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COLLABORATIVE CARE AT A DISTANCE: STUDENT THERAPISTS' EXPERIENCES OF LEARNING AND DELIVERING RELATIONALLY FOCUSED TELEMENTAL HEALTH

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There is mounting evidence that telemental health is an effective delivery method for treating a variety of mental, emotional, behavioral, and relational health problems. While many of the therapeutic skills leading to the effectiveness of face-to-face treatments are transferable, the effectiveness of telemental health requires unique skills. The purpose of this phenomenological study was to determine the experience of learning how to use videoconferencing to deliver relationally focused mental health care. Participants included 10 graduates of a COAMFTE-accredited master's degree program emphasizing training in telemental health. Each student had practicum placements that required videoconferencing to deliver relationally based psychotherapy. Analysis of interview data revealed (a) personal reservations about distance delivery; (b) the importance of scaffolding student learning through curriculum, supervision, and mental health-care delivery protocols; (c) the technological barriers associated with this delivery method; and (d) overcoming technological barriers through intentionality.

Telehealth (the delivery of medical services via videoconferencing technology) has changed practice in both the medical and mental health fields (Krupinski & Weinstein, 2014), and is quickly becoming an important approach for improving the standard of care. This is in part due to (a) the affordable and ubiquitous nature of telecommunications technologies, and (b) the convenience for both clients and providers. Telehealth overcomes many barriers that contribute to physical and mental health-care disparities including physical distance, cost, and time efficiencies (Brazell, 2015; Townley & Yalowich, 2015).

There is mounting evidence to suggest that a wide variety of traditional treatment models can be applied effectively through videoconferencing (Antonacci, Bloch, Saeed, Yildirim & Talley, 2008; Bashshur, Shannon, Bashshur, & Yellowlees, 2016; Spence et al., 2011). These studies have shown that treatments delivered through videoconferencing are as effective as face-to-face treatments for a variety of mental, emotional, and behavioral health conditions that are of mild-to-moderate severity (Doss, Benson, Georgia & Christensen, 2013; Dunstan & Tooth, 2012; Simpson

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& Reid, 2014). While this is the case, it cannot be assumed that mode of delivery does not affect treatment. Just as talking on a telephone is different than talking to someone in person, providing treatment through videoconferencing is different than doing so face-to-face. Even with the best audio and video quality, there is a decrease in the number of auditory and visual cues that participants can access. This can be especially problematic in the provision of couple, family, and other relationally based therapies where there is such a heavy reliance on nonverbal cues and information needed for assessment and intervention that may only be available through physical proximity.

The physical environment in which psychotherapy is provided (e.g., seating, tidiness, decor) has been shown to impact treatment (Jackson, 2018). Consequently, it is imperative that the environment of treatment setting be informed by treatment modality and match the needs of the client. For example, therapy provided face-to-face in the therapist's office may need to be modified when provided in a client's home, a medical exam room, or other locations. It would follow that modifications may be needed to accommodate the unique virtual environment of videoconferencing (Dunstan & Tooth, 2012; Jones et al., 2015; Levy & Strachan, 2013).

Training in the use of videoconferencing is needed and data about how relationship-focused therapists can provide quality treatment to individuals, couples, and families are missing from the literature. In fact, current literature is lacking when it comes to adequately describing training in the use of videoconferencing (or any other telecommunications technology) as a mental health treatment delivery medium in general. Conde et al. (2010) have lamented the paucity of qualified trainers in telehealth as a barrier to its growth. This sentiment has been echoed by Dunstan and Tooth (2012), who recommend that further studies on telehealth training be conducted through university programs providing mental health services via telehealth to rural communities.

Marriage and Family Therapists (MFTs) seem reluctant to embrace the use of telehealth. Akyil et al. (2017) reported that family clinicians rarely if ever used telemental health and another study reported that MFTs expressed a high level of discomfort using this modality, which the authors attributed to a lack of training (Hertlein, Blumer, & Smith, 2014). However, Hertlein et al. (2015) found that over 85% of the MFTs they sampled reported that they were somewhat interested in learning about web-based services. Pickens et al. (2019) evaluated the degree to which family therapy training programs provide training in telemental health. They found that while more than two thirds of those responding were in favor of integrating telemental health within their programs, most were not addressing it at all within their curriculum.

Not only is there a paucity of guidelines for how to train clinicians in this modality but there is also a lack of research demonstrating what competencies and skills are needed for the effective delivery of telemental health services. This is especially the case for training in relationally based therapies. This is alarming considering that many professional counseling associations, through their codes of ethics, have specifically identified a need for clinicians to be better trained in this modality (American Association of Marriage & Family Therapy, 2015; American Counseling Association, 2014; American Psychiatric Association & American Telemedicine Association, 2018). In the absence of a solid literature base, clinicians have little guidance in how to: (a) ethically practice using this modality, (b) understand what skills are needed and how they can develop them, and (c) where to look for appropriate training. Caldwell et al. (2017) have estimated that it takes state regulations and professional standards 10 or more years to catch up with innovations in practice. This leaves clinicians practicing in environments where existing regulations are either insufficient to provide adequate guidance or open for interpretation as to how they apply to the delivery of telemental health services.

