The perspective of mental health providers on Shared Trauma, Social Isolation and Technology during the COVID-19 pandemic with adolescents at therapeutic schools

by

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DISSERTATION
submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Social Welfare (Ph.D.)
in the Wurzweiler School of Social Work
Yeshiva University – Wilf Campus
New York

(July 13, 2023)

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Section One: Study Overview

This qualitative study explored the experiences of mental health professionals working in private and/or public therapeutic schools with a focus on technology, social isolation, and shared trauma as potential moderating influences. It was conducted with the inclusion of mental health professionals from New York and New Jersey schools. The data was gathered by interviewing eight mental health professionals, with the phenomenological approach utilized to explore the unique experience of each clinical mental health professional. Interviews were conducted via Zoom and coded to identify themes connected to the potential identified factors (Creswell & Poth, 2018).

With the COVID-19 pandemic, mental health professionals were immediately forced to transition to a remote therapeutic model, causing challenges not only for the provider, but also for the clients. This study attempted to understand this transition through exploring the individualized experience on the micro level as defined by Bronfenbrenner's ecological systems theory (Onwuegbuzie et al, 2013). The goal was to learn more about the phenomenon experienced and develop an understanding that can be contributed to future research with the implementation of new interventions to support the challenges reported.

At the time that this article is being written, there is new research emerging to provide more of an overview on the COVID-19 pandemic and the impact it has had on society. However, in this study, the focus was to explore mental health professionals' experiences based on the three factors discussed above to fill in the gaps on the impact of the pandemic. Presently, there is limited available data on the experiences of mental health professionals with social isolation, let alone with COVID-19 being an impacting factor. Social isolation led to technology taking on a major role for the mental health professionals in providing services to their clients.

Technology was utilized in mental health services prior to the pandemic with the purpose of increasing access to services in certain communities; however, the identified problems led back to difficulties with one's ability to access these resources (Gloff et al, 2015). While the pandemic raged on, providers needed to remain present for their patients despite the traumatic experiences they encountered themselves. These challenges resulted in mental health professionals having to manage these shared trauma experiences.

This study sought to demonstrate the experiences of mental health professionals and identify the phenomena through themes. The interviews identified that the majority of the participants reported being personally impacted by social isolation, the negatives and positives of technology, and shared trauma. In addition, many of these mental health professionals found that communication with their students was affected, and that they needed to adapt their skillset to improve student engagement. These participants also struggled with feelings of helplessness, issues with boundaries, and discussed their need for guidance. Nevertheless, each participant felt consistently motivated to continue providing care to their students. These themes can provide crucial strides to the micro level in showing the challenges and success of the therapeutic relationship for both the providers and the clients. This can lead to greater change and interventions on the practical level as well as policy on the macro level.

The National Association of Social Work (NASW) has established many rules and regulations to keep providers within certain guidelines. These rules and regulations are centered around the four prima facie duties in order to help social workers stay on task when working with clients. The four prima facie duties are autonomy, beneficence, justice, and non-maleficence. The principle of autonomy in the context of social work is the client's ability, capacity, and understanding regarding their condition and treatment. The principle of

beneficence ensures that all actions taken towards the client are in their best interest and with the positive intent of helping. The principle of justice desires that the treatment is justifiable for the particular client's needs. Lastly, the focus of the principle of non-maleficence is to avoid any potential harm or pain towards a client (Beauchamp & Childress, 2001). In addition to the guidelines provided for ethical principles, the NASW also provided a model for teletherapy (NASW, 2017). The NASW highlights the importance of these ethical principles through four sections to ensure that client information remains confidential, that the system of delivery maintains privacy and security, that there is continued education for social workers, and lastly, that there is full transparency towards the public with the utilization of telehealth services (NASW, 2017). This study sought to identify provider experiences through the framework of these four prima facie duties, which provide insight to the social work profession. They serve as a guide for the conduction of social work services which will be displayed in this article.

Section 2: Study Problem

Overview of the Problem

Mental health professionals working in therapeutic schools with adolescents during the COVID-19 pandemic faced many challenges both personally and professionally. This change started with the COVID-19 virus and the immediate transition from in-person to remote services. Prior to the pandemic, adolescents were a significant and imperative focus in research, with further analysis in psychotherapy-related research needed to comment specifically on adolescents with psychiatric illnesses. Facilitating the change to a virtual environment for the delivery of individual therapy fell onto the mental health professionals and required immediate interventions with little to no time of preparation to ensure this could become as smooth of a transition as possible for such a high needs population. The trouble with this transition was that it was so highly focused on continuing to provide services to the patient population that mental health professionals became faced with the challenges of having to adapt to these changes with little support and time. Further challenges were posed to their own mental health as they dealt with working and living amidst social isolation.

To explore this transition, a study conducted at a university in the Netherlands found that the lack of in-person human connection and social networking due to the pandemic is contributing to mental health illnesses, while a systematic review by Imran et al (2020) found that there was an intense fear among individuals experiencing social isolation. In Stubbe et al (2021), the authors tested the relationship between the COVID-19 lockdown and factors such as changes in mental health, stress, and sleep, specifically in college art students (Stubbe et al, 2021). It was found that mood disorders such as anxiety and depression have become a common occurrence, much of which has been affected by the pandemic (Stubbe et al., 2021). Similarly,

Imran et al (2020) explored the psychological burden that was caused by quarantine, evaluating literature with similar themes to those mentioned in Stubbe et al (2021). Adolescents who were experiencing these intense psychological feelings and emotions may have sought out therapy during this time, increasing the amount of clients these providers see, which can add to the mental health professionals' own personal experiences with social isolation and shared trauma (Tosone et al, 2016).

On reviewing pre-pandemic literature in Imran et al (2020), it was understood that many of these adolescents had experienced medical conditions such as cancer, higher levels of medical care, past epidemics such as Ebola, and wars dating back to World War II, all of which contributed to isolation. The studies conducted after the onset of the pandemic showed an increase in adolescent screen time with symptoms of irritability, anxiety, and restlessness (Imran et al., 2020), displaying the aftereffects of universal social isolation.

As discussed in Goodrich (2020), mental health professionals have the role of teaching and guiding individuals to manage their feelings and emotions. With the transition of therapeutic services becoming more distant and switching from being in-person to remote, this change will result with those they counsel having to turn more to their own internal compass as well as their peers for direction. This will then come full circle with mental health professionals having to continue to provide direction and guidance with constant reinforcement to make up for the transition and lack of structure in their practice (Goodrich, 2020; Ho et al.,2021)

This data represents the overall changes and challenges that mental health professionals are having to react to with their clients because of the COVID-19 pandemic. Nevertheless, more research on COVID-19 is being conducted to understand its impacts on adolescents, adults, and

medical staff due to the recent onset of the pandemic, which may help address the potential problems mental health professionals are facing.

History of the Problem

With the onset of the COVID-19 pandemic, there has been a great need for mental health services as the pandemic has led to a mental health crisis. During lockdown, adolescent students had no choice but to isolate in their homes with their families. Their only engagement with their classmates, friends, teachers, and mental health professionals were through virtual means. It can be hypothesized that this change did not come without consequences to both the students and their engagement with their mental health professionals. It was found that a child's mental health and social environment are positively associated (Lamblin et al, 2017). Lamblin et al (2017) explain that an adolescent's growth comes from social relationships, specifically outside of one's direct family.

With this change and restriction towards their clients, mental health professionals are now in the position where they must find ways towards fostering the continuation of therapeutic relationships to ensure their clients remain developmentally on track. However, with the abrupt transition from in-person to remote, there has been little time to integrate such techniques. The implementation of online platforms such as Zoom and Microsoft teams has allowed professionals in the academic setting to provide oversight to a continued learning and developmental environment with the goal of making these platforms as similar as possible to in-person services (Ho et al., 2021).

Previously, there were many hesitancies with the adjustment of transitioning therapeutic services from in-person to remote. Some of the challenges faced include the ethics and concerns about client confidentiality which were accompanied by concerns about the efficacy of the

delivery of services (Bekes et al, 2020). However, due to the acute nature of the pandemic, virtual services have become a new norm utilized by providers nationwide. In order to explore this new norm, further research is necessary to understand the impacts of COVID-19.

Mental Health Needs for Adolescents

The needs of adolescents regarding mental health and the therapeutic relationship have been an important and increasingly relevant topic. While prior to the pandemic, adolescent development and mental health were still significant and imperative research interests, the COVID-19 pandemic has been a turning point in the way that mental health issues are viewed in connection to social isolation. When individuals were mandated to stay at home, transitioning children to forms of remote schooling, the social isolation they experienced changed the way they functioned and interacted in daily life.

Not only did the COVID-19 pandemic force individuals into social isolation, but it created a society that relied on virtuality. Given the immediate transition to remote learning as well as remote therapy, individuals receiving these services during the COVID-19 pandemic were faced with an increased amount of engagement with technology. While technology was the only available way to bridge the gap between the in-person classroom and social isolation, it has its own complexities which can also be explored in relation to mental health and engagement. As discussed previously, Lamblin et al (2017) identified that adolescence is a time in which youth are at higher risks of mental health issues, which can be due to social isolation or dysfunction. Mental health professionals working with adolescents have an extremely important role with ensuring that the technological services being offered do not add to the concerns of increased screen time that can further perpetuate mental health issues and reliance on technology.

The Use of Telehealth Services

While technology can impact adolescent mental health directly, therapeutic services can also be directly impacted by the switch to remote therapy. Therefore, the use of telehealth services provides its own challenges and benefits in understanding the problem faced by adolescents during this time. To explore this issue, it is first necessary to analyze the validity and efficacy of these services. In a systematic literature review, Gloft et al (2015) looked at clinical outcomes on telemental health in adolescents. This review served as a follow-up to other studies, which showed a consistent pattern of mental health professionals, specifically psychiatrists, migrating their services from small suburban areas to larger urban cities. To address this issue, prior research found that services provided remotely were utilized to address problems in communities that had shortages in mental health providers. However, most of the virtual services that were being offered in these small towns were targeted at adults rather than adolescents. Therefore, the objective of this systematic review was to explore telehealth services as a means for adolescents. Among the 9 RCT studies analyzed, one study found that in-person services resulted in better outcomes than remote, four found equal adequacy between the two with no difference reported, and one study found that telehealth yielded better results (Gloff et al, 2015).

In order to further explore the benefits and challenges of telehealth services, Wangelin et al (2016) completed a pre-pandemic evaluation, in which they identified many useful purposes of technology in providing mental health counseling. While the utilization of technology comes with its own challenges, it also solves many of the issues presented by in-person services. For example, telehealth services address the stigma surrounding mental health illnesses that many face, as patients engaging in services are often better able to keep their treatment private (Wangelin et al, 2016). Furthermore, telehealth services utilizing cognitive behavioral therapy

have been a successful intervention in patients diagnosed with anxiety disorders due to the possibility for stress in situations of meeting someone new face-to-face in a new environment. As a result, those with anxiety can often exhibit a pattern of avoiding treatment by not attending in-person services. However, with remote services, patients can attend from the comfort of their homes, which goes a long way in continuing the therapeutic relationship.

Regardless of the availability of telehealth itself, the ability of clients to reach services was further explored in Stewart et al (2017). The authors focused on many of the barriers for providing successful evidence-based treatment, specifically trauma-focused cognitive behavioral therapy delivered via technology. In Stewart et al (2017), the focus was on providing services to youth diagnosed with PTSD in underserved financial communities, all of whom faced barriers to services. The barriers identified that prevent adolescents from receiving treatment included transportation, parking, cost of transportation, work schedule, and lack of insurance benefits. The belief was to provide a safe and secure environment that allows a child to feel comfortable to talk about their trauma due to their vulnerable situation. Furthermore, one concern was that by providing teletherapy, there may not be appropriate service providers able to intervene if a child became at risk. The environment in which an adolescent received services was another factor identified that required preparation to ensure continued support was available with the use of telehealth services. It was found that with preparation, trauma-focused cognitive behavioral therapy could be provided successfully via telehealth services (Stewart et al, 2017). These findings open the door for the development of mental health professionals' experiences which may have faced the positive benefits of telehealth through their ability to provide care more accessibly to underserved patients.

These studies speak to some of the benefits and nuances of telehealth and provide an understanding of its validity for individuals in need. However, it is necessary to evaluate both the benefits and challenges of therapeutic services when no other option is available.

Relevant Policies and Judicial Decisions

In order to prevent and manage the consequences of the pandemic on adolescent mental health, official government mandates and policies are necessary. The Coronavirus Aid, Relief, and Economic Security Act (CARES) provided a means of protecting adolescents and assisting mental health providers (Goldman et al 2020). The mental health branch of the CARES Act provided millions in funding to multiple different mental health organizations to help them continue to provide services during the pandemic. Furthermore, several grants were awarded to go towards emergency activities as well as suicide prevention programs (Goldman et al 2020).

Following the CARES act, there was an increased focus on supplying funding and resources towards mental health interventions. Many programs were supplied funding to ensure the continuation of service providers to assist those impacted by the pandemic. Part of the process also involved incorporating many large governing agencies such as the Federation of State Medical Boards to become more lenient with license renewals. Furthermore, these agencies allowed for multiple states to be included in being able to provide services despite previous restrictions with state reciprocity. A major change that was put in effect by the U.S Department of Health and Human Services (DHHS) was allowing providers to utilize technology platforms for telehealth services that were "not deemed" HIPPA compliant. This change was to allow for the immediate continuation of services to ensure that access for those who needed it remained available (Goldman et al 2020).

Despite DHHS allowing for non-HIPPA compliant platforms to be utilized, it was still extremely necessary for providers to ensure that client information remain protected. In Lustgarten et al (2020), the authors discuss different modes of delivering services such as text messaging, emails, different apps, telehealth, and telephonic means. The article highlights different methods such as encrypting email information when communicating with clients in attempts to protect their information, checking iCloud storage and ensuring the security of a location, and having access to electronic medical records that can provide a safe and secure location to document client information (Lustgarten et al, 2020).

Conclusion

To conclude, this study problem suggests that is likely that COVID-19 has had significant impacts on the experiences of mental health professionals working with adolescents facing challenges regarding mental health, development, and screen time. In addition, pre-pandemic literature emphasizes the barriers towards telehealth and therapy in general, indicating that many of the struggles identified by patients may be difficult to address therapeutically, thus impacting the experiences of these providers. The added burden of COVID-19 leads to increased consequences that both mental health professionals and adolescents face in regards to their daily functioning. As a result, this study sought to understand the experiences of mental health professionals working with high-risk adolescents, in order to ultimately address many of the issues these adolescents face. Firstly, it reviewed the relevant literature relating to mental health professionals and COVID-19. Secondly, it developed this theory further by collecting qualitative data to establish the thoughts and experiences of mental health professionals. Thirdly, it contributed to the field of social work by gaining a greater understanding of the ways in which

listening to the experience of mental health professionals can allow us to benefit adolescents more in therapy.

Section 3: Literature Review

Introduction

This section will summarize the present literature relating to the therapeutic experience during COVID-19, while also synthesizing important information that will support the need for further research on this topic. It will also introduce the relevant factors this study used to evaluate the therapeutic experience in relation to both COVID-19 and high-risk adolescents with previously diagnosed mental health disorders. In order to examine the literature, this review has been organized into three categories, each representing a major theme relating to the experiences of mental health professionals during the COVID-19 pandemic.

Methodology

To further understand and explore mental health professionals' experiences during the COVID-19 pandemic, this review of the literature has been organized into three general themes: shared trauma, technology, and social isolation. Search terms included but were not restricted to adults AND social isolation, therapists AND social isolation, COVID-19 AND social isolation, COVID-19 AND therapists, COVID-19 AND teletherapy, therapists AND remote work, shared trauma AND community violence, shared trauma AND therapists, and shared trauma AND COVID-19. The articles utilized in this study were mostly found via Google Scholar, YU Find, American Psychological association, The Journal of Social Psychology, and the Montefiore Library. These search engines often redirected the researcher to other search engines such as PubMed and Elsevier. The seventeen articles utilized in this literature review ranged in publication year from 2008 to 2022, with most being published in the last 10 years.

Findings

The first theme to be explored is social isolation, which includes the subsections of social isolation among adults prior to the pandemic and social isolation during the pandemic. This section will first evaluate social isolation in the general population, while also indicating a need for further evaluation of the relationship between mental health professionals and social isolation. The second theme is technology, which can be divided into the adequacy of telehealth services, including ethics and confidentiality, and mental health professionals' experience with telehealth services. The third theme is shared trauma, a concept in which a client's personal traumatic experiences can be projected onto the mental health professional and amplify the trauma of the provider who is undergoing the same traumatic event. In the case of COVID-19, which affected both mental health professionals and patients, mental health professionals were forced to take on their own trauma from the pandemic as well as that of their patients.

While this literature review provides a significant look into the current understanding of these topics, limitations of these articles and gaps in knowledge do exist and should be explored in future studies. This literature review will conclude by discussing these limitations and gaps, and specifically how they relate to the topics explored in the study. These gaps should be pursued in order to understand the lasting impacts of COVID-19 on the therapeutic experience and improve the delivery of telehealth services in the future.

Social Isolation

Pre-Pandemic

In analyzing the therapeutic experience during the COVID-19 pandemic, social isolation must be discussed in order to properly analyze this experience. While the current literature examines social isolation generally in relation to adolescents and older adults, it does not presently highlight the experience of mental health professionals with social isolation. Our study

intends to fill the gap of knowledge surrounding social isolation experienced by mental health professionals during the COVID-19 pandemic. The research to be included in this section of the literature review will be focusing on our general understanding of social isolation in adults.

The concept of social isolation has been studied extensively (Taylor et al, 2018; Wright et al, 2017), although not with therapists. While perception of relationships is a strong indicator of the effects of isolation (Taylor et al, 2018), culture also plays an important part in that perception (Wright et al, 2017). However, the connection between social isolation and other mental health issues including loneliness and depression has been well documented. A systematic review by Wright et al (2017) explored existing articles on loneliness and social isolation in adults in New Zealand, with factors including physical and mental health in adults. This review of nine articles included eight quantitative studies and one qualitative study. The methods that were utilized by the author to select eligible articles was based off the mixed methods appraisal tool. In the articles reviewed, it was found that loneliness in adults was correlated to suicidal ideation, gender (specifically, being female), mental health issues such as depression, being independent, and physical health issues such as vision loss (Wright et al, 2017). Furthermore, social isolation and feelings of loneliness were dependent upon one's cultural group. There was a correlation between one's cultural and environmentally-based experiences and loneliness. Culture played a major role in feelings of isolation as one's ability to feel connected to those around them is related to levels of comfort and ongoing discrimination. This study highlights the importance of how the macro and micro systems impacting a person can further relate to one's overall mental health which can be directly related to social isolation. However, future research could further explore the specific cultural groups impacted to provide targeted interventions to decrease social isolation and loneliness (Wright et al, 2017).

Through exploring the same themes as Wright et al (2017), Taylor et al (2018) took a purely quantitative approach by reviewing an existing data set from the National Survey of American Life. This data set focused on subjective and objective social isolation experienced from friends and family that could lead to symptoms of depression or emotional anguish. The sample size was 1,439 adults, ages 55 and older. As shown in Wright et al (2017), social isolation can be a major determining factor in an adult's overall health, implicating the importance of this research to continue evaluating this relationship. As such, the authors in Taylor et al (2018) developed two models of social isolation: objective and subjective social isolation. While objective social isolation focuses on physical changes occurring as a result of the isolation, subjective social isolation is one's interpreted perception of the quality of the relationships and social activities that they have developed and engage in (Taylor et al, 2018).

Using these definitions, Taylor et al (2018) focused on objective social isolation only, later including subjective social isolation as well. Results found that feelings of subjective social isolation that were specifically focused on perceived poor relationships with *both* family and friends was correlated to higher levels of depressive symptoms. Similarly, subjective social isolation solely involving friends also showed higher levels of symptoms of depression and emotional anguish. On the other hand, the study on objective social isolation showed its association with symptoms of depression; however, when the new findings of subjective social isolation were added, objective isolation did not show any change or significance regarding depression. This research shows how one's perceptions and beliefs are an extremely important indicator for the perceived feelings and experience of being socially isolated (Taylor et al, 2018).

While these studies do evaluate different forms of social isolation, they do not represent the type of isolation experienced during the COVID-19 pandemic, in which individuals were not

able to freely engage with friends and family members. Social engagement with those not living in one's home were transitioned to fully virtual and remote methods. These restraints may disproportionately impact certain individuals or groups, implicating the complicated nature of social isolation. Furthermore, social isolation that is forced or sudden may have very different consequences to those presented in this study. Due to the present gap in literature on social isolation in mental health professionals, these findings detail the experience of adults in general, which can be applied to our understanding or our study population until data specific to mental health professionals is collected.

Pandemic Experience

To further understand the factors impacting those under lockdown during COVID-19, the pandemic experience of social isolation must be examined. As previously mentioned, COVID-19 brought upon a specific form of social isolation as individuals were suddenly forced into quarantine but had technology to connect them. As a result, this form of social isolation presents uniquely and should be distinguished from prior examples.

The literature in relation to the pandemic is still developing, but an increasing number of studies are being published in relation to social isolation. These studies were mostly quantitative in their attempts to observe large populations of individuals affected by the pandemic (Holaday et al, 2022; Siegmund et al, 2021; Sams et al, 2021; Elmer & Stadtfeld, 2020), though smaller qualitative studies are also emerging (Eppler, 2021). Each of these studies found that social isolation significantly impacted their participants. One such study is a cross-sectional analysis by Holaday et al (2022), who focused on this newfound form of social isolation that became evident during the pandemic. The authors analyzed different measures that were taken to decrease the spread of the COVID-19 virus and how these measures impacted the participants. Variables that

were analyzed included having a history of mental health or neurological illness, specifically depression and dementia, as well as one's ability to access the internet. It also included medical care access related to one's ability to receive care. The targeted population were adults over the age of 65, and the study included 8,125 participants who responded to the Medicare current beneficiary survey, with the focus relating to feelings of social isolation and COVID-19 (Holaday et al, 2022).

