‘Living in a Zoom world’: Survey mapping how COVID-19 is changing family therapy practice in the UK

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Following the COVID-19 pandemic, psychological therapies rapidly moved online in mid-2020. The Association for Family Therapy and Systemic Practice in the UK (AFT) surveyed the attitudes and practices of systemic therapists in the UK in early October 2020, exploring members’ views and gathered information about ongoing needs. A sample of 312 people were included in a mixed methods analysis. In total, 65% of respondents felt their overall experience of using online video technology professionally was positive, further reflected in responses to two open-ended questions. Detailed thematic analysis revealed that many positive comments were related to the practical advantages of online working, whilst many negative comments were related to technique and the therapeutic relationship. Possible respondent biases are discussed, and the implications of this change in practice are explored. It remains to be seen if this marks the beginning of a more permanent shift in our field as we explore the potential of new technologies.

Practitioner Points

- The vast majority of UK systemic therapists felt that their experience of online video technology was positive.
- They noted many practical advantages but also identified many challenges regarding therapeutic techniques and the therapeutic relationship.
- Therapists developed a range of creative solutions to maximise the therapeutic opportunities of online video.

Keywords: coronavirus; COVID-19; family interventions; family therapy practice; family therapy training; online therapy training; Systemic therapy; telemental health; teletherapy

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Introduction

A virulent novel coronavirus emerged in China in December 2019, spread rapidly and, on 11 March 2020 with 118,000 cases in 114 countries, the World Health Organization declared Coronavirus Disease 2019 (COVID-19) as a pandemic. Although the main focus was on public health measures and the medical treatment of those with severe forms of the illness, the need for psychological crisis interventions and remote delivery of mental health services was recognised early, with academic papers appearing in February (e.g. Duan and Zhu, 2020; Xiang et al., 2020) and April (Zhou et al., 2020).

The first COVID-19 cases in the UK were confirmed at the end of January 2020, and the government introduced obligatory COVID-19 lockdown measures on 26 March, directing people to stay home except for essential purchases and essential work travel (if remote work was not possible), closing schools and many businesses. This initial lockdown was followed by ongoing restrictions, regional lockdowns and a further national lockdown for the month of November.

In March, the National Health Service (NHS) provided guidance to prevent its spread and began to enable staff to work online. Most NHS services swiftly adopted new remote access and home working policies. Many clinicians were enabled to work online from April but, due to information governance concerns, the need to procure IT equipment and the trial of different video conferencing platforms, some clinicians experienced a few months of disruption before making a full transition to remote delivery. By the middle of the year, the use of videoconferencing or ‘teletherapy’ became the ‘new normal’ for psychological therapists. Papers began to appear proposing that the pandemic could be an opportunity to further develop digital approaches and improve mental health services overall (e.g. Torous et al., 2020 and Moreno et al., 2020, which appeared in March and July, respectively).

Prior to the pandemic, systemic therapists had explored the potential advantages of remote digital therapy as well as its challenges (e.g. Borcsa and Pomini, 2017; Wrape and McGinn, 2018), but a European survey of 252 systemic couple and family therapists, which included 6 respondents from the UK, revealed that, although 81% had used information and communication technology (ICT) for clinical communication (e.g. email), only 4% had worked with families online (Borcsa et al., 2020).

In March, soon after the forced transition to teletherapy, a survey of 145 psychotherapists from North America and Europe revealed that, overall, they had developed a ‘somewhat positive’ attitude towards
online therapy (Békés and Aafjes-van Doorn, 2020). CBT therapists expressed more positive attitudes than psychodynamic therapists. The views of systemic therapists were not specifically reported, although just under 15% of respondents said they used a systemic approach. It is not known if any of the 35 respondents from Europe included systemic therapists from the UK.

Another study conducted in March was an Austrian survey of 1,547 psychotherapists which included clinicians with psychodynamic, humanistic, systemic and behavioural orientations. This concluded that, across the four therapeutic orientations, Austrian psychotherapists ‘coped well with the rapid change from the provision of psychotherapy through personal contact to psychotherapy via the Internet’ (Probst et al., 2020). Although the majority of the therapists felt well informed about online therapy, several therapists stated that they wished to have further information and training on data protection and security (Humer et al., 2020).

