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ORIGINAL PAPER

"There is Just a Different Energy": Changes in the Therapeutic Relationship with the Telehealth Transition

Judith L. M. McCoyd[1] · **Laura Curran**[1] · **Elsa Candelario**[1] · **Patricia Findley**[1]

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Abstract

The therapeutic relationship (TR), including its therapeutic frame, is the foundation of the therapeutic endeavor. In response to the COVID-19 pandemic and the rapid transition to videoconferencing for therapeutic encounters, we employed a cross-sectional exploratory survey with 1490 respondents to understand how practitioners adapted to the changes. In this secondary analysis focused on the TR, we analyze the clinicians' (N = 448) spontaneous narratives about facets of the TR. Temporally, we focused on how these adaptations occurred during the initial part of the pandemic before vaccination was available and while the TR was still adapting to teletherapy videoconferencing under the duress of pandemic crises. We find three broad themes: (1) It is a "much more remote relationship"; (2) The "connection…remains surprisingly strong"; and (3) It is "energetically taxing." Each reflects clinicians' views of the TR as altered, but surprisingly resilient. Although grateful for the safety of virtual therapeutic encounters, clinicians mourned the loss of an embodied encounter, experienced depletion of energy beyond Zoom fatigue, and nonetheless recognized their clients' and their own abilities to adapt.

Keywords Therapeutic relationship · Therapeutic frame · COVID-19 · Telehealth · Teletherapy · Adaptation

Introduction

The therapeutic relationship is the heart of psychotherapy and influences therapy outcomes even more strongly than modality (Luborsky et al., 2002; Wampold, 2012). Before COVID-19, therapeutic work typically took place in person with therapist and client meeting privately in a consistent space to work on collaborative therapeutic goals, while attending to the "therapeutic frame." The face-to-face, in-person encounter was considered optimal for this work, but COVID-19 disrupted these relationships and led to the common adoption of videoconferencing to maintain (or establish new) therapeutic relationships. At the time of our data collection and analysis, there was little empirical work specifically examining the nature of therapeutic relationships under the rapidly changing circumstances of the COVID-19 pandemic. Although more has since been written (see this journal December 2021 and March 2022; Tosone, 2021), this study builds on this emerging literature, allows examination of how clinicians adapted to the changes in the therapeutic relationship in real time, and theorizes the alterations in the relationship. This paper uses data from a larger study on how social services workers responded to COVID-19; here, we focus exclusively on the specific period of clinicians' adjustment to a global pandemic and on how shifts to videoconferencing impacted the therapeutic relationship (TR) and therapeutic frame (TF).

We briefly summarize literature well-known to clinicians that is related to the therapeutic frame and the nature of effective therapeutic relationships. We then situate the experience of our research respondents at a time when many therapists were hesitant about adopting teletherapy (before 2020) and discuss more recent literature about clinicians' perspectives on the telehealth transition. We follow with a brief overview of our methods and present our results from a study of clinicians who transitioned to teletherapy as a result of the COVID-19 pandemic. The qualitative data were

✉ Judith L. M. McCoyd
jmccoyd@ssw.rutgers.edu

Laura Curran
lacurran@ssw.rutgers.edu

Elsa Candelario
elsa.candelario@rutgers.edu

Patricia Findley
pfindley@ssw.rutgers.edu

[1] School of Social Work, Rutgers University, 120 Albany St., Tower 1, Suite 200, New Brunswick, NJ 08901, USA

collected in the late summer/early fall of 2020, before vaccination was available and as clinicians were recognizing that pandemic conditions were not going to be short-lived; in order to continue psychotherapeutic work safely, they would need to adapt to videoconference sessions. These data therefore reflect the thoughts of clinicians about how the therapeutic relationship was changing as they themselves were adapting their practices to teletherapy under the duress, and shared trauma (Tosone et al., 2003, 2012), of the pandemic. Our findings coalesce around three central themes: It is a "much more remote experience"; The "connection… remains surprisingly strong"; and It is "energetically taxing." We illustrate how changes to the therapeutic relationship reflect larger social and relational shifts, while also identifying how clinicians assessed the impact on their ability to sustain therapeutic relationships during crisis-inspired transitions.

Therapeutic Relationships and the Therapeutic Frame

As clinicians no doubt understand, the TR grounds the work of psychotherapy and has been found by most research to be even more important than clinical modality (Lambert & Barley, 2001; Luborsky et al., 2002; Wampold, 2012). The TR has evolved from early Freudian "blank slate" therapeutic ideals to a much more interactive and relational set of interactions, with varying degrees of mutual disclosure. Classically, Rogers (1957) identified the "necessary and sufficient conditions" of psychotherapy: the first three relate to the therapeutic frame, or the structuring of the relationship whereby the therapist and client are together solely for the purpose of therapeutic contact with the client in some degree of distress and the therapist able and willing to assist in a private, safe environment. The TR is characterized by therapist authenticity and genuineness, unconditional positive regard toward the client, and empathic understanding. Recent scholarship reinforces the importance of these qualities or "common factors" as necessary for effective therapeutic work. These qualities of the TR undoubtedly structured clinicians' thoughts as they managed their own responses to the pandemic while attempting to maintain professional TRs during the transition to videoconference sessions.

