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# Therapists' Perspectives on Aiding Individuals to Maintain Social Connection While Struggling With Health Concerns

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# Therapists' Perspectives on Aiding Individuals to Maintain Social Connection While Struggling With Health Concerns

by
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## Approval Page

This applied dissertation was submitted by Shari Howington-Carlin under the direction of the persons listed below. It was submitted to the Abraham S. Fischler College of Education and School of Criminal Justice and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova Southeastern University.

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## Statement of Original Work

I declare the following:

I have read the Code of Student Conduct and Academic Responsibility as described in the *Student Handbook* of Nova Southeastern University. This applied dissertation represents my original work, except where I have acknowledged the ideas, words, or material of other authors.

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Shari Howington-Carlin
Name

November 29, 2021
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## Abstract

A Phenomenological Study: Therapists' Perspectives on Aiding Individuals to Maintain Social Connection While Struggling With Health Concerns. Shari Howington-Carlin, 2021: Nova Southeastern University, Abraham S. Fischler College of Education and School of Criminal Justice. Keywords: Social Connection, Integrated Health Care, Global Pandemic

This applied dissertation was designed to explore therapists' perspectives on aiding individuals to maintain social connection while struggling with health concerns. Social relationships support physical and psychological well-being, yet individuals struggling with physical or mental health issues often have difficulty maintaining their relationships. Therapists, as health professionals, often discuss physical as well as emotional health concerns with their patients, including components of physiological and psychological heath care. Emerging neuroscience is aiding in understanding how research in this field supports early intervention for health outcomes around healthy social and family relationships during chronic disease or illness onset.

The researcher conducted a phenomenological study by means of an asynchronous virtual focus group with ten experienced therapists. The participants in this study all hold a valid therapy license and have been in practice for at least five years. Each participant therapeutically serves individuals who have some medical diagnosis and are dealing with the challenge of feeling isolated or estranged from family or friends.

An analysis of the data indicated that overall, the therapeutic role is critical to establishing a safe space of therapeutic wellness for the client and suggests that practicing healthy boundaries during a pandemic are challenging and necessary to limit therapeutic vicarious grieving. Findings recommend partnering with clients to compassionately collaborate on the therapeutic process, enabling clients to effectively manage their internal world, their thoughts, feelings, and behavior. Creative support such as art and mindfulness as therapeutic interventions are helpful with those reluctant to embrace talk therapy. Barriers identified by the participants included problems with emotional regulation, family systems crisis, practical barriers, and experiencing a global pandemic.

## Table of Contents

# Chapter 1: Introduction

## Statement of the Problem

Human beings are hard wired for social connection (Bandura, 2001; Lieberman, 2013) but when health problems arise, the sense of human connection may decrease (Umberson et al., 2006; Umberson & Montez, 2011). Individuals experiencing mental or physical health challenges often have difficulty in maintaining healthy relationships or feeling connected to those important to them (Thoits, 2011; Uchino, 2006). A lack of social connectedness is associated with a number of negative outcomes, including depression, cognitive decline and increased mortality (*The Health*, 2010). Studies have noted a higher rate of physiological decline or disease such as recurrent myocardial infarction, autonomic dysregulation, high blood pressure, slower wound healing, cardiovascular disease, and cancer, to name a few, when relationships were challenged or absent (Umberson & Montez, 2010). These findings seem to hold true across the lifespan, as close family relationships in childhood directly affect physical and mental health (Chen et al., 2017) and health in later life poses strengths and vulnerabilities directly related to close social ties (Rook & Charles, 2017).

Though it is clear that social relationships support physical and psychological well-being (Bandura, 2001; Thoits, 2011), health professionals and society in general have significantly underestimated the relevance and importance of social relationships as healthy components of mental and physical health care (Rook & Charles, 2017; Uchino, 2009; Uchino, 2004; Walsh, 2011; Walsh, 2021). Woods and Denton (2014) conducted a study that explored possible mediators of associations that linked family and romantic relationships to physical and mental health. Out of this research the Biobehavioral Family

Model (BBFM) was constructed as a biopsychosocial approach to health that measures family emotional climate, emotional dysregulation (biobehavioral reactivity) and health outcomes of individuals in the family (Woods & Denton, 2014). Therapists have developed and use an array of intervention strategies to improve health and relationship quality (Weir, 2018) and many of them involve utilizing an Integrated or Collaborative Care Model that includes mental and physical primary care (Brucker & Shields, 2003). However, we do not know enough about how such models are integrated into therapists' daily practice and how, in general, therapists work with clients struggling to maintain relationships during times of mental/physical health challenges. It is important to develop our understanding of this phenomenon further because many individuals are living longer with several chronic physical conditions and mental health concerns such as loneliness, isolation, anxiety, and depression (Golden et al., 2009; Martire & Helgeson, 2017).

### *Phenomenon of Interest*

The problem explored in this study is that even though it is known that social relationships support physical and psychological well-being, individuals struggling with physical or mental health issues often have difficulty maintaining their relationships. Therapists, as health professionals who often discuss physical as well as emotional health concerns with their patients, are significantly positioned to advocate and educate the public on the importance of healthy relationships as healthy components of physiological and psychological health care (Bachelor et al., 2010). Developing a deeper understanding about therapists' use of integrative treatment models and any additional strategies when working with clients around these issues may allow for the development of more targeted and or holistic treatment strategies for the therapists and perhaps aid in developing a

model for maintaining human connection while facing physical/mental health challenges (Walsh, 2011; Walsh, 2021). Phenomenology will be used to describe, understand, and interpret the meanings of the lived experiences of therapists serving clients or patients dealing with psychological and physiological health issues while being challenged to stay connected to friends and family.

### *Background and Justification*

Human interaction is indicative of the social exchange that pushes and pulls individuals together and apart (Fiske, 1991). Psychologist Albert Bandura discussed social cognitive theory as an interactive agency whereby individuals contribute to their own behavior, action, and motivation as a response to reciprocal relationships with other individuals (Bandura, 1989). Human connection represents a grounding force that maintains stability for the individual while other areas of life are changing (Lieberman, 2013). During a physical or mental health crisis, diagnosis or illness, relational and family support and intervention are instrumental to successful health care service provision. Adherence to treatment protocol, treatment decisions, stress levels, adaptation to diagnosis or illness and influence over health behaviors are greatly influenced by close relationships and family members (Ruddy & McDaniel, 2013; Ruddy & McDaniel, 2016).

Emerging neuroscience is aiding in understanding how research in this field supports early intervention for health outcomes around healthy social and family relationships during chronic disease or illness onset. Research shows a complicated interaction linking an individual's biological makeup and his/her social and physical environment, having a lasting effect on the individual's mental and physical health

(Patterson & Vakili, 2014). According to Maltzman (2016), examining research and practice as a biopsychosocial and multidisciplinary protocol regarding human mental and physical health since evidence converges across these multilevel systems. Genetic and epigenetic factors influencing maladaptive behaviors or resilience are being studied along with the effects of social support and how psychological and pharmacological treatments are influencing health outcomes (Maltzman, 2016).

A team-based delivery model for patient services with a biopsychosocial approach including a physician, dietician, pharmacist, and therapist has shown to improve care for patients and reduce hospital readmission (DeCaporale-Ryan et al., 2017). A team-based pilot study was done with primary-care that included therapy that consisted of cognitive behavior therapy (CBT), stress reduction and mindfulness training. The data was collected, and health outcomes were measured on self-report questionnaires. Two of the themes that emerged were the link between physical symptoms and mood, thought and activity and feeling connected or understood (Gerskowitch et al., 2015). In another study conducted in 2015, the patient-therapist working alliance and patient expectations had a significant effect on outcome of treatment benefits and coping skill changes (Burns et al., 2015).

Evidence-based therapy (EBT's) treatments prove their efficacy through research trials. The research supports evidence that EBT's prevent relapse, lead to more rapid recovery and are more cost efficient. Surprisingly, EBT's are rarely used in community mental health settings. The factors that influence this include provider issues and perceived limitations of the EBT's (Marques et al., 2016).

The history of collaboration or strategizing with other professionals within the

mental health field has previously led to consult psychiatrists to maintain an evidenced based model that supports the integrity of practitioners in the health care setting. However, in 1991, Wright and Friedman encouraged therapists, psychologists, and other mental health professionals to discontinue traditional connections with psychiatry and concentrate on improving relationships with those in the primary care medical field. The goal was to develop a standard for a core of information pertinent to train, accredit, and credential therapists working within healthcare settings (Tovian, 2017).

A study conducted by Holt-Lunstad et al. (2017), found that despite increasing evidence, the quality of relationships and the sense of feeling socially connected to the important people in an individual's life decreases risk for a wide range of diseases as well as risk for mortality however, funders are slow to acknowledge this as a direct relationship or determinate of public health. Healthcare agencies, government organizations, private or public health care tend to fund other determinate factors such as economic, cultural or a diagnosable health disability instead of recognizing the need for advancing relationship health and social connection as a public health priority (Holt-Lunstad et al., 2017; Holt-Lunstad, 2021).

The well-being of a community is directly related to quality of fundamental social relationships and family life for each individual (Cummings & Schatz, 2012). This includes the pervasive influence of physical, psychological, cultural, social, and financial health of children and families. Over the past 35 years, more than 100 research trials have shown the effectiveness and efficacy of therapy and interventions to support healthy relationships to prevent distress or divorce. Although the intent of programs like these are designed for public health, their effectiveness is highly questionable due to few therapists

and counselors actually using evidence-based interventions (Marques et al., 2016). An important question to be answered moving forward is: Do we have an effective model to disseminate interventions to the public that link their physical and mental healthcare to the health of their relationships and family wellness (Hahlweg et al., 2010)?

### *Deficiencies in the Evidence*

The field of medicine is swiftly developing and utilizing integrated health care teams to address physical, psychological, and relational needs of patients. Due to chronic health care needs and the strain illness can put on relationships due to complex treatment protocols, therapists, psychologists, and other health care providers across the spectrum are struggling to develop new competencies to aid families and individuals transition smoother through a health care crisis (Bridges et al., 2015) while supporting the patients' social or family relationships (Hunter & Maunder, 2016).

The standard of practice is for therapists to use research or evidenced based therapy models with their clients that are targeted towards presenting problems (DeFife et al., 2015). Other intuitive models that lack empirical evidence may not be considered valuable or legitimate for therapeutic practice (Hussain, 2013). Existing models that approach mental health care from a holistic perspective include the Cognitive Behavior Therapy (CBT) model, the Psychotherapeutic Yoga (YBP) model, and the Biobehavioral Family (BBFM) model (Burns et al., 2015; Gerber et al., 2018; Woods & Denton, 2014). Holistic models consider both physical and psychological challenges. However, it is unclear how these models approach social connection and the maintenance of healthy relationships as part of the mental health component of treatment. It is also unclear if and how therapists use these types of integrated models in their daily practice and what other

techniques or strategies they may use to augment these approaches.

### *Audience*

The information gained in this study should aid therapists, psychologists, and other healthcare providers, as well as clients and patients involved in the healthcare system seeking to understand the phenomenon of new integrated medical models that involve collaborative methods to support physiological and psychological health with the aid of healthy family and social relationships.

## Definition of Terms

*Social Connection* is defined as an individual's subjective sense of having close and positively experienced relationships with others in the social world (Seppala et al., 2013).

*Biopsychosocial Approach* is defined as this approach includes the influences of biological factors, psychological factors, and social factors when looking at overall health ("Biopsychosocial Approach", n.d.).

*Integrated Health Care* is defined as an approach characterized by a high degree of collaboration and communication among health professional sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient (*Integrated Health*, 2013).

*Family Systems Crisis* is defined as an upset in a steady state or period of heightened family tension and imbalance causing a disruption or breakdown in an individual's or family's usual pattern of function, finding that their usual ways of coping or problem solving do not work (Assessing Family, 2018).

*Global Pandemic* is defined as an outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population (Merriam-Webster, n.d.).

**Purpose of the Study**

The purpose of this phenomenological study was to discover the lived experiences of therapists as they work to aid clients with physiological and psychological health issues to maintain their social and family relationships. The setting of the study consisted of an asynchronous on-line platform focus group. The on-line focus group was conducted to collect data from licensed therapists to gain insight into their perceptions of helping clients maintain healthy relationships in the face of physical or psychological health challenges.

# Chapter 2: Literature Review

The purpose of this phenomenological study was to discover the lived experiences of therapists as they work to aid clients with physiological and psychological health issues to maintain their social and family relationships. The literature review provides an analysis of studies related to the design of integrated or collaborative health care models that include social support with physical and mental health care. Collaboration and intervention in the healthcare field was studied, in its relationship with supporting social connection as necessary to common health care practice, as much as regulating diet, exercise, and sleep. Patterns and themes that have been discovered from reviewed literature sources were reviewed, including: the theoretical framework, integrated care models, therapeutic interventions, along with techniques and strategies utilized to support individuals and families during the intervention of a health crisis, and barriers to maintaining health and human connection.