To address the need for training, we received funding through a United States Department of Agriculture/National Institute of Food and Agriculture (USDA/NIFA) Higher Education Grant to revise the curriculum and practicum experiences of our master's degree Marriage and Family Therapy program to emphasize training in the remote delivery of relationship-focused mental health services through videoconferencing. At that time (2008), there was limited guidance on legal and professional standards related to the delivery of these services. In addition to integrating literature and experiential learning activities into the curriculum, we developed relationships with medical providers in rural communities and practice placement sites in rural medical centers that

functioned as end user, or place where the telemental health services were being provided in the client's community.

Globally, rural areas are prime destinations for telemental health because of the high level of need, remote locations, lack of access to mental health-care providers, and opportunities for addressing stigma-related challenges (Bischoff, Springer & Taylor, 2017; Taylor et al., 2018). However, we have found that telemental health is an appropriate treatment modality for other circumstances where there are barriers to meeting with clients face-to-face. For example, telemental health is a reasonable solution for providing couple and family therapy during local or global pandemics in which individuals, couples, and families are required to limit social interactions, travel, and time outside the home or workplace to slow the spread of disease. In short, telemental health can be an appropriate modality for providing needed clinical services in any situation where people are limited in their ability to meet face-to-face.

The purpose of this study is to fill an important gap in the literature by researching beginning therapists' experiences of providing couple and family therapy remotely through videoconferencing. We were particularly interested in identifying the unique skills and considerations beginning family therapists identified as critical in the training of this treatment delivery modality. While researchers and clinicians have offered some recommendations for practice (Glueck, 2013), there is a pressing need for empirical studies to identify the unique skills necessary to effectively deliver relationally focused therapies via telemental health.

METHODS

A phenomenological research design was employed using Moustaka's (1994) psychological approach. This approach was deemed most appropriate because the researchers were interested in understanding the lived experiences of participants providing mental health treatment via distance technology in rural medical clinics. This approach is appropriate when one wants to both develop deeper understanding of the features of the phenomenon and desires to contribute to the development of practices or policies (Creswell, 2007; Moustaka, 1994).

Sample

Purposeful sampling was used to recruit former graduates of a family therapy master's degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). Accepted guidelines for phenomenological research (Creswell, 1998; Morse, 1994) suggest a minimum of six interviews or until data saturation is reached. A total of 10 interviews were carried out for this study at which time the researchers determined that data saturation was met.

Participants included eight females and two males ($n = 10$). All participants were Caucasian. Participant ages ranged from 24 to 57 years. Years since awarding of the master's degree was 1–5. All were practicing as marriage and family therapists at the time of the interview. As graduate students, their master's degree program emphasized training in telemental health and collaborative health care. Telemental health and collaborative care literature was integrated in couple and family therapy courses and each student participated in a unique 12-month practicum experience during which they provided therapy in a collaborative care environment using videoconferencing to residents of rural communities (each with populations of fewer than 2000).

To increase accessibility and to reduce stigma, the end user was the rural community's medical clinic. Going to the medical client made it appear to others that clients were visiting their physician for a regular check-up. As part of our protocol, student therapists also traveled to the rural community once a month to collaborate with medical providers, strengthen relationships with end-user site personnel, and have face-to-face treatment sessions with select clients. Nearly every client received at least one face-to-face treatment session.

Procedures

Individual interviews were carried out with the goal of understanding the therapists' experiences of providing relationally focused therapy through videoconferencing. A semi-structured

interview protocol was developed to help guide the interview (Creswell, 2007; Moustaka, 1994). Regardless of the number of people in the room, treatment was relational/systemic in nature. Therefore, the interviewer's questions were aimed at identifying family therapy students' experiences in providing systemic therapy using this modality. Examples of these interview questions include: (a) "Tell me about what it took for you to succeed in using technology in your placement site" and (b) "What challenges did you experience using this modality?" All interviews were audio recorded then later transcribed verbatim by the researchers.

The interviewer was a marriage and family therapist who had never had experience with any form of telemental health and who was not familiar with the telemental health literature, but who was interested in learning about this treatment medium. This facilitated an approach to the interview that was characterized by curiosity and exploration of participants' experiences that were free from bias that might be related to one's own experience of delivering treatment with this medium. The interviewer kept a field note journal in which he recorded his observations of each interview. Following an emergent design, the interviewer was intentional in staggering interviews. Emergent design suggests that the initial plans for research cannot be tightly prescribed, and that the process may shift after the researcher enters the field and begins to collect data (Creswell, 2008; Moustaka, 1994). This allowed the researcher to (a) transcribe the interviews, (b) review his field notes, and (c) conduct a rough analysis of the transcript prior to conducting the next interview (Creswell, 2008; Moustaka, 1994).

Analysis

Two data analysts, one of whom was the interviewer and both of whom had taken doctoral-level courses in pertinent research methodology, independently examined the transcripts following the methods described by Moustaka (1994). Using horizontalization (Moustaka, 1994), these analysts immersed themselves in the data by systematically reading the transcripts and identifying significant statements, sentences, or quotes that provide understanding of how the participants experienced the phenomenon. Each independently read and reread transcripts exploring the meaning behind significant statements until themes emerged and crystallization occurred. Next, the researchers developed clusters of meaning from these statements and placed them into themes. To increase trustworthiness of the results, a third analyst, who was not a mental health provider, examined the identified themes in light of the clusters, and analyzed, merged, and triangulated the data. The data analysts reached consensus in their conclusion that saturation was reached with regard to the discovered themes.

