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TELETHERAPY IN TRAINING: A TRYING AND TRANSFORMATIVE EXPERIENCE

JAMIE-LYN RICHARTZ
NATASHA SMITH
KAYLEIGH SABO
MARIA ANGELICA MEJIA
Department of Family Therapy, Nova Southeastern University, Fort Lauderdale, Florida

Recent changes in federal and state laws, largely brought on because of the novel coronavirus, have underscored the need for revolutionizing the clinical training experience for Marriage and Family Therapy (MFT) programs and their implementation of telehealth services. This article addresses the current telehealth training in MFT programs, featuring the process of teletherapy training at Nova Southeastern University's (NSU) Department of Family, including adaptation to current policies and procedures. This study utilized semistructured interviews with eight graduate- and post-graduate–level MFT students at NSU who received telehealth training prior to participating in a teletherapy-based clinical practicum at NSU's Brief Therapy Institute. The emergent themes from the analysis included crisis management, flexibility, and self-care. Lastly, we discuss the implications and limitations of our study and suggest areas of future research. The information provides knowledge on necessary training topics and expands the literature on teletherapy.

Keywords: telehealth, teletherapy, family therapy, AAMFT, ethics, training, self-care

On January 31, 2020, the Secretary of the U.S. Department of Health and Human Services declared a public health emergency in the United States due to the complications and implications of the COVID-19 pandemic (Azar, 2020). This declaration has been instrumental in ushering in the current advancement of the

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Address correspondence to Dr. Anne Rambo, LMFT or Dr. Maria Mejia, LMFT, at Nova Southeastern University, 3301 College Ave., Fort Lauderdale, FL 33414. E-mail: rambo@nova.edu or mm2574@nova.edu

field of telehealth. Since the declaration, bands of restrictions and regulatory requirements that were implemented in the field of telehealth have been lifted to allow millions of Americans to safely access the health services they need during the pandemic. The removal of these restrictions, coupled with the need for a safe means of providing health services during the public health emergency, catapulted telehealth to the top of the service modalities in the health field (Burgoyne & Cohn, 2020). With telehealth receiving such prominence, and little evidence in sight that this prominence will fade away, programs within the field of marriage and family therapy (MFT) have had to alter their training to better prepare MFT students for providing therapy in the virtual world.

EFFECTIVE MARRIAGE AND FAMILY THERAPY TRAINING IN TELETHERAPY

The American Association for Marriage and Family Therapy (AAMFT) has been integral in shaping the MFT field into a respected profession, establishing both the Code of Ethics and Core Competencies for marriage and family therapists. Additionally, AAMFT, through its Commission on Accreditation for Marriage and Family Therapists Education (COAMFTE), has identified pertinent areas of study for training programs that seek to educate and equip future generations of therapists. These areas include but are not limited to family systems; family therapy theories; human development; diversity and inclusion; legal, ethical, and professional issues in the field; and research. In addition to these core areas, MFT training programs that are accredited by COAMFTE also incorporate a robust clinical practicum component, as clinical experience is required for state licensure (AAMFT, 2020).

As evidenced in the listing of the core areas of study, most MFT training programs have not historically placed a significant emphasis on therapy through telecommunication. In fact, COAMFTE accredited programs did not allow graduate or postgraduate students to offer teletherapy services until recently (Commission on Accreditation for Marriage and Family Therapy Education, 2020). This lack of telehealth training in MFT programs was brought to the spotlight in March of 2020 as the United States and the world entered a public health emergency. As lockdowns increased all over the world, MFT professionals and MFT training programs were left scrambling to find ways to provide continuity of care for their clients. The historical lack of emphasis and training in telehealth may have been due in part to the various barriers that inflicted the practice. A review of the laws that governed the practice of telehealth in the United States from 2008 to 2015 reveal that there were numerous Medicaid and Medicare restrictions placed on the types of services that could be offered, the health providers who could offer those services, and the modalities in which these services could be provided (Schmit et al., 2019). However, with many legal restrictions being implemented and many

Americans remaining isolated at home due to the pandemic, now is an ideal time for MFT training programs to establish robust training courses in telehealth practice and policy.