It was in this context that Reenee Singh (CEO) and Nigel Jacobs (Chair) proposed that the Association for Family Therapy and Systemic Practice in the UK (AFT) conduct a systematic investigation of the attitudes and behaviours of systemic therapists in the UK. The survey had three main aims – to map how COVID-19 was changing family therapy practice in the UK, discover respondents’ priorities for support and training in relation to the new ways of working, and identity family therapists who would be interested in contributing to a future training initiative. The survey is unique in that it included open questions to ascertain UK systemic therapists’ views of the move to online and this is the main focus of this paper.

### Methods

#### Procedure

A total of 2,311 AFT members were invited to complete a survey mapping how COVID-19 is changing family therapy practice in the UK. Survey topics emerged from discussions between RMCK and AFT’s board and CEO. FB was consulted and helped to refine and structure the questions.

Although the survey was publicised via the AFT newsletter on 17 August, only 29 respondents completed it before a stand-alone email invitation was sent to all members on 30 September 2020. The survey was closed on 13 October 2020. Respondents followed an email link and were presented with the aims of the survey and a series of closed and open questions. Participants could withdraw at any time.
Materials

The online survey was conducted on the platform Wufoo and consisted of 11 questions. Some demographic information such as level of qualification, work setting and experience of using video technology was also collected.

Participants

Of the 2,311 AFT members invited to participate, 316 people (13.67%) responded. Three respondents completed the survey twice, and one respondent was a test subject. After removing these responses from the data set, 312 (13.50%) respondents remained.

Respondents’ characteristics are summarised in Figure 1. Almost half of the sample (47%) are qualified family and systemic psychotherapists, followed by qualified systemic supervisors (28%). The largest area of practice was private practice (30%), followed by CAMHS (24%). Participants could select multiple areas of practice.

Study design

The present study used a mixed-methods approach. Quantitative information was gathered from demographic and Likert-style questions, whilst qualitative information was gathered from respondents’ free-text comments. A full version of the survey is available from the first author.

Data analysis

All information gathered from the survey was anonymised, and participants were assigned random numbers to protect their identity.

Figure 1. Respondents’ demographics. Chart A displays the highest level of qualification. Chart B displays the different areas of practice.
Quantitative. Descriptive analyses were conducted with Microsoft Excel. Frequencies were calculated for categorical variables for questions 2–6 and 9–11 of the questionnaire.

Qualitative. Participants’ free-text responses were analysed using the qualitative data analysis software Dedoose Version 8.0.35 (Dedoose, SocioCultural Research Consultants LLC, 2018), following Braun and Clarke’s (2006) guidelines for inductive thematic analysis.

Inductive analysis

Initially, one researcher coded all free-text responses. A second researcher independently coded 10% of the data set (n = 32). The two researchers compared their coding for the 32 respondents. The researchers reconciled differences through discussion and collaboratively generated a list of codes. Following this, a third independent researcher sense-checked the codes.

Once all responses had been coded, four main categories were identified, relating to the impact on families and clients, impact on clinicians, the therapeutic relationship between the clinician and family, and practical impacts.

A fourth independent researcher was brought in to further sense-check the codes and categories. The second category was split into personal impact and the impact on the clinician’s techniques. The iterative process included merging subthemes, reallocating statements to fit the new subthemes and renaming subthemes to best capture their contents.

Upon reviewing the final categories, a new theme was added to the positive aspects responses: impact on clinicians – working with the wider system, in order to better capture two of the subthemes originally placed in the impact on clinicians – personal section. However, this category did not seem appropriate for the responses received for the challenges question. Therefore, the challenges responses were left with five themes, and the positives responses with six themes.

Results

Attitudes towards professional use of video technology – rating scales

The majority of respondents (87%, 270) reported that their professional use of online video technology had changed ‘to a great extent’ since the introduction of the COVID-19 pandemic regulations. Of these...
270 respondents, the majority (76%) felt that their overall experience of using online video technology professionally was positive, whilst a small proportion felt their overall experience was neutral (12%) or negative (13%).

