

Lessons from the Transition to Relational Teletherapy During COVID-19

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When the World Health Organization declared the coronavirus outbreak a pandemic, clinicians were challenged to maintain continuity of care. Teletherapy became the primary means of service delivery for many who had never or only sparingly used it. The Family Institute at Northwestern University, in response to encouraging findings with respect to the effectiveness of teletherapy and recognizing advantages with respect to access to care, launched our teletherapy services in 2018. As a relationship-based organization, we were keen to exploit the opportunity that teletherapy provides to integrate additional members of the client system into the treatment. Over these two plus years, we have learned a great deal. Our learning was greatly accelerated by our transition to a 100% teletherapy practice in the wake of the pandemic. Teletherapy is a different context. Intentionally managing the context's constraints and exploiting its strengths is key to providing high-quality couple and family therapy. This step is often overlooked or resisted when teletherapy is an occasional add-on to a face-to-face practice.

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Stress. Lack of entropy, a condition arising when the external environment or internal sickness makes excessive or contradictory demands on an organism's ability to adjust. The organism lacks and needs flexibility, having used up its available uncommitted alternatives (Bateson, 1979, p. 249).

On March 11th, the World Health Organization declared the coronavirus outbreak a pandemic. As precautionary orders led therapists to vacate offices and most citizens to shelter in place, clinicians were challenged to maintain continuity of care. To stay connected to clients during a time of urgent need, many therapists adopted some form of teletherapy. Although the manifold impact of communication technology on human interaction has long been acknowledged (Bargh & McKenna, 2004; White, Harvey, & Abu-Rayya, 2015), few developments have so comprehensively transformed the basic interpersonal context of psychotherapy. Amid such upheaval, we are powerfully reminded of the relevance of Bateson's definition of stress, which illustrates the risk of maintaining "business as usual" (Bateson, 1979). Deprived of the full range of nonverbal information that therapists spend years learning to discern and utilize, therapists understandably struggled with videoconferencing technology. To maintain vital therapeutic relationships,

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however, it became essential. As Bateson reminds us, to expect that these relationships will continue unaffected by their new medium is folly. Even as we continue to reel from recent developments, we are prompted to reflect on the opportunities we have encountered through the swift transformation of one traditional relationship-based therapy practice to one that, as of this writing, provides only online therapy.

The practice of teletherapy (also referred to as telemental health, telepsychology, telemedicine, telehealth, or telepsychiatry) is neither new nor uncommon. Within behavioral health, an industry has grown up around its use. Companies such as BetterHelp, Talkspace, Regain, Pride Counseling, Teen Counseling, Faithful Counseling, and Online Therapy offer services that include live chat, text, phone, and video chat for varying target populations. These services are typically not covered by insurance. Blue Cross Blue Shield aggressively promotes its own platform called MDLIVE, which purports to connect patients to board-certified physicians who may address behavioral health concerns. The model of therapy these companies offer does not resemble the weekly face-to-face 50-plus-minute session the field has long held to.

Utilization of teletherapy within traditional group and individual psychotherapy practices is also growing. Accessibility advantages for consumers, including rural, disabled, and housebound clients, have been touted (US Department of Health and Human Services, 2016) and have led to increased access to care for military veterans (Mott, Hundt, Sansgiry, Mignogna, & Cully, 2014). In response to increased use, various professional associations have established guidelines, including those of the American Association for Marriage and Family Therapy (AAMFT, 2017), and the American Psychological Association (APA, 2013). Organizations have also emerged to provide training and certification, including The Board Certified-teleMental Health Provider (BC-TMH, 2020) and Zur Institute Certificate Program in teleMental Health & Digital Ethics. Despite this, teletherapy has not become a mainstay of couple and family therapists. One prominent constraint has been insurance companies' inscrutable reimbursement policies. While those had improved somewhat prior to COVID-19, the crisis spurred lawmakers to force insurers, virtually overnight, to provide reimbursement and loosen regulations related to practicing across state lines. While it remains to be seen if these changes will hold, what is clear is that teletherapy now has an even firmer foothold in the field.

THE RAPPROCHEMENT OF TELETHERAPY AND RELATIONAL THERAPISTS

An essential question for any practice is whether teletherapy is effective and acceptable to clients. Outcome studies indicate that teletherapy is a viable treatment option. It has good user satisfaction (Campos et al., 2018; Holmqvist, Vincent, & Walsh, 2014), has been used with diverse populations (Alavi, Hirii, Sutton, & Naeem, 2016; Paris et al., 2018; Slone, Reese, & McClellan, 2012) and presenting problems (Carlbring, Andersson, Cuijpers, Riper, & Hedman-Lagerlöf, 2018; Pasarelu, Andersson, Nordgren, & Dobrea, 2017; Turgoose, Ashwick, & Murphy, 2018) and has been found to have outcomes similar to traditional face-to-face psychotherapy (Hilty, Ferrer, Parish, Johnston, Callahan, & Yellowlees, 2013).

