BACKGROUND

Rising rates of relationship distress amid the novel Coronavirus pandemic (COVID-19) have been speculated about in the popular media, explaining that couples are experiencing elevated rates of tension, anxiety, and grief (Bader, 2020). The interpersonal challenges arising from this global crisis are...
unprecedented in this generation (Lebow, 2020). Couples and families working from home and social distancing are managing anxieties about a pandemic, balancing work with household chores and often home-schooling, and managing a healthcare system that is now less accessible and riskier. Additional work stress, particularly amongst essential workers, 87% of whom reported stress increasing since the beginning of the pandemic (Hammonds et al., 2020), likely increases relational distress in the home, according to the Spillover-Crossover model of work and home domains (Bakker & Demerouti, 2013). The impact of “cabin fever” has also led some couples and families to experience higher levels of stress than before the pandemic, although the effects of quarantine and social distancing have also afforded some the ability to slow down and focus on needed relationship maintenance (Perel, 2020). Either way, it seems to be an opportune time for some couples and families to engage in relational therapy, now conducted remotely via telecommunication technology and termed “teletherapy.”

In recent years, there has been increased scholarly focus on teletherapy, namely around training and education issues for therapists such as accessibility, convenience, and competence in delivery of teletherapy services (Benson et al., 2018; Bischoff, 2004; Blumer et al., 2015; Cravens Pickens et al., 2019). While teletherapy for marriage and family therapists (MFTs) had been considered a specialized service until recently, training and delivery in this modality is now requisite of MFTs who want or need to continue seeing their clients due to social distancing. Although many MFT graduate programs have supported the integration of teletherapy into training programs, most did not offer such training opportunities prior to the COVID-19 pandemic (Cravens Pickens et al., 2019). Additionally, the pandemic has forced clinical trainees and supervisors to transition to teletherapy in a relatively short amount of time, likely impacting the way clients are receiving services as well.

The pandemic and stay-at-home orders have also impacted the ways MFTs provide clinical services and the ways couples and families receive therapy services. The novel experience and influx of new teletherapy clients is also partly the result of more clients simply having the technology to connect to therapists remotely. Between 2000 and 2019, the percentage of American adults who use the internet jumped from 50% to 90% and the number of American adults who are home broadband users has increased from 1% to approximately 75%, with variance amongst groups based on age, race, income, gender, education, and community (Pew Research Center, 2019). On the whole, Americans are becoming more connected and the likelihood that services, including telehealth and teletherapy, will increase in the future is strong.

Given the current status of the COVID-19 pandemic and the mandate for couples and families to transition to telehealth delivery, it is essential to explore the lived experiences of clients who have received teletherapy with a partner or family member during this time. Understanding the experiences of these clients can improve the delivery of these services and our understanding of best practices for MFT teletherapy. Thus, the purpose of this study was to explore the lived experiences of individuals in teletherapy, specifically those engaging in teletherapy with a romantic partner or family member.

LITERATURE REVIEW

The ability to deliver healthcare services through telecommunication technologies helps overcome barriers to accessing mental health services, specifically to underserved populations (Goss et al., 2017) and those with difficulties attending traditional/in-person clinical sessions (Hilty et al., 2013). While both convenience and economic benefits are associated with teletherapy (O’Reilly et al., 2007), couples and families are turning to relational therapy more than ever since the COVID-19 pandemic began (Greenfield, 2020). In addition to increased technology accessibility, the pandemic is bringing many people closer together emotionally; added distress requires support, and many turn to their
partners or family members in the absence of others who would typically be a part of one's social circle and community (Perel, 2020), such as coworkers and peers.

Efficacy of teletherapy

A growing body of empirical evidence has shown support for teletherapy as an effective mode of delivery for therapeutic services for individuals (Godleski et al., 2012; Hilty et al., 2013; King et al., 2014; Rees & Maclaine, 2015; Spence et al., 2011); however, less is known regarding the experiences of clients and efficacy of relational teletherapy. Efficacy studies of teletherapy have consistently shown favorable outcomes in areas of client satisfaction and therapeutic alliance (Duncan et al., 2003). The efficacy of teletherapy for several presenting issues, including depression, anxiety, and substance use disorders has also been documented (Rees & Maclaine, 2015). However, most of these studies have been quantitative (Backhaus et al., 2012; Wrape & McGinn, 2018) and focused on individual, not relational, teletherapy.