The therapeutic frame consistently relates to the environmental aspects of the therapy- from Freud's (1912/1913) blank slate and stance sitting behind the patient (1912, 1913) to Winnicott's consistent holding environment (1961) to Rogers' reflective listening (1957)- the frame is characterized by therapist abstinence (not reacting to the client as typical social interactions might dictate), anonymity (refraining from being known as a real/whole person), and neutrality (responding only through the understanding of the client's perspectives) (Cherry & Gold, 1989). These qualities ensure focus on the client, including consistent and predictable routines that support the work of therapy itself by creating a space where therapy is expected to take place without interruption. Again, with the advent of COVID-19, clinicians' lives were disrupted in ways that challenged "therapist abstinence" and the therapeutic frame's focus on predictable routines, spaces, and avoidance of interruptions.

Gelso's tripartite structural model of the therapeutic relationship (2019) consists of the real or personal relationship (what happens in the embodied and concrete parts of the relationship), the working alliance (the work toward common therapeutic goals and commitment to well-being of the client), and the transference—countertransference configuration (the prior patterns, historic schema, and less conscious phenomena that influence the therapeutic relationship). This model is useful for teasing out the working alliance as a part of the TR that may be resilient under circumstances of crisis. Both the real relationship and transference/countertransference configuration are apparently more influenced under conditions of threat, particularly since the TR is ideally to take place within a "safe holding environment." Collectively, for the purposes of this paper, we understand critical components of TR and therapeutic alliance to include authenticity, empathetic connection to the client, and use of the therapist's embodied self to attend to clients' emotional and therapeutic needs; we understand components of the TF to include a consistent and private office space, an environment that limits interruptions of therapy, predictable routines, and therapist abstinence. These characteristics of TR and TF were typical prior to the transition to telehealth and are the focus of our analysis.

Clinicians' Perspectives on Telehealth

Prior to the 2020 Onset of COVID-19

Clinical social workers historically believed in "the necessity of a face-to-face relationship" for a positive therapeutic relationship (McCarty & Clancy, 2002, p. 155). Even with the growth of telehealth platforms like crisistextline and others, many expressed severe misgivings about telehealth in any form (text, email, telephone, and videoconference). This was despite empirical evidence largely from allied disciplines of teletherapy's effectiveness (Berryhill et al., 2019; Norwood et al., 2018) and initial empirical support for the presence of a therapeutic alliance in videoconferencing psychotherapy (Simpson & Reid, 2014). Clinical social workers worried about confidentiality, reimbursement, the therapeutic relationship, and general efficacy if therapy was conducted in teletherapeutic ways (not always differentiated by modalities) (McCarty & Clancy, 2002). In a 2015 issue of *Clinical Social Work Journal* devoted to cybertechnology and clinical social work practice, articles often addressed concerns about

confidentiality and other ethical issues, still with a tilt toward skepticism about telehealth modalities. Lopez (2015) was one of the few to examine the therapeutic alliance through the lens of social presence theory, noting how website-based therapies could be used as an adjunct to traditional therapies. Lopez reflected that text and email convey less social presence or connection, whereas a tailored website with specific communications between specific therapists and their clients conveyed greater social presence. Lopez (2015) found that clients and therapists felt the therapeutic alliance benefited from the additional therapeutic website services that maintained a degree of social presence (or known relationship).

Zilberstein, in the same issue, asserted "Psychoanalytic and relational therapists tend to feel the most uneasy about technology's presence because the idea of digital media conflicts more with underlying theories and trends" (2015, p. 153). Zilberstein traced concerns about changes in technologically mediated relationships (whether in social media, education, or therapy) and acknowledged that while many therapists were hesitant, adolescents and young adults embraced the technological interactions. She noted "Since psychotherapies always develop within a cultural context, they must remain sensitive to these changing norms and adapt expectations, understandings, and techniques accordingly" (2015, p. 157). Thus, while some clinicians embraced e-therapy in the pre-COVID context, the profession was broadly ambivalent about adopting these technologies. Nevertheless, a pandemic would require changes, and rapidly.

Developments in Teletherapy Since 2020

There is a growing literature about clinicians' experiences during the onset of the COVID-19 pandemic. Yet limited research specifically aims to explore the dynamics and conceptualize shifts in the TR and TF under these crisis conditions. In one of the few articles that bridges clinician perspectives on telehealth pre-COVID to the year after its onset, Cristofalo (2021) observed that videoconferencing, initiated years prior to the pandemic in her health setting, had been used in ways that benefitted managerial goals rather than health social worker or patient wellbeing. She argued that social workers were asked to use videoconferencing in situations that impaired their ability to fully assess psychiatric conditions and implicitly indicated that the TR was negatively affected by an inability to assess needs or intervene effectively. Despite these concerns, Cristofalo (2021) reports being pleasantly surprised by greater degrees of access for some clients with the transition to videoconferencing as the pandemic began. She nonetheless cautioned that "telehealth can create significant inequities in access to and quality of care" (p. 402) and that even non-profit healthcare conglomerates were prioritizing "monetary gain" (p. 401) over patient equity and well-being. Disney et al. (2021) similarly examined telemental health usage among refugee mental health providers early in the COVID-19 pandemic. They noted how telemental health offered access to some, but reinforced inequities for others who lacked technological literacy and/or access, a finding echoed by other studies in this period (Mishna et al., 2021).