Results found that these preventative measures led to expressed emotions of sadness and loneliness across people of different backgrounds. Feelings of social isolation and loneliness were a common occurrence at the start of the pandemic. This research presently recommends that primary care, along with mental health professionals, work and develop rules and regulations that allow for the models of telehealth to develop further, as the internet was a factor that assisted with feelings of connectivity amongst people (Holaday et al, 2022). While this research is useful, a limitation of this study was that all participants included from Medicare had to be independent and could not have a healthcare proxy. This distinction highlights one's capacity and autonomy to make their own decisions due to a level which deems competency, excluding individuals who may have been significantly affected by the pandemic but lack full independence. Another limitation of the study was the article's focus on the older generation, as the targeted population to be explored in our present study is specifically mental health professionals, whose ages may range from young adults to those older in years.

Siegmund et al (2021) explored a subset of the population impacted by the same restrictions and safety measures as those in Holaday et al (2022). The article examined the relationship of physical activity and depression, as well as social isolation and depression in adults with the age of 65 and above. Due to the constant concerns of exposure to COVID-19, all

mandates and recommendations advocated for isolation and distance amongst individuals. Older adults engaged in less physical activity than younger adults, which caused an increase in symptoms of depression due to the fact that these individuals were further impacted by social isolation. With older adults, physical activity and engagement are always encouraged for one's mental health. The requirement to shelter in place during COVID-19 in order to decrease the likelihood of exposure and to contain the virus further impacted these individuals (Siegmund et al, 2021). With the study including 805 participants who responded to survey questionnaires, the results showed that with more social isolation experienced, the greater the symptoms of depression one experienced (Siegmund et al, 2021).

These findings indicate the need for medical professionals, specifically nurses, to provide psychoeducation to older adults in order to promote the importance of exercise as a means of preventing social isolation and subsequent depression. Furthermore, more social programs are needed to assist the population with remaining connected and engaged to counteract the social isolation. This can be achieved through nurses advocating to change policies, programs and procedures as more research and data become available. This social isolation from the pandemic can have a lasting effect on the physical and mental health of older adults, showing signs of mental health issues at an increased rate in relation to the typical change of decreased engagement in older age (Siegmund et al, 2021).

Furthermore, a cross-sectional study by Sams et al (2021) studied strengths and activities with relation to loneliness and emotional anguish during COVID-19 in adults aged 60 and older. The importance of focusing on adults and the need for the study was due to the higher increased risk this population faces with becoming ill, higher rates of mortality, and long-term psychological effects. The study included 501 adults nationwide who received surveys and

measurement tools to fill out. This study found that after 3 months of enduring the pandemic, adults reported higher levels of psychological distress and mental health challenges. The most common mental health diagnoses observed were depression, general anxiety, and health related anxiety (Sams et al, 2021). It was noticed that the older adults, who were at high risk of experiencing higher levels of distress, were those suffering from medical health conditions (Sams et al, 2021). It was also found, surprisingly, that there were minimal differences in loneliness and emotional distress experienced between people of color and Caucasians. People of color were predicted to have a more difficult time due to the systemic challenges they faced; however, results showed similar results compared to white adults in similar situations (Sams et al, 2021). Like the findings of Holaday et al (2021), these results indicate the shared effects experienced by individuals of many different backgrounds and racial groups. Future studies could further explore this unexpected discovery to understand what the experiences of people of color were like and the potential coping mechanisms utilized.

A unique accidental finding of this study was that these experiences did not change significantly with race (Sams et al, 2021). While it would be expected that certain racial groups, specifically those placed at societal disadvantages, would possibly experience greater degrees of social isolation and hardship, there were no significant changes found. However, it was identified that one's living environment, as well as their social support systems, did have an impact on negative feelings and mental health issues related to isolation. As a result, while environmental factors were shown to impact outcomes in this study, the findings indicate that individuals with many different backgrounds were impacted by the safety measures imposed during the pandemic.

In taking a slightly different approach from the studies discussed above, Elmer & Stradtfeld (2020) analyzed the impacts of social isolation on both physical and mental health. The authors found that social isolation is associated with increased risk of heart disease, stroke and mortality, and psychological distress, resulting in symptoms of depression (Elmer & Stadtfeld, 2020). This study utilized quantitative methods by studying two different samples. The first sample consisted of 73 participants and the second contained 50, with the mean age of the samples being 20.75 years and 21.73 years, respectively. The study took place over a weekend remote trip where the goal was to test if participants still felt isolated despite being within a social group in which there were no pre-developed relationships (Elmer & Stadtfeld, 2020). The measurement tool for social interactions was radio frequency identification (Elmer & Stadtfeld, 2020). While a major focus of this research emphasizes the possibility of social isolation leading to depressive symptoms, it has also been shown that the reverse is possible as well. If someone is showing signs of depressive symptoms, that could lead one to social isolation (Elmer & Stadtfeld, 2020). Based on these findings, services provided remotely can be evaluated regarding their impact on mental health. Mental health professionals could encounter many issues as each person's level of interaction and engagement can impact individuals differently, which would require different therapeutic strategies.

Furthermore, this "depression-isolation hypothesis" discussed in Elmer & Stadtfeld (2020) is related to one's social distancing. It is believed that depressive symptoms impact one's desire to engage with others, which further contributes to social isolation (Elmer & Stadtfeld, 2020). Social beings thrive off engagement with others, however, when someone appears depressed, they can be removed and distanced by those close to them in order for those

individuals to avoid the emotions of their negativity (Elmer & Stadtfeld, 2020). In this way, one's attitude, mental health, and social activity are interconnected.

Eppler (2021) was the only article found during this review that focused on the experiences of mental health professionals during the first few months of COVID-19. This study specifically focused on the experiences of 55 clinicians providing marriage and family therapy. Using a Qualtrics survey, the researcher asked each participant to answer open-ended questions relating to their most meaningful and least meaningful clinical experiences since transitioning to teletherapy at the start of the pandemic. The results featured a range of findings, many of which will be further explored in this literature review. However, in regards to their emotional wellbeing, these participants described feeling more anxious and stressed during this time, as well as less connected to those around them. Some participants noted that they felt lonely without the typical engagement they would have from their colleagues when they worked in-person. While this study did not expand on these particular emotions and experiences regarding loneliness and isolation, these findings indicate the effects that social isolation can have on those providing mental health services. Nevertheless, one limitation of this study involves the method of using surveys to answer a broad research question, which may have inhibited participants from providing more in-depth responses regarding their experiences. In addition, the study was limited by not asking additional questions to further evaluate components present in these participants' experiences (Eppler, 2021).

The research presented in this section identifies the serious mental health consequences of the measures taken during the COVID-19 pandemic. While Holaday et al (2021), Siegmund et al (2021), and Sams et al (2021) focused on participants of older ages, Elmer & Stadtfeld (2020) explored these relationships with a younger age group and Eppler (2021) focused on marriage

and family therapists. Findings from all studies suggest that the impacts of COVID-19 have spanned across individuals of all types, while also contributing to an acceleration of mental health effects in older adults specifically. Given that many different types of adults were impacted, it can be understood that the mental health professionals treating these mental health issues were also similarly impacted by the isolation they experienced. However, it is undeniable that the experiences of mental health professionals working specifically with students at therapeutic schools are unique in that they must battle both their own social isolation and the challenges their patients face, as well as shared trauma. This therapeutic experience specific to the pandemic will be explored in subsequent sections of this study.

Technology

Telehealth and Challenges Faced

With the measures of social isolation in place, working remotely became the new normal in the spring of 2020 during the onset of the pandemic. Remote work infiltrated fields of all types, causing individuals to spend an increased amount of time using technology to complete their daily tasks. Telehealth became a popular method of practice for healthcare providers treating non-emergent and non-life-threatening matters, such as therapy and counseling. While the progression of telehealth allowed individuals under care to continue receiving services, it also involved many challenges in regards to providing adequate services.

Bee et al (2008) explored pre-pandemic telehealth interventions, later to be followed by pandemic-focused literature (Bekes et al, 2020; Chenneville & Mette, 2020). In their systematic review, Bee et al (2008) focused on remote services and their effectiveness with clinical interventions due to the many different mental health diagnosis barriers. These remote services included those delivered via the internet (telehealth) and by phone (telephonic). The initial idea

with this expansion of service delivery was to provide to communities with little access to mental health services as well as to provide clinical expertise with more challenging diagnoses (Bee et al, 2008). In this systematic review, 13 studies were included, all randomized control trials, with 10 focusing on telephonic services, two via telehealth, and one via videoconference. The authors analyzed the 13 articles using a quantitative approach to compare and evaluate if there were any significant findings. The method utilized to choose the designated articles was the Cochrane Collaboration for Depression, Anxiety and Neurosis, which focused on 23 different aspects of a study which allow for the determination of inclusion in this systematic review (Bee et al, 2008). The utilization of telephonic services was viewed as a highly effective method of service delivery. This finding is due to the accessibility and functionality of allowing therapy to be provided at any location. However, utilization of telehealth and telephonic services can be limited if an individual does not have the financial means for a phone or computer, which can pose a challenge for providing services remotely (Bee et al, 2008).

While many beneficial effects were noted in pre-pandemic research, these studies did not evaluate a situation like COVID-19, where all individuals were abruptly forced into telehealth in order to continue services. In an article written by Bekes et al (2020), the authors focused on the changes and experiences of analytic mental health professionals who had to abruptly transition to remote work due to the pandemic. 190 analytical mental health professionals were provided with surveys in attempts to explore the therapeutic relationship and analytical process with the model of remote rather than the previous in-person services (Bekes et al, 2020). This change to remote services is extremely important as it was the only available form of therapy being offered at the start of the pandemic due to safety concerns. This study found that mental health professionals were able to adapt and provide a similar environment to in-person services for patients, despite

technological challenges and comfortability amongst providers (Bekes et al, 2020). The mental health professionals surveyed did report that they had previous experiences providing telehealth services prior to the pandemic. This previous experience represents a limitation of this study, as many other providers may not have engaged with this work prior to the pandemic (Bekes et al, 2020).

Furthermore, the analytical mental health professionals did report several changes that occurred with full transition of services to the telehealth model. The concept of transference and countertransference can play a prevalent role in the therapeutic relationship, and they must be addressed to ensure the relationship amongst provider and patient can develop. One concern raised was how services offered via telehealth may prevent the ability of this dynamic to both develop and resolve due to the perception of the person not physically being present (Bekes et al, 2020). Similarly, communication is not only verbal but can also be understood physically. With telehealth services, there can be a lack in the usual patterns of communication, which can further impact the therapeutic relationship through remote services. Lastly, remote services provide a challenge of allowing the mental health professionals to interject and guide the safe space fully in conversation due to a lack of physical presence. While previously mental health professionals could utilize other forms of communication like body language to interject while therapy is accruing, in the telehealth model, communication has been reduced to mostly verbal, though body language may still play a role. Despite these present limitations, the analysis suggests that the benefits may possibly outweigh the risks when no other option is available, as no services would do harm to clients needing access to therapy (Bekes et al, 2020).

While the previous article analyzed both the challenges and the effectiveness of teletherapy, Chenneville and Mette (2020) focused on the ethical concerns with providing

services remotely during the COVID-19 pandemic. In this review, the article discusses the ethical principles that guide social work, such as beneficence and nonmaleficence (Chenneville & Mette, 2020). Due to the increased need for providers due to the mental health concerns arising during the pandemic, if mental health professionals were unable to provide remote therapy, this would ethically contradict and hurt patients seeking treatment. The article discusses guidelines such as informed consent, illustrating the present benefits and risks, as well as confidentiality and the challenges faced with services being held remotely (Chenneville & Mette, 2020). Nevertheless, this research was limited by the lack of clear-cut guidelines established to help guide and govern service providers during the pandemic (Chenneville & Mette, 2020).

Thus, the literature discussed in this section of the review demonstrates the challenges present with regards to the patient and mental health provider's relationship. Not only is this relationship developed through communication, as discussed in Bekes et al, but it is also developed and maintained through the efficacy of the services, respect of ethical considerations, and confidentiality. It is imperative that providers, along with hospitals and corporations, be mindful of these concerns when providing therapy remotely in order to ensure patients receive adequate care. These potential issues are especially important as telehealth continues to be used increasingly more frequently when compared to prior to the onset of the pandemic.

Remote Therapy

While the challenges of the telehealth model in relation to the efficacy of services, as well as ethics and confidentiality, pose challenges for both providers and patients, the unique experiences of the mental health professionals and the way in which the therapeutic experience is impacted are necessary to understand. Although the services offered must be adequate and effective, the relationship between the mental health professionals and the patients must be

preserved. The experiences of patients may impact the mental health professionals' experiences, as providers must adapt the delivery and methods of their services to each individual patient.

In a quantitative research study by Doorn et al (2021), the authors explored why some patients had an easier time than others in adjusting to this new way of life at the start of the pandemic. The factors that were perceived to play a role in the outcome of the participants were the different attachment styles exhibited. The three factors identified for further exploration were collaborative therapy, attachment avoidant, and attachment anxiety (Doorn et al, 2021). This study surveyed 466 participants within the first few weeks of the pandemic who received therapy via the telehealth model. Following the initial survey, 121 participants took a follow up survey. The study found that there was a decrease in attachment anxiety and anguish. For patients who had lower levels of attachment avoidant, they were able to report lower levels of distress in the therapeutic process while receiving services online. Avoidant attachment styles have shown in past research to have better outcomes due to the higher level of functioning seen in previous samples when compared to attachment anxiety. This shows how attachments styles, specifically anxiety, can play a pivotal role in receiving services online (Doorn et al, 2021).

Bekes et al (2021) also focused on the transition at the beginning of the pandemic, but this time, the focus was on the mental health professionals' challenges with transitioning from in-person services to telehealth services. In the study, 1,257 mental health professionals participated by filling out surveys at the start of the pandemic describing the challenges they were experiencing with going fully remote. Three months later, mental health professionals filled out another survey providing an update with how their transition was regarding the delivery of online teletherapy services. The four major themes that were reported by mental health professionals included the challenges in their ability to connect on an emotional level with

patients, both the mental health professionals' and the patients' distractibility due to not being in a controlled therapeutic environment, the patient's right to privacy and confidentiality in their environment, and the mental health professionals having boundaries set in place in the therapeutic relationship. All four of these factors made maintaining a positive therapeutic relationship a challenge (Bekes et al, 2021).

Besides the four themes discussed above, Bekes et al (2021) also found that older and more experienced clinicians had a less difficult time with challenges in the transition to online services when compared to younger clinicians. Furthermore, most of the factors identified previously improved with time. In fact, at the three-month mark following the initial survey, the only factor that did not see any improvement, but rather declined, was distraction for both the mental health professionals and clients. Remaining focused and on task can be very difficult with the telehealth model as the environment may not be a controlled or secure setting. One gap in the present literature is the problem of distraction for clients and mental health professionals. Distractions within the telehealth model can play a big part in the delivery of services and requires further research to understand the experiences of mental health professionals with relation to their environment. Additionally, there needs to be further research focusing on how social isolation can affect both the mental health professionals themselves and the therapeutic relationship by impacting one's ability to focus. Future studies could focus on providing trainings to mental health professionals on finetuning their telehealth clinical skills as a method to improve the delivery of services (Bekes et al, 2021).

In addition, Lin et al (2021) explored further challenges presented by mental health providers during the pandemic. In this quantitative study, the authors examined the perceptions of mental health professionals when comparing in-person to telehealth services, as well as the

skills and therapeutic interventions utilized in sessions. The 440 participants who engaged in this survey ranked the top 28 interventions they utilized in both in-person and remote sessions. Within the 28 interventions chosen, the participants were divided into 3 different categories for further analysis. The results found that mental health professionals felt that their therapeutic skills were not as strong and were not as successful when they utilized remote services instead of in-person services. The practitioners who reported these doubts in service delivery were predominately young, new male clinicians with little training in the online telehealth model. Many of these younger male mental health professionals tried to utilize their own experience and play upon the developed relationships with their clients to provide services, which was perceived to be difficult via online platforms (Lin et al, 2021).

The reported challenges of mental health professionals being able to relate to their clients via the telehealth model draws questions as to what specific changes in the remote model caused mental health professionals such difficulties in connecting to their clients. As discussed in the article, communication in the therapeutic alliance and continuing to utilize the model of developing rapport are always constantly at play while providing psychotherapy. This study further explores mental health professionals' experiences to gain a better understanding of what factors alter the present dynamics of their therapeutic relationship when utilizing telehealth services (Lin et al, 2021).

Eppler (2021) further explored these issues, but from a qualitative standpoint. As previously mentioned, this study surveyed mental health professionals who provided teletherapy to couples and families during the first few months of the pandemic. The responses indicated that teletherapy led to a negative impact on morale, as well as general fatigue and frustration. While many participants indicated that their most meaningful experiences were similar to those

conducting therapy in-person (seeing clients progress in their goals), they felt that conducting therapy remotely brought complications and hardships. These mental health professionals recounted issues with safety and confidentiality, boundaries between work and personal life, and challenges with technological glitches. However, they were able to use some of these glitches to improve the effectiveness of therapy (i.e., encouraging family members to assess one another to promote connection). They also found that conducting teletherapy allowed these participants to view their clients' home lives and personal spaces in more detail, which afforded them the opportunity to gain a better understanding of these clients. Nevertheless, these topics need to be evaluated further in future research in order to understand their implications.

In evaluating mental health professionals' perspectives on telehealth and teletherapy, the literature reviewed in this section identifies many of the important aspects involved and barriers present. Whether through attachment styles or merely within the transition from in-person to remote, many providers felt that their skills were not as strong and the relationship was lacking in an online format. Similarly, while many initial difficulties improved with time, factors such as distractibility or technical glitches remained a challenge. In order to cultivate stronger relationships and maintain therapeutic skills despite the challenges that exist for telehealth, a greater understanding of these challenges must be addressed. Further research is required to understand the complexities of the virtual format in greater depth and how they can affect mental health professionals working with high-risk adolescents with previously diagnosed mental health disorders.

Shared Trauma

COVID-19 not only impacted the therapeutic experience through the effects of isolation on mental health and the challenges of the teletherapy, but the experience of shared trauma

amongst individuals was evident as well. In order to understand the concept of shared trauma, literature evaluating therapy during traumatic periods must be reviewed. Tosone et al (2016) explains this concept in their study, in which the authors examined a community wide crisis and the impact it had on the providers who served the affected population. Hurricane Katrina had devastating impacts on the victims that were receiving services from mental health professionals, many of which were mental health related. The study recruited 244 mental health professionals and utilized two scales to account for their experiences, trying to capture the shared trauma that was experienced by the mental health professionals (Tosone et al, 2016). To accurately account for and analyze this information, the researchers utilized the Technique-Specific Shared Trauma Posttraumatic Growth Inventory, a tool developed to understand the shared trauma experienced.

The Technique-Specific Shared Trauma Posttraumatic Growth Inventory identified the reciprocal nature of shared trauma and its correlates to the secondary trauma and the posttraumatic stress that is experienced by the providers (Tosone et al, 2016). It was found that one's personal traumatic experiences can further influence providers and add to their own or already developed traumatic experience. The client's experience can be projected onto the mental health professionals, which can further amplify the personal traumatic experience of the provider and their own primary trauma (Tosone et al, 2016). This finding defines shared trauma and allows it to be understood further. While this study provided a framework for identifying shared trauma within the therapeutic experience, the lack of male mental health professionals in the surveyed population limited its ability to evaluate this phenomenon across gender differences.

A previous study by Tosone et al (2011) took a different approach, yet with a similar theoretical model, by focusing on the impact of shared trauma on mental health professionals in

New York City following the 9/11 attack on the World Trade Center. This study explored and gained further understandings on the shared trauma and the impact it had on attachment style, further posttraumatic events, and the responses from these traumatic experiences. Furthermore, the study focused on the impact and experiences that both mental health professionals themselves had and the experiences from those around them. To recruit a sample, participants were sent surveys via mail and out of the 1,297 potential participants, 481 were able to be utilized for this study.

This Tosone et al (2011) study found that attachment styles, specifically insecure attachments, served as factors that directly impacted mental health professionals during times of trauma. Specifically, individuals with greater predispositions and risk factors to trauma have a higher risk for shared trauma experiences (Tosone et al, 2011). Insecure attachment styles were impacted more due to the lack of resilience found to be correlated with those having an insecure attachment. On the contrary, mental health professionals that had secure attachment styles were found to have been better equipped and able to manage their shared trauma (Tosone et al, 2011). While the study focused on many of those directly affected by the incident, the survey population included only New York City social workers and not mental health professionals from other states who could have had their own experiences with the 9/11 tragedy. This limits the study with regards to generalizability. Another limitation is that 9/11 was a traumatic incident that was a single occurrence, while the COVID-19 pandemic has been ongoing and has forced society to adjust to the new reality. It has led to a situation in which mental health professionals are continuously reliving their trauma.

Major tragedies like Hurricane Katrina and 9/11 can lead to years of shared trauma during their aftermaths, similar to the threat of consistent community violence. Community

violence has become more prevalent over the years and for those mental health professionals who try to address it, more signs of fatigue begin to show. In a qualitative study by Day et al (2017), the experiences of eight mental health professionals on the Virginia Tech shooting and the impact it had on their mental health were explored through interviews. Trauma of any kind, whether it is firsthand or secondary, can impact anyone that it comes into contact with. In each way, trauma can show long lasting impacts depending on who the individual may be, or the group impacted. The participants chosen either provided care on campus or in the community to those impacted by the tragedy. This article found that the mental health professionals directly impacted by the tragedy themselves experienced heightened responses when working with clients who experienced the same trauma. One coping mechanism identified to alleviate effects of this trauma was for the mental health professionals to set boundaries when working with very traumatic cases and limiting hours of providing counseling to allow for more self-care (Day et al, 2017).

