ORIGINAL ARTICLE

The transition to teletherapy in marriage and family therapy training settings during COVID-19: What do the data tell us?

Amy A. Morgan PhD[1] | Ashley L. Landers PhD[2] |
Jessica E. Simpson MS[3] | Jody M. Russon PhD[2] |
Jenene Case Pease PhD[2] | Megan L. Dolbin-MacNab PhD[2] |
Krista N. Bland MS[2] | Jeffrey B. Jackson PhD[2]

[1]Department of Family Science, School of Public Health, University of Maryland, College Park, MD, USA

[2]Department of Human Development and Family Science, College of Liberal Arts and Human Sciences, Virginia Tech, Blacksburg & Falls Church, VA, USA

[3]Department of Family Social Science, College of Education and Human Development, University of Minnesota, St Paul, MN, USA

Correspondence
Amy A. Morgan, Family Science Department, School of Public Health, University of Maryland, 4200 Valley Drive, Suite 1142, College Park, MD 20742, USA.
Email: aamorgan@umd.edu.

Abstract

In the wake of the COVID-19 pandemic, little is known about how university training programs transitioned to teletherapy. This study describes the transition of two university marriage and family therapy (i.e., master's and doctoral) training clinics to teletherapy and presents preliminary analyses of the types of clients and cases that converted to teletherapy. A series of chi-square analyses, a t-test, a logistic regression model, and a multiple linear regression model were employed. Four key findings emerged: (1) most cases converted to teletherapy; (2) Hispanic ethnicity was the only demographic characteristic to significantly predict conversion to teletherapy; (3) individual cases were significantly more likely to convert to teletherapy than relational cases; and (4) the number of prior in-person sessions attended significantly predicted conversion to teletherapy. Teletherapy conversion implications are discussed across four systemic levels: client, student trainee, supervision, and larger systems.

KEYWORDS

COVID-19, marriage and family therapy, MFT programs, relational therapy, students, supervision, teletherapy, therapy, trainees, training settings

At the time of this study all authors were affiliated with Virginia Tech.

- -

In March of 2020, the World Health Organization (WHO) officially characterized the novel Coronavirus disease (COVID-19) as a global pandemic (World Health Organization, 2020a). By February of 2021, the United States accounted for approximately 25% of confirmed cases and 20% of deaths worldwide (World Health Organization, 2020b). Efforts to contain the virus included testing and, most notably, stay-at-home orders (Centers for Disease Control, 2020). Over the span of 2 weeks in March of 2020, traditional, in-person methods of working, learning, and socializing changed dramatically. Businesses transitioned employees to work from home, schools converted curriculum to online learning, and a wide range of healthcare services moved online. In particular, mental health providers rapidly transitioned from in-person mental health care to teletherapy.

Teletherapy refers to the use of technologies, particularly video conferencing, to remotely provide mental health care, including evaluations and medication management services and psychotherapy treatment (Whaibeh et al., 2020). Teletherapy has demonstrated success across various clinical settings, presentations, and populations (Shore, 2013; Whaibeh et al., 2020). However, before the COVID-19 pandemic, Marriage and Family Therapists (MFTs) reported a hesitancy to embrace teletherapy due to concerns around confidentiality, training, risky clinical situations, licensing and liability, and impact on the therapeutic relationship (Hertlein et al., 2015). Yet, circumstances of the COVID-19 pandemic dictated that MFTs swiftly transition to teletherapy in order to provide continuity of care. While much is still unknown about the trajectory of COVID-19, teletherapy will likely remain the primary vehicle of treatment delivery for some time. Best practices for client care and supervision are in dire need now that the initial transition to teletherapy has passed, and we settle into long-term teletherapy practices. Additionally, MFT training programs need guidance on converting to teletherapy in a way that sufficiently addresses the needs of clients, student trainees (hereafter referred to as trainees), supervisors, and university and larger systems alike.

Although conceptual papers have begun to emerge on these topics (see Burgoyne & Cohn, 2020; Sahebi, 2020), the empirical literature has yet to describe the impact of transitioning to teletherapy across the many systems involved in treatment delivery and has not yet used data to describe the types of clients and cases that converted to teletherapy in the midst of COVID-19. This study fills a gap in the literature by analyzing data from two university MFT training clinics to examine the types of clients and cases that converted to teletherapy during COVID-19, as well as describe the impact of this transition on the many systems of mental health treatment delivery, from clients to trainees to supervisors to larger systems (e.g., university departments, licensing boards, program accreditation bodies, etc.)

LITERATURE REVIEW

In the past decade alone, the use and availability of telehealth (i.e., technology-based delivery of general healthcare) resources have increased exponentially (Armstrong et al., 2018). A study of a nationally representative consumer survey found that for mental and physical health services, live video communication rates rose from 6.6% to 21.6% between 2013 and 2016 (Park et al., 2018). Additionally, almost two-thirds of participants reported willingness to use video calling to discuss health concerns, especially those living in rural areas and those enrolled in Medicare (Park et al., 2018). Teletherapy smartphone applications have become a popular way to address mental health concerns and management, including stress regulation, skills training, symptom management, and behavioral activation (Bush et al., 2019; Proudfoot et al., 2010). More than half of smartphone users in the United States reported downloading a mobile application for health-related purposes (Krebs &

Duncan, 2015). Increased availability and lower cost of teletherapy platforms have likely made the delivery of mental health interventions increasingly viable. In 2013, approximately 350,000 Americans used teletherapy services. By 2018, the number of Americans using teletherapy services increased to about 7,000,000 (Waldman et al., 2020), suggesting that teletherapy was a growing trend even before COVID-19. Scholars estimate that the number of teletherapy interactions may exceed 1 billion by the end of 2020 (Coombs, 2020).

Teletherapy effectiveness

Teletherapy is associated with numerous benefits including time and cost efficiency, accessibility, particularly for rural and vulnerable populations, flexibility, increased ease in case management, and sustainability (Cunningham et al., 2013; Hull & Mahan, 2017; Shore et al., 2018; Wade et al., 2019). Teletherapy may also address barriers to therapy such as stigma, distance, scheduling, and childcare (Glynn et al., 2020; Wells et al., 2019). Synchronous teletherapy is an effective approach to providing services for a number of mental health challenges such as anxiety disorders, substance abuse disorders, post-traumatic stress disorder, and psychiatric hospitalizations, (Godleski et al., 2012; King et al., 2014; Rees & Maclaine, 2015; Spence et al., 2011) and can be as effective or more effective than in-person services in client engagement, satisfaction, and outcomes (Bashshur et al., 2016; Hilty et al., 2013; Neufeld et al., 2007; Ruskin et al., 2004).

Teletherapy has been effective in addressing anxiety, autism spectrum disorders, chronic pain, depression, eating disorders, post-traumatic stress disorder, substance use disorders, and pediatric traumatic brain injury (Boisvert et al., 2010; Bouchard et al., 2004; Godleski et al., 2012; Herbert et al., 2017; Hilty et al., 2013; King et al., 2014; Mitchell et al., 2008; Rees & Maclaine, 2015; Sánchez-Ortiz et al., 2011; Wade et al., 2019). Factors contributing to clients' willingness to engage in teletherapy include familiarity with teletherapy applications, perceiving teletherapy as beneficial, and lack of barriers (e.g., transportation, provider availability) to receiving teletherapy services (Gagnon et al., 2004). Females are more likely to use teletherapy and be satisfied with services (Gagnon et al., 2004; Polinski et al., 2016). Studies involving teletherapy services with veterans suggest that age, sex, race, and disability are not predictive of treatment outcomes (Gros et al., 2011) and that teletherapy may be a suitable approach across the lifespan (Price & Gros, 2014).