RESULTS

Data analysis highlighted four aspects of the MFT students' experiences. First, these therapists described the process of understanding how their perceived reservations were the first barriers to providing unbiased and quality care to their clients. Second, each clinician described programmatic scaffolding that was critical in (a) assisting them in developing competence in delivering telemental health services and (b) in creating collaborative relationships with key personnel on the medical care team. Third, the therapists described the technological challenges that often accompany using technology in providing systemic therapies. Fourth, each clinician described the specific and unique ways they learned to overcome the technological barriers when treating individuals, couples, and families. Themes and subthemes within these four cluster areas are presented below to illustrate the experiences of student therapists providing telemental health services. See Table 1 for a summary of the findings.

Personal Reservations About Distance Delivery

Each of the student therapists had supervised experience providing couple and family therapy face-to-face prior to their first videoconferencing session. While they had readings, coursework, role plays, and supervision to prepare them for providing therapy at a distance, their experience of providing therapy face-to-face was the context for how they interpreted and evaluated their experiences with telemental health. This experience became a contextual barrier they needed to overcome and appeared to be developmental and universal among all of our therapists. This phenomenon

Table 1 <i>Telemental Health Themes and Subthemes</i>			
I. Personal Reservations about Distance Delivery	II. Programmatic Scaffolding	III. Technological Barriers	IV. Overcoming Technology Barriers through Intentionality
a. Managing multiple environments b. Minimized spontaneity	a. Support from program faculty and advanced students b. Established protocol related to collaborative care c. Established protocol related to coordination with end-user site staff	a. Limitations in the functioning of the technology b. Limited access to visual and auditory cues c. Difficulty developing rapport d. Telemental health is not for everyone.	a. Focusing on the benefits to communities b. Attending to verbal and nonverbal cues c. Planning in advance d. Relying on end-user site personnel e. Capitalizing on being there in person

was likened to new therapists learning to deal with the anxiety of being in the same room with a client; however, for distance therapists they needed to learn to manage their own anxiety around what it meant to *not* be in the same room with their client. Across the participants, there were two significant subthemes related to their ambiguity of providing therapy via distance. The first is that the physical distance between the therapist and clients would limit the therapists' abilities to *manage multiple environments*. The second was that physical distance and the technology would limit the therapist's ability to *be spontaneous*.

Managing multiple environments. Almost without exception, participants described worry that telemental health delivery impaired their ability to control the client's physical environment and facilitate systemic changes. One therapist summed it up best:

You couldn't control anything on the other end. . .doing therapy at the [University clinic] you're both in the same situation. So, if it's too hot or too cold, I had control over the thermostat. . .or control over whatever. But I couldn't control things on the other end (#3).

Most referenced initial doubts of developing the level of rapport needed for a sound therapeutic relationship when managing both environments. One therapist said, "I was kind of skeptical at first, wondering how you could really develop rapport if you were not sitting there with them (#6)." Another therapist said, "I worried about how comfortable the patients would be with it. . . if they would buy into it. . . if [the patients] could really still be affected (#8)." Another expressed concern that they would not be able to be empathetic and responsive to client distress:

If a patient started crying [face-to-face], I could hand them a tissue box, or if there was not one, I could go get one. If a patient started crying [during a videoconferencing session], I just watched her wipe her tears away. I wanted to do something for her but I could not control anything on that end. I did not even know where there were tissue boxes to tell her to go get. [. . .] It was frustrating. (#3).

Other therapists described their personal reservations that continuity of care, no shows, and cancellations may be negatively impacted because they are not in the same physical room as their

client. One therapist stated, “Are clients going to show up? They know I will not be sitting there waiting for them at the hospital (#7).” This highlighted their assumptions that physical presence is a motivator for clients to come to treatment.

Lack of control over their physical environment also affected their confidence in managing client safety issues such as suicidal ideation, potential violence, emotional outbursts, or relational conflict. One therapist said: “I could not control anything on my end (#3).” Another said “I was worried about the safety of my clients. . .not being able to be there and calm them down (#10).” This new working environment forced therapists to think about safety issues in different ways. Simple things such as walking a client to a colleague’s office, or ensuring that a client who was suicidal actually went to the hospital became very disconcerting. One therapist expressed:

[Distance] was a challenge because you are however many miles away from [clients] and they say ‘I am going to hurt myself.’ Okay, ‘I need you to walk to the hospital across the street.’ How do you know they go there (#8)?

Relatedly, another therapist insightfully suggested that her personal reservations about the technology may have been more of a barrier than the technology itself. She explained, “In the beginning, I think [clients] could pick up on some of my uncertainty about the technology (#10)”. As the therapists developed more experience in providing treatment, they were able to recognize that the perceived barriers were mostly related to their inexperience, and that the clients were appreciative of the services they were receiving.

Minimized spontaneity. Not being physically present and the technology were also perceived as barriers to spontaneity. This was a concern expressed particularly by those preferring models that encourage experiential activity, such as structural or experiential therapy where enactments and role plays are the norm. Initially these relational therapists felt restricted in being able to respond creatively. This forced them to think about how they could be more creative in applying their relational theories. These beginning therapists expressed that because of the distance they were not able to conduct therapy with the same degree of in-the-moment flexibility that they were accustomed to in face-to-face modalities. For example, one therapist said, “You don’t have all your papers. You had to plan ahead. A lot of the different activities, you had to make sure you had prepared. You just couldn’t go make a copy of it (#8)”. Another therapist commented:

I am very spontaneous, and I like to . . .be a very active member of the therapy process, and . . . I was very limited . . . I [could not even] just grab a paper and say, ‘Oh let’s do this,’ there [had] to be paper already in the room. That was hard for me (#9).

