting, but she quickly found this was not adaptable to telemental health and could not provide this for her clients, "I needed to learn more strategies and be more mindful of how I was communicating with clients online." Nancy often used EMDR with clients in her practice but shared that it did not seem to translate virtually and was unable to continue using this as an effective intervention.

The worry regarding effective care or capability with telemental health was common among all but three of the CSWs. Kate had no concerns. She worked part time as a sign language interpreter which is all virtual, so she felt very confident with telemental health. Her experience had been created through a different type of job, but it helped her feel confident working virtually in her private practice. Helene and Sandy were new to telemental health but did not express concerns over their ability to be clinically effective. One of the questions in the interview was "How did the experience of providing telemental health services impact you professionally?" so they had an opportunity to talk specifically about what it was like for them. They both shared stories of the experience, but not in the context of concern regarding their ability to be effective therapists.

Working From Home Works. This theme represents how the CSWs felt about using telemental health and what it was like to work from home. Both concepts are presented together since it was a connected experience that occurred when the shelter in place order was given. If they did not have telemental health as an option, they would not be working from home, and if they were not required to work from home, they would not have used telemental health. There

were four aspects that emerged—protection from COVID-19, more free time in their day, more flexibility with their work schedule, and telemental health as preferred for some clients.

Protection from COVID-19

The beginning of the pandemic was frightening for many individuals. There was little known about the COVID-19 virus and the shelter in place order was designed to slow the spread of the virus and protect those who were medically vulnerable. Four of the CSWs in this study were either medically compromised due to auto-immune diseases or lived with an elderly parent that they wanted to protect. Helene's mother lived with her and working from home meant she was able to insulate her mother from the possibility of catching the virus: "It was fortunate for me because I had an elderly parent with medical complications and me being home improved my parent's ability to function. It also made it easy for me to be present and care for her more." Janet shared that not only did she really appreciate working from home, but she was also grateful to have a way to stay healthy: "I would say that I didn't find it hard, and if anything, I found it really rewarding and really enjoyable. It was easier for me. I'm someone with chronic health conditions so it felt so much safer working from home." Kate's experience was powerful. She remembered how afraid she was to catch COVID-19:

> It was very hard. I was dealing with fear. I have a bunch of autoimmune diseases and I was very worried about catching COVID. Was anybody confident that this was going to work out? I was worried every day that I was going to catch COVID and die.

Working from home brought comfort, security, and a sense of feeling protected during the early months of the pandemic. The shelter in place order ended up being a very important benefit for some of the CSWs in this study and was a very positive experience for them

professionally and personally. They were grateful to be able to continue working while protecting themselves and their loved ones from COVID-19.

More Free Time in the Day

One of the unexpected benefits of working from home for the CSWs was the discovery that they had extra time in their days for non-work activities. Seven of the CSWs cited this as a part of their experience of working from home. Some of this was due to the nature of the shelter in place order and that everyone was now at home due to the pandemic. Schools were closed, sports and after school activities were canceled, and social gatherings were eliminated from calendars. One of the ways they utilized this extra time was to engage in self-care activities and this will be discussed in greater detail below in the section of *self-care is a priority*.

Another way they used the extra time in their days was to spend more time with their families. Three of the CSWs who had children at home noticed how much more time they had with their families because of this situation. Ashley really appreciated this and stated,

> I'm not one of those moms who is dying for their kids to get back to school when fall comes. I really enjoyed the extra time we got to spend together as a family which was really good, and I loved being together more often.

Michael lived with his nuclear family during the shelter in place order and they were all working or schooling from home. He shared that his family members had more time to spend together since there were no other options for social connections. They watched movies and made family mealtime a priority.

For Amy, she cited that her extra time was directly related to the fact that she now worked from home. When she finished seeing clients for the day, she could walk out of her bedroom, which had become her home office, and was able to be fully present with her family.

There were no distractions from other colleagues or unfinished work tasks to take up her time, "I felt more effective as a mom and wife because as soon as I was done with work, I was ready to be with my family." Before working from home, she would often stay late at the office, rushing to get things done and then rushing to get home with her family. Working from home eliminated that problem.

Four of the CSWs stated they had extra time in their day due to the elimination of a commute to an outside office and they found this to be a positive aspect of their experience. There were no questions in the interview that inquired about this specifically; rather, it emerged as they shared how the transition to work from home impacted them. Helene is one of the CSWs who cited this as a significant bonus while she worked from home:

> One of my offices is a lengthy drive so I had no commute, and just the time saved in working exclusively from home and having all your groceries delivered, and not going out at all. However that plays out, it created space for me to do other things that are important to me spiritually, emotionally, and physically.

Janet found extra time in two unexpected areas. She had no drive into her office and did not need to look quite so professional, so her daily routine changed in a good way, "There were so many things about my life that improved. I didn't have to commute the 45 minutes each way to work or spend an hour getting ready every morning."

The CSWs noticed and appreciated the extra time they had in their days due to the shelter in place order. Since the majority of social, school, recreational, and sporting activities were no longer available, CSWs were able to spend more time with family members and really enjoyed the quantity of time and quality connection. They saved time as they no longer had to drive to and from their office, put effort into looking professional, or spend extra hours at the office

finishing last minute tasks. These were all seen as a benefit and validates the theme that for the CSWs in this study, working from home really worked well for them.

Flexible Work Schedule

Working from home and the use of telemental health created a more flexible way to approach scheduling with clients and how the CSWs structured their workday. Seven of them cited this as a benefit to working from home. They could change session times to fit their daily schedules better and could still see clients if problems arose that might have previously prevented a session from happening, such as bad weather or transportation issues. Cindy became much more flexible with her schedule:

> Most of the time, I would say, your appointment is your appointment, and I won't change it unless you need me to. But now, we were all sitting around with time on our hands so I was like, okay, let's make it easy for me and see if I can squeeze everybody together rather than have a bunch of gaps in my day.

Nancy and Michael both changed their work schedule to begin later in the day so they could get exercise and get a daily workout completed. They were glad to have the opportunity to make exercise a priority and stated this was good for them emotionally and physically. Janet felt as though she had more control over how she spent the time in her day, and this gave her a sense of freedom and flexibility. She could change her client sessions to fit her day better: "I felt like I had so much more control in my life, and I had so much more time."

Now that the CSWs were working from home, the time constraints and expectations that were previously embedded in a professional office setting were either relaxed or removed. This allowed them to move their work schedule around to fit their day better and they perceived this as a very positive impact on their experience of the pandemic.

Telemental Health is Preferred for Some Clients

The final reason working from home worked for the CSWs in this study was the realization that telemental health was a great option for some of their clients. Four of the CSWs remarked on this specifically. Rhonda was one of the CSWs that struggled to use telemental health at the beginning of the pandemic and was unsure if it would work for her or her clients. She needed help with the use of the technology, but surprised herself with how quickly she got used to it and how effective it was. Even though she no longer works from home, she is still able to offer telemental health to her clients if they want to use it, "It's so much safer on an icy day or a day when someone isn't feeling 100% to be able to switch over to Zoom. It's opened up a possibility that is a very big plus!"

Janet felt very strongly that the option for telemental health would be a significant support for her clients. She works with a population that had to deal with many different types of barriers surrounding a commute into an office for in-person therapy services. Many of her clients are HIV positive and the pandemic heightened their concerns for catching COVID-19 due to their already compromised immune systems. She saw virtual sessions as a way to keep them safe while still providing support for them:

> Offering telehealth services made things so much more accessible to my clients. People who wouldn't drive if the weather was bad or had scheduling problems could now keep their sessions. Also, some of my clients have compromised immune systems and it would not be ok for them to be standing outside waiting for a bus and then be on a bus load of people, and then coming into an office during the pandemic. Even folks who didn't have technology could set up a phone session during that time. I hope clients continue to have access to this forever.

While not every CSW specifically commented on this during the interviews, all ten of them kept telemental health as a part of their practice when the shelter in place order was lifted

and they moved out of their home offices. Even with the initial insecurities many of them had about their ability to be effective through a virtual platform, telemental health was a good enough experience that both the CSWs and some of their clients continued this type of therapy.

There was one CSW who did not feel like working from home worked as well for her. Ashley's three young school aged children were at home with her during the shelter in place order and the pandemic. Not only was she responsible for taking care of herself, and all her clients, but she was now required to manage her children's education and behavior daily and be their social planner as well. Ashley is someone who had historically struggled a lot with anxiety, and she stated that it got even worse through the pandemic. The transition to work from home deeply impacted Ashley's role as a mother. It was challenging to watch her children with their own struggles:

> I've watched my youngest struggle academically ever since the pandemic. She was struggling before in preschool, but I've seen the negative impact of her not able to have a real year in kindergarten. I never really understood until Covid how important that first year is. They learn their building blocks for reading and things and that was all on me. I became the teacher. I became the one responsible for that. It was very challenging. My older two did a little better, they needed more academic support from me, but this trickled down them too. I'm actually only this year seeing a greater independence from me and needed support from me.

The added pressures she felt as a mom, and the shared experience with her clients had a direct impact on her mental health. She felt the weight of supporting her clients while trying to support her kids and her mental health, "I mean, everybody had anxiety just because of the pandemic, but it created more for me for many reasons. Especially having kids during the pandemic and navigating social situations with others." It was difficult for her to find a confidential and quiet location to do her telemental health sessions, "It got a little bit harder when the kids needed access to the computer, so I had to get creative with where I would go. I would usually go into

my bedroom, and I'd have to use my phone for the sessions." Even with the ability to have a confidential space away from her children, she found it challenging to have any consistent work schedule:

> There was a lot of multi-tasking going on. I felt like there were a lot of interruptions because I had to be mom and teacher. It became pretty clear to me early on that I didn't have the ability to provide telemental health during the school day because the kids needed me.

There is only one CSW interviewed with this experience. While it is not generalizable to the findings of this study or integrated into the themes of this research, it was valuable to include as it could have possible implications for further research and implications for practice. This will be talked about in the discussion section.

The Shared Reality is Harder. The CSWs interviewed for this research had a unique experience in that they were living and working through the pandemic alongside their clients. They did not necessarily feel as though they were going through the exact same life situations as their clients. However, they did feel that it was harder for them to hold space for the emotional and mental worries of their clients that arose from the pandemic as they attempted to find space and support for their own. Examples of what emerged from this theme were deeply emotional and heavy stories about how the CSWs struggled with the fear of the unknown regarding the global trauma of the pandemic, amplified and increased mental health problems, and empathetic connections and disconnections.

Fear of the Unknown

The fear of the unknown was a common, shared experience by the CSWs and their clients. The beginning of the pandemic held many unanswered questions and the CSWs had to keep their fears separate from the therapeutic experience. Kate shared how grateful she was to

work from home to protect her health but had many of the same worries her clients felt. Her commitment to her profession kept her dedicated to show up for them and she strove to be supportive despite her fear of the unknown:

> It was very hard. Whenever you're dealing with someone who's dealing with the exact same thing, there's a bunch of issues. You are simultaneously going through a lot of unknowns about what to do and they're going through the same unknowns. I tried to be an active, listening presence with them and not freak out, which is basically what I could have done every day. It was very challenging. I was in the dark as much as them, so it was very challenging not to fall in the rabbit hole every day with them.

Sandy was deeply affected by her clients and the struggles they would talk about during a session. She tried to manage her personal fears and mental health difficulties, but soon the reality of what was going on became overwhelming. She was unable to put her fear and stress aside during sessions and would become triggered by choices her clients made:

> This was the first time on a global scale that we were all going through the same trauma at the same time. I was hypervigilant and really scared about Covid, and I had some clients who weren't, and were mad they had to stay home. I would get triggered when they would tell me they were going out or wouldn't wear a mask. I think it was that the stakes felt so high because I was walking alongside someone dealing with their trauma, and dealing with my own was hard. It was the unknown. I was literally like "oh shit, is this the end of the world? And that was scary for me and my clients too.

Amplified Mental Health Problems

Rhonda saw the pandemic as shared time in history that brought about new losses and stressors in her life as well as those of her clients. She was aware that the emotional struggles she felt were made worse by her client's difficulties. As a professional, she did not want to reduce the support and care her clients needed but was acutely aware of the toll this was taking on her:

> Our life felt duller, as we were going along and trying to support people who have a double whammy going. I mean, dealing with mental health issues and these challenges that were so hard and had so much fear. So, walking alongside them was heavier for me.

The pandemic caused Cindy to feel more committed to her profession than ever before. She was aware of how much people were struggling, especially her clients. It was a lot to deal with, but she felt very grateful she was able to be present and supportive to those she worked with. She viewed her role as a clinical social worker as essential and felt called to show up for her clients during this crisis:

> I felt much more committed to my profession and much more dedicated because there was a need there that I could meet, and I was figuring out how to meet that need. We've seen the impact of the pandemic on mental health overall, especially on young people. I feel like I personally took my job more seriously, and it became much more a part of my identity. I stepped back from a lot of people and a lot of things and put the energy into my work. I found a lot of gratitude and joy in seeing my client's success and seeing them really overcome a lot so it wasn't all heaviness. It just became much more rewarding and that filled me.

Sandy struggled to manage the pressures of running her practice, supporting her staff, show up for her clients, and manage her own emotional well-being. It got to a point where her mental health became compromised. The fear of the unknown became too much for her to endure and she entered a three-week residential program:

> I was paralyzed with fear. I really was not able to organize myself like I normally can emotionally. So, I was just dysregulated and afraid. It didn't feel right to try to lead anybody cause what a fucking mess I am, and I have no business telling anyone anything. I can't make you feel better. I ended up going to a residential treatment program because it didn't feel ethical to continue what I was doing. That was probably the best gift I've even given to myself.

Empathetic Connections and Disconnections

While it was difficult to share the experience with clients, not every aspect of it was negative. Michael shared that he felt a deepened sense of empathy with his clients due to the share experience, but it was also very difficult for him to bear witness to all the issues they were

experiencing alongside how much he struggled during the pandemic. As he walked alongside his clients during the pandemic, he was stretched to learn and grow in several areas:

> You talk with a client, and they tell you these struggles that they are having, and I can't always comprehend it. But I think during the pandemic, the fear about what was going to happen, I was really able to empathize because I was feeling fear too. I learned that I don't have to fix it for them, it's ok to sit with the stress. I learned the importance of mindfulness, just trying to stay in the present moment with my clients. So many of them were catastrophizing and I knew I couldn't fix the situation. It wasn't possible to fix what was going on in the world. I built up more empathy, because even with people who I disagreed with at the time, I also saw their fear, helplessness, and hopelessness. A lot of people were feeling that.

Ashley also found herself able to empathize a little more deeply with her clients:

> There are a lot of times a client comes to talk to you about something and you have to try and put yourself in their shoes, but to then already be, to some degree, in their shoes, it made it easier to empathize and help them work through those things because you were dealing with the same issues.

Nancy felt that the continued pressure to be present for her clients took a toll on her emotionally. In addition to her pre-pandemic clients, she took on new clients during the pandemic. It felt like everyone was dealing with heavy issues in their lives and needed more support. While she was grateful to have the work and be helpful for her clients, the increased level of client issues was difficult to deal with, "I mean, clients forget that we're human and forgot that we were really in it as well. That was tough. I guess it felt like burnout, or compassion fatigue. It definitely felt like that. We were all going through it." There were times she felt so frustrated with her clients it was difficult to be empathetic:

> Some of my clients, who were mentally unstable to begin with, would get COVID and they would make it sound so dramatic. I was thinking Oh my god, My entire family all had COVID too and yes, it was horrible, but they would take it to the next level. It felt like such an exaggeration and just looking for sympathy. Especially when I was going through it myself. It just got exhausting after a while.

One of the CSWs, Helene, did not feel as though the shared reality caused her emotional or mental hardship. She acknowledged the severity of what was happening in the world and with her clients, but it did not impact her personal wellbeing:

> It felt similar to any other time that I'm going to do my best to empathetically understand the circumstances of my client. What is true is that we all have shared experiences, and this was just a new, shared experience. I don't think it created some sort of significant addition to the therapeutic relationship.

She credited her many years as a clinician, her faith in God, and the strong support system she had that kept her balanced during this time.

This study offers insight regarding the heavy emotional and mental weight the CSWs carried as they worked and lived through the pandemic while providing care for their clients. They were committed to be present with and for their clients during this time of crisis, but the added pressure of managing their personal fears and worries created a more exhausting and difficult experience for them. All the CSWs in this study cited a need for more intentional self-care as a new priority to help manage their well-being. This theme is discussed below.

Self-Care is a Priority. Each of the ten CSWs interviewed shared that their self-care improved during the time they worked from home. They all had some self-care routines in place, but during that time they either increased their efforts or added new ones to help manage their mental health. The actions of self-care were described in terms of exercise, bathing, improved diet, scrolling on social media, taking time to be with family, connecting with colleagues, enjoying hobbies, and self-reflection. Some participants used the actual phrase "self-care" to talk about these activities while others shared examples in reference to the ways they supported their personal and professional well-being during the time they worked from home. This theme

represents ways in which the CSWs found self-care through connections. Connections to a professional system, personal/social support system, and connection to actions of self-care.

Connection to Professionals

The CSWs realize that working from home removed their ability to be in touch and connected with their colleagues and their professional support system. They missed the face-face connections and felt the loss. To mitigate this, six of them made efforts to stay in touch by setting up Zoom meeting or phone calls. As a practice owner, Sandy desired to be an example to her staff of healthy self-care habits and sent them books on self-care, orchestrated Zoom yoga classes, connected regularly with them, and encouraged them to take care of their well-being first before trying to take care of their clients. Rhonda really missed seeing people at the office and she realized that the daily connections she had with colleagues prior to the pandemic strengthened her emotional and mental well-being. She stayed connected to them virtually which was very supportive:

> It felt really challenging not being in the building with my team. So much happens in the context of a day and in between sessions. You're communicating with people, and we had lunch together, and I was used to seeing everyone throughout the day. That was extremely challenging, but our team did a great job addressing it until we could be back in person. We would meet on Zoom for supervision and professional support, talk on the phone, share funny stories or books we were reading… really anything to feel like we were still together.

Nancy had two offices that she rented in different locations, but they were both therapy practices, so she saw other therapists every time she was in the office. They became her friends as well as a source of professional support. She recalled how important it was for her to stay connected to her colleagues. The isolation and elimination of any face-to-face time with her fellow therapists was challenging:

> I felt like I wasn't surrounded by other therapists anymore. I am on my own, but I rent from people so I'd see the other therapists in the other offices, and we could touch base about a client and check out ideas with each other. It was vital to have that connection with other therapists and not having any of that and all these clients was really really tough. We all leaned on each other and not having that was really tough.

An unexpected connection to professional support was noted by two of the CSWs. They noticed that as they were in sessions with clients, they were able to shut off their fears or anxieties and focused completely on the client and the session. Janet became more purposeful to integrate self- care interventions during sessions due to the higher level of need that her clients presented, "One aspect of my therapeutic work that changed was more focused work with clients in session like meditation or relaxation exercises. It helped them but also benefited me as well." She found that as she walked her clients through different self-care activities, she herself engaged in them as well.

Connection to Personal/Social

The connection to personal/social emerged as the CSWs shared ways in which they either connected inwardly to themselves, or outwardly to friends and family. Cindy noted that some of her self-care was more inwardly focused, "I became much more reflective and contemplative. If I was out walking the dogs, I would just try to be more present which felt really good. Again, I didn't have that before, so it was really restorative." Eight of the CSWs shared how important it was for them to stay (virtually) connected to friends and family members who they did not live with and six shared how much it helped to spend time with the family members they were living with. Michael really appreciated the time he spent with his family watching movies and having family meals every day. He met with friends on a regular basis virtually and these actions improved his overall sense of well-being personally and professionally:

> I noticed I was able to manage my stress and my anxiety better. I was also depressed during the work from home period, so I needed to figure out how to show up for myself. I think COVID changed my life. It really helped me focus on my values and act on them.

Amy had a self-care routine that blended time with her family and time with an action of self-care. She and her husband implemented a strict daily schedule to give her and her children a sense of predictability and consistency.

> It was nice to have one controllable factor. When it was noon, we'd look at the schedule and say, "Okay, it's lunch time. Or at ten the schedule would say walk time, so we'd all take a break and go for a walk."

This schedule helped mitigate some of her anxiety and made her feel less out of control. It also provided her time every day to be away from work and focused only on her family.