Relational teletherapy

Family-based teletherapy was explored by Anderson et al. (2017) in their feasibility study of family-based treatment for adolescent clients \( n = 10 \) with anorexia nervosa (AN). They found that emergent treatment issues were not only managed identically to in-person family-based treatment of AN, but that parents had high rates of satisfaction with the treatment offered (Anderson et al., 2017). Findings from this study also suggest that family-based telehealth interventions are uniquely suited to meet the treatment demands of adolescents without adequate treatment options (Anderson et al., 2017). Furthermore, the experiences of couples receiving teletherapy were explored and reported that couples experienced a positive shift in expectations and specifically noted that teletherapy allowed them to become fully immersed in the therapeutic process (Kysely et al., 2020).

Yang et al. (2020), in their focus-group study of family-based early intervention (EI) telehealth services, found that families who use telehealth for EI preferred to think of it as a supplement, not a replacement, to traditional family-based EI services. Conceiving of teletherapy as a supplement to traditional therapy, and not necessarily as an alternative, may be useful as people transition back into traditional therapy after social distancing subsides.

In their study of clinical and ethical considerations for family teletherapy, Wrape and McGinn (2018) elaborate on various facets of the therapeutic process and client experiences that MFTs should consider. They found that issues around managing multiple clients in session and barriers to the joining process or creating rapport were areas that MFTs must consider and seek to understand further (Wrape & McGinn, 2018). They called on MFT researchers to specifically understand attrition and engagement with family services/psychotherapy via telehealth. As well, Wrape and McGinn (2018) suggest MFTs identify differences in rapport or alliances with couples and families and their therapists and explore the joining process.

Although research on client experiences of teletherapy during COVID-19 have yet to be published, Stanley and Markman (2020) provide suggestions for therapists to help couples nurture and protect their relationships during this time, which include, (1) being intentional (“decide, don't slide”) about working together as a united front during transitional times, particularly as co-parents, (2) increasing safety and protection within and around their relationship (“make it safe to connect”), and (3) recognizing patterns of blame, withdrawal, and negative escalating cycles in the relationship (“do your
While valuable anecdotal data, no empirical studies have examined experiences of clients who have transitioned to relational teletherapy during the pandemic, nor focused on the relational aspects of these experiences. This study sought to fill this gap by exploring the experiences of individuals in therapy with a partner or family member and to grasp the relational elements of these experiences amid the COVID-19 pandemic.

**METHOD**

To learn more about the lived experiences of individuals participating in relational teletherapy, we used a hermeneutic lens and a phenomenology framework (Heidegger, 1982; Saldaña, 2015). Hermeneutic phenomenology is a qualitative research method that holds the researcher as the primary instrument for data collection and data analysis (Saldaña, 2015) and focuses on understanding the lived experience of a particular phenomenon (van Manen, 1990). Phenomenological studies strive to explore the significant meanings inherent in an individual's lived experience(s) (Merriam, 2009).

The guiding research questions for this study were: (1) What has the process of transitioning from traditional/in-person therapy to online/telehealth therapy been like for couples and families? (2) Are there certain benefits to engaging in teletherapy as opposed to in-person therapy? (3) Are there particular challenges when engaging in telehealth therapy with partners or family members(s) and how are they managed? (4) What advice would clients give couples or families considering teletherapy? and (5) What advice or feedback would clients give to therapists to improve the process of teletherapy delivery?

**Procedure**

After receiving Institutional Review Board (IRB #20200417) approval from the first author's university, data for this study were collected using a variety of recruitment methods. Emails to MFTs currently seeing clients in relational teletherapy, professional listservs, such as the Family Therapy Section of the National Council on Family Relations and the American Association of Marriage and Family Therapy, social media postings on sites where couples and families may be likely to frequent, and Amazon Mechanical Turk (MTurk) were all used. Of the 214 individuals who clicked the link and consented to participate, only 25 were eligible to participate and completed the entire survey. Upon starting the survey, participants were presented with informed consent followed by a description of the study. If participants agreed to terms and met criteria, they were then provided with five open-ended questions and a series of demographic questions. Participants were informed that their participation in the study was entirely voluntary and that they could stop the survey at any time. They were also informed that there was no way of identifying their anonymous answers after the survey was submitted. Participants were provided with the opportunity to enter a drawing for one of four $25 Amazon gift cards.