Despite this, two therapists commented on how they needed to learn how to overcome this barrier of minimized spontaneity by finding what would work so they could engage their clients in therapy. One said:

I’m very experiential. . .I would hold up a story or a poem or music lyrics and have it on the screen for them to look at while doing something with them. So, I learned to be more experiential while not being there. . .I would have never thought that was possible or to be experiential when you are not there. (# 5).

In this way, the therapist was still able to engage couples, families, and individuals through enactments, storytelling, and the use of space in treatment much like one would do face-to-face. It just took more creativity in engaging the clients in relational ways. Another therapist echoed this by saying: “I got to do some experiential activities, like empty chair, through the camera, and it actually worked really well (#8).” This allowed therapists to heighten the emotional processes that couples, families, and individuals were experiencing through the remote manipulation of their emotional space.

Scaffolding for Success

Participants explained that the way the master’s program was structured (e.g., telemental health course work, role plays, MFT supervision, intentional interactions with advanced students) and the treatment delivery protocol (e.g., emphasis on relational therapies, collaborative care, medical clinic as end-user site) provided important scaffolding for their success. They explained

that the scaffolding of their experience increased their confidence and facilitated the development of competencies.

The role of supervisors and more advanced therapists as scaffolding. In this subtheme, participants described the importance of connecting with other MFTs who had experience providing telemental health with individuals, couples, and families, specifically their supervisor and advanced students, to navigate challenges. One therapist said, “It was nice to have [my supervisor’s] support. . . I didn’t fit into the system because I didn’t understand it, and so it was nice to have that introduction (#3).” Another therapist echoed this theme, “I think it helped that [my supervisor] was there too. With us being students, it helped us have more credibility. . . my supervisor helped me with [understanding how to do telemental health] (#10).” Another therapist said, “They [the supervisors] have more relationships with these people since they’ve been involved [in the communities] for years. Going out with the new therapists in the beginning and helping introduce them. . . so having information about the sites would be helpful, beyond the list of doctors (#6).” Even after the therapist had an established relationship with the community, the supervisor provided important support that built competence and confidence in their skills: One therapist stated, “I still check with my supervisor if I am uncomfortable and say, hey am I doing what I need to do? I’m fully licensed, it’s like I am still learning (#8).” Others described how having MFT supervision helped them design systemic interventions that would facilitate long-term change even when treating one person in the room. Finally, another therapist summed it up by saying, “Our supervisors were always really helpful in asking what is going on and listening (#5).” It was clear that the supervisors’ preexisting relationships with end-user site personnel, their own experience with providing relationally focused telemental health, and their accessibility to the student therapist was important scaffolding for student therapists.

Mental health-care delivery protocol related to collaborative care with medical providers. Telemental health was delivered within a context of collaborative health care, which included a prescribed protocol for collaborating with medical providers. Therapists found the model of collaborative health care to be scaffolding that facilitated their success in engaging their clients in treatment while overcoming barriers of stigma, distance, and technology. It also became one of the primary tools in building a therapeutic relationship with their clients and in establishing credibility and confidence with both clients and medical providers. The collaborative care model forced student therapists to think relationally as they built trust and engaged multiple systems in the treatment process. One therapist commented on how critical it was to not work alone and to establish a relationship with the medical providers so they would have referrals:

The doctors were able to see me, get to know my personality a little bit. So, when they referred someone to me they could say, ‘there’s a great therapist you could see. . . he works really great, he’s really kind, gentle and nurturing.’ If they set that up already then, the client knows what to expect going into the session (#10).

Another therapist said,

I think the biggest thing was building those relationships. . . [I] just tried to be present as much as I could when I was there. . . [to] walk around the hospital and smile and say ‘hi’ to people and introduce myself whenever I could. I did it so they knew who I was and so from their point of view if they knew who I was they would probably be more likely to refer someone (#8).

Therapists said that the collaborative care protocol encouraged them to be proactive in their interactions with medical providers. One therapist stated, “I have to be proactive in order to facilitate communication with the doctors. . . especially being off-site. They didn’t reach out to me to contact me for anything [unless I was proactive] (#10).” Another therapist said, “It’s a lot of self-motivated collaboration. I really learned how to be assertive with getting a hold of doctors and making sure we were giving the best care to our clients and our patients. . . it taught me about self-motivated collaboration (#9).” Another therapist said of rural physicians, “it was less about updating them on everything I’m doing in therapy and more about learning what the medical providers needed and wanted to know from therapy (#3).” The therapists recognized that in order to be successful there had to be a level of trust. One therapist said, “just getting to collaborate with them

and getting their take on things, gains their trust. They were the ones referring the patients (#6).” Another therapist said that collaboration and trust building included more than just updating doctors, it also included, “fine tuning my ability to write letters of acknowledgement for referrals [to the doctors] (#1).” Once those relationships were built with the providers, referrals came quickly and the student therapists felt like an important member of the team:

I look back on working with the PA’s, us together focusing on caring for a patient, and that’s when I really caught the spark of the beauty of collaborative care. I suddenly felt important. . . I remember thinking that in the rural setting, they were really grateful for the work I was doing for their patients. . . them actually valuing my opinion helped me realize I could contribute (#10).