## Theoretical Framework

The theoretical framework for the study is the social support theory of health communication (Cassel, 1976). Barnes (1954) first identified patterns of social relationships not described as families or work groups. Cassel (1976) noticed and identified the connection of social relationships with health, finding that social support theory is a subset of health communication theory. Social support theory explains the provision of a preventive and protective social factor undergirding an individual's vulnerability. This theory elaborates on how an individual's social stress can affect their health. Social networks are directly related to and intimately connected to social support. Nevertheless, these terms are ideas and concepts that describe the structure, process, and

function of social relationships. Social networks can be thought of more as the web of relationships that surrounds and protects an individual (Umberson et al., 2010).

Social relationships have a powerful impact on health communication, education, and health behavior. One theory does not adequately explain the connection and link between social relationships and health. Health components of social relationships that are closely related are social integration, social network, and social support (Berkman et al., 2000). Social integration refers to the reality or existence of social ties. Social network refers to the web of social relationships around individuals. Support is one of the important functions of social relationships. Social networks are the bridges or links connecting individuals that may provide social support and that may also serve other functions such as advocate or educator (Glanz et al., 2008).

**Social Support**

Social support is the perception and practical experience of being cared for. It is the awareness that assistance and care is available from others through different types of resources such as informational, emotional, or communal companionship. Social support is concerned with how networking aids individuals to cope and process stressful events. It accomplishes this by enhancing psychological well-being (Shumaker & Brownell, 1984). Social support is divided and organized into four different types of support (House, 1981). Emotional support is related to sharing life experiences (Reblin & Uchino, 2008). Empathy, love, trust, and caring are available and exchanged in the relationship which creates or supports a culture and community (Kaye & Harrington, 2015). Instrumental support involves the availability of tangible resources, services, and aid that directly assist an individual if needed (Morelli et al., 2015; Semmer et al., 2008). Informational

support is the availability and provision of suggestions, information, and advice that an individual can use to address a crisis or problem (Yao et al., 2015). Appraisal support involves information that is helpful for self-awareness and evaluation purposes: constructive feedback, affirmation, and social comparison (Glanz et al., 2008).

The perception of practical experience of social support was investigated by Baker et al., (1992). A mixed methods questionnaire and interview study was conducted to assess 729 adults with mental health problems receiving state Community Support Services (CSS). The purpose was to investigate the availability and adequacy of social support. Results indicated that the availability of social support was significantly correlated with quality of life in the SLDS throughout the nine months of the study. Degree of satisfaction with the life domains were correlated to both quantity and quality of accessible social support (Baker et al., 1992).

Trevino et al. (2013) conducted investigation into the relationship between quality of life and perceived social support. Data collected from 71 young adults with cancer from The Interpersonal Support Evaluation List (ISEL), The McGill Quality of Life Questionnaire, and The Prolonged Grief Disorder Scale found a correlation between a better quality of life and psychological outlook with higher levels of social support due to the availability of having someone to discuss problems with (Trevino et al., 2013). The quality and quantity of close supportive relationships are integral to the health and advancement of humanity (Dunkel Schetter, 2017).

**Social Support in Times of Stress**

Social support is widely acknowledged in the research literature to be an important protective factor of health during times of stress (Morrelli et al., 2015). During

times of stress related to disease management, friends and family members provide an important source of aide, specifically related to key tasks of chronic disease management. Some of these tasks include communicating with providers, managing medication, organizing treatment protocols, and assisting with ADL's, transportation, and financial decisions (Rosland et al., 2013).

Relationships and social support have been known to powerfully affect human health and survival (Eisenberger & Cole, 2012; van Woerden et al., 2011). In 2014, a longitudinal study examined relationship quality across ten years with regard to immune function as a known marker of biological stress. Five biological inflammation markers were studied alongside how individuals perceived social support or strain from family, spouse, and friends. Results showed modest protection against inflammatory risks with perceived sense of support, while risk of inflammation increased substantially with strained relationships, and positive associations with social support were not as strong as the negative associations of social strain resulting in inflammation (Yang et al., 2014).

Of the different types of social support, emotional support involves caring for, and empathizing with, another individual in such a way that they feel understood (Collins et al., 2014). Over the last three decades research points to higher emotional competence (EC) and its positive role in supporting social and marital relationships (Lopes et al., 2004; Lopes et al., 2005; Schutte et al., 2001) as well as greater health and well-being (Schutte et al., 2002), while lowering the risk of psychological problems (Gross & Munoz, 1995). Mikolajczak et al. (2015) conducted a study that sought to identify if emotional competence (EC) or emotional intelligence (EI) related to social relationships had an influence on physical health. The study surveyed 10,000 adults in

Belgium and found emotional competence (EC) and social support to be strongly related to physical health based on the participants' perception of social support, whether the support was emotional and/or tangible (Mikolajczak et al., 2015). The study revealed in one-year individuals with a higher level of EI took 128 fewer doses of medication, spent less time in a hospital, and on average, had lower health insurance costs by $361, as compared to those with lower levels of EI (Mikolajczak et al., 2015). Mikolajczak et al. (2015) concluded that emotional competence (EC), combined with social support, had a significant predictive element above other predictors of health, such as physical activity and diet, as examples of multiple variables in constant interaction and this information highlights the most reliable factors of health, including the value of EC alongside social support. The findings suggest that more research should be conducted to identify how emotional intelligence affects social support and mental health more specifically (Mikolajczak et al., 2015).

Diong et al. (2005) conducted an empirical quantitative study via several survey measures, that examined the interrelationships of social support, anger, coping, stress, and health in Singapore with youth and adults, ranging from 13-64 years of age. Diong et al. (2005) examined the relationship between experienced stress, the perception of social support or lack of it, and how coping strategies and relationships affected health and found that higher levels of anger control were recorded with individuals that perceived greater levels of social support, use of active coping skills, and lower use of avoidance coping skills. The active coping and perception of social support were also related to healthier outcomes, psychologically and physically, such as less reported illness, less visits to a medical clinic, and less time missed from work (Diong et al., 2005). Similarly,

a longitudinal field study of 116 adults, examined how self-efficacy and social inclusion of marginalized individuals repeat a cycle of disempowerment, social disconnection, and economic and health decline (Koudenburg et al., 2017). Koudenburg et al. (2017) noted an indirect effect from social inclusion, the gain of personal autonomy which indicated a positive effect via self-efficacy. Dickerson and Zoccola (2009) conducted research highlighting positive social connections closely support a wide range of positive effects on health and wellness, while evidence of deficient family or social conflict links relationship stress to implications of illness and disease.

**Difficulty Maintaining Social Connections During Health Challenges**

Social support is instrumental in providing aide during health challenges; however, several factors contribute to maintaining social support. Lee et al. (2017) conducted an empirical quantitative study with 1,722 Caucasian, African American, and Latino adults, through the Veteran's Administration Center for Clinical Research in Ann Arbor, Michigan that examined specific ways care givers help with or hinder disease management when supporting or caring for individuals with chronic illness. Data collected from 703 survey respondents on caregiver support characteristics reported that they provided consistent disease management help to a friend or family member who was suffering with at least one of five chronic health conditions such as diabetes or heart disease (Lee et al., 2017). Caregivers that provide in-home support and live with those they are caring for, such as a spouse, sibling, or other relative or friend, reported arguing more with those they care for compared with those who do not live with the person due to lack of respite for the caregiver (Lee et al., 2017). Medication side effects also contributed to perceptual and relational trouble within the relationship between the care

giver and the medically needy individual receiving care (Lee et al., 2017).

Social resources that are available are predicated or mediated by an individual's attachment style or willingness to connect to support available. In 2014 an empirical quantitative study was conducted to examine how social resources mediate relations between attachment dimensions and challenges and distress after trauma and loss (Shallcross et al., 2014). Shallcross et al. (2014) collected survey data from 1,084 undergraduates, mostly adults between 19-21 years of age, at a large public university in the Midwestern metropolitan area. The study found that social withdrawal followed by health challenges is associated with having fewer social resources for an individual, which puts the individual in a type of double bind, having to navigate a health challenge that may be challenging physically, emotionally, and practically, with limited information and resources (Shallcross et al., 2014).

Difficulty maintaining social support during withdrawal and isolation is obvious to the bystander but not necessarily to the individual involved in the health crisis. A 2018 study titled The English Longitudinal Study of Aging collected and processed survey data from 7,731 adults over the age of 50. The goal of this study was to investigate relationships between health literacy and social isolation. Data was used to gage and assess perception of social support or sense of social isolation. The study revealed that isolation and low health literacy are high risk factors that contribute significantly to poor social connection and poor health outcomes, psychologically and physically. Data compared those individuals designated with high health literacy which was measured by correct understanding of medical labels to those who did not comprehend the medicine labels. The study noted that social isolation was more common among those functionally

impaired and depressed who also had a limiting chronic illness, such as a stroke, heart disease, or lung disease (Smith et al., 2018).

Another study conducted in 2018 explored implications of perceived support and how that affects an individual's well-being. Quantitative data was collected to measure social connectedness, non-social personality, pro-sociality, social desirability, and social sharing of emotion. 285 complete surveys were submitted by U.S. citizens over the age of 18. 58% of those individuals were male, and 73% were Caucasian. Findings revealed that during a health crisis, individuals with higher levels of social support handled interpersonal emotional regulation in more positive ways, reporting more perception of improvement in their quality of life, than those without support, who reported more negative emotional responses and less satisfaction with emotional regulation (Williams et al, 2018). These negative emotions included fear, sadness, exhaustion, and confusion. Experiencing these emotions can change the way an individual perceives support or relationships and whether or not they benefit from them. In 2017, in Chicago, IL, at the Forum for Behavioral Science in Family Medicine, information was shared from four categories for the purpose of providing support to patients or clients, during difficult transitions due to mental or physical health crisis. These areas are assessment, listening, education, and instilling hope. Assessing the amount or lack of support can be critical in providing collateral support opportunities for the individual. Listening actively will clarify obscure information that the patient may not be overtly forthcoming about, such as not having practical, emotional, or social support; and psychoeducation can be used to refer individuals to groups where support can be one of the many benefits used to navigate complex relationship and health challenges. Instilling hope involves maintaining

a professional presence that is positive, encouraging, and supportive which many include recommending faith-based organizations, extended family, peer groups, and community groups such as NAMI as collateral support. Maintaining a hopeful collaboration encourages individuals to stay supported by connecting to a network of resources that they feel comfortable with which may benefit them in times of crisis (Sherman & Hooker, 2018).

In an empirical longitudinal and quantitative study published in 2013, perceived social support was investigated to see what interventions of social support made a difference in health status or health decline for those in the study. All 1,011 participants were adult women over the age of 40 with early-stage breast cancer from a Midwestern metropolitan area. Data was collected via several surveys. Clinicians provided convenient psychological support for those patients reporting low or no social support at the time of diagnosis for early-stage breast cancer. Findings indicated that patients going through early-stage breast cancer with a decline in social support around the time of diagnosis or surgery, benefitted from psychological support via telephone or in person. Patients who reported lower levels of social support and did not receive support through telephone or personal visitation, noted elevated levels of symptoms of depression (Thompson et al., 2013).

**Biopsychosocial Model of Health Care**

For centuries, physical health has been assessed and treated separately from mental health. However, in the past two decades a vital amount of research has indicated primary care quality is improved when mental health care is combined or assimilated into general primary care (Barnett et al., 2012; Happell et al., 2012). This kind of care is

considered integrated or collaborative care, combining primary care, such as a doctor and nurse, as well as a psychologist, psychiatrist, or therapist to manage the total health of an individual (Pomerantz et al., 2010). One of the most significant treatment barriers for receiving mental health services is that an individual may not realize they have a mental health issue. Receiving primary care does not have the stigma associated with mental health care, therefore, identifying mental health concerns at a regular healthcare visit is significantly efficient, saving time, money and perhaps dignity (Vogel et al., 2012).

Federal initiatives substantiated and provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) addresses the goal of transforming mental health systems collaboratively within the health care arena by integrating psychological care into and inside the primary care atmosphere (Power & Chawla, 2008). The Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ), for example, assesses how providers comply or adhere to model components that are essential to the integrated tool kit, to combine mental and physical practices more smoothly. The PPAQ identified several positive characteristics as treatment guidelines that result in a high standard of usefulness for collaborative providers of degree of provider preparation or current clinical structure, to support treatment compliance as a primary care quality improvement strategy initiative (Beehler et al., 2020).