THE INTERSECTIONALITY OF LAWS AND ETHICS THAT GUIDE TELETHERAPY

Marriage and family therapists, in addition to having to acclimate to the changes in laws, will have to also ensure that they are abiding by the profession's code of ethics, namely the AAMFT Code of Ethics. Standard six of the AAMFT Code of Ethics outlines acceptable conduct and expectations for therapists working with clients on electronic/telecommunication platforms. The code primarily requires MFTs to (1) receive adequate training in the appropriate technology prior to implementing its use with clients, (2) follow all applicable laws when engaging in telehealth practices, and (3) continue to maintain confidentiality while engaging in telehealth practices. Additionally, it requires MFTs to inform clients of the potential risks and benefits associated with using telehealth services (AAMFT, 2020). Prudent MFTs will develop policies and procedures to govern their day-to-day practice to ensure that all applicable laws are being followed while simultaneously maintaining fidelity to the Code of Ethics.

CURRENT TELEHEALTH PERCEPTIONS

Telehealth, broadly described as any use of electronic communication methods to promote client care, is a widely used tool within the medical field (Chaet et al., 2017). Until the global pandemic, telehealth had been limited in its use due to perceptions around safety, confidentiality, quality of care, and reimbursement issues. With the rapid shift within the medical and mental health fields to providing telehealth in the face of a pandemic, both positive attributes as well as unforeseen challenges were uncovered.

Favorable Perceptions of Teletherapy

Prior to the pandemic, teletherapy was used primarily to provide care to individuals who had difficulty accessing in-person services due to barriers such as distance and chronic health conditions (Velasquez & Mehrotra, 2020). Historically, individuals who were unable to access services in person due to transportation issues were accommodated by agencies that provided in-home care. The addition of teletherapy has allowed more clients to be seen within their own homes without a therapist needing to travel there. Traveling clinicians, which is common amongst

agency settings, are now able to save time originally spent traveling by using teletherapy instead. In a 2018 study conducted by Shigekawa and colleagues, there was little clinical significance in the client outcomes between in-person versus teletherapy in areas such as assessment outcome measures, building alliance, and interventions.

The use of teletherapy can also help to improve financial situations for clients. Previously, clients may have been required to pay for public transportation, taxis, or gas to get to in-person sessions. This severely limited the ability of those who did not have the means to pay for the transportation or who did not have these options available to them in their area (Tuckson et al., 2017). Telehealth provides a more accessible option for such individuals to obtain services (Sprague, 2014). Clinicians who are certified in specific methods of therapy (such as hypnotherapy and eye movement desensitization and reprocessing [EMDR]) that may not be as common in most therapy offices/facilities are now available to be accessed by clients who may not have previously be able to access them in the past (Moring et al., 2020).

Lastly, the reimbursement of teletherapy amongst major insurance providers, including Medicare and Medicaid, has allowed for many organizations and private practices to reduce overhead costs of their practices (Medicaid, n.d.). A longer study would be needed to better understand if their patient caseloads were affected positively or negatively considering the increase in telehealth services.

Unfavorable Perceptions of Teletherapy

The sudden increase in teletherapy usage in a short adaptation period has not only brought light to many benefits, but also many challenges. Most notably reported is the difficulty using technology for both clients and clinicians (Dorsey & Topol, 2016). The use of technology can be problematic for those not adept with it, including those in the elderly population. In the situation of teletherapy, clinicians are often expected to be the "experts" in technology. However, lack of training and knowledge on technology may limit the ability of the clinician to either access the means for therapy or both access the means for therapy or instruct the client on how to use the technology during sessions. In relation, the ability to provide adaptive accommodations for clients in need, including language accommodations, may not be as easily accessible for those utilizing telehealth methods (Moring et al., 2020).

In addition to the lack of training and knowledge on technology, it is important to highlight the "digital divide" that may occur between those who have easy access to technology and those who do not. Many individuals seeking services, and those who may be greatly impacted by the COVID-19 pandemic, are at an economic disadvantage. These individuals include those who have low-wage jobs, are of a lower socioeconomic status, lack of access to affordable health care and/or

housing, and are people of color (Velasquez & Mehrotra, 2020). The increased use of technology to provide teletherapy services has left underprivileged individuals behind and without the ability to access much needed therapeutic services.