Evidence has emerged for the effectiveness of online applications of family- or couple-based interventions for various populations and presenting concerns, including multi-family psychoeducational groups (Sapru et al., 2018), family-based treatment for early-onset OCD (Comer et al., 2017), parent-teen therapy for ADHD (Sibley, Comer, & Gonzalez, 2017), child-parent relationship therapy (Hicks & Baggerly, 2017), and Behavioral Couples Therapy for problem gambling (Nilsson, Magnusson, Carlbring, Andersson, & Gumpert, 2018). Online relationship enhancement programs have also proven effective (Doss, Benson, Georgia, & Christensen, 2013; Doss, Georgia, Roddy, Nowlan, Benson, &

Christensen, 2016; Roddy, Rhoades, & Doss, 2020), although the procedures differ from traditional psychotherapy. To our knowledge, no empirical literature has emerged that directly compares the efficacy of live and telehealth applications of “classic” systemic treatments such as structural, strategic, solution-focused, or narrative therapies.

The preliminary and *ad hoc* flavor of this literature may reflect a relatively low enthusiasm of the CFT profession for teletherapy, the exigencies of federal research funding, which neglects relational issues generally (Wittenborn, Blow, Holtrop, & Parra-Cardona, 2019), or both; however, the field’s wariness about advanced communication technology has been noted for some time (Negretti & Wieling, 2001). Although the promise of teletherapy grew with the development of the internet, mental health professionals were late and cautious adopters (Jencius & Sager, 2001). Bischoff (2004) pointed out the benefits of convenience and access alongside disadvantages related to client confidentiality and the loss of immediate physical presence. In subsequent years, few couple and family therapists reported using teleconferencing often in their clinical practice, and most balked at the prospect of using teletherapy as the primary mode of contact (Hertlein, Blumer, & Smith, 2014). Nevertheless, recommendations for and reflections on relational teletherapy with specific populations emerged; these populations included: rural underserved (Bischoff, Hollist, Smith, & Flack, 2004), families of children with traumatic brain injury (Gilkey, Carey, & Wade, 2009), military couples (Farero, Springer, Hollist, & Bischoff, 2015), and parents and infants (Widdershoven, 2017).

Despite any historical aversion to the adoption of teletherapy, organizations closely linked to the practice of couple and family therapy have proposed educational core competencies and professional guidelines reflecting the growing prominence of internet technology in national and global life (Blumer, Hertlein, & VandenBosch, 2015). Professional guidelines from the American Association for Marriage and Family Therapy (AAMFT, 2017) focus on best practices and urge practitioners to track the development of a rapidly evolving set of technologies and concomitant legal, regulatory, and ethical issues.

IMPLEMENTING TELETHERAPY AT THE FAMILY INSTITUTE

The Family Institute at Northwestern University is now in its 51st year. While perhaps better known nationally for graduate education, scholarship, and client-centered research, the Institute has a large, scientifically informed, relationship-based clinical practice. Nearly 200 therapists provide over 90,000 hours of service annually through our staff practice and Bette D. Harris sliding scale clinic. Noting the promise of findings in the general psychology literature alongside the success of some specific relational applications and recognizing the advantage with respect to access to care, The Family Institute launched its teletherapy services in 2018. As a relationship-based organization, we were especially keen to exploit the opportunity that teletherapy provides to integrate additional members of the client system into the treatment. As systemic therapists, we recognized the value of expanding our ability to perceive larger patterns within the client’s relational context (Breunlin & Jacobsen, 2014; Rampage, 2014).

Standard considerations when starting a teletherapy practice include: understanding the legal and ethical landscape (including deciphering complex regulations regarding practicing across state lines that vary per state and type of license), selecting a videoconferencing platform with an eye to clients’ privacy and security (including HIPAA compliance), drafting informed consent procedures, establishing documentation and coding practices with an eye toward reimbursement, developing protocol and procedures to assure quality of care, facilitating client communication, and designing clinician training curricula. Coverage for each of these areas is provided through professional organizations and regulating bodies and varies widely according to location and license. Although a full

account of these requirements is beyond the scope of this paper; a note of caution is warranted. As was well stated in AAMFT's guide, *Best practices in the online practice of couple and family therapy* (AAMFT, 2017), clinicians who provide teletherapy are signing onto an *additional* set of standards and expectations for practice, not just a different set: "All of the legal and ethical obligations typically attached to therapy apply, as well as those additional standards that specifically relate to online service provision. For example, when a client agrees to participate in online therapy, they are not waiving any of their existing protections for confidentiality, privacy, or other consumer protection. MFTs are still responsible to the full breadth of applicable state or provincial law and the AAMFT Code of Ethics." (AAMFT, 2017, p. 8).