Protocol related to coordination with staff at the medical clinic. Program faculty established a protocol for coordinating with the staff and other important allied health professionals at the end-user sites. Therapists explained that this protocol highlighted once again the importance of relationship building and harnessing the multiple systems in a client’s sphere of influence to affect change. These student therapists described the importance of building relationships with the staff as critical in trouble shooting technical challenges they would experience, as well as making sure the clients were comfortable prior to sessions beginning. Most of these staff members were trusted by the clients, and greeted the clients when they came in. One therapist described this process in this way: “Through the structure provided by the program, I was able to learn the ins and outs of how to collaborate with physicians, how to make staff, even janitors, feel like they are part of the care team. Because in a way, you know, everybody serves their purpose at the site (#9).”

Part of the relational scaffolding provided to the beginning therapists was that they were taught to think systemically about how every interaction with a staff member could impact how they are perceived by the entire hospital system and by their clients. One therapist said, “by the staff knowing my personality and the importance of my role, in a roundabout way, kind of permeated the hospital. . . that I really love what I’m doing, that I want to take care of my clients (#10).” They found that when relationships with staff occurred, word spread quickly in the community about the trustworthiness of the therapist. Another therapist said, “If the staff didn’t trust me and have confidence in me, I knew that was going to affect everything (#2).”

These results suggest that there is more to successful telemental health care than merely providing services via technology. Rather, the therapist must think systemically in how every relationship with staff members, providers, and clients can influence the culture of treatment. Our student therapists learned that they must be seen as caring about the community and developing relationships beyond superficial conversations with the end-user site (e.g., staff and doctors) to facilitate success with their clients. The participants readily acknowledged that the program provided important structure essential to their growth as a therapist in thinking systemically and using their systemic skills in building relationships of trust with end-user sites and clients.

Technological Barriers to Telemental Health

An important theme identified by all of the therapists was the unique challenges that they faced in how to manage the technological aspects of providing therapy at a distance. All of the beginning therapists reported instances in which technology limited or prevented delivery of mental health care. They cited instances in which the technology (a) did not work as it should, (b) limited the ability to access visual and auditory cues, (c) limited the ability to develop rapport, and (d) resulted in challenges in working with specific populations.

Limitations in the functioning of the technology. Each of our therapists cited instances where the technology did not work as expected and explained that these problems proved to be a disruption to treatment. Therapists explained that these occurrences were more disruptive when they, themselves, were less experienced. These problems included not having clear video, mute being on at the end-user site, video or audio lagging behind, the system shutting down at the end-user site, or poor connectivity (including dropped connections). One therapist in a resigned voice said, “I had to realize that it was going to happen, and I just couldn’t have control over that. . . there was one session in particular where the equipment went down six times in 45 min (#2).” Another therapist reported the stress associated with technological disruptions, “It was hard to be calm when the

technology didn't work (#5)." Another therapist said, "It was pretty consistent [technology problems]. . . sometimes it wouldn't work, and we would just reschedule. I did feel bad about that (#6)." Another therapist captured this challenge in the following statement:

I did not like [when we lost the connection]. I had several experiences where a client was . . . finally opening up, and the system would shut down. I hated that. It drove me crazy. It happened pretty frequently, these glitches, and it was really no one's fault, but it was frustrating (#9).

Limited access to visual and auditory cues. Therapists also reported that the technology limited their ability to carry out technical aspects of therapy. A common barrier was restricted access to visual and auditory cues. One therapist described their experience:

I think it is a lot easier to miss things when you are looking at a screen. So much of therapy for me is [dependent on me] being very observant. The body language—where are they looking? Are they making eye contact?—or just movement. Stuff like that is harder to track on the TV than when I am sitting in front of someone. I am not saying it is not possible; it is just something to keep in mind (#7).

Visual challenges were exacerbated when clients positioned themselves in a way that further limited the visual field, such as sitting at a table or sitting close to the camera. One therapist said, "During a [face-to-face] session, you can read body language, it's harder to do through a screen. You can't see it as well (#8)." This limited the therapists' ability to observe nonverbal cues: "you can't see clients feet tapping, wiggling their legs. . . with distance you can only see maybe from the chest up (#10)." Another therapist explained:

[. . .] being able to see body language was impaired via telehealth. I think that is something I normally pick up pretty easily in a room, but in telehealth, I could not really tell sometimes. Sometimes the quality [of the video] was pretty bad so I could not really catch the nuances in their facial expressions (#9).

While visual challenges were most frequently mentioned, three therapists in particular mentioned that there were limitations to what they and their clients could hear. One of these therapists said, "[my clients] had a hard time hearing and there was a delay, which can bother people." In this instance, the therapist was able to supplement the video with the use of the "chat" function to address the auditory challenges. In an instance of couple therapy the therapist asked the partner to share what the therapist was discussing and to facilitate small therapeutic enactments. Another therapist said, "facial expressions, body language, and even sometimes the audio, I could not actually hear what they were saying and I had to ask them to repeat themselves (#3)." In addition to these, several therapists also cited as examples difficulties in understanding the comments that one client will make while their partner, parent, or child were also speaking, which would likely be easily heard and understood during a face-to-face session. This resulted in the therapist needing to set important ground rules about who can talk and when. But in setting these types of ground rules the therapist may risk missing important perspectives and experiences of others in the room.

Problems related to limitations in the field of view and control over the client's physical space is also illustrated by a statement by one therapist who discovered during the session that, unknown to her, the client's husband was physically present in the room. The therapist said:

There was one time I did not even know she brought her husband into session, because the camera was not pointed [at him], until she finally looked over at him. I had to ask, 'Who are you looking at?' She said 'Oh, I should have told you (#3).'