Teletherapy in MFT

As a field, MFT has fallen behind other mental health disciplines (Caldwell et al., 2017) in providing adequate teletherapy training (Pickens et al., 2020). This may be, in part, due to MFTs discomfort in providing teletherapy because of training gaps, concerns related to ensuring confidentiality, managing risk and crises from a distance, maintaining the therapeutic relationship, and adhering to licensure regulations (Hertlein et al., 2015). The majority of licensed MFTs report high levels of discomfort in providing therapy exclusively online but report feeling more comfortable in providing treatment online if it is a supplement to in-person therapy or if the client would not otherwise have access to services (Hertlein et al., 2015). MFTs face unique challenges in doing relational work via teletherapy (Lebow, 2020). Some challenges are logistical, such as fitting all family members on screen and finding adequate space for all family members involved (Wrape & McGinn, 2019). Special considerations must be taken with relational teletherapy, including determining which subsystems in the home should participate in therapy, managing partner or family member escalation, and additional

creativity and coordination with caregivers when working with young children (Burgoyne & Cohn, 2020). Other concerns, more therapeutic in nature, are the therapist's ability to use their physical presence as an intervention, especially in cases of conflict, and the ability to pick up on non-verbal interactions between family members, as well as ensuring confidentiality when screening for intimate partner violence (Wrape & McGinn, 2019).

In addition to challenges associated with online relational work, there is also a lack of available teletherapy training. Although the American Association for Marriage and Family Therapy added technology-assisted professional services to its code of ethics in 2015 (American Association for Marriage & Family Therapy, 2015), the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) does not prioritize core competencies in teletherapy and may impede trainees' ability to count teletherapy hours due to requirements that trainees be in the same location as their clients (Commission on Accreditation for Marriage & Family Therapy Education, 2017; Pickens et al., 2020). In one study, only half of faculty members in COAMFTE accredited MFT programs reported including any type of teletherapy curriculum in their courses (mostly concerning laws and ethics), though most reported believing teletherapy training should have a place in the curriculum (Pickens et al., 2020). Even in training clinics that provide teletherapy training, the percentage of clients engaged in teletherapy services was extremely low prior to the COVID-19 pandemic (Burgoyne & Cohn, 2020).

Teletherapy in MFT training clinics

As the COVID-19 pandemic worsened, MFT training programs were tasked with the ethical dilemma of ensuring continuity of client care while addressing mounting concerns related to the spread of the virus. Some programs rapidly transitioned from in-person to online services. This may have required administrators to effectuate unanticipated systemic modifications related to client intake processes, documentation, billing, and supervision (Scharff et al., 2020). Teletherapy, particularly in training settings, has implications that span multiple systems. Currently, most of the literature on teletherapy addresses systems involving clients and licensed clinicians (e.g., Godleski et al., 2012; Herbert et al., 2017; Hertlein et al., 2015; Hilty et al., 2013). In training settings, however, clinical training, supervision, and other larger systems (e.g., university and departmental policies) must also be considered. At present, research addressing the latter three systems is scarce, with the most attention dedicated to online supervision (e.g., Jordan & Shearer, 2019; Twist et al., 2016). For many supervisors, the transition to online supervision was unanticipated and required rapid adaptation to structural changes while still attending to trainees' needs (Sahebi, 2020). Supervisors are responsible for ensuring that clients receive competent and culturally informed services that address various intersectionalities, with the addition of attending to the impact of COVID-19. At the same time, supervisors must also attend to trainees' intersectionalities and encourage their exploration of how the pandemic may be affecting not only their therapeutic work, but their own anxieties (Sahebi, 2020).

Although studies have been conducted on MFTs providing teletherapy services in healthcare settings (Springer et al., 2020), the literature fails to adequately address MFTs providing services to clients in the context of their own homes, which many are now doing in light of the COVID-19 pandemic. Consequences of such an unprecedented transition, especially for trainees, may include softening of boundaries between clients and clinicians, limited private space, decreased sense of control of the therapeutic space, altered therapeutic relationships, stressors related to technological difficulties and limitations, and difficulty interpreting limited nonverbal cues (Burgoyne & Cohn, 2020; Scharff et al., 2020).

Our transition to teletherapy

Together, the authors of this study represent master's and doctoral student trainees, clinic directors, program directors faculty, and supervisors from two COAMFTE accredited MFT training programs (i.e., master's and doctoral) at Virginia Tech. The master's program clinic, the Center for Family Services, is in the urban area of Northern Virginia. The doctoral program clinic, the Family Therapy Center, is in Southwest Virginia, a rural area in the Appalachian region. Although these clinics operate separately, there was collaboration and overlap in the steps taken to transition from in-person therapy to teletherapy. Once the severity of COVID-19 became apparent, we conversed regarding ways to promote the safety of clients, trainees, and MFT supervisors from the spread of COVID-19 while concurrently prioritizing continuity of care. Based on university, state, and federal guidelines we developed health and safety plans and acquired an online telehealth platform (i.e., Zoom) compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Drafting our teletherapy policies and procedures was truly a collaborative effort among faculty, and further facilitated by the generosity of COAMFTE Program and Clinical Directors, who were willing to share their materials with other training programs and clinics. We provided trainees with in-depth training related to teletherapy service delivery and specific protocols for implementing telephone sessions, video sessions, and clinical documentation. Clinic administrators, in consultation with the university legal counsel and other relevant units, created teletherapy consent documents and procedures. Supervision was initially conducted via case report or live supervision via Zoom, however, trainees were eventually able to record teletherapy sessions, which facilitated the process of asynchronous video supervision.

Present study

The context of MFT training clinics is unique, as multiple systems must be considered—from client to trainee to supervisor to the university administration to larger systems (e.g., licensing boards and program accreditation bodies). Currently, the literature provides little guidance in adequately training MFT students, conducting supervision, and interacting with larger systems in the transition to teletherapy. Using data from our two MFT training clinics, the purpose of this study was to provide a preliminary data analysis of client characteristics, group differences, and predictors of those who converted to teletherapy. We conclude with a discussion of important considerations for transitioning to teletherapy across four levels of an MFT training system: client care, student training, clinical supervision, and larger systems.

METHOD

This study represents an analysis of existing data collected from two university MFT training clinics (i.e., master's and doctoral). Our two training clinics are not co-located and represent distinct (i.e., urban and rural) demographic areas of the state.

Sample

Clients were invited to opt-in clinic data collection during intake procedures. Demographic data were collected pre-COVID at baseline (i.e., intake) between 2012 and 2020. Teletherapy conversion and the

number of teletherapy sessions were measured between the date of teletherapy conversion (March 23, 2020) and the start of data analysis (June 10, 2020). Only clients active prior to COVID were included. Participants were not compensated. Original clinical data collection (IRB 09-727; IRB 18-306) and analyses for this study (IRB 20-501) were approved by the Virginia Tech Institutional Review Board. This study utilized a sample of 171 clients ($n = 38$ children and adolescents (0–17 years); $n = 129$ adults (18+); $n = 4$ did not provide age) comprising 101 distinct cases of individuals, couple, and family households who opted into the clinic data collection. The client sample characteristics are presented in Table 1 for the total sample, Falls Church and Blacksburg locations, and clients that did and did not convert to teletherapy. Table 2 presents the sample characteristics by case constellation offering a comparison between individual and relational cases. Table 3 presents teletherapy conversion characteristics at both the client and case level.

Measures

Converted to teletherapy

Conversion to teletherapy was a dichotomized variable reflecting active clients (i.e., not in the process of terminating) who attended at least one teletherapy session (1) and clients who opted out of teletherapy (0) after both MFT training clinics converted to teletherapy on March 22, 2020.

