A Tale of Two Clinicians:
The Impact of COVID-19 on the Provision of Therapy

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Abstract

The influence of COVID-19 is far-reaching and will likely have long-lasting effects on social work practice in general and specifically on the provision of therapy. In this article, the authors, one a registered social worker and doctoral student and the other a registered psychologist and assistant professor, will discuss the substantial impact of COVID-19 on their private practices, utilizing a narrative framework. The primary focus is the crumbling of boundaries, including the lack of delineation between home and work life, privacy and confidentiality issues for both clients and therapists, and challenges with online therapy delivery. In addition, the authors discuss the alterations to caseload and case management, the forced and sudden transformation of the very nature of therapy, the unique challenges faced by clients from varying demographic backgrounds, and the experience of collective grief, shared trauma, and parallel processing. The article also highlights the unique challenges that two women therapists have faced during this global pandemic while carrying the bulk of household and child-care responsibilities.

Keywords: COVID-19, therapy, mental health, social work, boundaries

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The sudden global emergence of COVID-19 brought unimaginable, ever-changing, and unrelenting challenges. It affected how the world functioned, how businesses and governments were run, and how people interacted with each other, among numerous other difficulties. No one was prepared for the short- or long-term consequences of this global pandemic. In this article, we focus on the impact of COVID-19 on the provision of therapy and how our experience of COVID-19 has led to many questions regarding how to support our clients when we have also been so profoundly challenged. In other words, how do we, as clinicians, make meaning of our narratives while simultaneously assisting clients in making meaning of theirs? We endeavour to explore and expand our experiences as psychologist and social worker providing therapy during COVID-19. We frame our trials and tribulations through a narrative lens and hope to provide insight into our own lived experiences and considerations for the future of therapy in a forever-changed world.

At the time of completing final edits on this manuscript (September, 2021), there have been 227,980,194 reported cases of COVID-19 worldwide, resulting in 4.7 million reported deaths (World Health Organization, 2021). In Canada, there have been 1,569,186 reported cases and 27,370 deaths (World Health Organization, 2021). Given this global pandemic's novelty, there is scant literature investigating the impact on individuals' mental health and psychological functioning or on the provision of therapy. However, anecdotally, as experienced in our personal and professional lives and evidenced in social media and the mainstream

media, the psychological consequences of COVID-19 have been profound, widespread, and indiscriminate.

Literature Review

A search for scholarly articles about COVID-19 and therapy resulted in several editorials and conceptual papers but only two research studies. The limited number of editorial and conceptual articles appeared to be either client- or clinician-focused. The client-focused papers emphasized the enormity of psychological impacts during COVID-19 and the profound effect it was having on clients' thoughts, emotions, and behaviours, such as fear, isolation, and uncertainty (e.g., Pillay & Barnes, 2020). In the clinician-focused papers, there was an emphasis on job stress, fear of contracting COVID-19, general anxiety (Probst et al., 2020), ethical dilemmas, handling emotions, fatigue, and the need for self- care (Banks et al., 2020).

The two research studies to date examined the challenges and experiences of ethically practising psychotherapy during COVID-19. McBeath et al. (2020) surveyed 335 psychotherapists in England about their challenges and experiences using information communication technology (ICT). Most therapists felt challenged by working remotely, struggled with the reduced interpersonal communication associated with online therapy, and experienced feelings of isolation and fatigue. In the second study, Banks et al. (2020) analyzed qualitative, international data collected from 607 social workers about the ethical challenges of COVID-19. The authors identified multiple challenges:

> Keeping and maintaining trust, privacy, dignity, and service user autonomy in remote relationships; allocating limited resources; balancing rights and needs of different parties; deciding whether to break or bend policies in the interests of service users[;] and handling emotions and ensuring the care of self and colleagues. (p. 570)

In response to COVID-19, the International Federation of Social Workers (2020) developed a guide entitled *Practising During Pandemic Conditions: Ethical Guidance for Social Workers*, which highlighted the following ethical challenges:

- People without access to the technology or the skills to use it, or when contact has been lost, may not be able to access services.
- Threats to privacy from home-based ICT systems, which may not be reliable or secure.
- Difficulties in ensuring privacy and confidentiality—both in service users' living conditions and providers' households.
- Difficulty seeing or sensing non-verbal gestures.
- Difficulties creating empathy and building trust, especially with first-time assessments.
- Difficulty maintaining boundaries between personal and professional life for both service users and providers.