The majority of respondents reported that their views about using online video technology professionally had changed ‘to a great extent’ (59%) since March 2020. Of these 183 respondents, the majority (87%) felt their overall experience was positive, whilst a minor proportion were neutral (8%) or negative (5%).

**Positive aspects and challenges – qualitative data**

There were 298 responses to both positive and challenging aspects of practice online. Where participants had offered positive/negative statements in the wrong question section \( n = 25 \), these were recoded in the correct valence category. A total of 619 units of analysis were coded from the responses to the positive question, and 588 units were coded from the responses to the challenges question.

**Themes identified in response to the ‘What was the most positive aspect of practicing using online video technology?’ question**

A total of 22 themes were identified within the 6 overarching themes (see Figure 2).

**A. Impact on families/clients**

*Able to continue working with families despite COVID-19*

In some NHS services, where face-to-face work continued, policy did not fit with family therapy practice. An individual focus meant that a child could attend a CAMH service with ‘one parent... and no siblings’ (ID315). Working online made it possible to continue work with families and to do so without the encumbrance of masks for families and therapists alike.

A sense of commitment to continuing to deliver a service was evident in many responses. Going online meant being able to continue therapeutic work commenced before lockdown, ‘keeping therapy on the road’ (ID42). However, the range of possibilities stretched from ‘keeping in touch’ (ID251) to therapeutic conversations that address ‘very complex and painful areas’ (ID55).
Figure 2. Positive and negative themes identified in response to the challenging and positive aspects of practicing using online video technology.
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Figure 2. Continued
Client satisfaction

Some respondents were surprised at how many clients expressed a preference for working online over meetings in the clinic or consulting room. Where respondents provided more detail, reasons varied from anxiety about leaving home (not specifying whether this was COVID-19 related), to finding online interaction more comfortable. A number of respondents noted that adolescents in particular may prefer online to face-to-face encounters.

Positive clinical outcomes

For some, prior assumptions about online therapy had not been confirmed by experience, so that respondents ‘now accepted that therapy can be of a high standard’ online (ID50). This ‘realisation’ (ID241) extended to clients exploring values and beliefs (ID3), ‘focus[ing] deeper on their thoughts and emotions’ (ID16), and ‘process[ing] trauma’ (ID285).

B. Impact on clinicians – personal

More effective use of time, greater productivity and reduced expenses

For some, going online ‘encouraged’ allocating ‘more time between each session to prepare’ (ID166). Others had used the time to increase their direct clinical work. Working from home and online meant fewer expenses, including for babysitters (ID16, ID267) and room hire.

Advantages of working from home

Lockdown at home afforded more time for oneself and family. Some linked this to an ‘improved work life balance’ (ID47) and a ‘slower pace of life’ (ID75), which left respondents feeling ‘grounded’ (ID214) and able to attend more to selfcare (ID133, ID75).

Therapist satisfaction

A number of respondents appreciated that online technology can ‘accommodate what seems to be enormous and challenging tasks’ (ID14). The application Zoom was particularly regarded. One respondent felt
positive about working online in the future, but ‘wouldn’t want to live wholly in a zoom world’ (ID121).

**Learning new technology skills**

A number of respondents commented on the challenges of learning new ways of working. Most mentioned this in the spirit of embracing the challenge: ‘it has been positive to develop new tech skills’ (ID200), although for one respondent, it was ‘a case of having to’ (ID312).

**Access to online training and supervision**

For some respondents, supervision had increased (ID15). Others noted training and CPD opportunities became more varied – one respondent had ‘attended’ training in Canada.

**Clinicians can keep earning income**

For a small number of respondents, working online during COVID-19 meant they were able to continue to work and earn an income.

**C. Impact on clinicians – working with the wider system**

*Maintained and improved access to formal meetings with colleagues*

A number of respondents highlighted the use of technology to facilitate meetings with colleagues – large and small teams – and when consulting to external teams. One respondent noted they could work more straightforwardly with a residential, shift-working team (ID159). When working across several locations, this change was attributed to a shift in cost-benefit calculation when travel is removed from the equation (ID117).