Engagement in teletherapy

The number of teletherapy sessions was used as a proxy for engagement in teletherapy. This variable represents sessions attended after the conversion to teletherapy on March 22, 2020 through June 10, 2020, ranging from 0 to 19 sessions.

Case constellation

Case constellation was measured as individual (1), couple (2), and family (3). A dichotomized variable was created that reflected whether the case was individual (0) or relational (1), which included both couple and family case constellations.

Engagement prior to teletherapy

The number of therapy sessions attended prior to the conversion to teletherapy in March 2020 was measured as a continuous variable, ranging from 1 to 235 sessions ($M = 28.2$, $Mdn = 15.0$, $SD = 35.1$).

Age

Clients were asked to provide their age in years.

TABLE 1 Client sample characteristics (n = 171)

	Total sample			Falls Church (n = 111)			Blacksburg (n = 60)			Telehealth (n = 142)			Did not convert (n = 29)		
	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD
Age (3–78)		31.69	16.57		32.87	18.00		29.48	13.33		32.56	16.58		27.59	16.19
Gender															
Male	79	46.20		47	42.30		32	53.30		62	43.70		17	58.60	
Female	91	53.20		63	56.80		28	46.70		79	55.60		12	41.10	
Race															
White	92	53.80		48	43.20		44	73.30		72	50.70		20	69.00	
Black	11	6.40		9	8.10		2	3.30		9	6.30		2	6.90	
Asian	15	8.80		11	9.90		4	6.70		13	9.20		2	6.90	
Latino	10	5.80		10	9.00					10	7.00				
Other	34	19.90		31	27.90		3	5.00		31	21.80		3	10.30	
Ethnicity															
Hispanic	37	21.60		34	30.60		3	5.00		36	25.40		1	3.40	
Not Hispanic	126	73.70		76	68.50		50	83.30		100	70.40		26	89.70	
Relationship status															
Single	64	37.40		56	50.50		8	13.30		55	38.70		9	31.00	
Partnered	25	14.60		12	10.80		13	21.60		21	14.80		4	13.80	
Married	53	31.00		30	27.20		23	38.30		40	28.20		13	44.80	
Separated	5	2.90					5	8.30		5	3.50				
Divorced	12	7.60		13	11.70					13	9.20				
Religion															
Christian	46	26.90		29	26.10		17	28.30		42	29.60		4	13.70	
Jewish	5	2.90		4	3.60		1	1.70		1	0.70		4	13.80	

(Continues)

TABLE 1 (Continued)

	Total sample			Falls Church (n = 111)			Blacksburg (n = 60)			Telehealth (n = 142)			Did not convert (n = 29)		
	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD	n	Percent or mean	SE or SD
Muslim	6	3.50		4	3.60		2	3.30		4	2.80		2	6.90	
Mormon	5	2.90		3	2.70		2	3.30		5	3.50				
Buddhist	7	4.10		5	4.50		2	3.30		7	4.90				
Hindu	1	0.60		1	0.90					1	0.70				
No religious affiliation	50	29.20		32	28.80		18	30.00		37	26.10		13	44.80	
Income															
Below $20,000	31	18.10		18	16.20		13	21.70		29	20.40		2	6.90	
$20,000–$39,999	37	21.60		31	27.90		6	10.00		32	22.50		5	17.20	
$40,000–$59,999	23	13.50		13	11.70		10	16.70		17	12.00		6	20.70	
$60,000–$79,999	10	5.80		6	5.40		4	6.70		9	6.30		1	3.40	
$80,000–$99,999	11	6.40		8	7.20		3	5.00		10	7.00		1	3.40	
$100,000 and over	42	24.60		33	29.70		9	15.00		31	21.80		11	37.90	
Education															
Less than high school	33	19.30		32	28.80		3	5.00		25	17.50		8	27.50	
High school	11	6.40		9	8.10		2	3.30		11	7.70				
Some college	28	16.40		16	14.40		12	20.00		24	16.90		4	13.80	
Bachelor's degree	49	28.70		30	27.00		19	31.70		43	30.30		6	20.70	
Master's/prof. degree	22	12.90		14	12.60		8	13.30		17	12.00		5	17.20	
Doctorate	12	7.00		5	4.50		7	11.70		8	5.60		4	13.80	

TABLE 2 Client sample characteristics by case constellation ($n = 171$)

	Individual case ($n = 58$)			Relational case ($n = 113$)		
	n	**Percent or mean**	***SE* or *SD***	***n***	**Percent or mean**	***SE* or *SD***
No. of sessions pre-tele (1–235)		39.16	49.91		22.55	22.50
No. of sessions post-tele (0–19)		7.86	3.64		5.41	3.76
Age (3–78)		35.11	16.20		29.27	16.56
Gender						
Male	28	48.30		51	45.10	
Female	30	51.70		61	54.00	
Race						
White	33	56.90		59	52.20	
Black	3	5.20		8	7.10	
Asian	8	13.80		7	6.20	
Latino	3	5.20		7	6.20	
Other	10	17.20		24	21.20	
Ethnicity						
Hispanic	10	17.20		27	23.90	
Not Hispanic	47	81.00		79	69.90	
Relationship status						
Single	29	50.00		35	31.00	
Partnered	10	17.20		15	13.30	
Married	12	20.70		41	36.30	
Separated	3	5.20		2	1.80	
Divorced	3	5.20		10	8.80	
Religion						
Christian	19	32.80		27	23.90	
Jewish	1	1.70		4	3.50	
Muslim	1	1.70		5	4.40	
Mormon	2	3.40		3	2.70	
Buddhist	4	6.90		3	2.70	
Hindu	0	0.00		1	0.90	
No religious affiliation	18	31.00		32	28.30	
Other	12	20.70		27	23.90	
Income						
Below $20,000	21	36.20		10	8.80	
$20,000–$39,999	12	20.70		25	22.10	
$40,000–$59,999	6	10.30		17	15.00	
$60,000–$79,999	5	8.60		5	4.40	
$80,000–$99,999	1	1.70		10	8.80	

(Continues)

TABLE 2 (Continued)

	Individual case (n = 58)			Relational case (n = 113)		
	n	**Percent or mean**	**SE or SD**	**n**	**Percent or mean**	**SE or SD**
$100,000 and over	9	15.50		33	29.20	
Education						
Less than high school	4	6.90		29	25.70	
High school	6	10.30		5	4.40	
Some college	14	24.10		14	12.40	
Bachelor's degree	22	37.90		27	23.90	
Master's/prof. degree	4	6.90		18	15.90	
Doctorate	3	5.20		9	8.00	

TABLE 3 Conversion characteristics

	Clients (n = 171)		Cases (n = 101)	
	n	**%**	**n**	**%**
Converted to telehealth	142	83.00	86	85.10
Campus				
Blacksburg	45	75.00	27	73.00
Individual	17	37.80	17	63.00
Couple	12	26.70	6	22.20
Family	16	35.60	4	14.80
Falls Church	97	87.40	59	92.20
Individual	37	33.30	36	61.00
Couple	16	14.40	8	13.60
Family	58	52.30	15	25.40

Gender

Clients were asked to provide their gender. The response options were male (0), female (1), and trans-identified (2).

Race

Clients were asked to provide their race. The response options included White (1); Black or African American (2), American Indian, First Nation, or Alaska Native (3); Asian (4); Native Hawaiian or Pacific Islander (5); Middle Eastern or North African (6); Other (7); Mexican/Mexican American (8); Dominican Republic (9). A dichotomized variable was created that reflected whether the client identified as a person of color (0 = no, 1 = yes).