**Participants**

The target population for this study were individuals participating in couple and/or family teletherapy during the COVID-19 pandemic. Criteria for inclusion were twofold; participants had to be at least 18 years old and receiving teletherapy with a romantic partner or family member. As an initial effort
to gather dyadic data, we also asked clients whether their partner or family member would be willing to take the survey and prompted them to generate a code to link dyadic data. Twenty-five participants engaged in teletherapy with a romantic partner or family member(s) participated. Participants varied in age ranging from 18 to 54. Sixty percent of participants identified as female \( (n = 15) \), 36% identified as male \( (n = 9) \), and one participant (4%) identified as transmale. The majority of clients identified as White (72%), while 16% identified as Latinx, 4% as Native American, 4% as Middle Eastern, and 4% South Asian. Eighty-eight percent identified as heterosexual and 75% as college educated. Fifty-six percent of participants reported being from a suburban area, 40% from an urban area, and 4% from a rural area. Participants represented various regions throughout the U.S. and one participant lived outside the U.S.

Within our sample, most participants reported receiving couple or family teletherapy for 1–3 months (68%) and all but two participants (92%) reported transitioning to teletherapy with a partner or family member(s) due to social distancing related to the COVID-19 pandemic. It is important to note that no qualitative differences were found between those participants who did transition to teletherapy and the two who were already engaging pre-pandemic. Over half \( (n = 14) \) of the participants were engaged in marital or couples therapy, with the remaining in family therapy (16% with an adult family member and 8% in parent–child therapy). Two participants (8%) were unsure of the primary basis of their current teletherapy and two participants (8%) selected “other” when asked about their therapeutic mode. Most clients reported engaging in teletherapy with a romantic partner or family member(s) while physically together in their residence in the same room (80%), while two participants reported engaging in teletherapy with their partner or family member(s) in the same residence, but in separate rooms. Three participants reported engaging in relationship-focused teletherapy in different homes or locations.

Of the 25 participants, 92% reported other people living in the home besides themselves. Thirty-six percent of participants reported living with just one other person, 20% reported living with two other people, 20% reported living with three other people, 12% reported living with four other people, and 4% reported living with more than four people. Within the subset group of participants who reported engaging in marital or couple relationship therapy, 24% identified having children under the age of 12 years and 12% reported having adolescents (12–17 years) or young adults (18–24) living with them. Finally, 40% reported using Zoom as a teletherapy platform, 24% reported using Doxy-me, 8% reported using thera-LINK, and the remaining participants reported Simple Practice, TheraNest, Google Teams Meeting, Better Help, and two were not sure. One participant reported using a telephonic platform (i.e., phone therapy).

**Data collection**

A Qualtrics survey containing five open-ended questions was used to explore participants’ experiences. Participants were asked to respond to questions in open texts boxes and encouraged to share as much or as little as they found appropriate. Participants were asked to share their contact information (email address) if they were amenable to follow-up interview questions via the telephone or teleconference for member checking and elaboration on the survey responses. Upon initial analysis of the survey results, 15 participants indicated they were open to follow-up interviews; however only two participants agreed to our requests for follow-up and were interviewed via Zoom after initial data analysis to provide more in-depth and nuanced comments to initial responses and study themes. Participants responded to follow-up questions in interviews ranging from 10 to 30 min. Interviews were recorded and field notes and analytic memos were taken from these interviews.
Analysis

All three authors engaged in analysis. The authors are all White, cisgender female, assistant-rank faculty from the United States who have all practiced MFT from a postmodern, social constructionism lens. Despite similar identities and training, the authors’ backgrounds and experiences are nuanced, and divergent perspectives were raised during the interpretive analysis processes. When questions were raised, and codes and themes were identified, the authors came to a consensus through dialogue and finding shared meaning systems; as well, the authors served as one another’s auditors in the analysis process and re-coded some of each other’s data. We chose to also analyze the data through a social constructivist lens, due to the inherently systemic nature of social constructions. Social constructionism explores the co-creation of understandings in the world within the systems that such understandings are created in and works from the assumption that there are shared realities, created in relation with others, rather than individually (Burkitt, 1996). Social constructionism shares with hermeneutic phenomenology interest in the dynamic role of human experience and shared understanding and awareness in the creation of knowledge (Andrews, 2012). While both hermeneutics and social constructionism support and encourage relativism, hermeneutics attempts to conserve concepts of truth that are meaningful to those who experienced the phenomenon of interest, even against compelling criticisms of objective thought or meaning.

