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FROM MARCH 2020 TO MARCH 2021 – PSYCHOTHERAPISTS ABOUT WORKING IN THE COVID-19 PANDEMIC. COLLECTIVE AUTOETHNOGRAPHY

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Summary

The incentive to write the article was to record the work experiences of a psychotherapists team in an exceptional time from March 2020 to March 2021. Psychotherapists who, without planning it beforehand, left their offices and sat in front of the screens, underwent a quick IT course and participated together with their patients in a great experiment: Psychotherapy in the COVID-19 pandemic. The authors used the Collective Autoethnography method to collect and develop the research material. It is a qualitative research method appropriate for the exploration of new social phenomena that evoke strong emotions and affect both individuals and groups. The research has shown that both adaptation to work in the pandemic and return to offices are processual in nature, varying in pace and rhythm individually (for patients and psychotherapists). The emergence of transgression, i.e. a creative transformation of thinking, acting and environment, requires a favorable context in which the key is the team support. In online psychotherapy, we collect a different type of information about families and individual patients, requiring adjustment of developing and understanding of setting and contract. Introducing online psychotherapy to a greater extent than it was before the pandemic will allow to use this way of treatment for those people, who found it unavailable or difficult to access. Opening up to consultations in a team, a wider environment and interdisciplinary work of psychotherapists is a supporting factor in the processes of adaptation and transgression. Remote work involves physical and mental overload of psychotherapists, hence additional attention needs to be paid to supervision and personal comfort.

Introduction

The COVID-19 pandemic, which reached Poland on March 4, 2020 with the first diagnosed patient, was received by some with disbelief and denial, by others with horror, but by most with surprise. Harari [1] in the book published in 2018, *Homo Deus. A brief history of tomorrow* announced the end of the era of wars, famine and pestilence and described the condition of the 21st century human, characterized by i.a. a false sense of security and the belief that epidemics happened in the past and elsewhere. However, in March 2020 it also happened in our country, as well as around the world. In the March 2020 issue of *Lancet*, Brooks et al. [2], based on already published studies, lists the negative psychological effects of quarantine that are identical to the symptoms of post-traumatic stress disorder: cognitive disorganization and negative emotions (confusion and anger). The stressors which caused these conditions were present for a long time of the quarantine, and they were: fear of infection, frustration, boredom, inadequate supplies, inadequate information, financial loss and the stigma of disease. Some researchers suggest that the consequences will be long-term. In a situation of stress or trauma, a person undertakes protective, adaptive and then transgressive actions, i.e. actions that exceed the existing material, social and symbolic boundaries, and allow to transform reality [3]. To understand the psychology of a pandemic better, we can refer to the classic concept of Jaspers' borderline situation, defined as an inevitable situation that "always means benefit or loss, chance or limitation" [4, p. 136]. An analysis of scientific publications on psychotherapy from the memorable first year of the pandemic presents some attempts to reflect "on the spot" upon the impact of the spread of the virus and social isolation, health anxiety and other consequences on psychotherapeutic work. Numerous publications discuss the topic of online psychotherapy, comparing the effectiveness of online and direct contact (f2f) interactions. Research by Humer et al. [5] is based on an analysis of a survey conducted among 1547 psychotherapists from Austria on online psychotherapy after the introduction of restrictions related to COVID-19. The main concerns of the respondents involved the safety and data protection in online work, whereas the comparison of the efficiency of psychotherapy via the Internet and therapy with face-to-face contact showed no differences. Also, the pre-pandemic meta-analysis (2,160 studies and 15 randomized controlled trials) by Florean et al. [6] on the effectiveness of programs for parents, which were aimed at increasing the competence and educational efficacy of children, showed that there is no significant difference between online and face-to-face support. Interestingly, behavioral performance was better in children whose parents received online support than those who waited for specialist assistance. Ryu et al. [7] write about the use of virtual platforms in psychiatric care. According to the authors, the number of tele-psychiatric institutions in the United States has doubled in recent decades, a trend that has been intensely reinforced by the COVID-19 pandemic, which had a particular impact on the sudden increase in the number of online psychotherapy sessions. Looking ahead, the authors perceive online therapy as a more efficient opportunity to combine clinical practice and scientific research by introducing new quantitative research methods of treatment process assessment. They emphasize the importance of technologies such as machine learning algorithms that are up to 96% effective in reading subtle human emotions that are not consciously recognized

by humans. Inchausti et al. [8], in their article about psychological interventions over the COVID-19 pandemic time, point out the challenges of securing access to mental health services. According to the authors, these activities should involve on the one hand identifying and monitoring groups at higher risk of developing mental disorders i.e. healthcare workers on the front lines of the fight against the pandemic, people infected with COVID-19 suffering from anxiety about their own health and prolonged isolation, family members of seriously ill patients and people having psychiatric treatment in the past and suffering the consequences of the pandemic now. At the same time, on the other hand, new ways of implementing psychological interventions should be sought, including the use of technology for telephone consultations or via the Internet platforms. It issues many challenges to therapists in terms of learning new technologies, adapting therapeutic techniques to online work, drawing attention to specific conditions and additional parameters of therapy in lockdown and arising questions about the purpose of therapy in such unusual conditions. The authors also share their experience from previous clinical work on adapting and conducting technology-assisted therapy in the situation of the COVID-19 pandemic. They pay particular attention to the role of renegotiating the therapeutic contract, discussing and adjusting it to the conditions of online work. They also indicate the need for a flexible approach to symptoms in response to increased stress in a crisis situation, such as anxiety, fear, anger, guilt, as well as obsessive behavior and behavioral dysregulation. At the same time, they emphasize the key role of basic therapeutic techniques such as validating the patient's experiences, sharing and revealing by the therapist their own emotions related to the pandemic, which allows to normalize the patient's experience. The authors also recommend providing a safe and comfortable place for online therapeutic work, both on the side of the therapist and the patient. They also suggest using webcams in such a way that the patient's figure is visible from the waist up, so that the non-verbal communication can be used at least partially. The situation of the pandemic should not distract from the purpose of therapy, such as increasing the patient's autonomy, overcoming crisis situations and strengthening healthy parts of the self even within the limitations caused by lockdown.