Ethnicity

Clients were asked if they identified as Hispanic (no = 0, yes = 1).

Education

Clients were asked to provide their highest level of attained education. The response options were: elementary school (0); some middle school (1); some high school (2); high school graduate (3); some college (4); trade school (5); associate's degree (6); bachelor's degree (7); master's/professional degree (8); doctorate/medical degree (9); other (10). A dichotomized variable was created that reflected whether the client had low educational attainment of a high school education or lower (0 = no, 1 = yes).

Household income

Clients provided their gross household annual income. Response options were: below $20,000 (1); $20,000–$39,000 (2); $40,000–$59,000 (3); $60,000–$79,999 (4); $80,000–$99,000 (5); $100,000 or over (6). A dichotomized variable was created to reflect if the household was at the poverty level (Department of Health & Human Services, 2020) of $20,000 or less (0 = no, 1 = yes).

Missing data

All variables had less than 11% missing data, with an average of 3% missing data across all variables. There was no systematic pattern of missingness. Missing data were addressed using listwise deletion. This approach is reasonable with sufficient sample sizes with adequate power where data are missing completely at random (Kang, 2013). Using a t-test and series of chi-squares, no significant differences were found between clients with and without missing data regarding age, gender, being a person of color, ethnicity, income, or education.

Analytic procedures

Analyses were performed in SPSS Statistics Version 26. First analyses were conducted on all clients included in the total sample ($N = 171$). Differences in age between clients that converted to teletherapy and clients that did not convert were explored using a t-test. Differences in gender, being a person of color, Hispanic ethnicity, low education, and income between clients who converted and clients who did not convert were explored using a series of chi-square tests. Second, analyses were conducted by cases ($N = 101$ distinct households). Differences in household income were explored between cases that converted to teletherapy and cases that did not convert using a chi-square test. Differences in case constellation (i.e., individual vs. relational cases) were explored between cases that converted and cases that did not convert using a chi-square test. Third, a logistic regression model was used to examine contributing factors to conversion to teletherapy including the number of in-person therapy sessions attended prior to teletherapy, case constellation, and Hispanic ethnicity. The contributing factors included in the model were selected based on earlier analyses, which suggested

they may be associated with conversion to teletherapy. Fourth, a multiple linear regression model was used to examine contributing factors to engagement in teletherapy also including the number of in-person therapy sessions attended prior to teletherapy, case constellation, and Hispanic ethnicity. With a sample size of 171 clients and 101 household cases, the sample was sufficient in size to detect a medium size effect at the $p < .05$ value (Cohen, 1992).

RESULTS

Conversion to teletherapy

Most clients ($n = 142$, 83.0%) converted to teletherapy including 87.4% of clients ($n = 97$) in Falls Church and 75.0% ($n = 45$) in Blacksburg (Table 3). The t-test revealed that age did not significantly differ for clients that converted to teletherapy ($M = 32.56$, $SD = 16.58$) than clients that did not convert ($M = 27.59$, $SD = 16.19$) ($t(165) = -1.474$, $p = .740$). Chi-square tests revealed the relationship between conversion to teletherapy and the following demographic characteristics were not statistically significant: gender ($\chi^2[5]$ (1, $n = 170$) = 2.08, $p = .150$), being a person of color ($\chi^2(1, n = 171) = 3.23$, $p = .072$), poverty ($\chi^2(1, n = 171) = 2.97$, $p = .085$), low educational attainment ($\chi^2(1, n = 171) = 0.06$, $p = .802$), and household poverty status ($\chi^2(1, n = 101) = 1.23$, $p = .267$). However, the chi-square test results indicated that the relationship between Hispanic ethnicity and conversion to teletherapy was statistically significant ($\chi^2(1, n = 163) = 6.66$, $p = .010$), with clients of Hispanic ethnicity being more likely to convert to teletherapy than clients of non-Hispanic ethnicity. The chi-square test results also revealed that the relationship between case constellation and conversion to teletherapy was statistically significant ($\chi^2(1, n = 101) = 4.18$, $p = .042$), with individual cases more likely to convert to teletherapy than relational cases. The logistic regression model was statistically significant, $\chi^2 = 18.03$, $df = 3$, $n = 163$, $p < .001$ (Table 4). The number of sessions attended prior to the conversion to teletherapy was not statistically significant. Case constellation significantly predicted conversion to teletherapy ($b = -1.376$, $p < .05$); clients in individual therapy were more likely to convert to teletherapy. Hispanic ethnicity also significantly predicted conversion to teletherapy ($b = 2.425$, $p < .05$); Hispanic clients were more likely to convert to teletherapy.

Engagement in teletherapy

The clients that converted to teletherapy ($n = 142$) attended a mean average of 7.32 sessions ($SD = 3.14$, range 1–19) post conversion to teletherapy. A multiple linear regression was calculated to predict greater levels of engagement in teletherapy based on the number of sessions attended prior

TABLE 4 Logistic regression of factors associated with conversion to teletherapy ($n = 163$)

Contributing factor	B	SE B	Odds ratio
Number of sessions prior to teletherapy	0.010	0.010	1.010
Relational case constellation	−1.376*	0.580	0.253
Ethnicity	2.425*	1.044	11.297
Constant	−0.328	1.218	0.720

*$p < .05$.

TABLE 5 Multiple linear regression analysis of factors associated with teletherapy engagement ($n = 142$)

	B	$SE\ B$	β
Number of sessions prior to teletherapy	0.019	0.008	.179[*]
Relational case constellation	−2.343	0.620	−.289[***]
Ethnicity	1.149	0.688	.125
R^2	0.144		
F	8.662[***]		

*$p < .05$.

***$p < .001$.

to teletherapy, case constellation, and Hispanic ethnicity (Table 5). A significant regression equation was found ($F(3,157) = 8.662, p < .001$), with an R^2 of .128. Both greater number of sessions attended prior to teletherapy ($\beta = .019, p < .05$) and individual case constellation ($\beta = -2.343, p < .001$) were significant predictors of higher levels of engagement in teletherapy.

DISCUSSION

As technology continues to play a more significant role in healthcare, research is needed to improve experiences and outcomes of teletherapy. The purpose of this study was to provide a preliminary analysis of clients and cases who converted to teletherapy. In the discussion that follows, we interpret our findings and situate them within our own transition to teletherapy in two MFT training settings (i.e., master's and doctoral) at Virginia Tech. The transition to teletherapy in our training clinics had implications across four systems (i.e., clients, trainees, supervision, and larger systems). As such, we begin with the most proximal (i.e., clients), in which we discuss empirical findings, followed by a conceptual discussion of other systems. This study is among the first to provide an important illustration of the transition to teletherapy in MFT training settings.

Clients

Four key findings emerged from the results of this study. First, most clients (i.e., 83%) converted to teletherapy. This number is much higher than rates documented in the literature of people willing to engage in teletherapy (i.e., two-thirds; Park et al., 2018). A higher conversion rate may be explained by the fact that teletherapy was the only choice for therapy in the context of the pandemic. In non-pandemic circumstances, clients usually have the choice between in-person therapy and teletherapy. These findings raise the possibility that clients may be more open to teletherapy when in-person therapy is no longer an option, which was also anecdotally congruent with feedback from our trainees.