This experience and others helped therapists learn the importance of talking to their clients about their physical environment at the beginning of the session and even to have them use their camera to show them the space they were in to ensure the therapist knew who was in the room.

Difficulty developing rapport. Therapists' initial worries about difficulties in developing rapport with technology-mediated therapy turned out to be an important barrier that needed to be overcome. Reflecting on her experience, one therapist said, "I was kind of skeptical at first, wondering how you could really develop rapport if you weren't sitting there with them. . . and even with

that I was still able to build rapport (#6).” Another thoughtfully expressed, “It takes more to build trust through a screen than in person (#7).” Another therapist described:

The interaction, engagement, and rapport building. . .are difficult aspects to incorporate [using videoconferencing technology]. That is one of the more difficult aspects to incorporate because it is not in-person every time. It is very different. That is something I felt like I learned, building that rapport when you are not in-person (#8).

In fact, therapists articulated that clients appeared to feel uncomfortable for the first few sessions and that they had to actively work to help their clients feel at ease. One therapist said, “definitely they [the client] had a problem at first. . .you could tell they were anxious. They would say things like, ‘can you hear me’, or ‘this is weird’; and they would say, ‘is there anyone in the room over there?’ They were more anxious (#3).” Another therapist said, “pretty much all of them said the first session they felt weird sitting there talking to me (#9).” As a result, therapists had to develop new skills for making the client feel more comfortable, so “they felt less weird as time went on (#9).” Therapists described spending more time talking to clients, and recognizing that doing good relational therapy required a different ebb and flow in treatment when using telemental health. It required more in-depth conversations and sharing of information so trust could be developed. This meant that treatment on the front end of telemental health took longer than in-person treatment. The therapist had to be careful to not move too quickly into intervention mode and to recognize that allowing clients to feel comfortable was the first important hurdle to be overcome. “The more accustomed people are to doing therapy that way [with distance technology] then all the kinks will be or have been worked out (#7).” Ultimately all of the therapists reported that “by the end of it, it [telemental health] was normal to [the clients] (#3).”

Telemental health is not for everyone. Several of the therapists stated that they recognized there were unique challenges when providing relational therapy with clients at a distance. In every case, these challenges were either related to the nature of the problem, the age, or developmental stage of the client, or client preference. While it was not universal for all of our therapists, these examples highlight why relational and systemic treatments are so important to underserved communities, and the need for training programs to assist therapists in applying relational interventions to address these barriers.

Young children were the most commonly cited population with which our participants struggled. These therapists described challenges in providing relational therapy when parents wanted them to provide one-on-one treatment with young children. They reported difficulty in keeping the children’s attention and being limited by the technology in their ability to intervene in ways that would increase their attention. For example, one therapist gave the example of an 8-year-old client who “had a hard time watching the screen and [was] playing all over the room (#6).” Another therapist said it is “hard with younger boys to keep them focused and engaged with me (#10).” For beginning relational therapists, learning to be assertive via distance, and maintaining the structure in session, required ongoing supervision and reminders on how to apply their systemic models through this modality.

Student therapists also reported that at times doing couple therapy was challenging, particularly in managing the couple’s anxiety and angry outbursts. One therapist said, “Couples therapy was harder to do. I think because couples can get so heated. It is easier [for them] to ignore [the therapist on] a screen than [a therapist] in the room (#4).”

Only one therapist described challenges in providing family therapy. This was in relation to working with larger families in a small physical space (including a large room with a limited visual observing area). The therapist said, “I only have so much room to work with. If they brought in five people, it would have been really difficult to work with. The most I had was three, which fit [on the screen] (#10).”

Overcoming Technology Challenges through Intentionality

According to our participants, the overarching strategy for addressing technology as a barrier to quality mental health care was being intentional in all aspects of therapeutic process. Intentionality was divided into several subthemes that included: (a) being intentional in understanding the benefits to the communities, (b) attending to verbal and nonverbal communication, (c) attending

to auditory and visual cues, (d) planning in advance, (e) capitalizing on face-to-face sessions, and (f) relying on the end-user site for assistance.

Focusing on the benefits to communities. Recognizing the benefit of the services they were providing to the community moderated frustrations with technological challenges for these beginning therapists. As one said, “[it is] way better than not being able to provide therapy at all (#7).” Participants made statements indicating that they were able to justify the modality despite its limitations because it “filled a gap, a mental health gap (#8)” and was allowing them to provide important systemic-based services to individuals in rural areas who would not otherwise be able to get them (#6 & #10). One therapist explained, “knowing that I was providing a needed service was probably the best part of it. That felt good (#9).” This same therapist also said that it helped her tolerate challenges with the technology to recognize that no other mental health professional was living or working in the community and that professionals are “not going to drive long distances” to rural areas to “visit a few clients (#9).” It helped another therapist to recognize that the medical providers were seeing the benefits of telemental health. She said, “I remember thinking that in rural settings, they were really grateful for the work I was doing for their patients (#3).”

Several of the therapists reasoned that because “everyone knows one another (#4)” in a small town, many clients would prefer to have a mental health therapist who does not reside in the town and who does not know them in other contexts. One therapist explained,

there is something to be said for the therapist to be providing mental health services for a small town who does not live in that community. There is a huge benefit. It really eases a lot of the fears for the client (#7).

Another therapist reported recognizing the benefits of not being from the community by saying:

It also created a distance, which I think the clients liked. Being in a small town, you know everybody. So obviously you know the therapist there. A lot of them said they appreciated that I did not live there, that I did not know everything that was going on, and that I was not a part of it (#4).