The use of the integrated behavioral health model within the primary care practice effectively lowers the cost of services for individuals, adds to productivity of health care of the whole individual, not just the physical component, therefore supporting the best continuum of care for the patient (Herbst et al., 2018). Due to an increase in teamwork and collaborative efforts in health care, medical professionals have reexamined the use of

medication, finding that collaboration can be more cost effective and less problematic than prescribing medication for patients (Robiner et al., 2013). For these reasons, integrated care models for pediatric, adult, and community care have been established to serve the detailed needs of the particular population more accurately. Models are rated or valued for safety, accuracy, impact, and efficiency in the delivery of health care services (Shearer et al., 2012).

**Integrated Health Care Models**

In 2010, two studies conducted in the New York Veterans Affairs (VA) system outlined the basic components that formed the integrated health care being provided by behavioral health professionals within the primary care environment. Both studies indicated the methods or models used were beneficial for assessing and implementing behavioral health care within the collaborative care model (Funderburk et al., 2010). The Collaborative Care Research Network (CCRN) was established due to the dramatic increase in integrated health care in the past decade to identify variables in integrated care strategies for different types of settings where collaboration is being utilized in order to evaluate quality and service practices. The diversity of settings incudes pediatric, adult and community care models for the benefit of accurately defining best care practices and continuity of care for each individual population (Sieber et al., 2012).

One of the strongest and most popular strategies designed for removing many of the barriers to consistent and efficient mental health care for patients and families is the integration of behavioral health within the primary care system. This is a key strategy for several reasons. Integrating the care within the collaborative health care system means more individuals receive some basic assessment, intervention, and psychological

treatment, if necessary, without having to extend their resources to seek health care for psychological services (Oppenheim et al., 2016). These collaborative models allow for a more personalized psychological assessment and implications for more successful detailed care due to having the input of the entire healthcare team on board for the patient. The therapist, the dietician, the nurse, the pharmacist, the physician, and other various healthcare providers have an opportunity to contribute to the design of a treatment plan, all bringing specific strengths to add to the wellness of the whole individual (Palmer Kelly et al., 2020).

***Pediatric***

Demonstrating the usability and receptiveness of psychological services within the pediatric primary care format is critical to seamless integration of behavioral health collaboration inside the general health care system. Cohesiveness between service providers is vital to provide or ensure optimal patient provision and support. These new collaborative models have to align intrinsically with the biopsychosocial models of care in order to interphase or encompass all areas of health of the child and the family (Moser et al., 2014).

In a recent study examining the effectiveness of a doctor-office collaborative care (DOCC), comparing that type of service to enhanced usual care (EUC) in the pediatric primary care, the DDOC model incorporated the cost analysis of services and found this model precipitated lower costs for psychological health care for children. It was also noted that this model has the potential for providing improved clinical effectiveness both during the time of service and the follow-up period while also providing a cost savings benefit (Yu et al., 2017).

In order to improve pediatric health and identify the collateral benefits of the social well-being of the family, one model used is the Family Check-Up (FCU). This model has the potential to improve family function as it supports reductions in childhood problematic behavior. Early childhood prevention of behavior problems are identified as well as care-giver social support and relationship satisfaction with the goal of assessing these factors to provide positive change or improve the function of the family (McEachern et al., 2013). Therapists use several traditional family and parent interventions such as cognitive behavioral therapy and family systems therapy as well as collaborative conceptual models that utilize the clinical expertise and judgment of the entire team for simple and complex cases. Much of the substance of the model chosen for intervention for parent training include the psychoeducational benefits of each model as it relates specifically to the assessment needs of the child and family. The criteria taken into consideration are the characteristics of the caregiver/parent, medical setting, cultural issues, communication barriers, developmental level of the child and economic challenges. The information shared and accountability provided by an integrated pediatric model at this level offer a broader strategy for successfully implementing interventions for a child and family (Mullins et al., 2014). Additionally, a qualitative study was conducted in 2017 for the purpose of evaluating therapeutic alliance as part of the intervention for a child and family. The process of quick rapport building was the therapy method utilized with school age children. The intent was to further develop most effective therapy methods. The main tasks for the child therapist that stood out from this inquiry was structuring the session, such as discussing expectations and time allotment, letting the child lead and make choices during the session, participating with the child,

exploring the child's expressions, and showing understanding and regulating emotion (Haugvik & Mossige, 2017).

### *Adult*

Health care organizations are rapidly shifting toward and beginning to utilize an integrated primary care (IPC) model which combines behavioral health and mental health to be addressed as a routine part of the physical exam. Although there are several evidenced-based interventions available to address medical concerns of mental health or behavioral health, the challenge within the primary care setting is that it has to be brief and succinct. Two of the most popular topics during a routine exam relate to sleep and physical activity (too much or too little). Motivational interviewing and cognitive behavioral therapy are two of the most common interventions used by therapists within these collaborative office settings (Funderburk et al., 2018).

### *Community*

In the last decade many communities are exploring the use of collaborative care models for health care service to save money and provide more health care, as well as therapy for groups that may not naturally receive services. These culturally sensitive integrative models allow more underprivileged individuals and families to receive health care or counseling from an interdisciplinary health care team. The provider service approach is patient-centered and encourages family and community involvement (Bruner et al., 2011). The bio-behavioral model supports the family and community involvement. One of the most critical areas of need relates specifically to the national initiative to increase mental health services for youth as related to the community for the sake of prevention. Collaboration between stakeholders, health care service providers,

researchers and community volunteers are essential to implementing evidenced based programs combatting substance abuse and addiction (Henderson et al., 2017).

Therapists in every setting use the integrated healthcare models because more individuals will agree to mental health care if it is packaged in a model of complete wellness that comprises physiological, social, and mental health (Jung, 2021). Family or general practitioners are the first health care providers that 70% of patients confide in about mental health issues or relationship challenges (Chomienne et al., 2011; Grenier et al., 2008). Those therapists practicing privately are often connected virtually or locally to a specific general care or other type of provider to ensure the well-rounded approach to health care (Angell & Bolden, 2015).

**Therapeutic Intervention**

Assessing and measuring the effectiveness of therapeutic psychological intervention is directly related to strategizing collaborative efforts. One mixed-methods study assessing teamwork identified 9 areas connected with elevated team function in the integrated healthcare domain (Brown et al., 2015). Some of the dimensions of teamwork included sharing a common philosophy, change adaptation, conflict resolution and encouraging team collaboration to interphase ideas of service. Defining a purpose such as the goal of providing efficient, healthy, and helpful services to the client also supports advancing the evolution of higher team function and greater success for both provider and patient (Goh & Eccles, 2009). In an integrated medical approach, a therapist is utilized to support coping behavior when medical disorders and family crises are present (Heru, 2013).

### *Role of Therapist*

In family centered care, the role of the therapist extends to educator, mediator, diplomate, active listener, and coach for the entire family as well as the individual (Anderson et al., 2009). Short- and long-term goals are assessed and defined with practical avenues of reaching the health and relationship milestones. This consideration of social and relational needs is an important factor in reducing disease activity in both the mental and physical realm for the patient by implementing health literacy within the family or support system (Fields et al., 2018). The role of health literacy for families and caregivers supports reaching treatment goals and avoiding communication barriers. Mental health literacy is comprised of recognizing symptoms and having a vocabulary that encourages communication about thought and feeling. Communication and understanding the treatment for the patient is vitally important for vulnerable populations such as children, traumatized individuals, those with disabilities, and geriatric individuals (Pollard et al., 2014).

Approximately one fourth of patients receiving primary care for chronic pain also report or meet the criteria for major depression. Most often, these patients fail to receive counseling or treatment for depression or if they do, their physical pain is not discussed. When these types of co-occurring health issues arise within the infrastructure of a collaborative treatment model such as a clinic or primary care office, strategies such as emphasizing self-care, impact of pain on the patient's roles and relationships, pain management techniques, and flexible scheduling break down the stigma associated with receiving psychotherapy. This integrated atmosphere allows the therapist to assess and treat a greater number of individuals, many of whom would not have sought

psychological treatment (Poleshuck et al., 2010).

### *Techniques and Strategies*

A structured family systems assessment can be a valuable tool to help identify strengths and weaknesses in the health of the family in the way an individual would receive a yearly physical. The McMaster model of family assessment for example, examines six areas of family function: behavior control, problem solving, affective involvement, communication, affective responsiveness, and roles (Heru, 2013).

The McMaster Family Assessment Device is used to examine family function which is one of the smallest microcosms of the human social experience. In 2019, a quantitative study was conducted using this model and analytical and descriptive surveys to chart the data. The purpose was to measure healthy conversations within a family unit that had a family member suffering with mental, physical, and cognitive impairment. The findings noted that family function may reduce stress and increase mental health while improving the overall wellbeing of the family (Agren et al., 2019). The McMaster Family Assessment is used to examine or measure family function and social support (Wang et al., 2016), along with The Behavioral Health Measure and Adverse Childhood Events, with the aim of understanding and supporting the bio-psycho-social connection as it relates to human health (Nakao, 2016).

The Behavioral Health Measure is a short self-inventory reporting general types of emotional or psychological stress and (dis) function developed for assessing mental health wellness or illness in an outpatient environment (Kopta & Lowry, 2002). A mini-mental status exam is also used in outpatient settings, because of its brief but highly accurate evaluation of current mental function or status. Trauma informed school nurses

and school counselors use Adverse Childhood Events (ACE's) and Child Trauma Screen (CTS) to aid in evaluating mental health status for youth (Lang & Connell, 2017). The structure and reliability estimate for these measures support appropriate use in primary care settings, schools, some faith-based communities and are an example of integrating the assessment of mental health during the assessment of physical health (Bryan et al., 2014). These types of assessments or screening tools are used alongside a therapeutic technique known as therapeutic alliance.

Therapeutic alliance, often known as therapeutic presence, is the therapist's authentic ability to make and maintain connection with the client, without perceived judgement. This type of tool allows for engaging in a more in-depth manner with the patient, ultimately resulting in positive changes physically, emotionally, and relationally (Geller, 2017; Webb et al., 2012). An empirical quantitative study conducted for the purpose of finding support for previous research, which noted that therapists utilizing solid, problem-focused cognitive therapy techniques, elicited positive changes in depressive symptoms (Feeley et al.,1999). Again, in 2007, Strunk et al. showed that patients who used CT skills reported a lower rate of depression relapse in the following year. In the same investigation, inventories, assessments, and rating scales were utilized to gather information samples from both patients and therapists. Two predictors of patient symptom change with therapists using cognitive therapy in an integrated model included the importance of the therapist adhering to the concrete cognitive therapy techniques and the role of the therapist maintaining the working alliance, also known as therapeutic alliance, in affecting the goals and outcome of the therapeutic experience (Bucci et al., 2016).

Multiple types of communication are being utilized in health care, including tele-health, which includes therapist sessions, via phone, web, or skype formats. A qualitative study was done in 2014, for the purpose of understanding the role of therapeutic alliance as it relates to social presence and support. Data was collected via interview to explore how telehealth, or the world-wide web is used to support clients and therapists. Implications highlighted variations in social support as beneficial to traditional treatment and aiding the therapeutic alliance (Lopez, 2015).

The quality of daily social interactions, including perceptions of perceived support, distress resulting from negative social exchanges, and feelings of loneliness, can be self-reported in a brief inventory designed by the National Institute of Health (NIH) as a Toolbox for the Assessment of Neurological and Behavioral Function. This report is designed to appraise social support, companionship, and social distress (Cyranowski et al., 2013). Using social and behavioral information gathered from such assessments allows therapists to understand how communication impacts health and wellness as health pertains to interpersonal relationships and social interaction. Solution focused therapy, a type of positive psychology, is used by therapists in creative interventions to improve relationships and health. One of the creative modalities used is a vision board for the individual to display goals (Burton & Lent, 2016). Included in this type of intervention of positive psychology, is communication relevant to relational development and self-care and maintenance. Three specific areas involved in this intervention are expressions of appreciation or gratitude, enjoying a sense of frivolity or humor, and self-disclosure, which concentrates more on any positive sources of psychological health and wellness of the individual (Sullivan & Stulmaker, 2013).

One therapeutic strategy used often in working with patients with physical illness, particularly within an integrated care system, is promoting wellness through health literacy such as psychoeducation, teaching emotional intelligence and self-science as preventive strategies for supporting mental health before a problem exists. Health literacy is composed of understanding and identifying feelings, becoming aware of thoughts and behaviors that often accompany those feelings, gaining ideas for problem solving related to thought or behavior change, stress management and relaxation training (Bridges et al., 2015). During a quantitative study conducted in 2019, for the purpose of validating that well-being might be an important stimulus and intervention for those navigating a health care crisis, by supporting both physical and psychological health, it was found that positive well-being was a strong component raising the over-all health in vulnerable groups (Boyle et al., 2019). Therapist assisted; internet cognitive behavior therapy (ICBT) is also effective with clients with physical health issues and is particularly relevant in that it can overcome distance/ time/ access barriers that hinder the acquisition of health care services. This strategy is utilized through patients and therapists reviewing materials on the internet while providers offer support and follow up on patient motivation via weekly phone calls (tele-med) and email. This is an organized and collaborative effort that is initiated through integrated care at a primary care office or clinic (Hadjistavropoulos et al., 2014). This strategy supports and underlines the effectiveness of social connection and relationships as important components to individual physical and mental health. The role of the therapeutic alliance in the emerging electronic health communication conduit directly suggests the importance of therapist-client relationship (Beckner et al., 2007). The interpersonal mechanisms that connect

close relationships to health outcomes in a therapeutic relationship are directly related to attachment style, culture, ethnicity, socioeconomic position, gender, and attitudes about regulating stress (Pietromonaco & Collins, 2017).