Second, our findings revealed that ethnicity significantly predicted conversion to teletherapy in that Hispanic ethnicity clients were more likely to convert than non-Hispanic ethnicity clients. This finding is likely explained by the fact that the master's training clinic, which had the vast majority (i.e., 92%) of the Hispanic clients, has Spanish-speaking therapists; a scarce resource in the community and, therefore, one that clients would likely be reluctant to relinquish. The remaining demographic characteristics such as age, gender, being a person of color, education, and household income did not meaningfully predict conversion to teletherapy. Although findings are mixed on which demographics

predict conversion to teletherapy (Gros et al., 2011), research suggests that some demographic charac-
teristics (e.g., gender) may predict teletherapy engagement (Gagnon et al., 2004; Polinski et al., 2016).
Our findings indicated that all demographic characteristics, except ethnicity, did not predict conver-
sion to teletherapy. In this way, demographic characteristics may predict teletherapy engagement in
"normal" circumstances but may have less predictive power when in-person therapy is no longer an
option.

Third, individual cases were significantly more likely to convert to teletherapy than relational
cases. We theorize that while existing relational stress was, and continues to be, intensified by circum-
stances of the COVID-19 pandemic, the field of MFT has room to grow in terms of understanding
how to engage families in family therapy via teletherapy. Couples and families may be experiencing
distress related to the virus itself, loss of loved ones impacted by the virus, unemployment and/or eco-
nomic stress, caregiving responsibilities, children's remote learning, and exacerbated distressing rela-
tional dynamics (Lebow, 2020), indicating an increased need for relational therapy. Individual cases
converting to teletherapy at a higher rate may be among the most important findings of this study,
as it underscores the importance of advancing the quality of relational teletherapy. Furthermore, this
finding offers an intriguing area for further research: how does buy-in to (tele) therapy change based
on individual or relational constellations? It may be that individual therapy is easier to prioritize, as it
is one's own mental health, whereas family therapy may be more about the collective.

Finally, a greater number of sessions attended in-person prior to teletherapy were associated with
higher levels of engagement in teletherapy. In addition, individual case constellation was associated
with higher levels of engagement in teletherapy. These clients may have had greater rapport with their
therapist, and possibly higher commitment to continuing in therapy. The number of sessions predict-
ing teletherapy conversion and engagement is consistent with clinical literature suggesting that the
therapeutic alliance, developed by working together over time, is a salient characteristic of treatment
engagement and sustaining clinical change (Wampold, 2015). And, for individual cases, it may be that
continuing in individual therapy reflects prioritizing individual mental health and possibly the ease of
attending by oneself.

Student trainees

From a student perspective (third and seventh authors), the transition to teletherapy was simultane-
ously rapid and slow. Policies changed and adapted constantly. At the same time, the actual seeing of
clients was at a standstill as clinic administrators, students, and clients attempted to determine how
best to move forward in a way that would meet everyone's needs. Clinic-wide meetings were held to
address concerns and to train students (e.g., maintaining client privacy and managing risk), on the
HIPAA-compliant Zoom platform, and accessing the university virtual private network to complete
documentation.

At the master's level, one of the biggest student concerns, especially for those who intended to
graduate in May 2020, was acquiring enough hours to graduate and if hours obtained via teletherapy
would satisfy COAMFTE requirements. Teaming hours (i.e., clinical hours obtained by observing
other trainees' cases) were also halted, further reducing opportunities for trainees to obtain clinical
hours. Supervision also changed drastically. While the supervisor could join a live Zoom call, super-
visors were no longer available onsite for in vivo consultation. If there were risk concerns or crises,
supervisors were not immediately available and had to be contacted via phone. This left students with
feelings of uncertainty, as they did not have the same safety net they had in the clinic. At the doctoral
level, one unique aspect of the transition to teletherapy was that students were allowed to conduct

phone sessions before they were permitted to conduct video sessions in order to prioritize continuity of care while technological procedures were determined. In some ways, the phone sessions made the transition more difficult for the trainees because of the need to adapt their therapeutic style twice (i.e., phone and video).

Supervision was helpful during the transition to teletherapy because of the necessity to communicate the constant changes that were occurring on the administrative level. Additionally, trainees experienced the clients as helpful with the transition by being understanding and open to trying teletherapy. Overall, clients were flexible in adjusting to multiple policy changes, and were creative in managing complications related to privacy and technological issues. One challenging aspect was not feeling in control of the therapeutic space. Students were unable to use their physical presence to interrupt conflict, help de-escalate clients, or utilize an experiential intervention. At times, it was difficult to have all family members on the screen at the same time. Therapists had to choose between asking family members to use different screens or asking the family to focus the camera on the person speaking. Missing nonverbal interaction patterns was a common concern when therapists were unable to see the entire family on the screen. For family cases with children, we found it difficult to engage younger children throughout the session. Group supervision was particularly helpful as students could share their successful experiences and creative solutions and offer empathic support for the difficulties they were facing.

Supervision

Supervision changed substantially in light of the shift to teletherapy during COVID-19. There were two main supervisory considerations to address. First, we developed training tools (including a guide available in Appendix S1) offering students structuring techniques and language to carry out their first teletherapy sessions (practical training). Second, we worked with students to creatively manage challenges related to starting or continuing therapy using a teletherapy platform. We also addressed trainees' ambivalence about using these platforms and helped them brainstorm how to hone their approaches in this new format. Although some students and clients naturally shifted into the teletherapy experience, others struggled to adjust or felt the loss of an in-person connection. This process mirrored the supervisory experience. As supervisors, we had to adjust to using Zoom to deliver feedback. We saw this as an opportunity for noticing isomorphic processes between ourselves and our supervisees.

Practical training

We created a written guide to support trainees in transitioning their clients to teletherapy in a way that instilled hope, built up trainee confidence in the new system, and promoted structure. We oriented our guide around the following items: welcoming the client, consenting for teletherapy, setting a precedent for assessing safety and confidentiality, addressing privacy issues, considering clients' past experiences with web-conferencing systems, and discussing potential communication disruptions. We then had a teletherapy transition workshop where we reviewed the guide. Supervisors intentionally role-played a client who was worried about confidentiality. The faculty member demonstrated how to use therapeutic techniques to address the clients' concerns and build a working teletherapy relationship. Students reported that the role-play was particularly helpful for adopting the recommendations into their practice.

Client and student trainee challenges

During and after the initial transition period, which primarily focused on administrative and tech-nological issues, clients and trainees began to recognize ways in which teletherapy was lacking or challenging. We found that there were two primary reasons trainees brought teletherapy concerns to supervision. First, some struggled to work with clients who rejected teletherapy. Typically, these clients were concerned about privacy and confidentiality. Second, trainees observed their clients' challenges associated with getting the whole family to engage in therapy over remote platforms. In ad-dressing these two issues, supervisors aimed to generate possibilities with their trainees. Specifically, what is the "middle ground" between rejecting teletherapy altogether and doing sessions remotely (e.g., code words for stopping the session, phone sessions)? When concerns were not mitigated, su-pervisors encouraged trainees to help clients weigh the potential risks of privacy with the benefits of therapy.