Just before the pandemic, a monograph about online work was published under the editorship of Weinberg and Rolnik [9]. It included the issues of conducting online individual, family, couples and group psychotherapy, as well as supervision, training and conferences, and was a significant help at the beginning of introducing remote work. Solomon and Siegiel [10] in their monograph about relations in psychotherapy, referring to research in the field of neurobiology, emphasize that not only words work in psychotherapy. Physical presence triggers mutual tuning and mutual regulation at the neural and somatic levels (smells, gestures). Online work deprives patients and psychotherapists of this channel of building and enhancing relationships. Also, according to Porges [11], people in physical proximity immediately activate a primary mechanism at the level of the nervous system that makes it possible to judge whether it is safe to be close to another person or not. Person sends signals that he or she is uncomfortable: the expression of the eyes, micro-tensions of the body and face, movements of the limbs that can be noticed only in direct contact, the psychotherapist does not obtain such information in remote contact. In conclusion, it is important to emphasize the difference between conducting online psychotherapy before the pandemic and working in such a form during the pandemic. In the latter case,

the decision to introduce remote contact is a forced situation, which should be taken into account e.g. in case studies.

Methods

Qualitative research methods are hardly replaceable in learning about social phenomena that are new, surprising, and cause anxiety in the participants who create a "hot" conceptual apparatus that allows these phenomena to be conceptualized. Among qualitative methods, apart from observations, interviews, and methods that fit into the participatory trend of research, autoethnography plays an important role, in particular collective autoethnography (CA). Autoethnography is an empirical method that allows systematically and scientifically record thoughts, emotions and actions in a new, emotionally stressful experience that the pandemic situation has been. It allows the researcher, while remaining in the role of an observer, to be simultaneously a participant in the studied phenomenon. The auto-ethnographer creates reality actively and coauthors meanings and values. Anderson presents a clear description of the types of autoethnography and its history [12]. The author focuses on analytical autoethnography i.e. self-conscious introspection aimed at better understanding both oneself and others. The researcher is a complete participant of the study group or context (setting), is guided by the analytical research plan, strives to improve the theoretical approaches to wider social phenomena. In collective autoethnography (CA), empirical material concerning one research problem is described by several authors, which allows to understand the subject of research and place it in social interaction. The CA method searches for connections with the broader context of psychological and sociological theories. The analysis of the entire research material also includes noticing the relationship between auto-ethnographers, their mutual influences and the interactive impact on a broad social context (workplace, family). In addition, the CA method is characterized by external correctness, which means the possibility of making generalizations, and the reliability of qualitative research consisting in the correct documentation of the material (e.g. recordings or quotations). On the other hand, the credibility of the qualitative method is demonstrated by the possibility of re-performing the same test by repeating the same procedures [13], which CA also fulfills.

Apart from autoethnography enthusiasts in the literature of the subject, there are also sceptics who point out the weaknesses of this method of scientific cognition of reality [14], mainly pointing to the danger of crossing the border between science and art, which especially concerns evocative autoethnography [12, 14].

The method that gives many points of view and at the same time frees the text from the egocentric "saturation of the author" is the aforementioned *collective autoethnography*. Lapadat et al. [16] use the term of *collaborative autoethnography* for this method and emphasize the impact of creating a common ethnography, consisting of individual narratives, on building trust in the team and promoting creativity. CA enriches the intersubjective perspective that not only has a positive impact on the team, but also on psychotherapeutic work. CA allows one to see the studied phenomenon in both nuanced and holistic ways. Thanks to author's own reflection, it is possible to capture personal, even intimate individual

experiences, as well as to notice and register differences between the perception of the same situations by different people. The CA method also allows to register cultural differences that elude other empirical methods. An interesting proposal among qualitative studies using CA is the article [17] *How psychotherapists make use of their experiences from being a client*, in which the author analyzes the experiences of 6 psychotherapists-researchers from their own individual, group, family or couple psychotherapies. The descriptions of transferring experiences from the role of a client to a psychotherapist, deepening the understanding of clients through own experience, and the usefulness of negative aspects of own therapy can be found in the narratives. In the conclusion, the author emphasizes that CA is a new measure to observe basic processes of knowledge construction. A contribution to the description of teaching in the situation of the COVID-19 pandemic is an unpublished work of a group of English-speaking students who participated in the course of *Ethics in Medicine.* The authors of the CA included in 7 diaries their personal learning experiences during the pandemic [18] in the situation of the university's closure. In their work on CA, Wężniewska et al. [19] describe organizational difficulties when they worked in a team of four on their narratives. They also indicate the power of team autoethnography, introducing the thesis that it is a form of self-therapy, "self-healing and co-treatment", and conclude that CA is "a meeting of people who have decided to share their own inner world" [19, p. 341].