Connection to Actions of Self-Care

Connection to actions represents that they found that activities of self-care were very helpful to improve their mood, feel healthier in their bodies, and support their overall mental well-being. All ten of the CSWs shared different ways they did this throughout their day. Helene shifted her priorities and became more intentional in the way she took care of herself. She had more time in her day to do so, and the pandemic caused her to re-evaluate how she spent her time and what was truly important to her, "I gave myself permission for things that I would have felt stressed doing before. It was a time to give myself the green light for self-care and for family balance." She found herself going outside for breaks to sit in the sun and relax in between sessions. "That was very energy producing for me and I've tried to incorporate that into my workday more and more now." All ten of the CSWs either started or improved their exercise and healthy eating routines. Nancy stated that since she had more flexibility with her schedule, she would start her clients after she was finished with an outdoor work out class, "I would be able to

be silly in a workout class with eight other women and we would all complain about our families, the workout class itself, things like that." Kate continued much of her pre-pandemic self-care routines. She calls herself a bit of an introvert, so not much changed for her. She continued regular hikes with her husband and dogs, read, exercised daily, and ate healthy.

One last connection to activity that five of the CSWs shared was the creation of new ways to transition out of work mode. They noticed a need for some intentional time to spend moving psychologically and emotionally out of work mode before they opened their office door to rejoin their families again. Four of them would scroll on social media, watch the news, or read a book at the end of their workday. Rhonda talked about new activities she experimented with to help her transition out of work mode. One of the best ways she found was to take a bath, "I soak after work to wash it all off. I'm just releasing what isn't mine. That's my transition."

For Kate, the weight of the pandemic problems of her clients became heavy to manage. She leaned into her years of experience as a therapist and created some ways to help her transition out of work mode once she was done with her day:

> I would have to have some transitional activities to help me get out of that space. It was challenging and scary. Everybody was talking about the pandemic all the time. It was hard to talk about anything else; how it was screwing up their families, and the divisiveness, it was very provocative. So, I would scroll through social media or read through some news articles to just kind of get rid of it. And then, I would usually go cook to get a re-set.

I felt it was important to include the stories of self-care from the CSWs who participated in this study. They were truly front-line workers. Their commitment to show up for their clients despite the severity of what was happening in their lives and in the world is truly inspiring. In the midst of social isolation and the many fears of what the future might bring, these individuals

worked extra hard to take care of themselves so they could take care of their clients. The profession of social work is represented here by true heroes.

Everything Will Be OK. One last theme that emerged from this research was a result of the last question the CSWs were asked in the interview. They were asked what advice they would offer their pre-pandemic self. One overwhelming response was a version of "we are all in this together, so do not worry so much because everything will be ok!" All ten of the CSWs expressed positive, supportive advice for themselves, but it is significant to the results of this study to note six of the ten responded with a version of offering reassurance to themselves that the pandemic was not the end of the world, and they would make it through just fine.

When the pandemic began, the CSWs had no idea what the future would hold, and many aspects of their lives were in flux. The world became a scary place, and the fear of the unknown was heavy. Kate offered herself the sage advice of, "Be not afraid. Things will work out. Just trust what you trust, whether it's God or whatever it is. Use your creativity and know you will be able to find ways to cope and get through." She was one who expressed a high level of anxiety with the unknown of the pandemic and struggled to stay out of the scary "rabbit hole" of fear. Ashley had also struggled with high levels of anxiety throughout the pandemic and had difficulty trusting her ability to be an effective, virtual therapist. She stated, "I would have told myself that everything is going to be just fine. Everything will work out and we are going to get through it."

There was no blueprint or training manual available to the CSWs on how to navigate a worldwide pandemic and national shelter in place order. They had never provided telemental health for their clients previously, and they all felt the challenge of this novel situation. Amy and Sandy were both owners of a private practice during the shelter in place order and they carried

extra responsibility to make decisions for their staff and their practice with little guidance or support. This created extremely high levels of anxiety and stress for them and was a significantly negative memory of their experience of working from home. Amy wished she could have given herself freedom to relax and appreciate the time she spent at home, "It's going to be ok. Embrace the opportunity to be home. Be curious about it and just see what you learn from it because in the end it's going to be ok." Sandy, whose mental health was so compromised that she checked herself into a three-week inpatient program, needed to simply know, "Don't worry so much, the world isn't going to end."

Even though they were the ones caring for others, the CSWs wanted to be reassured and reminded that they were going to be ok. In a time of crisis, like the COVID-19 pandemic, people need support, and these social workers were no different. The future remains unknown and there is no way to predict what difficulties lie ahead for these ten CSWs. What they have helped us to understand is that whoever you are, you can make a difference in the life of someone who is struggling by simple reassurance. It is going to be ok.

Composite Textural/Structural Descriptions

The following section provides the composite textural/structural description of each CSW. This was achieved after a textural description was developed through phenomenological reduction and a structural description was developed through imaginative variation. All ten of these can be found in Appendices F and G. The composite represents a narrative of each CSW's experience. It is not designed to mirror the themes; rather, to offer the reader an insight into the essence of the lived experience of the CSWs who participated in this study.

Sandy's Composite Textural/Structural Description

Sandy found the overall experience of working from home and using telemental health to be mixed. She appreciated the flexibility it gave her, was grateful she could stay connected to her clients, and felt effective with the use of online therapy. She had a heightened level of intimacy with her clients as she saw them in their homes and perceived they were more comfortable and at ease at home. She enjoyed the extra time in her day since she had no commute and was able to save money on gas and food expenses. Since she was fearful of catching COVID-19, working from home granted her a feeling of protection and she saw this as an added benefit.

As a practice owner though, she had anxiety in relation to practical issues such as insurance reimbursement, the transition of her staff to telemental heath, and her desire to lead and support them as best she could. Her stress was intense. She worried that if she made the wrong decision her staff or clients might catch COVID and die. It was difficult for her to be present for her staff and she doubted her ability to be effective in this role. This was a reaction to her fear of the pandemic, the unknown of the future, and her historical trauma. She felt like the world was falling apart and the global trauma of the pandemic was overwhelming to her. Sandy was unable to regulate herself despite her many efforts. She tried meditation, yoga, exercise, and processing her fears with friends and colleagues, but nothing worked. The problems and fears her clients had made this situation worse and she found herself unable to adequately help them. Her fear became the overarching experience, and her deteriorating mental health became a crisis. Sandy knew that her self-care needed to be a priority and she made an important decision to check herself into a residential inpatient treatment program. She stated it was the best gift she

could have given herself, her practice, and her clients. Once she returned home, she protected her mental health by reducing her client load, took one week off every month, and made her self-care routines a priority. As she reflected on the pandemic and the work from home order, she wishes she could have had less fear about the whole situation and stated, "The country is not really okay, but like, I'm okay, and the people around me are okay and we're not all going to die of this horrible disease". The advice she would have offered to her pre-pandemic self would be "Don't worry so much, the world isn't going to end."

Rhonda's Composite Textural/Structural Description

Rhonda struggled with her transition to work from home and the use of telemental health. She was not well equipped to do sessions virtually and needed a lot of outside support to get her set up and trained. It was hard for her to figure out ways to send handouts to clients and to get paperwork signed electronically. Rhonda had never used telemental health and was not confident that therapy could be effective through a screen and doubted her abilities as a virtual therapist. After a few weeks the initial difficulties smoothed over, and she discovered that telemental health was not as hard as she feared! There were some very positive moments she shared with clients and recalls with warmth how connected she felt to them even over a screen. It was a time that both her and her clients worked together to make this experience work and she was very grateful for it. She thought this could be a very beneficial way to offer therapy for clients after the pandemic was over, especially on days when weather was bad, or transportation was an issue.

Rhonda did not do well with the isolation that accompanied working from home and found her mental health to be impacted. She felt depressed and stressed. She lived with her

partner, so she was not completely alone, but she missed seeing her colleagues every day and the opportunity to be with her friends. Spending time with others gave her energy and the loss of it left her feeling flat. The virtual experience was draining. She also found it challenging to carry the weight of all the issues her clients were experiencing while she was experiencing many of the same.

There was a lot of fear of the unknown and her body was reacting to the stress she felt. She recognized the need for more intentional self-care and put effort into different types of interventions to improve her emotional, mental, and spiritual wellbeing. She changed her diet, connected more often with friends and colleagues (virtually), increased her spiritual practices, and started meditating. A daily bath became her new way to transition when she finished her workday. She would soak and wash it all off, a way to release the difficulties of the day. As she reflects on what advice she would offer her pre-pandemic self it was simply, "Just relax. Stay in the moment and it will all work itself out."

Janet's Composite Textural/Structural Description

Janet had a couple of difficulties with the transition to work from home and the use of telemental health, especially in the first few weeks. She did not know how to transfer data to her clients virtually such as how to get forms signed or how to give clients a worksheet or handout, but she quickly found ways to address those issues. Some of the traditional techniques she used with clients were not effective virtually, and she changed the way she implemented certain skills or interventions. She also felt frustrated with the lack of direction from social work organizations on best practices and guidelines for telemental health and did her own research to find answers. Once these issues were sorted out, the experience was enjoyable for her. She had

more flexibility and time in her day, she was able to protect her health and her elderly mother's health, and she made self-care a priority. She started eating healthier, lost weight, moved her body more throughout the day, found comfort in the relationship with her partner, and felt less depressed overall. She modeled self-care behaviors to her clients in sessions, and this became another form of support for her emotional and mental wellbeing.

Many of her clients lived with situations that had no connection to anything she had experienced in her life, but the pandemic gave them a shared sense of knowing and understanding together. This deepened her sense of empathy toward her clients. Some even inquired about her well-being and were truly concerned that she was ok. She acknowledged that at times the losses her clients shared in session triggered her grief and it was difficult to keep that from spilling out into a session. To help mitigate these difficulties she utilized peer consultation and supervision to ensure she was maintaining appropriate boundaries and to process feelings of grief or sadness. When I asked Janet what advice she would give her pre-pandemic self she quickly replied:

> Oh gosh! If there was any advice I could give myself, it would have been not to go back into the office! I think I can be my best human being, and therefore a better therapist, when I'm taking care of myself. Working from home just fits my lifestyle so much better!"

Nancy's Composite Textural/Structural Description

Nancy was able to transition to telemental health relatively easily, but she did not enjoy the experience. She doubted her ability to be effective online and thought she was a better therapist in person. She was frustrated at the lack of guidance on telemental health guidelines from social work organizations and worried that she was doing it wrong and/or would be unable to handle an emergency such as a suicidal client. She missed the option to be face-to face with

her clients and had to eliminate certain therapeutic interventions that did not work through a virtual platform. She did appreciate the lack of a daily commute which gave her more time in her days and saved her money on gas and other travel expenses. She had greater flexibility with her schedule and the times she saw her clients which allowed her to spend more time with her family.

She shared that she felt grateful to still be working and took on more clients because so many people were struggling and needed extra support. This eventually became a stressor for her though due to the increased hours and heavy topics from her clients. The exhaustion she felt from sharing the intense mental health struggles her clients faced dominated her days. She experienced compassion fatigue and struggled to find empathy for her clients at times. The fear of the unknown was a common theme for her clients, and this added to her stress. Nancy knew she needed extra support and made efforts to include self-care activities daily. She joined an outdoor, socially distanced workout class and found this to be incredibly helpful. The break from work and the connection with other women felt very supportive. She spent time doing home projects, spent more quality time with her family, and scrolled on social media. She found that connecting with her colleagues was vital for her well-being and made intentional efforts to stay in touch with them for personal and professional support. I asked Nancy what advice she would give her pre-pandemic self: "I would have told myself to get that office in the basement done sooner. I honestly didn't think this was going to stay as long as it did. I am shocked at how many people still want virtual!"

Cindy's Composite Textural/Structural Description

Cindy found the experience of working from home and the use of telemental health to be

a mixture of positive and negative. While it was easy to get set up in her home office and use her computer to perform sessions, it took a while to feel effective and comfortable with it. She worried she might not be a good enough therapist online and needed to find more creative ways to provide interventions for her clients. She had never used electronic health records for her practice and tried three different platforms before she found one she really liked. This learning curve was difficult, but she is glad she embraced the change.

Even though she appreciated the flexibility with her work schedule and with her clients as well, she struggled with the separation between her work time and her home time. Since she lost the drive to and from work, she would step from home duties right into work mode without much intentional time for transitions. She had to create new ways to transition after her workday was finished which became a form of self-care for her.

Cindy struggled with how to best support her teenage boys during this time. She observed how difficult it was for them to be so isolated from their friends, school, and social activities. It was also heartbreaking to watch her friends, family, and clients lose jobs and deal with intense hardship due to the pandemic. The weight of this exhausted her and occasionally she noticed she was less sensitive to some of the issues her clients brought up. It bothered her when they complained about small situations compared to the trauma and suffering she saw with other clients or individuals in her personal life. Through this, she realized how important it was to take care of her mental health. Self-care was now a daily activity for her to keep her emotionally well balanced and mentally focused. She became more contemplative and reflective, took her dogs on daily walks, and scheduled breaks from clients throughout her day. She made sure to move her body more each day, eat better, and stay connected with close friends or family.

Through all of this, Cindy was incredibly grateful to have had the ability to work through the pandemic and felt a renewed appreciation for her role as a social worker. It was rewarding for her to walk alongside her clients and support them despite the emotional weight she carried due their many fears and problems. She felt a deepened sense of connection with them knowing they were all going through it together. Cindy's advice to her pre-pandemic self was "Look for opportunities to improve and grow, don't worry so much, be flexible and find what works for you!"

Michael's Composite Textural/Structural Description

Overall, Michael found his transition to telemental health to be positive. He appreciated working from home and the flexibility and freedom it provided him. Virtual therapy was not difficult for him, and he enjoyed finding new interventions to use in sessions such as podcasts, YouTube, music, on-line games, and some social media platforms. There were a couple clients that needed more support than he could offer through telemental health, and it was challenging to find appropriate resources since most social service agencies were remote. He felt the weight of his clients' problems and how difficult life was for them. The fear he had about the unknown of the future mirrored his clients' fears and it was difficult for him to know how to manage this. He experienced feelings of depression, anxiety, and a sense of helplessness.

He had been encouraging his clients to improve their self-care habits and realized he also needed to implement more self-care actions to support his mental health. Since he lived with his nuclear family during the shelter in place order, he leaned into them for emotional and social connection. His mother was a social worker who had to work from home as well, so he was able to get professional support from her which he stated was crucial in the absence of his colleagues.

He exercised more, ate healthier, and reached out often to friends. As a therapist, he felt as though he grew quite a bit during this time. He was challenged to extend more empathy for his clients, learned how to be more mindful in sessions, and practiced the skill of allowing a situation to be difficult without the need to fix it. When asked what advice he would give his pre-pandemic self he said: "Don't be too hard on yourself, you don't need to be the hero, and take really good care of yourself."

Amy's Composite Textural/Structural Description

Amy found her experience of working from home was mixed. As a practice owner, she felt a high level of stress and worry surrounding the decisions she needed to make for her practice and staff, the financial stability of the practice, and the adjustment of her clinicians and their clients to the use of telemental health. This was so stressful for her she described it as traumatic. The anxiety she felt stemmed from the unknown future and not knowing if her practice would survive. Another challenge was her lack of confidence in her ability to provide therapy over a screen. She questioned her effectiveness and felt that she was a better therapist in the office with her clients. The isolation of the pandemic increased mental health issues among many of her clients and not all of them did well with virtual sessions, especially children. All of these worries felt out of her control, and she had to work very hard to stay balanced. She found that when she focused on her clients' issues during a session, she was able to be fully present with them which quieted her anxieties. This became an unexpected type of self-care for her; she could provide support for her clients and simultaneously find relief from her fears.

Despite these challenges, she felt like she was a better mother and wife during the time she worked from home and was able to spend more time with her family. She took advantage of

down time to play with her children, take daily walks, have regular family meals, and was able to tuck her children in every night. It was important to spend time away from the house and so they took several long weekend trips away for camping and boating. These new ways to take care of her well-being became very important to help her deal with her challenges. The advice Amy would give to her pre-pandemic self was "It's going to be ok. Embrace the opportunity to be home. Be curious about it and just see what you learn from it because in the end it's going to be ok."

Helene's Composite Textural/Structural Description

The transition to working from home and the use of telemental health was relatively stress free for Helene. She had a confidential space to work in even though her parent lived with her, and she found more time in her day without her commute. This time was used for self-care activities that she seldom made time for before, one major area of growth for her. She started exercising, ate better, and engaged in more contemplative practices. Helene was grateful she could work from home to protect her parent from COVID-19 and spend more time with her but needed regular breaks from this responsibility. She created new ways to find time away from her parent such as taking long walks, sitting on her porch, and staying in her bedroom/office more. The isolation was not difficult as she is more of an introvert and enjoys time alone, but she noted that isolation was not necessarily healthy for her well-being. The lack of connection started to deplete her emotionally, so she made intentional efforts to stay connected (virtually) to colleagues and friends throughout the pandemic. She saw the switch to telemental health and the pandemic related problems to be just like any other problem she might help a client through. The shared reality did not cause her to struggle more in her personal life or with her mental

health. Her identity as a social worker and her years of experience helped her develop this perspective, even though she did miss the option to be more hands on and involved with her clients. Helene's advice to her pre-pandemic self was, "Be more aware of what is valuable to you in the moment. Be more fully present in all areas of your life and don't wait until later, or a better moment for that, because it might not come."

Ashley's Composite Textural/Structural Description

Ashley really struggled with her transition to telemental health and working from home. The primary reason for this was the need to multi-task during her day. Her children were young and needed help with their schooling. Her youngest needed direct teaching and all three of them required support, guidance, and general care throughout each day. It was not possible to hold daytime sessions with her clients due to the many interruptions from her children; and since the office and family computer was used for school, she often had sessions on her phone in her bedroom. Ashley did appreciate the time with her family and was grateful for this unexpected situation, but quickly realized she needed time away from the stressors of the home. She found different ways to be out and about safely and enjoyed engaging in new activities and outings with her children. They even got a puppy which added emotional support for everyone.

Ashely struggled with anxiety before the pandemic, but stated it got worse during the time she worked from home. Some of this was centered around the difficulty her children had with the isolation during the shelter in place order. She worried about their wellbeing and felt unsure about her ability to be their teacher and mom at the same time. Professionally, she doubted her effectiveness with virtual sessions and did not feel that her younger clients benefited

from telemental health. It was difficult for her to hold the struggles and fears of her clients alongside her heightened anxiety.

Through all of this, Ashely was committed to more self-care and made intentional efforts to support her emotional and mental health. She exercised more, ate healthier, stayed connected with colleagues and family, took on-line courses to support her professional well-being, and spent time with her family on their boat. Ashley's advice to her pre-pandemic self would be: "I would have told myself that everything is going to be just fine. Everything will work out and we are going to get through it."

Kate's Composite Textural/Structural Description

Kate adjusted to telemental health service delivery for her clients seamlessly. She worked part time as a sign language interpreter and all those services were done using a virtual platform, so she experienced no learning curve. She loved the option to work virtually and felt very grateful she could help her clients, colleagues, and friends with the use of this technology. Another reason she appreciated telemental health was due to her heightened fear over catching COVID-19. She had health issues due to several auto-immune diseases and was worried she might die if she caught the virus, so this was a wonderful alternative for her.

Not all her clients were as pleased with this transition. Some of them were very unhappy with the loss of in-person sessions, but she addressed it just like any other loss to grieve and process. Kate had been in private practice for several years, but she still struggled with the balance to walk alongside her clients in their fear and loss while experiencing her own as well. The unknown of the future was frightening, and Kate had no way of knowing that any of them, including herself, would come out of the pandemic alright. She tried to reassure her clients but

felt that she was in the dark as much as they were. To mitigate her fears, she made sure to continue her self-care routines such as regular exercise, spiritual practices, healthy eating, and reading. She added some new ways to transition out of the heaviness of her workload such as scrolling on social media, reading the news, and cooking. Kate did miss the option to meet in person with friends and family but identifies as an introvert, so this loss was not a significant factor for her. She met with friends and family over Zoom which helped her stay connected to those she loved.

The advice Kate would give her pre-pandemic self is: "Be not afraid. Things will work out. Just trust what you trust, whether it's God or whatever it is. Use your creativity and know you will be able to find ways to cope and get through."