The Family Institute conducted a yearlong pilot program to work through the considerable number and complexity of issues facing a large practice that was adding a new service delivery option. Legal, ethical, and technical resources were sought, a manual created, and training was provided for therapists. Despite these efforts and high satisfaction ratings from our clients and our clinicians, teletherapy remained just 2% of our practice prior to the COVID-19 pandemic. In the week of March 15–21, however, we vacated our offices and our practice became 100% teletherapy.¹ While we had the meaningful advantage of having piloted and run a teletherapy practice for several years, this transition forced us to "up our game." The American Psychological Association provided high-quality resources that we adapted to our practice (2020). The checklist in Table 1 is one example. What we did not anticipate, however, was how steep our learning curve would be with respect to the clinical practice of couple and family therapy via videoconferencing.

WHAT WE LEARNED²

The novel context of teletherapy transforms the flow of information between therapist and client system. A fundamental systemic principle is that change in context imposes new constraints and lifts others (Pinsof, Breunlin, Russell, Lebow, Rampage, & Chambers, 2018). Intentionally managing the context's constraints and exploiting its opportunities is crucial. Though rudimentary to the integrative systemic approach the Institute is known for, this step was often overlooked or resisted when teletherapy was an occasional add-on to a face-to-face practice.

Preparation

Consider the "office environment" of teletherapy: effectively, the portion of the therapist's home that is visible on clients' screens. While there may be value to "humanizing" a therapist through what the environment discloses about them personally, some content may be problematic. Such details force a client to interact with the therapist's personal life in a way that may be activating and, depending on the client and the personal information communicated, may violate boundaries and basic standards for professionalism.

Pets pose an interesting dilemma in this regard. Many of our therapists have found that sharing pets (the therapist's and the clients) has been one way to exploit the advantage of the context. Pets have proven especially helpful in work with children, adolescents, and

¹It would be difficult to overstate the extraordinary team effort it took to move our entire organization off site. We are deeply grateful for the talents and the above and beyond efforts of our colleagues within our Shared Services and Client Care teams for making it possible for us to seamlessly serve our clients and mission.

²We are grateful and indebted to the many talented clinicians at The Family Institute whose professional development with respect to teletherapy has informed this paper and now the field. Special thanks go to Ariel Horowitz, Benjamin Rosen, Emily Klear, and Nikki Lively who generously shared insights and case examples that are represented here.

TABLE 1
Checklist for Providing Teletherapy^a

Screen client(s) to determine whether videoconferencing services are appropriate:

- Consider client's clinical & cognitive status—can the client effectively participate?
- Does the client have technology resources for a videoconference: e.g., webcam or smartphone?
- Does the client have physical space for a private teletherapy session?
- Is parent/guardian permission required?
- Assess risk to determine if the client is appropriate

Technology:

- Do you and the client have adequate internet connectivity for videoconferencing?
- Have you shared with the client(s) how to download and join a Zoom meeting?
- Are you using a password-protected, secure internet connection, not public or unsecured WiFi?
- Schedule all your appointments in Zoom with separate meeting ids & passwords

Office setup:

- Is the location private? Is it reasonably quiet?
- Make sure the room is well lit
- To improve eye contact, position your camera so it is easy to look at the camera and the client
- Remove personal items or distractions in the background
- Check the picture and audio quality. Can you see and hear each other?

Consent:

- TFI's service agreement has a provision for electronically mediated service, including teletherapy

When offering teletherapy *for the first time*, confirm: (a) services will be provided via a videoconferencing platform that is HIPAA compliant. (b) There are risks to privacy that do not exist in face-to-face therapy that cannot be completely removed despite following best practices

Beginning of EACH teletherapy session:

- New clients must verify their full name and date of birth
- In the case of minors, determine where the adult will be at that location
- Confirm client's location & phone number if case there is technical difficulties or an emergency
- Review importance of privacy at your location and client's location
- All individuals present for the virtual visit must be within view of the camera
- Confirm that no one will record the session without permission
- Turn off apps and notifications on your computer or smartphone. Ask client to do the same

Note. American Psychological Association Services, Inc. <https://www.apa.org/practice/programs/dmhi/research-information/telepsychology-services-checklist.pdf>.

^aAdapted from: Office and Technology Checklist for Telepsychological Services (2020).

adult animal lovers who often delight in connecting with a therapist who shares that affection. It is also the case that clients, particularly those whose need for the therapist's undivided attention, can be negatively impacted by the presence of the therapist's pet who is a rival for that attention. Assessment and collaboration with the client before introducing pets is warranted and often yields useful feedback.