Team of self-research researchers

Our team consists of 9 people, 2 are physicians specializing in children and adolescents psychiatry, the remaining 7 are psychologists. We are all psychotherapists having work experience of various lengths from 3 to 40 years. Developmental age patients with various symptoms (including eating disorders, anxiety disorders, depression, suicidal conditions) are referred to our team by psychiatrists. We conduct family therapy, therapy for family groups, parental dyads and individual psychotherapy for adolescents and young adults. We conceptualize psychotherapeutic work referring to systemic, psychodynamic and cognitive-behavioral theories. During the research period (in whole or in part), 3 people were on parental leave. In the first weeks of the pandemic, we worked remotely from our homes, hence supplementing the description of the group with the family context of auto-ethnographers is reasoned. All members of the team have their families, one person has three and another two school-age children. Working remotely from home required reorganizing family life, taking into account the need to share electronic equipment with family members. It was a challenge, but at the same time, families were our support in the difficult situation of the pandemic.

Self-reflection in social context is a natural aspect of being a psychotherapist, as well as mutual teaching and engagement in dialogue. Work organization, which includes joint weekly team meetings and group supervision of conducted cases, fosters reflection and deepens the understanding of own and colleagues' activities. Hence, we discussed the experiences related to work in the pandemic on ongoing basis, introducing organizational and substantive changes. Also, the idea of developing this experience in writing was the result of collective self-observation. After the first months of work in the pandemic, the

team made some attempts to organize experiences, initial recapitulation, and references to established concepts. These considerations generated further questions and the answers to them required systematic studies. An aim emerged from our discussions: to describe the unique situation, to present how the team members behaved, how they understood and how they interpreted the new reality. How did the patients respond to the changes in psychotherapy? Hence, we formulated the research problem, which, according to the rules of qualitative research, should be an open-end question, not suggesting an answer, allowing to learn about the beliefs and attitudes of the respondents [20, 21].

Research problem

Research problem: how did the reactions and attitudes of psychotherapists towards patients and work form in the situation of the COVID-19 pandemic?

Specific questions:

1. What were the first reactions of psychotherapists and patients to the pandemic situation?
2. How did the introduction of remote work go?
3. Can we make the first summaries of work in the pandemic?

The first step was to develop the issues, around which each team member described their individual observations and reflections: a) the first reaction of therapists to the information about the epidemic in the context of therapeutic work - their attitude to remote work before the epidemic, b) contacts with patients - their responds to proposals for online psychotherapy, who continued therapy, returns to f2f offices, but also unique experiences: what surprised therapists, what was the most difficult for them in remote work and during the pandemic, and other activities, e.g. supervision, meetings, conferences, c) long-term consequences - what we will remain after returning to "normality".

People whose professional and personal situation made it possible to devote time to writing ethnography participated in the research. One person from the team took on the role of the coordinator of joint activities; individual descriptions created by team members independently of each other were sent to her e-mail address.

Autoethnography analysis

The collected research material, in accordance with the posed detailed questions, has been divided into threads which constitute the basis of the analysis of each autoethnography. Their authors are marked with symbols from A1 to A8. The descriptions were not kept on the ongoing basis, , but were a form of reconstruction of events, thoughts and emotional reactions in the period from March 2020 to March 2021. The analysis of the material was illustrated with quotations, and the quoted words of auto-ethnographers are in italics.

Thread 1: First reaction to the information about the pandemic and the restrictions connected with it

The authors' reports included descriptions of emotional reactions: *surprise, disbelief* (A1), *shock* (A2), *dissent, anger… confusion and feeling of being lost* (A5), *anxiety* (A8), and over time, *increasing sense of temporariness, feeling of suspension* (A1). Emotional reactions, in most cases, were related to the need to cancel therapeutic sessions, supervision, meetings and classes with students. In some descriptions, the authors referred to the places and exact situations in which they learned about the closure of their workplace: *The need to implement epidemic restrictions came very suddenly. Suddenly enough that I remember that in this particular afternoon, I was running a support group for parents with my colleague, and if the meeting had been scheduled for a later hour, it certainly wouldn't have taken place. Exactly when we were setting up the chairs in the therapy room, the management decided to lock the door to the clinic. Two late parents, unfortunately, could not join the meeting at that time ...* (A4).

There are also descriptions of "internal dialogues" full of doubts and ambivalence to the lockdown*: Maybe these restrictions are too excessive. Do they panic*? (A8) or: *A brief sense of "a break in life" (maybe also a kind of relief, everything has stopped - a holiday from life)* (A1).

With the following days of struggling with life in the pandemic, reflections arose:

After a week it becomes clear that the new reality will take a while (A7). The next words (A6) reflect the processual nature of adaptation to the new situation: *At first, I was convinced that somehow you need to wait out this time. I did not realize that the restrictions and changes concerning the way of working do not apply to a few weeks, but rather to many months.*

An example of reflection on the wider context of the pandemic is A1's statement: *In the first phase – anxiety about the course of the pandemic in Poland - remaining in the shadow of the tragedy in Bergamo. Lack of institutional security, own mobilization, mobilization of management and staff of the clinic, the need to provide financial support to the hospital.*

In the long term, when it is known that the change is becoming ordinariness, the authors recorded their observations concerning the work of colleagues directly involved in the organization and treatment of patients in inpatient wards: *Functioning of the clinic for many months can be described in the metaphor of martial law (the change of the clinic space, parts of clean and dirty, changing the function of rooms, masks, measuring the temperature, etc.).I admire the staff and the management of the clinic (initially available almost around the clock)* (A1).