The role of the mental health professionals in being able to support and listen to their clients may appear easy, however, it can come with its own difficulties for the providers. For mental health professionals to be able to support clients, they also must be able to take care of themselves and be aware of how their own experiences with trauma, as well as shared trauma experiences, are able to remain in check. Mental health professionals have shown the importance of professionalism and interpersonal awareness based on experiencing the firsthand trauma themselves. However, it is necessary for mental health professionals to be able to set boundaries with the experiences of themselves, their family, and their clients. This allows for mental health professionals to become more aware of traumatic experiences and further the therapeutic

relationship by becoming more conscious of the potential symptoms experienced as well as the counter transference (Day et al, 2017).

In order to properly evaluate the therapeutic experience during COVID-19, shared trauma must be incorporated into the framework of analysis and questioning. Like the incidents, tragedies, and challenges explored in these studies, COVID-19 was a shared experience, with many of the struggles encountered by patients affecting mental health professionals as well. Nevertheless, further research, as with this study, serves to explore first-hand accounts of shared trauma when the predisposing threat can affect its recipients in more vastly different ways. With the pandemic being a more complex vehicle driving trauma and adverse events, this study will further explore how the concept of shared trauma presents when the trauma in itself is not always as easily evident. Furthermore, in this study, the target group of patients these mental health professionals work with are adolescents with previously diagnosed mental health disorders. Therefore, the concept of shared trauma will be further explored as a factor that may have either greater or lesser effects when experienced by individuals with prior mental health issues.

Other Moderating Factors

COVID-19 and Medication

Due to the recent onset of the COVID-19 pandemic, the research literature surrounding mental health professionals working with adolescents and changes with medication have not been published at the time of writing. However, limited research does exist on COVID-19’s impact on availability, accessibility, and distribution of medication in general. Medication management during the pandemic became a challenge due to the lack of continuity of medications. For those they rely on medication, the pandemic created disruption due to issues with accessibility (Dunlop et al, 2020; Hirschtritt et al, 2021). As discussed by Dunlop et al,

(2020), the substance use population had a major challenge with receiving medication that required in-person management. The focus of this discussion was on the withdrawal of services, workplace safety, and harm reduction while bearing in mind the ethical considerations of beneficence and the safety of all parties involved (Dunlop et al, 2020).

For opioid users going to the clinic to receive their methadone or buprenorphine, the travel during the pandemic could have posed a risk to their health. Concern amongst the providers was raised due to the addictive nature of the medications to counteract with withdrawals and the ability of these patients to commute to their providers, which could put those traveling at higher risk. Researchers explored these challenges through examining other methods of monitoring clients using technology to help prevent the spread of the COVID-19 pandemic. Another factor that was discussed included the safety concerns of the providers distributing the medication. With the clients traveling to their appointments, the risk of illness could increase for not only themselves but also for the staff members of the facility providing the treatment (Dunlop et al, 2020).

While Dunlop et al (2020) focused on those with substance use disorders, in Hirschtritt et al (2021), the authors analyzed data from 13 weeks before and after the first COVID-19 pandemic death to account for potential changes in medication refills. The specific medication that was taken into consideration was psychotropic in nature. Prior to the start of the pandemic, medication providers were seeing 0-5 patients via telehealth, whereas during the pandemic, those numbers jumped up to 20 weekly. The study gathered its research by analyzing adult data from the Kaiser Permanente Northern California electronic health records, which is a health care system that includes pharmacy and patient health records (Hirschtritt et al, 2021)

The medication changes based on this study showed little to no change amongst most psychotropic medications. In March of 2020 there was an increase in the number of antidepressants and antipsychotics being taken compared to previous years. There was also a slight decrease in benzodiazepine and hypnotic prescriptions. However, present data shows that in April 2020, most medications returned to the average number that were being taken before the pandemic. Furthermore, at the start of the pandemic, there was concern surrounding a shortage in stockpile of psychotropic medications. It is believed that this occurred due to both patients and prescribers alike starting to stock up on these medications due to fears of being unable to maintain the present course of taking and prescribing medication. Lastly, a slight change identified a decrease in the elderly with filling prescriptions compared to young adults. This may be understood by the lack of access these individuals had to technology and prescriber concerns of the side effects on older patients with fear that comorbid diagnoses and treatments may have adverse reactions with the patient's current medications (Hirschtritt et al, 2021).

While these studies provide valuable information, limitations exist. These articles do not focus on therapeutic schools during the COVID-19 pandemic, but rather on medical practices. From this, school-based support with medication may be more limited due to the nature of the environment and lack of medical resources available, as many schools do not have access to providers who are able to prescribe medication. Some common themes identified in the discussed articles focus on safety concerns with regards to prescribing and providing medication and switching to telehealth services. Telehealth services has become the preferred method of communication during the pandemic to ensure safety amongst the patients and providers (Hirschtritt et al, 2021; Dunlop et al, 2020).

Dual Diagnosis

Similarly to the literature on medications, there is no present available research on mental health professionals working with patients with a dual diagnosis in a school environment during the COVID-19 pandemic. Most present research looks at individuals with comorbidities of mental health and another, non-mental health related diagnosis, in order to determine the challenges students face (Salm, 2017; Milani, 2021; Lambros, 2016). A case study by Salm (2017) focused on ways of providing support in a school system for students and providers through the lens of collaboration. The article identified the need for collaboration amongst different professional departments within schools for dual diagnosis (academic/mental health comorbidity) students due to the high demand of services required to help them succeed. The team focused on implementing changes with services involving psychologists, teachers, social workers, and school coordinators. Of the 21 interviews conducted, this included members of the team as well as students who have not yet received the services as a method of gathering their experience and perception of what they need for successful support (Salm, 2017).

The framework that was utilized as a guide was the Canadian Interprofessional Health Collaborative (CHIC). The CHIC found and focused on four specific competencies- role clarification, team functioning, student centeredness, and communication- as a means to increase functioning and collaboration, which was a massive support to providers with helping dual diagnosed students. The major focus of support identified with the competencies listed above focus on the clients' specific needs and ensuring all staff involved in the treatment were aware and on the same page to ensure continuity with the services delivered (Salm, 2017).

Similarly, an article by Milani (2021) focused on dual diagnosis within the general population of individuals 18 years and older, with a focus on effectiveness of services within the transition to an online model. A major factor as identified in the previous article by Salm (2017)

was continuity of services with feelings of inclusion. Both articles identified that participants wanted to feel that the services being offered remotely were still continuous and felt like they were included with the direction and support being offered (Milani, 2021).

In Lambros et al, (2016), the authors focused on 61 adolescents ages 4-22 with dual diagnoses of developmental disabilities and mental health disorders from the Esperanza Mental Health Service program. The program was located in San Diego, California, with the most common diagnoses included being autism, intellectual disabilities, pervasive developmental disorders, anxiety disorders, and attention deficit hyperactivity disorder. Amongst many of the students, one third of those included also had medical challenges that made remaining in school challenging at times. The present research focused on the academic and mental health services offered to these students and the impact it had. The implementation of services included academic interventions and therapeutic behavioral support from psychologists in classrooms to help with behavioral challenges. Family mental health professionals were also provided for the purpose of cognitive-behavioral, solution-oriented and play therapy for the adolescents and their families. The results found that integration of these programs in schools helped decrease student absences and suspensions, which resulted in students receiving services at a more consistent rate (Lambros et al, 2016).

Some limitations of the studies discussed above include the lack of having to react to the COVID-19 pandemic and the immediate quarantine with academic services going fully remote. Another limitation is how the studies do not focus on dual diagnosis mental health problems but specifically focus on a combination of substance use and mental health disorders and/or developmental disabilities and mental health disorders, rather than strictly mental health comorbidities. Amongst the articles discussed above with clients who are dual diagnosed, the

common themes are continuity of services with little interruption, collaboration amongst providers, and further exploration of the perspective and inclusion of the participants with what care they would like to receive (Lambros et al, 2016; Milani, 2021; Salm, 2017).

Accessibility

Furthermore, concerns exist today regarding the accessibility of services for vulnerable populations, and how remote services relate to financial challenges or availability (Das, 2022). With the utilization of technological services, the fear of client confidentiality is threatened as technology may not always be safe and has the potential for data leaks. In addition, with services, mental health professionals are trained to utilize the environment to create what is known as a safe space. A safe space is defined as an environment where individuals feel able to identify and express themselves without having to worry about judgement or bias by surroundings factors. Some fears that arise with the technological realm of delivery of services include the challenge of mental health professionals being able to provide a safe environment due to a patient's physical and emotional presence (Bekes et al, 2020; Bekes et al, 2021, Lin et al, 2021). In addition, some challenges adolescents may face include a lack of resources, which may be a preventing factor in being able to connect to technological services. When clients are remote, their environment can present with distractions, which can further pose a challenge for mental health professionals in creating this safe space for the therapeutic relationship (Bekes et al, 2020; Bekes et al, 2021; Lin et al, 2021; Charczuk, 2021, Day et al, 2017). This lack of accessibility impacts mental health professionals who may find challenges in providing their services. Inability to provide services can thus relate to the social isolation, shared trauma, and issues with technology that they face.

Conclusion

The literature on the therapeutic experience and COVID-19 indicates the challenges that mental health professionals may have experienced during the height of the pandemic and throughout its progression. Mental health professionals were faced with a new way of providing services, in which they were abruptly handed social isolation, a transition to providing telehealth services, and shared trauma. The research shows that social isolation in adults, both pre-pandemic and due to the forced physical isolation of the pandemic, can lead to increased mental health issues. These mental health issues, including symptoms of loneliness, depression, and psychological distress, are likely to present unique challenges to mental health professionals, who may also be impacted by the transition of services to technology and shared trauma.

Increased challenges with telehealth services, including mixed results on the adequacy of services themselves and both confidentiality and ethical issues, pose further challenges to mental health professionals. On one hand, pre-pandemic research indicates positive effects of telehealth services, such as benefits for patients with anxiety and proper efficacy in services provided to patients with PTSD (Wangelin et al, 2016). However, the sudden transition to the telehealth model may help to explain some of the barriers present in the research published after the onset of the pandemic. These challenges include decreased forms of non-verbal communication, ethical issues, distractions, and mental health professionals' perceptions of their skills and therapeutic relationships or lack thereof.

Lastly, the role of the mental health professionals in a situation of a shared experience such as COVID-19 must include shared trauma in its exploration. This concept of shared trauma, as evaluated in tragedies like Hurricane Katrina and 9/11, indicates how providers who undergo trauma similar to that of which they work to treat, may experience amplification of their own trauma (Tosone (2011, 2016, 2019), Day (2017)). This shared trauma can also interplay with the

mental health challenges posed by social isolation, causing further psychological distress to mental health professionals and thus impacting the therapeutic experience.

While the literature provides meaningful background, it has multiple gaps and limitations. As previously mentioned, social isolation should be evaluated in regards to mental health professionals specifically in order to provide further relevance to this study. Furthermore, while telehealth is thoroughly explored in this review, it is not evaluated in relation to mental health professionals working with high-risk adolescents, who face challenges regarding confidentiality, ethics, and efficacy. Lastly, shared trauma in an experience similar to or including COVID-19 should be evaluated, as trauma was not evident for every individual during the pandemic. Similarly, trauma in adolescents may present differently to the way it presents in adults, and as such, shared trauma may follow a different course.

In conclusion, the literature provides significant findings relating to its three themes yet fails to fill much of the necessary content with regards to the therapeutic experience in relation to COVID-19 and high-risk adolescents. This study sought to fill the gap in knowledge in how mental health professionals were impacted by the pandemic, and the experiences of mental health professionals working with adolescents with previously diagnosed mental health disorders during this complicated and novel time. Not only does this knowledge provide the necessary information in assessing the experiences that occurred during the height of the pandemic, but it also serves to understand and address the lasting consequences that pandemic has caused. Furthermore, it provides a framework for future approaches toward social isolation, telehealth services, and trauma. The study explores the question of “What were the experiences of mental health professionals who provided counseling to adolescents with psychiatric diagnoses during

the COVID-19 pandemic?" This question will be discussed further in the next section in relation to the existing theory.

Section 4: Theoretical Framework

The objective of this study is to explore the experience of mental health professionals working with adolescents at therapeutic schools during the height of the COVID-19 pandemic. The four theories explored in this study include the theory of reasoned action, the theory of planned behavior, Bronfenbrenner's ecological systems theory, and constructivist self-development theory. These four theories seek to understand internal and external motivation in an individual's behaviors that impact themselves and those around them. The different systems that are identified in Bronfenbrenner's ecological systems theory allow for a further analysis of specific behaviors, and the constructivist self-development theory identifies the trauma reaction in an individual. These theories reason as to why mental health professionals may think and interact in a certain way, while planned behavior and reasoned action can further look at an individual's beliefs, thoughts, and behaviors.

Reasoned Action Theory and Planned Behavior Theory

The theory of reasoned action (TRA), introduced by Ajzen and Fishbein in 1980, supports the focus of an individual's beliefs and ideas. The context of one's own personal beliefs and ideas provides a guide to explaining how and why a person may conduct themselves a certain way based on the present subjective norms. One's intentions and the way in which they may present themselves can be understood and directly related back to their belief system (Vogel et al, 2005).

Vogel et al (2005) explain the theory of reasoned action through understanding and explaining the relationships and beliefs people have and act on. This theory's primary purpose is to provide a context to help explore a person's previous thoughts and relate it to the behavioral actions taken. The theory of reasoned action starts by explaining how every person's behavior

starts based on one's judgement. One's judgment can be understood through the subjective norm which helps to alter one's thought process. Based on the societal factors at play and one's beliefs, this acts as a framework for how a person will behave (Vogel et al, 2005).

Hennessy et al (2018) introduced a new aspect to this theory. They identify external variables such as "past behavior, demographics and culture, attitudes towards targets, personality, moods, and emotions, [and] other individual difference variables such as perceived risk and intervention or media exposure" (p. 246). This theory allows for a deeper understanding and a broader context as to the reasons behind certain actions that people take, as outlined based on the variables discussed previously. A critical concept of reasoned action theory is the prototype/willingness model which focuses on high-risk behaviors that are based on social responses and reasoned cognitions (Hennessy et al,2018). This theory explains how adolescents may engage in risky behaviors based on relating themselves to a social image that also engages in such behaviors (Hennessy et al, 2018).

Reasoned action theory may provide an understanding as to why mental health professionals may be willing to continue to provide therapy when adapting to constant changes and demands placed upon them both physically and mentally. The beliefs formed can be described through the expectancy value (EV) model which looks at expectations that individuals desire and links them to our behaviors. The expectations can be either a positive and or negative experience depending on one's judgement; however, this development allows for one to form an opinion or behavior (Hennessy et al, 2018). For example, during COVID-19, many mental health professionals, despite experiencing COVID-19 themselves and having to struggle, wanted to see clients to help those suffering. These mental health professionals looked at the desired behavior of giving back and found the method of teletherapy to be a successful intervention. The

judgement created was to help patients remain connected rather than isolated, and by utilizing the teletherapy model, their patients would still be able to process and engage in treatment (Hennessy et al, 2018).

In Vogel et al (2005), the authors utilized the theory of reasoned action to explain different psychological factors such as social supports/norms/stigma, self-disclosure, and the purpose of the behaviors of following through with relation to one's attitude. All of these factors were analyzed through the lens of what reason a person would have to seek professional help. The theory was utilized in this study to focus on substance use and the exact reasons and factors that would cause a person to change and align their beliefs to getting support through counselling. This theory helps provide a framework for understanding the reasons why mental health professionals may put their own mental health at risk through the shared trauma they may be experiencing to help the high-risk population of adolescents (Vogel et al, 2005).

The theory of planned behavior (TPB) is an extension of the previously discussed theory of reasoned action. TPB begins with behavior beliefs, or the beliefs and thoughts that one creates prior to following through on an action. This involves reflecting on the outcomes of the potential behavior that may come from the perceived belief. The next step of the theory of planned behavior is known as normative beliefs, in which one's perceived beliefs view the subjective norms as possible elements that may allow or prevent the behavior from happening. The aspect of the process looks at control beliefs that conclude what the behavioral action and response may look like (Ajzen et al, 2011, p. 102).

The theory of planned behavior's focus of looking at intentions, specifically those which a person believes and acts on, focuses on the three factors of subjective norms, attitudes, and the belief and ability of potential control (Ajzen et al, 2011). The utilization of this theory allows for

further contextual understanding for how and why mental health professionals act the way they do based on their perceived beliefs and the outcomes predicted. Mental health professionals perceive the overall social isolation experienced as negatively impacting a client's mental health. The subjective norms during the pandemic have transitioned the method of delivery with services and have led to the utilization of telehealth models. TPB applies to the mental health professionals' goals of non-maleficence and beneficence. Furthermore, this impacts the experience of the mental health professionals themselves as they must deal with their own challenges in this transition. By adapting their services and possibly changing their methodology when working with clients, mental health professionals may experience varied emotions and difficulties.

In George (2004), the author explored the theory of planned behavior with relation to online shopping, specifically with a focus on factors of trustworthiness and the perceived beliefs and controls of having successful results. The perceived belief created was the risk associated with the model of online shopping. The perceived behavior of online purchasing is the amount of control one has and the potential outcome of the expected result of receiving one's product as described. The perceived control is prior to the purchase, as one holds the money and not the goods in question that will be bought. Following the purchase, the individual now does not have the money or the goods bought and creates a perceived perception of potential fear of loss until they receive the perceived end result of the product (George, 2004).

The relation of this literature to the present study ties into mental health professionals perceived beliefs of the outcome of providing services. The question asked attempts to understand how the problem of social isolation relates to the experience of mental health professionals. Mental health professionals see and understand the social isolation impacting not

only the clients but themselves as they are unable to aid their clients during such a challenging time. The perceived goal and plan the mental health professionals hold is from the teletherapy services, where they can continue to assist the client through the challenging time. The reason created starts with the theory of reasoned action which ties to their beliefs. This translates into the theory of planned behavior which in turn translates to the perceived result and goals set by the mental health professionals in order to help their client manage the present crisis.

Although these mental health professionals may have been mandated to transition to teletherapy by their employers as part of their job, ethically, many may have felt that they could not abandon their clients during COVID-19. They also had to adapt their strategies to the present situation. As a result of the way in which these theories affect their beliefs and actions, the experience of mental health professionals is affected by the trauma they may have faced. This idea of vicarious trauma will be explored further through the constructivist self-development theory.

Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner's ecological systems theory explains the impact of one's personal relationships and environment on their development through the model of a multilevel system. In Onwuegbuzie et al (2013), the authors explain Bronfenbrenner's ecological systems theory and the five levels involved, starting with factors closely related to an individual and progressing towards larger societal factors. The closest level to an individual is the microsystem, which focuses on immediate relationships, specifically patterns developed, and responsibilities held that directly impact an individual (Onwuegbuzie et al, 2013). The next level for an individual is the mesosystem which focuses on more distant relationships a person may experience and the impact those relationships may have on each other. These relationships could involve those at home,

work or school, and social life, as well as how these relationships intertwine and affect each other. One example is an individual who ends a relationship that they are very invested in. As a result of this situation, they may face difficulties opening up to other potential long-term partners in the future (Onwuegbuzie et al, 2013; Erickson et al 2018).

The next two sets of systems focus less on an individual's direct relationships and more on the factors of their environment. As such, the third level is the exosystem, which explores how a factor or experience caused by one's environment can impact an individual and the way in which they react. For example, if an adult's work life is very stressful, it may have an adverse effect on their wellbeing, which may translate to them being more aggressive or on edge around friends and family. The focus is how a factor outside of one's control, such as stress at work, then impacts another factor, such as stress at home.

The next system is the macrosystem, which includes factors such as societies, communities, and polices that circuitously affect all individuals. In the context of our study, the COVID-19 pandemic was on the level of the macrosystem, as changes to polices were made which in turn resulted in changes to everyday life. Rules regarding social isolation made it so individuals were unable to be within six feet of each other, thereby prohibiting social gatherings. This directly impacted the way mental health professionals had to engage with their clients, effectively necessitating the shift to the telehealth model (Onwuegbuzie et al, 2013; Erickson et al, 2018).

The last system is the chronosystem. The chronosystem emphasizes the development of adolescents and the relationships that interplay during the life span of a child growing up (Swick & Williams, 2006). In the context of adolescents, this theory explores how certain changes in the environment directly and indirectly alter an adolescent's experiences, which could have an

impact on their personality and development. The COVID-19 pandemic impacted adolescents' ability for growth and development by changing the "norm" of what adolescents would typically engage with in relation to social interaction with peers, experiences with in-person learning, and allowing for self-exploration in their identity. For instance, in Hamer et al (2009), children were analyzed based on time spent using technology and physical activity, finding that those impacted by less physical activity were specifically within the age range of nine to fifteen years old. These deficits can lead adolescents to experience psychological distress, which can later lead to further mental health problems. These findings identified that adolescents impacted by lower levels of physical activity will have great struggles with their mental health when entering adulthood (Hamer et al, 2009). These factors impeded on lives of adolescents based on the COVID-19 element that was directly correlated to the macrosystem and the changes in policy (Swick & Williams, 2006; Erickson et al 2018).