Final Synthesis

The CSWs interviewed for this research had to move their in-person therapy services to telemental health almost overnight due to COVID-19 and the shelter in place order. The process to get a home office set up posed few difficulties and they discovered the biggest learning curve were the logistics of how to use a virtual platform for therapy. The CSWs had to figure out ways to share documents or handouts with clients, find secure and stable telemental health programs to use and trouble shoot with clients when glitches or poor connections occurred. There was frustration at the beginning over the lack of direction or guidance from professional organizations regarding guidelines and best practices for telemental health use. None of the CSWs had used telemental health previously so this posed a challenge. They were worried that they might "do it wrong" or that the interventions and therapeutic strategies they used when they were with clients might not translate over a screen.

Telemental health was a novel way for the CSWs to perform therapy, and the insecurity and unknown of how well they would be able to care for their clients was a significant concern. They believed they were a better professional in person and could not imagine that virtual sessions would be good for their clients. In the absence of readily available training or direction, they felt unsure in their capability to perform this type of therapeutic service and had doubts that they would be effective online. Overall, they were pleasantly surprised to discover their clinical skills translated just fine and clients adapted well to this new way of therapy.

There were some exceptions. It was challenging to do virtual therapy with children, and the younger the child was, the more challenges there were. The younger clients had short attention spans and it was difficult to provide play therapy through a screen. The CSWs had to find creative ways to keep them engaged and involved in the sessions. Some modalities were not effective through telemental health such as EMDR and brain spotting and needed to be put aside until face-to-face sessions could begin again. There were some clients who were more high risk such as those who had eating disorders, engaged in self injury behaviors, or lived in abusive homes and virtual sessions were not helpful. The CSWs found this to be one of the more difficult experiences of telemental health use.

There were many unexpected advantages to telemental health use and the ability to work from home. They were surprised to find that they had extra time in their day for non-work activities. Without the commute to and from their pre-pandemic office, or the expectation to look professional from head to toe, they had more hours in each day to accomplish other tasks. Often this extra time was used for self-care activities or more time with family. There was more freedom to change their schedule to fit their day better. They could put time in-between sessions

to take a break, or they could put them back-to-back to be finished with their day sooner. If a client canceled last minute, they used that free hour to do tasks around the house, exercise, have a meal, or spend time with family.

At the beginning of the pandemic, there was little knowledge about what might happen to someone who caught COVID, and that unknown was frightening. Some participants had auto-immune diseases or lived with family members who were medically compromised. Parents worried about their children getting COVID and some stated they were afraid this disease would kill them if they caught it. Participants expressed how grateful they were to be able to work from home, safe from the threat of catching the virus; but this did not shield them from the impact of isolation. While the shelter in place order was designed to protect each other and prevent the spread of the virus, the CSWs felt sad and lonely over the forced isolation from friends, family, and colleagues.

The CSWs saw that the pandemic amplified already existing mental health problems with their current clients. They also saw an increase in new clients because of the stress, fear, and isolation that arose due to the pandemic and the shelter in place order. They noted that their caseloads grew in number and intensity in the early months of the pandemic.

Clients were not the only ones who struggled with their mental health during this time. While the CSWs felt grateful to still be working, there was a definite negative impact the pandemic and shelter in place had on their well-being. They described this experience with words such as compassion fatigue, exhaustion, grief, anxiety, fear, stress, loneliness, and panic. This was due several factors. One was the shared reality of living through the pandemic and shelter in place order alongside their clients. They struggled with how to balance the difficulties

they had in their personal lives as they tried to be present and supportive to the issues their clients brought to sessions. The CSWs felt as though their clients were clueless to the fact that they were also trying to live amid a pandemic, and this caused feelings of frustration and annoyance. They sometimes lost empathy as clients would complain about issues or situations that seemed mild compared to other clients or their own life. Often, the problems their clients shared would amplify their own anxiety, fear, and sadness. It was difficult to find ways manage their feelings so that it did not alter the ways they provided care during a session.

All the CSWs shared how important it was for them to prioritize their self-care interventions and routines due to the heavy emotional and mental load they were enduring. There were no exceptions to this. The majority of them had existing self-care habits that became more frequent or was now a priority. They saw this as a time to adjust the way they looked at their values of self-care. They felt more freedom to give themselves the green light to take better care of their bodies, minds, souls, and relationships. Many added new options into their daily schedule or started habits they always desired to have, but never implemented. Examples of this include healthier eating, more or new exercise routines, reading, spiritual practices, meditation, yoga, and frequent connection with colleagues, friends, and family. New hobbies were explored, new trails were hiked, and pandemic puppies were welcomed into families. The CSWs spent more time with the family members they were living with and came up with new options for recreation and travel. They believed their self-care efforts helped them grow stronger emotionally and mentally and many have kept them in place still today.

The interviews shone light on two subsets of CSWs that shared a higher level of stress, anxiety, and fear than the others: practice owners and those with children at home. The practice

owners talked about the added pressure of ensuring the financial survival of their practice and the physical, mental, and financial well-being of their staff. The fear of making the "wrong decision" was heavy and they described the stress as traumatic. They had no guidance for how to make decisions regarding how long to work from home, how to best support their staff, how to bill insurance for telemental health, when to bring people back into the office, or how to train their staff on telemental health best practices. This fear of the unknown and pressure to take care of the practice and their staff made their experience of the pandemic more stressful and anxiety provoking than non-practice owners.

Those who had children at home shared how difficult it was to manage their work schedule as they also tried to be a teacher, a day care provider, and an event planner every single day. Those who had teenagers at home provided minimal educational support, but shared the emotional damage they observed in the mental health of their teens as weeks of isolation turned into months. They felt deep pain and frustration to know they were helpless to change the situation for their children. Those with young children struggled the most with a regular work schedule and shared how much multitasking needed to be done throughout the day. They sacrificed work hours to ensure their children were getting the educational support and teaching they needed in addition to the daily tasks of providing meals, play time, and behavior management. This was a significant contributing factor to how they remember the experience of working from home and how difficult it was for them.

After the shelter in place order was lifted, and at the time of the interviews, all the CSWs have continued to offer telemental health services. Now that they are back into their pre-pandemic office, they appreciate the option to use telemental health and state that many of their

clients prefer virtual over in-person therapy sessions. Despite the ups and downs the ten CSWs endured during the pandemic and the shelter in place order, telemental health has become a permanent option for therapy and has changed the way they provide care and support for their clients.

The following chapter will discuss ways in which these findings are linked to current research, novel findings of this study, and contributions to the current body of literature. It will also address implications for social work practice and education. Limitations and areas for future research are also presented.

CHAPTER FIVE

DISCUSSION

COVID-19 and the pandemic that swept across the world changed the way humans stayed connected. In the United States, several states enacted a shelter-in-place order during the early months of the pandemic in the attempt to slow the spread of the virus. In this new reality, humans depended on technology to keep us in school or work; and to help us stay connected to others and the world while we stayed at home (Sullivan-Tibbs et al., 2022; Wiener et al., 2021). Among other professions, many clinical social workers in private practice had to move their in-person therapy sessions to telemental health sessions almost overnight. This was not a familiar method of service delivery for many and they were forced to adjust and learn a new way to provide therapy services (Childs et al., 2024; Griffith et al., 2023; Merrill et al., 2022).

The purpose of this study was to better understand the lived experience of CSWs who transitioned to provide telemental health services during the national shelter in place order as a response to the global COVID-19 pandemic, and how this impacted them professionally and personally. A qualitative, phenomenological mode of inquiry was best suited as this study explored the unique, lived experiences of a very specific population in relation to a specific concept or construct order (Creswell, 2007; Groenewald, 2017; Padgett, 2008). In this case, what it meant to be a clinical social worker and their personal experience of living through the national shelter in place during the COVID-19 pandemic. Ten CSWs were interviewed for this study. The interviews were transcribed verbatim, and the data were coded, grouped into units of meaning, and organized into six themes and eleven subthemes. Transcendental phenomenology

was the data analysis framework that was used (Moustakas, 1994). A textural description, structural description, and a composite textural/structural description for each CSW interviewed were written to further illuminate the phenomenon under study, as well as a composite synthesis of all ten CSWs to offer the reader a thick and rich narrative of the overall essence of the experience.

Summary of Findings

The current study sought to understand the experiences of private practice licensed clinical social workers (CSWs) in Illinois who transitioned from exclusively providing face-to-face psychotherapy to providing online psychotherapy in the beginning of the COVID-19 pandemic. I used Zoom to interview ten CSWs between April 2023 and August 2023. Using transcendental phenomenology (Moustakas, 1994) as my analytic model, six themes emerged from the interviews. Two described their professional experiences and four described an integration of personal and professional experiences: (1) the transition to telemental health, (2) professional insecurity, (3) working from home works, (4) the shared reality is harder, (5) self-care is a priority, (6) it is going to be ok. The subthemes are (a) challenges, (b) guidance on best practices for telemental health, (c) insurance reimbursement, (d) protection from COVID-19, (e) more free time in the day, (f) flexible work schedule, (g) telemental health is preferred for some clients, (h) fear of the unknown, (i) amplified mental health problem, (j) empathetic connections and disconnections, (k) connections.

Themes

The Transition to Telemental Health

The CSWs interviewed for this study had never used telemental health to provide

therapy services prior to the pandemic. There is research that indicates multiple barriers were a factor in why many CSWs did not use telemental health in their practice. Some examples include strict insurance regulations, lack of training, negative perceptions of its efficacy, and inadequate technology. In light of this, it was unknown what type of impact this transition would have on the CSWs (Brooks et al., 2013; Romney & Baird, 2015; Shore et al., 2018). The CSWs in this study expressed that the difficulties for them included challenges with the physical transition to telemental health service from home, the need for guidance on telemental health best practices from social work organizations, and insurance reimbursement and liability worries.

Challenges

The experience the CSWs had as they moved to a home office and began the use of telemental health was initially challenging. Almost all of them described several difficulties with the transition. They were unsure of what type of virtual platform to use, did not know how to problem solve technical issues, had to create new ways to do certain types of therapeutic interventions, and needed to quickly get a home office prepared. One of the CSWs was so out of touch with technology that she had to hire a technology specialist to come into her home to equip and teach her how to use telemental health. Many of the CSWs already had a home office they used for personal use, but some of them had to transform their bedrooms into an office. It was challenging to transform that space so that it looked professional and was comfortable for them to work in. One CSW had to do this because her school aged children used her home office for their classroom. In addition to that, she regularly had to use her phone for her sessions since her children used her laptop for school. She found this to be very challenging. The CSWs stated they had to learn new ways to virtually share handouts, forms, or documents with clients. They had

never done anything like that previously and it took some time and internet searching to figure it out. They remembered this as a frustrating aspect of their telemental health learning curve. One CSW had never used an electronic health records (EHR) platform for her note taking, scheduling, or billing, and had to set one up in the early weeks of the pandemic. This was a challenging task in addition to learning how to use telemental health.

These findings support existing research which shows that virtual therapy sessions can be more challenging due to a variety of factors such as lack of privacy, unstable internet connections, out of date computers, tablets, or phones, insufficient or inadequate training, and user errors on the client's side (El-Miedany, 2017; Luxton et al., 2014; Myers, 2019). These difficulties had been documented well before the pandemic. The research done after the pandemic cited these difficulties as well, but new problems appeared in the literature that were specific to the circumstances of the pandemic. Due to the speed in which individuals transitioned to work from home, there was little time to prepare the home to be a place of work, purchase necessary equipment or video-conferencing services, or acquire advice or training on how to adjust in-person therapeutic interventions to virtual ones (Békés & Doorn, 2020; Holmes et al., 2021; Kranke, Kranke et al., 2024; Lawson et al., 2022; Sullivan et al., 2023).

While none of the CSWs had used telemental health for therapy services before, one CSW had worked as a sign language interpreter which was done through a virtual platform, so she felt very confident in her ability to use and be effective with telemental health. Even though she had not used virtual platforms for her psychotherapy practice, her comfort level with it mitigated any anxiety or worries she might have had and therefore she did not experience the transition as challenging.

Research done after the pandemic supports this finding. In a McBeath and associates' study (2020) one third of social workers interviewed had already used telemental health prior to the pandemic. This subgroup expressed more confidence in their ability to effectively provide virtual therapy sessions for their clients. Contrary to this research though, one quantitative study of over 1,500 therapists in Austria found that those who had experience with telemental health prior to the pandemic reported no difference in the perceived stress and job-related worry and fears than their peers who had reported no experience with telemental health (Probst et al., 2020). There is little research comparing the experiences of CSWs who had used telemental health prior to the pandemic to those who had not. An area for future research could explore what amount of training and experience CSWs might need to feel confident and effective with the use of telemental health.

Guidance on Best Practices for Telemental Health

Working outside of their scope of service delivery was another concern for the CSWs as they began to use telemental health. The CSWs who were interviewed had never used or contemplated using telemental health due to the many barriers that existed, so they did not have proper training or guidance on best practices for telemental health use. Their knowledge and skill level for how to implement telemental health ethically and safely were not at the standards one would expect due to the quick nature of the pandemic and shelter in place order. They wished NASW or other social work organizations offered direction earlier in the pandemic. This experience was remembered as one of the reasons they struggled with the initial transition.

Recent studies support the findings of this study that CSWs felt frustrated by the lack of direction and training (Benudis et al., 2022; Cogan et al., 2022; McCoyd et al., 2023). There was

confusion about how to follow state and federal mandates, how to best deliver services, limit liability, and still maintain the integrity of legal and ethical guidelines (Duquette & Morgan, 2021; Hilty et al., 2023; McCoyd et al., 2023). This lack of direction and information created a situation where social workers felt unsure about how to provide virtual therapy ethically and effectively, and this added to the challenges they had to address when they transitioned to telemental health.

Insurance Reimbursement

One negative aspect of the transition that emerged from the interviews for two of the CSWs who owned therapy practices (i.e., a business with two or more therapists) was the fear that insurance companies might not pay for telemental health services. Prior to the pandemic, clinicians were required to be trained and certified by each insurance company before they were allowed to provide telemental health. It would be unethical to do so without the proper approvals and insurance fraud to submit to insurance companies for reimbursement (Duquette & Morgan, 2021; McBeath et al., 2020; Merrill et al., 2022). Initially, there was no way to know how to address this novel problem.

At the beginning of the pandemic and shelter in place order, insurance companies were slow to communicate how they would handle the influx of telemental health sessions and if they would reimburse CSWs for that service. Both practice owners expressed a tremendous amount of stress, anxiety, and fear surrounding this unknown situation. They were unable to reassure their staff that they would get paid for telemental health or that there would not be legal or professional consequences for providing virtual therapy services. One went so far as to describe it as the most traumatic experience of the pandemic.

Research done with social service agencies show that administrators and supervisors shared the same worry in the early days of the pandemic. As with the two practice owners in this study, this added a different layer of stress during the initial transition. There was no reassurance that telemental health would be reimbursed (McBeath et al., 2020; McCoyd et al., 2023; Sullivan et al., 2023). One article which focused solely on the experience of private practice psychotherapists cited this as a concern as well. There was no information if any of these participants were the owners of a private practice that employed other practitioners, so there was no discussion regarding the pressure to provide support and guidance for staff members (Duquette & Morgan, 2021).

In early March of 2020, the federal government classified COVID-19 as a public health emergency and several states responded to this by issuing a shelter in place order which required mental health workers to provide services from home. By mid-March, Medicare and Medicaid relaxed telemental health guidelines and stated they would provide reimbursement for this type of service even for clinicians who had not been previously approved or trained to do so (Duquette & Morgan, 2021; McCoyd et al., 2023). Social service agencies and clinicians who were in Medicare and Medicaid insurance panels were soon given the reassurance they needed. Private insurance companies were slower to respond, but eventually they did provide assurances that telemental health would be covered. Many insurance providers also eliminated co-payments or client deductibles for a period of time. (Duquette & Morgan, 2021). While this did not directly impact the reimbursement for clinicians, it is possible it allowed clients to remain in or begin therapy since financial obligations were no longer a barrier. This could be an area of future research.

Despite all these challenges, the CSWs expressed that the learning curve was short, and they were able to adapt to the use of telemental health very quickly. This transition did impact them professionally due to the very nature of what the shelter in place created because they all had to change their method of service delivery and office location. This study reveals that the transition had the most significant impact upon the CSWs who identified as practice owners. They experienced higher levels of stress and anxiety due to the uncertainty that insurance would reimburse for telehealth services and the pressure they felt to support and guide their staff in this new, uncharted pandemic landscape. There is no current research that specifically discusses the experience that private practice owners had regarding the additional stressors they experienced due to the pandemic and the shelter in place order and, as such, this study provides a novel contribution to the literature. An area for future research would be how to provide support and guidance for private practice owners in the face of a future communal crisis.

Professional Insecurity. One prominent theme that several of the CSWs in this study experienced was a feeling of insecurity about the use of telemental health while working from home. This encompassed the fears the CSWs had surrounding their effectiveness as a virtual therapist, and how to provide care for clients who were not well suited for telemental health.

A majority of the CSWs in this study were very concerned about their ability to provide effective telemental health services for their clients. They felt as though they were better therapists in person and could not imagine how telemental health could be helpful for their clients. They appreciated the energy and rapport that in-person sessions produced and doubted their ability to create that through a screen. They shared concerns that they would not be good enough, able to engage with their clients, or have the clinical skills to do virtual sessions. As

professionals, they felt deeply committed to continue providing care for their clients and had no choice but to make the adjustment.

These findings are heavily represented in research done on provider perceptions of telemental health. Many CSWs prefer in-person sessions for accurate assessments of a client's emotional and physical state, to build rapport, and pick up on non-verbal cues (Alston et al., 2022; Benudis et al., 2022; Duquette & Morgan, 2021). Many did not believe their clients would like telemental health or find it helpful, and this reduced a desire to use this method of care (Jenkins-Guarnieri et al., 2015; Luxton et al., 2014; Shore et al., 2014).

Research done on therapists and mental health workers following the pandemic cite these same worries when they started using telemental health (Alston et al., 2022; Fernández-Álvarez & Fernández-Álvarez, 2021; Gabbard, 2021; Hilty et al., 2023; McBeath et al., 2020). The newer research holds a different element though because clinicians were forced to provide virtual therapy and many of them did not have adequate training or even the desire to use telemental health. This added a different perspective. Many were unsure of legal and ethical guidelines for telemental health, appropriate types of interventions to use, ways to handle an emergency with a client, and protection of confidentiality (Doran & Lawson, 2021; Duquette & Morgan, 2021; Lawson et al., 2022; McBeath et al., 2020). Since they had not chosen to be a virtual therapist, they had not done previous research or training to be up to date and practiced in this type of service delivery.

The CSWs in this study felt insecure with their ability to provide adequate therapy for some of their clients who were high risk or were not well suited to use telemental health. Clients who struggled with self-injury behaviors, had eating disorders, or expressed suicidal ideation

were considered high risk clients and many did not feel equipped to address these types of clinical issues through a virtual platform. They quickly discovered that younger children were not well suited to therapy through a screen. Play therapy was the primary modality the CSWs used prior to the shelter in place order, and this did not translate well through telemental health. Other interventions that the CSWs could not execute via telemental health were EMDR and brain spotting.

One recent article studied social service providers and the impact COVID-19 had on their level of burnout and resilience during the pandemic. It was a mixed methods study which included a sample of private practice social workers (448 participants out of 1472 interviewed). Those in private practice talked about the difficulties they had when they switched to telemental health. They found there were some populations that did not do well with virtual therapy such as children, older adults who were not technologically adept, and those who were under resourced. They struggled to execute certain therapeutic modalities such as eye movement desensitization and reprocessing therapy (EMDR) and play therapy and found it difficult to perform accurate assessments of suicidality and substance abuse issues in clients (McCoyd et al., 2023).

Feelings of professional insecurity surrounding the use of telemental health is represented in the literature, both before and after pandemic. The research shows that some clients are not well suited for telemental health such as children or individuals with more serious mental health conditions or home situations. This is made more difficult due to the lack of training in best practices for telemental health for the CSWs interviewed. One study showed that clinicians experienced less professional self-doubt after the first several weeks of the pandemic as they

adjusted to the novel experience of working from home and using telemental health (Doorn et al., 2022). This indicates training in telemental health would have mitigated these insecurities.

Working from Home Works. The CSWs that were interviewed for this research had several reasons they felt that working from home, and the use of telemental health, worked well for them. The reasons were protection from catching COVID, more free time in their day, more flexibility with their work schedule, and telemental health is preferred for some clients.