I read these messages on WhatsApp and, at times, it was like a live recording from the front line ... Thanks to this group, we were together. The healing factor of universality had an effect. An initiative to create a schedule (within private time) of therapeutic support for medical personnel was quickly created by psychotherapists (A8).

Next, the questions about returning to therapeutic work in a situation that excludes work in offices can be found in the autoethnographies. Weekly, substantive and organizational team meetings, which usually brought psychotherapists and trainees around the snack

table, also became impossible. The internships were suspended and the first team meeting, conducted remotely by the Zoom platform, was held on March 17, 2020. We made the decision to start online psychotherapy. The authors write about the difficult beginnings: *To say that the first reaction to the information about remote work was a shock is like saying nothing. This is the world of psychotherapists, long divided into supporters of online work that allows it to reach a wider group of people, and purists like us, emphasizing the importance of personal contact, was to be reconciled due to external circumstances. In our team, we hadn't worked remotely before, we didn't know how to do it* (A2).

The feeling I remember from the first phase of the epidemic is, first of all, taking up challenges, despite the thought "it cannot be done". Primarily in the context of online family therapy. Before the pandemic, I had the opportunity to conduct individual online psychotherapy - thanks to it, I had no doubts that under certain conditions, it is possible and effective. However, I had no experience with remote family therapy (A3).

Before the epidemic, I thought that it was impossible to work online, that such work would be superficial. It is difficult to build the alliance and "feel" the patient - only a part of the body is visible. There is no direct contact and access to some non-verbal messages, and disturbances and disruption may appear on the line. I thought that online therapy is a loss of quality and nobility of therapy - a bit like the difference between watching a live performance at the theater and a movie (A5).

For a therapist who has never worked with clients online or even used the opportunity to work on communication platforms in other areas of life, changing the way of thinking and approaching the necessity to undertake online therapeutic work was quite a challenge. The idea of working with families online seemed ridiculous and grotesque to me (A6).

In all statements we can notice the need to change thinking, undertake new activities, that were a challenge, concern about patients and doubts related to the effects of proposing and introducing online psychotherapy.

The descriptions indicate two directions of activities of the team members: searching for studies on online psychotherapy in Polish and English-language magazines and learning new IT technologies and equipping offices with hardware. The latter is illustrated by a quote from A1 text: *Progressive organization of online clinical work from home, then the need to provide conditions for online work in the clinic without the support of the institution (e.g. cameras were purchased from the Foundation's funds). Expecting each team, each person to solve the above by the internal funds.* Based on the calendar of events in the material of A8, the following sequence of events can be recalled: *on March 12, I canceled my therapeutic meetings with families by phone, without giving anything in return, but on March 19, I conducted the first remote sessions*. The description of online psychotherapy will be presented in the next thread.

Thread 2: Online psychotherapy

Despite the team's agreement on the necessity of telephone contact with patients and offering remote meetings, we started with doubts, questions and concerns. The ethical concerns related mainly to the confidentiality of the meeting and the choice of a safe communicator. The emerging questions concerned responsibility for the context of the

meeting (A5): *Who is responsible for ensuring that the patient provides himself with the appropriate conditions for a therapeutic meeting (that he or she is alone in the room, does not record and there is no one to enter or overhear). Which communicator is the safest?* (A7): *How can you work when you are out of control, when you don't know what happens behind the screen?* (A8): *How to maintain remotely the trust built in the office during face to face contact?*

Another topic of discussions in the team were the technical and organizational matters of therapeutic sessions, both on the side of psychotherapists and patients. Technical difficulties started with the quality of the Internet connections, network load (A8): *everyone in the family uses one optical fiber, parents work remotely, siblings learn remotely and a teenager connects to a psychotherapist ...* as well as access to a computer and finding *.... appropriate conditions ensuring a sense of comfort and intimacy to have an honest conversation with the therapist* (A6). We also dealt with unclear regulations regarding the settlement of visits in the AMMS system. Wider contacts and consultations in the community as well as quick reaction of the management proved helpful. (A8): *We had* (the code) *94,481 - psychotherapy session via tele-information systems, but in the nationwide chaos, not every NHF* (National Health Fund) *accounted for these visits, ours did.*

Patients' reactions to telephone contact and the proposal for online therapy surprised the therapists: it often happened that teenagers, their parents and entire families expressed their willingness to continue the therapy remotely (A2): *Meanwhile, the patients surprised us. Rather, they perceived it as an exceptional concern that, despite the limitations and difficulties, we keep in touch with them. There were also those who did not decide to work remotely, calling it "profanation of therapy" or emphasized the difficulty of talking about their intimate matters to the computer. Out of them, some severed relations and others contacted months later, seeing that the pandemic would last longer than anyone expected, asking for continuation of their therapy.* Account of A7*: To my surprise, a significant number of patients switched to online contact without any major questions. A few did not continue - some sped up the process of ending therapy, and a few gave up because they were fed up with sitting at their computer with other duties, or they were afraid that it was not safe via the Internet.*