It is difficult for both clients and therapists to enter a therapy mindset when using teletherapy at home. For clients, there is a sequence that typically precedes and follows face-to-face therapy that does not take place with teletherapy. The ritual of coming to and leaving the office bakes in a transition into and out of therapy. This transition period becomes part of the work, as it delineates a period of preparation and processing. By comparison, the sequence around a teletherapy session is truncated. Similarly, a therapist occupies a physical and psychological space at work that cues and supports maintaining a therapeutic focus. The demands that a therapist who is working from home faces, including rapid role shifting, managing distractions, and competing demands, are taxing. Our therapists have found that being intentional about this transition is helpful. Establishing a ritual to enter a therapeutic mindset, such as completing documentation or using a mindfulness exercise, are examples. It is also important to explicitly prompt clients to separate themselves from distractions in their home environment.

Receiving teletherapy via videoconferencing will likely activate a set of responses to screen-related cues that are not conducive to therapy. Observing those behaviors and re-orienting to the present can become a useful part of the therapy process; one that is likely applicable to many treatment plans. Inserting a step at the start of therapy to quit notifications from computers or phones before the session (such as emails, Facebook, etc.), and make the window as full screen so as not to be distracted by other windows or pop-ups, is a way to establish an electronic boundary around the session.

Reading Feedback

A complaint that therapists often report when using teletherapy is that the quantity and quality of the feedback that they get from clients is more limited. Feedback informs the therapist on every level, including the client's responsiveness to the treatment plan, the strength of the alliance, and the resonance of hypotheses being pursued (Burgoyne, 2018). While many clinicians have found the feedback that they receive in the videoconferencing format improves with time, it is helpful to involve clients in addressing this challenge.

Verbal feedback is constrained because Zoom's technology will often drown out one voice to amplify another, so it is important that only one family member is talking at a time. This, along with intermittent lag time when connectivity is poor, changes the usual flow of conversation. Feedback from clients' nonverbal behaviors and facial expressions is far more limited as it is impacted both by the technology and the equipment the client and therapist are using. Practice where to look to assure the best eye contact possible. Different teleconferencing software and hardware configurations function differently. For example, while looking at the camera may seem a logical choice for the therapist, it may give the client the impression that the therapist's gaze is directed above or below the client's face. Moreover, there are tradeoffs in individual sessions to having the client sit further from the camera. The advantage is that their nonverbal cues are more observable. If access to facial expression is favored, ask them to sit closer and invite the client to report on their physical response. This can be done easily by adding onto "how do you feel" a simple addition, "and what is your body saying, can you tune into that and describe it to me?"

The therapist reactions may also be less scrutable to the clients. Being more obvious or expressive to punctuate feedback in a way that fits the intention can be helpful. More important is the therapist checking in with clients about how they are experiencing the context. This creates an opportunity to process the loss the client may be experiencing due to not having access to the therapist in the familiar way.

In couple and family sessions choices regarding how best to use the space and position the camera will be guided by the treatment goals and practicalities. Observations regarding family therapy are shared within the Family section below. In couple therapy, if a couple is sharing the screen facing the camera, the tendency to focus on the device and therapist rather than the partner is even greater than in person. Much as a therapist would do in the treatment room, the therapist will need to prompt them to face, speak to, and notice one another. Unexpected advantages to having couples use separate devices have been frequently observed, particularly with highly reactive couples. Many partners have been better able to articulate their experience, stay regulated, and observe their partner's expression and affect with less reactivity when on a separate device. One client observed, "seeing her face fall apart when I told her what I was thinking was shocking, I didn't realize it hurt like that."

Self-of-the-therapist feedback is also relevant. Above and beyond the significant cognitive load generated by current extreme macro conditions, therapists also contend with "Zoom fatigue," as it has been dubbed (Fosslien & Duffy, 2020). The lack of visual breaks and need to maintain a constant gaze and hyper focus to compensate for the flattening quality of the medium is demanding. Our therapists generally have found that they need to manage their

expectations, slow down, and be highly intentional about attending to the alliance. The more solution-focused and directive among our therapists have reported learning that teletherapy has called them to consider their pacing to avoid therapy turning into “school.”

Privacy

Even when the family members know and support the therapy, concern about being overheard persists. Testing for privacy before the session and troubleshooting solutions (e.g., ask family members not engaged in the treatment to put on headphones, test white noise machines) is useful. Despite therapists' efforts to ensure privacy, some parents struggle to honor those requests when child is having an individual session. At the start of one session with a 15-year-old, the client reminded his father that he was having teletherapy, and not to come to the basement where his computer was. The father agreed. Twenty minutes later the father opened the door and came downstairs to exercise in a separate room in the basement, running past the client and apologizing. The therapist wisely used the event in a later family session to discuss the importance of agreements for building trust.