On March 6, 2020, in response to the Coronavirus public health emergency, the U.S. Congress passed a resolution that allowed the U.S. Department of Health and Human Services to make several changes to the law regarding telehealth services. The act waived certain Medicare restrictions and requirements and allowed clinicians to offer a wider array of services to their clients in good faith without fear of repercussion (*Coronavirus Preparedness and Response Supplemental Appropriations Act*, 2020). Clinicians were now able to serve clients using a wide array of approved virtual platforms that did not have to be HIPAA (Health Insurance Portability and Accountability Act) compliant (*Coronavirus Preparedness and Response Supplemental Appropriations Act*, 2020). These changes would allow for the continuation of vital health services for the many Americans who found themselves in a new normal of lockdowns and diminished in-person activity.

Additionally, telehealth poses a different set of risks to confidentiality, such as through hacking and "zoom bombing" (Hall & McGraw, 2014). Even though many teletherapy platforms have adapted and provided HIPPA-complaint software, such as HIPPA Zoom, financial costs can be associated with such software. The clinician's inability to limit access of other individuals and control their physical environmental factors, either through their own lack of computer protection software, or even family, housemates, or pets that may be in the home, the door for liability in terms of confidentiality swings open wider.

Other safety and liability concerns are commonly reported concerns among clinicians. Unclear guidelines and training have led to potential issues of liability for many clinicians (Botaitis & Southern, 2020; Stoll et al., 2020). When looking at location, ethical and state guidelines can prohibit or limit services from being given to clients who are not within the state in which the clinician is licensed (Florida Legislature, 2019). While many states have easier temporary licensure applications to adapt to the needs during the pandemic, the clinician has only the word of the client to ensure that they are located where they are reporting and that it is within a state that the therapist is legally allowed to practice. It is important to note that registered interns are only able to practice within the state that they are registered and are not eligible to obtain temporary licenses in most states (Florida Legislature, 2019). Additional barriers surround clients signing necessary documentation, such as consent for services and consents for information releases to outside parties.

The largest safety concern revolving teletherapy is in the event of crisis management. Therapists handling high risk cases indicate that barriers of not having their client in the office including lack of ability to gain physical sight of the client to evaluate for any physical marks or injuries, the potential for dropping out of a telehealth session, and the lack of ability to reach the client if emergency

care is needed (Moring et al., 2020). For example, the therapist may not be able to provide emergency services with an accurate address for the client if the client did not honestly provide their current location.

THE BRIEF THERAPY CLINIC'S DEVELOPMENT OF A TELETHERAPY MODEL

The Brief Therapy Institute (BTI) at Nova Southeastern University (NSU) provides therapeutic services to individuals, couples, and families in the local community, with particular attention paid to underserved populations. BTI additionally acts as a premier training center for NSU's Department of Family Therapy graduate and postgraduate-level students. Services rendered by students take place in teams of up to six students and a supervisor. Traditionally, students rotate between sitting behind a one-way mirror observing therapy sessions and facilitating therapy sessions with live clients in the therapy room. Cases are conceptualized between therapy sessions and each student engages in supervision with AAMFT approved supervisors. BTI's client population includes individuals of varying racial, religious, ethnic, sexual orientation, and socioeconomic backgrounds.

When COAMFTE announced on March 21, 2020 that students in accredited MFT programs would be able to provide teletherapy services, staff and faculty members at the BTI moved quickly to develop a teletherapy model that would allow clients to continue receiving therapeutic services throughout the pandemic (Angiuli, personal communication, 2020). BTI secured a HIPAA-compliant version of Zoom to provide a secure virtual environment in which future dialogical conversations would take place. In addition to selecting the virtual platform, NSU's Information Technology department assigned a team of technicians to collaborate with the team at BTI in developing an electronic system through which students and faculty members would be able to communicate and collaborate remotely. This electronic system would allow for the accessing, completing, and submitting of pertinent forms and documents. Software programs such as SharePoint and DocuSign were secured to help in the development of this system and a telehealth manual was created by the staff of BTI (Angiuli, personal communication, 2020).