Use of isomorphism

The challenges experienced as a result of COVID-19, and the sudden shift to telehealth, were over-whelming. As a program, we aimed to remain motivated by focusing on our communities of interest in this critical time of need. After the shift to telehealth, we were faced with finding new ways to sup-port and respond to each other remotely. Trainees often brought up worries about the effectiveness of their work. Trainees reflected on the difficulties associated with their personal styles on a webcam. Some were also concerned about not picking up on the emotional nuances expressed in session. As supervisors, we validated these concerns, recognizing that the shift to teletherapy was new and sud-den. We also noted that we, as supervisors, were experiencing some of the same concerns about our telesupervision. In our experiences conducting supervision, we saw moments of mis-attunement and disconnection arise, requiring us to readjust our ways of responding in this new medium. With this awareness, we helped our supervisees recognize how adapting to a new medium provides us with new opportunities. Specifically, we asked supervisees to "get curious" during the times when they felt disconnected or mis-attuned. For example, one supervisee noticed that her client kept looking off to the side whenever the supervisee asked her questions about her feelings. The supervisee discussed this observation and was concerned about the client "opening up" over Zoom. We encouraged the su-pervisee to ask about this clients' tendency. We learned that the client was looking toward a picture of her mother who had passed away the previous year. The trainee was then able to explore the times in session when the client "looked to her mother," which further yielded fruitful clinical conversations. As supervisors, we recognized that the more we adapted our styles to meet the current situation, the more we demonstrated engagement, support, and attunement in our tele-supervisions. This way of modeling adaptive engagement helped our supervisees believe in their own capacity to do the same with their clients.

Larger systems considerations

The transition to teletherapy yielded several larger systems considerations that influenced our decision-making: MFT program faculty and staff, university administration (department, college, and university levels), the state licensing board, and COAMFTE. In some cases, these considerations facilitated the transition to teletherapy, and in others they created barriers or slowed the transition

process. Occasionally, the larger systems requirements did not align with each other or with the smaller systems (clients, students, supervisors), which created additional complexity and required advocacy on behalf of the MFT programs, our trainees, and clients. Throughout this process, we learned several lessons that will inform our work in the future.

First, in terms of our university, we collaborated and consulted with multiple units including our home department, data privacy and security, university legal counsel, emergency management, environmental health and safety, and information technology. This was to ensure that we were following university guidelines related to preserving the health and safety of faculty, staff, students, and clients. It also helped us determine how to best proceed with offering teletherapy services (e.g., getting HIPAA compliant Zoom for teletherapy sessions and supervision, determining options related to conducting live or video-supervision, handling client billing, etc.) and ensured that our teletherapy policies and procedures aligned with legal, ethical, and data privacy and security requirements. We found that "joining forces" with other clinical training programs and the campus counseling center allowed us to speak with one voice about our common needs (e.g., video and/or live supervision, etc.) and professional standards. Having this type of "critical mass" expedited many processes and even helped the university create some standard technology policies across units. When challenges arose, it was typically when our university partners did not understand elements of clinical work or clinical training, such as the need for supervision. Generally, these issues were resolved with education and a collaborative spirit of mutual and creative problem solving.

Another important larger system to consider was the licensure board within our jurisdiction. Specifically, we needed to determine whether our students could practice teletherapy and receive technology-assisted supervision, and whether teletherapy services could be offered across state lines. We also needed to consider the long-term impact of what we were offering in terms of our students' ability to be eligible for licensure as MFTs. We regularly consulted with the licensure board for updates and used this information to develop our policies and procedures, in consultation with other university units (e.g., university legal counsel, data privacy, and protection). A closely related system that required attention was COAMFTE. Per COAMFTE guidance, the master's and doctoral program each submitted a contingency/emergency plan for how they would continue to meet the accreditation standards and students' training needs. These plans were in addition to plans required by our home department and other university units. Overall, these plans required aligning sometimes contradictory information from the COAMFTE, the licensure board, and our home department/university. Ultimately, our goal was to ensure our students' ability to graduate on time and eventually obtain licensure. In the end, flexibility offered by the COAMFTE regarding clinical hours was helpful and aligned well with the flexibility offered by our licensure board.

Implications for teletherapy in MFT training settings

As we reflect on our transition to teletherapy over the past months, we have identified many lessons learned. In this article, we presented findings from our transition to teletherapy that suggest a few important implications for MFT training settings transitioning to teletherapy. First, we were not surprised that offering practical training guides supported trainees' confidence. Trainees recognized how their proactive and structured stance during the transitional session could serve to support their re-joining with clients remotely. Second, we encouraged trainees to embrace ongoing adaptations and look for possibilities, instead of restrictions, in their use of teletherapy. When clients struggled with transitioning to teletherapy, we developed creative strategies for supervisees to discuss with their clients. Third, we reframed clinical challenges or setbacks in the context of our current circumstances

and encouraged everyone to "give themselves grace." Finally, we challenged ourselves to recognize how faculty and supervisors' teletherapy transition might be creating isomorphic patterns in our trainees' work with clients. This required us to be transparent about our own struggles (e.g., zoom burnout, mis-attunements, joining difficulties) with our trainees and model how we are adapting to meet these challenges.

In addition to the above clinical and training-related implications we also recommend considering the transition to teletherapy in a systemic manner. Every decision made in the transition to teletherapy required considerations across multiple systems. In navigating these multiple systems, all at the same time, we primarily learned the importance of advocating for the short- and long-term needs of our trainees and clients, especially in cases where understanding of standards for clinical care and clinical training was more limited. We also were reminded of the importance of forging strong relationships with larger systems including key university partners and COAMFTE, as this helped mitigate many of the barriers we encountered in the process of transitioning to teletherapy. Finally, keeping the welfare of our students and clients at the front of all decision making provided a sense of clarity about our goals and desired outcomes.

Based on our empirical findings, another significant implication is the importance of MFTs as relational teletherapy providers, especially those who are Spanish speaking. Pre-pandemic literature would predict lower rates (i.e., two-thirds; Park et al., 2018) of teletherapy engagement while this study found most clients (83.0%) and cases (85.0%) converted. Most notably, individual cases and Hispanic clients were more likely to convert to teletherapy. These findings underscore the importance of our field attending to the provision of quality relational teletherapy, especially for Hispanic clients, as well as the need for rigorous teletherapy training and best practice guidelines. In this way, MFTs may be uniquely situated to address a critical need for relational teletherapy both during and beyond the COVID-19 pandemic.

Limitations and future research

Our findings are among the first to describe the conversion to teletherapy in MFT training settings. As such, these findings are an important first step in shaping our understanding of teletherapy and provide a glimpse into the types of clients and cases that converted to teletherapy in MFT training settings. However, our findings are limited to preliminary, cross-sectional data. With most cases converting to teletherapy, the number of cases in the non-conversion group may have been underpowered. An additional limitation at the case-level is that we were not able to capture if all family members converted to teletherapy; rather, we only know if the overall case converted. There was also considerable variance in the pre-teletherapy clinical engagement variable (1–235 sessions; $M = 28.2$, $Mdn = 15.0$, $SD = 35.1$). Although the median number of sessions prior to teletherapy was fifteen, there were some outliers due to a few longtime clients. The large variance within this variable may have impacted measurement and analysis. However, we also contend this is a strength of the study as the distribution of this variable in our analysis likely reflects the reality of many training clinics that have several longtime clients.

Furthermore, our data only measured conversion to teletherapy (yes or no) and basic tenets of clinical engagement (i.e., number of sessions). Additional research (e.g., longitudinal research, randomized controlled trials) is needed to examine client engagement, retention and dropout, therapeutic outcomes, and if teletherapy produces similar outcomes to in-person therapy. Do certain relational treatment models translate better than others over teletherapy? How do we effectively address and treat violence or escalation when we are not physically in the same room? Future research should

address these questions and examine how to effectively deliver relational therapy in virtual contexts. Additionally, we are constrained in our ability to compare these findings to pre-COVID-19 teletherapy research. We hypothesize that our findings are inextricably connected to characteristics of the pandemic. Future research should continue to examine teletherapy, broadly, as well as the specific circumstances that predict teletherapy engagement. Finally, our findings indicated that individual cases were more likely to convert to teletherapy, and it is unclear how to best serve couples and families in teletherapy. In "normal" circumstances, relational therapists usually have little-to-no difficulty fitting couples and families in a therapy room. In remote contexts, it is challenging to determine how many people can fit on one screen and navigate the technical challenges that accompany these decisions (Lebow, 2020).