Protection from COVID

The participants felt relieved they could work from home, safe from the virus. Since there was little knowledge about COVID at the beginning of the pandemic, the CSWs with a compromised immune system experienced a high level of fear that they might catch the virus or pass it on to a loved one at home who was medically vulnerable. Working from home was seen as an extra layer of protection and it was remembered as a very positive aspect of their experience, despite the fear they held of getting sick.

Research done after the pandemic cites that many individuals appreciated working from home to be safe from catching COVID. Several studies show that social workers who were worried about catching COVID associated working from home as a way to keep them and their families safe (Alston et al., 2022; Bender et al., 2021; Cogan et al., 2022; Lawson et al., 2022). The fear of catching COVID, especially before the vaccine was available, is reported to have added more stress and anxiety to social workers and was a contributing factor in some studies to burnout (Childs et al., 2024; Gabbard, 2021; Holmes et al., 2021). There is correlating evidence which shows that mental health professionals who did not have the option to work from home during the shelter in place order experienced higher levels of job-related stress, symptoms of

burnout, increased levels of anxiety and depression, insomnia, and compassion fatigue (Alston et al., 2022; Banerjee et al., 2020; Holmes et al., 2021; Ross et al., 2021).

More Free Time

During the shelter in place time period, many social, school, and recreational activities were no longer available. Individuals and families now had extra time in their day by the simple fact that there were no other options to fill their non-work or schooling hours. A majority of the CSWs interviewed commented that this was an aspect of working from home that they noticed and appreciated. They were able spend more time with families, engaged in self-care activities more regularly, and exercised more.

Some of the CSWs stated this extra time was because they no longer had to drive to and from their offices. Without the commute, they used that time for other activities with family, for work or household tasks, or downtime for themselves. Some of them really appreciated the relaxed approach they had with getting ready for work in the morning. Since they were only viewed from the waist up, they had less pressure to put time and effort into looking professional. They saw this as a nice benefit to working from home.

Only three studies provided evidence that social workers found the loss of a commute as a positive outcome of telemental health use and working from home (Duquette & Morgan, 2021; Lawson et al., 2022; McBeath et al., 2020), but none of them indicated that this gave them extra time in the day. Two of these studies indicated the lack of a commute brought financial savings which was seen as a benefit (Lawson et al., 2022; McBeath et al., 2020). There were no studies which showed that working from home during the shelter in place order created extra time in a CSW's day for non-work actives and there is scant research in the literature which highlights

possible benefits that CSWs experienced while working from home. This experience of extra time is a novel finding from this study and could be an area for future research.

Flexible Schedule

The CSWs in this study felt that working from home allowed them to be much more flexible with their work schedule throughout the day. Some of this was directly correlated to the fact that they and many of their clients were at home, and so everyone had more flexibility in general. They appreciated that they could move sessions around to fit the needs of their days better. This allowed them to be available to help their children with school, have meals with their families, and do more self-care activities during the day. If a client canceled a session last minute, the free time was often used for non-work activities. They could see clients later in the day if they wanted to exercise in the morning or put sessions back-to-back to end the day sooner. These benefits were seen by the CSWs to have a positive impact on them professionally and personally.

There is a scant amount of research in the literature which reflect these findings. Two studies found that social workers who used telemental health and worked from home during the pandemic cited greater flexibility with their work day as part of their experience, but offered no details as to what they did with the extra time (Kranke, Barmaksezian et al., 2024; McBeath et al., 2020). A quantitative study on adults who worked at home during the pandemic found that one of the benefits cited was more flexibility in their workdays, and time and money saved due to the reduction of travel to and from work. There was no distinction on the types of professions represented (Tahlyan et al., 2022).

There is emerging research which indicates that some social workers had less free time in their day due to a higher case load. The pandemic created a nationwide mental health crisis and many social workers saw more clients due to this (Alston et al., 2022; Duquette & Morgan, 2021; Kranke, Kranke et al., 2024; McBeath et al., 2020). Two CSWs from this research indicated they saw more clients during the shelter in place order, but this did not change the belief that they had more time throughout their day for non-work activities than they did prior to the pandemic.

These findings, while not completely novel, are not well represented in the literature and could be a focus for future research. The ability to work from home and provide telemental health may be indicators for a better work/life balance and for CSWs and their families. There are also indications that this is a preferred option for medical safety if future pandemics or biological crises occur within a community.

Telemental Health is Good for Some Clients

The CSWs interviewed for this research had never used telemental health with their clients prior to the pandemic, but they all were quick to adapt and grateful they could continue to work and support their clients. Through the experience of working from home, the CSWs discovered that telemental health was a great option for some of their clients. For example, if the weather was bad or a client had or transportation issues, they could use telemental health for their sessions. Since travel was no longer an issue, last minute cancelations were no longer a consideration for clients who had no childcare, were sick, or had time constraints. One CSW worked with HIV clients and those with socioeconomic disadvantages. She stated that virtual

sessions were often better for them medically and financially. They no longer had to expose themselves to the possibility of getting sick or use precious resources on travel.

There is a large body of research which looks at how clinicians feel about the use of telemental health and provides overwhelming evidence that telemental health use is effective and that clients and clinicians alike find it to be a positive option as well (Gros et al., 2013; Jenkins-Guarnieri et al., 2015; Khwaja, 2020; Luxton et al., 2014). The research done prior to the pandemic is largely representative of clinicians who chose to use this type of service delivery so there is a belief that they had the appropriate training and felt prepared to do so. Additionally, clients who had access to, and used telemental health prior to the pandemic, chose this type of service delivery rather than being forced to due to a worldwide pandemic. An example were individuals in rural or medically underserved communities, or those who could not travel due to an injury or illness, mobility problems, or transportation issues (Choi et al., 2014; Doarn & Merrell, 2014; du Toit et al., 2019; Kim et al., 2013; Ruskin et al., 2018). Previous research indicates that virtual sessions were used when clients faced smaller life hassles like car trouble, an inflexible schedule, childcare problems, or bad weather, (Hilty et al., 2013; Johnson, 2017; Neufeld & Case, 2013; Perle & Nierenberg, 2013). Prior to the pandemic, the use of telemental health was not a widely used option for many CSWs or for their clients (Brooks et al., 2013; Romney & Baird, 2015; Shore et al., 2014). One study found that before the pandemic, only 29% of private practice social workers used telemental health, and by 2021there was an estimated 80 % who used virtual therapy as an option for clients (Duquette & Morgan, 2021). Another one found that insurance claims for telemental health in the United States went up by 1019.3% between March 2020 and December 2020 compared to entire year of 2019. From

December 2020 to August 2022, telemental health claims were 1068.3% higher than pre pandemic levels. In-person visits increased by 2.2% each month during this time period and by August 2020, in-person visits had risen to 79.9% of pre-pandemic claims. Overall claims to insurance companies between March 2020 and August 2022 rose by 38.8% overall (Cantor et al., 2023). This shows that while not all clients find telehealth to be their chosen way to experience therapy, a large percent still utilizes this type of mental health service.

The CSWs in this research found telemental health to be a positive addition to the way they provided therapy and all of them have kept this as an option for clients. While many stated some insecurity about it being effective at the beginning, the overall experience for the CSWs was positive. After the shelter in place order was lifted and clients could come back to an in-person session, all ten of the CSWs stated they have clients who would rather use telemental health for therapy. One CSW has remained in a home office and only offers telemental health, but the other nine are back in their non-home office and have adapted a hybrid practice. One practice owner stated that she believed therapy is better in person and did not allow her staff to remain fully remote. They are expected to be in the office, although they do offer telemental health to clients.

The results of this study show that there are some clients who prefer telemental health for therapy sessions for a variety of reasons and the CSWs who were interviewed now feel effective and competent to provide this type of care.

While there is a robust body of literature which looks at telemental health and working from home during COVID-19, much of it is on provider and client perceptions, efficacy, ethical standards, and training needs. There is a growing number of studies which provides insight into

the negative effects this time had on mental health providers such as burnout, compassion fatigue, mental health struggles, and social justice concerns. The clinical social workers interviewed for this study did not discuss the negative effects found in the literature. There are several explanations for this counter-finding. It is possible that the CSWs interviewed did not suffer from as many negative consequences. Because I interviewed CSWs a year after the pandemic ended it is possible that their memory of difficulties dimmed over time. It is also possible that CSWs who were negatively impacted by the pandemic, especially those who experienced burnout or compassion fatigue and are no longer working or engaged in professional communities, would not have responded to the recruitment email. This would have resulted in a biased sample of CSWs. Those who wanted to be interviewed and share their story were more than survivors of the pandemic, they were thrivers.

Future research could address the gap in the literature which looks at private practitioners who had never worked from home and used telemental health previously, and the impact this time had on CSWs.

The Shared Reality is Harder. The CSWs interviewed for this research had a unique experience in that they were living and working through the pandemic alongside their clients. This is considered a shared reality and is characterized by a time when CSWs and the person receiving the therapy both belong to the same community, group or geographical location that has been affected by the situation at hand. In this experience the CSW suffers double exposure. They or their family are individually and personally affected by the crisis, and simultaneously they provide professional services or psychotherapy to persons adversely affected by the same crisis. The double exposure is an added layer of stress and distress for CSWs (Baum, 2012, p. 37;

Kretsch et al., 1997; Nesbeda, 2014). The shelter in place time period fits this definition and this study provides evidence that the CSWs interviewed did indeed experience it as a shared reality. The overwhelming consensus was that their experience was made more difficult since they had to endure personal stressors and uncertainties of the pandemic while guiding their clients through theirs at the same time. Examples of what emerged from this theme were stories about how the CSWs struggled to manage the fear of the unknown regarding the global trauma of the pandemic, and how it amplified mental health problems and empathetic connections and disconnections.

Research done prior to the pandemic has documented multiple examples of shared realities that have occurred throughout the world. The COVID-19 pandemic is far from the first-time social workers have been called upon to show up in the middle of a crisis or tragedy to provide care and support for those affected. Examples include the 911 tragedy in New York (Goin, 2002; Seeley, 2008), hurricanes and earthquakes (Nicogossian & Doarn, 2011; Norris & Bellamy, 2009; Weisler et al., 2006), high conflict and war zones (Hamid et al., 2020), and other biological disasters (Maunder, 2009; Peng et al., 2010). There is ample research which provides evidence that when a CSW is experiencing the same tragedy as their clients, at the same time, they are susceptible to amplified mental health struggles, compassion fatigue, and burnout (Adams et al., 2006; Baum, 2010; Whitebird et al., 2013).

There is a growing body of evidence in the literature which supports the pre-pandemic findings. Social workers who lived and worked through the pandemic suffered from increased emotional, mental, and occupational stressors. The experience of a shared reality is closely associated with higher levels of burnout, compassion fatigue, depression, anxiety, exhaustion, and PTSD symptoms (Alston et al., 2022; Holmes et al., 2021; Kranke, Barmaksezian et al.,

2024; Probst et al., 2020; Ratzon et al., 2022). The sample of ten CSWs interviewed for this research is only a portion of the thousands of CSWs in the United States, and around the world, who had to live through a shared reality during the pandemic. Although not representative of all social workers, the global nature of the event suggests that the insights and stories captured some of what social workers experienced during this unique time in history.

The Fear of the Unknown Regarding the Global Trauma of the Pandemic

The CSWs interviewed for this study shared how much fear they felt regarding the unknown possibilities of the future. They did not know what would happen if they or a loved one got sick with COVID, they were unsure about what the future held for the world socially, financially, and occupationally, and they did not know when or if the pandemic would ever end. This fear was often echoed by their clients and the CSWs felt inept in their ability to provide any source of reassurance or comfort to their clients. They were in the dark about the future as much as everyone else was. The CSWs responded with feelings of helplessness and anxiety. They struggled to hold space for the fear in their lives alongside their clients' fears.

There is emerging literature which supports these findings. One study (Gabbard, 2021) talked about the fear of the unknown as Covid anxieties. CSWs and clients alike were worried about catching COVID and dying and they felt hopeless about the future when it seemed so uncertain. COVID was talked about as the great leveler which removed barriers between client and clinician. Everyone was living through pandemic at the same time and there was a shared awareness regarding the fear of the unknown future. This was reported to increase the psychological stress of the CSWs and contributed to high levels of depression and anxiety.

The fear of how, or if, the world was going to recover from COVID-19 is a theme in recent literature. CSWs and clients alike wondered how this public health emergency would be resolved. In the early months of the pandemic, there was little information and this shared reality added to already high levels of stress and anxiety. CSWs had no direction or answers for themselves or their clients and this had a negative impact the emotional well-being the CSWs (Hall et al., 2022; Holmes et al., 2021; Sullivan-Tibbs et al., 2022). The lack of timely information from governments, public health agencies and professional agencies on how to respond to the pandemic occupationally was noted as stressful and frightening for many CSWs. Without adequate guidance on safety measures or accurate information on the virus itself, the fear of exposure to COVID-19 was indicated as a high cause for amplified stress and reports of PTSD for CSWs working during the pandemic (Hilty et al., 2023; McCoyd et al., 2023). One quantitative study of social workers in Scotland showed that 88.4% expressed their greatest stressor was the fear of catching COVID-19 and 49.3% met the clinical qualifications for acute stress disorder (Cogan et al., 2022).

This new body of evidence supports the finding of this study. The fear of the unknown and the global trauma of the pandemic was a shared reality for the CSWs interviewed for this study. The experience created high levels of emotional distress, anxiety, stress, and fear for them. The fears their clients shared with them, and the CWS's inability to mitigate them, were contributing factors to why this shared reality was so difficult.

Amplified Mental Health Problems

The CSWs interviewed for this study shared stories of how much harder life became for them during the pandemic. They cited increased feelings of depression, anxiety, fear,

exhaustion, loneliness, and sadness. The isolation caused by the shelter in place order was a contributing factor and added to their struggles. As they continued to work from home through virtual platforms, the added responsibility and weight of caring for their clients made their experience even more difficult. The CSWs expressed that the intensity of their clients' clinical issues was amplified due to the pandemic and dominated client sessions. The regular exposure the CSWs had to heightened mental health concerns for themselves, their families, and their clients made the shared reality harder for them to manage.

The body of literature on the mental health consequence of a crisis, trauma, or disaster is robust. There have been numerous studies which validate how deeply a person is impacted by these types of circumstances (Adams et al., 2006; Javed et al., 2020; Miller, 2012; Tosone et al., 2012). Research done following the pandemic has contributed significantly to this body of work. There is no doubt the COVID-19 pandemic created a mental health crisis and had wide-spread influence on the negative ways individuals were impacted by this global crisis. Reports of depression, anxiety, addiction, suicidality, marital distress, PTDS, and grief rose during this time (Banerjee et al., 2020; Duden et al., 2022; Lawson et al., 2022; Rajkumar, 2020; Talarowska et al., 2020; Zhai & Du, 2020).

The research on social workers who worked through the pandemic reflect this data. The experience of providing care for their clients while they had to manage personal mental health difficulties is directly correlated to reports of increased rates of burnout, compassion fatigue, job-related stress, anxiety, depression, and PTSD (Childs et al., 2024; Hall et al., 2022; Holmes et al., 2021; McCoyd et al., 2023). Multiple studies provide evidence that CSWs who worked during

the pandemic endured significantly negative consequences for their emotional and mental well-being (Bender et al., 2021; Peinado & Anderson, 2020b; Probst et al., 2020; Ratzon et al., 2022).

The results of this study confirm and reflect current research which provides evidence that CSWs who endure a shared reality during a time of crisis, such as the COVID-19 pandemic, are vulnerable to greater mental health struggles. The CSWs in this study experienced higher levels of anxiety, depression, loneliness, sadness and fear due to the shared reality. An area of future study could focus on how social work values might impact the commitment social workers have to continue providing care despite significant personal difficulties.

Empathetic Connection and Disconnection

The CSWs who participated in this study had opposite experiences of empathetic connection. Some of the CSWs indicated that the shared reality caused them to have a deeper empathetic connection with their clients. They felt closer to their clients because they were experiencing very similar situations in life. They saw this as a positive aspect and appreciated the ability to find a deeper way to understand and be present for their client. Other CSWs shared how much they lost the desire or ability to be empathetically connected to clients. They felt a loss of compassion towards clients and found it difficult to respond with emotional care to issues they deemed small or inconsequential. Additionally, they felt frustrated that clients did not seem to understand or care that they were also going through difficulties related to the pandemic and the shelter in place order. These reactions impacted their ability and desire to be present for their clients.

A shared reality experience is unique in that the CSW is experiencing the same or similar situation that their clients are. The pandemic has already been noted to meet the criteria of a

shared reality experience and previous research regarding how that has impacted CSWs has been discussed. The concept of a compromised empathic connection is often associated with exposure to a shared reality and the consequence of compassion fatigue and burnout. It is also only seen in light of the fact that a continued empathic connection with individuals who are suffering has been present which is what causes the emotional depletion (Adams et al., 2006, 2008; Wagaman et al., 2015). Symptoms of compassion fatigue and burnout include feelings of apathy, powerless, anger, guilt, depression, and loss (Cocker & Joss, 2016; Ratzon et al., 2022; Whitebird et al., 2013). Behavioral impacts can be seen through increased moodiness, withdrawing from social situations or relationships, and increased anxiety (Adams et al., 2008; Kapoulitsas & Corcoran, 2015). As a result of this, CSWs who experience compassion fatigue or burnout have a higher chance of feeling less empathetic and more disconnected from their clients.

The current research provides evidence that, for CSWs, the shared reality increased rates of provider compassion fatigue and burnout (Childs et al., 2024; Holmes et al., 2021; Kranke, Barmaksezian et al., 2024). One recent study showed that the rate of social worker burnout went from 40 percent prior to the pandemic to 60 percent at the height of the pandemic. This was due to a higher level of need for services and the emotional exhaustion due to added responsibility of providing care for clients who presented with higher levels of mental health struggles themselves (Kranke, Barmaksezian et al., 2024). Another study showed evidence that as the personal life of a social worker became more challenging, their ability to be empathically present for clients was compromised (Childs et al., 2024).

The CSWs in this study were on the front lines regularly providing empathy, care, and support for their clients. While some of them found this to be a point of connection for them to their clients, others reached a point of emotional exhaustion and struggled to find the compassion they previously held for their clients. While these are not novel findings, they do reflect current literature and research that a shared reality can bring a CSW closer to their clients as they empathetically connect with a common situation, or it can cause burnout or compassion fatigue which shuts the empathetic connection down.

Self-Care is a Priority. The CSWs in this study experienced higher than normal levels of stress due to the pandemic, their mental health struggles, and the heaviness of the shared reality with their clients. For all of them, this was a time in their lives they had to re-evaluate priorities to maintain their emotional, mental, physical, and professional well-being. The overarching theme was loud and clear. They all made self-care a priority. The actions of self-care were described in terms of exercise, improved diet, scrolling on social media, taking time to be with family, connecting with colleagues, enjoying hobbies, spiritual practices, and self-reflection. Considering the shelter in place order, many options for self-care activities were no longer available, and new ones needed to be created.

This research has already documented the emotional and mental consequences a social worker suffers when a traumatic event, such as such as the COVID-19 pandemic shared reality, impacts their life. There is a large body of research done prior to, and following the pandemic, which provides several mitigating factors to protect social workers from compassion fatigue and burnout. That mitigating factor is self-care (Kranke et al., 2022).

Research done prior to the pandemic on mitigating factors to prevent compassion fatigue and burnout include: high job satisfaction, support from peers and supervisors, strong social supports, a sense of mastery in their lives, good internal copings skills, and higher levels of resiliency (Gil & Weinberg, 2015; Quinn et al., 2019; Shoji et al., 2014; Waegemakers Schiff & Lane, 2019). Other supportive interventions that have been noted to reduce CSWs' stress include: a strong self-esteem, time spent with friends or family, and physical activity such as a sport or going to the gym (Adams et al., 2008; Harker et al., 2016; Kapoulitsas & Corcoran, 2015; Schwartzhhoffer, 2009; Waegemakers Schiff & Lane, 2019).

One of the most cited mitigating factors for burnout and compassion fatigue after the pandemic is for social workers to have connection. This includes professional, personal, and social connections.