In Swick & Williams (2006) it discusses the many adverse challenges families may experience that can directly impact adolescents. To further understand how these challenges can affect adolescent development, the systems in Bronfenbrenner's Ecological Theory may provide context to direct and indirect factors which may cause stress and explain potential changes in behavior. These changes then must be addressed by the mental health professionals that they see during this time. The mental health professionals have had to adapt to the requirements of the macrosystem with technology, using different modalities to address the potential problem of social isolation for the clients and then the shared trauma experience that both the mental health professional and adolescent are going through. As mental health professionals, they must look at the microsystem which is directly related to an individual's immediate relationships and impacted behavioral patterns. Mental health professionals also must recognize the mesosystem

and ecosystem to see other environmental relationships and patterns that are occurring in adolescents' lives, such as school, social engagements, and the new norm of social isolation. Furthermore, the chronosystem is even more important for mental health professionals working with adolescents, as this present experience can alter the normal trajectory of a child by leading to mental health struggles or changes to one's personality (Swick & Williams, 2006; Erickson et al 2018; Onwuegbuzie et al, 2013).

With all the changes and demands mental health professionals are enduring, with little preparation to guide them, the factor of shared trauma and the impact it has on the providers as previously seen by other communities' crises can take a toll. This could impact a mental health professional's own personal mesosystem as the shared trauma could play a factor in their role to provide services to their clients (Onwuegbuzie et al, 2013; Erickson et al 2018).

Tosone (2019) discusses shared trauma by analyzing crises from natural disasters to mass shootings and terror attacks, and the impact they can have on communities as well as the mental health professionals treating those affected. The experience of such trauma, if untreated, can change one's perception and outlook, which can alter one's typical functioning (Tosone, 2019). To address these challenges that mental health professionals experience, the recommendations include supervision, further training, and other forms of professional support as a means to help decrease symptoms of such shared trauma and shared stress experiences (Tosone, 2019).

Constructivist Self-Development Theory

Mental health professionals remain in a very vulnerable position when working with their clients. As counselors continue to work with clients who have and or could be experiencing trauma in the moment, these constant exposures may start to take a toll on the providers

emotionally. It was previously thought that based on the mental health professionals' experiences, their response to client trauma could be explained through the context of burnout and countertransference. Trippany et al (2004) explain that while mental health professionals work with clients who are survivors and/or presently going through a traumatic experience, the providers can experience what is known as Vicarious Trauma (VT). The most common forms of trauma providers experience as a result of their clients' trauma include physical, emotional, and sexual abuse, as well as adverse childhood trauma, domestic violence, natural disasters, and terrorism (Trippany et al, 2004).

Mental health professionals have had to manage the pandemic not only on an emotional level, but also on a functional level by having to switch their practices to remote and finds ways through technology to continue to provide services. With the present adjustment, mental health professionals were still having to provide services to clients, which further perpetuated the trauma the mental health professionals themselves may have been experiencing by adding the burden of their clients' experiences. This experience can be described and understood through the self-constructivist self-development theory. Whereas vicarious trauma focuses on the impacts of the patient's trauma on the mental health professionals, self-constructivist self-development theory emphasizes the impact that this trauma can have on the self. Therefore, constructivist theory takes vicarious trauma one step further to understand the affect another's trauma can have on a mental health professional. Furthermore an individual who has been impacted by vicarious trauma can have the symptoms that are experienced and the impact on their life monitored through the lens of the self-constructivist self-development theory by monitoring the developments of further impairment or progression with functioning (Trippany et al, 2004;Saakvitne et al, 1998).

The self-constructivist self-development theory focuses on how an individual's experience of a traumatic event and their history can be an indicating factor to the way the trauma may impact and develop in an individual (Saakvitne et al, 1998). McCann & Pearlman (1992) explore their different factors that further explain the focus of treatment and the overall interpretation of the experience. These factors include cognitive schemas, self-capacities, and intrusive trauma memories. This theory can provide a deeper understanding of VT that is experienced by providers encountering individuals who have experienced their own trauma.

An individual's own view of themselves, the subjective norm they subscribe to, and the ways in which they fit into society, can all be understood through cognitive schemas. An individual's own cognitive schemas explain how they see themselves fitting into the overall bigger picture of the world, while also identifying how they believe they fit in on a micro level. This micro level could include the individualistic view on feelings of safety within themselves and their surroundings, levels of comfort they have created for those around them, the strength of developed relationships, and the feelings of closeness as well as one's own comfort level for being independent (McCann & Pearlman, 1992).

With these experiences, individuals can predict, based on past and present familiarities, ways of reacting to potential future experiences. Similarly, this method can be used as a defense mechanism to help individuals predict an experience and the potential outcome with the impact it could have based on their lives. This idea can be understood further with PTSD, as responses to certain situations often draw from previous experience. The past experiences that control one's perception and belief are intrusive trauma memories. These intrusive trauma memories act as a reminder when faced with a situation that can trigger a past memory of an experience (Saakvitne et al, 1998).

One's ability to manage their thoughts based on their experiences comes from the factor of one's capacities, which is dictated by the amount an individual can handle and manage. The amount one can manage is dependent on one's self-confidence. Furthermore, one's unique experience impacts one's capacity and allows for each individual to be able to manage their trauma at different levels. With mental health professionals coming into contact frequently with clients who have created many of their own unique cognitive schemas, mental health professionals are able to draw on their own cognitive schemas by finding the best ways to treat these patients with the interventions and theories available (Saakvitne et al, 1998). In regards to COVID-19, mental health professionals may have varied experiences in managing their trauma while also tapping into their own cognitive schemas. These experiences can be further explored in this study.

Conclusion

The four theories listed above help to provide context to the overall pandemic through the lens of mental health professionals' beliefs and the decisions they make towards assisting their clients. Mental health professionals can look at the many different layers of Bronfenbrenner's Ecological Systems Theory to explore and understand the impact that the COVID-19 virus has had on their clients based on the micro and macro level. At the same time, mental health professionals have had to become more mindful of themselves and the shared trauma experience to ensure they can continue to effectively maintain and remain aligned to their beliefs systems. They also must plan accordingly with providing services that they recognize align to the ethical value of beneficence.

Section 5: Research Question

Introduction

This section will discuss the overall research question of this study, its significance, and the three sub-questions that the research question will be broken into. This study sought to understand the experience of mental health professionals working with adolescents with previously diagnosed mental health disorders during the Covid-19 pandemic. While the literature review provided an overview of the existing data on the impacts of Covid-19, further research is necessary to understand the therapeutic experience in particular. Furthermore, the experiences of mental health professionals working with a specific subsection of adolescents has not been well-documented and it is necessary to understand these viewpoints through qualitative measures.

Research Question

What were the experiences of mental health professionals who provided counseling to adolescents with psychiatric diagnoses during the COVID-19 pandemic?

The experiences of mental health professionals during COVID-19 may be similar for individuals on average. However, the experiences of mental health professionals working with high-risk adolescents may be understood differently based on the previous nature of the therapeutic dynamic, paired with the challenges of the pandemic. A qualitative framework is the best way to complete this investigation. By answering this overall question, the research team has been provided with a deeper upstanding of the mental health professionals' needs and experiences in working with a high-risk population. This also allows for future research to addresses any reported challenges or gaps discovered.

Sub-questions

How has social isolation impacted mental health professionals as they transitioned to teletherapy?

The pandemic has caused significant social isolation as mental health professionals were unable to provide services in-person due to fear of contracting the virus themselves or putting their patients at risk. As a result, evaluating the effects of social isolation on the mental health professionals themselves, as well as how the effect it had on their students impacted them is necessary. This evaluation is necessary to the field of social work, as through understanding this issue, we can work on improving our skills with individuals who faced the effects of social isolation.

How has technology impacted the services provided?

The immediate solution to social distancing during the pandemic was switching to a teletherapy model that could be conducted over platforms such as Zoom. Furthermore, these services have continued to be used despite the lifting of lockdown. However, given the societal reliance and utilization of technology, many challenges exist with this new form of providing services. It was critical to identify how the use of technology has impacted these services when no other option was available and students were in need.

"How has the shared trauma of COVID-19 impacted mental health professionals?"

Mental health professionals, just like their students, have been impacted by the changes of the pandemic and are undergoing this shared traumatic experience. Recognizing the trauma that exists for mental health professionals was extremely necessary as they continued to work with students undergoing the same challenges. If the needs and experiences of mental health professionals were not understood, their own health and the services they provide to their

students could be compromised. The precise methodology to be used to explore these questions will be discussed in the next section.

Section 6: Methodology

This section will discuss the methodology design utilized in this study including the type of research conducted, as well as the reasons behind the selected design, the participant sample that was used, the collection method and data analysis, ethical practices, credibility, and researcher bias. This study sought to better understand mental health professionals' experiences in working with adolescents diagnosed with psychiatric illnesses through the factors of shared trauma, technology, and social isolation. These topics were explored through a phenomenological approach with qualitative analysis via interviews. The objective of this study is to gain a further understanding of mental health professionals' experiences during the Covid-19 pandemic with a focus on the three moderators.

Definitions

Social Isolation, as defined in this paper, identifies feelings of disconnectedness and experiences of emotional and/or physical distance (Taylor et al, 2018). The lack of connectivity in society during the COVID-19 pandemic was a result of the necessity of individuals to physically distance themselves from one another to prevent further spread of the virus. With the constant fear in society of getting sick, social isolation mandates were issued worldwide to help prevent the spread of the virus. Individuals continued to remain connected via telephonic or virtual means; however, the attempt to remain connected remotely was a new concept that lacked the same attributes involved in physical contact. The social isolation that was subsequently experienced had a direct correlation with increased mental health issues (Wright et al, 2017).

Shared trauma is understood when both the client and the mental health professionals are experiencing the same crisis concurrently (Tosone et al, 2016). With the pandemic, all individuals were affected and at risk of contracting the virus, regardless of age, race, or gender.

The pandemic instilled fear in many individuals regarding if they or their family members would become ill and what the outcome would be. With many deaths occurring during the COVID-19 pandemic, most people either experienced or know someone who experienced the COVID-19 virus symptoms. With both the client and mental health professionals potentially experiencing the same fears and challenges, providers re-experienced their trauma and had constant reminders of the damage the pandemic had done (Tosone et al, 2016;Tosone et al, 2011).

Technology within reference to the present study is defined as the usage of electric devices that allow for connection to others (Lustgarten et al, 2020). Due to the mandated lockdown and the fear of contracting the virus, many services such as classrooms, meetings, and doctor appointments were forced to transition to remote methods (Irman et al, 2020). Thus, technology was the bridge that allowed for the continuation of therapeutic services within a safe distance to prevent the spread of the virus.

Therapeutic schools can be defined as a specialized environment that provides support for students that may have difficulties emotionally, educationally, socially, and behaviorally (Kuo, 2017). By understanding the population these types of schools serve, one can further obtain a deeper understanding of the impact of COVID-19 through the lens of the mental health professionals.

Research Design

Existing literature on the experiences of mental health professionals is scarce. Regarding research on mental health professionals in general, the current main focuses are the impacts and utilization of different modalities with clients, as well as past traumatic events and the changes that follow them. However, little research focuses specifically on the perceived experiences of mental health professionals. Presently, most research focuses on macro topics rather than micro.

By understanding the experiences on a micro level, researchers can start to help identify common themes which can provide a greater overview and context to the bigger picture of the macro topics.

The current literature has focused on shared trauma experiences such as 9/11 and the Virginia tech shooting, as well as the impact they have had on the community both directly and indirectly. Furthermore, the present research from this experience has shown the role that providers take and the challenges that are faced when these mental health professionals have also experienced this trauma firsthand. The COVID-19 pandemic has become a more macro event that has and continues to impact both clients and mental health professionals. On this larger scale crisis that has continued to impact society, many other factors in both clients' and providers' lives have been affected. These factors include social isolation and the necessary transition to utilizing remote technology.

Previous literature has discussed social isolation and the impact that it has had on the mental health of adolescents and the older generations. However, there is minimal literature on the experiences of mental health professionals and what they have done both personally and professionally to manage the social isolation caused by the COVID-19 experience. Similarly, there were previous studies conducted with technology and providing remote services due to limitations communities faced due to location and access. Individuals were able to travel if they wanted to, but the availability to therapy was made more accessible by the presence of remote services. However, due to COVID-19, many providers went fully remote, and this change was due to public safety which took away the aspect of choice. There is limited data regarding this transition and the impact it has had on the mental health professionals and their experiences while maintaining the therapeutic relationship. This research study hopes to bring understanding

to the experiences of mental health professionals working with adolescents diagnosed with psychiatric diagnoses during the pandemic with the factors of shared trauma, technology, and social isolation.

Phenomenological Approach

The analysis of this study used the phenomenological approach, which allows for the exploration of a lived experience in the context of a deeper underlying present phenomenon (Creswell & Poth, 2018). Within this type of research design, the phenomenon being explored is set up to potentially present perceivable patterns within the multiple participants included. In selecting active participants, each individual must be a part of or have experienced the studied phenomena. Those participants typically present their story through structured interviews, with the potential to provide answers based off the questions asked. This information is typically recorded onto a device or a system capable of capturing the questions and answers. Once the data collection is gathered from the response statements, the researcher transcribes the transcription of data onto a document via the computer or hand writes the questions asked and the participants' responses. The next step is the data analysis, which looks at identifying major concepts and findings that could later be developed into themes. Once all transcriptions are analyzed, themes can be identified, effectively analyzing the data from a qualitative vantagepoint. This process continues until either all participants identified are interviewed with enough themes for analysis or until saturation is achieved (Creswell & Poth, 2018; Padgett, 2016).

Limitations of Phenomenological Approach

There are some challenges with utilizing the phenomenological approach. The first limitation is that the researcher must ensure the participants chosen are not those that are familiar

with or can present any conflict of interest. Likewise, if a participant does not answer some questions, it can discredit the emergence of some themes that otherwise would have proven a stronger result in probability of becoming a main theme. Furthermore, researchers must make sure that they keep their own thoughts and beliefs at bay when identifying and interpreting themes to avoid any personal bias to be included. The focus is to ensure that the researcher is able to remain open minded to the themes identified and allow for the interpretation to not include one's personal beliefs, thoughts, or direction to prevent bias. Lastly, qualitative research as a whole can feature limitations that include the difficulty in its ability to attribute correlation to causation, the lack of generalizability and reliability of the findings, and the time-consuming nature of the research (Creswell & Poth, 2018; Padgett, 2016).

Data and Subjects

The data collected for this study involved mental health professionals with a clinical license in a psychiatric school setting. As with most qualitative research, the most common method of sampling is a purposive sample (Padgett, 2016). The process for selecting the subjects through a purposive sample is due to the desired necessity to have participants who are knowledgeable and have experienced the phenomena that is being studied. Campbell et al (2020), defines purposive sampling as a method of selecting participants that strongly fit the criteria needed to provide a lush amount information in the desired field of study. Furthermore, with purposive sampling, it focuses on the importance of the participants drawing on their unique experiences while integrating the general topic or phenomena of interest that is being studied (Campbell et al., 2020). The sample utilized in this study was limited to mental health professionals who hold professional degrees and that work in schools for children with psychiatric diagnoses.

Participant recruitment began with contacting therapeutic schools in New York and New Jersey. Schools were found by utilizing Google Search, and each school discovered through Google was further investigated using its website in order to ensure that it was an existing therapeutic school in one of these two states. The researcher contacted these schools by calling the main number listed on the website and requesting to speak to either the clinical director or the principal. The researcher was either redirected to one of these individuals or was told to leave a message to which the school contact could contact the researcher if interested in the study. If the researcher spoke to the clinical director or principal, they would explain the objective and methods of the study. Early in the study, if that individual was interested, the researcher would send them a follow-up email with the solicitation letter, including the consent and confidentiality agreements (refer to Appendix D) to be passed along to the mental health professionals at the school. Once a mental health professional contacted the researcher as a potential participant, the researcher would then provide them with the demographic survey to see if they met the inclusion criteria and did not meet the exclusion criteria. However, after reaching out to a handful of schools and having challenges with recruitment, the researcher began to include the demographic survey in the initial email to the school contact. If the researcher did not hear back from either the clinical director or the principal at the school, he would reach out a second time.

After a potential participant responded to the demographic survey, the researcher would inform them as to whether they had fulfilled the requirements for the study. If the potential participant was eligible for the study, the researcher would coordinate with them via email to determine a date and time for the interview. The participants were informed that the interviews would last for approximately thirty minutes, though interview lengths ranged from twenty to forty-five minutes. Each interview was conducted using Zoom, which generated automatic

transcripts that were saved to the researcher's computer. Immediately following each interview, the researcher would send a follow-up email to the participant thanking them for their completion of the interview. The researcher would also immediately send a $15 Amazon gift card to their email as well as a list of resources should the participant need additional support.

The inclusion criteria in the study limited the participants to clinical mental health professionals working in either New Jersey or New York, being fully licensed to practice in the state in which they work and working in a therapeutic school's clinical department directly with adolescents ages 10 to 18. The staff could be employed either part time or full time. There were no inclusion criteria as to the number of adolescents on the participant's caseload, as long as the mental health professionals engaged in providing services to their patients remotely during the pandemic.

The mental health professionals also must have been employed during the pandemic at the school for a minimum of six months and have had at least two years of service working as a mental health professional. Participants must have been at least three years post-license. Accepted clinical licenses included doctor of psychology (PsyD), clinical psychologist (PhD), licensed school psychologist (LSP), licensed clinical social worker (LCSW), licensed social worker (LMSW), licensed professional counselor (LPC), clinical social worker (CSW), licensed social worker (LSW), licensed marital family therapist (LMFT), creative arts therapist (CAT), or psychiatrist (MD). Furthermore, the mental health professionals must have met with students no less than biweekly. The exclusion criteria included mental health professionals that did not work in New York or New Jersey and did not directly work with adolescents ages 10-18 on a clinical level of one-on-one treatment.

As mentioned previously, the goal of the number of participants to be included ranged from 10-15 interviewees or until saturation was reached. Mental health professionals were recruited from multiple locations with the intention of obtaining both diverse participant samples and school populations. Creswell and Poth (2018) explain that *saturation* is the point of acquiring a sufficient amount of data required for a study. Saturation may or may not have been reached with the designated number of participants selected in the research design. Recruitment included contacting clinical directors of therapeutic schools. The researcher reached out to potential school directors via phone or email as a means of potential recruitment. These clinical directors then distributed the information to the mental health professionals who work at the school. Since saturation was not reached using this method, contacting professionals through snowball sampling and posting to Facebook groups specific to mental health professionals was used as a secondary form of recruitment. Snowball sampling utilizes the researcher's connections to ask individuals if they know of other people in the community who may be interested in the study, which in turn starts a chain reaction to find potential participants for recruitment (Noy, 2008). As previously discussed, the data collection process was done by the researcher with one-on-one interviews in an open-ended format, using the virtual platform Zoom. The mental health professionals that were interviewed must be licensed and practicing in either New York or New Jersey. Participants received a $15 virtual Amazon gift card for their participation in the study, regardless of whether they completed the study.

Limitations Of the Sample

One limitation of purposive sampling is that the research conducted cannot be generalizable to the study's entire population. Furthermore, another limitation is that due to the research being conducted solely in New Jersey and New York, the results cannot be generalized

across other states where psychotherapy practices may differ. In addition, the sample was limited by the challenges in recruitment faced during the data collection process of this study. While the sample achieved saturation, the study ultimately featured fewer participants than expected and participant recruitment to reach saturation took much longer than expected. Therefore, limitations exist in the small sample size used to collect data for this study. This limitation, as well as the theories behind the challenges in recruiting participants, is further explored in the Discussion section.

Procedures

Prior to each interview, to ensure that the participants selected met the criteria for the study, each potential candidate will receive the information in Appendix B. These potential candidates received the information through Qualtrics using a confidential survey for the vetting process for participants. These individuals provided demographic information in order to determine if they met the inclusion criteria. Once these potential candidates were deemed to be appropriate participants for the study, participants then underwent the informed consent process. Participants were informed prior to the start of the interview of the voluntary nature of this study as well as the purpose of the study. Consent was given through a form that all participants were emailed to sign and send back to the researcher prior to the start of the interview. All recorded information was placed into a file on the researcher's laptop that was protected by a password for access to review any information. The designated computer that held the data also required a different passcode to unlock it to ensure further protection of participant data. The researcher plans to delete all consent forms and identifiable data from his computer in three years from the completion of this study. Furthermore, these individuals were given a list of mental health resources at the time of receiving the informed consent, in the event that the interview brought

up challenging emotions or reminders of past trauma. Participants were made aware at the start of the interview that if at any point during or after the interview, they no longer wished to take part in the study, they had full ability to withdraw.

Measurements

Before the interviews started, the researcher collected the demographic information, such as gender, age, years of experience in the field, highest academic degree achieved, the state in which the participant is employed, ethnicity, and the clinical licensure held. The questions listed below were utilized to answer the research question. Each interview was semi-structured, such that the questions were used as a guide to generate conversation but allowed for follow-up and further discussion.

1. Tell me about your experience working with adolescents prior to the pandemic and during the height of the COVID-19 pandemic.
2. How did social isolation affect you?
3. How did social isolation affect your practice as a mental health professional?
4. How did the use of technology and telehealth services affect you and your practice as a mental health professional?
5. How did the trauma of the patients you worked with affect you?
6. How did the trauma of the patients you worked with affect your practice as a mental health professional?
7. Reflecting on your experiences, what challenges, if any, have you experienced that are unique to this population and setting?
8. Can you compare your experience today with your experience at the height of the pandemic?

9. What do you see for the future of the field of psychotherapy based on your experience during COVID-19?

10. What motivated you to stay in this position during the pandemic?

The questions listed below were utilized to gather basic demographic information to further provide support and context to the participants involved in the study

1. What gender do you identify as?
2. What ethnicity do you identify as?
3. What is the highest level of education held?
4. What state are you employed in?
5. How many years have you had your license for?
6. What is your specialty or focus on in the field, if applicable?
7. Which clinical license degree do you presently hold?
8. Do you work as a direct provider of mental health services for your clients?
9. How frequently do you meet with your students?
10. How long have you worked at your present place of employment?
11. What is the age range of your present case load?