Family therapists were ahead of the curve in adopting videoconferencing before 2020 (Békés & Aafjes-van Doorn, 2020). In tracking use of teletherapy during the transition from pre- pandemic conditions through the early part of the pandemic, several studies determined that the focus on therapeutic goals had continued and that the majority of clinicians and their clients were pleased with teletherapy (Burgoyne & Cohn, 2020; Hardy et al., 2021; Maier et al., 2021). In one of the few studies to track the adjustment during a defined period very early in the pandemic (1 week in March 2020), Békés and Aafjes-van Doorn (2020) found that clients they interviewed were very positive about the transition as were psychotherapists, although much less so than clients. Psycho-dynamically oriented therapists had more concerns than those who practiced cognitive behavioral methods, though both groups were concerned about less connection with clients, fatigue, and their own sense of competence and authenticity. Broadly speaking, the initial transition went well for their sample of European and North American psychotherapists (Békés & Aafjes-van Doorn, 2020), a finding mirroring other studies tracking the transition (Ashcroft et al., 2021). In their qualitative investigation, Mishna et al. (2021) described how the creative use of communication technologies (not teletherapy alone) allowed social workers to remain flexibly connected with their clients in the early days of (or more specifically 6 weeks into) the pandemic. Another common finding among general health and mental health providers (Khoshrounejad et al., 2021) and psychotherapists (Heiden-Rootes et al., 2021; McKenny et al., 2021) addressed how technological glitches like buffering and telehealth's inappropriateness for some forms of assessment and intervention added to a sense of fatigue when using videoconferencing. Notably, students' perspectives about maintaining the TR in e-therapy in the context of the pandemic were more positive. Earle and Freddolino (2022) found that MSW students generally had positive attitudes about the ability to create a virtual alliance and many anticipated practicing in a virtual context post-pandemic. Likewise, Mitchell's (2020) qualitative study based on interviews with six U.K. integrative psychotherapists provides the most in-depth discussion of dynamics related to the TR/TF, noting shifts in the TR/TF but also its transferability to the videoconferencing context at the start of the COVID-19 pandemic. The small sample size, however, poses significant limitations and warrants replication. In sum, recent research has focused on clinician adjustments and their expressed concerns or acceptance of the transition to videoconferencing. Little work, however,

has systematically focused on clinicians' perspectives on the TR and TF or theorized the alterations in TR and TF during the pandemic shift to telehealth. We fill this gap.

Methods

This paper uses data from a larger study of social worker responses to COVID-19 that employed an exploratory, cross-sectional survey design and asked: (1) how agencies and social service workers managed service disruptions and safety risks associated with COVID-19; (2) how social service workers perceived and experienced shifts in clients' needs; (3) how social service workers adapted to the transition to technology-mediated interactions with clients and their perceptions of clients' acceptance of teletherapy; and (4) how social service workers coped with COVID-related transitions and demands. Each item included open text boxes for respondents to elaborate on their answers. Although the survey did not explicitly ask about the therapeutic frame or the TR, many respondents offered comments about aspects of each in the text boxes and those comments are the data we used for this secondary qualitative analysis. Serendipitous discovery has a long and honored tradition in qualitative inquiry (Åkerström, 2013; Padgett, 2016) and is well understood by methodologists to be a beneficial focus of additional analysis. The analysis in this paper focuses solely on the qualitative data spontaneously offered that related to components of TR or TF. These data were offered in the context of the respondents' descriptions of their concerns about the transition to teletherapy.

Sample

We recruited a convenience sample from a listserv of 37,224 individuals who had participated in continuing education events associated with a school of social work in New Jersey. We sent an introductory letter, consent form, and survey instrument via email to the listserv, inviting individuals to participate in a Qualtrics (Provo, UT, 2020) survey. We collected data from August through September 2020, fully understanding that only very motivated individuals were likely to respond given the ongoing adjustment to pandemic circumstances before the availability of vaccines. Respondents needed to be employed in a public or private agency or in private practice (group or individual) as the COVID-19 pandemic began. The institutional review board of the host university approved the study. Of the 1642 individuals who responded to the survey, 1490 completed the survey. For this study, we used only respondents who identified themselves as being engaged in clinical mental health services in agency or private practice settings, and who provided qualitative data via the text boxes (N = 448). In terms of demographics, 89% of our clinician sample identified as female, 11% identified as male, and one person identified as non-binary. Most respondents are white (84%), 4% are Black/African American, 5% are Hispanic/Latinx and 2% identify as Asian, with others identifying as multiracial or Native American representing less than 1% each. The modal age group is 50–59 (23%) with 40–49 year-olds (22%) and 60–69 year-olds (21%) representing the next largest groups. The sample came from the New Jersey (NJ) area, an epicenter of the early COVID-19 pandemic. The first diagnosis of COVID-19 in NJ came on March 2, 2020 and by March 21, 2020, Governor Murphy issued Executive Order 107 which closed all but essential businesses until later in the summer (NJ.gov, 2021). For our sample of mental health workers who generally provide supportive and therapeutic services, their adjustment to the spring requirement to either close their practices or turn to remote services was still unfolding just before we collected our data. Although businesses were opening again by summer 2020, hope for a return to normal was tempered by a fear of this deadly and still mysterious disease. We wanted to understand how clinicians were adapting their practices, adjusting to their clients' needs, and managing their own mental health needs under pandemic circumstances.