Maintaining rigor

Hermeneutic phenomenological research does not specify that a certain sample size is needed; however, saturation of the data is a common metric for determining sample size in this method. According to Miles et al. (2014) the internal validity, purposefulness of the results, and insights gained from qualitative research have more to do with the depth and richness of the knowledge gathered than with the number of participants in the study. Thus, our study aimed to recruit enough participants to achieve data saturation, the point at which any further information will add no new insights to the data already collected (Gehart et al., 2001). Open coding continued past saturation to ensure that codes were reflected throughout our data. After the 20th interview, we achieved saturation and no new codes were generated thereafter.

We achieved transferability in our study by having two participants provide detailed descriptions and probing them to expand on their meaning in follow-up interviews. Additionally, transferability was achieved using purposeful sampling (Saldaña, 2015). We accounted for dependability (Lincoln & Guba, 1985) by having all three authors code the data individually before meeting for peer debriefings. After initially coding the data, additional peer debriefings were conducted to add more credibility to the coding process and to ensure a hermeneutic phenomenological framework was guiding the analysis (Daly, 2007; Lincoln & Guba, 1985). Self-reflective journals, memos, and bracketing were utilized to document and examine thoughts, biases, assumptions, and positionality of the researchers.

RESULTS

The findings of this study are organized by five overall themes that arose from participants’ experiences in teletherapy with a partner or family member. In general, many participants experienced a positive shift to relational teletherapy and “made do” or persisted with relational teletherapy given the unforeseen circumstances of the COVID-19 pandemic. Participants also reported a shift in the
safe therapeutic space experienced as a result of engaging in relational teletherapy and often reported experiencing convenience associated with engaging in teletherapy from their homes. Furthermore, participants highlighted the logistical challenges of relational teletherapy related to internet connection and lack of privacy. Lastly, participants shared that the effectiveness of teletherapy hinged largely on the therapist’s ability to accommodate to the nuances of teletherapy, or therapist accommodation.

“Making do”

The first theme reflected participants’ beliefs about their ability to persist in relational therapy amidst the COVID-19 pandemic and social distancing; that they would rather “make do” with what they have for therapy, rather than go without therapy altogether. One participant illustrated this sentiment: “I actually prefer in-person therapy, but because of the situations here right now, I don't have a choice.” Another echoed this viewpoint, “It does feel a little less personal, not being in-person, compared to being online. This is managed the best we can knowing this will not last forever.” Across all responses, the concept of “making do” reverberated throughout, reiterating that while switching to teletherapy is not what they initially agreed to, finding the benefit was worth the discomfort that comes with change: “It was a different experience. The more intimate contact of a therapy makes a difference, but considering the circumstances, it was a good service.” Another reiterated a similar feeling but also saw the benefits to using telehealth services, rather than having no therapy services during the pandemic:

The process of transitioning has been gradual. It was a little difficult in the beginning. I had my doubts whether it would be effective. However with time, I found that telehealth services would be effective. I have come to like the services considering the present pandemic situation. During these testing times, it is much more safer and convenient.

The benefits of “making do” with relational teletherapy were consistent throughout the responses, reflective in statements such as, “It's a great resource when the situation is needed,” and, “[it gives] the ability to continue receiving much needed help in a situation where in-person is not an option.” The overarching sentiment of “making do” was reflective in one participant's statement, “Telehealth is certainly better than nothing!” Further, some participants offered advice for “making do” to those who are considering relational teletherapy as an alternative to in-person sessions during the pandemic, advising, “I would tell them that it will take some getting used to but it is worth it to do it this way rather than to just stop having therapy during the pandemic.” Also, adding “I would recommend finding a therapist you connect with because it may be a bit more difficult to build a connection through telehealth therapy.”

Safe therapeutic space

The second theme reflected participants’ beliefs about the safe therapeutic space of teletherapy and connected to elements of comfort, authenticity, and the perceived naturalness involved with receiving relational teletherapy in their homes. This theme was illustrated by one participant who said, “My partner and I love being in our own environment because it feels safe;” and “…it quickly became a very natural feeling and an even more positive experience than in person.” There was a general sense from participants while both in-person therapy and teletherapy were beneficial for meeting the emotional needs of couples and families in distress, teletherapy was credited for providing clients
with their own emotional safe space to engage in therapy with a partner or family member(s), as one participant stated, “This home environment represents a more human lens in my opinion. Sessions feel more organic and less pressured.”