Narrative Inquiry and Narrative Therapy as a Theoretical Framework

Narrative therapy, stemming from postmodern therapy, started to gain traction in the late 1980s (Polkinghorne, 2011). *Narrative therapy* is a style of therapy in which the interpretation of an individual's experience is explored through language (Phipps & Vorster, 2011).

Individuals can have different experiences of the same event, and narrative can help them to make sense of their experiences and interactions with others and how these impact their experience of reality. *Narrative inquiry* was pioneered by Connelly and Clandinin (Lindsay & Schwind, 2016). They built upon Dewey's (1938) notion that experiences in one's life are continuous and interactive. The overlap between narrative inquiry and narrative therapy is vast. Ontologically, narrative inquiry and narrative therapy question the nature of reality. In both, there is an emphasis on the possibility of a multitude of perspectives, none of which is either wholly right or wrong. There is also an acknowledgement that research and personal narratives are value-laden; that is to say, an individual's personal views, thoughts, and feelings are inherently present.

In the mid-1970s, therapists (de Shazer, 1991; White & Epston, 1990) began to adopt narrative inquiry to characterize the narrative approach to therapy. Narrative therapy's primary focus is on people's interpretations of, or meanings assigned to, the events or happenings occurring in their lives. Narrative therapists (a) focus on client strengths, (b) view the client as a partner, (c) focus on meaning rather than behaviours, and (d) utilize self-narratives or stories (Brown, 2007; Carr, 1998; Polkinghorne, 2011). In narrative therapy, the emphasis is on clients' assigned meanings or interpretations of life events or actions rather than merely on the events themselves. It is through this lens that we not only approached therapy with our clients during the pandemic but also how we have conceptualized and framed this article.

Our Self-Narratives About the Provision of Therapy During COVID-19

Jennifer

As a social worker who has worked in agencies and private practice for almost a quarter-century, to say that I have become comfortable in how I conduct counselling sessions would be an understatement. To give you a glimpse of the space I have created, I must first elucidate that I am a white woman who comes from a place of privilege. I have had the luxury of going back to school and am in my first year of doctoral studies. I am a wife, a mother of three, and a business owner. My private practice is my own. For the past two decades, I have upgraded my skills through course work, conferences, and seminars. However, the one area I had chosen not to become familiar with was online counselling using ICT. Upon reflection, the reasons were twofold. Part of what I believe has made me a good counsellor is my ability to engage clients and read the unspoken communication to help facilitate the movement of the narrative they have been telling themselves. The other was my lack of confidence in understanding technology.

Lindsey

As a registered clinical, counselling, and school psychologist, I have worked in part-time private practice providing individual treatment, consultation, and assessment to children, adolescents, and adults for nearly a decade. Until recently, I did not own my private practice but instead worked under the umbrella of larger group practices. Throughout my time in private practice, I have experienced career disruptions due to my two children's births. However, those experiences were incomparable to the disruptions that would later come due to COVID-19. Through my supervised and then autonomous practice, I have worked on growing as a therapist and have continually assessed and reassessed my treatment approach and outcomes.

I am a white woman of privilege, having had the opportunity to complete my education sequentially, without pause, and to begin working while still completing my doctoral dissertation. I have a large, blended family with four children ranging in ages from 4 to 17. I have also recently begun a tenure-track position in the Faculty of Education at the University of Windsor. Through the years, I have further developed my knowledge and understanding of the therapeutic process and areas of practice and have had the unique opportunity to provide supervision to practicum students; however, until COVID-19, I also had never practised ICT. Reflecting on this, I think that it was mostly a matter of time. Always working full-time elsewhere, managing a family, and practising part-time, among many other things, left very little room for taking on online counselling, which at the time seemed unnecessary to the provision of therapy.

The Challenges of COVID-19

As regulated professionals, we are called on by our codes of ethics to provide service to those in need. During the current pandemic, the need for reflection on ethical principles and the weight each is given has been constant. We have consistently challenged our ethical decision-making by asking how we balance service responsibilities with our safety and well-being. An additional hurdle has been the sudden need to learn best practices in providing therapy in non-traditional formats. The role of ICT, including phone, email, video-conferencing, and online assessments, has increased in popularity over the last few years (Barr Taylor et al., 2020; McBeath et al., 2020). However, the use of such technologies in the provision of therapy before COVID-19 was limited, and neither of us had received training or had had experience in these methods.

In addition to ethical and technical considerations, after reflection on our experiences and in line with the limited literature, three main themes emerged: (a) alteration of caseloads; (b) crumbling of boundaries; and (c) collective grief leading to mirrored processing by clients and clinicians. In the next section, we expand on these themes and provide insight into our experiences of delivering therapy during COVID-19.