Survey Instrument

Structured, close-ended items followed by open-ended items with text boxes provided the frame for the survey. Questions pertained to demographic and descriptive information about the respondents and their practice settings; COVID-19's disruption/s of their services; shifts in clients' presenting needs; and most important for this analysis, the experience of moving clinical practice to teletherapy. Much of our qualitative data came in textboxes related to a question asking clinicians to select whether teletherapy is "just as good as in-person," "not as good as in-person," "better than in-person," or to indicate if they were not using teletherapy methods. Clinicians wanted to explain the nuances and rationales for their answers in detail. We also examined their personal challenges (and coping strategies) in balancing work and home life.

Analysis

We used thematic analysis, a systematic and flexible approach applicable across varying qualitative data that allows identification of emergent themes and patterns (Braun & Clarke, 2006). In the larger study, four members of the research team reviewed all the qualitative data, generating and agreeing on a set of broad initial coding categories. For this secondary analysis, we focused on any qualitative data related to the therapeutic relationship (TR) and

therapeutic frame (TF). Two team members reanalyzed these data. Although the survey did not explicitly interrogate these concepts, their robust emergence in our initial analysis prompted our further investigation. The two team members who reanalyzed these data using analytic lenses of TR and TF refined and expanded the initial codes, examining data solely related to the change from in-person clinical encounters to synchronous videoconferencing (we will use this and teletherapy synonymously). Attentive to the components of TF and TR derived from our literature review of the concepts, we analyzed how our respondents described any changes in those components, while remaining open to other findings related to TF or TR. Our analysis relates only to this form of teletherapy (not text or email forms). The team members kept analytic memos and met regularly to review and reconcile codes, examine relationships among the codes and the extant literature, eventually reducing codes into higher order and analytically richer, interpretive themes. Regular meetings, memo-ing, peer debriefing, and reflexivity checks all enhanced the analytic rigor (Creswell, 2013).

Results

Three broad themes capture the ambivalence with which our respondents viewed the transition to teletherapy. The first theme, it is a "much more remote experience" reflects the respondents' sense that videoconferencing for purposes of therapy creates a more physically and emotionally distanced experience, stripping away office practice routines and rituals that provide the therapeutic frame of privacy, predictability, and physical presence. The second theme that the "connection remains surprisingly strong" captures the surprise many respondents felt as they recognized the losses entailed by the transition to teletherapy and also encountered better attendance, a wider lens into clients' lives, and other qualities of the work that enabled changed yet adequate therapeutic relationships. The final theme concerns their perceptions that teletherapy is "energetically taxing" in different ways than in-person therapeutic interactions.

Theme 1: It is a "Much More Remote Experience"

When respondents assessed how the change to teletherapy affected their practice, they often related something similar to the idea that teletherapy felt "more remote." Three subthemes contribute to the larger thematic construct of the more remote experience; subthemes are normative within qualitative analysis (Braun & Clarke, 2006; Padgett, 2016). Each sub-theme relates to identification of the losses (intangible, specific, and TF- and TR-related) that create distance (remoteness) in telehealth. The first involves the "intangible losses" resulting from disembodied interaction; a key aspect of this sub-theme is the respondents' sense that a critical but hard to specify element of the therapeutic relationship has changed. Sub-theme 2 encompasses specific losses that respondents could identify clearly. These were related mainly to the loss of body language, eye contact, and the distractions of videoconferencing. Here, many specified the loss of nuance: they mourned the loss of emotional indicators usually conveyed in subtle body language. Although faces are on view during teletherapy sessions, nuance was also lost as video "smooths out" subtleties in facial expressions. These changes in ways of relating and communicating led clinicians to identify a loss of critical clinical information, which in turn created more emotional distance in the therapeutic relationship.

The final sub-theme addresses respondents' perceptions of changes (losses) in the therapeutic frame and relationship. It encompasses four codes concerning how therapists try to maintain the therapeutic relationships to which they were accustomed during office work. The first concern is the disruption associated with changed routines of practice: the office no longer provides a safe private space or the physical setting for the predictable therapeutic frame. A related code captures the effort, (lost) time, and disruptions associated with the use of technological platforms. Clinicians described emotional connections (TR) disrupted by electronic connectivity interruptions (TF). Many also reported struggling to develop therapeutic relationships with new clients, while established therapeutic relationships flowed more easily. They concluded that "the screen is a barrier" and that being unable to use one's body to help clients self-regulate, or to join with the client by leaning forward, impairs therapeutic connections, interventions, and the TR on some levels. Together, these three sub-themes identify three forms of loss that together constitute the "more remote experience" our respondents described (Table 1).