**Facilitating multi-agency networks**

A number of respondents observed that organising multi-agency meetings was more straightforward, with more of clients’ professional networks willing to attend. Two responses suggested the practical burden of arranging meetings had decreased: ‘people’s … willingness to join network meetings more quickly than before’ (ID86).
For some, meetings that would not have taken place happened quite straightforwardly. One Scottish respondent noted that meeting ‘remotely’ had reduced a sense of geographical isolation, creating a new sense of ‘professional connectedness’ (ID271).

D. Impact on clinicians – techniques

Adapting and developing therapeutic skills

For some participants, online therapy was a better option than telephone therapy.

Others sought ways to ‘adapt’ (ID306) their in-room practice to the online world, and on occasion, this was a collaborative development with clients (‘a family that decided to zoom in from different rooms’ ID9). Overall, 11 respondents mentioned being more creative, e.g. ‘New learning of how to present self of therapist to individuals and couples … use my hands and face and vocal tone to express interest and engagement, use bits and bobs on my desk to illustrate ideas about families’ (ID307) and ‘so many ways of being creative and interacting with people online with a webcam’ (ID28). ‘Reflective conversations can still occur … family therapists cannot notice all that is happening to family members such as becoming upset, however we can then ask the family members to notice and to check out with each other which is a huge positive’ (ID215). One respondent felt that working online had become ‘more directive’ (ID101), and another noted they were ‘focusing more on language as a means of communication and change’ (ID25).

Increased access to resources

For a small number of participants, working online had begun to open up access to online psychoeducational and other resources, with features such as screen sharing facilitating this.

E. Impact on clinician–family therapeutic relationship/process

Improved attendance and engagement

A number of respondents noted that non-attendance had decreased, in some cases to zero. Fathers’ increased attendance was particularly noted.
While engaging very young children could be challenging, a number of respondents noted that many teenagers seemed to prefer online sessions.

**Improved therapeutic relationship and open communication**

A number of respondents noted that working online could be more focused, direct and ‘intimate’ (ID113, ID171, ID294). Some young people were ‘freed up’ (ID299) to ‘state their concerns’ (ID216) online as compared with face-to-face working. For some respondents, this was contrary to expectation: ‘I thought the loss of “atmosphere” and emotion in the room would hinder but that has not really proven to be the case’ (ID138).

**Clients feel more at ease**

A number of participants noted that being at home seemed to put clients at ease, perhaps leading to less anxiety about therapy (ID49) and a feeling of safety for some (ID44).

**Greater insight into clients’ homes and lives**

For some the change in context provided a ‘window’ onto family life, absent from the consulting room. Some felt a greater understanding of how families ‘operate’ (ID297), for example, the importance of pets emerged more clearly (ID3).

**Positive shifts in power dynamics**

A number of respondents stated that power was ceded to families by the fact that they were in their homes and had more control; for example, being able to choose to not be on camera, being in the session but out of view.

**F. Practical impacts**

_Improved accessibility to therapy_  

This broad category captured how online therapy could lead to more equitable provision, overcoming barriers to attending sessions such as needing childcare, the costs of travel, difficulties arising from disability and so on. This category excludes issues of geography, which we locate elsewhere.
No need to travel

The stress of travel was noted, especially for parents with young children, as was length of journey, particularly for rural communities. Positive environmental impacts were noted.

Overcoming geographical distance

Some comments in relation to geography went beyond mere convenience. Where children have left home (e.g. to university), therapy becomes a possibility. Others described scenarios where family members live in different countries. Families could have access to particular specialist services.

More flexibility and convenience

This category captures a general sense that online working introduces a new flexibility to therapist and client alike. This includes where respondents work, times families can be seen, how respondents make use of this flexibility to structure their days, what sessions and meetings they attend, and so on. A general sense of feeling less constrained by work and organisational contexts emerged here.

Themes identified in response to the ‘What was the most challenging aspect of practicing using online video technology?’ question

Overall, 16 themes were identified within the 5 overarching themes (see Figure 2).