Another therapist, acknowledging the local mental health provider, said,

People wouldn't go to her even though they knew they needed mental health treatment because they had to sit next to her at a PTA meeting the next day. . . So I think in a way, having someone from the outside, although at first I thought it would be a bad thing and I wouldn't be accepted, [but it] ended up being a really good thing (#9).

As the participants began to recognize the challenges related to access to care in these rural communities, they were able to understand the impact that they were making on the clients they were serving. This allowed them to expand their view of the benefits of telemental health services, and motivation to determine how they could best provide systemic-based services.

Attending to verbal, nonverbal, auditory, and visual cues. All our therapists mentioned the need to develop skills in adjusting their verbal and nonverbal communication when providing therapy through videoconferencing. One therapist said, “I became very intentional about what I was doing. In an in-person session, I'd move a certain way to make a point, but, in front of a screen, I would be more intentional about what I was trying to say (#7).” Therapists noted that they “had to be very calming, speak softly and slowly (#10).” Another therapist shared, “I would slow down and I would pronounce my words more [carefully] (#3).” This therapist also explained that ambient noise was far more distracting in videoconferencing than face-to-face: “I tried to minimize noise in the room I was in so I could hear it clearly (#3).”

The therapists recognized the need for being more intentional in observing clients and the environment. One therapist stated, “I became super aware of facial expressions. . . hyper-aware of what I could see, and [I would] ask questions about some of those things to kind of draw out what I couldn't see and feel (#10).” This included relational questions that would engage “outsider” perspectives of the problem and solutions. Another therapist commented that because she could not see the nuances of facial expressions, she asked more questions: “if they were crying or something. . . I had to ask more (#6).” Therapists would ask more questions and “ask them [clients] to

repeat themselves (#3)” more often so that they could access information that may not be readily available when the therapist is not physically in the room.

Two therapists talked about how they came to use the technology and the challenges associated with it to enhance treatment. One said,

You are talking to a screen right now. I am not there. You can get to anxiety, nervousness with someone that withdraws. . . that is just uncomfortable. So that is what I mean. The [technology] is a therapeutic tool because it is something new they might not have had before and you can pick up some other patterns or something. . . We would talk about the cameras. Now we are talking to a camera about a camera, so that was always a very intentional conversation about, “What is this like for you? What are the obstacles to this for you?” So the distance was a therapeutic tool in-and-of itself (#7).

Planning in advance. Our therapists said that they had to be more intentional about planning for sessions in advance, giving special attention to the relational interventions they wanted to provide. According to protocol, therapists would visit the rural communities once a month. They would anticipate what they would need for relational treatment sessions for the coming month and attempt to put things in place when they made this monthly visit. One therapist said, “You had to plan ahead. A lot of the different activities you had to make sure you had prepared (#8).” This included bringing out paper, materials, crayons, and handouts, and, in one case, even a sand tray so they were on hand when needed. About this, another therapist said,

I learned more organization, because if I went out to the community and had forgotten something, then I just didn’t have it. . . It helped me develop a longer [term] mindset for planning into the future. . . Like next week I’ll have them do a drawing activity, so I’ll have to make sure to have construction paper and markers there, and have to let the staff know that. So, I was thinking ahead. . .with distance there was a lot more planning involved (#2).

For nearly all the participants, planning did require additional work. It made them be more intentional in what they were doing and in how they were following their systemic model and how they could apply it using this modality. One therapist said:

The process of distance therapy took a lot more energy and took a lot more adjustment. For example, if I wanted to give my patients a print out and I could not [do it if it wasn’t already there]. . .The only way I could get papers to the patients was to bring it out once a month if I assigned them homework or anything (#3).

Despite careful planning, most of the therapists described needing to be flexible and adaptive when things did not go as planned. One said, “I guess I learned how to be more creative with doing things. . .You developed a lot more flexibility. . .if it didn’t go according to plan (#5).”

Capitalizing on being there in person. The telemental health protocol required therapists to be physically present in the community once a month to provide face-to-face sessions and to coordinate care and collaborate with medical providers and staff. These community visits and face-to-face sessions were valued by the participants. One therapist said, “face-to-face meetings are the best. . .without it, I think my clients would shy away. All my clients have literally said, ‘I really enjoy these face-to-face meetings’” (#10). Other therapists talked about how they maximized their in-person meetings to do relational interventions they were not able to do as effectively via video-conferencing. For example, one therapist said, “I knew I could only do an intervention like that once a month. . .I would think ‘Ok, this is my only opportunity this month if I want to do it, so I’d better do it now’. . .I really had to capitalize on that time (#2).” Many therapists described being strategic about scheduling first appointments as face-to-face and in including that person’s parent, partner, or friend in that session. Others used the face-to-face sessions to help clients not only feel connected to them but also to familiarize them with what therapy would look like over the next few sessions via distance technology. Setting the expectation that therapy should include more than one person was discussed early on.

Participants also described the need to be seen in the community as a way of establishing rapport and demonstrating investment in the community. Therapists said they were intentional in

doing things like going to local places to eat and attending a school football or basketball game and the local health fair. All of this helped them be seen as caring about the community. “I went to a baseball game. . .getting to know the staff there. . .being physically [present], them seeing me is kind of an investment (#5).” One therapist said, “I learned that some people or some cultures aren’t as willing or eager about [coming to therapy], so putting yourself out there and continuing to try is important because it is beneficial to the client (#8).” Another said that being seen was critical in breaking down stigmas of mental health that were common in rural communities. “I went to a rural mental health fair that the hospital put up. I had my little booth that said, ‘mental health’ and people would see it. . .I realized that saying behavioral health specialist, as opposed to mental health therapist, made a big difference in how people received me (#9).”