Theme 2: The "Connection…Remains Surprisingly Strong"

The second large theme captures the surprise many clinicians express that the emotional connections with clients (TR) remain strong, despite the losses identified above; they are even more surprised by some unexpected benefits of teletherapy. In the first sub-theme, respondents identify the import of safety as the primary benefit that compensates for losing the in-person connection. In the second sub-theme, they articulate that teletherapy is "better than a mask" because face-to-face screen-based sessions allow for greater access to the nuances of expressed emotions and facial expressions than masked faces. Our respondents were also surprised by clients' enhanced comfort. Attendance improved with greater flexibility around scheduling and the absence of time-intensive commutes, and many

Table 1 Theme 1: It is a "much more remote experience"

Sub-theme 1: There are "Untangible [sic]" losses	It is effective but in-person treatment has an untangible [sic] quality that telehealth does not
	…new patients I work with online don't seem to take the therapy as seriously when they're in their own home and/or surrounded by people and the things of their home life. It's therefore a *much more remote experience* I think in every way
	Working mostly in a telehealth capacity has made the work less rich, and less satisfying overall. Although many of my patients I have had for years and have an established rapport, there's still that fullness of the in-person session that is lost and can't be thoroughly replicated online
Sub-theme 2: Specific losses can be identified	
Body language cues	The encounter is intensified, in the focus on facial expression, and enervating. At the same time, information that can be gleaned from posture, attitude, even fidgeting, is lost
	I miss the immediacy of the in person, whole body encounter
	Missing body language. Difficult to perform initial evaluation
Eye contact	I cannot look person in the eyes and do not feel presence in the same way as in person
	The biggest impact is being unable to see clients face to face. There is something lost having a session virtually
Nuance	It's impossible to pick up the nuances of body language and emotional shifts from clients. Some sessions are more like "life coach" than therapy. That's not my thing
	Video "smooths" out detail making nuances of facial expression indiscernible
Focus (due to distractions)	More distractions and interruptions
	Client is more focused in person
	Some challenges with clients being distracted or multitasking during sessions
Subtheme 3: There are therapeutic frame and therapeutic relationship changes	
The therapeutic frame is disrupted: office rituals and sense of safe space are lost	One of the most impactful ways COVID19 has interrupted services is by disrupting the framework of therapy. There is a stronger need to reestablish the therapeutic frame virtually and continue to monitor it. Clients also have vocalized the impact of the absence of the physical office space which ensured privacy
	...lost ritual of coming to the office for sessions
	Providing teletherapy from home is much harder than you would think. Just finding privacy is difficult with kids/spouses/pets. And it is for clients, also
	Some clients have to be in their cars because family members are home
Technology impacts the therapeutic relationship	Tele-health platforms take away from the practice of psychotherapy, as each session time is spent on how to connect, rather than in connecting
	You can't see the whole person, there is buffering and technology glitches and it's easy for the client to be interrupted
It's harder to build relationships with new clients	And taking new patients is definitely not the same—it's harder to get to know a new patient and vice versa, AND I think there's less staying power in it
	I think the most difficult issue is creating a therapeutic alliance with new clients
	As long as we already have a relationship it is just as good. If it's a new client, it's difficult to connect
"The screen is a barrier": Emotional connection and embodied use of self are impaired	More difficult to make emotional connection for therapeutic alliance
	I also realize how often I shift my posture to bring people in for greater intimacy or to calm someone, so this has hurt my ability to be more direct and confront clients. They are already struggling and there isn't a way to use my whole self to bring calm to sessions
	It's more difficult to attend to a client's emotional needs remotely. The screen is a barrier

Table 2 Theme 2: The "connection …remains surprisingly strong"

Safety outweighs the wish for in-person sessions	I have several clients who regularly ask when I will be returning to in-office sessions. I tell them I am continuing with telehealth for the foreseeable future because I have several family members with preexisting conditions and I am not comfortable risking infecting them
	I'm not going to do in-person until after there is a vaccine. My private practice expanded significantly during COVID. and I am not comfortable risking infecting them
	I will not go back to face to face until there is a vaccine and every client provides proof of having a vaccine
Teletherapy is better than using a mask	I believe that with the in-person regulations, the tele-therapy has been fine. The biggest advantage is not having to wear masks, allowing me to see client's facial expressions
	I have been very anxious during these times. My employer has required face-to-face sessions, though I have advocated strongly for tele-health as a preferred option for better validity (I can see a person's unmasked face via video and they can see mine; it is safer)
Teletherapy adds to comfort levels	With few exceptions clients were pleased with the ease of available hours and most felt as comfortable as in person
	Clients are more willing to access services when it's more convenient. Less cancellations for me
	Some have enjoyed telehealth because they can be in the comfort of their homes and eliminate the commute to/from my office
	Also I find clients seem comfortable talking in their own homes
	Clients tend to be more open. The clients feel comfortable in their own space. We acknowledge that it's different and try to keep the conversations the same as in person
Teletherapy provides "greater intimacy"	I have the opportunity to SEE inside the client's world
	More intimate and open for some patients
	Clients seem more likely to show and they appreciate being seen in their homes which results in improved and more candid disclosure
	More information about home, family impacting issues
Teletherapy works with surprisingly strong connections	We've adapted, but I miss the information I can gather in person. My connection with clients, however, remains surprisingly strong
	I have been surprised that tele therapy works as well as it does, but I cannot say it equals real in person contact