Teletherapy training was promptly developed for staff, students, and faculty members at BTI. These trainings included not only the logistics of how to navigate the model, but they also included information on how to develop contingency plans for potential emergency situations that may arise during the course of teletherapy. Several training sessions were offered to students, staff, and faculty members prior to the start of the new semester. The goal was to ensure that students and faculty felt confident in delivering therapy services remotely. Further policies and procedures were developed based on the students' and clients' preferences for each practicum.

STUDENTS' PERCEPTIONS, CONCERNS, AND LIVED EXPERIENCES OF TELETHERAPY

We invited current NSU graduate and postgraduate-level students in the Family Therapy program to participate in a semistructured interview. Students who were selected to participate were currently registered in a clinical practicum that applied the use of teletherapy. Participants also needed to have previous experience in providing live in-person therapy sessions. It was also recommended that these students had participated in the teletherapy training offered by BTI. A total of eight students provided responses for the semistructured interview, and the interviews were completed electronically by Zoom or by phone due to the complications of the pandemic. A cross analysis was performed on the responses provided by the participants. We identified and catalogued themes and significant differences that emerged during the analysis of the participants' responses.

For the purpose of this article, we were self-reflective as we too were part of the teletherapy practicum experience. Kayleigh Sabo provided semistructured interviews to her master's-level practicum colleagues and Jamie-Lyn Richartz and Natasha Smith provided the same interviews to their doctoral student colleagues; all of the interviews were conducted by Zoom. All the investigators received 10 questions that would be used for the data gathering interview. The investigators also included their lived experience as part of the data set. All the students who were interviewed were enrolled in the fall 2020 semester internal practicum course. The students interviewed comprised of a diverse set of participants encompassing varying ethnic, racial, cultural, socioeconomic, and age groups. It is important to note that the students interviewed consisted of one male student and six female students. At the completion of the interviews, the investigators completed an analysis of recurrent themes that were presented across the data set.

Emergent Themes

Flexibility Afforded by Teletherapy. There was a consensus amongst all the interviewed students that teletherapy provided both the therapist and the client with greater flexibility. Teletherapy opened an avenue that allowed therapists to provide therapy and clients to receive services from the comfort of their own homes. Student 1 talked about the ease and convenience of teletherapy as a huge pro, citing that this flexibility may be a reason why most clients usually showed up and were on time unless there was a miscommunication in information (e.g., the Zoom link having the wrong time). The students agreed that the flexible nature of teletherapy provided a great benefit to all involved.

The participants also expressed some concerns in reference to the challenges of providing teletherapy services from their homes versus the university clinic. Student 4 discussed how the flexibility often impacted their ability to "get buried in work"—since there was not a disconnect between their home and the therapy

room, it became easy to not have appropriate self-care boundaries without the physical boundaries present. There was also a concern about teletherapy being the best modality to implement with certain clients. For example, student 7 warned that the flexible nature of teletherapy coupled with higher levels of comfort experienced with receiving therapy at home can prove to be detrimental for some clients; furthermore, they believe that future practice should provide an assessment of fit for all clients, noting that in-person therapy (when safely possible) may be a better fit for some clients. Likewise, student 5 discussed that while the flexibility was helpful for clients who may have a harder time accessing in-person services and reduced no-show rates for clients, the flexibility of teletherapy led to a difficulty in creating a therapeutic space where the therapist's personal life was not occasionally brought into the "room."

Crisis Management Training. Several interviewees shared that MFT students need training in crisis management if they are to competently provide teletherapy services. When providing therapy in a virtual setting (especially when clients are receiving these services in their homes), there is always a possibility of a crisis occurring. MFT students need to be equipped with the necessary training and tools that will allow them to safely and adeptly handle crisis situations that may occur. Student 3 discussed how that even though the telehealth checklist was a helpful procedure, there wasn't really much explanation or plan of what would be done if an emergency did occurred (e.g., when the therapist may need to call the client's emergency contact). Of all the proactive policies and procedures that were created specifically for teletherapy, this is the one that was touched on the least and could be talked about more according to student 4, who discussed the difficulty in properly "observing" a client's more physical characteristics, such as body language and "energy" that is typically noticeable within a shared physical space. Both students 4 and 5 felt that having clear trainings and procedures for crisis management within teletherapy would be helpful to have established prior to seeing clients, as well as trainings to deal with smaller crises, such as when technology fails during sessions.