There is a large body of literature which cites the importance of regular connection to a professional support system. Examples include regular meetings with a supervisor or with a peer supervision group, connection to fellow colleagues, or to join an online professional support groups (Bender et al., 2021; Childs et al., 2024; Harms et al., 2022; Kranke, Barmaksezian et al., 2024; McCoyd et al., 2023). This improves a sense of job satisfaction, helps the CSW process complicated or difficult clinical issues, and creates a sense of community within their professional world. Kranke Barmaksezian et al. (2024) specifically cited that connection with other professional provides social workers an opportunity to acknowledge the shared trauma of the pandemic. This helps facilitate the social workers' recognition of the how that trauma impacted themselves and their clients.

Personal connection includes time with family, friends, and intimate partners. Examples in the literature cite how helpful it is to have quality time with children or other family members, have game or movie night, enjoy family meals together and plan recreational or leisure activities to do together (Bender et al., 2021; Cogan et al., 2022; Hilty et al., 2023; Kranke, Barmaksezian et al., 2024). This provides the CSW with a feeling of belonging and reduces the negative effects of isolation and loneliness.

The last area noted for connection is social connection. There is less research on this, but it is starting to emerge. It is valuable to note that the self-care suggestions in the current literature represent virtual social connections which would make sense as most options for social outings were not available during the pandemic. Examples in the literature include joining an online book club, joining a group through social media apps or virtual platforms, attending therapy via telemental health, and joining a virtual workout class (Cogan et al., 2022; Harms et al., 2022; Hilty et al., 2023; Kranke, Barmaksezian et al., 2024).

There were two studies that talked about how important flexibility in the workday was to help the CSW feel more in control of their schedule and in charge of creating a routine that worked best for them. Other helpful actions included regular breaks throughout the day including exercise as a regular routine (Hilty et al., 2023; McCoyd et al., 2023).

Lastly, some self-care actions that can help reduce the effects of compassion fatigue and burnout are more solitary and reflective such as mindfulness practices, yoga, spiritual supports, breathing exercise, and guided meditations (Peinado & Anderson, 2020b).

The CSWs who participated in this study were intentional about adding self-care activities into their daily schedule. This was due to the awareness of how difficult, stressful, and

challenging the pandemic was for them. This was correlated to the shared reality they experienced with their clients and the hardships they endured personally. While these are not novel findings, future research could focus on what types of self-care actions were most helpful for CSWs during the pandemic to provide a pathway of support if there is another time in the future where the normal self-care options are no longer available. The overall experience from the CSWs did not indicate they had suffered from burnout or compassion fatigue, and it is very likely a result of their self-care efforts during the pandemic.

It Is Going To Be OK. This theme represents a reflective look back from the CSWs who participated in this research. The last interview question they were asked was "What advice would you give to your pre-pandemic self?" The overwhelming response was a version of "do not worry, everything will be ok." This represents the wish for reassurance and support that they wanted and needed in the beginning of the pandemic. They were afraid, insecure, isolated, and attempting to navigate a worldwide pandemic while they supported and cared for their clients.

Even though we have research which provides ways to mitigate compassion fatigue or burnout (Bender et al., 2021; Childs et al., 2024; McCoyd et al., 2023), training programs for emotional preparedness for a disaster (Kranke et al., 2022), telemental health competencies for social workers (Merrill et al., 2022), and strategies for healthcare workers to stay emotionally connected and heathy during COVID-19 (Bender et al., 2021), these were not helpful in March of 2020 to the CSWs from this study. This novel finding, that they wanted and needed reassurances, is so simple it seems common sense. And yet, none of them expressed that they were able to find this outside support. Future research could investigate ways professional agencies, fellow social workers, and social service agencies could offer trainings, resources, or

connection points for social workers in the face of future disasters. Schools of social work could include in their education models of preparedness on how to provide support to social workers in case traditional supports were rendered ineffectual. It would be a valuable contribution to the body of literature to discover what social workers in private practice might need for emotional, professional, and mental support amid a large-scale crisis such as the COVID-19 pandemic.

Implications

Social workers are often called onto the front lines of a tragedy to provide care and support for those who have been impacted. This study highlights the challenges and benefits that Clinical Social Workers (CSWs) experienced when they made the dramatic switch to telemental health during the shelter in place order caused by the COVID-19 pandemic. This was a novel situation that had never occurred in history. Findings suggest that CSWs transitioned quickly to telemental health care and were able to provide effective therapy services for their clients, even though they initially struggled with feelings of professional insecurity due to lack of experience or training. The CSWs interviewed for this study discovered that there were many benefits to working from home. Additionally, they experienced emotional and mental hardship due to the shared reality of living through the pandemic while simultaneously providing therapeutic care for their clients. Through the efforts of regular self-care, the CSWs were able to mitigate the effects of compassion fatigue and burnout. The following sections will discuss considerations for changes and recommendations in social practice, social education, and direction for future research.

Social Work Practice

This study found that social workers had a high level of insecurity over the use of

telemental health at the beginning of the pandemic. They were unsure that they would be successful or that they would be able to take care of their clients effectively. Implications are that social workers need training to be effective. Recommendations are that agencies and private practices offer a wide variety of skills competencies and training for different or emerging therapeutic interventions on a regular basis. In light of the pandemic, this should also include telemental health or other types of virtual therapy platforms.

Research done after the pandemic shows that many social workers felt insecure using telemental health. This was a result of no or little training, inadequate technology, and the inability to provide appropriate therapy for clients who did not do well virtual platforms. This caused them to feel less than proficient and could impact the quality of therapy they were able to offer (Madigan et al., 2020; Wilkerson et al., 2020).

Continuing education is an effective strategy to help prepare social workers for future situations that they might not have expected. The pandemic is a good example of why agencies should create opportunities to learn and grow in new and different types of therapy. It is not possible to know what the future will bring, and so if social workers are able to be prepared it allows them to pivot more quickly and respond more effectively to take care of their clients. One option of a future continuing education offering would be training on telemental health best practices for treatment with clients for whom telemental health has traditionally been less effective. For example, CSWs could learn different interventions for children who have shorter attention spans and basic training to teach children how to use technology for a telemental health session. Other strategies could include as shorter session time, physical activity that the CSW and child can do together such as yoga, deep breathing, stretching, or a body scan. Another

option would be to develop a therapy box with the child's caregiver which could have coloring books, fidgets, dolls or stuffed animals for pretend play, or blocks or Legos to build with. These items could be pulled out during sessions to help keep the attention of the child while talking through therapeutic topics.

Another recommendation is that social work agencies help pay for their staff to attend off site trainings, attend conferences, or take a course at a college. These efforts to build into the skill set and knowledge base creates a more confident and proficient therapist. In the face of a future disaster, or difficult client, these social workers will feel more equipped and competent to handle the situation that is in front of them. This can help eliminate initial insecurities or ineffectiveness when a situation arises. This is also a protective action for the client, so they are not receiving inappropriate or uninformed care. The NASW Code of Ethics and CSWE are very clear that social workers are to be competent and ethically trained in any type of intervention that they use with a client (Assembly & Assembly, 2005; CSWE, 2022; Joiner, 2019). Private practices and agencies are supporting the values of social work by promoting continued education and not allowing their staff or social workers to perform therapeutic services they have not been trained or competent in. This has implications for education and agencies could work with local schools of social work to provide training or continuing education opportunities for their social workers.

Findings from this study found that social workers who shifted to telemental health during the pandemic were exposed to higher levels of emotional and mental strain due to the shared reality of caring for their clients as they lived through the pandemic. Self-care became an important part of their daily routine, and these actions made them feel better and protected them

from the effects of compassion fatigue and burnout. Current literature cites that during the pandemic, social workers were more susceptible to those conditions (Benudis et al., 2022; Lawson et al., 2022; Sklar et al., 2021). Implications are that social workers with better self-care habits can be better social workers. Based on the findings of this study and the previous research, it is recommended that private practice owners, and agency administrators and supervisors create a paradigm that promotes self-care as a value, rather than something that is given to the staff. This can be done in many ways, but the goal is to create an environment where the social workers and staff feel empowered and supported to choose when and how they need to take care of their emotional and mental well-being. For example, a practice owner could set up a room that could be used for yoga, meditation, or exercise. Or they could allow a social worker the freedom to leave during the day to go to a yoga class if that is a better option of self-care for them. A recommendation is that those in leadership take a subtle shift in how they create the paradigm of self -care. Maybe they do not bring self-care into the office; rather, the social worker is given the freedom and flexibility to decide for themselves what is most helpful. For example, if a social worker wanted to stay home and attend a staff meeting virtually because that felt better for them and made their day more relaxing, there would be freedom and support to do that. Perhaps they wanted to have a work from home day or needed to come in on a weekend to finish paperwork or see a client. The leadership would trust that the social worker knew what they needed and knew how to take care of themselves. One study cited how important it was for social workers to talk with fellow peers, especially in a time of crisis or shared trauma, as a way to normalize their feelings and experiences of the situation (Kranke, Barmaksezian, et al., 2024). Agencies could consider informal gatherings for their staff to allow these conversations to occur.

A final recommendation would be to develop a response strategy for their agency which includes how they will communicate to their staff in crisis situations and what they can expect from the supervisor. Many agency supervisors and practice owners were unsure how to respond or best lead their staff at the beginning of the pandemic. A disaster response strategy would offer comfort to staff members that they would know how to respond should a crisis occur. These can be ways to promote and protect the emotional and mental well-being of social workers, especially in times of high stress or crisis.

Implications for Social Work Education

One of the findings from this study is that CSWs were not trained to use telemental health before the shelter in place order during the pandemic. The result is they did not feel prepared or skilled to use telemental health and were worried they would not be effective for their clients. The implications for this are that schools of social work need to prepare social work students to use telemental health to ensure they can provide ethical and effective virtual therapy services. They can do this by incorporating a course on telehealth best practices as a requirement into their curriculum or it could be offered as an elective.

The Council on Social Work Education (CSWE) has released the 2022 Educational Policy and Accreditation Standards (EPAS) which specifies the curricular content and educational context to prepare students for professional social work practice. Despite the influx of telemental health use during and following the pandemic, they do not offer guidance on the specifics of how educators should integrate digital and technology ethics into a curriculum. The direction that is offered states the social workers should understand the ethical use of technology in social work practice but offers no direction on what that looks like.

Next steps to consider would be to find alternative competency programs to use in the classroom. For example, The Coalition for Technology in Behavioral Sciences (CTiBS) published a comprehensive competency framework on the use of telemental health in 2017, and the National Association of Social Workers (NASW) developed and published the Standards for Technology in Social Work Practice which were integrated into the Codes of Ethics for NASW in 2017 (Merrill et al., 2022). These are both excellent resources to use for the education of students and social work professionals alike.

Another consideration as to why it would be valuable to teach telemental health efficacy and ethics is to protect clients from social workers who might behave in an unethical way or are simply bad at how to perform telemental health therapy. Telehealth is going to remain an option for therapy and many social workers have continued to use this once the pandemic ended. It is unlikely these therapists will choose to get training after they have been using it for years. The lack of proper training puts clients at risk. It also raises the possibility that social workers might behave in unethical ways. There are no supervision requirements, and this creates a problem trusting the efficacy of telemental health social workers.

Another finding from this study was that social workers did not know where or how to get information on how to respond to the COVID-19 pandemic. The implications of this are that schools of social work and professional organizations need to have a bigger and louder response for the social work community in the face of a crisis. The pandemic and shelter in place order was very disorienting and social workers did not have guidance on how to respond personally or professionally during this crisis. The lack of timely information from governments, public health agencies and professional agencies on how to respond to the pandemic occupationally was noted

as stressful and frightening for many CSWs. Without adequate guidance on safety measures or accurate information on the virus itself, the fear of exposure to COVID-19 was indicated as a high cause for amplified stress and reports of PTSD for CSWs working during the pandemic (Hilty et al., 2023; McCoyd et al., 2023).

Schools of social work, professional agencies, and continuing education (CE) providers such as NASW can make efforts to work with other agencies or schools of social work to collect CE training resources that would provide quick guidance and help train for future situations. One example is a continuing education course called Telebehavioral Basics for Social Worker Educators and Clinicians Responding to COVID-19 which was released at the end of April 2020 to provide basic training and support for the use of telemental health. This was done by educators at a school of social work as a response to the pandemic (Wilkerson et al., 2020). Schools of social work have an opportunity to be a resource to their communities in the face of a disaster or crisis.

An area of future consideration for schools of social work and professional organizations is to create a set of standards to teach social workers on how to implement new types of technology in a future crisis. It is vital that the social work profession attempt to look forward and consider responses to different types of national or global crises. How would we respond to a massive cyber-attack that left us without the use of telephones, internet, or television? How would we respond to a financial crash with no access to banks, a data breach that left social workers without access to client files or data bases, or wide-spread chemical warfare? Continued effort is needed to better prepare the social work profession and practitioners to respond when

we are called back onto the front lines of a crisis. The classroom is an appropriate avenue for this type of training and education.

Implications for Future Research

The findings of this study showed that the practice owners felt more stress and anxiety during the pandemic than non-practice owners. They had extra responsibilities associated with being a practice owner such as making decisions for their practice, staff, and clients over how to respond to the pandemic, worries about insurance billing and reimbursement, and concerns over the efficacy of telehealth for their staff and clients. This was made more difficult for them as they were also struggling with the effects of the pandemic and working from home. There was no research found in the literature regarding the experience of private practice owners and how they felt about working from home and as such this is a novel finding.

Implications for research could focus on what practice owners want or need to feel supported in a crisis like the pandemic. What does the added weight of financial responsibility do to impact a practice owner? This could lead to new ways to approach the fee structure of a private practice to eliminate the responsibility from just one person. Perhaps private practices are not the best idea for the future and a co-op type option could work? Additionally, it would be interesting to know if there were any similar characteristics of practice owners that might cause them to naturally feel more anxious, or perhaps they care more than average which is why they worry more. This information could be used to provide continuing education training for practice owners to help give them options for best ways to take care of their well-being and run a successful business. Practice owners should be on the front lines of receiving guidance, support, and training if a future crisis forces a change to their traditional work environment.

Information gathered from this research could be useful to social workers who have extra caring responsibilities as part of their job. One example to consider is a CSW who was working from home during the pandemic and had to provide school support for their children. There is scant research on this population, but it is hard to imagine there is not a significant sample available. They would have had to sacrifice client hours to help their children with school and perhaps had extra stressors dealing with behaviors or issues with multiple children sharing technology. There are two studies that reported that female social workers who had young children at home experienced more stress than those who did not (Alston et al., 2022; Kranke, Barmaksezian et al., 2024) Results from this type of research has direct implications to practice. If a CSW is emotionally compromised or too distracted with childcare duties to see clients during the day, they might not be able to provide effective or consistent therapy for their clients. This population of CSWs might need different types of support or self-care to maintain their emotional and mental health.

Another finding from this study is that working from home worked. The CSWs found this to have many benefits. There is not a lot of research which address the positive impacts of the pandemic for social workers. Implications from research can explore the factors that made this option to work from home so positive. It would be helpful to have a wide variety of home situations represented to see if one type of setting was more conducive to positive feelings of working from home. For example, is a small, crowded apartment the same as a two-story home with a dedicated office, or does it matter if there are multiple children in the home compared to an empty nester. Some research indicated that CSWs liked working from home because they saved money and time without the drive (Kranke, Barmaksezian et al., 2024; McBeath et al.,

2020). This dissertation research discovered that working from home brought unexpected benefits such as greater flexibility with how they scheduled their day and extra time in their day which they used for non-work activities. A quantitative inquiry could provide insight to determine if these findings are generalizable. Results from this type of research would have direct implications to practice and could provide practice owners or agency administrators with empirical data to help them decide if a hybrid work environment would be beneficial to their staff.

Limitations

There are several limitations to this study. The first one is the sample of social workers that were interviewed. The participants were all from the State of Illinois, who were in private practice and were clinical social workers. Findings should be looked at with caution as individuals outside this demographic may report a different experience. The sample is further limited by the small number of people of color. Black and Latinx communities were hit harder by the pandemic, and this was especially true in Cook County, Il (Unruh et al., 2022). Social workers from this demographic would likely have a client base that looked more like them and might have had a more difficult experience of the shared reality. Additionally, the results might look different had more men been interviewed or social workers who had the extra responsibility of educating their children.

Another limitation is that social workers who had a hybrid practice or a fully remote practice prior to the pandemic might report a different experience with technology than social workers who had never used telemental health for therapy previously. Therefore, the findings about the experiences the social workers had with technology cannot be generalized.

This was a retrospective study which is another limitation. The interviews were done in 2023 and this research investigated a time period from March 2020 through August 2020. The reflective memory from the CSWs could have influenced their responses and memory from that time. Additionally, since I was completing the analysis, my involvement with the data could be a limitation. It is not possible that every possible horizon or unit of meaning was uncovered during the analysis of this research. I may have missed nuances or themes due to my present experience at the time I interviewed each participant and when I analyzed the data. It is possible that other themes would have emerged had this research been performed closer to the shelter in place order.

Conclusion

In conclusion, this study explored the lived experience of ten clinical social workers who made the dramatic switch to work from home and use telemental health during the pandemic. They shared stories about what those first few weeks were like, full of fear and uncertainty. They all had committed to figure out how to use this new type of virtual therapy for their clients and wanted to ensure that they could be a present source of help and support for them. As the weeks and months went on, many of them struggled with the heavy weight of the emotional and mental toll that was being exacted upon their clients, and on them and their families. They worked very hard to take better care of themselves and made sure that their self-care was a priority so that they could continue to care for others. As the weeks continued to go on, they found how much they enjoyed working from home. They spent more time with their families and were able to engage in their self-care activities more. Once the pandemic was over, all but one CSW went back into their pre-pandemic office. They do not miss the forced quarantine, but there

were many benefits and growth opportunities that they remember happening during that time. During the shelter in place order, I owned a private practice and found the transition to telemental health and working from home deeply challenging. I struggled to maintain my mental health and feel as though I suffered from compassion fatigue. I was surprised and inspired by the dedication I saw in the CSWs I interviewed for this study. Their commitment to their clients was inspiring and their resilience, impressive. It is my hope that this research reminds others that there are social workers out there who are truly making a difference. And that the profession of social work truly makes a difference

APPENDIX A

INTERVIEW QUESTION GUIDE

Script of narrative for email/online communication to potential participants

Dear Colleagues,

I am Ph.D. Candidate in the School of Social Work at Loyola University Chicago and am seeking individuals to share their story for an important study. The primary purpose of this study is to better understand what it was like for clinical social workers who switched from in-person to telemental health services due to COVID-1919 and the work from home mandate, and how this transition affected them personally and professionally. To participate in this study, you must currently be a licensed clinical social worker in the state of Illinois, worked in a private practice from March 2020 through July 2020, and switched to telemental health service delivery during that time.

As a participant in this study, you will be asked questions pertaining to your work environment before and after the work from home mandate, what it was like to transition to telemental health service provision, the professional and personal impact you experienced working from home, and what it was like to provide counseling services to your clients during the COVID-1919 pandemic while simultaneously living through it in your personal life. The interview will take approximately 1-2 hours to complete. Participating in the study will contribute to a better understanding of how to prepare social workers to pivot care efficiently and competently in an emergency, provide insight into what social workers need so they can provide quality care despite environmental changes, and a better understanding of the steps and interventions they can take to stay emotionally, professionally, and mentally healthy during a long-term crisis.

This research has been reviewed and approved by the Research Ethics Board of Loyola University Chicago. If you have any questions, concerns, or comments about your rights as a participant, please contact the Office of Research Services at: 773-508-2689.

I would welcome the opportunity to meet with you and interview you. If you are interested, please contact me, Juli Chaffee, at jchaffee1@luc.edu to schedule a time and location that is convenient for you. Thank you for your time and consideration.

Sincerely,

Juli Chaffee, MSW, LCSW
PhD Candidate
School of Social Work
Loyola University Chicago

APPENDIX B

RECRUITMENT SCRIPT

Demographics Questions

Professional Information

1) How long have you worked in private practice? _____
2) How many people are employed at your practice? _____
3) What is your highest level of licensure? _____
4) On average, how many clients do you see a week? _____
5) On average, how many of your sessions are still virtual? _____
6) On average, how many of your sessions are still done in a home office? _____

Participant Information:

1) What is your age? _____
2) Please specify your relationship status.
   - Married
   - Single
   - In a long-term relationship
   - Divorced
   - Widowed
3) Please specify your gender.
   - Male
   - Female
   - Other (Please fill in the blank): _____

3 Please specify your sexual orientation.
   - Heterosexual
   - Gay
   - Lesbian
   - Bisexual
   - Other (Please fill in the blank): _____

6) Please specify your ethnicity. (check all that apply)
   - White
   - Hispanic or Latino
   - Black or African American
   - Native American or American Indian
   - Asian
   - Native Hawaiian/Other Pacific Islander
   - Other (Please fill in the blank): _____

7) Please specify your highest level of completed education:
   - High School
   - Bachelors
   - Masters
   - Doctoral
   - Other (please specify): _____

8) Please list the first name or initial of the individuals who lived in your home during the work from home mandate between March 2020 and July 2020, their age, and their relationship to you?