noted a sense of comfort as clients engaged from their own homes. The ability to (literally) see into clients' homes and (figuratively) into their lives generated a greater sense of intimacy, knowledge, and disclosure. Finally, our last subtheme observes how respondents expected a sense of loss but acknowledged surprise about the endurance of the therapeutic connection in a virtual space (Table 2).

Theme 3: It is "Energetically Taxing"

Overwhelmingly, our respondents described teletherapy as more demanding; they felt like they were working "harder than ever." Many found teletherapy to lack the interactive energy created by in-person encounters. Instead, teletherapy was a "draining" experience. Clinicians expended more energy to maintain the therapeutic relationship but got far less back from the interaction. Teletherapy was additionally depleting as (1) clients assumed greater flexibility and availability on the part of clinicians and (2) providers had to learn to set limits (for both themselves and their clients) in their new work from home context. Managing the inevitable "technical glitches" and physical strains associated with screen time was yet another source of depletion. Finally, the personal challenges of family life (especially COVID-era childcare concerns), fears for their own health, and the larger community and cultural trauma brought by COVID left many with a deep fatigue. All of this was in addition to the "Zoom fatigue" that has been well-documented. In sum, the decreased "energy in the room" combines with therapists' extra efforts to maintain the TF and TR in ways that magnify the energy drain (Table 3).

Discussion

In 2015, Zilberstein raised concerns about the ways technology would change the provision of therapeutic services and the nature of therapeutic relationships. After describing some of the neurobiological findings about technology usage, she implicitly noted the tension between accessibility and boundaries. She described how psychoanalytic clinicians worried that "intrusive" emails and seeing into one another's physical spaces via videoconferencing would break the therapeutic frame that promotes transference and

Table 3 Theme 3: It is "energetically taxing"

Clinicians assert it is harder to do teletherapy	I've never worked harder in my career as a therapist This time, we were all experiencing the same shit, and 1 hour on zoom felt like 5 in person. It was exhausting–to be with problems, and then my life. Much easier to feel grounded in my own well-being when sessions are in person Telehealth more draining than in person sessions Not as fulfilling due to lack of physical presence. I found myself really needing to "push" myself to stay as completely engaged as possible–cause if I can't–neither can my client!! The job actually felt harder to do Telehealth is more exhausting mentally and physically for myself as a clinician which has left me no other option but decreasing the number of sessions per day and reducing number of open cases
Clinicians miss the energy of in-person, face-to-face sessions	There is just a different energy in person Clinically it is still sound, yet myself and the patient misses the energy of face to face Miss being in person, the closeness, and energy Missing an essential element of therapy, namely the connection and felt emotion in the room Pros: convenient, more insight into people's environments, Cons: lack of interactive energy "in the room" Energetically taxing. Much prefer face:face. Prefer now working in garden w social distancing
Clinicians find fluid professional boundaries exhausting	Difficulty keeping session time boundary (e.g., going over 45–50 min session to ~ 60–65 min, impacts rest of day which often looks like 7–9 sessions) I had some trouble balancing my availability to clients because I was working from home. I ended up working more which was somewhat detrimental to my own mental health Difficulty setting boundaries between home and work life; they all blur Boundary issues require constant reassessment, as clients are perceiving an increased "availability" and "flexibility" in cancelling/rescheduling appts at "off" hours due to remote therapy scenario
Technology and "Zoom fatigue" are energy-depleting	It is exhausting looking at a screen for many hours a day….Technology can be and is subject to glitches Internet connectivity was inconsistent, which negatively impacted sessions Additionally, as a clinician, I experienced an increase in eye strain and headaches, increased emotional stress as related to virtual sessions (had to create an appropriate "background," quiet home setting) Technical glitches, therapist fatigue
Personal challenges lead to further exhaustion	Working from home while taking care of my own children Juggling working from home with the children from home is an extremely challenging task I don't feel as available to patient as I'd like to because I'm so burned out with my own things going on at home—with my kids, my spouse, and my elderly mother—who are all suffering in their own ways as well. A lot of things seem meaningless and overwhelming now in my own life Increased fatigue, job stress, rate of death and illness for clients, fear of death and illness for clients and staff, use of telehealth formats Decrease in job performance and productivity due to fatigue, poor focus, deconditioning, poor sleep, grief, and larger existential changes

transferential clinical work. Earlier research with clinical social workers showed they worried that "cyber communication" was a "slippery slope," useful administratively but likely to become a Pandora's box of ethical challenges about boundaries (Mishna et al., 2012). Yet Zilberstein noted that empirical findings had not found the level of detriment some clinicians feared and implied that the high degree of technology-familiarity and increased accessibility, especially among youth, would move more therapeutic work into technological spaces. She appears prescient in view of the COVID-19 pandemic. Given Earle and Freddolino's (2022) findings that MSW students are very accepting of teletherapy, we expect this acceptance to continue, despite more seasoned clinicians' initial hesitations.