Alteration of Caseloads

The drastic change in caseload at the beginning of Ontario's lockdown in March of 2020 was staggering. Before March 16, 2020, Jennifer typically engaged in 25 hours and Lindsey in 8 hours of counselling sessions during an average week, but once the lockdown order was given, those caseloads became zero. We cancelled all of our sessions and informed clients that we would contact them via email or phone in the coming weeks. The next several weeks were spent investigating different online platforms and attempting to learn how to use them correctly and effectively. Initially, we put off ICT counselling; however, in April 2020, we realized that offices would not be reopening soon. The Ontario Collegeof Social Work and Social Service and the College of Psychologists of Ontario sent out multiple e-blasts suggesting that counselling be provided online unless deemed an emergency. These suggestions are still in place almost a year later. And so, we undertook the enormous task of learning how to provide counselling through ICT. In reviewing our caseloads, we found that many clients were under the age of 10 and had some form of learning disability or challenge. Many clients, including the adolescents and adults, but especially the children under 10 years of age and those with a learning disability, required more than talk therapy. For example, we were accustomed to using

games, art, or a whiteboard to draw pictures for explanations. How was this going to be possible in an online format?

In the transition to ICT, our caseloads dropped by over 70%, as a considerable number of clients were young children or adolescents and adults who preferred to receive services in person only. We struggled to adapt our counselling approaches to the online platform; for example, drawing concepts on paper (rather than a whiteboard) and holding them up to the camera, being overly expressive with our faces and hand gesturing, trying desperately to pick up what was not being said through a camera. Before COVID-19, we both had had several pro bono therapy clients who became unable to participate in ICT because of a lack of access to technology and stable internet connections. For example, Jennifer had two adult women clients who were mothers and had experienced an extensive amount of trauma. Each woman was on government-subsidized income, and neither owned a computer. They did not want to engage in telephone sessions, as there was no privacy with their children always at home during the lockdown. Both women were in the middle of their therapeutic work, but now Jennifer could no longer be of service to them. She asked their support workers about getting computers for these clients, but the cost was too great, and it was deemed not to be a necessity.

The first stipulation in the Code of Ethics and Standards of Practice for the Ontario College of Social Workers and Social Service Workers (2008) states that "a social worker or social service worker shall maintain the best interest of the client as the primary professional obligation" (para. 1). Jennifer and her clients were unable to convince the support workers of the necessity of counselling, especially during the pandemic: their voices fell on deaf ears. Unfortunately for social workers in today's postmodern society (i.e., characterized by fluidity, complexity, uncertainty, and reflexivity in society; McGregor 2019), the environment that had been built on trust among professionals, service providers, and service users has become disembedded. Through social exclusion, the significant gap between the rich and the poor has continually widened (Powell, 2001). For these clients, it was impossible to uphold the first ethical code because of the constraints of the pandemic and the lack of support from the social agency.

Before the pandemic, we saw many clients in one day; however, we now see only a few, and we are exhausted by the end of it. This is a new phenomenon for us. Before providing therapy virtually, we would finish the workday, transition into home mode during our drives home, prepare dinner, help with homework, and engage in our children's bedtime routines. However, now, after only a few hours of virtual sessions conducted in our home offices, we feel as if we have nothing left—our water pitchers are empty—and we struggle to be present with our own families, who need us more than ever. While we have been called on to be everything to everyone, the months of the pandemic have creptby, and our superwomen capes have become worn and ragged. Because of these challenges, we are both at a point of not feeling capable of taking on new clients despite the non-stop referrals and the ever-growing need for therapy.

The Crumbling of Boundaries

Before March 16, 2020, our morning routines included waking up, getting ready for work, and helping our children get ready for school. We would drop our children off at school and transition into work mode while driving. We would walk into our respective offices and, more days than not, feel refreshed and ready to see clients. Now, our children's schooling—online or in person—dictates our morning routines. Our clinical spaces are now a spare room in

our respective houses. Every aspect of our lives—clinical, family, social, and academic—are all in one place. We must now wear all our hats at the same time. Though physically it provides ease, emotionally and mentally it is incredibly taxing. Our clients are now in our homes, and we are in theirs.