Additionally, participants often referred to the ease and relief of being able to virtually connect with their therapists in their own personal space as opposed to going into a physical office building for their appointments. For instance, participants stated, “I love the fact that I do not have to go into any particular building physically in order to be able to have a soulful discussion about my issues and challenges” and “When you go to an office it’s a bit intimidating, with telehealth we have stayed in a known environment which makes therapy a bit less overwhelming.” One participant advised therapists regarding the enhanced emotional safety in the therapy space:

My advice is to remember that when people are in their own space they tend to feel and speak differently than when they’re in somebody else’s. I feel some real honesty and growth can come from tele-therapy as long as it’s done with caution and intention. As the world around us moves to a digital age it becomes more comfortable and more natural to utilize tele-therapy.

Additionally, participants elaborated on the anxiety and apprehension associated with waiting rooms at therapy offices. One participant shared about teletherapy, “I don’t have to worry about what people are thinking of me in the waiting room.” While many participants shared their perspectives on the positive aspects of this theme, safe therapeutic space, some elaborated that their home environment contributed to a lack of emotional engagement and naturalness: “Easier to talk to people in person;” “It was hard to get out of the home mindset and stay engaged in the therapy session. I appreciate setting boundaries for my home life and my therapy space;” and “It does feel a little less personal not being in person compared to being online.” Similarly, one participant shared that teletherapy created barriers in terms of emotional expression:

I mostly just don’t feel like I am getting my point across as well and that I hold back in a way. For example I find myself not using language I would in person. I just feel different.
So far I haven’t found a way to feel more open in the online environment.

Furthermore, participants cautioned prospective clients: “make sure you have a quiet place where you can fully be engaged and be consistent.” In general, participants wanted to share both the advantages and increased sense of emotional safety in the therapy space associated with engaging in teletherapy with a partner or family member(s), as well as the disadvantages (i.e., lack of emotional engagement and expression related to relationship-focused teletherapy engagement) when compared to in-person therapy.

Finally, participants expressed some concerns about the physical space and lack of privacy in their environment to effectively engage in teletherapy. One participant shared: “There’s definitely challenges of having a quiet place in order for you to focus on just therapy…” and “A little challenging to find a private space outside the home to ensure privacy;” and “…we try to find a space that is quiet in our home.”

**Convenience**

The third theme centered on the ease and practical benefits of relational teletherapy; specifically, convenience. Participants often referred to the money-saving and time-saving benefits of teletherapy:
“…it is time saving and very convenient for both parties involved”; “It saves time and gas”; and “My usual appointment time is when traffic is really bad so it has been nice to not have to deal with that on the days of my appointment.”

Participants also emphasized the benefit of privacy related to teletherapy. One participant stated, “I enjoy that after an appointment I’m already in my safe space and can continue on with self-care versus getting in the car and having to drive somewhere.” This same participant reflected on the flexibility of relational teletherapy, sharing, “My partner smokes and has benefited from being able to take a break to smoke, calm down, and process for a couple minutes before continuing dialogue.”

Logistical challenges

The fourth theme that emerged reflected the logistical challenges participants faced during teletherapy. Participants often referred to the concerns related to the internet connection and bandwidth required for teletherapy. For instance, one participant said, “The process was more time consuming because I had to make sure my technology worked as well as my Wi-Fi.” Another participant echoed this statement: “Sometimes it can be hard to communicate with the therapist when there is lag time or connection issues…” Thus, participants cautioned therapists to have a steady internet connection when conducting teletherapy.

One participant discussed the increased responsibility associated with the practicality of teletherapy, sharing, “I am the mother and it falls on me to deal with reminding everyone when to log on. I didn't have to do that very often when we drove to our appointments.” Another participant cautioned therapists that sessions “should not be that long or tedious.” Thus, there was a general sense from participants that logistical challenges of teletherapy also meant being attentive to clients’ time and additional duties involved with engaging in relationship-focused teletherapy.

Participants also shared concerns about the inability to connect to more than one device with relational teletherapy; one participated gave the following advice: “It would be better if there were multiple (ways to connect); it's hard for both of you to be on the camera during couples counseling.” Another participant echoed: “Trying to keep both of us in view at all times while keeping the screen close enough to see the therapist.”