CONCLUSION

There is still much to learn about teletherapy ranging from client engagement, retention, and dropout, to best practices for clinically effective teletherapy, especially in relational contexts. This study is among the first to examine differences among clients and cases who converted to teletherapy across two MFT training clinics. We are encouraged that, despite the deeply troubling circumstances of the COVID-19 pandemic, most clients and cases converted to teletherapy regardless of demographic characteristics. Perhaps most notably, individual cases converted at a significantly higher rate, indicating a dire need for MFTs to advance our understanding of how to best provide relational teletherapy services. Future research is needed to identify best practice and training guidelines as MFTs provide essential services, and particularly relational teletherapy, both during the COVID-19 pandemic and beyond as we move toward the "new normal."

ORCID

Amy A. Morgan https://orcid.org/0000-0002-1983-1088
Jody M. Russon https://orcid.org/0000-0002-2982-3436
Megan L. Dolbin-MacNab https://orcid.org/0000-0003-0877-023X
Jeffrey B. Jackson https://orcid.org/0000-0002-9756-7841

REFERENCES

American Association for Marriage and Family Therapy. (2015). *Revised American Association for marriage and family therapy code of ethics*. Retrieved from https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

Armstrong, C. M., Ciulla, R. P., Edwards-Stewart, A., Hoyt, T., & Bush, N. (2018). Best practices of mobile health in clinical care: The development and evaluation of a competency-based provider training program. *Professional Psychology: Research and Practice*, *49*(5–6), 355. https://doi.org/10.1037/pro0000194.

Bashshur, R. L., Shannon, G. W., Bashshur, N., & Yellowlees, P. M. (2016). The empirical evidence for telemedicine interventions in mental disorders. *Telemedicine and e-Health*, *22*(2), 87–113. https://doi.org/10.1089/tmj.2015.0206.

Boisvert, M., Lang, R., Andrianopoulos, M., & Boscardin, M. L. (2010). Telepractice in the assessment and treatment of individuals with autism spectrum disorders: A systematic review. *Developmental Neurorehabilitation*, *13*(6), 423–432. https://doi.org/10.3109/17518423.2010.499889.

Bouchard, S., Paquin, B., Payeur, R., Allard, M., Rivard, V., Fournier, T., Renaud, P., & Lapierre, J. (2004). Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. *Telemedicine Journal and e-health*, *10*(1), 13–25. https://doi.org/10.1089/153056204773644535.

Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process*, *59*(3), 974–988. https://doi.org/10.1111/famp.12589

Bush, N. E., Armstrong, C. M., & Hoyt, T. V. (2019). Smartphone apps for psychological health: A brief state of the science review. *Psychological Services*, *16*(2), 188–195. https://doi.org/10.1037/ser0000286.

Caldwell, B. E., Bischoff, R. J., Derrig-Palumbo, K. A., & Liebert, J. D. (2017). *Best practices in the online practice of couple and family therapy* [PDF file]. Retrieved from www.aamft.org/Documents/Products/AAMFT_Best_Pract ices_for_Online_MFT.pdf

Centers for Disease Control. (2020, May). *CDC activities and initiatives supporting the COVID-19 response and the President's plan for opening American up again*. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/ downloads/php/CDC-Activities-Initiatives-for-COVID-19-Response.pdf

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*, 155–159. https://doi.org/10.1037/0033-2909.112.1.155.

Commission on Accreditation for Marriage and Family Therapy Education. (2017). *Accreditation standards: Graduate & post graduate marriage and family therapy training programs (version 12.0)*. Author.

Coombs, B. (2020, April 4). *Telehealth visits are booming as doctors and patients embrace distancing amid the coronavirus crisis*. CNBC. Retrieved from https://www.cnbc.com/2020/04/03/telehealth-visits-could-top-1-billion-in-2020-amid-the-coronavirus-crisis.html

Cunningham, D. L., Connors, E. H., Lever, N., & Stephan, S. H. (2013). Providers' perspectives: Utilizing telepsychiatry in schools. *Telemedicine and e-Health*, *19*(10), 794–799. https://doi.org/10.1089/tmj.2012.0314.

Department of Health and Human Services (DHHS). (2020). Annual update on the HHS poverty guidelines. *Federal Register*, *85*, 3060–3061.

Gagnon, M. P., Cloutier, A., & Fortin, J. P. (2004). Quebec population and telehealth: A survey on knowledge and perceptions. *Telemedicine Journal and e-Health*, *10*, 3–12. https://doi.org/10.1089/153056204773644526.

Glynn, L. H., Chen, J. A., Dawson, T. C., Gelman, H., & Zeliadt, S. B. (2020). Bringing chronic-pain care to rural veterans: A telehealth pilot program description. *Psychological Services*, https://doi.org/10.1037/ser0000408.

Godleski, L., Darkins, A., & Peters, J. (2012). Outcomes of 98,609 US Department of Veterans Affairs patients enrolled in telemental health services, 2006–2010. *Psychiatric Services*, *63*(4), 383–385. https://doi.org/10.1176/appi.ps.201100206.

Gros, D. F., Yoder, M., Tuerk, P. W., Lozano, B. E., & Acierno, R. (2011). Exposure therapy for PTSD delivered to veterans via telehealth: Predictors of treatment completion and outcome and comparison to treatment delivered in person. *Behavior Therapy*, *42*, 276–283. https://doi.org/10.1016/j.beth.2010.07.005.

Herbert, M. S., Afari, N., Liu, L., Heppner, P., Rutledge, T., Williams, K., Eraly, S., VanBuskirk, K., Nguyen, C., Bondi, M., Atkinson, J. H., Golshan, S., & Wetherell, J. L. (2017). Telehealth versus in-person acceptance and commitment therapy for chronic pain: A randomized noninferiority trial. *The Journal of Pain*, *18*(2), 200–211. https://doi.org/10.1016/j.jpain.2016.10.014.

Hertlein, K. M., Blumer, M. L., & Mihaloliakos, J. H. (2015). Marriage and family counselors' perceived ethical issues related to online therapy. *The Family Journal*, *23*(1), 5–12. https://doi.org/10.1177/1066480714547184.

Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: A 2013 review. *Telemedicine and e-Health*, *19*(6), 444–454. https://doi.org/10.1089/tmj.2013.0075.

Hull, T. D., & Mahan, K. (2017). A study of asynchronous mobile-enabled SMS text psychotherapy. *Telemedicine and e-Health*, *23*(3), 240–247. https://doi.org/10.1089/tmj.2016.0114.

Jordan, S. E., & Shearer, E. M. (2019). An exploration of supervision delivered via clinical video telehealth (CVT). *Training and Education in Professional Psychology*, *13*(4), 323–330. https://doi.org/10.1037/tep0000245.

Kang, H. (2013). The prevention and handling of the missing data. *Korean Journal of Anesthesiology*, *64*(5), 402–406. https://doi.org/10.4097/kjae.2013.64.5.402.

King, V. L., Brooner, R. K., Peirce, J. M., Kolodner, K., & Kidorf, M. S. (2014). A randomized trial of web-based videoconferencing for substance abuse counseling. *Journal of Substance Abuse Treatment*, *46*(1), 36–42. https://doi.org/10.1016/j.jsat.2013.08.009.

Krebs, P., & Duncan, D. T. (2015). Health app use among US mobile phone owners: A national survey. *JMIR mHealth and uHealth*, *3*, e101. https://doi.org/10.2196/mhealth.4924.