APPENDIX C

DEMOGRAPHIC FORM

CONSENT TO PARTICIPATE IN RESEARCH

(Verbal Consent)

Introduction:
You are being asked to take part in a research study being conducted by Juli Chaffee MSW, LCSW for a doctoral dissertation under the supervision of Dr. Jonathan Singer in the Department of Social Work at Loyola University of Chicago.

You are being asked to participate because you are a licensed clinical social worker in the state of Illinois and worked in private practice from March 2020 through July 2020 and switched from in-person services to telemental health service delivery during that time period.

Purpose:
The purpose of this study is better understand the experience of clinical social workers who switched from in person to telemental health services due to COVID19 and the work from home mandate, and how this transition affected them personally and professionally. Participants for this study must have been a licensed clinical social worker in the state of Illinois and worked in private practice from March 2020 through July 2020 and switched from in person services to telemental health service delivery during that time period.

Procedures:
If you agree to be in the study, you will be asked to participate in:

- An interview that will be conducted by the researcher through the video conferencing platform Zoom.
- An interview that will be audio recorded.
- An interview that is expected to last between 60 to 90 minutes in total.
- Reviewing the study findings to ensure that your experiences are represented in the interpretation of the data.

Risks/Benefits:
Participation in the interview has no perceived risks involved beyond those experienced in everyday life. It is possible to that one might experience some distress recalling events during the work for home order. If supportive services are needed, a list of counseling referrals will be available.
There are no direct benefits to participants. Participating in the study will contribute to a better understanding of how to prepare social workers to pivot care efficiently and competently in an emergency, provide insight into what social workers need to provide quality care despite environmental changes, and a better understanding of the steps and interventions they can take to stay emotionally, professionally, and mentally healthy during a long-term crisis.

Confidentiality:
Following the completion of the interviews, an outside transcription service will transcribe the recordings. In order to protect participant confidentiality, the researcher will use participant pseudonyms during the recording and transcription process. Audio files, transcripts and related computer data files will be stored on password protected computer and will not contain names or other identifying information and will be assigned an identification number. Recordings will be destroyed immediately following transcription. Transcripts and related computer data files will be kept for seven years following the date of the final interview as is the requirement of the LUC IRB.

Voluntary Participation:
Participation in this study is voluntary. If you do not want to participate in this study, you do not have to do so. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions:
If you have any questions about this research study, please feel free to contact Juli Chaffee, MSW, LCSW, doctoral student in the School of Social Work at Loyola University Chicago at jchaffee1@luc.edu. The dissertation chair is Dr. Jonathan Singer, who can be contacted at jsinger1@luc.edu.

If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Statement of Consent:
Do you agree to participate in this study? Do you agree to be recorded?

APPENDIX D

CONSENT TO PARTICIPATE IN RESEARCH

Introduction to the study:

My name is Juli Chaffee, and I am a doctoral student in the School of Social Work at Loyola University Chicago. The purpose of this study is to gain a deeper understanding of what it was like to provide telemental health services to clients during the work from home mandate due to the COVID-1919 pandemic. The following interview will take 1-2 hours to complete. You can stop the interview at any time. Do you have any questions before we begin?

1. Tell me a little bit about what your work environment was like before the pandemic started?
    a. How often were you in the office?
    b. What was the office setup like?
    c. Who worked in your office?
    d. What type of therapeutic interventions or modalities did you provide?
2. I'd like to ask you some questions about how your work experience changed once the shelter in place orders were issued. Can you tell me where you provided services and how that decision was made?
3. What was it like for you to make this adjustment?
    a. How did you set up your home office?
    b. What was difficult with this adjustment?
    c. What was positive with this adjustment?
4. How did the experience of providing telemental health services impact you professionally?
5. How did the experience of providing telemental health services impact you personally?

6. In what ways did you support your professional and personal wellbeing during the shelter in place order.

    Probe question if needed: Can you tell me what was most helpful in supporting your sense of wellbeing? Can you tell me what was least helpful in supporting your sense of wellbeing?

    Probe question if needed: How was this similar or different from the ways you took care of your wellbeing pre-pandemic?
7. A unique aspect of being a therapist during the pandemic is that you provided counseling services to your clients while simultaneously living through it in your personal life. Can you describe ways this shared experience impacted you as a therapist?
8. Can you describe ways this shared experience impacted you in your personal life?
9. As we end the interview, I would love to know if there is any advice you would give to your pre-pandemic self after living and working through the shelter in place order?

This completes the interview process for this study. Do you have any questions about the topics we discussed? Are there other things that you would like to discuss at this time that you think would help me understand what we have been discussing?

Thank you for participating in this study. If you have additional questions, I can be reached at jchaffee1@luc.edu.

APPENDIX E

THEME DEVELOPMENT AND OPEN CODING

Sandy
Practice Owner
2 offices, 12 staff, high trauma clients. They made the decision to work from home for self and staff.
Adjustment
- Worry for health of staff and clients
- Am I making the right decision?
- Worry about insurance paying.
- Flexible schedule
- Post experience working from home but didn't like not having the option to go in
- Stress, fear of the unknown
- "I am not ok."

Professional impact
- Global trauma- we are all in this together.
- Professional insecurity (am I good enough)
- Burnout and compassion fatigue.
- Fear
- Personal trauma was triggered and amplified.
- Be present with clients.
- Support my staff was important.
- Paralyzed by fear.

Personal impact
- Took time off for self-care (residential program)
- Worked less- better work/life balance.

Pre-pandemic
- Time with others
- Exercise, meditation

Shared experience
- The end of the word
- Fear of the unknown
- Loss of hope
- Helpless as a professional

Advice
- It's going to be ok."

Janet
Sublet office from other therapist, moved to home, bedroom for office.
Mostly minority population clients, adults
No negative adjustment
Post
- No commute
- Better work/life balance
- Personal safety due to underlying health issues -this was post- felt relief.

Very rewarding working from home
Less stress
Professional impact
Financial stress/worry- will insurance pay
Lack of guidance, training, support from prof org- caused worry, stress.
Logistical issues (signing consents, etc.)
Challenging
Creative solutions with new interventions, coping skills
Problem solving
Well being
Self-care was more intentional (diet, exercise, lost weight)
Connection with Colleagues
Improved work/life balance
Helping clients helped me feel better.
Shared experience
Self-care work with clients benefited me personally and professionally.
Heightened sense of professional purpose
Challenging
"in their shoes" more empathy
Shared sense of humanity
Personal
Intentional transitional activities
Countertransference with clients
Clients activated my grief.
Grief over many losses- personal connections, romantic partners,
Advice
Don't worry so much.
Self-care is a priority.

Rhonda
Shared office space with other therapists, substance abuse clients
Adjustment
Challenging to work with technology and logistical issues
Panic stricken.
Unsure about efficacy
We all pulled together.
Surprised how well TMH worked for everyone.
Professional impact
Very challenging
Isolation was hard.
Loss of connection with colleagues
Flexible schedule (client and self)
It wore on me (burnout)
Personal impact

TMH was exhausting (burnout)
Depressed
I'm a better therapist in person.
Self-care improved/health improved.
Life felt duller.
Professional well-being.
Prioritize self-care.
Connection with colleagues
Connection to support system
Personal well-being.
Stress caused a physical crisis.
Met with support systems more.
Needed to work on improving health.
Prayer, meditation
Shared experience
Challenging
The load felt heavier.
Shared fear
Fear of the unknown/future
Shared experience personal
Intentional transition time
New ways to transition.
Advice
It will all be ok.

Cindy

Rented office, high trauma clients, pregnant women, brain spotting.
Home office, 2 teen boys and husband at home
Adjustment
Nerve wracking
Stressful learning new technology
Flexible schedule
Better work/life balance
More clients
Increased job satisfaction
Grateful to be helping clients.
Prof impact
Creative with new interventions and strategies
Professional growth and development
Challenging to learn something new.
More committed to my profession
Pride in my profession/helping in crisis.
My professional identity became a bigger part of who I am.
Intentional transitions
Prioritized what was really important to me (work life balance?)

Professional well-being.
- More self-care
- Connection with colleagues
- Professional training

Shared experience
- Shared sense of humanity
- Compassion fatigue (lost empathy toward clients)
- Heavier emotional load
- We are all in this together.
- counter transference

Shared experience personal
- More reflective and contemplative
- Grateful

Advice
- Make it work/be flexible.
- Use this time to grow and improve personally and professionally.

Nancy

Sublet offices 2 different locations. Moved to home – set up office in basement. 2 teen children and husband at home

Works with high trauma client, addicts, ages 18 and up- "I'm used to the heavy load."

Adjustment
- I'm a better therapist in person.
- Professional insecurity (am I good enough online)
- Difficult to adjust to TMH.
- Flexible schedule
- Convenient
- No commute

Professional impact
- Loss- connection with colleagues very difficult
- No guidelines from professional organizations on how to do telehealth.
- No training or experience- I felt in the dark
- Fear, nervous, will I get in trouble/am I doing this right?
- Panic- fear about what to do if a client is suicidal online (no guidelines)
- Loss of professional environment and experience working from home
- Loss of EMDR as an intervention
- More clients- good and bad.
- Not good boundaries – took too many clients.

Personal
- Intentional transition time
- Heavy trauma clients difficult to disconnect.

Well being
- Prioritize self-care (exercise, scrolling,)
- Flexible schedule
- Better work/life balance

Connect with Colleagues
Create new ways to transition.

Shared experience
We are all going through this together.
Compassion Fatigue
Client trauma and mental health issues were amplified.
Hard to keep self-care a priority.

Advice
Be better prepared for a crisis "We are all in this together."

Ashley

Worked for a practice, owner decided to work from home, moved to home office, 3 young school aged kids at home.

Professional impact
Professional insecurity – can I do telehealth- am I good enough?
Lack of professional confidence
Challenging – multi tasking (mom, teacher and therapist)- a significant influence
Creative with interventions and strategies online
Child clients did poorly
Better work/life balance (less travel, more time with family)
More flexibility

Work and home blended together (negative)

Personal impact
Stressful -three roles- marriage suffered.
Challenging to do telehealth from home.
High anxiety working from home.
Hard to see my kids struggle – a significant aspect to her experience.
Isolation was hard.
Very taxing emotionally

Well being
Self-care (exercise, dogs, walks, boating, family time)
Professional connections with others/online training
Creative interventions and strategies with clients

Personal well-being- the same except the professional connections

Shared experience Professional
More empathy for clients "I could put myself in their shoes."
It made my emotional load heavier.
Provoked my anxiety.
The combo of all the shared issues (political, racial, covid,)

Personal
Shared humanity
Macro view – the whole world is going through this.

Advice
It's going to be ok.

Amy
Practice Owner
Two small children at home, Made the decision to work from home for whole practice.
Negative experience with telehealth
- Kids, high trauma population, teens, personal dislike
- I'm a better therapist in person.
- Challenging using technology
- Fear, worry, stress.
- Worry about insurance paying/finances. BIGGEST trauma professionally- pay bill.
- Client issues spiked.
- Better work/life balance
- More flexibility with hours/job
- Challenging to do telehealth effectively.
- Professional insecurity (am I still good at this online?)
- Doubted abilities.
- More fully present at home. When I was done, I was done.
- Better mom and wife

Professional well-being.
- Self-care was a priority.
- Needed support from colleagues.
- In office one day a week
- Frustrated at lack of guidance from professional organizations re: telehealth.
- Wanted to be back in person asap for client and self.
- Judgment toward other professionals who wouldn't do in person.

Personal well-being.
- Self-care
- Strict schedule with family/kids
- Time away- vacation
- Needed a sense of control in personal life.

Shared Experience- Professional
- Sheer terror regarding covid.
- Panic, fear
- Compartmentalized my anxiety to help clients with theirs (Helping clients helped me)
- Shut down my feelings while in session – this was helpful professionally.

Shared Experience Personal
- Work was a relief and break from my personal anxiety and fear about covid.
- Husband had to "talk me off the ledge."

Advice
- It's going to be ok.
- Embrace time with family.
- Be curious.

Helene
2 offices, practice owner made decision to work from home, high trauma clients.
Adjustment
- Privacy was an issue.

Relief (staying home is safe and keeps me and family healthy)
Home was no longer a sanctuary.
No separation work/home
More self-care
Flexible

Professional impact

Loss of identity as a professional (wanted to help more)
Difficulty with work/home balance
Lost clients who didn't/couldn't do TMH.
More time/no driving
Intentional transitions

Personal impact

Loss passion for things that I enjoyed pre-pandemic.
More contemplative
Isolation was difficult.

Professional well-being.

Breaks throughout the day.
Connection with colleagues

Personal well-being.

Isolation was negative.
Green light for self-care
Worked on getting a better work/life balance.
Lost connection to the outside world (negative) (felt this was unhealthy)

Shared experience professional

More empathy with clients

Shared experience personal

Difficult to separate work and personal life.
Needed more intentional transitions.

Advice

Prioritize self-care.
Be present in the moment.

Kate

Already worked from home but never telehealth so telehealth felt like a better boundary in her home.
increase in clients.
I felt grateful to be working and helping others.
Confident that I could do telehealth.
We are all in this together.
Self-care improved- this was both professional and personal well-being.

Exercise, healthy eating, connect with friends, hikes with husband/dog.

Professional well-being.

Talk and process with other colleagues.
35 years' experience helped me manage the stress.

Not a lot of difference in my self-care pre- pandemic except that connections were not virtual.
Shared experience

Fear of the unknown (same as clients) – these issues provoked my fears and worry.
I have autoimmune disease and worried about getting covid.
I wasn't confident this would work out, so it was hard to support clients (lack of hope?)
It felt very challenging going through this with my clients.
Don't go down the rabbit hole with my clients – I was also afraid.
I had to work at being an active, listening presence rather than give in to my emotions.
Is this the end of the world?

Personal shared experience:

I needed an intentional transition activity after work Social media scrolling, news, music, cooking I needed a re-set.

Michael

Worked at a practice, moved to home office in basement.

Loss

Lost clients due to telehealth – teenagers didn't want to do video.

Loss Support of colleagues

Loss of clients due to telehealth. They didn't do well.
Felt helpless, very tough to do telehealth.

Better work/life balance

Self-care was a priority, more exercise, flexible hours, more time w family.
Clients who stayed like telehealth
Better work/life balance

Professional impact

Adapt to change.
Be creative with interventions/coping strategies.

Personal impact

Intentional transition activities: talk and process the day.
I needed a re-set.
Home was no longer my sanctuary.

Well-being- I felt a lot of stress and anxiety due to covid.

More intentional self-care

Exercise, eat healthy, leisure time, better structure to my day.

Shared experience

The unknown- brought fear, stress and anxiety to self and clients.
Higher empathy with clients
Professional growth
Catastrophizing
Is it the end of the world?
Just be present for clients.
We are all in this together.
Felt grateful and humbled for the life I had.
Shared humanity
Shared struggles with the rest of the world.

Advice

Self-care is important.
All in this together – Don't worry so much.

Possible themes:

1. I am grateful
2. Losses/grief
3. Self Care is a priority
4. Better work/life balance
5. We are all in this together
6. Fear of the unknow/fear
7. Professional insecurity
8. Challenges
9. I need to be creative with telemental health use
10. Telemental health is working
11. Isolation
12. The shared experience is hard
13. The learning curve
14. The transition to telemental health
15. Professional Identity

It's important to use the structural experience to do my analysis, because so much of the interview and reflection is about how they themselves thought about their experience looking back on it How did they perceive their experience? They perceived it as challenging, rewarding, an opportunity for growth, uncertain/fearful.

What are the underlying structures that influenced these perceptions?
Their commitment to clients, there are desire to make a difference, I need to continue working, uncertainty about their ability to do telehealth.
The structures that influenced their perceptions are their values as a social worker.

They perceived it as challenging, and the underlying structures underneath that were insecurity in their ability to do tele mental health. The lack of training, education, and guidance on how to do it effectively.

They perceived it as rewarding, and the underlying structures that support that were as sense of gratitude that they could still be working, and still be present and helpful for clients.

They perceived it as growth as a professional, and the underlying structures that support that are the ways they had to adapt and adjust the way they provided therapy.

They perceived their experience as being part of a bigger picture in the structures that supported that was the awareness of what the world was going through and the common human experience.

They perceived it as uncertain or fearful, the structures underneath that include fear of the unknown what would happen with Covid and what the future held - We are all in this together.

APPENDIX F

TEXTURAL DESCRIPTIONS

The Textural Descriptions provide a description of who the CSW is and what it was like for them to switch to telemental health and work from home.

Sandy

Textural Description

Sandy is 44 years old, identifies as a white, bisexual female and is married. She has been in private practice for 11 years and currently sees an average of six clients per week. When the work from home order was issued in March of 2020, she was the sole owner of a private practice in two locations with twelve staff. Sandy states that since going back into the office, she has continued to see most of her clients virtually. The transition to work from home was not difficult because she already had a home office set up and was relatively comfortable with technology. She enjoyed telemental health for service delivery and felt "an increased level of intimacy" with her clients and observed that "being in their own home can shift the way that they feel like they're able to show up in a good way." She also appreciated the flexibility in her schedule and extra time in her day with no commute.

The actual decision to work from home though, was filled with uncertainty and worry, "I lived with the fear of making the wrong decision. I really thought if I make the wrong decision, people will die and that felt like too much pressure." She grieved the loss of choice: the choice to go into work, the choice to go out in her community, and the choice to spend time with her friends, "I just missed my friends. I remember just wanting to hug them and it was all excruciating." The added pressure she felt of the pandemic, the unknown of the future, and the weight of her clients' traumas had a significant impact on her.

> I mean, on the surface (working from home) was easy. It was really more just the emotional upheaval of what the fuck is happening in the world? And I don't think I'm okay and I don't think my clients are okay. I don't know how to exist right now. I don't

> know how much therapy was done other than, like, we're just being scared together right now.

Once she realized insurance would reimburse for telehealth services, a big part of her stress was alleviated, and she shifted her efforts towards self-care. This was now a priority for her, and she encouraged her staff to make it a priority as well. She utilized exercise, tapping (a method of tapping fingers on different parts of the body to alleviate stress or to self sooth), meditation, and connection with friends and family to help manage her fear and stress. She sent her staff books on self-care, orchestrated Zoom yoga classes, connected regularly with them, and encouraged them to take care of their well-being first before trying to take care of their clients. Despite all these efforts, it was not long before she realized she needed more mental health support. The fear of the unknown became too much for her to endure and she entered a three-week residential program:

> I was paralyzed with fear. I really was not able to organize myself like I normally can emotionally. So, I was just dysregulated and afraid. It didn't feel right to try to lead anybody cause what a fucking mess I am, and I have no business telling anyone anything. I can't make you feel better. I ended up going to a residential treatment program because it didn't feel ethical to continue what I was doing. That was probably the best gift I've even given to myself.

Once returning home, Sandy kept her self-care as a priority by reducing her client load, working three weeks on and one week off, and continued actions such as exercise, meditation, yoga, watching movies, and connecting with friends and colleagues. This created a better work/life balance for her that allowed her mental health to remain stable throughout the rest of the work from home order.

Rhonda

Textural description

Rhonda is a 66-year-old white woman who identifies as a lesbian and is in a long-term relationship with her partner. She has been in private practice since 2005 and currently sees about seventy five percent of her clients in person. Prior to the shelter in place order, she worked with clients in person and saw about 20 clients per week. Her work consisted mostly of psychoeducation, group work for addictions, and family therapy. Transitioning to telemental health from home was difficult for her. She stated that, "tech stuff was really challenging for me. I had to hire a computer guy to come in and get me set up." She also worried that using telemental health wouldn't work or that she wouldn't be able to do "good enough" therapy, "I thought how in heavens name can this possibly work? But I was blown out of the water at how effective it was!" She now loves the option for telemental health, "It's so much safer on an icy day or a day when someone isn't feeling 100% to be able to switch over to Zoom. It's opened up a possibility that is a very big plus!" The initial worries and challenges with using telemental health gave way to some beautiful interactions between her and her clients. She recalled one particular group session with fondness:

> We had a lady one time that had a three-month-old baby boy. He was in our group with us, and other people had their dogs or other pets, and it was such a positive thing. We were all in each other's houses with each other which was such an amazing phenomenon. It was a miracle really. Everyone just pulled together and figured it out.