Therapist accommodation

The final theme that emerged throughout the analysis centered on therapists’ accommodation to teletherapy. Participants often referred to the effectiveness of teletherapy as hinging on the therapists’ ability to recognize and accommodate to the nuanced environment wherein teletherapy was conducted. For instance, one of the participants cautioned therapists to recognize the nuances of the online space and boundaries therein:

The other feedback I would offer is that I think therapist[sic] should continue to monitor their own presence in the space. I have found my therapist to be offering more personal stories than when we were in her office. And I’ve noticed her also say "I wish I could hug you right now" a couple times. I don't think those things are problematic per se, I just think it's important to consider how we show up in different spaces and how that could impact a client.
While many participants shared that their therapists were doing an effective job transitioning to teletherapy, they wanted therapists to know that they may engage differently online. For instance, one participant stated “(I) discovered that I don't feel as open speaking through the computer… I feel like I hold back a bit more than I do in person.” Another echoed this sentiment and shared that “when people are in their own space they tend to feel and speak differently than when they're in somebody else's.”

Some participants expressed frustration over the lack of accommodation to the nuanced environment and suggested therapists implement connection-building activities where connection may have been lost through physical distance. For instance, one participant suggested “a breather exercise or something similar that could help in the connection between the therapist and client.” Another participant suggested the therapist could “use techniques to break the cold barrier of distance.”

There was a general sense from participants that therapist accommodation also meant being attentive to the therapist's own space and utilizing tools to maintain the continuity of care. One participant shared that they would appreciate if the therapist would “provide materials we can print out on our side that you have also to feel more connected;” others maintained that it was important to “maintain eye contact with the camera, have a well-lit and steady camera set up.” In general, participants wanted to share the unique ways that they may experience teletherapy that differ from in-person therapy; they wanted therapists to recognize the nuances of the space and to be creative and develop strategies and activities that account for those nuances and make up for any gaps in the continuity of care, rapport, and safety.

DISCUSSION

The current study explored the experiences of clients receiving teletherapy with a partner or family member amid the COVID-19 pandemic. Five themes emerged from the data: “making do,” safe therapeutic space, convenience, logistical challenges, and therapist accommodation.

“Making do”

The idiomatic expression “making do” was widely used during World War II and generally means using what one has available to them to persist through unforeseen circumstances. The British Ministry of Information issued the pamphlet “Make Do and Mend” that was intended to provide individuals with useful tips on how to be frugal and creative with limited means during harsh times of war rationing (Magruder-Newman et al., 2018).

It is unclear at this time if the COVID-19 pandemic will yield a similar expression that serves as a summation of experiences for coping with limited means during a national crisis; however, it has been suggested that couples and families are persisting and rearranging priorities amid the pandemic to focus on their interpersonal relationships (Greenfield, 2020; Perel, 2020). These client/extra-therapeutic factors should be considered in context to successful therapy outcomes (Blow & Sprenkle, 2001). Couples and families have had to adjust, and as one participant put it regarding the adjustment to teletherapy, “It will take some getting used to, but it is worth it.”

Safe therapeutic space and convenience

Among some of the most documented advantages of relational teletherapy in the literature are reduced stigma, feasibility, and increased access for couples and families who may benefit from relational
treatments (Kruse et al., 2017; Wrape & McGinn, 2018). Indeed, these benefits parallel many of the experiences shared by our participants in the themes of safe therapeutic space and convenience. Specifically, convenience and comfort of engaging in relational teletherapy from one's home environment or “safety zone” (Kysely et al., 2020), reduced waiting room anxiety, and time-saving benefits were expressed throughout both themes for the current study. Although one of the main teletherapy training barriers discussed in the MFT literature involves time consumption and financial cost for graduate programs (Cravens Pickens et al., 2019), the juxtaposition is that these economic and time-saving benefits are what clients often cited as advantageous to their participation in relational teletherapy. From a client motivation standpoint in context to common factors (Blow & Sprenkle, 2001), client agency and accessibility are of utmost important when considering successful therapy outcomes.