Lebow, J. L. (2020). Family in the Age of COVID-19. *Family Process*, *59*, 309–312. https://doi.org/10.1111/famp.12543.

Mitchell, J. E., Crosby, R. D., Wonderlich, S. A., Crow, S., Lancaster, K., Simonich, H., Swan-Kremeier, L., Lysne, C., & Myers, T. C. (2008). A randomized trial comparing the efficacy of cognitive–behavioral therapy for bulimia nervosa delivered via telemedicine versus face-to-face. *Behaviour Research and Therapy*, *46*(5), 581–592. https://doi.org/10.1016/j.brat.2008.02.004.

Neufeld, J. D., Yellowlees, P. M., Hilty, D. M., Cobb, H., & Bourgeois, J. A. (2007). The e-Mental Health Consultation Service: providing enhanced primary-care mental health services through telemedicine. *Psychosomatics*, *48*(2), 135–141. https://doi.org/10.1176/appi.psy.48.2.135.

Park, J., Erikson, C., Han, X., & Iyer, P. (2018). Are state telehealth policies associated with the use of telehealth services among underserved populations? *Health Affairs*, *37*(12), 2060–2068. https://doi.org/10.1377/hlthaff.2018.05101.

Pickens, J. C., Morris, N., & Johnson, D. J. (2020). The digital divide: Couple and family therapy programs' integration of teletherapy training and education. *Journal of Marital and Family Therapy*, *46*(2), 186–200. https://doi.org/10.1111/jmft.12417.

Polinski, J. M., Barker, T., Gagliano, N., Sussman, A., Brennan, T. A., & Shrank, W. H. (2016). Patients' satisfaction with and preference for telehealth visits. *Journal of General Internal Medicine*, *31*(3), 269–275. https://doi.org/10.1007/s11606-015-3489-x.

Price, M., & Gros, D. F. (2014). Examination of prior experience with telehealth and comfort with telehealth technology as a moderator of treatment response for PTSD and depression in veterans. *The International Journal of Psychiatry in Medicine*, *48*(1), 57–67. https://doi.org/10.2190/PM.48.1.e.

Proudfoot, J. G., Parker, G. B., Pavlovic, D. H., Manicavasagar, V., Adler, E., & Whitton, A. E. (2010). Community attitudes to the appropriation of mobile phones for monitoring and managing depression, anxiety, and stress. *Journal of Medical Internet Research*, *12*(5), e64. https://doi.org/10.2196/jmir.1475.

Rees, C. S., & Maclaine, E. (2015). A systematic review of videoconference-delivered psychological treatment for anxiety disorders. *Australian Psychologist*, *50*(4), 259–264. https://doi.org/10.1111/ap.12122.

Ruskin, P. E., Silver-Aylaian, M., Kling, M. A., Reed, S. A., Bradham, D. D., Hebel, J. R., Barrett, D., Knowles, F., & Hauser, P. (2004). Treatment outcomes in depression: comparison of remote treatment through telepsychiatry to in-person treatment. *American Journal of Psychiatry*, *161*(8), 1471–1476. https://doi.org/10.1176/appi.ajp.161.8.1471.

Sahebi, B. (2020). Clinical supervision of couple and family therapy during COVID-19. *Family Process*, *59*(3), 989–996. https://doi.org/10.1111/famp.12591

Sánchez-Ortiz, V. C., House, J., Munro, C., Treasure, J., Startup, H., Williams, C., & Schmidt, U. (2011). "A computer isn't gonna judge you": A qualitative study of users' views of an internet-based cognitive behavioural guided self-care treatment package for bulimia nervosa and related disorders. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, *16*(2), e93–e101. https://doi.org/10.1007/BF03325314.

Scharff, A., Breiner, C. E., Ueno, L. F., Underwood, S. B., Merritt, E. C., Welch, L. M., Fonda, C., Weil Malatras, J., Lin, B., Hormes, J. M., Pieterse, A. L., Gordis, E. B., Halpern, L. F., Pazienza, R., & Litchford, G. B. (2020). Shifting a training clinic to teletherapy during the COVID-19 pandemic: A trainee perspective. *Counselling Psychology Quarterly*, 1–11. https://doi.org/10.1080/09515070.2020.1786668.

Shore, J. H. (2013). Videoconferencing in the delivery of psychiatric care. *American Journal of Psychiatry*, *170*(3), 256–262.

Shore, J. H., Yellowlees, P., Caudill, R., Johnston, B., Turvey, C., Mishkind, M., Krupinski, E., Myers, K., Shore, P., Kaftarian, E., & Hilty, D. (2018). Best practices in videoconferencing-based telemental health April 2018. *Telemedicine and e-Health*, *24*(11), 827–832. https://doi.org/10.1089/tmj.2018.0237

Spence, S. H., Donovan, C. L., March, S., Gamble, A., Anderson, R. E., Prosser, S., & Kenardy, J. (2011). A randomized con- trolled trial of online versus clinic-based CBT for adolescent anxiety. *Journal of Consulting and Clinical Psychology*, *79*(5), 629–642. https://doi.org/10.1037/a0024512.

Springer, P., Bischoff, R. J., Kohel, K., Taylor, N. C., & Farero, A. (2020). Collaborative care at a distance: Student therapists' experiences of learning and delivering relationally focused telemental health. *Journal of Marital and Family Therapy*, *46*(2), 201–217. https://doi.org/10.1111/jmft.12431.

Twist, M. L., Hertlein, K. M., & Haider, A. (2016). Electronic communication in supervisory relationships: A mixed data survey. *Contemporary Family Therapy*, *38*(4), 424–433. https://doi.org/10.1007/s10591-016-9391-9.

Wade, S. L., Raj, S. P., Moscato, E. L., & Narad, M. E. (2019). Clinician perspectives delivering telehealth interventions to children/families impacted by pediatric traumatic brain injury. *Rehabilitation Psychology*, *64*(3), 298. https://doi.org/10.1037/rep0000268.

Waldman, S. D., Waldman, C. W., Waldman, R. A., & Abuabara, J. O. (2020). How to Use Technology and Telehealth to Enhance the Interprofessional Community of Practice. In S. Waldman & S. Bowlin (Eds.), *Building a patient-centered interprofessional education program* (pp. 113–119). IGI Global.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238.

Wells, C., Malins, S., Clarke, S., Skorodzien, I., Biswas, S., Sweeney, T., Moghaddam, N., & Levene, J. O. (2019). Using smart-messaging to enhance mindfulness-based cognitive therapy for cancer patients: A mixed methods proof of concept evaluation. *Psycho-oncology*, *29*(1), 212–219. https://doi.org/10.1002/pon.5256.

Whaibeh, E., Mahmoud, H., & Naal, H. (2020). Telemental health in the context of a pandemic: The COVID-19 experience. *Current Treatment Options in Psychiatry*, *7*, 198–202. https://doi.org/10.1007/s40501-020-00210-2.

World Health Organization. (2020). *WHO Director-General's opening remarks at the media briefing on COVID-19—11 March 2020*. Retrieved from https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

World Health Organization. (2020). *WHO coronavirus disease (COVID-19) dashboard*. Retrieved from https://covid19.who.int

Wrape, E. R., & McGinn, M. M. (2019). Clinical and ethical considerations for delivering couple and family therapy via telehealth. *Journal of Marital and Family Therapy*, *45*(2), 296–308. https://doi.org/10.1111/jmft.12319.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

How to cite this article: Morgan AA, Landers AL, Simpson JE, et al. The transition to teletherapy in marriage and family therapy training settings during COVID-19: What do the data tell us?. *J Marital Fam Ther*. 2021;47:320–341. https://doi.org/10.1111/jmft.12502