There were also refusals justified by housing limitations, one of the authors (A8) quotes the mother of a teenage patient: "*we do not have conditions, one room, an infant and ... no, it is not possible"*. The author (A3) of autoethnography writes about the reactions of patients who were in individual therapy: *Some of them initially wanted to wait out - stop the therapy for the epidemic time, but when it turned out that the isolation was prolonged, they tried to cooperate remotely and most of them continued the therapy.* Another author (A6) says about individual therapy of adolescents*: Apart from a single case, clients started therapeutic contact in the form of online meetings or telephone calls. Some sessions were carried out more systematically and punctually than in the office. Other processes were disrupted, there was information about the lack of appropriate conditions for conducting therapy in this form or excuses such as: "I overslept", "I mistook the days", "They did not wake me up".*

The following quote is an account of the author (A4) running a parent support group:

Meetings of the support group for parents were organized remotely. Of course, it didn't go without quite a lot of technical support and assuring participants of the effectiveness of

such a solution. Fortunately, parents were very motivated to get support. Even if it was to connect via the Internet. The experience of running a therapeutic group in a remote mode was something extraordinary for me. On the one hand, I had the feeling that the transfer of therapy to the virtual environment, unfortunately, led to the disappearance, or rather: the dissolution of the specific therapeutic structure or therapeutic milieu that is clearly visible when an encounter takes place in a specific place, at a specific time and under set conditions. A few people meeting on a communication platform in comparison with a face to face meeting, was certainly devoid of some kind of decorum. It also provided numerous, sometimes frustrating technical difficulties. The frustrations of running such a group included interruptions of the Internet connection, poor quality of participants' equipment (there is nothing more frustrating for the therapist conducting the online therapy than the terrible quality of the patient's microphone, which makes the patient unable to hear / understand the message directed to him/her), but also the need to structure the utterance in such a way that only one person can speak at the same time. Unfortunately, in the virtual world it is very difficult to have a lively discussion by several people at the same time. Nevertheless, the therapeutic process planned for 12 weeks was extremely fruitful. We observed proudly how the parents give each other helpful feedback and support. They shared the feeling that the meeting time was the moment of the week they waited for and their week was focused around it. Despite the impoverished form, parents appreciated the possibility of continuing the meetings despite the prevailing pandemic. They were glad that they "weren't left in the lurch". They still continue to use the online platform to keep in touch, but no longer need the presence of therapists. The last sentence of the statement introduces the topic of the benefits of remote therapeutic work, which will be developed in the next subsection.

The impediments connected with remote work can be classified into three groups. One is related to technical disruptions: hardware, connection quality and limitations resulting from the very essence of remote contact. The next group consists of difficulties and dilemmas regarding the setting, therapeutic alliance, and the course of the session, it can be titled: substantive problems. The third is about ethical doubts and both mental and physical challenges for the therapist. The ethical and substantive doubts and difficulties arising from online psychotherapy are illustrated by the following statements:

A5*: At the beginning, definitely the hardest part was to overcome the barrier in my head and the inner conviction that such work is worse, less valuable and cannot be successful. You had to change your mind to feel the hope of this work, the benefit for patients who can get support even from distance, and the feeling that this form of work could be "good enough" in the pandemic.*

A3 and A6 authors write about cases that leave the psychotherapist worried about the health and life of patients: (A3) *The most difficult moments of remote work concerned patients with suicidal thoughts. The lack of in-person contact in the office heightened my anxiety as a therapist (e.g. I think that turning off the computer is much easier than leaving the office). The questions about responsibility in this type of process have arisen: Does it change in comparison to the processes carried out in person? Does it require recontracting? Should online therapy with patients with such problems be conducted remotely at all? Therapeutic sessions with patients at the initial stages of mourning were also very difficult, at that time the lack of direct contact was extremely acute.*

(A6) *I experienced some difficult moments when an online meeting was started by a crying, trembling teenager who was during or just after an argument with their parents. On the one hand, I was anxious about the patient's mental state, and aware of the need to calm him or her down so that the conversation would be possible. I was also concerned about proper understanding of the situation and adequate therapeutic intervention. On the other hand, there was a feeling of crossing certain boundaries, violating the patient's home space, initially without awareness and consent of other family members. Such cases required self-control, a clear-headed look at the situation and a way of conducting the conversation so as not to lose contact with the teenager, and at the same time to ensure that other household members were aware of the ongoing conversation and thus the specific presence of the therapist under their roof.* The author of the above statement draws attention to the situations of transgression between therapy types. It can be hypothesized that online therapy is a combination of family or individual therapy with an intervention in the patient's environment.