The themes elaborate on previous studies that have supported telehealth as a feasible, effective, and safe alternative to in-person therapy (Wrape & McGinn, 2018). While participants emphasized the enhanced safety they experienced while engaging in relational teletherapy, some described the difficulty felt in talking with their therapist via telehealth. Undoubtedly, emotional and physical safety—both with the therapist and within close relationships—are the foundations of being able to be open and vulnerable in healthy relationships, as noted by Stanley and Markman (2020) in their recommendations for therapists who are helping couples protect and preserve their relationships during the COVID-19 pandemic. Thus, maintaining awareness around engagement of clients and creating both a physical and emotional space conducive to effective relational therapy are important suggestions for therapists (Wrape & McGinn, 2018).

Logistical challenges

Common logistical challenges to teletherapy (Kysely et al., 2020; Simpson & Reid, 2014; Wrape & McGinn, 2018) were highlighted and affirmed by our participants; namely, internet connectivity, privacy issues, and accommodating to physical space constraints while in virtual modalities, again, highlighting the importance of extra-therapeutic factors in the context of change (Blow & Sprenkle, 2001). While studies have shown that teletherapy addresses some barriers more notable for couples and families, such as scheduling and childcare responsibilities (Kysely et al., 2020; Wrape & McGinn, 2018), our participants did not seem to highlight this as a benefit, which may be explained by the fact that less than one-quarter (24%) of our participants reported having children under the age of 12 years in the home. It is important to note, however, that parents with children may be dealing with a myriad of challenges due to the impact of COVID-19 and the effects of quarantine and lockdowns, especially among marginalized communities (e.g., low socioeconomic families, essential workers, communities of color, etc.).

Additionally, MFTs are called upon to discuss technology issues, should they occur, from the outset of therapy, and make a strategic plan for which family member(s) will be tasked with the responsibility of ensuring that technology is charged (in some cases, multiple devices), prepared to handle signal loss, etc. (Blumer et al., 2015; Wrape & McGinn, 2018). For instance, one of our participants spoke to the increased responsibility she felt as a mother to remind family members of these very tasks, such as when to log on, confirming they were virtually connected to the therapist, etc. Thus, therapists might consider having open problem-solving discussions about this assignment, make a plan ahead of time and even rotate the responsibility of who will be tasked with such duties to eliminate the stress of one particular family member, taking into account client agency (Blow & Sprenkle, 2001; Wrape & McGinn, 2018).
Therapist accommodation

This theme firstly addresses suggestions for future research as laid out by Wrape and McGinn (2018), who urged MFTs to further understand how therapists manage multiple clients in session. The data revealed that in order to manage multiple clients, therapists must accommodate to the nuances of clients’ particular therapy modes, acknowledge the unique barriers of multiple clients, and to emphasize the potential benefits of teletherapy. Wrape and McGinn (2018) also called on MFT researchers to understand engagement with family teletherapy. This theme highlighted how engagement in teletherapy is centered on actively creating rapport where it may be lost by distance, and not simply assuming that rapport is being maintained through different modes of delivery (O’Reilly et al., 2007).

If clients and therapists can find ways to accommodate to the nuances of teletherapy, they may be able to achieve similar levels of satisfaction as compared with in-person therapy, consistent with Anderson et al.’s (2017) findings that emergent treatment issues for AN can be managed through teletherapy identically to in-person family-based treatment and Kysely et al.’s (2020) findings that shifts in expectations allow for a more immersive therapeutic process. When the nuances of teletherapy are accommodated for, it may also act as a long-term supplement to traditional in-person therapy, and not a replacement, as previously found in Yang et al.’s (2020) sample of families using teletherapy for EI.

CLINICAL IMPLICATIONS

Based on the findings of this study, there are several clinical implications for relational teletherapy that are important to address. Practically speaking, participants reported a desire to have more structure and consistency in their therapy sessions and stressed the importance of the therapist helping the client feel more comfortable and at ease with teletherapy platforms.

In consideration of the study’s themes, safe therapeutic space, convenience, and therapist accommodation, common factors such as client and extra therapeutic factors should be emphasized (Blow & Sprenkle, 2001; Sprenkle et al., 1999). Specifically, instilling hope in clients who are “making do” align with the unique aspects of MFT theories that bring about change (Davis et al., 2012). From an intervention standpoint, utilizing techniques with a postmodern grounding, such as Solution Focused Brief Therapy (SFBT), Narrative Therapy (NT), and Collaborative Language Systems (CLS) can be useful in considering successful therapeutic outcomes such as relationship factors, client-extra-therapeutic factors, and hope and expectancy (Bliss, 2005; Reiter, 2010). These models are grounded in theoretical assumptions that the future is both constructed and negotiable, which is particularly valuable in times of uncertainty (Malinen, 2004). Interventions geared toward identifying strengths, exceptions, and previous success with coping can assist clients in feeling more confident in using teletherapy and feel a sense of structure in their relational telehealth sessions.