As noted above, empirical reports of mental health practice adjustments have proliferated (Ashcroft et al., 2021; Hardy et al, 2021; Heiden-Rootes et al., 2021; McCoyd et al., under review; Mishna et al., 2021) and findings of frustrations with technological adjustments, awareness of enhanced client needs, and gratitude for teletherapy's safety

have been ubiquitous. This study adds to this literature through its specific focus on the pandemic-driven shift to teletherapy's impact on the therapeutic relationship (TR) and the therapeutic frame (TF). While many professions (e.g., teachers, healthcare professionals) learned to adjust to virtual environments, mental health clinicians had additional challenges as they navigated management of boundaries that are part of the TF (therapeutic abstinence) and worked to assure that the TR remained intact. Mishna et al. (2021) noted clinicians' sense that clients felt freer to attempt communication outside typical working hours and our sample reported the same dynamic, with many reporting difficulties maintaining boundaries between professional and private time/realms.

The TR is grounded in deep communication between therapist and client and historically this communication has been assumed to entail (if not require) extensive non-verbal (full body rather than just facial) as well as verbal communications (Priebe et al., 2020). The common factors literature (Lambert & Barley, 2001; Wampold, 2015) reinforces how a therapist's ability to read clients' body language creates a consistent safe space in which to work (TF). The TR involves therapists' abilities to use their own bodies to illustrate empathy for clients and to assist in clients' emotional regulation also. Yet as Theme One indicates, our respondents often felt that many of these qualities were lost during the first 6 months of the pandemic transition to videoconferencing for therapeutic work. Some struggled to name the intangibles that were lost, qualities like richness, nuance, and connection. Many reported frustration that technological challenges and video-buffering undermined verbal and non-verbal communication. Certainly, our clinician-respondents sensed that connections are harder when the only non-verbal communications are facial expressions. Notably, relational couples and family therapists (CFT) have also observed that missing body information is a challenge of teletherapy. Heiden-Rootes and colleagues coined the term "dys-appearing body in teletherapy" observing that "teletherapy introduced a therapy process disorder—the dys-appearing body of therapists and clients—that needed to be worked through or accommodated in order to continue effective CFT practice" (Heiden-Rootes et al., 2021, p. 349). In contrast, others note that the screen allows for a deeper focus on, and ability to read, facial expression, thus compensating for other losses (Mitchell, 2020). Yet our respondents not only identified the challenges of missing body language, but described more specifically how their embodied practices such as shifting toward a client or using their bodies to help regulate client's emotional states were lost in teletherapy, potentially threatening the TR.

Our respondents also remarked on the loss of the office routines and the clients' commitment to coming to the office that have traditionally been part of the therapeutic framework. They worried about how their clients' lack of privacy, occasionally less safe-feeling venues like cars, and other mutable routines could disrupt the TF and therefore the efficacy of the TR in teletherapy. The frame traditionally provides a "holding environment" (Winnicott, 1961) that also sets aside that time and space for the therapeutic endeavor, something that no longer functioned that way in virtual (often changing) environments. Further, Gelso's (2019) "real relationship," the embodied and routinized parts of the TR that are also part of the TF, is compromised as the physical part of the encounter is stripped away and the routines of meeting and greeting are transformed. Nevertheless, our respondents also recognized that the work went forward, and that health safety clearly outweighed their concerns about impairment of the TF. Even so, most of our respondents believed that they had salvaged fundamental components of the TR. They believed that their effectiveness would have been more impaired in a context where masks covered facial expressions and muffled voices. Our findings follow the reflections of clinicians describing their ability to maintain a TR/TF using teletherapy during the COVID-19 crisis and the way the TF becomes a co-created therapeutic environment (Ruden, 2021; Saidipour, 2021). Saidipour (2021) offers a Winnicottian metaphor to articulate a model for the therapeutic process including an enduring yet flexible TR/TF that is 'good enough' to survive a collective crisis and shared trauma. This is also consistent with findings of a recent study reporting that relational couples therapy clients had some challenges making the transition to teletherapy but were "making do" and found home-based treatment to provide a "safe therapeutic space" (Maier et al., 2021, p. 310).