While there were some very touching moments, Rhonda felt the challenges of working from home were heavy. A few examples include figuring out how to get paperwork signed virtually, showing visuals or videos during a group or family session, and dealing with computer

glitches on both sides. Another challenge was staying connected to colleagues. She felt very isolated working from home wanted to create a way to change that:

> It felt really challenging not being in the building with my team. So much happens in the context of a day and in between sessions. You're communicating with people, and we had lunch together, and I was used to seeing everyone throughout the day. That was extremely challenging, but our team did a great job addressing it until we could be back in person. We would meet on Zoom for supervision and professional support, talk on the phone, share funny stories or books we were reading… really anything to feel like we were still together.

Her feelings of isolation gave way to depression:

> It was really hard. It wore on me. Now I live with someone, so it wasn't that I didn't have anyone to process with, but there was a sense of depression that came along with this. It is really draining to be on a computer for days in a row. It was much more draining to be on the computer than in person for me because I really thrive with people. It just left me feeling a little flat.

Rhonda was grateful to have the support of her partner and the virtual support of colleagues, but it was still a struggle to see all her clients online. Now that she is back in the office, the option for telemental health does not feel so exhausting since most of her client interactions are in person.

Janet

Textural Description

Janet is a 41-year-old white woman who has been in private practice since 2017. She is a solo practitioner who sublets an office from another practitioner and currently sees an average of 25 clients per week. Prior to the pandemic, she used to see all her clients in person, but since the shelter in place order was lifted, she sees over half of her clients virtually every week. Janet identifies as queer and lives with her nesting partner who is male and her 73-year-old mother.

Her transition to telemental health was relatively seamless. She converted her bedroom into an office and felt relieved she could continue providing services to her clients while staying healthy. She stated, "I would say that I didn't find it hard, and if anything, I found it really rewarding and really enjoyable. It was easier for me. I'm someone with chronic health conditions so it felt so much safer working from home." Even though she found working from home a positive experience, there were some challenges. For example, she had to figure out ways to get handouts or worksheets to clients during a session and how to get legal documents signed like consent forms and office policy forms for new clients. Many of the traditional therapeutic interventions that she did in office also needed to be tweaked a bit, "I do think it [working from home] challenged me to think creatively. I was trying to be creative about how we would utilize different skills together and I found a lot of solutions online that I could use so that was helpful."

Another challenge was to ascertain what the legal and ethical guidelines were for providing telemental health services. She was frustrated that the social work profession was slow to provide structure, "I did a bunch of research to find out what is legal and what do we need to have in place. That information was not highly accessible. I had to do a lot of work to find that stuff out. But once I had access to it, I was able to set it up. I found a lot of guidelines to make sure everything was on the up and up."

Working from home opened so much more time for her. She put less effort in to getting ready every day since she only needed to be presentable from the waist up and with no commute, found an extra two hours in her day as well. Self-care became more of a priority:

> So again, without that yucky commute, and not having the pressure to dress and look a certain way for the workplace, I was able to make so much more use of self-care activities. I could take a walk or do yoga in-between sessions. If I had a no-show client, I was like, I don't care, I'm going to just use the time for things that made me feel good. I

made a point to connect regularly with other colleagues and encouraged them to do the same.

Janet's commitment to greater self-care spilled out into her therapy sessions with her clients. She became more purposeful to integrate self- care interventions during sessions due to the higher level of need that her clients presented, "One aspect of my therapeutic work that changed was more focused work with clients in session like meditation or relaxation exercises. It helped them but also benefited me as well." She found that as she walked her clients through different self-care activities, she herself engaged in them as well.

Janet works primarily with clients who are HIV positive and could never fully identify with her client's life as she does not live with HIV. The pandemic created a new experience where she was able to walk more closely with them since they were all experiencing this together:

> Having something mutual was interesting. One thing I noticed, not good or bad, but just noticed was that my clients would ask about me much more frequently, like, "how are you, is everything ok?" I tried to be careful about maintaining a professional relationship, but I could definitely tell that they cared about me and were reciprocating in a way that was closer to what you might do with a mutual relationship that a professional one.

Another example of a shared experience with her clients were feelings of grief and worry. She and her partner are consensually non-monogamous, and she felt a lot of sadness that she was unable to see any of her other partners during the shelter in place. She also really missed her friends, and it was difficult to see how lonely her mother was in isolation. When her clients would talk about their losses in sessions it would pull on her own feelings:

> There was a lot of worry and experiences of grief and as a result of that I found myself subliminating the heck out of that stuff when I was in sessions with my clients. I wanted to focus on their grief without my own counter transference showing up. I was fortunate

> though. I was able to talk through it with my partner and I made good use of peer consultation and supervision during that time.

Despite some of those feelings of loss, she felt so grateful that she could stay connected to clients through telehealth and continues to be grateful for this option.

> Offering telehealth services made things so much more accessible to my clients. People who wouldn't drive if the weather was bad or had scheduling problems could now keep their sessions. Also, some of my clients experienced terrible poverty and it would not be ok for a person with a compromised immune system to be standing outside waiting for a bus and then be on a bus load of people, and then coming into an office during the pandemic. Even folks who didn't have technology could set up a phone session during that time. I hope clients continue to have access to this forever.

Nancy

Textural Description

Nancy is a 49-year-old white female who is married and identifies as heterosexual. When the shelter in place order was issued, she had to transition to work from home along with her husband and her three teenagers. She has been in private practice for 18 years and sees an average of 28 clients per week. Prior to the pandemic, she sublet two offices from other practitioners in Chicago and in the North Shore. Currently, she still sees about half of her clients in person and the rest have chosen to continue with virtual sessions. Many of her new clients prefer that as well. Nancy works mostly with adults who struggle with addictions, clients with a trauma background and she also works with couples.

The transition to work from home was difficult in the beginning. She stated her husband took over the dining room table, her kids all went to their rooms for school and she "hid in the bedroom from my family to see clients." It was hard for her to get used to only seeing her clients virtually, "I mean, it was difficult. It was an adjustment. I'm used to being in person. I liked it better in person." There were some challenges working from home. She felt frustrated and out

of control of the therapeutic environment. Clients would have pets and children showing up during sessions or they wouldn't be as attentive during sessions. Another example of the challenges she faced was her emotional response to virtual sessions, "Normally, my rule is if you don't cancel within 24 hours, I can charge you. Well now, when they can stay at home, it's easy to literally lay in bed in their pajamas doing their session with me. I was like, this is ridiculous. They clearly were not preparing for their session. They didn't make the actual effort to come to their session, so that type of thing felt disrespectful." At home, her environment was not always professional either, "For example, if my husband would slowly try to walk in the door, and he'd see that I was working and then go out. These were the kinds of distractions that I couldn't stand." One of her therapeutic interventions was EMDR and she stated she was unable to be effective with this modality virtually. This was another challenge she faced and it was frustrating that this was no longer an option she could offer her clients.

Even though the loss of personal connection with clients and the professional environment of an office was hard, she felt grateful to still be working, "I could keep making money so that felt really good, just as a provider, you know, with a family." She stated that working from home allowed for more flexibility in her schedule, eliminated her commute which gave her more time in her day and reduced the stressors and cost of commuting. Another unexpected aspect she felt grateful about was an increase in her clients, "Once the pandemic hit, I just kept taking on new clients. All of these old clients were in a sudden relapse, and the sudden isolation, all of the adultery was getting busted, everything was falling apart. So many of our friends were losing their jobs, so I just kept saying yes."

Another struggle she expressed was worrying about her ability to be effective as a therapist using telemental health. "I don't think I'm my best online, or at least I know I really

wasn't in the beginning. It was really hard to get adjusted to that." She had no previous training or experience providing telemental health and this caused her some concern. It was challenging since there were no clear guidelines offered by professional communities early on and she felt insecure in her ability to do it correctly:

> One thing that really irritated me about our field is I wish we could have gotten guidance on rules quicker. We didn't really have rules at the beginning. Everyone was keeping their head above water, and it would have been nice to have some professional guidance. No one really had any training or rules of how to do this. I was like, Oh my god, what if something happens with them and I'm watching it with sheer panic as a professional. I did not like that, and I still don't like that.

The shelter in place order eliminated the opportunity to see colleagues in the office.

> I felt like I wasn't surrounded by other therapists anymore. I am on my own, but I rent from people so I'd see the other therapists in the other offices, and we could touch base about a client and check out ideas with each other. It was vital to have that connection with other therapists and not having any of that and all these clients was really really tough. We all leaned on each other and not having that was really tough.

This loss was hard, and she felt isolated at times. In addition to losing her professional support system, she lost some of her coping mechanisms and as a result, Nancy became more intentional to make self-care a priority. Her drive home used to be one of the ways she helped herself transition from work mode to home, "It definitely was like, Oh, there's no time to ride that commute from the city to home and disconnect. I'd have to find ways to disconnect quicker, and that was really hard." One self-care activity that helped was attending an outdoor work out class, "I would be able to be silly in a workout class with eight other women and we would all complain about our families, the workout class itself, things like that." Since she had more flexibility with her schedule, she would start her clients after she was finished with her work out. At the end of a long day, she found it helpful to stay in her room a little longer scrolling on social

media or the internet, or she would reorganize closets or drawers, and made it a priority to have quality time with her family.

Cindy

Textural Description

Cindy is a 55-year-old white woman who has been in private practice for 19 years. She identifies as heterosexual, is married, and has twin teenage boys, who transitioned to schooling from home during the shelter in place order. Prior to the pandemic, Cindy shared an office with another clinician. She averaged around 17 clients a week and saw them all in person. Currently about half her sessions are virtual and half are back in person. The physical transition to work from home was relatively simple. Her home already had an office that was ready to use, and her twins were juniors in high school and used their bedrooms for schooling. Her husband already worked from home and had a separate office, so she had no space sharing issues.

Cindy had never done telemental health sessions before and she was worried about it. "It was nerve wracking for me because I had never used telehealth before." She discovered she needed to be more creative in the interventions and interactions she had with clients. One of the interventions she offered clients was brain spotting, but she quickly found this was not adaptable to telemental health and could not provide this for her clients, "I needed to learn more strategies and be more mindful of how I was communicating with clients online." After a couple weeks of virtual sessions, she felt more comfortable and confident with this type of service delivery.

Another challenge for Cindy was implementing an online scheduling and billing platform. She had never used an electronic health record platform in her practice and decided to switch from paper files and billing to electronic since she would be working with clients virtually. She tried three different ones in the first couple months before she found one that

worked for her, “I was nervous about this, but fortunately I’m pretty tech savvy so it quickly smoothed out and I didn’t have any problems at all with it.”

Working from home had a significant impact on her in a variety of ways. One benefit she felt was the elimination of her commute and the need to only be presentable from the waist up. She found extra time in her day due to this and stated she spend more time with her husband and children. Even though this gave her more time in her day, she struggled with the transition from work mode to home mode, “I lost the transition to decompress on the drive home, or mentally prepare in my head for the day as I drove in. At home I would find myself getting one last thing done at 9:59, or barking orders to the kids or let the dogs out. Then I would go into my office, shut the door, and start. I lost that transition time which was very abrupt.” Another challenge of working from home was the stressors of household issues that she typically did not deal with while working at an office. Examples of this include hearing the noises of her kids and husband in the home, a dog barking during a session, or feeling the pressure to do housework when she had a break between clients. She was acutely aware of how much she missed connection with her colleagues, so she intentionally found ways to meet virtually for support and took more online training classes.

One positive aspect of telemental health was her ability to work through the pandemic. She felt very grateful for this as many of her clients felt more isolated, scared, and alone, “The most important thing was just being able to see people and provide service and connect.” Virtual therapy sessions meant she could see clients from a wider geographic area, and this brought her more clients, “I’ve been able to provide services to people down by St. Louis, the City of Chicago, other suburbs, and that’s been a huge positive to have a large pool of potential clients.”

Another unexpected positive result was personal growth. The challenges of the pandemic and working from home pushed her to grow and change both personally and professionally, "I feel like the experience of learning how to provide telemental health, the electronic billing, and just being there for my clients gave me confidence in terms of being able to adjust in a crisis."

Self-care became a priority for Cindy. She created some routines that felt very helpful, "I found myself taking a break to walk my dogs around 4:30 every day. I think just taking breaks, which traditionally I have had a hard time doing, and eating, stretching, and just moving around was good for me." The way she scheduled her clients changed as well, "I think I became more cognizant of how much better I would do if I took breaks. I'd schedule a 9:00 am session, then a 10:15, and then maybe 11:45. I started giving myself more space in my day." She also became much more flexible with her schedule, "Most of the time, I would say, your appointment is your appointment, and I won't change it unless you need me to. But now, we were all sitting around with time on our hands so I was like, okay, let's make it easy for me and see if I can squeeze everybody together rather than have a bunch of gaps in my day." She became more open to self-disclosure with her clients, and this became a form of self-care. For example:

> I've gotten more comfortable with telling my clients at times hey, I just can't do it today. Do you mind, if it works for you, if we can meet at a different time? I felt more comfortable asking my clients if they could accommodate me versus me always being the one to accommodate them. Some of those professional, strict walls of always showing up weren't quite as strong. I could show up in my human-ness."

Some of her self-care was more inwardly focused, "I became much more reflective and contemplative. If I was out walking the dogs, I would just try to be more present which felt really good. Again, I didn't have that before, so it was really restorative." In some ways, work became

a form of self-care. Even though it was difficult to walk through each day holding space for her clients, working was a coping mechanism to help her deal with the problems at home:

> I was trying to help two teen age boys navigate this, each with very different needs. One of my sons developed a weird health problem before the pandemic hit, so all of that got harder in a way. There was a lot of butting of heads with them and my personal struggles came from watching my kids struggle. I took refuge in my work. It was an escape from being so frustrated that I couldn't help my kids from the horrible social crap going on, and my utter disgust and fury about how other people were handling it. I could just close that off, what was happening to my kids, and throw everything into work. I wanted to share that because it was really a struggle and I feel like I'm so grateful for my work, more grateful than I've ever been.

Michael

Textural Description

Michael is a 33-year-old Hispanic male who identifies as heterosexual and is single. He has been in private practice for about 5 years and saw between 20 to 25 clients before the shelter in place order in March of 2020. Currently, all but one or two of his clients are in person on a weekly basis. His work from home environment was his family home which he shared with his mother, father and two brothers, one who was 27 and one who was 9. He set up his office in the basement of his house and used a white noise machine to mask noises coming from upstairs and to ensure his family could not hear the sessions with his clients.

Michael had little trouble with the physical transition to telemental health from home, but he did experience difficulty in how to best care for some of his clients. "I felt like some of my clients shouldn't have been virtual. One was struggling with schizophrenia and another who was stuck home with a parent who was abusing them. I thought virtual was not going to help them. They needed much more services. I felt helpless a little bit and like I had imposter syndrome because I didn't know how to help them." He lost the professional supervision he had at work, but his mom was a social worker so he would talk to her about his concerns to get advice and

guidance. Another difficulty with the transition to home was the inability to go into work. "If I have a hard day at the office, I'm able to at least go home which is my sanctuary. It is hard for me to separate work from home sometimes. When I did telehealth, I still take it home because I am already home." Even though Michael felt the loss of in person sessions, he believed most of his clients really liked virtual sessions. "I was able to see them feeling more relaxed at home compared to how they were in the office. I felt like they were able to be more expressive. I see a lot of kids and it improved our rapport and connection because technology is already a familiar platform for them to use."

Michael has some very positive memories from his time at home. He liked the flexibility in his schedule and stated he would see clients later in the day so he could sleep in and have more time to himself in the mornings. He also enjoyed spending quality time with his family and stated they all got so much closer during the shelter in place order. He also found a new sense connection with others in the world who were all experiencing the pandemic simultaneously:

> There was a common humanity that was very present as well. I felt like it really humbles you. I feel like we can get so into our day to day lives that we don't realize the actual importance of what life really is, but we are all in this together and it made me feel less of me as an individual and I saw us all as unit.

Self-care became more of a priority for Michael during the time he worked from home. He realized that he would encourage clients to boost self-care routines to improve their mental health, but he was not doing the same. He implemented a regular workout routine, changed to a healthier diet, spent more time with family, watched movies, connected with friends virtually, and looked for ways to improve himself as a professional, "I noticed I was able to manage my stress and my anxiety better. I was also depressed during the work from home period, so I

needed to figure out how to show up for myself. I think COVID changed my life. It really helped me focus on my values and act on them."

Amy

Textural Description

Amy is 36 years old, identifies as white, heterosexual, is married, and has two young children. She has been in private practice since 2016. She is the owner of her practice and employees several clinicians in four different offices. Prior to the pandemic, she averaged around 15 clients a week in addition to her administrative duties and clinical supervision. Her transition to work from home was relatively easy. She converted one of the spare bedrooms into an office and was intentional with some decorating and placement of her desk, so the background looked professional to clients. She always used headphones during sessions to ensure that client conversations would be private. The challenging part was trying to manage staff and run her practice virtually. She had some clinicians who struggled with technology and the use of the video platform for client sessions. There was a high level of stress dealing with some of the unknowns, for example, "It was very stressful because of billing issues. For a while insurance wasn't saying whether they were going to cover telehealth and so we had to make decisions to continue seeing clients and billing despite telehealth not being officially approved."

Another challenge was how difficult it was for her clients to lose in person visits. The isolation and loss of personal connection spiked symptoms of anxiety and depression in clients who were already struggling with that. She was worried that her ability to provide services virtually would be inadequate, "I think I'm more effective in person and there were some head games of am I good enough? Am I engaging enough? I don't feel effective enough. I really started doubting my effectiveness because so much of therapy is about energy and rapport. It

really challenged my sense of capacity and ability." Another challenge was the worry that telemental health would not be effective for many of the clients in her practice, "It is very difficult to be accurate with making a diagnosis or how you are helping them without seeing them. We do a lot of child and adolescent work and so much is done through body language, eye contact and human connection. We also had self-injury kids and eating disorders."

In addition to her self-doubt and worry, she felt that her attention-deficit/hyperactivity disorder (ADHD) made it even harder to stay focused on a screen for an entire session. She found herself getting distracted by noises in the home or other tasks on her mind. Amy felt guilty about this and had to create ways to keep her focused and less distracted. She would keep notes during a session, take more breaks in-between sessions, or use a hand fidget while in session with a client.

Amy found some positive side effects from her work from home. Due to her ADHD, she will do or take care of whatever task is in front of her. So, when she was finished with clients at home, she could leave her office and was able to be fully present with her family, "I felt more effective as a mom and wife because as soon as I was done with work, I was ready to be with my family." Before working from home, she would often stay late at the office, rushing to get things done and rushing to get home with her family. Working from home eliminated that problem.

Even though Amy enjoyed some aspects of her time working from home, she still struggled with anxiety and self-care became a priority for Amy. She made several changes to her life to ensure she was taking care of her emotional, physical, and mental well-being. "I went into the office once a week which was really helpful just to get away from the house for a bit. I started exercising a lot and we got a puppy. We took a lot of family walks and went away for long weekends boating and camping." The weight of responsibility to run her practice and

support her staff was heavy. She promoted two of her staff members to help make decisions about when and how to return to the office, how to support struggling clients and staff, and financial decisions. This was very helpful to her emotional wellbeing, and it allowed her to feel less anxious about running her practice effectively.

Helene

Textural Description

Helene identifies as a single, white woman and is 66 years old. She has been in private practice for 18 years and sees an average of 27-30 clients per week spread between two different offices. She now sees about 30 percent of her clients virtually and the rest are back in person. When the shelter in place order was issued, she moved her office to home where she lived with her 87-year-old parent. The transition was relatively simple. To keep sessions confidential, she moved upstairs and set up in her en-suite in her bedroom. She noted this wasn't an ideal location, but her office was on the main floor and her mother was there which eliminated any privacy for herself and her clients. She indicated that the shelter in place order and working from home was a mixed bag. "It was fortunate for me because I had an elderly parent with medical complications and me being home improved my parent's ability to function. It also made it easy for me to be present and care for her more. But it also limited my ability to have some space away from those responsibilities and that was at times difficult."