**Barriers to Maintaining Social Connections During Health Challenges**

Mental and physical health challenges often make it difficult, due to abnormal brain chemistry, for an individual to regulate their emotions or co-regulate with others in their social circles. This can lead to withdrawal, isolation, and loneliness. Chervonsky & Hunt (2019) conducted a quantitative study to assess the relationship between emotional regulation (ER) and social well-being of adolescents that also monitored mental health (specifically depression and anxiety). The Emotion Regulation Questionnaire (ERQ) and The Multidimensional Students' Life Satisfaction Scale (MSLSS) were used as measures (Gross & John, 2003; Huebner, 1994; Schutte et al., 2009). Findings suggest that poor social well-being and mental health seemed to be affected by the type of emotional regulation strategy implemented. Mental health, the ER strategy used, and social outcomes support important and collaborative roles in well-being (Chervonsky & Hunt, 2019).

Health challenges, especially mental health illness, makes keeping and maintaining healthy relationships difficult, related to misunderstanding the emotions and intentions of others due to altered perception. In 2018, a mixed-methods study was conducted to explore how social networks effected individual well-being, in relationship to physical and mental health. The goal was to investigate how an individual's personal well-being network (PWN) affected their care. This study was conducted over 30 months, included individuals aged 16-65, examining their social capitol and social networks as data was

collected noting people, places, and activities of social encounters. It was found that for the benefit of person-centered type therapeutic models, the locations and activities are instrumental in the social network for the health of the client. Some of the findings included the reduction of stigma or discrimination in getting or receiving help, increasing the positive outcomes of addressing physical health needs, and providing a solution-focused format for the individual that is strength and recovery focused (Sweet et al., 2018).

Certain health crisis', such as a urinary tract infection in older adults, may change a person's perception, making relationships difficult, due to the way the individual reacts to friends and family. Kalish et al. (2014) defined delirium as an acute fluctuation of cognitive awareness and altered attention or mental status. Incidence, prevalence, and significance is discussed as this combination of physical/mental health problems severely affect an individuals' ability to maintain or keep relationships due to cognitive impairment and difficulty in emotional regulation (Kalish et al., 2014; Kiely et al., 2009; Pisani et al., 2009; Shehabi et al., 2010; Witlox et al., 2010).

Secondary barriers to maintaining health and relationships and staying connected socially also include shame, judgement and withdrawal or isolation, cultural stigma, cost, transportation, accessibility, and health literacy. These dilemmas pose a threat to keeping and maintaining relationships during a health crisis, due to social, emotional, intellectual, and financial insufficiency.

Many individuals will seek primary care for physical needs or concerns long before considering going to a therapist to discuss emotional or behavioral issues such as anxiety, depression, or a relationship crisis (Grenier et al., 2008). One of the barriers in

this dynamic is shame or cultural stigma (Miller-Prieve, 2016). When an individual experiences shame or perceives negative or judgmental stigma, often the response to interpersonal stress is withdrawal or isolation. The lack of social connectedness can stimulate a cascade of problems for health care such as poor communication, lack of comprehending healthcare instructions, lack of ability to change/motivation, followed by increasing amounts of potential physical symptoms and psychological distress (Aanes et al., 2010).

Cultural bias regarding mental health care is prevalent in some ethnic groups. This is a barrier for many who may need mental healthcare but refuse to seek services due to the ideology of the individual's culture. For instance, some ethnicities feel that mental health problems should be dealt with within the family. This type of bias can also be spiritual in nature as some religious communities believe that mental health is only spiritual, therefore, any aid should come specifically from a religious or spiritual base (Andrade Vinueza, 2017; Green et al., 2020).

One of the largest barriers to therapeutic psychological health care is the cost. Many of the older theory models take an enormous amount of time for the individual and therapist to accomplish short- and long-term goals. Insurance plans only pay for a limited amount of therapy sessions and if a patient is self-pay, services can be expensive over time, thereby causing a financial stress or cost barrier for the individual (Rowan et al., 2013).

Transportation and accessibility can limit people from seeking care. Some individuals may not have access to transportation for a variety of reasons. Intense seasonal weather especially in rural areas could be a difficult barrier to overcome in

seeking health care of any kind (Paulson et al., 2015).

Health literacy, the means of comprehending and understanding the details of information, skills, and goal strategies discussed and agreed on in a treatment session is often a barrier to receiving adequate mental health care. Part of health literacy is the expectation that the client or patient is participating in the health care experience (Ronis, 1992). Lack of motivation or ambition on the patient's part is a potential barrier for successful mental health care. This is especially true of court-appointed patients who clearly have no desire to engage the health care system for meaningful, personal reasons. A patient's health beliefs, behaviors, and decisions about how health care is managed can also be a barrier if those beliefs are not truly healthy and practiced consistently by the patient (Davis et al., 2015).

**Chapter Summary**

Further research needs to explore long-term success rates for co-occurring mental and physical health issues that are handled with brief intervention and the effect this may or may not have on the patient's relationships or sense of social connection (Masters et al., 2005). Time is an expensive commodity for most health care offices, hospitals, or clinics. When an integrated model is established in a therapeutic setting, most of the assessment models are modified and the consultations and interventions for the patient are brief. This presents a potential limitation to successful long-term treatment results.

For decades individuals, communities and entire cultures have agreed that physical activity or exercise is beneficial for promoting good health. Recent advances in recommending exercise for the health benefit is limited to how much an individual is motivated to actually do the exercise. This is an example of why therapists use cognitive

behavior therapy with much success. How an individual thinks directly effects how that individual behaves. Changing the thinking process changes the behavior and although this is an important factor, integrating successful CBT programs into collaborative care models is an ongoing challenge in the public health system because culturally, individuals in the Western hemisphere have a more difficult time acknowledging the connection of mental and physical health or how either effect each other (Dubbert, 1992; Dubbert 2002). Continuing to educate the public about the benefits of a collaborative care model could warrant more research to support the efficacy and efficiency, impacting community comprehension and assimilation to more proactive wellness models of healthcare.

**Research Questions**

1. What is the lived experience of therapists helping clients to maintain healthy relationships in the face of physical or psychological health issues?

2. How do therapists describe their role in assisting clients in maintaining healthy relationships while managing physiological and psychological health issues?

3. What therapeutic techniques and strategies do therapists describe using to aid social and family connection during clients' health challenges?

4. What are the barriers therapists identify in helping their clients maintain healthy social and family relationships during health challenges?

# Chapter 3: Methodology

## Aim of the Study

For the purpose of this study, the qualitative approach was used. The topic of research is exploring the lived experience of therapists assisting clients coping with challenging health issues while the client is also trying to maintain life satisfaction sensing human connection. This phenomenological study explores the therapeutic experience of therapists' providing "real world" perspective and the types of situations that influence client care (Marshall et al., 2021). An interpretive approach allows this type of subjective topic to seek meaning while cultivating understanding. In addition, more qualitative research is being completed in the area of counseling in general because it utilizes expertise found throughout the field of counseling such as interviewing and advocacy (Hays et al., 2016; Hays & McKibben, 2021).

## Qualitative Research Approach

The metaphoric image of understanding qualitative research is much the same as looking at tiny threads of intricate fabric composed of different types of material, texture and color that seeks to provide an understanding of the complexity and detail of qualitative research as a whole (Creswell, 2013; Creswell & Creswell, 2018; Creswell & Poth, 2018). Qualitative research as an approach has been chosen for this study because the design examines the experience of therapists serving individuals going through challenging transitions utilizing the therapeutic tools that are used to benefit or increase life satisfaction and a sense of human connection.

The research design for this study is the Interpretative phenomenological Analysis (IPA) phenomenology. The IPA design will be used by this researcher to examine

intimate data and interpret study findings. IPA protocol was used as the guide for organizing thematic patterns and coded descriptions (Alase, 2017). For this research problem, qualitative methodology serves to explore the phenomena presented. This type of methodology or strategy is frequently used in the areas of education and social science to explore contextual topics that present social or cultural significance. The goal is not to prove a hypothesis but to explore a particular phenomenon (Hays et al., 2016; Hays & McKibben, 2021). This phenomenological strategy is suited for social research specifically to explore, discuss, and understand individual experiences and the meaning of those experiences (Brinkmann & Kvale, 2017). Collecting descriptive data aids the researcher in uniquely understanding the experience serving a particular population (Creswell, 2013). For this study a qualitative phenomenological approach is appropriate to explore the experience of therapists serving those with mental and physical illness who feel disconnected or isolated from family and friends. This phenomenological design also helps to understand the value of the therapeutic tools used by therapists in the study.

**Participants**

One of the strong points of qualitative research is that the participants bring multiple perspectives that allow a wider understanding of a topic. The participants broaden the lens from which a subject is seen or experienced by providing a more diverse view (Creswell, 2013). Nova Southeastern University's Institutional Review Board granted approval, and snowballing/chain measures and purposeful sampling were used to engage therapists who experienced this phenomenon (Creswell, 2018; Creswell & Poth, 2018).

The recruitment processes for participants were conducted through phone calls, email, and social media. The target population sample for this research was therapists that held a current and valid therapy license, had been in practice for at least five years (provides substance), are technologically adept, and directly and consistently served those individuals with a medical diagnosis while dealing with the challenge of feeling isolated or estranged to family and friends. The age, gender, and ethnicity of the therapists participating in this study were not important factors for the validity or reliability of this study. It is imperative to engage participants who have experience of the phenomenon to understand motivations and underlying reasons (Austin & Sutton, 2014). Potential participants were prescreened through email and phone call discussion. After being selected, and agreeing to participate in the research study, therapists returned signed informed consent via email or fax. This process took place over the course of one week. Informed consents were received, and individuals were contacted by email or phone and presented with procedures for the study. Participants had an opportunity to get any clarity needed on the process prior to having their account set up in the Focus Group platform. This research study was conducted with 10 therapists that hold a current and valid therapy license, have been in practice for at least five years, are technologically adept, and directly and consistently serve those individuals with a medical diagnosis while dealing with the challenge of feeling isolated or estranged to family or friends. The sample size included 10 participants for this research design because more detailed experience and complexity of the topic can be gathered, shared, and explored when gathering data from a group of 5 to 10 individuals (Stewart & Shamdasani, 2014; Barbour, 2018). The recruitment was not limited to a specific geographical area. The goal

of the sample size was to achieve saturation, the principle that enough data has been collected to analyze the lived experience to clarify and identify themes, and also to limit the scope of the topic, so as not to dilute its coherence (Saunders et al., 2018).

**Data Collection and Instruments**

Late 2019, in Wuhan, China, a unique human coronavirus called Covid-19 was identified, resulting in a global pandemic (Cucinotta & Vanelli, 2020). For health reasons, the need for social distancing and isolating has closed many institutions while only those providing "essential" services are conducting in person visits (Saberi, 2020; Inchausti et al., 2020). Due to the restrictions of personal interview meetings for the sake of health during a global pandemic, an online focus group was used to conduct this research. Online focus groups have increased in great number in the past decade in biomedical and health related research (Kite & Phongsavan, 2017). An asynchronous online focus group is a valid phenomenological approach in research as web conferencing supports solid communication, including both visual and aural cues, rivaling face-to-face focus group experience (Kite & Phongsavan, 2017; Stewart & Shamdasani, 2017). During a pandemic, the importance of continuing research, while keeping staff and participants safe is critical (Saberi, 2020). The online focus group design is a warranted model as it reaches dispersed populations such as those in rural communities while providing safety for health care providers and the individuals they serve (Kite & Phongsavan, 2017; Stewart & Shamdasani, 2017).

The benefits of online focus group research include improving the ease for participants due to the flexible scheduling, lower costs and reducing the time needed for the study, increasing the speed of the publication of the findings, while at the same time

preventing potential viral transmission to participants and staff (Saberi, 2020). Therapists and providers continue to develop technological competence as web conferencing supports sound research while protecting health and wellbeing (MacMullin et al., 2020). Further studies necessitate the need for researchers and participants to use technology consistently and adequately, especially during quarantine (Saltzman et al., 2020).