Postmodern therapists generally assume that there are exceptions to problems and yet-to-be-discovered affirming narratives and solutions in clients’ lives and relationships that can be utilized. In helping clients to adjust to teletherapy, therapists can search for exceptions or affirmative narratives in couples’ and families’ pasts when they learned new technologies or adjusted to new circumstances that were difficult to accept. Additionally, therapists can explore coping mechanisms couples and families have previously used to adjust to life changes. Therapists can also assess clients’ expectations of teletherapy by adapting the miracle question (De Shazer & Molnar, 1984) and asking them to envision ideal teletherapy sessions, or to consider indicators that would signal ideal teletherapy with their partner or family member. Such questions might include: “What will you notice is different about our interactions that helps you feel more connected?,” “What would have to happen for teletherapy to be
success?;” “What would have to happen for you to feel that I am accommodating to the nuances of our environment?” and “What strengths of yours might show up in this mode of communication that wouldn’t otherwise show up in person?”.

Therapists can continually monitor client engagement and reception to teletherapy by using scaling questions (Berg & de Shazer, 1993) to create concrete measures and highlight change or Session Rating Scales (Duncan et al., 2003) that include an easement of the virtual environment. These metrics can also be used to assist clients in assessing their own level of comfort with teletherapy, virtual rapport, boundaries in the remote environment, how well the therapist is accommodating to nuances, the physical arrangement of the space from where they are video-conferencing, and how their interpersonal relationships will improve when relational teletherapy is successful.

LIMITATIONS AND FUTURE RESEARCH

While attempts were made to recruit a diverse sample and create inclusive recruitment material, there are several limitations that should be considered. First, the data were collected from a mostly White (72%), female (60%), heterosexual sample (88%). Thus, it is possible that data from a more diverse sample would illustrate divergent or variant themes. Future researchers seeking to replicate this study should aim to collect a more diverse sample with considerations to greater diversity of gender, race, and sexual orientation. Future research should also consider how socioeconomic status, and thus access to technology and strong internet connection, impacts experiences of relational teletherapy.

Study participants were also self-selecting, and it is possible that they had strong views (either positive or negative) about the unique barriers, challenges, or advantages of relational teletherapy. It is also possible that the language used in our recruitment scripts limited participation. For instance, potential participants may have been less familiar with the term “telehealth” in the context to psychotherapy. As well, participants were not overtly asked to elaborate on what steps or strategies their therapist(s) took to better ease in the transition from in-person therapy to teletherapy. Future research should consider these important gaps and questions.

Lastly, it is important to further consider the dyadic and systemic data and explore the experiences between couples and families engaged in relationship-focused teletherapy. While participants were asked whether their partner or family member would be willing to take the survey, only one couple provided data from both partners; thus, data from these participants were not analyzed dyadically. Future research using dyadic data would clarify how multiple perspectives of the relational process affect couple and family members’ satisfaction with teletherapy, in addition to factors such as client retention, effectiveness outcomes, and other dependent variables.

CONCLUSION

The results of this study provide important insights into client experiences with relational teletherapy. Participants who engaged in relational teletherapy reported that a sense of “making do” with teletherapy was an important component to successful treatment, that safe therapeutic spaces were integral, that teletherapy offered surprising elements of convenience, and yet there were logistical challenges to which therapists must attend. Lastly, participants emphasized that therapists’ ability to accommodate to nuances in this new virtual environment was of supreme importance. Overall, experiences in this study were reflected in a quote given by one participant: “It’s splendid once you grow into it.” Relational teletherapy, while challenging at times, can provide surprising benefits. It is incumbent
upon MFTs to explore the unique benefits and challenges of teletherapy and to engage clients in a dialogue about the unique environment in which they now find themselves. We do not yet have an understanding of how the COVID-19 pandemic will impact our lives long-term; however, given the exigency of providing mental health services to couples and families, the MFT community must establish best practices and clear guidelines to ensure clients’ needs are being met.

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