While it was challenging to be with her parent all the time, she appreciated several aspects of working from home. She found herself going outside for breaks to sit in the sun and relax in between sessions. "That was very energy producing for me and I've tried to incorporate that into my workday more and more now." Another benefit was more time in her day. "One of my offices is a lengthy drive so I had no commute, and just the time saved in working

exclusively from home and having all your groceries delivered, or whatever. However that plays out, it created space for me to do other things that are important to me spiritually, emotionally, and physically."

The transition to telemental health services created some feelings of loss for Helene. "I feel like I lost some of my identity as a social worker. In my interpretation of social work, you roll up your sleeves and get your hands dirty. I feel like I've lost that ability." Helene credits her many years in private practice that kept her from feeling triggered or overwhelmed by the intersection of her pandemic experience and that of her clients. Even though the pandemic created unique situations for her clients, her clinical perspective did not change:

> It felt similar to any other time that I'm going to do my best to empathetically understand the circumstances of my client. What is true is that we all have shared experiences, and this was just a new, shared experience. I don't think it created some sort of significant addition to the therapeutic relationship.

Ashley

Textural Description

Ashley is 43-year-old Hispanic women who is married and has three children between the ages of five and ten. She has been in private practice for seven years and sees about 20 clients a week. Since returning to the office, about half of her clients are still virtual and the other half are in person. When the shelter in place mandate began, she transitioned to work from home along with her three school aged children. Her husband continued to go into work, so she was by herself to provide schooling for her children while seeing clients throughout the day. They already had a home office set up, and Ashley would see her clients in there. Once the schools had remote learning ready to go, the children needed access to the office and her laptop for school. "It got a little bit harder when the kids needed access to the computer, so I had to get

creative with where I would go. I would usually go into my bedroom, and I'd have to use my phone for the sessions." Even with the ability to have a confidential space away from her children, she found it challenging to have any consistent work schedule. "There was a lot of multi-tasking going on. I felt like there were a lot of interruptions because I had to be mom and teacher. It became pretty clear to me early on that I didn't have the ability to provide telemental health during the school day because the kids needed me."

Despite these challenges, there were aspects to the transition of working from home that were positive. "I'm not one of those moms who is dying for their kids to get back to school when fall comes. I really enjoyed the extra time we got to spend together as a family which was really good, and I loved being together more often." She was grateful that she could keep her children healthy by staying at home and could still work and bring in much needed income.

Ashley had never done telemental health before and was not sure how it would go. "I had a lot of self-doubt regarding my ability and thought it was something I could never do. I didn't see how you navigated all of that. But then the pandemic happened, and I had no choice. I had to jump right in." She adapted quickly to the use of technology for sessions, but found some clients were more difficult to connect with. One such population were the children she worked with. "I found it very, very difficult to provide telehealth to those clients because those were the clients I was getting on the floor with and doing play therapy. We were talking as we were building things and drawing pictures." She had to create new ways to connect with the children she was working with and took some continuing education classes and did some research on her own to develop new interventions. The use of telemental health services allowed more flexibility in her days which she was very grateful for, and in many ways gave her more time since she had no more commute, but she felt the loss of being in the office: "I do better with the structure of the

office and coming in. As a professional that really jarred me a little bit, not being able to. There was so much multitasking going on at home and then I felt like there was no separation between my work and home life. I mean it all just blended together which felt negative to me."

Ashley worked on her well-being by getting out of the house more often. "I like being home, but I realized that maybe I'm not such a home body. I really wanted to be out and about and it was very challenging for me to be stuck at home." She found relief in self-care activities outside of the home. "Taking a walk around Walmart was good for my personal well-being, just to get out of the house for a little bit. I would take the kids out a lot and we did a lot of things we wouldn't normally do because we had so many other options before. We did a lot of walking or go on our boat." Ashley got a puppy which was a good distraction for her and gave her some emotional support as well.

Kate

Textural Description

Kate is 67 years old white woman who is married and has one young adult daughter. She has been in private practice since 1994 and sees between 15-20 clients a week. Prior to the pandemic, she did in person sessions with her clients in her home office. Kate is fluent in American Sign Language and worked for a company that provides interpretation services for hearing impaired individuals. This type of work was fully remote, so she had a lot of previous experience using a virtual platform to provide services. When she needed to move all her clients to telemental health services, the transition posed no difficulties for her. "I didn't have a lot of angst about it at all. I thought, oh great, no problem! We can keep working, we have this technology, we don't have to stop. It was not an issue for me. It was more an issue, obviously, for the people who did want to come in and have a more tangible kind of experience."

The transition to all virtual sessions was a very positive experience for Kate:

> Honestly, I love it. It was good for me. I have two big dogs here barking, and my husband's here, and I was always a little ambivalent about having a home office so this is a nice boundary in a way. I'm a fan. I just don't feel like I'm missing much and especially with younger people, this is what they are doing anyway.

Kate did not sense that her work with clients was any less effective although she found it important to have a solid video connection. Often, she would trouble shoot with clients to achieve that, and if not, she would reschedule rather than try to have a session without a good video connection.

The loss of in person sessions was difficult for many of her clients. "Well, you know, it's just like any disappointment in life. It's just like any problem that you have to grieve and mourn and go through. There were so many things changing and so much unknown and this was just one part of it. I treated it as an issue to work through. It wasn't perfect, like many things in life it was an imperfect solution, but we could still talk and see each other." At times, the weight of pandemic problems for her clients became heavy to manage, but she leaned into her years of experience as a therapist and created some ways to help her transition out of work mode once she was done with her day:

> I would have to have some transitional activities to help me get out of that space. It was challenging and scary. Everybody was talking about the pandemic all the time. It was hard to talk about anything else; how it was screwing up their families, and the divisiveness, it was very provocative. So, I would scroll through social media or read through some news articles to just kind of get rid of it. And then, I would usually go cook to get a re-set.

Kate continued much of her pre-pandemic self-care routines. She calls herself a bit of an introvert, so not much changed for her. She continued regular hikes with her husband and dogs, read, exercised daily, and ate healthy. An area of loss was the elimination of in person

gatherings. She used to meet regularly with colleagues, friends, and family. Even though they used Zoom to stay in touch, it was hard to be physically apart. “We met a lot to talk and process what was going on. I couldn’t see my family though; I couldn’t see my sister. That was a little bit hard, and it was hard to not see people in general.”

APPENDIX G

STRUCTURAL DESCRIPTIONS

The Structural description provides a description of how the CSWs understood the experience of using telemental health and working from home through the structure of their relationship with themself, and with others such as staff, clients, family, or "the world".

Sandy

Structural Description

For Sandy, she understood her experience as frightening. As the whole world was shutting down, she felt the weight of the unknown and even wondered if this was the end of the world. The lens that she viewed this from was through her relationship with herself, her staff, and her clients. As a professional, and specifically as the owner of her practice, she felt the responsibility to make the right decisions for her staff and clients:

> I think the first thing was, I don't want to make the wrong decision. Some of the staff were more concerned than others. I was kind of afraid things were overblown, so I didn't want to, you know, make people go home and then not have sessions covered by insurance. It was just really stressful. I felt a lot of pressure on me to do the right thing, not just for me and my clients, but for the staff and their clients too.

Her clients were trying to make sense of this alongside her and as they exchanged stories and experiences, the reality of what was going on eventually became too overwhelming:

> This was the first time on a global scale that we were all going through the same trauma at the same time. I was hypervigilant and really scared about Covid, and I had some clients who weren't, and were mad they had to stay home. I would get triggered when they would tell me they were going out or wouldn't wear a mask. I think it was that the stakes felt so high because I was walking alongside someone dealing with their trauma, and dealing with my own was hard. It was the unknown. I was literally like "oh shit, is this the end of the world? And that was scary for me and my clients too."

Sandy's experience of working and living through the pandemic and the shelter in place order was intensely difficult and wrought with fear. She was able to find support and relief

through a myriad of interventions and can look back with a sense of gratitude and a sense of hope.

Rhonda

Structural description

Rhonda perceived her experience as challenging. The pandemic was a shared time in history that positioned her to deal with her own losses and stressors as well as those of her clients. The awareness of what was happening with in her own self and how she was interacting with her clients informed her understanding of the experience. As a professional, she did not want to reduce the support and care her clients needed but was acutely aware of the toll this was taking on her, "Our life felt duller, as we were going along and trying to support people who have a double whammy going. I mean, dealing with mental health issues and these challenges that were so hard and had so much fear. So, walking alongside them was heavier for me." Rhonda felt a high level of stress during the shelter in place order and needed to come up with new ways to take care of herself, "I mean, my body was reacting, the stress took me to a physical crisis, so I had to address that." She changed her diet to eliminate sugar, connected regularly with friends and colleagues (virtually), and increased her spiritual practices like prayer and meditation. She also talked about new ways to help her transition out of work mode. One of the best ways she found was to take a bath, "I soak after work to wash it all off. I'm just releasing what isn't mine. That's my transition."

Janet

Structural Description

Janet perceived her experience as a positive time of growth in her mental and physical health. The structure that influenced this was her relationship with herself and how her life

improved. The shelter in place order created a situation that allowed her to greatly improve her quality of life. She definitely felt the losses and stressors that accompanied the pandemic, but the overall time was populated with good changes, "I felt like I had so much more control in my life, and I had so much more time." Janet's health was a primary concern due to her chronic health conditions and her self-care included a change in eating habits. Previously, she struggled to eat healthy due to how busy she was and often defaulted to fast food or convivence foods. Once she started working from home, she felt more in control and was able to change her diet:

> I actually lost 75 pounds overall. My diet and my ability to move more during the day helped so much. As a therapist, you just sit all day, but also it was like the stress that was associated with that. Despite everything that was happening in the world, my stress level working from home was so much lower and my body just felt so much better. It was really an incredible time for me.

Her improved self-care habits had a positive impact on her mental health, "I'm also someone who struggles with seasonal depression and utilize medication support and my own therapy. I felt so much better during that time which is wild to me since I was locked inside so much."

Nancy

Structural Description

For Nancy, the time that she worked from home and her transition to telemental health was experienced as challenging and exhausting. This was primarily understood through her role as a CSW and the relationship with her clients. The continued pressure to be present for her clients took a toll on her emotionally, "I mean, clients forget that we're human and forgot that we were really in it as well. It was tough. I guess it felt like burnout, or compassion fatigue. It definitely felt like that. We were all going through it." There were times she felt so frustrated with her clients it was difficult to be empathetic:

> Some of my clients, who were mentally unstable to begin with, would get COVID and they would make it sound so dramatic. I was thinking Oh my god, My entire family all had COVID too and yes, it was horrible, but they would take it to the next level. It felt like such an exaggeration and just looking for sympathy. Especially when I was going through it myself. It just got exhausting after a while.

Many of her clients did not care about COVID and wanted to be back in person for therapy, "I would have some clients that their trauma was really coming up or new clients that needed more support. The more extreme their mental health needs were, the less they were worried about COVID. It was also during George Floyd and Trump and that stuff was triggering my clients more than COVID." These interactions with her clients, paired with the way she felt about how they handled their situations, was challenging to endure day after day.

Cindy

Structural description

Cindy's perception of her experience is truly a mixture of gratitude and grief. The time she worked from home and transitioned to telemental health brought losses, frustrations, and challenges; but right alongside she felt joy and gratitude. Her values and ideals were fundamental to keep her dedicated to her clients during the pandemic despite her personal struggles. The pandemic caused Cindy to feel more committed to her profession than ever before. She viewed her role as a clinical social worker as essential and felt called to show up for her clients during this crisis:

> I felt much more committed to my profession and much more dedicated because there was a need there that I could meet, and I was figuring out how to meet that need. We've seen the impact of the pandemic on mental health overall, especially on young people. I feel like I personally took my job more seriously, and it became much more a part of my identity. I stepped back from a lot of people and a lot of things and put the energy into my work. I found a lot of gratitude and joy in seeing my client's success and seeing them really overcome a lot, so it wasn't all heaviness. It just became much more rewarding and that filled me.

The shared experience was significant in many ways for Cindy. “I think it kind of helped deepen that shared sense of humanity and connection because we were all going through the same thing at the same time.” She talked about how difficult it was to witness how much her clients struggled through the pandemic:

> I’m helping people and watching them navigate really difficult things was made that much harder because of the pandemic. I personally became much less sympathetic to the complaints of other people that I felt were not really that big a deal. I felt like I was taking much more in, more emotion and heaviness in. But then, of course, I still needed to be there for my family, at least as much as my teenage boys would let me. But really anybody else, friends and social groups, I drew tighter boundaries around who I gave my time to.

Upon reflection, she stated, “I feel so much more grateful for my work than I have ever been. I’m lucky. How many people get to say that? I had so many teachers and nurses as clients. They were heartbroken. And it’s heartbreaking to watch. For me, I actually got busier and I’m happier than I was before the pandemic hit.”

Michael

Structural Description

Michael perceived his experience as one of growth. His observed this through his role as a therapist during the time he worked from home and provided telemental health for his clients. As he walked alongside his clients during the pandemic, he was stretched to learn and grow in several areas:

> You talk with a client, and they tell you these struggles that they are having, and I can’t always comprehend it. But I think during the pandemic, the fear about what was going to happen, I was really able to empathize because I was feeling fear too. I learned that I don’t have to fix it for them, it’s ok to sit with the stress. I learned the importance of mindfulness, just trying to stay in the present moment with my clients. So many of them were catastrophizing and I knew I couldn’t fix the situation. It wasn’t possible to fix what

> was going on in the world. I built up more empathy, because even with people who I disagreed with at the time, I also saw their fear, helplessness, and hopelessness. A lot of people were feeling that.

Professionally, he enjoyed the challenge to be more creative with the interventions he used and ways to implement them through the screen. "What I realized is that you can adapt and use technology as a benefit. I was incorporating videos, YouTube, video games, and music in my sessions." Many of his clients were more familiar with the use of technology than him, and they taught him new ways to use it in their sessions. He felt very grateful for this and found increased connection with clients through that learning process.

Amy

Structural Description

Amy perceived her experience as anxiety provoking. This was viewed through her identity as a practice owner and as a therapist, but also her own fears about the pandemic and the unknown:

> I remember one night going to bed with my son and just convincing myself that it wasn't as bad as it sounded, but then having sheer terror that it was as bad. I remember trying to rationalize myself down and the same time feeling panicked. When I was sitting with clients, it was an escape from my own anxiety because I was able to shift professionally and help my clients be calm. I'm sure I spent hours a day helping them rationalize and cope, but their anxiety didn't trigger anything of mine. But when I wasn't with them, I was like "Oh my god, is this really happening?"

She does remember most of her anxiety and trauma was from the finances and accounting of her practice, "If my business goes down, I go down and then where is the money going to come from? I mean, the finances were the most traumatizing for me by far." Despite the anxiety, she put concentrated effort into taking care of herself and her family. Amy and her husband implemented a strict daily schedule to give her and her children a sense of predictability and consistency. "It was nice to have one controllable factor. When it was noon, we'd look at the

schedule and say, “Okay, it’s lunch time. Or at ten the schedule would say walk time, so we’d all take a break and go for a walk.” This schedule helped mitigate some of her anxiety and made her feel less out of control.

Helene

Structural Description

Helene perceived her experience of working from home and the transition to telemental health services as a time of change and growth. This can be seen by the way she shifted her priorities and became more intentional in the way she took care of herself. “I gave myself permission for things that I would have felt stressed doing before. It was a time to give myself the green light for self-care and for family balance.” Since she is an introvert, it was comfortable for her to be at home and alone, but states it was not good for her well-being. “I think in some ways the isolation was very good for me and helped make room for some areas of my life that I’ve been ignoring, but it made to easy to keep isolated and that wasn’t so great for me.” She worked hard to stay connected with colleagues and had a strong emotional support system that she leaned into. She spent more time in reflective contemplation, enjoyed quality time with her parent, ate healthier and exercised more.

Ashley

Structural Description

Ashley’s identity as a mom and a therapist influenced how she perceived her experience of working from home and using telemental health with her clients. She understood it as a time of challenges and anxiety. She struggled sometimes with the balance of her own experience of the pandemic and separating it from her clients. “There are a lot of times a client comes to talk to you about something and you have to try and put yourself in their shoes, but to then already be,

to some degree, in their shoes, it made it easier to empathize and help them work through those things because you were dealing with the same issues." She felt the weight of supporting her clients while trying to support her kids and her mental health, "There was a lot going on in the news, and then you're hearing a lot from clients, and then you're dealing with your own stuff. It all got to me. It was hard at times. I felt like, when are we going to get a break? When are things going to get a little bit easier for everybody? It made the load feel heavier for me."

On a more personal level, this transition to work from home deeply impacted Ashley's role as a mother. It was challenging to watch her children with their own struggles:

> I've watched my youngest struggle academically ever since the pandemic. She was struggling before in preschool, but I've seen the negative impact of her not able to have a real year in kindergarten. I never really understood until Covid how important that first year is. They learn their building blocks for reading and things and that was all on me. I became the teacher. I became the one responsible for that. It was very challenging. My older two did a little better, they needed more academic support from me, but this trickled down them too. I'm actually only this year seeing a greater independence from me and needed support from me.

The added pressures she felt as a mom, and the shared experience with her clients had a direct impact on her mental health. She struggled with anxiety before the pandemic and felt that it got much worse throughout the shelter in place period. "I mean, everybody had anxiety just because of the pandemic, but it created more for me for many reasons. Especially having kids during the pandemic and navigating social situations with others."

Kate

Structural Description

Kate understood her experience in two very different ways. As a professional, her experience was very positive. She enjoyed the use of telemental health and working from home.

She felt confident in her ability to have successful therapy sessions and was happy to help other colleagues and friends with the learning curve of virtual interactions. “I worked with a lot of my friends and said look, it’s not hard. I’ll show you what to do. When we are all starting this there was a lot of figuring it out so I felt personally gratified that I could help my friends.”

The other very vivid understating of her experience was one of fear. This was in relation to her sense of self and her personal wellbeing due to her health issues. Added on to this was the empathy she felt towards her clients and the shared experience of going through the pandemic together. She strove to be present and available despite her fear of the unknown, or the chance she might get sick and possibly die from COVID:

> It was very hard. Whenever you’re dealing with someone who’s dealing with the exact same thing, there’s a bunch of issues. I was dealing with fear. I have a bunch of autoimmune diseases and I was very worried about catching COVID. You are simultaneously going through a lot of unknowns about what to do and they’re going through the same unknowns. I tried to be an active, listening presence with them and not freak out, which is basically what I could have done every day. It was very challenging. I was in the dark as much as them, so it was very challenging not to fall in the rabbit hole every day with them. Was anybody confident that this was going to work out? I was worried every day that I was going to catch COVID and die.

Kate was grateful to protect her health while she worked from home, but still acutely felt much of the same fears and worries her clients felt. Her commitment to her profession kept her dedicated to show up for them and offer the best support and care she could despite her fears.

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VITA

Juli Chaffee earned her bachelor's and master's degrees of science in Social Work at The University of Illinois, Chicago, in Chicago, Il. She earned her Ph.D. in Social Work from Loyola University in 2024. She has been in the field since 1991 working in residential treatment centers, psychiatric hospitals, schools, and churches. She has been in private practice in the far northwest suburbs of Chicago since 2008 and serves children, families, couples, and individuals. Her areas of passion include strengthening marriages and families, parenting and teen issues, depression, trauma/abuse, body image/balanced eating struggles and women's issues. In addition to her clinical work, she has extensive experience with community outreach, professional trainings, fund raising, and volunteer development. She worked as a chaplain for many years at the Lake County Jail and was the project manager in charge of building a community food pantry and resource center. Her research at Loyola focused on the experience of clinical social workers who transitioned to telemental health during the COVID-19 pandemic.

Juli Chaffee has authored a forthcoming publication for her Doctoral Thesis titled "Clinical Social Workers, Telemental Health, and the COVID-19 Pandemic." In 2020, she co-authored a book chapter in "Theory & Practice in Clinical Social Work", and in 2023 she co-authored a paper in the Journal of Family Trauma, Child Custody & Child Development. She has presented original research at three juried conferences. The first was in June 2018 at the 29th Annual Network for Social Work Management Conference, followed by August, 2018 at the 3rd International Childhood Trauma Conference in Melbourne, Australia, and finally in November, 2018 at the 64th annual Council on Social Work Educational Conference.