Collaboration With BTI and Practicums. Students 1, 2, and 3 all stated in some way how they wished there was more collaboration in some way. Students 1 and 3 cited increased communication with BTI specifically, proposing that if the practicums and BTI were in more contact about the process of scheduling, cancellation, and other office functions, there would be less confusion overall about these issues. These students felt that there were several people they had to go through in order to find out certain information or get a problem solved, and that led to a delay in knowledge and solutions for both the therapists and clients. Additionally, students 1, 2, and 3 all suggested that communication with other students (both in other practicums and MFT students in general) would be a nice way to debrief about both the process of therapy (such as different practicums' policies and procedures) and the experience of the pandemic as well. Student 4 and 5 both noted that BTI

worked diligently to adapt "on the fly." Student 4 expressed, "BTI did what they could with the constraints they could do—very much in the moment. [They] had no opportunity to prepare; it was very much 'this is happening, and we need to figure it out now.'"

Proactive in Preparation. Proactive policies and procedures were a topic significantly touched on by all the student participants. All six students emphasized the importance of their practicums having established policies and procedures that were designed to prevent certain issues or interruptions from occurring. For example, student 1 said "So things that we added into our dialogue, right, so we had the usual BTI policies and procedures, confidentiality, and we added to that introduction. Like, let's talk about the technology." Other policies and procedures that were particularly helpful to students 1, 2, and 3 included the telehealth checklist, having a signal with the client if they needed the therapist to stop talking due to privacy issues, and having a designated therapist to take over if the primary therapist got disconnected from the session.

Additionally, students 5 and 7 discussed how helpful it was to participate in mock teletherapy sessions prior to taking on a real-life teletherapy case and receive tips from their supervisors. Overall, the students in our study appreciated the efforts that the Department of Family Therapy at NSU put forth in preparing students for a virtual modality of providing therapy. Many praised the department for having procured a HIPAA-compliant version of Zoom and for the implementation of a safety checklist that was to be used at the beginning of every teletherapy session. One student mentioned that "NSU did, I feel, the best they could given the situation." Both students 4 and 5 felt that BTI and the practicum were proactive in adapting new policies and procedures, including HIPPA, but may have benefited from including a consent for teletherapy for the clients. Additionally, student 4 stated how they felt it would have been helpful if BTI had adapted to the legalities a bit quicker, due to the student's need to complete their classes and requirements, which was hindered by the delay.

Care for the Therapist. Students 1 and 3 mentioned therapist burnout. Student 1 placed heavy emphasis on the value of their practicum's discussion of burnout—"This [burnout] was always a part of the conversation. So even something as simple as having water or tea . . . Taking breaks to reset." Student 3 saw the teletherapy experience as both a pro and a con in terms of conceptualizing burnout. "I didn't realize how easily you can burn out from being on the computer so much. Being present with your clients in addition to watching hours of your colleagues give therapy on a tiny screen on top of doing all your homework and other classes online is overwhelming. However, it reinforced the importance of therapist self-care that I don't think I would have recognized if we had done therapy in person."

Student 4 felt that burnout was the most important factor within teletherapy. Student 4 stated, "Having to curb our own grief in those of us that may have lost

people along the way. We can't deal with our grief in session like our clients can, we have to set it aside until we are able to take care of ourselves." Both student 4 and student 5 agreed that participating in teletherapy during a pandemic was a breeding ground for countertransference due to hearing about experiences of loss, isolation, and social withdrawal that they were similarly experiencing alongside their clients. Student 4 stated, "We as therapists have to find alternatives ways to say something other than 'Yeah, me too.'" Both students 4 and 5 agreed that therapist burnout amidst the pandemic appeared to be more present when using certain models, such as narrative therapy, as the client's story and experience is heavily emphasized.