We have had many clients resort to receiving therapy in their car or on a walk to ensure they were not overheard. Zoom's whiteboard and chat functions can also be used to communicate more privately. An in-session option for creating privacy is to make use of Zoom's breakout rooms. This has been effectively used with high conflict couples and families. Family members can be asked to “go to” a breakout room, just as one might ask a client to take a break in the waiting room, to reduce tension and improve communication.

If privacy issues persist, this clearly compromises the treatment. At this juncture a therapist might opt to exploit the situation. If the treatment plan supports it, there is an opportunity to engage those members of the system who, for whatever reason, appear to be quite curious. Family therapists are often looking for the chance to expand the system; current circumstances pose a unique opportunity to do so. This strategy was used to invite into treatment a previously reluctant partner who would “accidentally” enter the room during many individual sessions being held with his partner. This created a less threatening transition into conjoint therapy.

Tending the Therapeutic Alliance

A strong therapeutic alliance has been repeatedly associated with positive outcomes in psychotherapy (Sprenkle, Davis, & Lebow, 2009). Bordin (1994) has suggested that the therapeutic alliance is a combination of tasks, bonds, and goals. The impact of teletherapy on these components of the alliance is unclear. Our experience with respect to bonds, in the context of the pandemic, is that our existing clients were grateful to have no lapse in their treatment and many reported they felt cared for. Although clients would remark that the teletherapy “feels” different, they remained engaged. In fact, our data indicate that our existing clients have increased the number of sessions they are having and are involving additional family members in the treatment. While this may be attributable to the crisis at hand, it also implies the therapeutic bond was not threatened.

This is not, however, to assume all aspects of the alliance over time can be cultivated just as one would in face-to-face therapy. For example, therapists who initially approached teletherapy as a stopgap suddenly found themselves deprived of the comfortable rhythms of in-person treatment and distracted by the novelty of videoconferencing technology, resulting in unfocused therapy. We have found that greater directness in defining and pursuing goals and more flexibility with respect to the tasks, makes for more successful teletherapy. As will be illustrated in the examples that follow, adjustments to the technology were commonly made in the service of the alliance.

Working with Children and Families

Our greatest concern in establishing a fully online practice was the potential impact on child and family cases. Our initial hypothesis, that teletherapy would be a poor fit for kids, proved partially correct; considerable adaptation was required. It is a testament to the creativity and commitment of our providers that we have seen no reduction in the size of our child/family caseload since the transition to teletherapy.³

Role of caregivers

At the Family Institute, the already integral role of caregivers in our work with children is expanded in teletherapy. Before work begins, it is helpful to meet with the caregiver(s) to test the equipment, establish expectations, and enlist their participation. We ask caregivers to suspend any expectations for their child's behavior that may have been formed by having the child in school conducted via teleconferencing. We encourage children to actively participate in conversation and to play with whomever is in the session and the therapist. Children can move around the room or change locations if confidentiality is not compromised. Caregivers may be asked to help set up a therapy space with art supplies, fidget toys, things to share with the therapist, and whatever else is important for session. Working with caregivers to ensure that the child is not overscheduled with teleconferencing prior to therapy may increase the child's ability to stay engaged.

Attention and focus

A significant challenge is maintaining a child's focus in teletherapy. This is especially true for children who struggle with executive functioning and those who are generally harder to engage. Compassionately normalizing the challenges, having a playful conversation about "distraction," and developing strategies with the child and family, such as making a game of seeing how long they can go without being distracted, are helpful. Therapists often find that new strategies must be devised for each client, and sometimes at each session, to help the client stay engaged. In the virtual environment, having a flexible plan and a variety of toys, props, and materials has proven essential. With one 11-year-old client with ADHD, changing the structure of the session itself proved helpful. The therapist distributed several five-minute breaks throughout the session, each with different activities to choose from. Each postbreak transition became an opportunity to help the client practice re-focusing. Other effective modifications have included shorter sessions, breaking sessions into therapeutic games, and parent coaching. In other cases, the treatment plan itself may be modified to suit the context. One 16-year-old client presented with moderate depressive symptoms, including anhedonia, lethargy, and depressed mood. He related wanting to stay in bed all day and do nothing. Although the therapist's cognitive-behavioral training led him to select behavioral activation, it soon became clear the client in the current context was not receptive. Instead, the therapist pivoted to reflective listening, mindfulness, and grounding techniques, with good results. It seemed to the therapist that the virtual context had attenuated their connection, requiring a stronger therapeutic bond for more directive work to be effective.