A6 writes about the unpredictability of what happens on the other side of the screen, i.e. the behavior of patients and changes in their environment: *Another category of difficult situations, less frequent or unusual in the therapy room, was the behavior of clients / patients disrupting the course of the conversation. What I mean here is yawning, snoring, puffing on a cigarette, eating and drinking, preparing meals, sounds of incoming text messages and e-mails, sounds of conversations, and even the sounds of using a self-service checkout in a store. Each time such situations required discussion, referring to the principles of the therapeutic contract and checking to what extent the place where the client stays facilitate a safe conversation.*

The office space is arranged by therapists, or at least they have some influence on it, for example by arranging armchairs, while working remotely they face with the variety of configurations of family members, as described by the author (A7): *Some families, even four people, sit on the couch next to each other and adjust the camera so that everyone is visible; others sit together but only part of the family is visible and the laptop is turned towards the speaking person; sometimes a family member is reminded to move closer because he or she is hardly visible. Other families sit at the table and turn the camera so that you can see the speaker, but at the same time you can't see the other participants. Moreover, it happens that they leave the room, move or hide under the table (when it comes to children). Other families participate in the therapy from several devices, sometimes from the same house, but from different rooms, and sometimes from different places or even towns. Of course, it should be the standard for families to have cameras and microphones turned on when they join therapy, but sometimes it happens mainly in teenagers, that the camera is turned off or the microphone is muted when the person doesn't speak. I ,as the therapist, see a window on my screen, or a few ones (plus an extra one - of my co-therapist) and I can only see a part of each person. Normally, in an office, I would see the whole person from head down, I would notice body language, all conscious or non-conscious movements. And now, ideally I can see a head, maybe a part of the body. The whole physicality of the patient escapes my notice. But I have never seen facial expressions so well - we cannot be so close to our patient in an office. It gives a different perception of the patient. What happens off-screen? A powerful source of information, doubts and anxiety. I don't know*

what happens off-screen, both in terms of what the patients do, but also what happens in the room or at home. I sometimes see the patient looking down / to the side and suspect that he does something on the phone; sometimes it happens that a child or a teenager plays or does something else on the computer.

Remote work provides a different type of information, not available in the office, that can be discussed and enables to formulate hypotheses useful for the understanding of family functioning.

The auto-ethnographers also described surprising situations and sometimes requiring the therapist to stay calm despite the grotesque or danger. The author of A7 describes one of such situations: *Patients are usually at their homes and do not often feel the boundaries they would have in the office - children show various toys or new things, household members often sit down with a cup of coffee or tea, finish their meals. It happened that during the session they get up to pour themselves drinking water, prepare tea or take something from the fridge, and even prepare a meal. The sight of a family cooking pasta and sitting down to dinner can baffle even the most experienced therapist. The participants of the therapy feel much more informally, sit in positions that are more comfortable for them (sometimes half-lying). Conclusively, through the camera I am at home of the family or the patient so they reveal a bit of themselves, their lives, their space - you can learn a lot from it and this is a topic for work. And a further background are pets, family members (children) peeping into the room or walking in the background, or a neighbor/ courier calling at the door, it is almost the standard in online family therapy.* In the next autoethnography (A8) you can find a description of a part of a family session, when a 6-year-old boy, a participant of the meeting, took the phone that the family used to connect to the meeting and put it in a drawer*: I couldn't see anything and asked, just like his parents, for setting us free ....* In a report from another family meeting, A8 author describes a situation in a 5-person family who was connected via a phone, just as the previous one: *It was their second meeting, the first was also remote. We were just building the relation and getting to know each other. There were three children and parents in the family, two teenagers and a three-year-old girl. When I asked a question a particular person, they passed the phone to that person. I put a lot of effort into making contact with the three-year-old, I asked her to draw something, she agreed, saying that she would draw a spider. After a while she showed me a ready drawing and I made the comment: what a beautiful spider. She replied indignantly: this is not a spider, this is my dad, the others burst out laughing. At this point, my painstakingly built contact with the child was irretrievably broken. Because the family did not continue the therapy, I did not get a chance to work with the family out this ambiguous material from the exchange with the girl. There is also a question about building a therapeutic alliance, especially with children, how to trust a therapist who is known only from the screen, just like cartoon characters?*

A8 author mentions the issue of having the first online meeting with a family. It is a situation of getting to know each other without prior contact in the office, building an alliance and trust. We hesitated for a long time over the decision to start both family and individual therapy. However, the queue of patients lengthened and we received new registrations, so we started the first remote consultations. The longer the pandemic and the transfer of many aspects of life to the virtual world lasted, the more ordinary contact

with online therapists became for patients. In conversations during family and individual therapy, the pandemic and the resulting difficulties were a regular topic: (A8) *Teenagers in my families began each session with complaining about being locked in their homes, about the necessity to wear masks, constant control of parents who did not go to work.* A2: *During the sessions there was an occasional frustration and burden from the prolonged situation. Plus this uncertainty: how long will it take? For a long time, each meeting ended with a summary that we would meet again online, "unless something should change, we will let you know".*

Family therapy is very often conducted in co-therapy, which has also been modified, as well as the participation of trainees having real time observations of the sessions. The author writes about co-therapy and trainees (A2): *The work in co-therapy also made a noticeable difference for me. First, people watching the therapeutic process behind the mirror couldn't help us. Secondly, virtual communication made it difficult for me to read not only the feelings and intentions of the participants of the therapy, but also the co-therapist. We often started a sentence at the same time or followed more separate tracks than during work in the office.* Many authors also mention an additional distorting factor, which is seeing yourself on a monitor. For some therapists it was a new, useful source of information about themselves in their relationship with patients, for others it was a factor that they got used to over time, and for others it was so disturbing that they turned this function off. In all autoethnographies you can find some information about technical difficulties and tiredness other than at work in the office.