Trustworthiness and Rigor

As defined in Elo et al (2014), trustworthiness includes key concepts such as dependability, credibility, transferability, conformability, and authenticity. Dependability ensures that the data remains credible and can be utilized within multiple different scenarios. Transferability focuses on identifying if that data can be utilized for other groups and individuals who are similar to the participants studied. Authenticity is explained as ensuring the research

shows an open and honest perspective from all sides and displays any possible realities that the research may find. Credibility refers to ensuring that the data found remains accurate as depicted in the study plan. Lasty, Conformability refers to the objectivity of this study. This objectivity can be explained by the ability of two individuals to agree on a study's significance or accuracy (Elo et al,2014; Shenton,2004). To ensure the trustworthiness of this study, the researcher's connection to this topic is disclosed here. The researcher has experience working directly with adolescents, in collaboration with various mental health providers, both in-person and virtually.

In order to achieve this definition of trustworthiness with the aspects that it entails, this study carefully employed its methodology. Firstly, this study conducted in-depth interviews to gain a detailed understanding of the participants' experiences. Secondly, while the data was analyzed in order to highlight certain themes, the researcher ensured that all realities of the mental health professionals' experiences were shared, whether they align with the general factors identified or whether they do not. These two methods ensure that the study remains authentic, credible, and conformable. In order to ensure that dependability is met, mental health professionals at multiple schools across New York and New Jersey were interviewed. Furthermore, to meet the specifications of transferability, multiple mental health professionals at different schools were interviewed rather than obtaining the experience of one mental health professional or mental health professionals from one school.

Qualitative research, unlike quantitative research, can have difficulties with generalizability. In the case of this study, data was collected from the interviews of mental health professionals. To ensure accuracy, the selection process of participants was conducted by reviewing the necessary criteria for the study, which was outlined and available for selection

from the Qualtrics survey. To ensure that the data reported remains rich, quotations were highlighted from amongst the participants to further help identify links between each data set.

Data Analysis

The interviews conducted were transcribed with a transcription software. The software that was utilized to conduct, record, and transcribe these interviews was Zoom. Once the interviews were fully transcribed, they were uploaded onto ATLAS.TI. Following the transcription of each interview, the researcher utilized the option of creating memos to highlight certain aspects of the interview that could correlate to potentially significant topics. Parts of the interview that were also highlighted include potential connections to existing literature discussed, as well as connections to themes or ideas that could potentially be explored further in the literature review. Following the process of creating memos, the researcher then began the process of coding using Microsoft Word. The researcher coded by identifying significant phrases, sentences, and sections from each data set. Following the initial process of coding, the researcher then reviewed each data set to identify similar codes that can be combined. After completing the most recent round of coding, the researcher started to identify general themes. Once multiple themes were identified, the researcher then wrote up the present themes, while also reviewing and adding to the present literature review based on the findings (Creswell and Poth, 2018; Padgett, 2016).

Ethical Consideration

It was imperative that ethical dilemmas were considered and addressed throughout the different stages of the study. As discussed in Creswell and Poth (2018), it is crucial that the identifying information of all participants remain confidential. This includes any piece of information that can be traced back to a participant. Furthermore, each participant was assigned

a number on an excel sheet that remained in a locked folder requiring a passcode. Each file inside the locked folder contained the recorded information from each participant to further ensure confidentiality. The computer that the data was carried on also had a separate password that is different from the folder to ensure an extra layer of protection.

As previously discussed above, participation was entirely voluntarily. In the informed consent process, all participants read the requirements of the study and were informed prior to the start of the study that their participation is voluntarily. Participants were also informed that they could withdraw from the present study at any point if they wished to do so, and that they were also able to decline answering any questions. Furthermore, following the interview process, participants were provided with a resource page should they feel like they are in distress due to participating in the interview questioning. This resource page included a list of mental health providers in the case that the need arose to speak with a trained professional (refer to Appendix E).

Furthermore, participants were ensured that Zoom would remain a safe space on the part of the researcher throughout the duration of the interview. This “safe space,” as defined by the study team, is a place where individuals can freely share their experiences and feelings without fear of judgment or a leak of confidentiality. Participants were also encouraged to ensure they were present in their own safe space prior to the start of the interview. This information was included on the consent form, and individuals were also asked to verbally verify at the beginning of the Zoom call that they are in a safe space. If the individual felt at any point prior to or during the interview that they are no longer in a safe space, the researcher notified the participant that they are free to cancel or reschedule.

Section 7: Findings

This study sought to explore and answer the following question: *What were the experiences of mental health professionals who provided counseling to adolescents with psychiatric diagnoses during the COVID-19 pandemic?* This question was explored through the lenses of social isolation, technology, and shared trauma.

Eight licensed mental health professionals at six therapeutic schools in either New York or New Jersey participated in semi-structured interviews. Three schools and three participants were practicing in New York, while the other three schools and five participants practiced in New Jersey. All of these participants had experienced remote clinical work with students during the height of the pandemic. The majority of participants (N=6) reported experiencing social isolation and/or seeing the impact it had on their clients, while many of those same participants (N=5) also experienced shared trauma.

Additionally, many of the mental health professionals identified the complexities of communication and engagement with students, which were both affected by telehealth, social isolation, increasing mental health challenges, and mask wearing. Crossing of boundaries and feelings of helplessness was also an important subject to breech during these interviews; they were significantly impacted through the changes the pandemic caused and the adaptations that mental health professionals had to make to accommodate their students.

The themes below provide a comprehensive look at the experiences of eight individuals and provides us insight to begin to analyze the changes caused by the Covid-19 pandemic. In order to truly understand the voices of all individuals involved, it is necessary to highlight the most common themes while also featuring views and experiences that were less commonly

discussed during these interviews. Thus, the findings below attempt to demonstrate the diversity of thought that can be expressed by a variety of individuals in a similar clinical scenario.

Demographics

The following table consists of the participant responses to the demographic survey questions presented in the Methodology section.

QUESTION	PARTICIPANT RESPONSE
GENDER	
FEMALE	75%
MALE	25%
ETHNICITY	
WHITE	62.5%
OTHER, UNSPECIFIED	37.5%
HIGHEST LEVEL OF EDUCATION HELD	
MASTERS DEGREE	87.5%
DOCTORATE	12.5%
STATE	
NEW YORK	37.5%
NEW JERSEY	62.5%
YEARS IN PRACTICE	
0-10	12.5%
10-20	12.5%
20-30	50%
>30	25%
SPECIALTY	
ADOLESCENTS	37.5%
OTHER	62.5%
CLINICAL LICENSURE	
LCSW	75%
SCHOOL SOCIAL WORK CERTIFICATE	12.5%
LPC	12.5%
ROLE	
DIRECT PROVIDER	100%
FREQUENCY OF SESSIONS	
DAILY	37.5%
WEEKLY	62.5%
LENGTH OF EMPLOYMENT AT SCHOOL	
0-1 YEARS	25%
1-5 YEARS	25%

5-20 YEARS	12.5%
>20 YEARS	37.5%
AGE OF STUDENTS	
HIGH SCHOOL	100%
MIDDLE SCHOOL	37.5%

Table 1. Participant responses to demographic survey.

As one can observe in Table 1, the majority of participants identified as female and White. Most had completed a master's degree in their field, while one had a doctorate. Many of these individuals had been in practice for many years, with six of the eight having practiced for at least twenty years. A few of these individuals specialized in adolescents, and the majority held an LCSW as their clinical license. All eight of the participants held the role of directly providing services to the students, and all verified meeting with each of their students at least once weekly. The length of employment at their school varied significantly. While the IRB-approved standards mandated that each participant work at that specific school for a minimum of six months, one participant had been working at her school for only two months. However, based on this participant's extensive clinical background and experience with adolescents at therapeutic schools, the decision was made by the researcher and the chair of the dissertation's committee to include this participant in the study. Furthermore, all participants confirmed working with high school students, with three of these individuals also working with middle school aged children.

Social Isolation

The Personal Effects of Social Isolation

When asked about feelings of being socially isolated during an emotionally challenging time, participants reported the impact that social isolation had on their own lives, the lives of their families, and the lives of their patients. Not only were these mental health professionals concerned about their patients, many of whom had additional struggles which social isolation

had made more complicated, but they dealt with these emotions while also feeling a sense of isolation personally. For all (N=8) of the individuals participating in this study, the pandemic necessitated working from home and limiting social contact. This required them to balance their work life of caring for their students as well as their own personal struggles. Every participant but one expressed being personally impacted by social isolation.

For the majority of participants, social isolation was dictated by the physical distance from their original work environment. For example, when asked about his personal experience, Mike stated that:

> "The big difference, I guess, between working prior to COVID and during the pandemic, was the isolation that I felt as a clinician myself because I'd no longer had my colleague down in the hall or in the next office that I can go bounce ideas off of as readily as I could when we're in the building. So that was isolating."

He later went on to say that "I missed seeing my colleagues. I missed sharing communal space." For Mike, not having the shared workspace with colleagues he could interact with had a significant impact on his everyday life. Being able to bounce ideas off of his colleagues also made him a better clinician and made him feel more comfortable in his client care-related decisions. Similarly, Bryan expressed the challenge that this isolation brought to his life and the disconnection it created, "I missed people, and I missed the interaction… so socially, I was terrible." Like Mike, he also "missed sharing communal space." For both Mike and Bryan, the mere presence of others in their work environment provided a level of social stimulation they needed on a day-to-day basis.

Robin also felt the burden of isolation from her colleagues and school environment. At first, she mainly observed that her family dynamic was affected by watching her children stay

home from school. She stated, “at home, it impacted me just because my kids were isolated from their friends, their sports, almost everything.” While observing the effect of social isolation on her children, she then went on to comment on the personal effect it had on her life when she was unable to work with her colleagues, “And then you're alone in your house. You're not in a school full of colleagues, and you know the whole life of the school. So you're kind of isolated.” For these individuals, working at the school they were employed at appeared to represent not only a job, but a community of colleagues that allowed them to socially connect with others during their everyday life.

Laura, on the other hand, was the only participant to note that she had not been personally impacted by social isolation. While she observed it happening to others around her, she had not experienced feeling socially isolated during this time. It is important to note this minority experience in order to represent the diversity present among individuals facing the pandemic.

The Social Isolation of Students

The majority of participants expressed their concern for their patients, many of whom had mental health and behavioral struggles that were often aided by social connection. While Laura noted that while she personally did not experience the effects of social isolation in her own life, her “concern was really the social isolation for many of their clients and the inability to get the clients to get back into the social nature of school.” While she noted that some of her students were more introverted and therefore less affected by the loss of in-person social interactions, many others needed these interactions to thrive. Furthermore, Jenny particularly expressed concern for her patients with trauma, many of whom were:

> “All the more traumatized by being isolated, and not having access to what they use to cope, whether it was their sports, or their friends, or going to school and throwing

themselves into the academics and that it definitely exacerbated the mental health issues, that were a result their traumas."

When asked how the isolation affected these students with trauma, she illustrated her concern for the impact that trauma rooted in home and family lives could have on one's commitment to mental health treatment. She stated,

"Not being able to escape it made a lot of the kids give up. Being totally immersed into the environment that has had created the stress, being totally immersed in their family situations, which created the stress, created the traumatic history, really created a sense of hopelessness for them or amplified their hopelessness and a lot, of them stop trying… Stopped…you know, figuratively showing up."

Furthermore, Jenny expressed how this social isolation affected her practice in the lack of support she had when providing services to her students. Her isolation led to a feeling of inability to properly serve her students, as **"**they were in crisis, they were emotionally really isolated and expressing that and didn't have any of the supports that they came to our school to get, and we were expected to continue to provide the same level of care, without having the resources on our end or on their end." In the face of isolation from her colleagues and clinical community, it was not only challenging, but maybe impossible, to give her students the support they needed when she herself felt a lack of support. The isolation from the school environment and from others in her field caused a loss of confidence in her work or ability to provide for her clients. While others did not discuss these fears in as much detail, most participants expressed concerns for their students in being isolated from the peers and typical school environment.

Dealing with social isolation while attempting to maintain normalcy during this time appeared to have had a profound effect on these mental health professionals, whether it be their

own feelings of social isolation or the worries they had for their students. Regardless of the specific concern, the individuals featured in this section, who represented the majority of participants on this topic, faced challenges that impacted their personal life and their life as a clinician. As expressed in these quotes, it appears to have impacted their experience as well as their perceived relationships with their students.

Technology

Since all services were conducted remotely, technology played a huge factor in the experiences of all of these mental health professionals in providing services. While technology allowed these students to continue to receive care, every participant identified benefits as well as challenges and difficulties. Among the challenges identified, these participants noted disrupted sessions and often limited student motivation and engagement. On the other hand, they also commented on the ways in which technology improved the accessibility of care and convenience for students, families, and clinicians. The specifics challenges appeared to vary depending on the individual and their prior experience with technology.

Challenges

The use of telehealth services provided an adjustment for practitioners who were not accustomed to using technology in their everyday lives, which participants noted was further complicated by technical issues such as Wi-Fi and computer breakdowns. Robin expressed her challenges with this transition, as she has struggled with providing services via telehealth. In response to a question regarding her computer proficiency, she described herself as “not what you call computer savvy.” She also explained that she received help from her husband and children in navigating Zoom, as well as troubleshooting Wi-Fi issues. Nevertheless, she often felt like a considerable amount of time was used to deal with technological issues like computer and

Wi-Fi defects, which took away from the session itself. Robin elaborates on this point by explaining that,

> "half of the session with me trying to get things going with the Zoom or with the Google Meet, and then [depending on] whether they have good wi-fi in their house and they were able to connect, a lot of times the session would just be on the phone… We would do it that way, but there was so much that got in the way of the delivery of services that it was extremely frustrating. It's frustrating for them. But it was extremely frustrating for me, you know. I felt like I was banging my head against the wall after the day and trying really hard to do my job."

For Robin, providing services became filled with added inconveniences- many of which negatively impacted her everyday life. This challenge with technology was increasingly complicated by providing technological services from a healthcare perspective and the ethical and legal ramifications of this change. Mike explained that it was an adjustment with "learning all the ins and out of Zoom and every other system that was coming up which ones were compliant with HIPAA, which ones weren't." For Mike, the challenge was not only in learning how to provide services on a new platform with technical complications, but also understanding how to provide services in an ethical and legally competent manner. While Mike was the only participant to make note of this specific concern, the majority expressed concerns regarding adjustments to technology in general.

Technology also challenged providers through their understanding of the students' response to telehealth care. As Rachel explained, "As time went on, I think that it got old in some way. That they felt that there was maybe something more missing in a virtual session. They were able to kind of avoid more direct questions, more direct counseling." According to

Rachel, students seemed less engaged in these virtual sessions, making it more challenging to provide them with the care they needed. Bryan echoed these sentiments and explained that students were also often absent, with Bryan explaining that "there were some who didn't show up." Rachel attributed these changes to their lack of structure during the school day. She illustrated this idea by stating that:

> "At times [they] got used to sleeping different hours because there was a lack of structure to the days… there were often breaks of time that they didn't have a class and during those time they'd often go back to bed and then not wake up on time."

She pointed out that the lack physical presence in school seemed to create a challenging environment for creating structure and providing motivation for the students receiving therapeutic services. For Rachel and Bryan, these difficulties in engagement created new challenges that they had not experienced before the pandemic.

Bryan's concern for his students also extended to their safety and wellbeing. With his students at home outside of the safety confines of the school, he worried about what topics he could discuss with his students. Bryan was particularly careful not to trigger his students or put them in an emotional state that could lead them to hurt themselves or others. He stated, "I'd be very very mindful of when we dance towards difficult topics, knowing that if a student went a little too far and had an emotional time, they could click off, and that was it." He continued to express that with many students at home by themselves, "I had to be very very careful not to put them in a position or let them go to a position where they were going to be in danger if things got too heated." Bryan remained cautious of the specific mental health challenges his students presented with, combined with their present situation of meeting virtually. While he was the only

participant to express these specific concerns, he presented a minority viewpoint that is worth noting in regard to remote therapy.

Positive Effects

While technology provided all of these clinicians with challenges, many were also able to recognize the positive impacts that it can have on the community and the students, particularly in the realm of accessibility. As Catherine expressed, "I think one positive thing that came out of it is telehealth in the sense that it kind of provides access to treatment to people that might not have been getting treatment." Participants described this improvement in accessibility as the ability to make it possible for individuals receiving therapy to access care in a time that they otherwise may not have. They also felt that this accessibility was accompanied by added convenience even after the height of the pandemic. Mike elaborated on this point, "it gave me more opportunity to continue services and provide them. You know with bad weather, people don't have rides and stuff like that so that was a definite positive to it."

Misty emphasized that technology still provides benefit even after the pandemic by allowing students who were unable to return to school to still receive services. At her school, a hybrid system was adopted in Fall 2020, though some families still preferred their children to stay at home from school due to fear of contracting the COVID-19 virus. She stated, "We did have some parents who were fearful of sending students. So we allowed them to participate virtually, even though we were open." This change also made it easier for parents who struggled to balance work and home lives with attending meetings regarding their education. Jenny provided an example of this through one of her student's parents, who didn't "have a place to do an hour long Zoom during the day. And so I meet with them in the evenings and it makes it viable to them. They both live over 40 minutes from the school, and so coming in-person would

be a hardship for them." The added convenience allowed Jenny to engage parents and students more directly and increase communication with students' families. This change could have a positive effect on individuals in the future by providing easier access to education and mental health services.

In addition, the participants reported that an integral piece of their experience during this time related to the increased convenience remote work provided to their own lives. Rachel felt the added flexibility provided an immense amount of benefit while she was fostering a newborn baby at home. She stated that working remote gave her the chance to balance her work life with her home life more easily: "that was really helpful for me to have that flexibility because I also had to manage my own family and kids." She later went on to say that if she was working full time in-person, she may not have been able to accept a newborn at that time. Furthermore, Bryan expressed that the transition to technology "changed [his life] forever." He elaborated on this point, explaining that the changes in mental health services caused by technology have changed his career trajectory through private practice: "my long term plan is to basically go to an all remote model at some point, just because it'll allow me to retire and be wherever I want to be in the world at any time and be able to maintain a practice." For these clinicians, the added convenience can possibly have life changing effects that significantly impact the way they practice.

When asked to describe the impact of technology on their practice during the COVID-19 pandemic, these mental health professionals shared a diverse view of challenges and benefits. However, all of these individuals recognized both the positives and negatives of this major change in their lives and the lives of their clients. The experience of working through technology

during the pandemic allowed them to have a better of understanding of how they want to shape their practice and what matters to them.

Shared Trauma

As discussed previously, shared trauma is understood when both the client and the mental health professionals are experiencing the same crisis concurrently (Tosone et al, 2016). With both mental health professionals and their students experiencing the effects of social isolation and technology on their mental health, six participants spoke about the experience of shared trauma during this time. The other two participants did not feel as though they had experienced shared trauma during their practice. However, for the six individuals who did endorse these sentiments, dealing with their own trauma while also trying to process the trauma of their clients led them to experience the burden of helping those undergoing the similar challenges at the same time. This created complicated dynamics as a few practitioners expressed feeling unprepared to address students' trauma that was a result of the pandemic, something that they as clinicians were unfamiliar with managing. In addition, some of the mental health professionals spoke about observing their students' trauma and mental health issues worsening in the face of these challenges.

Rachel described the difficulty in managing her clients who were dealing with issues she felt unable to support. Although she felt as a professional that "often we deal with our overthinking or anxiety or our negative self-talk," similar to that of her clients, she felt that the effects of COVID-19 pandemic were often too challenging to address as a clinician. She stated, "it was also a reality that we were not familiar with and so I think that was sometimes difficult to be able to manage." For Rachel, the new issues that arose from the pandemic were unchartered territory compared to the issues she was used to tackling. Based on her own anxieties with the

pandemic, she found it challenging to manage her own emotions while also "being able to support and help people through that when we were almost in the same position as well." In addition, her attempt at treatment was complicated by worsening mental health disorders in her students as a result of the trauma. She illustrated these difficulties, particularly when returning to school in-person where students with "anxiety and depression unfortunately regressed a lot, and I think that was really difficult to see as a therapist."

Catherine also spoke about the trauma she observed in her students. Since most, if not all, of her students had prior mental health issues, the pandemic "added so many different layers to that anxiety or depression." These layers created increasing complexities in her students, making it more challenging to face these issues and treat them. Jenny also noted that many of her students had previous trauma, exacerbated by "all of the things that normally complicate their trauma like lack of resources, lack of food, lack of supervision, all of those things, were really amplified." These lack of resources, food, and supervision were complicated by the pandemic as many parents lost their jobs or had to work from home. This ultimately led her to feel like "I couldn't provide to the families." While Jenny, like Rachel, also experienced feeling lost on how to target the issues her students were dealing with as she simultaneously experienced similar trauma, she additionally expressed a feeling of comradery with her students and coworkers due to this fact. "This was new to all of us, that even though I was struggling with how to figure out how to do groups on Zoom, everybody else was also and the kids were figuring it out also and so that set this COVID sense of we're all in this together. That really got me through it." Rather than feeling unsupported, she felt a comfort in knowing that learning how to handle these issues was new for everyone.