Our child therapists have relied increasingly on mindfulness exercises, which teletherapy is well-suited to. Particularly enjoyable is practicing mindfulness with a virtual robot. BrainPop and BrainPop Jr. videos, conveniently found on YouTube (<https://youtu.be/0ZpZOD6h6kU>), are good examples. Mindfulness skills have shown to help manage inattention (Chimiklis, Dahl, Spears, Goss, Fogarty, & Chacko, 2018), are helpful for

³We would like to recognize Natasha Varela, Director of the Child, Adolescent, Family team for her leadership during this transition.

numerous presenting concerns (Baer, 2007), and can buffer clients from the stress of life in a pandemic (Polizzi, Lynn, & Perry, 2020).

Younger children and play-based therapy

Younger children often benefit from having a 30-minute session and using the second half for working with caregiver(s). It is important to position the camera so the whole room can be seen. This allows the child to move around and engage different toys that the caregiver has (ideally) provided in advance. Therapists can follow the child's play, reflecting what is being enacted aloud, name emotions and actions. Therapists have found it helpful and fun to have their own stuffed animals, dolls, or puppets to show and use to play with the child through the camera. Screen sharing story books has proven workable as well.

Our therapists have been surprised at how effective and often intimate play therapy has been via teleconferencing with young children. Children have enjoyed taking their therapist on a tour of their space and introducing favorite toys, which they often spontaneously play with. Both structured and unstructured play therapy activities with stuffed animals, playdough, arts/craft supplies, and other toys have been effective. The therapist can mirror the child's play, punctuating themes relevant to the treatment plan. For example, a therapist playing with a 5-year-old observed the child pick up a very large fish that then "ate" a cat and spit it out. To mimic this, the therapist used a small keychain with a cat on it, moved her toy across the camera, and placed it off camera to show it had been "eaten." This reflection delighted the child, whose play then expanded on the theme.

School-age children

Our team has found school-age children are well served by engaging (alone or with their family) in virtual play. "Zoom-friendly" strategies that provide psychoeducation and skill building have become integral to teletherapy work. This usually involves digital games where the therapist shares their screen to play an online version of Jeopardy or draws on the Zoom whiteboard. There is a necessary initial investment of time to evaluate these tools, as there is a wide range in quality (AAMFT, 2019). The Jeopardy Labs website (<https://jeopardylabs.com/>), for example, has Jeopardy boards for teaching emotion labeling skills, thinking through what emotions others would feel in certain contexts, identifying coping skills for emotions/situations. Another example is a digital version (using Zoom's whiteboard) of a game called "grow a flower," often known by the name "hangman" in nontherapeutic contexts. Depending on age, developmental stage, and preferences of the client system, this game can facilitate thinking about a topic, such as emotion labels or coping skills, by selecting a word to guess that is aligned with the goals of the treatment plan.

Adolescents

Adolescents have had the most varied response to teletherapy. The transition from an online space typically reserved for socializing to a therapeutic context has been utterly seamless for some youth and "awkward" and anxiety provoking for others. Identifying what physical space the client will use for therapy has proven important regardless of the client's initial comfort level. A location that does not carry associations that are incompatible with therapy is helpful. This is not always practical given space constraints; problem solving is often necessary. It is different, for example, to have therapy in a bedroom while sitting on a bed than in a corner of the room with a setup of pillows. Defining a physical space, no matter how small, is helpful to establish a boundary.

Concerns about confidentiality are equally varied. Some adolescents are preoccupied with worries about privacy, while others appear oblivious. Discussing a teen's worries during a family session and creating a plan that parents support is an essential part of

socializing the teen to treatment. Parents have offered to take a walk during this time, watch TV in another room, or wear headphones if the space does not allow for adequate separation. Teens can download a white noise generator on their phone and place it outside the room. This has the added advantage of removing the phone from the session! Several clients use a parent's parked car. This provides both a separate space and the ritual of leaving the house for therapy.

Many clients, especially those in early to mid-adolescence, report that teletherapy "feels weird." As it is not uncommon for teens to be self-conscious in contexts where they feel exposed, sensitivity to how this plays out in teletherapy is useful. Certainly, a therapist showing up in a space that is social is unsettling. So are the "close ups" videoconferencing often includes. In addition to sitting further back from the camera, therapists can use the Zoom screen sharing feature to reduce anxiety often activated by the "up-closeness" of the therapist's face and the self-consciousness activated by the client looking at their own image. Those who remain anxious have benefited from an explicit desensitization process. A therapist can invite the client into a period of experimentation. A phone call to initiate the process, followed by teletherapy sessions of gradually increasing durations, along with anxiety reducing skill practice, will also support the client's growth.

Cognitive-behavioral therapists and other therapists who use written homework have found that Zoom's whiteboard/share screen function is useful for completing worksheets. Anything done in-session with a shared screen can be saved and sent electronically. These pages can be used to create a therapy binder of activities and skills learned. Clients can keep a "therapy journal" that they can write in during and outside of session for thought records and other activities.