Language is one of the most powerful ways people share their world, their experiences, and their lives (Brinkmann & Kvale, 2017). This dynamic reason is why an on-line focus group is one of the strongest data collection tools used in the present research. Data gathering techniques are specific methods that structure the approach for the research. Data collection for this type of research included broad, open-ended questions that allowed the individual to describe his/her experience and share more in-depth information. The site of data collection occurred virtually on- line, with the use of an on-line focus group. This research took place in an asynchronous on-line focus group made up of 10 therapists that hold a current and valid therapy license, have been in practice for at least five years, are technologically adept, and directly and consistently serve those individuals with a medical diagnosis while dealing with the challenge of feeling isolated or estranged to family or friends. On-line focus groups are gaining in advantages for researchers due to participation convenience, the ability to discuss with a whole group, and being respected as a valid and reliable data collection tool (Zwaanswijk & Van Dulmen, 2014). This phenomenological strategy aided in revealing themes therapists perceived in serving clients involved in a health crisis who felt estranged. The focus group questions are designed to reflect the four research questions, which were developed based on existing literature. The focus group protocol was reviewed by two

experts in the field, who provided feedback on clarity of the questions and alignment with the research questions. After IRB approval, the focus group questions were pilot tested with a group of therapists similar to those under study, for further refinement of the focus group protocol. The focus group protocol can be found in the Appendix.

**Procedures**

After IRB permission was established, a pilot test study was done to ensure the descriptive validity of the study questions with 2 therapists and 1 psychologist (Aziz, 2017). The procedures for selecting the sample were as follows. The individual therapists received an email regarding the details of the proposed study. If they were interested in participating in the study, they were asked to complete a questionnaire composed of various questions to identify if they qualified for the study. Those questions identified the population they serve, how long they have served that population and specifically how long they have had a valid therapy license. Depending on the feedback, this research study proposed to gather information from 10 therapists. This number seems suitable for best research purposes, for gathering sufficient data within a reasonable time frame. The individuals were given documentation clarifying the details of the study, the strategy of the asynchronous focus group, the consent form, and requirements of participation. Participants could ask questions helping them decide to join the study group or opt out. Informed consent was filled out upon agreeing to the study. FocusGroupIt.com asynchronous on-line platform was used to conduct this focus group. This platform is user-friendly, allowing different levels of technological expertise and simplicity of design. The first day of the focus group, 9 discussion threads were posted, and individuals had 3 days to contribute to the discussion. Additional questions were added,

based on replies. On the third day, individuals had another 3 days to consider their responses, while the conductor's clarifying questions contributed to further discussion. A final day was available for further submissions and contributions.

To stimulate the most ideal participation, daily emails were sent as a reminder. Several response options and the use of clarifying questions supported ideal communication in collecting detailed descriptions (Marshall et al., 2021). Following this process, information gathered, underwent reliable and valid analysis as this format produced a transcript of the focus group that can easily be examined and assessed (Creswell & Creswell, 2018; Creswell & Poth, 2018).

**Data Analysis**

The Interpretative Phenomenological Analysis (IPA) design was used by this researcher to examine intimate data and interpret study findings. IPA protocol was used as the guide for organizing thematic patterns and coded descriptions (Alase, 2017). The phenomenological data analysis outlined by Creswell & Creswell (2018), was used. This process began with bracketing, which called for the researcher to put aside biases about the study. Then the content was reviewed to ensure the questions support the phenomenon studied. When the transcript was examined, comparable or analogous comments made by participants were coded. Next, the themes were analyzed, bridging the experience with the phenomenon. The findings were discussed, which include details surrounding the themes and the lived experience of individuals contributing to the study. Lastly, the detailed processes of transcribing the discussions have taken place and data of those experiences were analyzed manually with IPA. Color coding and thematic grouping were used to highlight themes and key areas or topics. This was essential in coding the

vast groups of information more efficiently and thoroughly. The coding derived from real life themes is called in vivo codes. This type of data appears in actual data as it is collected (Marshall et al., 2021).

## Ethical Considerations

In order to provide validity and reliability to the research study, several foundational elements have to be established. The goal here is to move from general good ethical principles to establishing a solid practice in the form of example by guide or rule (Brinkmann & Kvale, 2017). The integrity of the researcher is important for the quality of the gathering of scientific knowledge and the processing and sharing the information. This may include balancing personal preference while remaining neutral for the sake of gathering unbiased information or material from those being interviewed (Brinkmann & Kvale, 2017).

The IRB process is instrumental in establishing ethical rigor for both the researcher and the participant. At the onset of the study, NSU IRB approval was collected. One of the key components is informed consent, where the participant is educated on the purpose and design of the study as well as the benefits and possible risks. Confidentiality is also a factor throughout the entire process ensuring that private data the participant provides will not be reported (Creswell, 2013; Creswell & Creswell, 2018; Creswell & Poth, 2018). Individuals were offered anonymity during the focus group and symbols were used during the analyzing phase. Lastly, all records and data collected during the study will be saved for three years following the study on an encrypted computer. After three years, all research documents will be erased.

## Trustworthiness

Methodology is the broad philosophy that guides or directs how data will be gathered and collected with the goal of producing trustworthy and valid information. This also includes how the data will be systematically analyzed once it is discovered. Utilizing the proper methodology is vital to the validity and reliability of the research being conducted (Mkansi & Acheampong, 2012).

The steps that were followed to ensure trustworthiness included having each benchmark of the research study under the guidance of a chair and a member, along with utilizing the IRB process, both, at the original site where the study is created as well as any IRB that might be included at institutions where the participants may be employed or associated. For the purpose of this study, this researcher engaged in personal review of possible bias so as to be aware of potential partiality. There are many procedures to aid and support the rigor and trustworthiness of a qualitative study and they may include engaging in reflexivity, member checking, peer debriefing, and collaboration with participants (Marshall et al., 2021). Member checking involves the participants being actively involved in the credibility of the discussion, which is why utilizing an asynchronous on-line focus group will add strength to credibility and validity of this study (Creswell & Creswell, 2018; Creswell & Poth, 2018).

## Potential Researcher Bias

The researcher is thoroughly involved in this process of gathering information through interviewing which could challenge the validity and reliability of the research due to the researchers' personal bias (Giles & Eyler, 2013). Qualitative research has been considered subjective (Marshall et al., 2021). For these reasons, this researcher

participated in personal inventory to support impartiality. There are three general criteria that support the quality of a good focus group interview, and they are that the interview be focused on the participant's answers, the length of relevant answers and the clarification of the participant's statements and contributions (Brinkmann & Kvale, 2017). This researcher purposed and used these criteria as a guide to ensure a more impartial role during information gathering and data collection and analysis. In order to undergird validity of the study, this researcher purposed to suspend all assumptions, prejudices, and predispositions throughout the study.

**Limitations**

The concentration of this study is narrow. It was to explore the lived experiences of therapists helping clients maintain healthy relationships during the challenge of physical or psychological health issues. With regard to possible limitations, the amount of interpretive data collected as a qualitative design, allows for perception and interpretation apart from that of the researcher.

Another limitation could be that the on-line focus groups do not allow for much control or structure. While that may lend itself to thematic awareness, it may also allow for much of the information to be obscure at best. One of the difficulties that could be considered a constraint to this type of research, could be loosely defining the different areas of research philosophy. Classifying and utilizing the qualitative approach can be challenging when it comes to describing and categorizing information that may present with interfacing emphasis and overlapping meanings (Mkansi & Acheampong, 2012). For this reason, outlining the methodology and using the technology for transcribing and analyzing the data for coding, themes and keynote topics is important. The most

important consideration with qualitative research is to insure the most balanced and reliable information gathering and data assessing while also being able to communicate the experiences and findings in their most pure form (Creswell & Creswell, 2018; Creswell & Poth 2018).

## Chapter 4: Findings

Chapter 4 considers the findings of this phenomenological research. The purpose of the study was to explore the lived experiences of therapists' aiding individuals to maintain social connection while struggling with health concerns. The research was conducted during a global pandemic. For this qualitative research, the Interpretive Phenomenological Analysis (IPA) method was used to consider four detailed research questions. The analytical process incorporated the following: examining and rereading, highlighting and note-taking, identifying reoccurring themes, noticing and connecting emergent themes, and identifying patterns throughout the study (Smith et al., 2009). The four questions that guided the study were:

1. What is the lived experience of therapists helping clients to maintain healthy relationships in the face of physical or psychological health issues?
2. How do therapists describe their role in assisting clients in maintaining healthy relationships while managing physiological and psychological health issues?
3. What therapeutic techniques and strategies do therapists describe using to aid social and family connection during clients' health challenges?
4. What are the barriers therapists identify in helping their clients maintain healthy social and family relationships during health challenges?

**Participant Background Information**

For this phenomenological study data was collected via an asynchronous virtual focus group. The recruitment process for participants was conducted through phone calls, email, and social media. The participants all hold a valid therapy license and have been in practice for at least five years so that they have experience that adds substance to the research. Each participant therapeutically serves individuals who have some medical diagnosis and are dealing with the challenge of feeling isolated or estranged from family or friends. The age, gender, ethnicity, or location of the therapists participating in this study were not requested. Letters were sent to therapist groups on Facebook to assist with recruiting participants. After obtaining permission, a recruitment letter was posted to the specific groups, and members responded via Facebook Messenger. The individuals who agreed to participate in the study were screened with a questionnaire and asked to provide an email as contact information. Ten participants took part in the study.

All participants agreed to consent to the study by signing on to the Focus Group It platform. This platform automatically allows the participants to engage in the study anonymously by assigning anonymity to the group members in the order of the activity at the start of the group, Participant 1 (P1); Participant 2 (P2); Participant 3 (P3); Participant 4 (P4); Participant 5 (P5); Participant 6 (P6); Participant 7 (P7); Participant 8 (P8); Participant 9 (P9) and Participant 10 (P10). Detailed instructions were provided as an explanation of the study and procedures were posted as the opening message to the focus group.

## Presentation of the Findings

The virtual asynchronous focus group was executed via Focus Group It. Using this format allowed each participant to give their approval for the data to be used for the study. The transcripts were examined and analyzed using IPA (Smith et al., 2009). Each transcript was carefully and thoroughly read for familiar themes and was color-coded. At the onset, words, ideas, and phrases were underlined and highlighted. Reflective notes were added during the process. Identified patterns created categories and as themes in the transcripts became evident, notes were amended and reviewed for clarity and classification. In this study, the themes highlighted are those with the majority of the frequency of the contributions of experience in the data, and the secondary themes are the outliers. In this chapter, the four research questions are referred to as RQ1 (research question 1), RQ2 (research question 2), RQ3 (research question 3), and RQ4 (research question 4). The major themes identified were as follows:  Critical therapeutic role, safe space and wellness, compassionate collaboration, creative support, emotional regulation, family systems crisis, and global pandemic. In addition to the seven major themes, the four evident secondary themes that emerged were vicarious grieving, boundaries, client centered presence, and practical barriers.

## Results for Research Question 1

What are the lived experiences of therapists helping clients to maintain healthy relationships in the face of physical or psychological health issues? This question brought to light the descriptors of the individual experiences of the participants in their therapeutic roles. Overall, the research participants engaged in discussion candidly about their experiences with this population and detailed information about creating and

sustaining the therapeutic role. However, while six of the participants (P1, P5, P6, P7, P9, and P10) expressed their therapeutic role as a positive and empowering relationship to the client, one participant (P8) did not answer this question, and four (P2, P3, P4, and P5) stated that while staying attuned to the client, the experience can be draining and exhausting. The major themes that emerged from RQ1 are critical therapeutic role, and safe space and security. There was also evidence of two secondary themes: vicarious grieving and boundaries.

### *Critical Therapeutic Role*

When examining the responses to this research question, several themes emerged. Eight participants discussed the experience of the therapeutic role with clients. P10 stated,

"Many times, therapists hold a spiritual role with clients seeking to maintain inner strength with assistance from their spiritual foundation." P9 commented,

"Our role as therapists in this very difficult dance of balancing physiological and psychological health issues while maintaining healthy relationships is one of support and guidance. Being able to empower the client to advocate for their own needs in relationships throughout this time is vital." P 7 added,

"The therapist's role is to encourage client to foster ideas of how to maintain healthy relationships while helping them address physical and mental issues." P6 stated,

"I focus on assisting clients in exploring overall wellness. I believe it is important to help clients see that being healthy in all areas of life leads to more life satisfaction." P5 contributed,

"My role meets people first by building rapport, and honoring and accepting "their model of the world". This requires active listening". P1 stated,

"I take a very holistic approach when it comes to supporting clients through a health crisis; recognizing that our general sense of well-being is impacted by many facets and systems, including our relationships. The remaining participants contributed statements that had a negative connotation or elaborated on the challenges of the therapeutic role." P2 stated,

"I sometimes worry that the client will become dependent on the therapeutic relationship but also want to model a healthy relationship. It is a balancing act." P3 adds,

"I pride myself on being empathic, but because I work with people that are grieving, they miss out on hugs, human interaction, close family and friends, which makes it more difficult on them and ultimately more difficult on myself." P5 stated,

"It can be draining but I feel grateful that my presence/input/feedback may help and offer insight(s) that clients wouldn't possibly have thought of or had access to otherwise."