Mike discussed recognizing the novelty of this shared experience that both himself and his students were working through. Like Jenny, he also appreciated a sense of commonality with his coworkers and students. During this period, he stated that "I didn't really have it all figured out yet for myself, and as I was working with my clients helping them figure it out, and it was kind of a mutual thing so we're going through this experience together. It was a shared experience that we were going through and that doesn't really happen very often." While he faced challenges through this process, he also expressed that the shared experience served to foster his relationships with his students. He added that there was additional trauma directly related to the effects of the pandemic due to social isolation and fears of the virus itself. However, he found it increasingly more difficult to process these feelings in the absence of his regular in-person work environment. He stated that it was "more exhausting to do it in isolation, especially when you're absorbing all this trauma that you hear from people and not necessarily having the debriefing opportunity with colleagues." The shared trauma he experienced was compounded by social isolation, in which he did not have the comforting environment he needed during a difficult transition.

Facing shared trauma presents a unique challenge that many mental health professionals expressed not knowing how to directly address. The COVID-19 pandemic created problems unforeseen, causing a difficult transition for many individuals around the world. The consequences on the children these clinicians served, many of whom had previous trauma and mental health disorders, led to challenges for the therapists attempting to deal with them, as many noted in their interviews. As discussed in this section, while a few of the therapists noted a sense of comfort in knowing they were not alone, others felt lost on how to navigate this process.

Communication and Skills

With social isolation and technology came a different way that individuals began to communicate, much of which lasted beyond the height of the pandemic. Zoom and Google Meet were the setting for business meetings, lectures, and family reunions. They also allowed for distractions and changes in how engaged one might be during a class or a meeting. For adolescents, who are young and whose social patterns can evolve significantly over time, the impact of the pandemic may have changed the way they communicate and engage with others. Seven of the participants spoke about changes in communication, and a different seven participants spoke about using their therapeutic skills to engage their students.

Communication

Communication between individuals consists of both verbal and nonverbal communication. As the majority of individuals discussed during their interviews, understanding nonverbal cues can often be more challenging when providing services via telehealth. For instance, Jenny described the impact of a lack of in-person communication on the ability for mental health professionals to work with these students:

> "With a lot of students that I was working with they're not especially forthcoming verbally, and being in the room with them, you get a lot of information from how they look, how they're talking to you, their facial expression, to their reactions to you and with that missing, it's very hard to create a rapport… but also to get the information you need to really have a session with them."

For someone who relies on nonverbal cues and physical reactions as part of their job, it became more challenging to understand her clients' situations without in-person contact. She also stressed the challenge in engaging teenagers at home, who can be difficult to engage "when

they're sitting in their bedrooms with all their distractions," as "to get them to focus on what you're doing, especially if they are initially resistant to being there" can be a challenge.

Robin expressed the difficulty faced with this population of adolescents, many of whom had social challenges. She stated:

> "I think in this situation communication was affected totally, not just by technology, but by the fact that we literally were not in the same room, because these kids, they don't read social cues. It's very hard for them to just be on a screen and understand what I'm saying or be able to express without seeing them fully in front of me."

According to Robin, not only was it more challenging to pick up on nonverbal cues as a therapist, but the students themselves had trouble with this, especially those who struggle with these nonverbal or social cues. As other therapists expressed, communication was further threatened by the use of masks. Catherine touched on how when school returned to offering in-person services, "everyone had a mask on. So then it's like reading people's facial expressions can be more difficult, like those nonverbal ques." Therefore, while school "should" have returned to normal, she felt as though communication was further complicated by mask-wearing and an inability to read facial expressions.

Engagement and Skills

The changes in everyday life that affected communication created challenges for the majority of these mental health professionals in engaging their students the way they had previously. As these participants went on to express, the complications of the pandemic had significant effects on students, and positively redirecting them after this change required creativity on the part of the mental health professionals. Rachel felt that once the changes made by the pandemic finally set in, she needed to work to reengage her students in their services: "we

felt frustrated definitely at times to say, now we gotta start over and support these students and kind of get them back." After months of the pandemic, Rachel believed that their students were no longer accustomed to the original form of services and had challenges remaining focused and motivated to continue. This attempt at engagement was overwhelming for a small subset of participants, some of whom were facing their own challenges with social isolation and focus during this time. For example, Mike felt the burden that came with this initiative, in that "it was hard to be that positive force for someone else, when you weren't actually sure what was happening with yourself." Misty also expressed these challenges in engaging her students, "sometimes it's really hard for young children to stay engaged, and it's easier to be in the room with them and use play therapy."

Bryan further expanded on these ideas. He illustrated that these changes made things even more difficult when transitioning back to in-person learning and services, as students responded differently to remote services and social isolation:

> "I definitely feel something is lost. It's not 100% the same. I refer to it as being good enough. My students had a difficult transition back. A lot of them got used to being in their own spaces, for some of them, they were school avoidant beforehand. And so COVID was like a dream come true. For others who have difficulty self-structuring, and don't have the external structures in a at home, things like playing video games, staying up all night like they…they just fell into patterns that were not helpful. And so we saw a lot of irritability when they had to go back to a traditional in-person model."

As he described, some students thrived off the remote environment that provided them with the privacy and flexibility they needed. Therefore, transitioning back to in-person schooling was challenging for them to readjust to the structure they didn't have before. Similarly, for children

who created unhealthy patterns due to the lack of structure, reversing those patterns became increasingly challenging. For Bryan, these challenges existed even years following the pandemic.

As a result of these challenges, half of the participants discussed how findings ways to engage students allowed for their own creativity to flourish. They also discussed the ways in which they were able to use their skills to adapt to these changes. For instance, Misty's challenges led her to readdress the way she provided services to engage her students and help them during a difficult time. She later went on to say, "It really forced me to think of the basics of the services we provide… it really forced me to just kind of rely on my people skills." Misty learned ways that she could use her personality to directly engage students in a setting full of distractions, while also using methods she had never experimented with before:

> "The younger students you know, we found ways to kind of play games, and whatever engagement looked like we kind of honored that so some of our more anxious students maybe didn't want to put their camera on or maybe only put an avatar up or maybe they just wanted to phone in and only be heard, or maybe just chat. So we got really creative in expanding our definition of engagement"

Furthermore, Rachel began to contact students and parents directly to help keep them engaged, in order to prevent students from not showing up to session. "I got cell numbers from kids that I didn't have before, so I can directly call them, and directly schedule with them. I was able to call different parents to remind teenagers to get onto a virtual session." Similarly, Jenny reported that she found "new tools and games to start sessions" to work with students who were resistant to coming to session. Mike continued to use his creativity as a tactic in his practice and has also introduced mindfulness to remain cognizant of the time he has with his students. He stated, "we had to plan creative ways of getting [therapy] to happen. The benefit of that is that it has continued

past the pandemic. We're back, we're kind of much more appreciative of the time we have together." These experiences taught him the importance of connecting with students in a way that allows them to get the most out of their services.

These participants emphasized the impact that altered communication can have in delivering mental health services. When communication was threatened during the pandemic by the roles of technology, social isolation, and mask wearing, these mental health professionals expressed that the ways in which they delivered services were affected. They also felt that engagement, due to communication failures and physical distance, changed these services and their delivery. Both required these providers to change their tactics and develop new and unique ways to work with students in order to continue providing care for their students. For these individuals, it was necessary to have proper communication and engagement from the student to provide therapy, as well as willingness on behalf of the healthcare provider to adjust their methods to best serve their students.

Feeling Helpless, Guidance, Boundaries, and Motivation

Feeling Helpless

While technology and remote services surely provided benefits, most therapists expressed insurmountable challenges that made providing sufficient services almost impossible. For three participants, this led to feeling helpless, as some practitioners felt lost in their ability to properly care for their students during this difficult time. Jenny, Robin, and Bryan spoke about feelings of helplessness as they struggled to support their students. All of these individuals felt that they were not providing services at the same level that they had previously, and that they felt lost in how to manage the struggles and worsening mental health statuses of their students.

Jenny spoke about feeling like her performance as a therapist suffered, ultimately at the detriment of her students' services. She stated, "I certainly wasn't performing at the same level I normally might… doing services over the phone is nothing like you know, you're working at 5% of what I normally would be providing." These feelings were further impacted as she faced students who did not have the appropriate access to technological services, or for those parents who lost their jobs and needed additional support. Although she was involved in efforts to support these families, she still felt like she was not doing enough: "We did deliver food [to families], but a lot of families were losing jobs. A lot of the parents didn't have money for anything… the school was providing but we weren't really able to do enough."

Robin stated that regardless of some of the tools she used during remote work, the services she was providing and the students receiving those services suffered too much. She illustrated that "without being able to be there in person, I don't think the delivery of services is very good. I really feel like things kind of stagnated." She went on to say, "delivery of services definitely suffered. I mean you just have to be honest about it. There's no way I could say that I was able to do my job the way I do it typically." Despite the attempts to keep things normal, these therapists expressed that remote services were merely not as supportive as providing the same services in-person. Bryan also felt increasingly frustrated by the stagnancy of the work he was doing. Although he was giving his practice all the effort he had, "I just felt like I was never giving them enough. It was a very frustrating time. I just felt like we're just kind of moving things, but not really taking care of them." Though they tried their best, each of these individuals felt a heavy weight on their shoulders to support students and provide services at the same level that they had previously.

Guidance

Helplessness was compounded by the issue of clinical support, which the majority of participants discussed during their interviews. While a few of the individuals described feeling supported from their clinical directors and colleagues, a few others wished they had more guidance and help from their community. Rachel spoke about the trainings and staff meetings her school put together to educate their clinicians on telehealth services. Even though the transition to virtual schooling was abrupt and could present as a very difficult transition to many, her school "had a ton of meetings and protocols on how to do things and so I think they made it very efficient right away so that was helpful." For Rachel, this clinical training and guidance allowed this abrupt transition to progress more smoothly. On the other hand, Jenny felt a lack of clinical support that contributed to her feelings of helplessness expressed previously. While she tried her best to stay at the job she was at during that time, she realized that she "didn't have the resources" or the "professional connections" with co-workers to stay at this job long-term. In the end, she stated that, "I didn't have the relationships with them to feel clinically supported in that role." She ended up relocating the next year to a position where she felt more supported by her team, where she continued to work with adolescents.

A lack of guidance became a necessary feature for this majority, and supervision became a part of self-care. Misty and Bryan both expressed that maintaining or asking for additional clinical supervision aided their mental health during this time. Misty found that receiving personal help through clinical supervision was a major factor in avoiding helplessness and was tantamount to keeping up with exercise and her own therapy. Similarly, Bryan also felt that supervision was a large part of being able to process his emotions and provide effective therapy without feeling lost. He explained that, having undergone supervision with his mentor for over 20 years:

> “it’s vital to offload a lot of the emotions that come with it. I personally believe that no matter how good your boundaries are, you can’t help but be affected if you’re doing this work correctly… I prioritize self-care in that way.”

Having the ability to receive guidance through others, particularly those who have been in the field and can relate to the experiences of a mental health professional appeared to be invaluable for these clinicians. It provided them with a feeling of comfort and support necessary to work through difficult and unforeseen circumstances such as the COVID-19 pandemic.

Boundaries

Furthermore, feelings of helplessness and needing guidance were intertwined with boundary issues for half of the participants. Working from home led to challenges with boundaries for these individuals, especially as they tried their best to engage their clients. In the effort to give all their effort to their students and being flexible, the confines of one’s work and personal life were often complicated. Catherine illustrated how the line between work and home life became blurry, as:

> “Pre-pandemic you work the school hours and you’re there from 8:30 to 3:30 and that’s it you know, I wouldn’t be checking my emails or getting phone calls outside of those hours. During the pandemic all of that went out the window. We had to use our personal phones, we used Google voice… so having parents text me and call me at all hours of the day… separating work and home was that much more difficult seeing as it’s something that I struggled with previously.”

The challenge of boundaries with work continued when Catherine’s school transitioned to a hybrid model:

> "even though we were back in the building I still had my email coming to my phone and I would be checking my emails at all hours of the day. So really having to like be strict with myself and be like, okay, like you no longer need your work email coming to your phone like you're back in the building like you no longer need your google voice. Like you're in an office with a phone. But, like switching back to that was really difficult, especially with families that would still like try to communicate with you via the google voice, or you know, outside of work hours."

Rachel expressed a similar struggle, particularly with having hours that now extended past the regular school day due to the accessibility telehealth services provided. She stated, "I'll leave school at 4 o'clock, live my personal life, and then log on to a family session at 8 o'clock, so I guess there's really not an end time… when you constantly have a meeting after a few hours or after dinner, it can kind of make those lines blurred a little bit." These boundaries appeared to become even more challenging with the ability of students to access therapists more directly, as in Robin's situation. While giving students her personal cell number helped her to engage her students, this led to Robin "getting calls on the weekends and evenings, and it wasn't because they were trying to bother me, or you know get into my personal space. They just really needed more because they needed to know we were there." The connecting feature of technology made it harder for Robin to find the separation from work that may have been beneficial to their own lives and mental health.

For Mike, boundaries were also threatened by the home environment that they worked from, and what they chose to show over video during sessions. As Mike described, his physical space could reveal a lot about himself to his clients, which could happen if "they hear conversations with me and my children, or the dog barking in the background… so allowing

them into a space that was more personal then I was used to." While this could be uncomfortable, it also provided an eye-opening experience for him. Not only did this change affect Mike himself, but this cross in boundaries led him to be let into the lives of his students, and he saw how it could often benefit him as a clinician. "They're also allowing me into their space, like I said, I'm in their bedroom or their dining room, and there's stuff going on in the background and some of it was eye opening. So I would never had that experience with them, just seeing them in an office." This unique experience allowed him to evaluate his students in their home environments, rather than in an external setting where they made not have been themselves.

Motivation

Despite feelings of helplessness and boundary issues, when asked about their personal motivation to continue their work during this time, all of the eight participants expressed continuing to feel motivated. The majority found motivation in helping their students. Many expressed a passion for their work, along with a sense of enjoyment in forming relationships with their students. Some of these individuals expressed that there was no other choice than to be there for their students: they would continue to stand by their patients despite the struggles they would face. Robin provided a quintessential example of these concepts. Although she had firsthand experience with the frustrations of the pandemic, she was motivated by the needs of her students. She claimed that her motivation was founded in seeing "that those kids just needed us. I mean, most of us just stayed. We just felt like we have to do this, and we're gonna come out on the other end. There was really no option, as far as I was concerned." In this quote, Robin expressed a sense of duty to her students in ensuring they were taken care of, and that the services they required continued despite all else. Misty echoed these sentiments, emphasizing her

commitment to her students' goals: "I am really motivated and connected to our students and helping them achieve their goals."

For Jenny, motivation stemmed from the powerlessness experienced by her students in being adolescents, and the commitment she had to guide them through a turbulent time, both in the world and in their development. She stated:

> "I think working with adolescents, the lack of power, that they have over their own lives, makes working with them much harder, and that's actually why I wanted to work with adolescents. It was because of that feeling of powerlessness that I feel like a lot of people don't recognize. But I think that's especially so when the rest of the world is out of your control also."

Jenny's mission was to support these individuals as that external support was essential in a period of their development where they had little power over their lives. In the time of COVID-19, where mental health professionals themselves felt a lack of control over their own lives, giving back to those who were experiencing an even greater sense of powerlessness provided meaning.

In a time where clinicians were doing their best to support their students and maintain their own mental health, feelings of helplessness were evident among some of the participants in this study. These feelings often necessitated guidance and self-care, and for those who did not receive this support, they described feeling lost. In addition, feeling this lack of guidance contributed to issues with boundaries for some, in which individuals did not have the means necessary to find balance. Technology and attempts at engagement also complicated boundary lines. Ultimately, many mental health professionals expressed that these experiences changed the way they conducted their practice.

Summary

The experiences of these mental health professionals working in therapeutic schools in New York and New Jersey during the COVID-19 pandemic exhibit the effects of the transition to a telehealth model. With social distancing and community lockdowns, these participants were forced to rely on technology to provide services to their students. This distancing caused social isolation among the majority of providers, many of whom did not have the physical community around them that they needed for their own mental health. It caused a dependence on technology for daily functioning, which was complicated by technical issues for the majority of individuals but also allowed them to observe increased accessibility and convenience for their students. Many of these participants also battled with shared trauma and the ability to balance their own struggles with that of their students, many of whom were facing the same challenges. These providers found that these experiences often caused changes in how they conducted their sessions and worked with their students. Communication and engagement were broadly threatened for many of these mental health professionals due to the pandemic, which had an immense impact on the work they were doing. Many of these clinicians were forced to respond and adapt in a way that was uniquely challenging to many.

These stressors led to some feeling helpless after observing the challenges in trying to provide for their students. Due to the effort and work they put in to give as much as possible to their clients, many longed for guidance and struggled with boundaries. All participants felt challenged by at least one of the complications that the pandemic introduced, and although themes were present across interviews, many responded differently to the same challenges. Ultimately, these themes highlighted the complexities that the COVID-19 brought to these mental health professionals and examined the views of these individuals during this time. The

following chapter will discuss these findings as they relate to the literature, as well as their indications for social work practice and education.

Section 8: Discussion

This study explored the experiences of mental health professionals working with adolescents at therapeutic schools during the COVID-19 pandemic, specifically focusing on social isolation, technology, and shared trauma. Using the qualitative data received from semi-structured interviews, the researcher categorized the experiences of these individuals into themes, including *social isolation; technology; shared trauma; communication and skills; feeling helpless, guidance, boundaries, and motivation*. These themes highlighted the general consensus of feelings and experiences provided by these participants.

To greater understand these findings, it is important to incorporate them into the discussion of how we can view the effect of the COVID-19 pandemic on the social work field. This discussion will first explore the three major themes of this study (social isolation, technology, and shared trauma) in regard to both the findings and the existing literature. The findings will then be explored in relation to broader ideas. For one, much of what was expressed by these mental health professionals throughout the findings was the need for clinical support. Although the changes caused by the pandemic were new for everyone, therapists tended to feel more comfortable and at ease with their work when they had sufficient clinical support, whether this support be through clinical supervision, school administration, or the help of colleagues. How these participants responded to the challenges presented in front of them is also necessary to understand, as it guides the way in which social workers can work through problems in general. Additionally, this discussion will explore the resistance of mental health professionals to engage in this qualitative study regarding their experiences during the COVID-19 pandemic. While saturation was reached, it is necessary to explore why it took so much outreach and time to obtain enough participants for data collection.

Furthermore, this discussion also serves as a guide to the implications of social work practice and education in the future. By understanding the issues at play and the changed dynamic of mental health services, the experiences of these participants can be used to guide subsequent measures in mental health. The theories behind these questions may relate to many of the other issues that were explored during this study regarding clinicians' experiences and how they responded to the pandemic.

Social Isolation, Technology, and Shared Trauma

Social Isolation

In their interviews, the majority of participants admitted to being impacted by social isolation during the height of the COVID-19 pandemic. Participants discussed missing their colleagues and being around other individuals in their everyday life. They missed the communal life that their job had traditionally provided them, which brought social connection and community along with it. These feelings of social isolation translated into both loneliness and a lack a sociality for many participants, as they had developed a sense of community from their school environment that they relied upon.

These mental health professionals also noted changes in their students as a result of social isolation, and many felt that during this time they were particularly concerned regarding the mental health of their students. Since many of these students had been previously diagnosed with mental health disorders, participants reported observing an exacerbation or worsening of these students' challenges. Participants were also concerned regarding recurring trauma for their students- many of whom were recovering from prior traumatic experiences. Being socially isolated from their peers and being stuck in a potentially traumatic or unhealthy environment at home may have contributed to mental health challenges.

The existing literature highlights loneliness as a result of social isolation. Recall that Holaday et al (2022) surveyed individuals over the age of 65 to uncover that many were experiencing loneliness and isolation during this time. In addition, Sams et al (2021) also made a similar conclusion in studying adults 60 and older, who reported higher levels of psychological distress and mental health challenges after undergoing the social distancing required during this time. The samples used in those studies differ from the participants of this study, whose ages ranged and who were selected based on their profession. In addition, the participants in this study did not report personally experiencing worsening mental health struggles such as depression or anxiety due to the pandemic. Rather, they did report that social isolation had negatively impacted their lives by removing their sense of community, which often provided a great deal of comfort for them. This sense of loneliness and community was touched upon in Eppler (2021), however, the participants reported losing a sense of community and feeling less connected to their family and friends. Nevertheless, it was not a central theme of that study, and therefore, social isolation during COVID-19 in relation to the loss of one's community is a topic that should be explored in future literature.

While participants did not report physiological distress or depressive symptoms in their own lives, these mental health professionals did discuss observing changes in the mental health and trauma reactions of their students. The literature discusses the impact of social isolation on mental health in general. Taylor et al (2018) found that both objective and subjective social isolation was associated with higher levels of depressive symptoms. In addition, Wright et al (2017) studied the impact of loneliness on many different factors, including its correlation to suicidal ideation, physical health issues, and one's culture and environment. While these individual factors would need to be addressed in the population of mental health professionals by

conducting further research, these studies can potentially provide context to the results found in this paper by explaining the impact one's social isolation could have over time. Nevertheless, scant research is available on the effects social isolation can have on individuals similar to the students of the mental health professionals in this study, who were adolescents in therapeutic schools with previously diagnosed psychiatric conditions. Thus, the findings featured in this study need to be explored further to validate the results as the existing literature currently does not offer enough research to conclude these findings.

Technology

Participants noted both positive and negative effects regarding technology in their transition to teletherapy. Technical and Wi-Fi related issues were often discussed as frustrations for the participants, in addition to a minority reporting their concerns for the ethical and legal aspects of remote therapy. Additionally, participants felt that their students were less engaged when using technology, and that virtual services did not provide many students with the degree of structure and motivation they may have needed. On the other hand, these mental health professionals noted that using technology to provide services made them more accessible to those who may have otherwise not had access to therapy. It also added an increased level of convenience for not only students and their families, but for the mental health professionals themselves.