A. Impact on families/clients

Concerns about digital exclusion

Poverty-related exclusion – lack of equipment, poor internet connection – was a common concern. Beyond affordability, some respondents felt specific client difficulties, such as social and communication difficulties, social anxiety and eating disorders, might interact with available technology in particular ways, constraining therapeutic possibilities. A lesser-voiced concern was that specific groups might be excluded, such as older people and particular religious communities who, for different reasons, may not adopt particular technologies.
Concerns about assessment and management of risk and safety

Respondents expressed a general concern with assuring client safety, within which specific concerns were voiced, including managing the risk of violence between family members, and noticing what is ‘off camera’, including assessing self-harming. One respondent was concerned that young children are less able to consent to therapy online. Some wondered if GDPR had particular implications when working online.

Difficulties assuring confidentiality

When online therapy is the only option, it may be harder to speak in confidence without being overheard by family members, housemates and so on.

Client dissatisfaction

Some respondents’ clients had not found therapy online wholly positive. Comments generally lacked specificity, with some adolescents’ dislike of seeing themselves on the screen being the only repeated and concrete observation.

B. Impact on clinicians – personal

More stressful/fatiguing

Respondents identified using technology as stressful and fatiguing in two ways. First, the stress and fatigue related to sourcing and using new technology, getting used to it, organising oneself in relation to equipment. Secondly, ‘within’ the technology, many respondents reported that working online fatigued and stressed them more than working face-to-face.

Therapist isolation

A number of respondents reported that loss of ‘corridor conversations’ (ID256) with colleagues had impacted significantly on them. One respondent felt the same way about the training context, for both tutors and trainees.
Therapist dissatisfaction

A small number of respondents felt generally negative about practicing online, making direct comparisons with face-to-face therapy, for example, ‘I do not believe you can fully replicate face to face family therapy work online’, and ‘face to face therapy is [a] better therapeutic experience’. One respondent felt it was important to be trained in specific skills in order to practice ethically online (ID130).

Difficulties with organisation/time management

In contrast to the general view of respondents that online working had freed up considerable time, a small number felt ‘lots of things take longer’ (ID311).

Difficulties in training/supervision

Some respondents (mostly teachers, rather than learners) felt it was more difficult (or impossible) to demonstrate relational practice online and that action methods could not be taught remotely. The absence of best practice guidance was lamented. IAPT training networks faced problems getting different systems to ‘talk’ (the university/NHS technology interface). The co-occurrence of training while learning a whole new way of working was a particular burden.

D. Impact on clinicians – techniques

Harder to use therapeutic techniques/resources

The majority of respondents felt that working online limited use of specific techniques: ‘genogram work/spontaneous drawing out of process/circular patterns/using props’ (ID74). Another respondent felt that ‘… a genogram or a sculpt. It’s not impossible, but it’s also not the same or as rich’ (ID250). A number of unexpected difficulties were raised, such as respondents feeling that it was less possible to take intra-session breaks.

Difficulties creating boundaries/managing conflict and emotions

A number of respondents drew attention to initial appointments when clients are distressed (ID119) or anxious (ID151). These responses
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noted that clients’ ability to de-escalate might depend on context, and it might be more difficult for therapists to support this remotely when clients are in the familiar confines of home. The possibility was raised that exploring issues of ‘personal resonance’ (ID46) might be more complex when the client is at home.

E. Impact on clinician–family therapeutic relationship/process

Difficulties engaging and motivating some people

For one respondent, being inside clients’ homes digitally made it more difficult to know when to suggest ending therapy where clients have ‘low motivation’ (ID233). Similarly, telephoning a client who has not ‘attended’ (as some NHS Trusts mandate) can result in the session going ahead, and a consequent lack of clarity about whether the family really want the sessions. Non-attendance may no longer function as the communication it once did. During sessions, adolescents can pick up phones and so on, apparently distracted or not paying attention.

Difficulties with the therapeutic relationship

Some respondents felt that feedback from clients was reduced, and for others, ‘emotional communication and shared, reciprocal experiences are extremely limited’ (ID106). A general sense of unease with being in an online world comes across in these comments.

Difficulties picking up on body language, facial expressions and feelings

Some respondents felt their view of people’s bodies, the totality of non-verbal communication and their ability to discern non-verbal communication through the digital space, were compromised.