When questioned about therapeutic role, most of the participants elaborated on the therapeutic relationship and three out of nine stated challenges in the therapeutic relationship.

***Safe Space and Wellness***

Three of the ten participants explained how their role was to create a safe place, while three discussed creating a platform for overall wellness. P8 did not contribute to this question. P2 explained,

"My role as a therapist is to create a safe place, a scared place for the client to open up and discover new things about themselves which help them to see they have so much more strength, skills, and talents than they thought." P4 said about their role,

"Neutral, supportive, caring, a safe place for them. Welcoming, pt. client-centered. I would maintain non-judgmental affect and body language." P5 explains their role,

"My role meets people first, by building rapport and honoring-accepting their model of the world. This requires active listening. It's (the work) nearly all about me giving my energy, holding sacred space, me listening attentively and me staying attuned to my client- whether I need to provide some solace/ideas/resolution/ or just keep listening actively."

Three of the participants discussed their role as overall wellness. P6 explained,

"I focus on assisting clients in exploring overall wellness. Relationships are an important part of a client's well-being as well as psychological and physiological issues. I believe it is important to help clients see that being healthy in all areas of life leads to more life satisfaction." P7 stated,

The therapist's role is to encourage client to foster ideas of how to maintain healthy relationships while helping them address physical and mental issues. P1 added,

"I take a very holistic approach when it comes to supporting clients through a health crisis; recognizing that our general sense of well-being is impacted by many facets and systems, including our relationships. I ask clients about their physical, spiritual, emotional, social, and cognitive health early on in our interactions."

### *Vicarious Grieving*

Two sub-themes appeared in relation to this research question, vicarious grieving, and boundaries. Participants contributed equally to both secondary themes. P8 did not participate. P3 discusses vicarious grieving and the difficulty it places on the therapeutic relationship.

"Because I work with people that are grieving, it is very difficult because of the population I interact with on a daily basis. I take on a lot of their sorrow on an everyday basis. I find myself feeling sorrowful and wanting to take my patients under my wing because I feel so sorry for them." P4 adds,

"Been there – it is emotionally exhausting." P5 states,

"It can feel draining. "Draining" feels like there's not a whole lot left to give. My cup gets depleted and I gotta figure out how to refill and recharge since it's (the work) nearly all about me giving my energy." P1 discusses vicarious grieving,

"Loneliness is a very painful part of the human experience. I think we can all empathize with clients who navigate isolation. Their pain is so evident that I often feel it too, in these support situations."

### *Boundaries*

The second sub-theme that is evident is boundaries. Four of the nine participants contributed discussion related to boundaries. Most said that boundaries are important and yet struggle with how to substantiate them with a needy population during a pandemic. P8 did not participate. P1 stated,

"When discussing healthy relationships communication skills and boundaries are regularly discussed." P2 added,

"I sometimes worry that the client will become dependent on the therapeutic relationship but I also want to model a healthy relationship. It is a balancing act." P3 stated,

"This health crisis has added another layer of loss to this population. Sometimes it is difficult to maintain those boundaries that I was taught are very crucial when assisting clients. Clients miss the human interaction, and as a result of trying to do work virtually, they want to get close. Surprisingly enough I have experienced many clients wanting to be friends, and sometimes breaking those boundaries that on a more face to face level I would be more careful not to break." P4 contributes,

"I believe that a therapist will naturally have some clients that they feel closer to. This will challenge boundaries, but it is important to know whose needs are getting met more. This can be very hard to do. Most importantly, therapists lend their ego to the client. Providing them supportive care, validation, and reassurance if appropriate."

There was a balance of discussion about the participants experiencing vicarious grief with their clients and how that reciprocal experience affected professional therapeutic boundaries.

**Results for Research Question 2**

The second research question probed the ideas behind how therapists view their role while aiding clients dealing with physical or mental health issues as they maintain healthy relationships. This question seeks to gain insight into therapists navigating their role for the client, both from an internal (collaborative) and external (support systems) perspective. The major emergent themes for RQ2 were compassionate collaboration and creative support. The sub-theme that surfaced was client centered presence.

***Compassionate Collaboration***

Of the ten participants, five discussed how to compassionately collaborate with the client to enable the client to effectively manage their internal world, their thoughts, their feelings, and ultimately, their behavior. P8 did not participate in responding to this question. P1 begins by explaining practical ways to compassionately collaborate on behalf of the client.

"A big part of my role as the clinician is to explore potential barriers and strengths, collaborate with the client to build their own solution. I may utilize motivational interviewing, psychoeducation, and brainstorming techniques to identify new approaches to maintain healthy relationships. I like to help the client explore their definition of forgiveness and challenge their beliefs if they are not helping them feel what they want to feel. We must not assume anything. Allow the client to lead." P5 stated,

"I create compassionate rapport by being aware and centered, by noticing, interpreting, ascertaining (I say to myself, "what is really going on here?"), and reminding clients they can always choose to "pass" or say "no thanks. I make space safe by reminding the client that s/he is the reason I am here." P6 explains collaboration,

"I believe that my role is to help others develop their own treatment plan to best address their needs based on each individual's value system. I typically focus on trying to assist clients in exploring their own values and how well they are working towards these values. If the client's behaviors conflict their values, I try to assist them in making the needed changes to better fulfill their needs. There are several parts to the process. The first step is to find out if the clients desire to improve former social relationships and assist them in doing so if desired." P9 states,

"My role as a therapist who is assisting clients in navigating their health issues, while maintaining healthy relationships is to educate the client on the importance of those healthy relationships as it pertains to self-care. The therapist steps into that role to create a safe space for the client to discuss their fears and concerns surrounding their illness, but to also allow space for any other processing that may need to be done along the way." P10 elaborates on compassionate collaboration,

"My role is for the client to realize that he/she/they have the ability for overall wellness even in their moments of despair."

***Creative Support***

The second major theme for RQ2 is the therapist utilizing and helping the client discover different types of support available to them. P10 begins the discussion,

"I assist clients through engaging in other support systems and engaging in self-love activities." P9 adds,

"There are so many losses that are experienced through a health decline, that it is imperative to keep steady constants around, especially when those constants make up a support system. As a therapist who is helping a client navigate their diagnosis or illness without an effective support system, you become their support system; you are there to answer their questions, provide resources as needed, advocate for them and listen to them." P7 states,

"I think a support system is important so helping a client recognize who in their life falls into that category. The client needs the space in therapy to be able to express their anxieties." Creative support is explained by P6,

"There are several parts to the process. The first step is to find out if the client desires to improve former social relationships and assist them in doing so if desired. After that I would assist clients in exploring options to create their own support systems (if desired). Finally, we might look at ways to be content and fulfilled internally." P5 expounds on this,

"Specific directives can address feelings of isolation or estrangement. Discharge negative emotions via personal artistic expression. We might write to their loved one(s), or they can dictate a letter, note or card, and I can transcribe for them. (Many clients cannot hold a pen/have difficulty writing). We can FaceTime or make a phone call. Letters "never to be sent" to their illness or diagnosis may be useful for discharging feelings. Sometimes simply reminiscing with lots of compassionate listening just helps people feel more connected and calm." P3 elaborates,

"It is a difficult task, the way I have challenged this issue is by trying to get group members to help themselves. By making sure that a group is doing what it is intended for, which is sharing similar problems and helping one another. I help clients by listening and making sure that they are in the right place for their needs. Because the elderly are very vulnerable and they need extra help at times, so building rapport is so important." P2 said,

"My role is to focus more on the healthy relationships and not give advice on the health issues." P1 added,

"I am in total agreement with empowerment and autonomy! I think another important piece is to help clients relate to others but also validating their unique

***Client Centered Presence***

One secondary theme appeared in relation to this research question, client centered presence, as it relates to the therapeutic ability to be aware of the client, cognitively and emotionally, and design the techniques to support each of their goals. Four of the 10 relayed information of the importance of client centered presence. P4 discusses client centered presence and what it takes to cultivate that in the therapeutic relationship,

"Client centered – how do they view their health issues – and start there. Starting point: their perception. It would take some time and exploration. It is possible to manipulate a patient into coming up with their own ideas or suggest one to facilitate the process." P3 added,

"I help clients by listening and making sure that they are in the right place for their needs. If they are not, I help them by also using a client centered modality." P5 stated,

"I make a safe space by reminding the client s/he is the reason I am here... I share that I am "here" to serve their highest good. I meet them where they are (their model of the world is honored to the utmost I am capable), and I believe energetically, they feel this is so. I create rapport with my tone, my eyes, my facial expressions, and my authenticity."

P6 contributed,

"I typically focus on trying to assist clients in exploring their own values and how well they are working towards their own values."

**Results for Research Question 3**

What therapeutic techniques and strategies do therapists describe using to aid social and family connection during clients' health challenges? This research question garnered many vast and creative responses. Participants candidly elaborated on types of expressive strategies and techniques that involve mindful connection. Five of the ten participants commented on types of emotional/physical expression strategies used during a health diagnosis and relationship crises. P8 did not contribute. Seven of the participants discussed techniques that allowed patients to feel a sense of connection to themselves and others.

***Expressive Strategies***

P10 stated,

"I use expressive art techniques to address stages of grief and inner child work. EMDR to address future events." P6 added,

"I try to help them find creative outlets such as art and writing to express their feelings. I like to use DBT, due to the many worksheets and exercises. I also like to use CBT Socratic questioning to challenge exaggerations in thinking that lead to cognitive distortions and obsessive negative thoughts." P5 contributed,

"As an art therapist, I offer materials suitable/appropriate for the particular clients' functioning level (oil pastels, watercolor crayons, or maybe acrylics). We might pick colors that represent "isolation" and DRAW/Paint it out and give symbols for the feelings. I offer art supplies and 2-D and 3-D interventions/projects/legacy project ideas." P2 stated,

"I use role play, empty chair technique, and client-centered affirmation therapy." P1 added,

"CBT is an excellent tool to assist the client in developing awareness about how their thoughts and perceptions directly influence their emotions and behaviors. I find that life review and memory sharing is another helpful technique. I also encourage writing, creative expression of emotion through art and music, physical movement with intention, and sometimes punching a pillow, using a stress ball, and letting out a primal scream in

***Mindful Connection***

Seven of the ten participants expounded of the strategies and techniques used to aid patients navigating a health crisis during social isolation or estrangement to help them feel connected to themselves and others. P10 stated,

"I use group therapy and online book clubs and expressive art techniques." P9 added,

"Many clients were fully able to grasp and apply the techniques throughout psychoeducational group work." P6 elaborated,

"I would also assist clients in exploring possible opportunities to create social networks through shared hobbies or interests (possibly via online forums), if there are any physical limitations. I would also connect them with local resources available. Use narrative therapy, share their own life experiences, as well as mindfulness." P5 added,

"Offering to help make a call the speaker phone, or Facetime with a family member, email, write a letter, would be among my tools I offer anyone missing social connection."

P4 states,

"Are they willing or able to discuss how or what the social connection struggle is? Techniques such as diagnosis specific support groups and activism are recommended."

P3 noted,

"Helping clients improve their technological skills so that they are able to connect with friends and family via Zoom, Facetime, and or other social medias like Facebook, Instagram or WhatsApp. They can call a friend or family member and ask them to join on a Zoom call or Facetime, these are ways of encouraging communication with their friends and family." P1 offered,

"A few of my favorite grounding techniques are box breathing, self-compassion, mindfulness, and grounding techniques. A few examples include religious or cultural traditions/rituals/prayer and meditation, access or connection to a support community, guidance and hope instilled through faith. These things help the individual feel connected to the "bigger picture". This is especially helpful in dealing with the isolation estrangement or the desire to feel connected."

**Results for Research Question 4**

The fourth research question probed what type of barriers therapists identify in helping their clients maintain healthy social and family relationships during health challenges? The two themes that emerged from this question had to do specifically with emotional control or awareness of feelings and the other had to do with navigating Family System Crisis'. A secondary theme appeared that highlights practical obstacles such as "too many appointments" or client not knowing how to use technology to stay in touch with telehealth or family/friends.

### *Emotional Regulation*

One of the major barriers mentioned as a central theme as a response to RQ4 was emotional regulation. Six of the ten participants discussed different types of challenges with emotional regulation for clients dealing with health issues and problems of social isolation. P10 commented on negative emotions and stated,

"Barriers for my clients are regulating anger and resistance for forgiveness for family members." P9 stated,

"Some barriers I have experienced with clients are their awareness of their own emotions, and how to effectively communicate such. Again, the lack of awareness and they don't know the coping skills to assist with these feelings." P6 added,

"Acceptance is a major hurdle. Clients have a difficult time managing emotions and react in ways that hurt other people. I think that health crisis situations bring on PTSD response far more often than people realize." P3 discussed,

"The number one barrier is fear. Most clients in my population are the elderly, and as a result, getting ill and having no one to care for them is extremely anxiety producing."