A4: *The most difficult aspect of working remotely was the greater feeling of tiredness. Perhaps it was due to the greater mental effort that should be put into a conversation with a person, which is reduced to a few modalities. Perhaps it has to do with a less comfortable working position. Or maybe the computer screen has nothing to do with in-person contact?*

A8: *I was so tired of keeping my full focus on the screen for many hours, as if I wanted to keep the patients' attention and the network connection by force of my own will, soaking up the information with multiple attention, trying to make up for the missing data ...* The two quotes below illustrate the technical difficulties that were, among other things, a source of tiredness. A1*: The main problem that I experienced in online family therapy is very poor technical quality (fading voice despite previous attempts to establish technical parameters, fading voice during gestures, head movements; the need to repeat statements, the necessity to squeeze at one device). Generally little freedom, little comfort for both sides, also difficulty using non-verbal communication…. work from morning until late evening hours - because we are at home, tiredness of working at the computer, back pain, difficulty with having work-life balance.*

A5: *The most difficult thing for me about work was that I couldn't always hear the patients. I couldn't understand them because of the interference or the connection hung in the middle of a sentence. I had a sense of lack of understanding and contact difficulties when you had to ask for repeating a few times or repeat yourself, such a game of "Chinese whispers". At that time, I also felt a tension between the feeling of being guilty that I could not understand the patient and the sense of lack of purpose and the desire to stop or postpone the session because I cannot understand the patient. After such a session, I mainly felt tired of being tense and listening carefully.*

The next statement by A5 reflects the dramatic nature of the situation in the context of the entire hospital. *A dramatic factor is the complete reorganization of work and equipment limitations. Obtaining computers with cameras and speakers, moving desks, often on your own, quickly, without any support of the institution, because in stationary departments downstairs there was a struggle to protect patients and create safe working conditions for the staff.*

The second thread presents the phenomena that patients and therapists faced in online psychotherapy. In most of the analyzed texts, apart from the hardships of remote work, the authors also noticed the bright sides of online work, which will be presented in the third thread.

Thread 3: We are heading for „normality"

The words describing the longing for the time before the pandemic appeared in the statements of therapists and patients, along with the formulated reflection: (A8) *It will not be as it was before*. Although the pandemic continues and has even been worse in recent months, the authors of ethnography have made an attempt to assess the year of work. Vaccinations of medical staff began in January 2021, and since February 1, we have been systematically returning to offices. The proposal for the next meeting in the office that we communicate families and patients is often met with enthusiasm: at last! However, when we arrange another session, they hesitate and request for continuing online therapy until the next time. This is due to certain conveniences and sometimes facilitations that can be noticed in online work.

A6's statement illustrates the benefit of remote contact: *Clients who had some difficulties of building a therapeutic alliance, in the conditions of online meetings, were relaxed, spontaneous, sometimes shortened the distance in a friendly way. I felt then that their level of anxiety and sense of insecurity decreased significantly, that they feel comfortable and safe at home and they greet me like a welcome guest. During first online sessions, but also later, when there was some interference, joking comments about the difficulties associated with this form of meetings were very helpful for both sides, they relieved tension and built the atmosphere of understanding and support in these specific circumstances. With time, more and more comments appeared regarding the appreciation of the possibility of continuing meetings or even the convenience resulting from the lack of necessity to move and the ease of connection with all family members at the same time, despite their physical absence.*

A7 author reports similarly: *Patients living far away do not waste time on traveling now. They can connect from different places, even on a business trip; they don't have to be physically together because everyone can connect from different places. There are even families who want to participate in therapy on their holiday. It is easy to find it out by analyzing the number of missed sessions - I noticed significantly fewer family disconnections than not reaching the office - families occasionally forgot to connect.*

A5*: Some patients also refused to come to in-person sessions, mainly because of the fear of the infection but also difficulties in having a conversation wearing masks.*

Initially, the return to work in offices was accompanied by organizational chaos, which is visible in A5 account: *The most uncomfortable thing for me was that when I managed*

to book an office for a specific time, set a date with a family, the family came, everyone had a negative epidemiological interview, the correct body temperature and the mask, and we entered the ordered room, it turned out that someone was already sitting there with another patient, or from today there is a bed and bedding warehouse from the Covid + ward. The face of the therapist in this situation is priceless, but it was also accompanied by a feeling of embarrassment and explaining to the family that they had to wait a while until we found another office.

The following quotes are therapists' answers to the question of what benefits they see in remote work and what they would leave in their practice:

A1: *time saving ... being able to use new technologies ...*

A2: *What will we keep when we return to "normality"? Perhaps most of all, the feeling that it could be different. This feeling will be in us and in our families. Some will remember fondly how they could be at work 10 minutes after getting up, help their child solve a task during breaks, and even cook and eat dinner on the porch.*

A5: *I will definitely keep a lot of flexibility and mobility, the feeling that you can be in several places at the same time. When you work remotely, it is possible to switch from one session to another within a minute, from a conference to a supervision or a training. You don't waste time on journeys or costs of travel and accommodation.*

In the next section, the attempt to interpret the research material will be presented and the conclusions will be formulated...