There are many examples of teens responding well to teletherapy when sessions are shorter and more frequent. A teen who had a history of resisting interventions started experiencing less predictable mood changes in quarantine. The therapist opted for multiple weekly check-ins for 30 minutes rather than one full session. This format helped the client maintain focus in the here-and-now. The multiple short sessions per week also allowed the therapist to better track the client's mood and preemptively create coping plans. The therapist recognized that in this case, the added convenience of teletherapy facilitated a strategy that was superior to what would have been feasible face-to-face.

Working with Families

Teletherapy offers two unique advantages in family work. Most notably, having fewer constraints on time and distance enables more members of the system to participate. Moreover, it allows the therapist to see the family in their living space. Some families enjoy sharing their space, others do not. The resulting exchange impacts the alliance and requires sensitivity. There are instances, such as when a family member is ill or when conflict is great, where having family members who live together call in from individual devices is a good strategy. When possible, however, it seems effective to have family members sitting naturally together rather than in separate rooms or lined up in front of the camera. The camera should be positioned to allow all family members to be visible. This allows the therapist to observe some nonverbal interactions. The therapist can explicitly narrate what they see and ask for clarification. In one family session with a teen, the family was positioned in the living room on different couches facing each other. Unlike face-to-face therapy, where a therapist must work hard to not be the focal point, the therapist in this case was simply not part of the scene. Outside the physical space, the therapist became less central and better able to observe nonverbal cues between family members, discuss what was not being expressed verbally, and more easily function as a director when appropriate.

When the family is in the same room, it is more challenging to manage the flow of communication over teletherapy. Collaborating with the clients to establish explicit rules of the road with respect to listening, speaking and turn taking is essential. Enactments are easily executed, however, all interventions with families via teletherapy appear to require more explanation than would ordinarily be necessary in face-to-face treatment. This appears related to the limits in the medium's ability to capture subtleties in clients' experience. One pensive and stoic grandfather reported to the therapist in an email post a challenging family session, that he "missed in-person sessions" because, he explained, the therapist "got me and helped them (his family) get me." Over videoconferencing he experienced the therapist as less perceptive and helpful, which impacted the alliance. While there can be advantages to having to be more explicit in teletherapy in order to accurately read feedback and guide the session, there is also loss with respect to artfulness.

At times, the context of teletherapy can limit effectiveness in facilitating whole family therapy. Particularly when starting with a new family over teletherapy, consider meeting with appropriate sub-systems ahead of time to build an alliance and ensure that there is a shared understanding of both the process and the goals. A therapist shared that he made the mistake of having a full family session without first meeting one of the family members, an adult child returning home from college. The therapist reported that while he felt that navigating this in person would have been quite manageable, over teletherapy, rapport was harder to establish with the young adult. The session turned into a screaming match with the adult child employing the mute function to exclude the therapist from hearing. Thus, while in the office allowing the family to engage in their conflict sequence for a period can be helpful, over Zoom more structure and facilitation is needed.

Working with Couples

As in family therapy, teletherapy appears to constrain the ability to quickly establish an alliance with a new couple. A highly intentional initial assessment helps build alliance and mitigates this problem. Utilizing Chamber's (2012) semi-structured four-session assessment that includes individual meetings with each partner has proven invaluable in teletherapy to promote the alliance and establish treatment goals. The importance of conducting such a careful assessment is underscored by reports that the incidence of intimate partner violence appears to have increased in the context of the pandemic (Bosman, 2020; Campbell, 2020). Individual sessions at the outset, and as needed throughout the treatment, increase the likelihood of crucial disclosures. Difficulty obtaining privacy for individual sessions may be symptomatic of an unsafe environment for the client. In cases where the privacy and structure of a physical office provides refuge from possible violence, couples teletherapy may be contraindicated.

The example of intimate partner violence highlights the relevance of the wider social context to the use of teletherapy with couples. While the pandemic has affected virtually all areas of relationship functioning, prolonged periods of couples living in close quarters has prompted clinicians to consider how to respond. One senior therapist echoed a sentiment heard often in our practice: "my clients are desperate for the chance to talk about what they are experiencing with their partners in quarantine, but they do not want to, at first pass, say what they feel in a couple session." They are afraid it will explode and then they will be "unable to escape the chaos and pain of living in the rubble." While in more normal times a couple therapist might urge partners to share what is on their mind in joint sessions, many therapists are recognizing that individual time with each partner has unexpected value in this context. Dysregulated partners can first "vent" to a therapist, who can help them to both process their affect and guide them to speak more effectively and directly to one another. Although they risk violating the dyadic frame of couple

therapy, individual teletherapy sessions with partners in service of shared treatment goals appear to offer a needed “pressure valve” in the current context. Therapists must then, of course, deal with all the well-known issues surrounding secrets shared with the therapist during couple therapy (Margolin, 1982; Sher, Niznikiewicz, & Mu, 2017).