P1 responded to P3 about fear, stating,

"Absolutely!" P2 contributed,

"The biggest challenge is clients fall back into old self-sabotaging habits and stop coming to treatment at the first sign of improvement."

### *Family Systems Crisis*

A family systems crisis, as a complex social system, has to do with how individuals within a family interact to influence each other's behavior. Four out of 10 participants contributed to this sub-theme about barriers. P6 states,

"The first barrier is codependency. Many clients have long established codependent relationships and that it is difficult for clients and significant family members to move away from, and that the health issues tend to lead the client to be unable to fulfill established patterns that have developed over time, leading to a family system crisis. Clients often have difficulty accepting these new limitations and lack a sense of purpose as a result. Family may have difficulty adjusting to clients' inability to participate in the role that they previously performed, leading to distress." P5 added,

"The one issue I have come face to face with is when a family member may have a vastly different view of what is appropriate for the patient, like when the husband/father is not in agreement with daughter! Therefore, I am torn, in between a rock and a hard place, to know how to honor the patient and the family." P1 noted,

"I would say the biggest challenge in helping clients maintain healthy relationships is challenging ingrained patterns of thinking. The biggest barrier is not having two parties willing to expend the same amount of energy into building or maintaining the

***Practical Barriers***

Participants contributed a host of practical examples that cause blockages or obstruction for clients navigating health issues and relationships. Four out of ten participants discussed challenging practical barriers. P8 did not contribute. P2 stated,

"Many times clients have several appointments and they miss a lot of therapy appointments. This hurts the consistency which is key if they want to change a behavior such as improve their relationships." P3 added,

"The number 1 barrier is fear. Fear of contracting the Covid-19 virus and/or becoming ill and not having anyone they can depend on for help. Another one of the biggest challenges is making sure that we can bring family together in a timely fashion." P5 discussed,

"Staying in touch can become very tricky once clients decline to a certain level where they can't email independently, or can't write letters, or can't speak." P4 offered,

"It is hard for a person with health challenges to not be focused on themselves.

***Global Pandemic***

The four research questions were answered by the participants, during a global pandemic. The participants expounded on the response to the questions, through the lens of a global pandemic. P9 stated,

"Throughout this pandemic, I found myself focusing much on CBT techniques to help clients regain some control throughout this past year of the pandemic especially. It has certainly been the perfect storm for negativity and helplessness." P5 added,

"Many folks may not have family/loved ones around during Covid, and some are also cognitively impaired, so they may not be aware of a pandemic." P3 contributed,

"This health crisis has added another layer of loss to this population. Their number one barrier is fear. Fear of contracting the Covid-19 virus and becoming ill and not having anyone to care for them. They miss out on hugs, human interaction, close family, and friends. This pandemic has made it difficult to maintain boundaries that I was taught are very crucial. Clients miss human interaction, and as a result, when trying to work virtually, they want to get close. Also, it's important to help the clients improve their technology skills so that they are able to connect and communicate with friends and

family. Because of the health crisis, people have not been able to travel and meet with their loved ones when they become ill and or are dying. This is very sad! As time goes by, there will be more problems with pandemics. As a result, the country and world has to be better prepared in managing health crises and the endangering viruses that we will face in the future."

**Summary of the Findings**

Chapter 4 presented the data collection and analysis, a synthesis of the findings, and a narrative summary of the response of the participants to each of the research questions:

1. What is the lived experience of therapists helping clients to maintain healthy relationships in the face of physical or psychological health issues?
2. How do therapists describe their role in assisting clients in maintaining healthy relationships while managing physiological and psychological health issues?
3. What therapeutic techniques and strategies do therapists' describe using to aid social and family connection during clients' health challenges?
4. What are the barriers therapists identify in helping their clients maintain health social and family relationships during health challenges?

During data analysis, several themes developed. The major themes were: Critical therapeutic role, safe space and wellness, compassionate collaboration, creative support, emotional regulation, family systems crisis, and global pandemic.

In addition to the nine major themes, the four evident secondary themes that emerged were vicarious grieving, boundaries, client centered presence, and practical barriers.

Overall, the participants contributed to the research through the lens of a global pandemic. Chapter 5 will comprise a discussion of the findings, their significance, and recommendations for future researchers.

# Chapter 5: Discussion

## Overview of the Study

The purpose of this phenomenological study was to record the perspectives of the lived experiences of therapists aiding individuals struggling with health concerns to maintain social connection. The primary investigator intended to explore and understand the role, strategies, techniques, and barriers therapists experience while helping clients with a physical/mental diagnosis navigate or manage social isolation. The qualitative methodology was used because it is the "process of naturalistic inquiry that seeks an in-depth understanding of social phenomena within their natural setting. It focuses on the "why" rather than the "what" of social phenomena and relies on the direct experiences of human beings as meaning-making agents in their everyday lives" (Ahmad et al., 2019, p. 2828).

The focus group discussions were conducted in a virtual asynchronous platform via FocusGroupIt. The therapists involved in the research responded to nine questions and interacted with each other via virtual discussion, elaborating on responses to clarifying questions. The primary investigator asked the inquisitive questions, to stimulate clarity or the recall of additional information. In response to the four research questions, nine major themes and four sub-themes emerged. In response to RQ1, the major themes were critical therapeutic role and safe space and wellness. Sub-themes, vicarious grieving and boundaries were discussed to a lesser extent, although still relevant. RQ2 captured high responses on themes of compassionate collaboration and creative support. The only sub-theme was client centered presence. In response to RQ3, the therapists discussed two main themes to aid clients navigating social isolation during a health crisis, expressive

strategies, and mindful connection. No sub-theme emerged. RQ4 garnered a thorough response with two themes, emotional regulation, and family systems crisis. Practical barriers developed as a sub-theme, with less frequency. Overall, the contributions to all questions were answered through the lens of/during a global pandemic.

## Interpretation and Context of the Findings - RQ1 The Role & Experiences

### *Critical Therapeutic Role*

Overall, the data collected revealed that all of the therapists felt that creating a therapeutic relationship was foundational to the experience for the client. Discussion elaborated on the different aspects of accomplishing this goal, in that, as important and necessary as creating the relationship is, several stated it can be very draining or exhausting. Importance of establishing and maintaining the therapeutic role was discussed as a vital part of the therapeutic goal for the client. These findings were consistent with those of Rober (2020), who highlighted the crucial purpose the role of the therapist plays in the client's improvement. Levi (2020) discussed the importance of the role of the therapeutic relationship within the potential space built by the therapeutic alliance**.** Chui and Hill (2020) reported therapists entering a session with a sense of exhaustion and not feeling calm were less effective. Fatigue, working with lessened interpersonal cues due to virtual technology, and feelings of isolation that apply to remote learning, were the experiences of therapists participating in a mixed-methods approach during the challenging global pandemic (McBeath et al., 2020).

### *Safe Space and Wellness*

More than half the participants agreed that creating a safe place or designing a sense of therapeutic wellness was part of the experience and important to the client.

Similarly, Santos (2020) discusses the therapeutic relationship and complexities such as systemic discrimination, while the psychoanalyst presents the clinical setting as a safe space. Likewise, Sinclair (2020) posited the physical environment of the therapeutic space serves as an important factor in whether clients feel comfortable engaging in therapy. Further research has been suggested to understand clients' presenting issues and cultural differences in the therapy room space. Minonne (2020) agreed with Santos (2020) that vulnerable populations need a safe space in the therapeutic environment. Additionally, Deans (2020) reported the value of creating a safe space in the therapy room to reduce the stigma connected with mental illness. Creating safe spaces where clients express psychological experiences, collaboratively utilizes therapeutic resources and strengths, producing healing and wellness.

### *Vicarious Grieving*

The first sub-theme, vicarious grieving was reported in detail by several of the participants. Participants found difficulty in creating psychological boundaries. To expand on this idea, Powers (2020) cited compassion fatigue following vicarious grief reveals the greater need for self-care for therapy providers. For this reason, Posselt et al, (2020) reported results from qualitative analysis that revealed findings in rapport and overall alliance with one's clinical supervisor are protective of the secondary stress from vicarious trauma in the therapeutic space.

### *Boundaries*

The second sub-theme, boundaries was noted by several of the participants as a challenge in the therapeutic space. Some participants expressed that the virtual therapy platform contributed to the difficulty managing professional boundaries.

Moreover, Wolson (2021) discussed reliable boundaries are more challenging to set and keep in cyber space and some clients have a difficult time relating meaningfully to a cyber analyst. To illustrate, the concept of boundaries in therapy offers layers of support, even in destabilizing times during a pandemic, such as consistent meeting times and therapeutic goals (Thomas, 2020).

## Interpretation and Context of the Findings - RQ2 The Shared Experience

### *Compassionate Collaboration*

Half of the participants discussed how partnering with clients to compassionately collaborate on the therapeutic process, enabled clients to effectively manage their internal world, their thoughts, feelings, and ultimately their behavior. Specifically, Agarwal (2018) found through purposeful snowball sampling, collaboration with a therapist that used empathic listening, affirmation, and was "in-tune" with them to connect mind and body, supported self-reflective learning. Clients' value practitioners who communicate clearly, listen carefully, and collaborate on manageable goals. For example, clients emphasized the importance of the practitioner's demeanor, rather than the specific type of treatment modality or the amount of provided time of the service (Percival et al., 2017). For this reason, Aoun et al., (2019) discussed qualitative findings that found compassionate collaboration is vital for effective and sustainable therapeutic care.

### *Creative Support*

Therapists discuss the importance of helping clients discover and utilize different types of creative support available to them. In a like manner, Tompkins (2021) explores the shared creative process that expands the client-therapist relationship while promoting the well-being of the client and the therapist as a shared journey, utilizing therapist

presence, authenticity, empathy, and unconditional acceptance to guide the client toward self-realization. Furthermore, Malyn et al., (2020) conducted interviews and found four themes developed in relation to creative support: relationship to self, relationship with others, relationship to facilitator, and an intermediate object.

### *Client Centered Presence*

One secondary theme appeared in response to this research question, client centered presence, as it relates to the therapeutic ability to be aware of the client, emotionally and cognitively, and design the techniques to support each of the client goals. Four out of ten participants discussed information about the importance of client centered presence. To explain, Cerone (2019) used case-based vignettes to illustrate how five open-ended questions help mitigate suffering and heighten a patient's sense of autonomy and self-worth. Person-centered therapy is highlighted as a powerful method to explore a patient's feelings and wishes in the face of critical illness. Subsequently, Walder & Molineux (2020) shed further light on ways therapists can understand and address client's experience, needs, goal setting, motivation, and confidence and stated client-centered care must be grounded in client reality. As a result, researchers agree that the social contracts of client-centered and person-centered therapies support and enhance inter-personal congruence (Frankel et al., 2019).

## Interpretation and Context of the Findings - RQ3 The Client Experience

### *Expressive Strategies*

Seven of the ten participants discussed an array of creative responses when describing strategies and techniques used to aid family/social connection during a client's health challenge. Five therapists highlighted techniques and strategies that allowed

patients or clients to sense a greater sentiment of expression as a sense of communication and relief. Interestingly, Haeyen & Hinz (2020) found in case vignettes that many mood-sensitive experiences and cognitive processes including patterns of attachment, appear in the first 15 minutes of art therapy and possibly illuminate a clients' preferred ways of processing information. "Expressive therapies continuum components, attachment patterns in the material handling process, and emotional regulation strategies during art making" provides crucial information that guide the goals and the therapeutic course (Haeyen & Heijman, 2020). Correspondingly, Lee & Toren (2020) discussed how poetic elegies shine light on the capacity of expressive journaling to heal loss. Many of the participants commented on the helpfulness of expressive arts in therapy as a means of managing loss of health or relationships. For example, Arellano et al. (2018) state that research supports the use of expressive arts combined with group therapy, as a therapeutic means to support grieving young adults. In addition, Nan et al., (2018) state in the past few decades expressive arts (EXA) has been used to support quality of life for patients and caregivers. Using a mixed-methods evaluation, findings showed remarkable improvement in non-pharmaceutical management of symptoms and psychosocial care combining expressive arts as an effective therapeutic approach. Findings also support the need for brief training for therapists not certified in expressive arts, to aid competent therapeutic expressive interventions.

### *Mindful Connection*

The second theme that emerged to aid clients navigating social isolation during a health crisis was mindful connection. Seven out of ten participants discussed a variety of techniques and strategies used to support mindful connection to oneself and others.

Findings suggest mindfulness, as awareness of thoughts and feelings without placing judgment, has been utilized in a large variety of therapeutic modalities.