Environmental Factors. One of the most noticeable differences for students 1, 2, and 3 when it came to giving therapy online versus in person was the actual physical environment. Particularly, the fact that the therapist was giving therapy from their home (and the client in their own home) rather than both therapist and client being in the same setting at BTI. Student 3 viewed this as more of a drawback, saying that the comfort level of being in their own home took away from that professionalism and that the physical separation from their client affected the overall connection between client and therapist—"I feel like in person . . . you can tell if your clients trust you more. I prefer to do in person . . . the whole atmosphere is different." Student 1 saw this separation a bit differently, saying, "I think to some extent, like the fact that I am in my own safe space that I can control, and the client is in their space, like oddly everybody is able to play from their home field." However, students 1, 2, and 3 stated that the concern for distractions (e.g., dogs barking, other people walking into the client's space, and technology not working) were heightened being online versus in person.

Student 7 mentioned that the virtual experience of providing therapy helped her anxiety, as she tends to absorb the energy in a shared physical space. Being at home added a level of comfort for her. These two factors combined helped her to be more present in the therapy session than she would have been if she were in person. Student 6 conversely viewed the telehealth experience as a setback, as she relies on the energy in the room to connect with her clients and help guide her therapy sessions.

Self of the Therapist. This was a theme found in interviews with students 1, 2, and 3, albeit in different ways. Student 1 saw doing teletherapy at home as a way for (1) the therapist to feel more confident and comfortable because they are in their own familiar environment and (2) the clients to be able to live in and be in the same environment that they are making change in (i.e., the "therapy" room). Student 1 commented, "If you learn something when you're in one space, both physically and mentally, you're more likely to recall it when you return to that space physically or mentally. I love the fact that our clients are healing in the space of their own homes." Student 2 saw doing teletherapy from home rather than being at the BTI office as more of a con in terms of overall confidence and professionalism as

a therapist. "I want a professional setting where I can't feel like I can just get up and go do something in my home." Student 3 expressed a mix of both student 1's and student 2's experiences, as they mentioned that while it was convenient and comfortable to be giving therapy from their own home, it did take away the feeling of being a mental health professional and increase the opportunity for being distracted.

Student 4 highlighted that learning and experiencing teletherapy in a training environment was a great experience to develop their therapeutic knowledge. Student 5 expressed how the experience of teletherapy assisted in their learning of how to deal with curveballs and the unexpected within sessions and added to the "therapist toolbox."

Client Factors. Like with other topics, while students 1, 2, and 3 had overall experiences with their observability of their clients, this theme was brought up by all students. Student 1 found no problem with being able to connect with their clients or with reading their facial or other physical expressions. Student 3 had more of a problem with the teletherapy format, implying that there was a greater disconnect with their clients than they had giving therapy in person. While student 3 was still able to see facial expressions, hand gestures, and overall posture from their clients, they did feel that there is an energy you get giving therapy in person that simply isn't there when you are looking at them over a screen.

Students 4 and 5 both agreed that the use of teletherapy can limit the observability of nonverbal cues and physical body within the session. Student 5 highlighted how this could be especially difficult when attempted to assess for self-injurious behaviors and/or situations of domestic violence in which evaluating the client's body is not necessarily an option in teletherapy. Students 4 and 5 agreed that there was often a disconnect with clients through the use of teletherapy, and the importance of having specific policy and procedure on clients utilizing their cameras for video based teletherapy sessions that is completed at intake.

Great Training for the Future. No matter what their pros and cons were, all the students expressed appreciation for the experience of giving teletherapy. These students all noted the advantage of becoming trained in teletherapy to potentially use out in the field at some point. Student 3 commented, "I feel leagues more confident in giving teletherapy than I did before actually doing it. Now I know what policies and procedures work and which don't, how to utilize technology better, and ways in which I would need to adapt my therapeutic style for future use of teletherapy." Student 7 mentioned being wary of telehealth prior to this experience and expressed her appreciation for having gone through this process—"It's not something that I would have naturally pursued; having gone through the practicum has helped me to realize that it is something that I can comfortably do."

Although all who were interviewed expressed gratitude for the training they received, students 7 and 8 expressed a need for a more thorough training in teletherapy for MFT students. Both students had received basic training in telehealth

prior to providing teletherapy services in their practicum. The training consisted of the introduction of safety checklists that would be implemented at the start of every therapy session to note the client's location, the assigning of a co-therapist who would take over the therapy session if the main therapist experienced technological difficulties, and an explanation of sharing/writing notes both during and after the therapy session. Although both students were very appreciative of the initial teletherapy training they received, moving forward, they believed that it would be beneficial to build upon the training, particularly adding crisis management and assessment of fit components.