Although all of these virtual sessions have brought about issues of privacy, confidentiality, and even client safety that must be considered and addressed, there have been several incredibly uncomfortable experiences that illuminate the crumbling of boundaries between client and clinician. In one session, a young adult via video was five minutes late for her booked appointment. When she joined, she was lying in her bed after just getting out of the shower, her body wrapped in her robe. Her robe opened during the session. Once her attention was drawn to the issue, the next 20 minutes were spent working through her feeling embarrassed. Another client has body-identity issues and did not want to see herself on camera. She figured out a way to keep her camera on but remove the image of herself on the screen. From the therapist view, Jennifer saw her and a small image of herself. From the client's view, all she could see was Jennifer. During one of our sessions, her partner walked out of their ensuite bathroom fully naked, facing the laptop camera. Neither the client nor her partner was aware of what could be seen. During a phone session with still another client, there was an echo, like a hollow or tunnel sound. When the client was asked where she was, she informed Jennifer that she had "taken [Jennifer] into her bubble bath."

These generalized and specific experiences have left us with many unanswered questions: How do we best respond to these situations? Where is the line between ethical boundaries and a client's comfort level—or the clinician's comfort level, for that matter? Does the nature of COVID-19 and ICT demand that our boundaries become more fluid? If so, is this something that we as clinicians agree with and are prepared to do?

Collective Grief, Shared Trauma, and Parallel Processes

One challenge that we have identified that has not yet appeared in the literature or in the International Federation of Social Workers ethical guidelines (2021) is how we help clients process their narrative about the pandemic when we have not processed our own. A commonality in both of our training is the ability to identify whom we cannot work with. Clients with issues and situations that are too close to our own issues would make it too difficult for us to hold a therapeutic stance of curiosity within firm boundaries. It is not unusual for clinicians to work with clients with whom they identify or who have had similar experiences; however, it is not best practice for a clinician and a client to simultaneously face the same trauma. As we discuss in detail below, COVID-19 has changed that.

During COVID-19, we have only worked with ongoing cases; therefore, rapport was already well established. COVID-19 and ICT have required us to adapt our approaches, to unlearn, learn, and relearn ways of best supporting our clients in an unfamiliar context. Feelings of inadequacy, fear of the unknown, and isolation have accompanied us throughout this pandemic. It is very troubling when logic and emotions do not line up. Our clinical training makes room for reason (e.g., What can I control? This will pass. I can continue to be the best I can be now.); however, our present feelings are not following that logic. They are inundated with anxiety, fear, sadness, and sometimes despair. These feelings present themselves at night or on a walk, on the rare occasions during the day when we are alone. We utilize our clinical

tools (e.g., reframing, deep breathing, Socratic questioning, and grounding), and we are better for a moment until the next wave of emotion washes over us.

As human beings, we have had people we know personally and care about contract COVID-19, some having to be hospitalized. Simultaneously, we have had clients whose friends and family have contracted COVID-19 and have had to be hospitalized. We have shared similar emotional experiences. Generally, when this happens, it is suggested that we as clinicians seek out consultation, supervision, and our own therapy. However, as clinicians, we know that our circle of colleagues is just as overwhelmed and burnt out as we are. We are constantly confronted with our own and others' vulnerability, and there seems to be a continued pivot to crisis work. As clinicians, this requires us to suspend treatment goals and adjust to the client's present needs.

One of our roles as a clinician is to normalize a client's feelings around the world's uncertain state. There have been times in our careers as clinicians when we have had difficulty managing our emotions (e.g., sadness, frustration, and anger) and have felt dysregulated (i.e., feeling unfocused and uncentred) when reflecting on a session. However, for the first time in the entirety of our careers, we have noticed feeling dysregulated during sessions, and we have had to attend to re-regulating ourselves while in session (e.g., deep breathing and making sure both feet are on the ground). For example, Jennifer had a client whose child had contracted COVID-19 and was asymptomatic. COVID-19 had affected the whole family, and the client's husband had had to be hospitalized and intubated. As her client was crying through the session and sharing her catastrophizing thoughts, Jennifer found that she was not the empathetic listener who would help her client develop and assign alternate meanings or assist her in lengthening her story, but rather a clinician who had to focus on combatting her defensive instinct to run away. The client tapped into Jennifer's fear, the fear that typically remains at bay in the deep recesses of ourselves and never presents in session. Once Jennifer regulated herself, she shared with her client that she was fearful with her, not for her. They processed what it was like for the client to see Jennifer rattled. They talked about how to regulate and what helped Jennifer transition back to the session. The client has since implemented those same tools and has said that that session was one of the most beneficial she had ever had.

Conclusion

The shared experience of COVID-19 has served to both isolate us and bring us together, as argued by Chen et al. (2020). The rapid global changes have affected every facet of society: individual, family, and community. We attempt to navigate the muddiness of service with the injustice of not finding ways to provide necessary tools for those who are unable to afford computers, and the frustration for us as clinicians increases. We are bound to speak up about inequities and injustices; however, that does not mean they are heard. We keep going and doing the best we can, and we too are affected.