Flow of therapy disrupted

For some respondents, unwelcome disruption of conversations by ‘glitches’ lead to questions about ‘attunement’ (ID280). The challenge of achieving ‘a smooth, natural rhythm to the dialogue’ (ID281) was for some respondents ever-present in the online world, and not merely a
| Items                                                                 | Number of respondents who selected this item (n) | Percentage of respondents who selected this item (%) |
|----------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------|
| Getting ready to take your work online, or expanding your work online | 117                                              | 37.50%                                            |
| Choosing the right technology for therapists                        | 154                                              | 49.36%                                            |
| Working practices (setting up your workspace for using online video technology) | 115                                              | 36.86%                                            |
| Helping clients to use online video technology, in order to get the most from online therapy | 166                                              | 53.21%                                            |
| Practicing safely online (assessing and managing risk)              | 234                                              | 75.00%                                            |
| Practicing using online video technology (adapting family therapy ‘rituals’ and techniques, etc.) | 199                                              | 63.78%                                            |
| Equalities and anti-discriminatory practice (e.g. attending to Social Graces, adapting to sensory impairments, working with interpreters, etc.) | 186                                              | 59.62%                                            |
| Supervision using online video technology                           | 128                                              | 41.03%                                            |
| CPD and post-qualification training using online video technology    | 179                                              | 57.37%                                            |
| Formative clinical training using online video technology (e.g. developing qualification competencies, etc.) | 116                                              | 37.18%                                            |
consequence of inadequate technology. Signal delays meant that conversations could feel less ‘dialogic’ (ID37).

F. Practical impacts

Difficulties with technology

While some respondents bemoaned their (and clients) poor wifi connections, one or two drew attention to the hassles of ‘getting set up well. i.e. headphones! lighting! noise machines…’ (ID199). It may be that those working in more specialist services faced particular difficulties sourcing appropriate equipment.

Support and training needs

Participants were asked about a range of items they felt would be beneficial for AFT to develop to support their professional use of online video technology. Respondents could select multiple items. The response rates are reported in Table 1. Respondents showed interest in all options, particularly more support regarding ‘Practicing safely online (assessing and managing risk)’ (75% response rate) and ‘Practicing using online video technology (adapting family therapy ‘rituals’ and techniques, etc.’ (64% response rate).

Discussion

The COVID-19 pandemic has presented a very significant practical, theoretical and ethical challenge for the ‘psy’ professions. The AFT members survey (August–October 2020) was intended both to understand the evolving state of family therapy practice during the pandemic and to inform AFT’s priorities for a profession-wide response in support of members.

Respondents to this survey had a generally positive experience of remote delivery, making many positive comments. A total of 65% of respondents rated their overall experience of using online video technology professionally as ‘positive’. A positive impact is most clear in responses concerning the practical consequences of moving into a ‘Zoom world’ where there were 267 positive comments compared with 129 negative ones. This trend is overturned when respondents comment on how moving online impacted on technique and the therapeutic
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relationship, where the balance of comments is clearly weighted towards the negative: 128 positive and 250 negative comments were coded within the impact on clinicians – techniques and impact on therapeutic relationship/process categories.

Family therapists rely heavily on non-verbal feedback, for example in response to triadic questions and to gauge whether hunches and hypotheses are on the right track (Palazolli Selvini et al., 1980), and usual ways of doing this seem to work less well online: ‘... family therapists cannot notice all that is happening to family members...’ (ID215). A sense of ‘unsafe uncertainty’ (Mason, 1993) in relation to therapeutic intent emerges particularly strongly in relation to these concerns.

The greatest number of negative comments related to the difficulties of using action methods and techniques, such as sculpting or enactments (‘unable to work in the ways that we would like - e.g. doing enactments’ ID283). This could be in part due to a lack of training offered in the use of online technology, such as using the full range of features in videoconferencing platforms. Considering that 63% of respondents requested that AFT focus on the use of online video technology and adapting family therapy techniques, this could offer an explanation for the larger number of negative comments regarding the use of action methods and techniques. There are no comments bemoaning difficulties with using techniques from narrative therapy. Perhaps narrative therapy enthusiasts did not participate in this survey, or more ‘cognitive’ techniques, such as externalising, are less impacted by moving to online working.