The literature explores teletherapy from both a pre-pandemic and intra-pandemic standpoint. Often, the research question is focused on the efficacy of remote services, with studies typically finding that telehealth was essentially equivalent to in-person services (Bee et al, 2008; Bekes et al, 2020). While the mental health professionals in this study did not discuss the details of teletherapy efficacy, they did touch upon decreased engagement from students,

which could translate into decreased efficacy. This decreased efficacy is specific to the experiences of these students, who were not in therapy by choice and may struggle with engagement and motivation as many adolescents do. In one study, Bornheimer et al (2022) found that for the majority of their participants, who were mental health providers engaging in remote service delivery during COVID-19, challenges in engagement existed. These challenges resulted from difficulties in building rapport and engaging clients remotely, as well as logistic challenges like limitations to technology or lack of response to phone calls. While the responses of young students in therapeutic school differs from adults receiving voluntary therapy, this study validates the problems the participants in this study had with engagement.

Additionally, as one participant pointed out in this study, teletherapy may present with safety concerns, particularly when working with vulnerable populations who may be high risk for self-harm. Bornheimer et al (2022) also addressed suicide risk assessment in their participants, with 57% experiencing challenges in conducting these assessments. These themes included assessment challenges due to physical distance as well as rapport-building challenges. Unfortunately, however, there is no direct literature on the topic of caution regarding triggering patients or preventing self-harm during teletherapy. Therefore, more research is necessary to understand this topic.

The lack of nonverbal cues discussed by participants in this study was validated by the literature, as Bekes et al (2020) noted that many mental health professionals felt challenges with in regard to a lack in physical presence. Similarly, Lin et al (2021) explored the lack of confidence in the therapeutic skills of these mental health professionals. While none of the mental health professionals expressed feeling as though their skills were not as strong in teletherapy, they did note that in order to engage their students they had to adapt and use their

skills in a different way. In addition, technological glitches were also previously discussed in the literature. As Eppler (2021) explored in their evaluation of mental health professionals during the pandemic, participants noted difficulties with these glitches, which were often unavoidable.

Furthermore, the literature also touches upon the improved accessibility and convenience provided by technology. Stewart et al (2017) found that many barriers exist for adolescents living in underserved financial communities, including transportation and its cost, one's work schedule, and a lack of insurance benefits. By providing teletherapy, services were made accessible for these individuals, who may have previously not been able to receive services. Similarly, Wangelin et al (2016) found that with remote services, patients with anxiety, who may normally avoid treatment, can be aided by the added convenience of receiving services in their own home. This relates to some of the participants of this study, who expressed that many of their students preferred the remote nature of services based on their comfort level.

Shared Trauma

The majority of participants featured in this study admitted to experiencing some degree of shared trauma, while also endorsing the effects of trauma in their students. Participants felt that they had trouble balancing their own emotions while also trying to support their students. Additionally, multiple therapists noted that the mental health challenges faced by their students had often regressed due to the traumatic experience of the pandemic. It was a challenge for many in learning how to address these issues, though a few participants (less than half) felt a sense of comradery and strength in processing this challenging time along with their students and coworkers. Nevertheless, as one participant pointed out, it could be more difficult to process these emotions with the added impact of social isolation.

The concept of shared trauma has been documented in the literature, a concept defined and explained by Tosone et al (2011, 2016). Tosone et al (2016) explored the ways in which a client's experience can be projected onto the mental health professionals during times when both are undergoing a shared traumatic experience. Similarly, Tosone et al (2011) focused on the impact of shared trauma on mental health professionals following the 9/11 attack on the World Trade Center, finding that attachment styles served as factors for the degree of shared trauma. In addition, Day et al (2017) showed that mental health professionals working with students involved in the Virginia Tech shooting had heightened responses if they were also directly impacted by the event.

As many participants in this study observed the worsening in mental health of their students, the literature also uses data to support this. Deng et al (2023)'s systematic review found that the prevalence of depressive and anxiety symptoms, as well as sleep disturbances in children and adolescents during the COVID-19 pandemic was relatively high at 31%, 31%, and 42%, respectively. Additionally, the prevalence of symptoms worsened as the pandemic progressed, consistent with the findings presented by the participants in this study. However, the shared experience of COVID-19 expressed as a positive by many of the participants in this study was limited in the literature. Nevertheless, one study by Abraham (2021) in evaluating the experiences of nursing students during the pandemic, found that while participants felt disconnected physically, "they remained connected in these shared concerns." Despite many of the challenges these students had in communication, many were still able to develop connected relationships through this difficult time. Nevertheless, further research must be done to further explore this topic, particularly in relevance to mental health professionals working with high risk adolescents.

Summary

The findings of this study, when compared to the existing literature on social isolation, technology, and shared trauma, indicate the increasing need for further research on these topics. While these three themes feature relevance in the literature that can shed light on the experiences of individuals during COVID-19, most of the studies present do not provide a detailed understanding of the experiences of mental health professionals working in therapeutic schools. Therefore, it is necessary to further evaluate many of the ideas and themes discussed by the participants in this study, and to determine the relevance of social isolation, technology, and shared trauma for this generation of mental health professionals. The other themes, such as *communication and skills; feeling helpless, guidance,* and *boundaries*; and *motivation*, will be discussed further in conjunction with social isolation, technology, and shared trauma in the next two sections.

The Need for Clinical Support

Whether participants were referencing social isolation, adjusting to telehealth services, or processing their trauma, clinicians repeatedly emphasized the need for clinical support. Without clinical support, these clinicians often felt helpless and lost. While the definition can vary for each practitioner, in this study, clinical support is used as an encompassing term that may include clinical supervision, administrative or director related guidance and support, and connections with colleagues. Bogo and McKnight (2008) discussed the purpose and necessity of clinical supervision in the social work field in their review of the literature:

> “Supervisors, often located at mid-level in the organization’s hierarchy, oversee the work of front-line staff as they carry out the mandate and purpose of an organization. The

> importance of education and support of workers has also been well recognized as a crucial aspect of supervision that contributes to effective practice."

Bogo and McKnight (2008) emphasize the importance of the supervisor's role in ensuring the employee is fulfilling their role as well as the organization's mission. In turn, supervision supplies employees with both education and support, which contributes to the effectiveness of services. Many of the individuals in this study described their supervision as such- it gave them the support they needed to provide better services and to feel more confident in their work. Without supervision or other forms of clinical support, individuals felt uncomfortable and their experience working with students was negatively impacted.

In relation to a variety of professions, clinical supervision is often described as a process that allows for critical reflection (Pack, 2009; Gilbert, 2001; McMahon; 2020; Stella & Taggart, 2020). According to Pack (2009), clinical supervision allows social workers to become "more aware of one's own value base to gauge the internal consistency of one's core values and beliefs." It is essential that these personal values align with the profession, and if there is conflict, supervision can serve as a means for clinicians to explore that conflict in order to continue practicing effectively (Pack, 2009). These thoughts are also applied to the field of nursing in Gilbert (2001), as well as psychotherapy in McMahon (2020) and Stella & Taggart (2020). In the within study, individuals who had helpful and consistent clinical supervision appreciated this fact: it allowed them to feel like they were practicing more effectively, which contributed to improving their experience during the pandemic. With the benefit of clinical reflection in difficult cases and an abrupt transition in practice, mental health professionals had the ability to analyze their actions and ask questions. They were also given the ability to feel supported by their work environment, allowing them to feel more confident in how they

managed their patients. In this way, clinicians could feel as if they are not alone. A sense of aloneness is what can lead to feeling incapable.

Clinical support extends beyond supervision, as previously discussed. For the participants, it also includes administrative or director guidance in other ways, such as providing an encouraging and supportive environment for workers. Gutierrez et al (1995) relatedly discuss the concept of empowerment practice for social workers, which is a method for "developing personal and interpersonal power through a process of self-awareness." Gutierrez et al (1995) found that in social work, organizations can implement empowerment practice by motivating and influencing social services administrators. Their results suggested that organizations that empower workers through "creating an employment setting that provides participatory management, the ability to make independent decisions about their work, communication and support from administrators, and opportunities for skill development will be more capable of empowering clients and communities." These practices and commitment to empowering clinicians can have major effects on the practitioners' experiences and effectiveness. While empowering clinicians may include many facets, employers and administrators can provide them with the appropriate guidance in order to foster independence and confidence.

Furthermore, clinical support often extends beyond the responsibilities of supervisors and administration: it can also include professional relationships and connections with one's colleagues. The literature supports the idea that coworker support and strong colleague relationships impact employee experience and commitment to one's job in a variety of fields (Ducharme et al, 2008; Ong and Khan, 2022). Most of the existing research is pre-pandemic, such as Ducharme et al (2008), who examined substance abuse treatment counselors and found that coworker support exhibited inverse effects on intent to quit. However, Ong and Khan (2022)

studied the role of coworker and supervisor support on stress in Malaysian school teachers, but this time during the COVID-19 pandemic. The results showed that although supervisor support was not shown to reduce teacher stress, coworker support did have a statistically significant impact. This teacher stress was linked to a higher rate of turnover. Recall that one participant in this study emphasized how not having strong professional connections with her colleagues during the COVID-19 pandemic had a very significant impact on her experience. She often felt uncomfortable with her work due to the lack of support. As a result, she ultimately left the school she was employed at during the COVID-19 pandemic. This mental health professional exhibits a real-life example of the results observed in both Ducharme et al (2008) and Ong and Khan (2022). It emphasizes that connections with one's colleagues and work community can have an immense impact on the stress one can experience at their job, as well as their commitment to their work. A lack of connections can be especially challenging during a high-stress time, such as the COVID-19 pandemic, which was filled with uncertainty.

The literature presented in this section regarding clinical support draws attention to the need for mental health professionals to have a supportive and empowering environment. Clinical supervision is often the most common form of clinical support to which social workers engage with, but other forms of support such as administrative guidance, empowerment practice, and colleague relationships are additionally important. Providing guidance to clinicians in difficult or new situations can be valuable in increasing clinician confidence and comfort. Other methods that can be used include educational lectures for practitioners regarding updates in practice, frequent meetings for the administration to check in with practitioners, and anonymous surveys to ensure that practitioners' needs are met. These methods can reduce provider anxiety and stress, create more comfortable and open relationships with others, and increase both job

satisfaction and individual effectiveness. They combat a sense of aloneness, which appears to be harmful to clinician experience.

Facing Challenges

This study found that all participants reported facing some degree of challenges during the COVID-19 pandemic. These mental health professionals were used to working with adolescents with complex issues; many of their students had behavioral or psychiatric conditions and attended therapeutic schools for the additional support they provided. As such, these mental health professionals were accustomed to facing clinical challenges, which required experience in the field along with innovation and commitment. The way in which these individuals responded to the challenges they faced with their patients during the COVID-19 pandemic was paramount to understanding their experiences during that time. During these interviews, many participants discussed becoming more creative in the way they engaged their students. To overcome the barriers placed by technology, these participants played games, used personality tools, and contacted patients directly. The experience challenged their commitment to their work. Facing challenges was an essential part of their experience.

As discussed in the literature review, Lin et al (2021) found that therapists during the COVID-19 pandemic felt less skilled in many therapeutic attributes when conducting virtual services compared to in-person services. These results indicated the difficulties that mental health professionals exhibit in adapting to teletherapy, often influenced by the fact that the use of technology can create a type of distance that feels impersonal to both parties. Thus, the quality of the care delivered during the COVID-19 pandemic may have declined if individuals were continuing with the same exact methods they had been previously. As a result, it is essential that mental health professionals have had to adapt to these challenges, especially during the abrupt

transition caused by the pandemic. With lower confidence and less experience performing these types of services, individuals require new ways of working with patients that they may have not tried before. For the eight mental health professionals featured in this study, all of whom went from in-person to remote services abruptly, adapting to this setback was crucial. It was necessary that they responded to this challenge in innovative ways.

These mental health professionals were able to remain committed throughout these challenging times. Eppler (2021) emphasized the resilience and adaptability of mental health professionals conducting virtual services during the first months of the pandemic. In their interviews with licensed marriage and family therapists providing remote therapy, Eppler found that participants consistently noted challenges, such as those in work and life balance, frustration with technology, and overall fatigue. Nevertheless, these participants were still able to find resilience despite these barriers. For instance, Eppler describes that in this face of technological difficulties, these mental health professionals "agreed they had to be more energetic and active." They also "took advantage of technological glitches to promote dialogue between partners. They encouraged family members to assess one another to promote connection. They appreciated that some clients seemed to benefit from the distance created by telehealth (e.g., using the lag time to slow down the interaction or having a less intimate physical space)." These findings emphasize the ability of mental health professionals to overcome challenges in unique ways in order to encourage the engagement of their clients and interpersonal connections created through counseling. To provide their patients with a continued effective level of care, they had to become more creative.

The mental health professionals in this study also spoke about self-care as a means to maintain their morale while facing these challenges. With boundaries crossed, feelings of

helplessness, social isolation, and significant adjustments, many individuals focused on self-care as a means of adapting to their new reality and handling their challenges. For some, clinical supervision served as a means of self-care. For others, a specific focus on their personal and family lives was necessary to recharge before the next workday. In their literature review, Posluns and Gall (2020) emphasize the importance of self-care for mental health practitioners. Specifically, they relate that mental health professionals need to understand the necessity of being proactive in approaching self-care and integrating it directly into clinical training programs. By implementing self-care into one's regimen, clinicians can "help prevent the downward spiral of stress, burnout, and professional impairment, and promote an upward spiral of well-being." These practices allow individuals, such as the providers interviewed in this study, to continue providing effective services.

Facing challenges is an essential part of being a mental health professional, and it was an increasingly important factor in considering the experiences of these professionals during the COVID-19 pandemic. In order to engage their students, many of whom were resistant to services in the first place, clinicians had to become more creative and adapt to their work in ways they may have previously not had to before. As Eppler (2021) points out, mental health professionals developed a sense of resilience in the face of these challenges. They also resorted to a focus on self-care that was emphasized during this challenging time. Overall, these challenges helped these mental health professionals develop new methods and skills, while also shaping the future of practice for many of these individuals.

Implications for Social Work Practice

While spring of 2020 has passed, the height of the pandemic has had a lasting impact on the field of social work and the therapeutic practice of many mental health professionals.

Countless mental health professionals continue to provide services via teletherapy or meet with families remotely. They continue to face challenges in understanding the impact of teletherapy on both themselves and their clients, especially as the mental health impacts of the pandemic continued to be uncovered. Due to the recent nature of the pandemic, the exact effects are unclear. However, according to Sams et al (2021), early research has shown that the pandemic had a substantial impact on psychological distress, such as depression and anxiety, in adults. Regardless, the lingering effects are complex and based on the data collected in this study, it is important to apply these lessons to social work practice.

As discussed in previous research literature, this study has shown the necessity of providing clinical support. Informed by this study's findings, clinical supervision is an essential component to ensuring the social worker can provide their patients with effective care (Bogo and McKnight, 2008; Pack, 2009). Clinical social workers should always be offered consistent supervision that meets the needs of that social worker and allows for discussion of complex cases. According to both Bogo and McKnight (2008) and Pack (2009), clinical supervision allows both the supervisor and the supervisee to ensure that the values of the supervisee align with those of the organization. This idea allows the individual's thoughts on a case or their current challenges to be explored to ensure they are managing their client in a way that is effective and value-based, rather than through emotion or mismatched ideals. Social workers who work independently (i.e., through private practice or other means) and do not have a direct supervisor should still ensure that they have some degree of supervision. For instance, one of the participants in this study who had a private practice along with his career at the therapeutic school described meeting with someone for supervision for his private practice. While this

"supervisor" was not his employer, meeting with a mental health professional with more experience allowed this participant to debrief and understand more challenging cases.

It is also necessary to provide the proper administrative guidance for these individuals. As discussed in Gutierrez et al (1995), social work administrators and organizations should adopt a practice of empowering their workers. Specific measures can be taken by these organizations to encourage this culture of empowerment. Gutierrez et al (1995) found that empowerment practice can be achieved through "staff development, enhanced collaborative approach, and administrative leadership and support." Each of these terms involves specific actions that can be taken by the administrators. For instance, Gutierrez et al (1995) explain that staff development includes the encouragement of advanced training, such as "access to conferences, training, and educational opportunities." Furthermore, they suggest that staff should be given flexibility in their schedules and encouragement towards self-care, as well as support to pursue entrepreneurship to develop work-related programs that match their own personal interests. Organizations should also foster a collaborative approach between colleagues and team members, who should have the connections to be able to both work together and challenge each other's thought processes. Lastly, social workers should feel that their administrators project leadership and advocate for both the organization and their workers. Providing social workers with a supportive work environment in which they feel empowered to provide care is paramount to ensuring their success (Gutierrez et al, 1995).

As discussed during the findings section, frustration with technology and challenges with its impersonal nature was an evident theme in this study. To combat the challenges presented by technology when using teletherapy, providing lectures, meetings, and developed protocols regarding teletherapy could be useful measures in continuing education for social workers. Due

to the recent nature of the adoption of teletherapy, social workers should be provided with guidance on the methods they can use to improve professionalism and effectiveness during virtual sessions. Recent literature is being developed regarding training in teletherapy since the COVID-19 pandemic (Scharff et al, 2021; McKee et al, 2022). For instance, McKee et al (2022) found that availability of training affected the uptake of teletherapy, whereas Scharff et al (2021) explored the experience of individuals undergoing a training program related to remote therapy during COVID-19. In addition, Bekes et al (2021) found that more experienced mental health professionals had an easier time in their transition to online services. This finding could represent the idea that more experience allows for mental health professionals to more easily harness their skills to provide services in different forms. For less experienced mental health professionals, however, who might not have the same strength or confidence in skillset, providing continuing education on this topic could help improve patient rapport and therapeutic effectiveness. A focus on the topic of teletherapy could teach these individuals how to harness their skills and increase their confidence when using remote services.

While organizational support and continuing education are necessary, social workers should also be given the room to speak about their experiences. For those who struggled in regards to social isolation and shared trauma, many social workers can feel that their profession requires them to bottle up their feelings and process them alone. However, in order to create better connections with patients, social workers must have a space to voice their grievances and speak about personal struggles.

Implications for Social Work Education

Social work educators can also incorporate these findings to pave the educational path of social work students and new social workers. Social work students entering the field after a

challenging pandemic must first understand the changes that the pandemic has created. In addition to the implications for social work practice, new social workers must become educated in teletherapy and remote therapy. Social work students should all receive courses in the ethics, professionalism, and rapport building of remote services. These courses can feature a myriad of resources to understand the progression of teletherapy, such as Bee et al (2008), a pre-pandemic view on remote services and their effectiveness, and both Bekes et al (2020) and Chenneville & Mette (2020), who evaluated the abrupt transition to remote therapy during the pandemic. Students can also work with social workers who provide services remotely to further understand the tools and methods they use in their daily practice.

In addition, social worker students need to understand the role of clinical support and supervision as they begin their practice. These students can reference Bogo and McKnight (2008) for a systemic review on the definition and importance of clinical supervision. Students must also keep in the mind the necessity of connections and collaboration with colleagues, as evidenced by both Ong and Khan (2022) and Gutierrez et al (1995). Social work educators must encourage their students to ask questions and seek support from those with more experience rather than feeling that they must provide services independently with no outside guidance. Learning the importance of these factors as students can set these new social workers up for success as they enter the field.

Implications for Policy

As mentioned previously in this study, the CARES Act focuses on mental health funding with the goal of improving access to care for patients who may have otherwise not been able to receive care (Goldman et al, 2020). While improving access to care for patients is incredibly important in the wake of the pandemic, social workers should also advocate for policies that

support the mental health of professionals specifically. As seen from this exposition of the experiences of mental health professionals working at therapeutic schools during the COVID-19 pandemic, facing challenges has been a major factor in the professional lives of these mental health professionals. Although Eppler (2021) highlights the resilience of these clinicians, mental health professionals may often require additional services for themselves. While these practitioners may have the educational tools to understand the benefits and process of receiving mental health resources, they may not have the salary, time, or benefits from their jobs required to access them. Organizations such as the National Association of Social Workers (NASW) can support advocacy efforts to increase the access of mental health services for mental health professionals.

Theoretical Understanding

This study contributes to the theoretical models of reasoned action, planned behavior, Bronfenbrenner's ecological systems, and constructivist self-development discussed in the theoretical framework. As seen previously, the theory of reasoned action explains an individual's actions based on their beliefs, and the theory of planned behavior is an extension of this concept that focuses on the beliefs and thoughts one creates prior to the action (Vogel et al, 2005; Ajzen et al, 2011). As predicted during the theoretical framework, these theories may explain why the participants in this study continued to provide services despite the challenges they faced. During the interviews, many of these individuals expressed that their motivation for continuing to provide services was to help their students. By using remote therapy as a tool to remain connected to their students, they were able to fulfill their goal. Their perceived belief regarding the impacts of COVID-19 and social isolation on their patients explained the action they took in staying at their jobs.

Bronfenbrenner's ecological systems theory, which explores the impact of one's relationships and environment on their development using a multilevel system model, can also apply to the experiences of these participants (Onwuegbuzie et al, 2013). For instance, the shared trauma these participants experienced is a part of the individual's life that can affect their mesosystem (the system involving relationships in one's home, work, or social life), which could then play a factor in their ability to provide therapy. As Tosone (2019) states and the findings of this study show, shared trauma had a large impact on the experiences of these mental health professionals. Similarly, constructivist self-development theory explains how a traumatic event and an individual's past can influence how trauma may develop in that individual, thereby through cognitive schemas (Saakvitne et al, 1998). For these participants, who may have experienced shared trauma or vicarious trauma, tapping into their cognitive schemas can allow them to manage their trauma and use the proper interventions to treat their patients.