Interpretation of research material, discussion of results and conclusions

The first reactions to the information about the pandemic described by psychotherapists were similar to the shock reaction of the first stage of stress and consistent with the symptoms of post-traumatic stress disorder [2]. The following process clearly emerges: shock, confusion, a sense of alienation, intensified by the lack of the necessary socio-emotional exchange resulting from direct contact, then the regulation of emotions, cognitive development, searching for information, knowledge, support in a team, in management, and in a wider environment. Then there is a change of thinking - a transgression [3], which concerned: overcoming one's own prejudices and fears, incompetence, especially in the technical and IT areas, withstanding the sense of responsibility for patients in a new, unpredictable situation, regulation of one's own emotional processes and dealing with ethical dilemmas. In addition to the fear for the health of oneself and the closest ones, the description of frustration and helplessness associated with being an observer of colleagues who work directly in danger in wards with patients infected with the virus can be found in the authors' accounts

On the basis of the collected research material, which is confirmed by the literature [10], it can be concluded that in remote psychotherapy we collect a different type of information about families and individual patients, requiring adjustment of methods of development and understanding. The simplest example is the answer to the question: how to distinguish real technical problems with connection from the phenomenon of resistance in psychotherapy. Psychotherapeutic work with patients required looking for new methods of establishing and maintaining contact and making decisions with limited influence and unclear information.

In online work, due to the lack of a wide range of sources of knowledge about patients, it was possible to experience how difficult it is to "read" another human being limited only to distorted image and sound. It was helpful to read some publications and exchange experiences with other therapists.

Another challenge for patients and therapists was dealing with a social situation different to the "consultation office" situation. Although patients host therapist at their homes through a screen, they reveal previously inaccessible areas of their intimate lives. We can observe and experience different ways of dealing with these distinct aspects of the therapeutic relationship. One of them is shortening the distance in the therapeutic relationship. For others, online contact becomes more anonymous, deprived of an element of social control, which also translates into the quality of the therapeutic relationship and causes that treatment takes place under different conditions. Hence, the relationship requires modification of the setting, contract, and constant monitoring of these changes and their impact on the patients' condition and the therapeutic relationship.

It turns out that topics related to the real risk of infection and the effects of isolation are introduced to the sessions, which requires developing them with empathy and respect for a diverse, individual response to the pandemic. It is also worth mentioning the processual nature of returning to work in offices, similar to adapting to the consequences of the pandemic. Again, new for both therapists and patients, the situation requires mindfulness of the individual rhythm and pace of adaptation. It is very encouraging and optimistic to discover the resources of patients that were activated in a borderline situation, e.g. the relationship of the parental group meetings. The given example and the descriptions of families' reactions to the proposal to continue psychotherapy remotely show the strength of the therapeutic alliance that has been built.

A separate problem was the appropriate equipment of psychotherapeutic offices with computers with cameras and a good sound system, as well as the software necessary for connections. All authors reported a faster, different psycho-physical stress associated with the extra effort and tension. The accompanying tension was related to, among others, concern for the quality of the connection, technical disturbances, as well as long-term sitting in one position in front of the screen. In this situation, it is especially worth considering your comfort of work.

The autoethnographies have shown that a person in borderline situations activates creativity and unused resources, but favorable conditions are needed to do this. What the favorable context to gain benefits and opportunities [4] from a borderline situation is, requires further research. Our CA shows that the team cooperation factor is fundamental. It is also important to be open to information from patients and seek solutions in a wider occupational environment.

The current epidemiological situation and the prognosis of specialists suggest that restrictions and temporary quarantines will accompany us for a long time[1], hence flexibility in switching from work in offices to remote and "hybrid" work would be useful. Hybrid work combines office and online meetings, when family members cannot participate

[1] https://pulsmedycyny.pl/prognoza-rozwoju-pandemii-covid-19-w-polsce-w-kwietniu-duzy-przyrost-hospitalizacji-1111362

in a session together with their family, or alternating meetings in the office with online meetings.

Based on the reading of the published articles on psychotherapeutic work in a pandemic [5-9, 18], as well as on the acquired experience, we have developed several guidelines useful in conducting remote therapy with families and individual with adolescent and young adult patients.

- Before the first online meeting, it is important to contact one of the parents on the phone, when the communicator for conducting the therapeutic meeting will be selected, and the technical basis for connection (e.g. required equipment) and the rules of the first contact will be established: the therapist will provide his or her Skype address and ask for connection at a specific time or inform that the parent will receive a link with an invitation to a Zoom meeting.
- It is also useful to provide an alternative method of contact (telephone) in case of connection problems or sudden disconnection of the Internet.
- Before starting the first conversation, the therapist should inform patients about the confidentiality of the meeting (where he/she is, there is nobody in the office and nobody hears the conversation).
- At the first meeting, it is worth discussing doubts and fears related to remote work, as well as the framework of meetings taking into account the patient's input (turned on cameras and microphones).

Final conclusions

1. The introduction of online psychotherapy to a greater extent than it was before the pandemic will allow to use this form of treatment in people for whom it was unavailable or difficult to access. This is a positive effect of the pandemic.
2. Remote psychotherapy requires modification of the setting and contract previously concluded with patients.
3. Individual, differentiated response of patients to a pandemic, requires adaptation to their rhythm and the pace of developing emotional processes.
4. Remote work is associated with the physical and mental overload of psychotherapists, hence ensuring the possibility of more frequent supervision and your own comfort of work is particularly important.
5. After the period of adaptation to the pandemic situation and its consequences, there follows the stage of searching for solutions and reaching for resources, but for this to happen, additional conditions are required, where the team cooperation factor is fundamental.
6. Openness to consultations in the community, interdisciplinary work is a supporting factor in the processes of adaptation and transgression.

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