Responses which drew attention to changes at the level of technique were often vague and suggested first order change (Watzlawick et al., 1974) – the balance of techniques had changed, doing more of this and less of that, using ‘the same frameworks but in a different way.’ (ID8). However, some therapists had created therapy systems that otherwise would not have been possible, with family members located on different continents (cf. Bacigalupe and Lambe, 2011), and one respondent described using multiple devices, so that family members could be in different rooms, as a way of creating a different context, allowing new conversational possibilities to emerge (ID9). These examples suggest beginnings of change at the level of the therapist’s relationship to technique and ritual and, in the former example, at the level of the therapist’s relationship to the idea of what counts as the relevant family system for the purpose of therapy.

While some respondents acknowledged that their assumptions about working online had been challenged and overturned, many still felt that working online meant that the therapeutic relationship
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either does not develop as well or is more at risk should the therapist misread (what is assumed to be) attenuated feedback available online.

This survey shows that systemic therapists were somewhat surprised that video conferencing works as well as it does. In addition, although there were no specific questions about its creative use, it also appears that most had not yet fully explored the facilities that video conferencing platforms provide. There were only six comments spontaneously volunteering information about the therapeutic use of virtual breakout rooms or whiteboards, for example: ‘Using mute buttons/emojis and white board has been valuable’ (ID21). This survey also identified that most systemic therapists wished for further training in the use of video conferencing. At the point of completion, this survey appears to register a moment in the evolution of the therapeutic use of this technology. The survey has confirmed that systemic clinicians can be creative and flexible, and we would predict that the discipline will go on to develop novel digital therapeutic approaches and techniques. This would be in keeping with a long tradition. Early family therapy practice was distinguished by a willingness to embrace new technologies (tape recorder, film camera, one-way screen), and some in the profession continue to innovate (e.g. Lee et al., 2010; McHugh et al., 2010; Tourunen et al., 2020). However, prior to COVID-19 this mantle had largely been handed on to others; the use of virtual realities (VR) to help with social anxiety and ‘avatar therapy’ for psychosis are perhaps the best-known recent examples of this (see Aali et al., 2020 for a review). The sudden arrival of COVID-19 meant that the majority of therapists either relied on their own resources, or those of employers (also caught out by the pandemic). There has been no time to develop specialist kit, or work through the implications of using existing technology in new ways, but we would predict that this is now more likely.

COVID-19 lockdown brought therapists into family homes in a way that many find unfamiliar. While Bateson and colleagues took film equipment into the suburbs to investigate family life (Geoghegan, 2017), contemporary therapists have on the whole preferred institutional settings. Attempts to rethink family therapy as a practice in the home have been few and far between (e.g. Jude, 2013; Summer, 2015). Therapists’ digital ‘presence’ in the family home is not the same as physical presence, but there are overlaps. Perhaps this limited resource of scholarly work needs to expand rapidly.
Limitations

As this study was conducted online, it might have caused some respondent bias towards a higher participation of systemic therapists with an affinity for new technologies or those who had a greater amount of prior experience of using video conferencing. It is somewhat reassuring to note that 87% of the respondents reported that their professional use of video technology had changed ‘to a great extent’, and only one person said their practice had changed ‘not at all’, and eight ‘not very much’. An examination of the open-ended responses for these nine individuals indicated that five of them might have been enthusiasts for this way of working prior to COVID-19 and this negligible number of respondents is unlikely to have biased the total results.

Finally, it has to be acknowledged that the study represents a snapshot. Further studies evaluating the use of video technology, especially once the lockdown measures are lifted, are indicated. More detailed surveys regarding the creative use of video conferencing technology will be helpful, and following up on our identified themes through the use of a focus group/individual interviews might lead to a richer and fuller exploration of this pivotal moment in the evolution of systemic practice.

Conclusions

This snapshot survey captures how systemic therapists in the UK have embraced the enforced change to online video practice. We anticipate that this marks the beginning of a more permanent shift in our field, in part because many clients are likely to demand ongoing access to this way of working, and as we develop the potential of new technologies.

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