Student 4 highlighted that having a training on teletherapy that included the basics, many alternatives and resources or engaging in teletherapy, and role playing of how to handle technology issues was crucial. Student 5 believed that creating and reviewing a specific training on how to handle situations such as involuntary hospitalizations while utilizing teletherapy would be essential for clinicians as the use of teletherapy continues to grow. Both students agreed that teletherapy and its continued application has opened the door for deeper research and policy creation.

Adaptation to Model. Student 2 expressed several issues with having to adapt their therapy model for online therapy. As a very hands-on person, it was hard for them to not be able to go to the whiteboard and write something, not be able to move their clients around the room, etc. Student 5 expressed similar concerns, such as how the utilization of models and not being able to "use the room" to assist with therapy was difficult. Student 1 attempted to use the physical separation of teletherapy to take notes during sessions to try something new, but they found that it created a disconnection from the clients and didn't continue to take notes. Other than that, both students 1 and 3 didn't see themselves needing to change their therapeutic style to work for teletherapy. Student 4 highlighted how the use of teletherapy allowed them to adapt their model a bit, including "going slower" and "being more deliberate with questioning." Student 4 also expressed how the use of teletherapy amidst a pandemic created a perceived greater countertransference when using models that related more to the client's story. For students that were more "technologically challenged" it was difficult to figure out how to demonstrate concepts virtually through whiteboard options or screen sharing.

DISCUSSION

A large piece of what we have learned is how powerful the work of therapy is despite the methodology in which it is provided. Teletherapy within a training environment, in conjunction with the COVID-19 pandemic has proven to be, as aptly described by one of our student participants, a "trying and transformative" experience. As previously highlighted, systemic reviews of the use of teletherapy have demonstrated little difference in client outcomes between in-person versus

telehealth care (Shigekawa et al., 2018). This concept was highlighted among our student participants who reported mild difficulty building rapport, utilizing their model within sessions, and completing sessions.

As evidenced in the research of Stoll et al. (2020), teletherapy opens doors in many ways and creates flexibility for both clients and therapists. While this flexibility allowed clients to be seen in a timely fashion and more clients to access services as highlighted by Sprague (2014), themes across the interviews highlighted the importance of balance within flexibility. A theme of comfort attached to flexibility demonstrated a concern about establishing boundaries related to self-care, client methodological fit, and professionalism.

Another common topic was self-care, which is vital for the health and wellness of those in the mental health field. Despite this knowledge, much research regarding teletherapy lacks an evaluation on telehealth in relation to perceived well-being of the therapist and therapist perception of satisfaction. The use of teletherapy compounded by the uncertainty and fears of the global pandemic has continued to reinforce the importance of providing and ensuring self-care among clinicians. Our study highlighted the slippery slope amongst boundaries when handling the flexibility of teletherapy. Themes across our study aligned with commonly accepted MFT beliefs of discussing and preparing for burnout and creating a self-care plan. While it was difficult to separate the difference between the increased burnout related to teletherapy or related to the COVID-19 pandemic itself, it appears that an appropriate self-care plan for teletherapy would need to be adapted in addition to a self-care plan for working with clients on an in-person basis.

The adaptation of therapeutic model to telehealth appeared to be a common point within our results, highlighting how the perceptions of therapists and their model are impacted within a teletherapy session. The use of models that often require a more active or hands-on therapist, including narrative, structural, and experiential, appeared to be most impacted due to change of environment, perception of reduced maneuverability, and a need for greater precision within the teletherapy room. While there are technological methods that can be helpful within teletherapy including the use of whiteboards and screensharing, the practice of clinicians in utilizing these skills may assist in reducing perceived differences. As previously demonstrated by Shigekawa and colleagues (2018), reviews of the use of teletherapy practices have demonstrated little difference in building the therapeutic alliance and client outcomes; with that being said, little research presented prior to this study dove deep enough into the application of specific models within the teletherapy room. Further study would need to be conducted to evaluate for any major differences or need for adaptations within model-specific interventions.