However, Gambrel et al., (2020) discuss a case study that identifies the benefit of art and mindfulness as therapeutic interventions especially for those reluctant to embrace more traditional types of talk therapy. Creating art as therapy allows for reflective thought and makes space for practicing mindfulness and reflection. To expound, Chen & Murphy (2019) investigated mindfulness, authenticity, and psychological well-being using the Mindful Attention Awareness Scale, Authenticity Scale, and the Psychological Well-Being Scale. Findings revealed that authenticity is the partial interceptor that supports relationship of mindfulness which directly connects to psychological well-being. The findings of this study suggest that person-centered therapy could be regarded as a type of mindful therapy. Finally, Huynh & Torquati (2019) surveyed the connection to nature, mindfulness, and psychological well-being. Results indicated that mindfulness remarkably mediated the relevance of connection to nature and psychological well-being. Mindfulness significantly regulated the relationship between perceived stress and two indicators of psychological well-being.

## Interpretation and Context of the Findings - RQ4 Obstacles & Challenges

### *Emotional Regulation*

One of the major themes highlighted in response to RQ4 as a significant barrier, was emotional regulation. Six of the ten participants recalled different types of challenges of emotional regulation for clients navigating health issues coupled with social isolation. Regulating anger, resistance for forgiveness, and lack of emotional stability were among the many types of difficulties mentioned with emotional regulation. In a like manner,

Kleinstauber et al., (2019) espoused the vital significance of using cognitive behavior therapy (CBT) with patients dealing with medical symptoms, along with implementing emotional regulation training (ENCERT). This mixed methods study revealed higher effectivity for use with patients having co-morbid mental disorders. In addition, Southward et al., (2021) utilized a qualitative study researching therapists' vignettes to discover the effectiveness of commonly used emotional regulation strategies. Results indicated the most useful strategy used for emotional regulation was "problem solving" and the least effective was "concealing emotion or expressive suppression". Finally, Lawson-McConnell (2020) discusses client-counselor attachment, with regard to the history relating to the capacity and contribution of the role of emotional regulation in the therapeutic setting, highlighting the importance of restorative emotional experience for the sake of client healing.

***Family Systems Crisis***

A family is a complex social system dictating how individuals within a family interact or influence one another's behavior. Four out of ten participants contributed to this sub-theme about barriers by highlighting codependency.

New limitations contributing to a lack of sense of purpose in the relationship may result in family having difficulty in adjusting to clients' inability to participate in the role they previously performed, causing distress.

For example, Kim et al., (2018) utilized a model to aid families adapting to a chronic crisis of mental or physical health by conducting a survey about family stress, family resilience, and family adaptation specifically with families who have a member with dementia. The results found that the communication process, difficult behavior of older

patients, and family stressors, had direct and indirect effects on how families adapt. Social support, the family belief system, and the organizational pattern had indirect effects. Subsequently, the interventions that aid a family's positive adaption, demonstrate an increased and improved family resilience. In the same way, family function impacts treatment and recovery outcomes. Family members in a family system potentially influence each other. Using electromagnetic radiation to measure activity in the brain, findings supported the importance and influence of healthy family member engagement as a significant factor related to function and well-being (Agner et al., 2021).

### *Practical Barriers*

The practical barriers contributed by participants explain blockages or obstructions for clients navigating health crises and relationship difficulties. Four out of ten participants discussed challenging practical barriers such as too many appointments, fear of contracting Covid-19, and not enough time to get important things done that accomplish a specific goal. For example, Alegria & O'Malley (2020) discuss the difficulty with securing appointments and navigating the insurance process while, at the same time, having too many appointments. Strategies are explored to support practical innovation in health care such as inclusiveness, community support, optimism, and practical sensibility. As a result, practical findings that aid clients include appointment reminders, cost-effective policies that limit session length, and involve outside community support when possible (Kilcullen et al., 2020).

As the Covid-19 virus devastates the entire world, many have died in a short time. Due to restrictions put into place to minimize transmission of the disease, many people have died alone due to requirements of social distancing. This pandemic has affected the

way hospice patients are cared for, how end-of -life care is being handled, and how bereavement ceremonies are performed. Those grieving are supposed to manage without usual social and cultural rituals due to policies in place to help alleviate the intensity of the pandemic. Conversely, Goveas & Shear (2020) discuss in a commentary, one of the challenges of the pandemic as a new diagnosis of prolonged grief disorder and authors suggest ways that might lighten this emerging problem.

### *Global Pandemic*

The participants responded to all four research questions during a global pandemic. All participant responses to questions are expounded on through the lens of a global pandemic. Consequently, Masiero et al., (2020) discuss in commentary four possible origins of trauma, decision fatigue in healthcare staff, complicated grief in those who lost loved ones, social losses related to mitigation of pandemic such as job loss or lack of social gatherings due to economic shut down, and loss of personal identity or social role. No other event has altered life around the world in such a dramatic way in modern history, as the Covid-19 pandemic. Therapists have increased telehealth support to provide therapy during the social distancing mandates. Family systems therapists completed an on-line study which supported the benefit of training in technology to provide telehealth therapy. Subsequently, Training in policy was also reported as a benefit to providing confident telehealth services (McKee et al., 2021).

## Implications of the Findings

The study found that the therapeutic role is critical to establishing a safe space of therapeutic wellness for the client or patient (Knock et al., 2021). Findings suggest that practicing healthy boundaries during a pandemic are challenging and necessary to limit

therapeutic vicarious grieving (Powers & Engstrom, 2020; Thomas, 2020). Findings recommend partnering with clients to compassionately collaborate on the therapeutic process, enabling clients to effectively manage their internal world, their thoughts, feelings, and ultimately their behavior. Creative support offers clients and patients the benefit of well-being, the combination of feeling good and functioning effectively, while the client utilizes the therapists' presence, promoting empathy and unconditional acceptance to guide the client toward established goals.

All participants discussed an array of creative responses when describing strategies and techniques used to aid family/social connection during a client's health challenge. Findings highlighted specific techniques and strategies that allow patients or clients to sense a greater sentiment of expression as a sense of communication and relief. These techniques are used to support mindful connection to oneself and others. Findings suggest the benefit of art and mindfulness as therapeutic interventions, especially for those reluctant to embrace more traditional types of talk therapy while creating art as therapy, allows for reflective thought (Gambrel et al., 2020).

Emotional regulation was found to be a significant barrier. Regulating anger, resistance for forgiveness, and lack of emotional stability were among the many types of difficulties mentioned with emotional regulation. Additionally, Kleinstauber et al., (2019) corroborate the vital significance of using cognitive behavior therapy (CBT) with patients dealing with medical symptoms, along with implementing emotional regulation training (ENCERT) for clients struggling with emotional regulation.

Another major finding is the presenting barrier that is the family systems crisis. New limitations contributing to a lack of sense of purpose in the relationship may result

in family having difficulty in adjusting to clients' inability to participate in the role they previously performed, causing distress. According to the data, practical barriers such as too many appointments, fear of contracting Covid-19, and not enough time to get important things done that accomplish a specific goal present as a significant barrier (Alegria & O'Malley, 2020).

All participants responded to all four research questions during a global pandemic. All findings are responses to questions expounded on through the lens of a global pandemic. Masiero et al., (2020) discuss in commentary four possible origins of trauma, decision fatigue in healthcare staff, complicated grief in those who lost loved ones, social losses related to mitigation of pandemic such as job loss or lack of social gatherings due to economic shut down, and loss of personal identity or social role. No other event has altered life around the world in such a dramatic way in modern history, as the Covid-19 pandemic. Therapists have increased telehealth support to provide therapy during the social distancing mandates. Family systems therapists completed an on-line study which supported the benefit of training in technology to provide telehealth therapy. Training in policy was also reported as a benefit to providing confident telehealth services (McKee et al., 2021).

**Limitations of the Study**

The study is limited in scope because it focused on therapists in healthcare during an unprecedented era in the course of a global pandemic. Participation by this unique population makes it very difficult to generalize the findings. According to Creswell and Creswell (2018), purposeful sampling, which was used, is not designed to promote generalizations, but rather to gather in depth information from a group of participants

who are exceptionally knowledgeable about the phenomenon of interest. In addition, one month of recruiting produced a participant group of ten individuals. Their sex, age, ethnicity, and common demographics are unknown so it is impossible to determine the diversity of the sample and to what populations that findings are generalizable. Furthermore, the study was qualitative which, by design, may limit the study due to the typical conceptual framework possibly being affected by the Global Pandemic; since the focus group was virtual asynchronous and findings are fundamentally interpretive (Marshall et al., 2021). The design of this study allows for interpretation other than that of the researcher.

**Recommendations for Future Research Studies**

This recent study highlighted findings that therapists serving clients with a health diagnosis while also struggling with social isolation, struggle with vicarious grieving and creating healthy boundaries due to the remote telehealth model. Wider sampling with quantitative research would include a more diverse range of demographics, enabling more information to be gathered about how to manage the vicarious grieving and setting more secure boundaries. Another suggestion would be to utilize a stratified purposeful sampling method to observe comparison or research details of identified subgroups or sub-themes (Creswell & Creswell, 2018; Creswell & Poth, 2018). Future research examining how to create a safe space and wellness for the client during diagnosis and isolation is recommended. Future research exploring best practices for utilizing expressive strategies and mindful connection in the therapeutic space is recommended. Additionally, further research is needed to address the benefit of joint or parallel creative processes and client's perceptions, especially from a culturally diverse platform (Duffey

et al., 2016). Therapeutic writing supports well-being, but future research should focus on the efficacy of the intervention for reducing social isolation and loneliness (Berg-Wegner & Morley, 2020). Finally, due to the limited nature of this study, and in order to secure a more diverse collection sample, recruiting participants from a wider range of demographics with random sampling would be beneficial.

**Conclusion**

In conclusion, this study sought to answer four research questions. The research questions were adequately answered as noted by the emergence of the major themes and sub-themes. This research implies therapists may benefit from upholding the importance of the therapeutic role, and the collaborative experience for the therapist and client. The participants agreed on strategies utilized, and barriers and challenges identified to aid the client navigating a health crisis while striving to maintain healthy social and family relationships, yet there is opportunity for more detailed training, especially with the technology of telehealth.

The critical therapeutic role is vital and dependent on creating a safe space that offers a sense of wellness to the client or patient. The challenge to the therapist in this endeavor is to build and maintain healthy boundaries while limiting vicarious grieving. Therapeutic alliance is maintained with compassionate collaboration of the therapist with client and creative support, for client utilizing other support systems available. The therapist practices client centered presence to know what the client needs to support clients' goals. Two of these support areas are expressive strategies, such as using art materials, and mindful connection, such as meditation, to aid client or patient to feel grounded and connected.

Four barriers, emotional regulation, family systems crisis, practical barriers, and global pandemic are challenges which therapists can receive on-going training to help clients navigate a diagnosis with less isolation. Therapists have increased telehealth support to provide therapeutic intervention during the social distancing mandates. No other event has altered life around the world in such a dramatic way in modern history, as the Covid-19 pandemic. The unique contribution of this research advocates for therapists to pursue and practice healthy boundaries intentionally during a pandemic. For example, utilizing the remote telehealth model, challenges of vicarious grieving can be minimized, while therapists' partner with clients to compassionately collaborate on the therapeutic process, enabling clients to effectively manage their internal world, their thoughts, feelings, behavior, and their sense of social connection during a health care crisis.

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# Focus Group Protocol

## Focus Group Protocol

**Research Question 1: What is the lived experience of therapists helping clients maintain healthy relationships in the face of physical or psychological health issues?**

1. What is it like for you, helping clients maintain healthy relationships while they are undergoing a current health crisis?
2. How do therapists describe their role in assisting clients in maintaining healthy relationships while managing physiological and psychological health issues?

**Research Question 2: How do therapists describe their role in assisting clients in maintaining healthy relationships while managing physiological and psychological health issues?**

3. How do you describe your role assisting clients navigating health issues while simultaneously trying to maintain healthy relationships?
4. How do you help clients navigate their diagnosis or illness while they are estranged or isolated from family or friends?

**Research Question 3: What therapeutic techniques and strategies do therapists describe using to aid social and family connection during clients' health challenges?**

5. What therapeutic strategies and techniques do you use to aid clients struggling with social connection during a health crisis?
6. What have you found to be the MOST helpful therapeutic techniques and strategies when aiding clients that have a health diagnosis, and are struggling with isolation or estrangement?
7. Please give some examples of specific strategies or techniques

you use most often and HOW you use them with this population.

**Research Question 4: What are the barriers therapists identify in helping their clients maintain healthy social and family relationships during health challenges?**

8. What barriers have you experienced while helping your clients to navigate health issues and healthy relationships?

9. What do you feel are the BIGGEST challenges in helping your client maintain healthy relationships as they struggle with health challenges? Please share any examples you may have.

10. Share additional thoughts or information that you feel supports this discussion.