Our respondents went a bit further than "making do," expressing pleasant surprise that even if engagement felt different, clients' attendance and comfort seemed to improve. They were also surprised by the continued therapeutic sense of connection and efficacy. Findings in pre-COVID literature on e-therapy showed the endurance of therapeutic efficacy during voluntary self-selected teletherapy, as well as acceptance by both therapists and clients (Amichai-Hamburger et al., 2014; Mishna et al., 2012). Despite those previous findings, our respondents were adopting teletherapy under the duress of the pandemic, not voluntarily. We were able to capture their extreme surprise that the TR remained intact, and that there were even additional benefits. This echoes recent literature that shows the endurance of the therapeutic alliance and in some cases an enhanced openness and intimacy as therapeutic work transitioned to a virtual context during COVID-19 (Mishna et al., 2021; Mitchell, 2020). This may also speak to Lopez' (2015) finding that greater social presence is associated with more acceptance of teletherapeutic modalities by both clients and therapists.

Beyond the openness of the co-created TF of the shared therapeutic environment, there is also a shared trauma.

Tosone et al., (2003, 2012) drew on experiences from September 11, 2001 and of Israeli clinicians to identify the heightened therapeutic intimacy and connectivity that can occur during moments of collective crises, particularly when clinicians are deeply self-reflexive and embrace self-care. Expanding on this concept in an edited volume related to COVID-19, Tosone (2021) was able to document shared resilience as well as shared trauma. Similarly, although our clinician sample worried about the change in the embodied relationship, they also were surprised at the strength of the connection that remained and generally felt assured that the therapeutic relationship remained intact and resilient.

Yet even with these positive aspects that join the imperative of safety, many therapists were unprepared for their tremendous loss of energy as they dealt with Zoom fatigue, overstretched personal and professional boundaries, and the removal of the "energy in the room." As can be seen by respondents' statements, Zoom fatigue was an understood concept early in the pandemic (Ramachandran, 2021), but our respondents were describing something beyond just the well-documented fatigue that comes from screen interactions. Our respondents missed the energy generated by interacting in-person and felt that something fundamental and fulfilling was thus lost. McKenny et al.'s (2021) survey of family therapists in the U.K. during COVID similarly identified fatigue among clinicians engaged in online family therapy, and Heiden-Rootes et al.'s (2021) respondents also defined teletherapy as exhausting (p. 349). Some of Mitchell's (2020) therapists also reported having to work harder to form a connection. Yet, previous studies did not interrogate energy depletion related to changes in the TF and TR in the teletherapy space. Our respondents specifically indicated that they missed the energy that came from in-person interactions with their clients. As a result, they found teletherapy to be "harder" and "exhausting" as they tried to compensate for the loss of the embodied components of the TR.

We cannot generalize our findings to all therapists' adjustment to the transition to online therapy due to the pandemic. Our respondents practiced in a relatively small geographic area in and near New Jersey. We have a convenience sample and derive our data from the spontaneous comments clinicians added about their beliefs about how transitioning to telehealth affected their practice with their clients. The serendipitous findings in the survey (McCoyd et al., under review) justified this secondary analysis of the qualitative data: had we queried this more directly, responses may have been more systematic, but the spontaneity with which they were offered shows that these were meaningful topics for the respondents. That respondents volunteered such a large volume of data about components of TF and TR illustrates how significant they believed those components to be.

Our findings suggest that as intimate therapeutic encounters moved online, clinicians missed the embodied interactions in multiple ways: they missed them as part of the TF in the lack of office routines; they felt their ability to assess and communicate easily was impaired by the missing body language; and they missed being able to use their own bodies to intervene and help clients regulate themselves. As Cherry and Gold (1989) had surmised, these therapists needed the TF for themselves, too, as a way of avoiding boundary violations and seemingly as a way to ground themselves in their therapeutic role. To enable effective TRs, they expended great energy to create and adapt their therapeutic connections (both emotional and electronic) in teletherapy. Although Zoom fatigue affected the TRs and TFs, extant suggestions to manage Zoom fatigue such as turning off cameras and physically moving (Ramachandran, 2021) would further threaten both the TF and TR by changing the TF and limiting connections and embodied interactions even more. Our respondents missed the embodied TR, to be sure, but they seemed to maintain the therapeutic alliance well, and to manage the boundary threats to the transference/countertransference. It may be that the frame of the screen will serve some of the therapeutic frame's functions in the future.

Moving forward, research should further explicate the vicissitudes of the virtual therapeutic relationship, both its factors and structure, from the perspectives of both clinicians and clients. It will be important to understand precise mechanisms for how energy is depleted while engaging in mental health therapeutic encounters beyond the already-understood Zoom fatigue. Our respondents, like many others during the pandemic, overcame their strong misgivings about teletherapy in order to achieve relative safety and were pleasantly surprised that the trade-off did not impair their therapeutic relationships more radically. They found the TR resilient and they adapted to these transformations and challenges in the therapeutic endeavor.

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Declarations

Conflict of interest The authors declare that there is no conflict of interest.

Ethical Approval The research was ethically reviewed by the university IRB, following the Belmont Report and the Declaration of Helsinki guidelines.

Informed Consent All respondents indicated understanding of the informed consent prior to completion of the survey.

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Judith L. M. McCoyd, PhD, LCSW is an associate professor for Rutgers University's School of Social Work. Her research and clinical practice involve perinatal health care and hospice. She coauthored *Grief and Loss Across the Lifespan* (Springer) and *Social Work in Health Settings* (Routledge).