As psychologist and social worker in various stages of our lives and careers, we have had our eyes opened by the overlap of our experiences. The injustices for some of our clients are profound. We have found almost identical struggles in working through balancing our personal, family, and client needs. We are cloaked in the expectation of relieving the pain and struggle of our children, our extended family members, and our clients. We are continually trying to live outside of the binary thinking of either helping others or ourselves. However, we

know that it all must fall somewhere in the middle and in truly believing that we can only ever do the best that we can at any given moment.

References

Banks, S., Cai, T., de Jonge, E., Shum, M., Sobočan, A. M., Strom, K., Truell, R., Úriz, M. J., & Weinberg, M. (2020). Practising ethically during COVID-19: Social work challenges and responses. *International Social Work*, *63*(5), 569–583. https://doi.org/10.1177/002087820949614

Barr Taylor, C., Fitzsimmons-Craft, E. F., & Graham, A. K. (2020). Digital technology can revolutionize mental health services delivery: The COVID-19 crisis as a catalyst for change. *International Journal of Eating Disorders*, *53*(7), 1155–1157. https://doi.org/10.1002/eat.23300

Brown, C. (2007). Situating knowledge and power in the therapeutic alliance. In C. Brown & T. Augusta-Scott (Eds.), *Narrative therapy: Making meaning, making lives* (pp. 3–22). Sage Publications. https://doi.org/10.4135/9781452225869.n1

Carr, A. (1998). Michael White's narrative therapy. *Contemporary Family Therapy, 20*(4), 485–503. https://doi-org.ledproxy2.uwindsor.ca/10.1023/A:1021680116584

Chen, C. K., Nehrig, N., Wash, L., Schneider, J. A., Ashkenazi, S., Cairo, E., Guyton, A. F., & Palfrey, A. (2020). When distance brings us closer: Leveraging tele-psychotherapy to build deeper connection. *Counselling Psychology Quarterly*, *9*(1) 1–14. https://doi.org/10.1080/09515070.2020.1779031

Dewey, J. (1938). *Experience and education.* Simon & Schuster.

de Shazer, S. (1991). *Putting difference to work*. W. W. Norton.

International Federation of Social Workers. (2020, November 10). *Practising during pandemic conditions: Ethical guidance for social workers*. https://www.ifsw.org/practising-during-pandemic-conditions-ethical-guidance-for-social-workers/

Lindsay, G. M., & Schwind, J. K. (2016). Narrative inquiry: Experience matters. *Canadian Journal of Nursing Research*, *48*(1), 14–20. https://doi.org/10.1177/0844562116652230

McBeath, A. G., du Plock, S., & Bager-Charleson, S. (2020). The challenges and experiences of psychotherapists working remotely during the coronavirus pandemic. *Counselling & Psychotherapy Research, 20*(3), 394–405. https://doi.org/10.1002/capr.12326

McGregor, C. (2019). A paradigm framework for social work theory for early 21st century practice. *The British Journal of Social Work*, *49*(8), 2112–2129. https://doi.org/10.1093/bjsw/bcz006

Phipps, D. W., & Vorster, C. (2011). Narrative therapy: A return to the intrapsychic perspective? *Journal of Family Psychotherapy, 22*(2), 128–147. https://doi-org.ledproxy2.uwindsor.ca/10.1080/08975353.2011.578036

Pillay, A. L., & Barnes, B. R. (2020). Psychology and COVID 19: Impacts, themes and way forward. *South African Journal of Psychology*, *50*(2), 148–153. https://doi.org/10.1177/0081246320937684

Polkinghorne, D. E. (2011). Narrative therapy and postmodernism. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy*. SAGE Publications. https://dx.doi.org/10.4135/9781412973496

Powell, F. W. (2001). *The politics of social work.* Sage Publications. https://dx.doi.org/10.4135/9781446219294

Probst, T., Humer, E., Stippl, P., & Pieh, C. (2020). Being a psychotherapist in times of the novel Coronavirus disease: Stress-level, job anxiety, and fear of Coronavirus disease infection in more than 1,500 psychotherapists in Austria. *Frontiers in Psychology*, *11*, Article 559100. https://doi.org/10.3389/fpsyg.2020.559100

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton.

World Health Organization. (2021, February). *Coronavirus disease (COVID-19) pandemic*. Retrieved September 21, 2021, from https://www.who.int/emergencies/diseases/novel-coronavirus-2019

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