Preparation and continued training are key to success. As highlighted above, unclear and lack of explicit guidelines and training could lead to potential liability for many clinicians (Stoll et al., 2020; Botaitis & Southern, 2020). Our research has found that the application of trainings, procedures, and mock experiences within learning settings increased positive perceptions regarding the use of teletherapy

among therapists. The adaptation and experience of utilizing teletherapy while within a learning environment has been a unique opportunity that clinicians have found to be helpful for their development of therapeutic skills. Being armed with information prior to engaging in sessions with clients helped to provide positive regard to the experience of teletherapy. Having a connection and assistance from NSU also appeared to be an important component to teletherapy, allowing students to feel supported by their institution.

Crisis management within teletherapy sessions has also shown to be a unique experience. Factors including reduced observability of clients, non-specific crisis management procedures, and a lack of environmental control colored our students' experiences. The concept of specific training on crisis management as an area of need was prevalent throughout our study for the students. Our research analysis showed limited previous research on methods or policies related to crisis management within teletherapy. This theme fell in line with prior research by Stoll and colleagues (2020) and Botatits and Southern (2020), both of whom discuss the increased potential for liability.

Overall, the desire to continue expanding the research and developing policies and trainings was present among our student interviews. While much of the research presented has focused primarily on perceptions of positive and negative attributes, insurance applications, and other financial-based implications, our research emphasized the experience of the therapist. One theme, however, that was not prevalent in the interviews conducted was the potential "digital divide" between underprivileged ethnic, racial, cultural and socioeconomic populations. It is thus important to note that special care and research is needed to specifically highlight the experiences of these populations from both the lens of the clinician and client.

CONCLUSION

This study suggests several ideas for consideration for therapists and health professionals that may use teletherapy. Perhaps one of the most applicable takeaways is the evident expansion of teletherapy in the future that was largely jumpstarted by the COVID-19 pandemic. First and foremost, teletherapy may provide another world of flexibility for clients and therapists alike. Whether it be due to distance, time constraints, or home obligations, teletherapy opens the door to a plethora of possibilities with therapy that wasn't widely explored beforehand. The interviews conducted suggest ideas of what does and doesn't work regarding teletherapy, and while this study focused on the behind-the-scenes experiences of teletherapy from students' perspectives, it would be beneficial for future studies to explore the clients' side of the teletherapy experience in order to bridge the two together. This could provide a more comprehensive look at the most effective components of teletherapy, including the effects of racial, ethnic, and socioeconomic status.

Within the field of family therapy specifically, it would be interesting to see how teletherapy develops regarding the adaptation of family therapy theories for online use. Several models (such as experiential and structural family therapy) use movement of the clients and furniture in the therapy room, so the creativity of the therapists who will begin to adjust these models to online platforms might be a topic for deeper exploration within the field. This idea of adaptation of treatment could be broadened to other health care settings that use more hands-on treatment methods as well.

There are several confounding variables that should be considered when looking at the results of this study. Firstly, the sample size was small, with eight total students being interviewed. While several major themes were found in many of these interviews (e.g., the importance of proactive policies and procedures), it is important to note that this cannot be statistically applied to represent the majority of student therapists who engage in teletherapy. Additionally, not all students were in the same program or year; for example, some interviewees were master's students and others were doctoral students. This difference might affect the students' overall abilities and experience with therapy in general, which could in turn affect their experience with teletherapy. Further research should warrant both a larger sample size and exploration into whether level of degree being pursued could affect the students' experience.

Lastly, it is important to consider that this study implies that both the clients and the student therapists have access to the technology and means to engage in teletherapy. Additionally, it also assumes that students and clients have a safe, private working space to participate in teletherapy and there are no language or accessibility barriers. Having enough knowledge about how to utilize technology is another important factor to recognize as playing a part in whether teletherapy is effective. We caution applying this implication within further research, especially when looking at students or clients who may not have the economic or social means to fulfill these requirements.

Overall, this study provides an emerging look at a new era of health care. Although there are a plethora of paths within the realm of teletherapy that could be traversed, this article presents a foundation to jump off and use as a stepping stone to the development of more effective telehealth in the future.

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