Teletherapy appears to help high conflict couples to reduce intensity. Videoconferencing inserts a useful sense of formality and a need for turn-taking. The necessity of speaking one at a time to be heard is a restriction imposed by the technology, not the therapist. When needed, encouraging the couple to look at the screen may reduce tension even more effectively than directing the partners to speak to the therapist in the treatment room.

The technology can also be exploited to serve conflict-avoidant couples. One long married couple engaged in a discernment process would, in the treatment room, successfully block the therapist from venturing into material with heightened intensity by simply shutting down. Because one partner travelled for work, the therapist convened the couple by teletherapy on separate devices. The physical distance increased their ability to tolerate intensity and engage in discussing important, long avoided material. The therapist was also able to exploit the screen-share function to share a drawing of the hypothesized problem sequence. Looking at the drawing provided sufficient distance for the couple to answer questions about what they were thinking and feeling at each step in the sequence, which greatly advanced the work of finding alternative behaviors. It is worth noting, however, that teletherapy can inadvertently create an illusion of progress that evaporates when the partners are not buffered by physical distance. Teletherapy is no different than face-to-face therapy in this regard; different strategies need to be employed at different points in the treatment process depending on the constraints the couple is facing and the model that the therapist employs.

While it is yet unclear to us if different models of treatment are better suited to teletherapy than others, clinicians in our practice are exploring how to adapt teletherapy to support their preferred model. For example, couple therapists who highlight working with emotion such as emotion-focused couples therapy (Goldman & Wise, 2018) have adapted teletherapy to support the goal of fostering emotional safety and affect regulation. Given that the therapist has limited ability to use their body language, it is necessary to rely on their voice to slow down or redirect interactions and be explicit about their intention to do so. Prompting the clients to observe and report on what is happening is helpful not only because teletherapy obscures the therapist from making certain observations, but to draw the clients' attention to what is happening within and between them. “What do you think that your partner's body language saying right now?”, “can you give voice to what your eyes are saying right now?” are examples. When couples are in the same space, the therapist can use physical proximity to increase the emotional intensity of enactments. Once again, inviting narration of the experience is useful; “can you feel your partner with you now?” “can you turn away from the screen and look into your partner's eyes and repeat what you just said.” When a couple is sitting side by side spontaneous touch often occurs. Punctuating this can amplify strengths or lead a partner to notice an experience they may fail to appreciate.

TELETHERAPY AND THE CALL TO ADAPT

Teletherapy, with all its tradeoffs, is here to stay. There are clear advantages with respect to access to and continuity of care, and to expanding the system engaged in treatment. The technology, however, poses challenges to relational therapists, and the field is evolving so quickly that adding it to one's practice can feel like jumping onto a moving train. Practitioners are advised to look to their professional associations, including state-based organizations to determine what legal, license specific, and payor-based rules apply. It is unclear which rules regarding practicing across state lines and reimbursement that

have been loosened in the wake of COVID-19, will revert, or evolve. This necessitates ongoing tracking. For example, just as work on this paper was in progress, The American Psychological Association announced that “PSYPACT,” the interjurisdictional compact between certain states allowing psychologists who apply and qualify to practice across participating state lines, has gone live (<https://psypact.org/>).

The learning curve at The Family Institute was steep and greatly accelerated by the Coronavirus crisis. Our experience to date suggests that teletherapy is viable and, while not necessarily preferred over in-person therapy, is associated with good client and therapist satisfaction. A survey of our clients and clinicians taken one week after our practice converted to 100% teletherapy, showed, on a 5-point Likert scale, that 86% of client respondents “agreed” or “strongly agreed” that teletherapy provides good quality of care; no one “strongly disagreed.” The following comments capture client sentiments: “I have a trusting relationship with my therapist and am comfortable with video communication, so teletherapy felt to me like a very natural extension of my existing therapeutic relationship,” “I like the teletherapy—it’s super convenient and easy. It is (also) easier to allow myself to get distracted and it’s tempting to do something else in parallel, particularly in group—(those) are the cons. On the plus, I feel just as connected to the therapist, and I feel secure in the session, and not having to commute is a big plus.” The survey of staff found that 80% of our therapists “agreed” or “strongly agreed” that teletherapy provides good quality of care, with the following capturing some of their experience: “I don’t see the televs. in-person as ‘better’ or ‘worse’, or ‘more’ or ‘less effective’ I think . . . each setting offers something unique and what’s more important clinically to me is how clients respond to the change in setting, and how we as clinicians handle it and address it with our clients.”

What has proven most important to using teletherapy with relational cases is to embrace the challenge and adapt. Attempting to work the same way as one would have in person does not generate a sufficiently open mindset to allow for learning. The work is more satisfying and generative when the therapist becomes curious about the medium’s potential.

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