Limitations

General Limitations

This study featured several limitations. First and foremost, this study featured a small sample size of eight participants. While saturation was reached due to repetitive interview content and the formation of themes, the experiences of eight mental health professionals is most likely not representative of the entire population of mental health professionals in a similar clinical environment. Second, this study required participants to volunteer, which can increase the risk of voluntary sample bias. Voluntary sample bias is explained as bias in which participants that volunteer do so because they have an opinion that they would like to voice (Koerber & McMicheal, 2010). Based on the schools' limited demographic location, multiple

participants may have experienced similar biases, and patterns in these biases could have formed and affected both the data and analysis of the study.

Third, due to the nature of this qualitative study, the results were nongeneralizable. The sample included participants from only either New Jersey or New York. While the results may be directly applicable to mental health professionals in those two states, mental health professionals in other parts of the country and throughout the world may have had different experiences. Fourth, due to the purpose of gathering mental health professionals' experiences from this study, some participants may have been hesitant to discuss some of the challenges they faced or the lack of support they may have experienced due to the nature of being employed by the school. For example, participants may have had concerns that although they were being told that the content of the interview would remain confidential, information may still end up leaking to their employers.

Lastly, due to the incentivization of participation with the $15 virtual Amazon gift card, individuals may have felt inclined to participate in a study they otherwise would not have. If financial need for the gift card was present, an individual may have signed up for the study without an actual desire to partake in the interview or fully invest in the interview. This may challenge the validity of the study while also placing some participants in a challenging position.

Difficulty Recruiting Study Participants

In addition to the limitations discussed above, the study had challenges in recruiting study participants. During the data collection period of this study, the researcher followed the protocol outlined in the Methods section of this article. The study team was surprised to find that despite contacting approximately 60 different therapeutic schools in the states of New York and New Jersey over the course of several months, only eight participants both qualified for and agreed to

participate in the study. Despite the smaller-than-expected sample size, eight participants appeared to be enough to reach saturation and conduct the analysis. Nevertheless, it is necessary to explore why the researcher had such difficulty recruiting participants. In speculating on this topic, multiple theories could be suggested.

For one, mental health professionals may have had a fear of revisiting the trauma they experienced during the COVID-19 pandemic. As discussed previously, some participants may have experienced shared trauma, as well as individual trauma in being socially isolated and dealing with both personal and professional difficulties. In Brooks et al (2019), the authors describe the presence of avoidant coping strategies as a mediator between trauma characteristics and posttraumatic growth. For individuals such as the potential participants for this study who have lived through traumatic experiences, an avoidant nature surrounding revisiting these experiences is common. Similarly, individuals may have also not felt interested in the study due to avoidance or fear of admitting challenges or helplessness. Admitting their shortcomings may be related to their trauma, as providers may have felt that they failed their students during this time.

Another theory is that mental health professionals at these schools may have not felt comfortable speaking about their experience due to fear of termination if the school were to become involved. Although it was communicated to all potential participants that information obtained in the interview would remain confidential, it is still possible that these individuals did not feel comfortable speaking openly about their experiences. Furthermore, it is also possible that these mental health professionals felt that there was no point to participating as their voice, as a single individual, would be insignificant. For these individuals, engaging in this study may have not been their greatest priority due to this factor. Additionally, it is also possible that

information sent to the points of contact at these schools did not reach the individual mental health professionals. The reasoning behind this lapse in communication could be attributed to the clinical director not receiving messages, or insufficient promotion of the study to these clinicians. Regardless, it is likely that miscommunication contributed to the lack of response. Lastly, it is necessary to consider the possibility of bias that may have occurred during the recruitment process. Bias towards the research study could have occurred through the messaging the researcher used in communicating to the school directors and potential participants, as well as through aspects unique to the researcher himself, such as gender or age. It may also have occurred due to a lack of connections the researcher may have had to a particular school.

While these theories can provide some thought for the difficulty in obtaining participants, this list is not exhaustive and further research would need to be executed to gain a better understanding of this failure in participant recruitment. As discussed previously, Creswell and Poth (2018) explain that qualitative researchers recruit a "small number [of participants] that will provide in-depth information about the central phenomenon." Based on repetition in themes seen in the Findings section, it can be assumed that this study did reach saturation. Although the researcher can never know for sure that saturation was reached with this sample, due to the difficulty recruiting participants it can be assumed that this study reached a sufficient degree of saturation while remaining ethical. For now, it is necessary to understand that this challenge of recruitment created a significant limitation for this study that can be used to potentially further understand the psychosocial complexities of the issues discussed in this article.

Future Research

Despite gaining an understanding of the experiences of a small group of mental health professionals during the COVID-19 pandemic, several research questions remain unanswered.

For one, future research could explore interventions regarding the challenges faced by individuals during this study. For instance, quantitative studies could be used to explore interventions regarding educating clinicians on teletherapy, or the differences in confidence between clinicians receiving sufficient clinical support and those who are not. These future studies could determine the importance of these clinical interventions and the degree to which they are necessary endeavors for future funding and exploration. Data on the residual impact of shared trauma during COVID-19 could also be collected to understand its effects on these mental health professionals following the pandemic.

Further research could also focus on applying this research question to a larger sample size in evaluating the experiences of mental health professionals working in therapeutic schools during COVID-19 across the United States. A larger quantitative study would be needed to validate the findings in this study. The results could be compared to the experiences of the individuals in this study to determine if geographical location may be an influential factor. In addition, including a larger geographical region or schools in more states would likely alleviate the limitations placed on this study by the difficulty it had in recruiting participants. Similarly, the experiences of mental health professionals working with adolescents in general could also provide an interesting research question to be explore further.

Furthermore, an interesting observation made in this study was that while mental health professionals admitted to being impacted by social isolation and they expressed concern for their students' mental health, they did not mention facing struggles with their own mental health. It is important to understand why this occurred which can be explored in further research. Lastly, further research should evaluate the challenges faced in recruiting participants for this study. As explored previously, there are many different theories for why participant recruitment collected a

smaller-than-expected sample size. These theories should be further evaluated, and additional studies should be done to understand challenges faced by researchers in collecting data from this population. This study's sample size and participant pool widely influenced the findings to the research question.

Concluding Thoughts

The findings of this study emphasize the challenges these mental health professionals working at therapeutic schools during COVID-19 faced being socially isolated from the community, while also observing their students struggle with social isolation. Mental health professionals also experienced issues in transitioning to remote therapy, though many were also able to recognize the positive ways in which using technology to provide services could improve their lives or the lives of their patients and families. Participants felt the effects of trauma alongside their students, battling their own struggles while also witnessing the mental health decline of many of their patients. They recognized the changes that occurred in communication with their students and used their skills to find new ways to engage them at a time when a lack of structure was protuberant. Additionally, some of the participants expressed feelings of helplessness, and emphasized the need for guidance during this period of uncertainty. The changes created in their lives often led to difficulties with boundaries, which prevailed after the height of the pandemic had passed. Nevertheless, the commitments these participants had to the wellbeing of their students served as their motivation to continue their work during this time.

These themes emphasized the need for clinical support for mental health professionals, particularly during challenging and uncertain times. They also stressed the resilience and adaptability exhibited by these participants, especially as they continued to overcome the challenges they faced. The goal for these mental health professionals was to provide the services

their patients needed and to normalize their situations as much as possible. In the process of doing so, they had to balance their own struggles with those of their patients. Though a perfect balance was never found, participants often found solace in the importance of the work they were doing, and the meaning it supplied them. These mental health professionals are necessary to the lives of the students they serve. The field of social work must provide them with the support crucial to move forward, even years following the COVID-19 pandemic.

Section Nine: Plan for Completion

	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023
Proposal Defense	*	*								
IRB		*	*							
Recruitment and Data Collection			*	*						
Transcription			*	*	*					
Data Analysis			*	*	*					
Writing Results				*	*					
Updating Lit Review						*				
Updating Methods						*				
Writing Conclusion						*				
Dissertation draft to Advisor/Committee						*	*			
Dissertation Editing/Revisions							*	*		
Dissertation Defense									*	*
Revisions/Submit Graduation Paperwork									*	*

Section: 10 References

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IRB APPROVED
Oct 07, 2022

APPENDIX A: INFORMED CONSENT

TITLE:	The perspective of mental health providers on Shared Trauma, Social Isolation and Technology during the COVID-19 pandemic with adolescents at therapeutic schools
PROTOCOL NO.:	9731613 WCG IRB Protocol #20225427
SPONSOR:	Yeshiva University
INVESTIGATOR:	Adam Gerszberg, MA 2945 Amsterdam Avenue New York, New York 10033 United States
STUDY-RELATED PHONE NUMBER(S):	(973) 647-2380 (24 hours) (646) 592-6841

Taking part in this research is voluntary. You may decide not to participate, or you may leave the study at any time. Your decision will not result in any penalty or loss of benefits to which you are otherwise entitled.

If you have any questions, concerns, or complaints or think this research has hurt you, talk to the research team at the phone number(s) listed in this document.

RESEARCH CONSENT SUMMARY

You are being asked for your consent to take part in a research study. This document provides a concise summary of this research. It describes the key information that we believe most people need to decide whether to take part in this research. Later sections of this document will provide all relevant details.

What should I know about this research?

- Someone will explain this research to you.
- Taking part in this research is voluntary. Whether you take part is up to you.
- If you don't take part, it won't be held against you.
- You can take part now and later drop out, and it won't be held against you
- If you don't understand, ask questions.
- Ask all the questions you want before you decide.

How long will I be in this research?

We expect that your taking part in this research will last less than an hour.

Why is this research being done?
The purpose of this research is to learn more about the mental health professionals' experiences with technology, social isolation and shared trauma during the COVID-19 pandemic.

What happens to me if I agree to take part in this research?
If you decide to take part in this research study, the general procedures include participation in an interview.

Could being in this research hurt me?
You may feel uncomfortable answering some of the interview questions.

Will being in this research benefit me?
It is not expected that you will personally benefit from this research.

What other choices do I have besides taking part in this research?
Your alternative is to not participate in this research.

DETAILED RESEARCH CONSENT

CONTACT INFORMATION:
The researcher and Principal Investigator, Adam Gerszberg LMSW, is currently A PhD Candidate at the Wurzweiler School of Social Work, 2945 Amsterdam Avenue New York, NY 10033. For questions, concerns, or complaints about the research study, please contact directly at:

Adam Gersberg, LMSW
Wurzweiler School of Social Work
2945 Amsterdam Avenue
New York, NY 10033
agerszbe@mail.yu.edu
(973) 647-2380 (24 hours)

If you require additional information about this study. You may also contact:

Christine Vyshedsky, PhD Chair
Wurzweiler School of Social Work
2945 Amsterdam Avenue
New York, NY 10033
Christine.vyshedsky@yu.edu
(646) 592-6841

This research is being overseen by WCG IRB. An IRB is a group of people who perform independent review of research studies. You may talk to them at 855-818-2289 or researchquestions@wcgirb.com if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You are not getting answers from the research team.
- You cannot reach the research team.
- You want to talk to someone else about the research.
- You have questions about your rights as a research subject.

This research study has been reviewed by the WCG Institutional Review Board (IRB) for Yeshiva University's Wurzweiler School of Social Work.

We would like to talk to you about a research study on the mental health professionals experiences with COVID-19. You will be one of between 10 to 25 people who will be participating in this study. This study is designed to learn more about the mental health professionals experiences with technology, social isolation and shared trauma during the COVID-19 pandemic. If you join the study, you will participate in an interview of approximately 30-45 minutes, which will be recorded with your permission using an audio recorder, then transcribed for review. This interview will take place over Zoom. If you decide you do not want to be recorded, the recording will either not start or will be stopped immediately. Recording is to assist the researcher with details of your response. Recordings will be destroyed when the research project is completed.

If necessary, with your permission, researcher may call to obtain clarification of comments made during the interview. Clarifications may or may not be recorded, subject to your permission. You have a choice about being in this study. If you decide to take part, you are free to stop participating at any time without giving a reason. It will not cost you anything to participate in this research. All participants will receive a 15$ Amazon gift card for participating in the study despite completion.

RISKS:

Possible discomforts or risks include evoking uncomfortable feelings related to the subject of the study. There is also a possible risk of loss of confidentiality. There may be risks the researchers have not thought of.

BENEFITS

You are not expected to benefit directly from your participation in this research. It is hoped that your participation in this study will generate important information about mental health professionals experiences during the pandemic and the impact of COVID-19. Resources will be provided along with the present document.

ALTERNATIVES
This is not a treatment study. Your alternative is to not participate in this study.

CONFIDENTIALITY:
Every effort will be made to protect your privacy and confidentiality by not using your name, meeting on Zoom, or in-person with the researcher. Additionally, interview information will be kept in a locked file available only to researchers and IRB personnel. The computer that the data will be carried on will also have a separate password that is different from the folder to ensure an extra layer of protection.

We may publish the results of this research. However, we will keep your name and other identifying information confidential.

We protect your information from disclosure to others to the extent required by law. We cannot promise complete secrecy.

Before your interview begins, you are encouraged to ensure that you are in a comfortable space.

Can I be removed from this research without my approval?
The person in charge of this research can remove you from this research without your approval. Possible reasons for removal include:

- It is in your best interest.

We will tell you about any new information that may affect your health, welfare, or choice to stay in this research. The research is canceled by the sponsor.

Please sign below if you agree to participate in this research study

I have read the consent form and I understand that it is up to me whether or not I participate. I know enough about the purpose, methods, risks and benefits of the research study to decide that I want to take part in it. I understand that I am not waiving any of my legal rights by signing this informed consent document. I will be given a signed copy of this consent form.

____
Printed name of participant

____
Signature of the participant

____
Signature date of the participant

____
Printed name of researcher

____
Signature of the researcher

____
Signature date of the researcher

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Protocol Level
Oct 07. 2022

APPENDIX B: Hard Copy of the Demographic Questionnaire

1. What gender do you identify as?
2. What ethnicity do you identify as?
3. What is the highest level of education held?
4. What state are you employed in?
5. How many years have you had your license for?
6. What is your specialty or focus on in the field, if applicable?
7. Which clinical license degree do you presently hold?
8. Do you work as a direct provider of mental health services for your clients?
9. How frequently do you meet with your students?
10. How long have you worked at your present place of employment?
11. What is the age range of your present case load?

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APPENDIX C: Semi-Structured Open-Ended Interview Questions

1. Tell me about your experience working with adolescents prior to the pandemic and during the height of the COVID-19 pandemic.
2. How did social isolation affect you?
3. How did social isolation affect your practice as a mental health professionals?
4. How did the use of technology and telehealth services affect you and your practice as a mental health professionals?
5. How did the trauma of the patients you worked with affect you?
6. How did the trauma of the patients you worked with affect your practice as a mental health professionals?
7. Reflecting on your experience with this population, what challenges compared to other mental health professionals if any affected you?
8. What is your present experience with the way your school is functioning with providing services?
9. What do you see for the future of the field of psychotherapy based on your experience during COVID-19?
10. What motivated you to stay in this position during the pandemic?

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Oct 07. 2022

APPENDIX D: Solicitation Letter with Consent and Confidentiality Agreements

Dear List Server Members, Faculty and Peer Scholars,

My name is Adam Gerszberg, and I am a Doctoral student at Wurzweiler School of Social Work. I am currently researching the experiences of mental health professionals in psychiatric schools during the COVID-19 pandemic. There is currently a significant gap in the literature on the experiences of mental health professionals during COVID-19, let alone the experiences of mental health professionals working in psychiatric schools. I hope you will consider taking part in this research study that will help me gather data on this matter.

This research is entirely voluntary, and your participation will remain confidential. If you agree to take part, you will be sent a demographic questionnaire via email. This questionnaire will be conducted through Qualtrics to ensure that the inclusion criteria are met. Following the review of the demographic survey, you will receive a virtual consent form that will require a signature and ask for a phone number so that you can be contacted to schedule your interview. You do not have to provide your name. If you do, your name and identifying information will not be used in any part of the research study. All data collected is kept for up to three years (as per federal guidelines) or until the researcher no longer requires it and then it will be destroyed. All participants will receive a $15 Amazon gift card for participating in the study, regardless of completion.

Please note that by filling out the demographics questionnaire and providing your email/ number, you will be consenting to participating in this study. You may choose not to answer any question in the questionnaire, or during the interview. You may choose to withdraw from the study at any time. Should you have further questions or concerns about your rights or about any aspect of this research, I encourage you to contact me at agerszbe@mail.yu.edu or the chair of my dissertation committee Christine Vyshedsky christine.vyshedsky@yu.edu

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Thank you for your time, and I hope you will choose to participate in this research! Adam Gerszberg LMSW, Ph.D. Candidate

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APPENDIX E: Mental Health Resources for Participants

Below are several resources to support your mental health needs.

Emergency Hotline Information

Department of Health Crisis Hotline 1-800-527-7474 Life Net Hotline Network 1-800- LifeNet (543-3638) NYC Well 1-800-692-9355 or text "Well" to 65173

Multiple Locations

Jewish Board of Children and Family Services To make an appointment: 1.844.ONE.CALL

Lifestance Health Lifestance.com

Bronx

Comprehensive Counseling LCSWs https://www.comprehensivecounselinglcsw.com/ 718-830-0246

Mosaic Mental Health 718-796-5300

Manhattan

Manhattan Mental Health Counseling 212-960-8626

Brooklyn

Comprehensive Counseling LCSWs https://www.comprehensivecounselinglcsw.com/ 718-830-0246

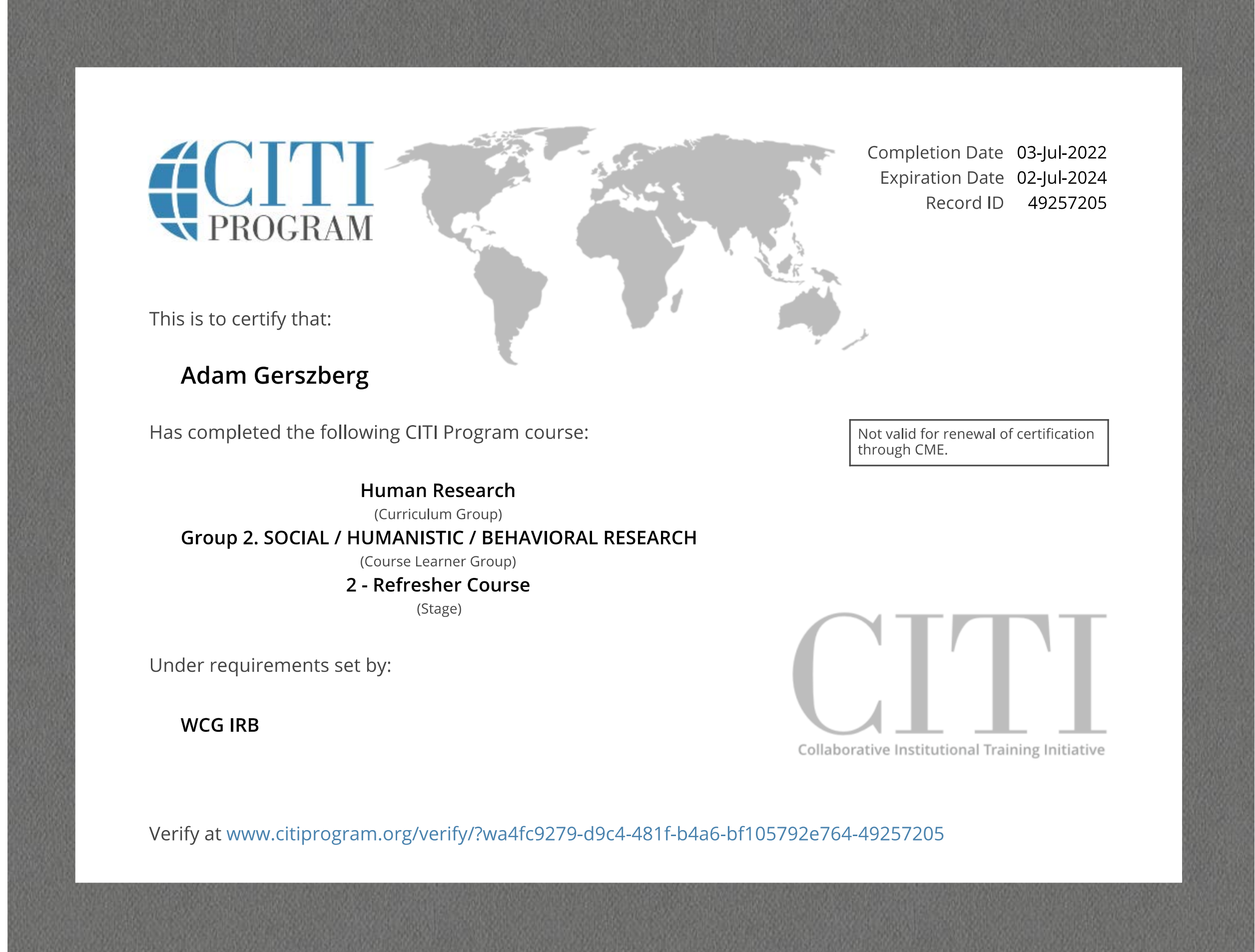
Queens

New Horizons Counseling Center108-19 Rockaway Blvd Ozone Park, NY 11420
Tel: 718-845-2620

New Jersey

St. Joseph's Health - Behavioral Health Outpatient Services 641 Main St, Paterson, NJ 07503
Tel: 973-757-4750

APPENDIX F: CITI Human Research Certificate


CITI PROGRAM

Completion Date 03-Jul-2022
Expiration Date 02-Jul-2024
Record ID 49257205

This is to certify that:

Adam Gerszberg

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Human Research
(Curriculum Group)
Group 2. SOCIAL / HUMANISTIC / BEHAVIORAL RESEARCH
(Course Learner Group)
2 - Refresher Course
(Stage)

Under requirements set by:

WCG IRB

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wa4fc9279-d9c4-481f-b4a6-bf105792e764-49257205