Relying on end-user site personnel. Because the therapists were not physically present, they had to rely on personnel at end-user sites to manage client needs and the physical space. This required an added degree of relationship building that was not anticipated by the therapists. If they did not have relationship capital with staff or a person at the end-user site was not available, challenges would be exacerbated, and frustration would result. One therapist reported:

There needed to be somebody on the other end that I could contact. . . It was frustrating when I would call and needed something because it was unexpected or unplanned and I would get her voicemail saying she was out of town. . . I did not know what to do; I could not drive two hours (#3).

When relationships with end-user site personnel were established, it provided the therapists with additional flexibility in managing the physical space and therapy sessions. For example, a staff member could be emailed or faxed a handout or other materials, and they could take it to a client if the therapist needed this to be done. Also, in times of crisis, the end-user site personnel could help bring in a medical provider to assist.

DISCUSSION

The effectiveness of telemental health has national and global implications to improve the mental health of individuals and families (Bischoff et al., 2017; Taylor et al., 2018). More research is needed to identify best practice strategies and the unique characteristics of this treatment modality. This study is important because it identifies the experience of learning how to deliver relationally based telemental health services via videoconferencing. While previous studies have explored other aspects of telemental health, such as its cost efficiency (Antonacci et al., 2008), effectiveness with symptom reduction in comparison to face-to-face therapy (Dunstan & Tooth, 2012), and ability to foster the therapeutic alliance (Foster & Whitworth, 2005; Singh, Arya, & Peters, 2007), no other published study has looked at the experience of relational therapists who are new to this modality. The results of this study provide insight into the issues, challenges, barriers, and strategies for learning to use technology to deliver relationally based mental health care, and what clinicians and faculty of family therapy training programs should consider when developing and delivering systemic-based training.

Another aspect that makes this study noteworthy is its use of interviews with therapists. Through interviews, unique insight was gained into the experiences and conditions which allowed them to be successful. Interviews revealed unique relational, individual, and technological barriers that may not have been identified otherwise. Interviews also identified what was needed to overcome barriers, be accepted by the end-user site community, and become integrated into the local treatment team.

This study adds to the literature by describing the challenges that MFTs experience using this modality. As reported by our participants, challenges include difficulty with verbal and nonverbal cues, limitations to spontaneity, inconsistencies in technology, limited control of the end-user site environment, and the overall task of maximizing the client experience despite the physical separation.

Limitations

While a collaborative care setting is one strength of this particular delivery model, it is a noticeable limitation to the transferability of the findings to other settings. We recognize that for

the majority of MFTs, the end-user site for telemental health services will be clients' homes (Luxton, O'Brien, McCann & Mishkind, 2012; Pruitt & Luxton, 2014) not collaborative care settings. This is especially true during times of mass seclusion such as in a global pandemic when, for health and safety reasons, clients may not be allowed to leave their homes.

Clients' homes are much different than a medical setting where nurses or other allied health professionals are part of a safety plan protocol when working with suicidal client, or high conflict couples or families. We recommend that clinicians who are getting trained in telemental health-care delivery receive specific instruction and supervision in how to address issues of client safety and how to develop adequate safety plans when working with clients at a distance in their homes. Additionally, clinicians will need to be prepared to deal with the distractions and interruptions that are common when providing services in the home (Luxton et al., 2012).

The pilot nature of our study is another limitation. While these results provide specific and important findings regarding the barriers and ways student therapists overcame the barriers associated with providing relationally based telemental health, additional research is needed to verify these results. There is also need for additional research that can identify the systemic educational barriers training programs may be facing when incorporating relationally based telemental health principles and practices in their programs (Pickens et al., 2019). Finally, and more importantly we need more research on the clients' experiences of receiving and benefitting from relationally based telemental health treatment.

Among the study's limitations is that the results may not be generalizable to experienced therapists who are learning to do telemental health. While each of the therapists participating in this study had some prior supervised experience providing therapy face-to-face, this was limited to a small number of sessions. They were simultaneously learning how to use the two modalities. Because of our participants' inexperience, it is difficult to tease out whether these challenges are unique to beginning therapists. Another limitation is that we were relying on participants' retrospective account of their experiences as beginning therapists. It is possible that the retelling of a past experience is so influenced by learning and current experience that we are not getting an accurate representation of the experiences we were asking about. There could be some advantages to using a methodology that allows investigators to follow participants over time.

Also, we acknowledge that while former supervisors did not interview the former students, the fact that the study was being conducted through the university where they received their graduate training could have influenced participants' responses. It is possible that some, or all, of the participants wanted their responses to reflect well on their graduate program and themselves. They may have unconsciously, or consciously, withheld information that could make them or the program look bad. This risk is heightened given that some of the respondents were actively maintaining professional relationships with the program faculty, some of whom are authors of this report.

That all of the participants are graduates of the same training program may also be a limitation in that this study's findings do not reflect diversity in training experiences. The model of treatment delivery used by the graduate program may also be a limitation to our emerging understanding of the experience of learning telemental health. In addition to the use of videoconferencing for treatment delivery, the model required that the therapists be physically present in the community where services were being delivered at least one day a month. During this visit to the community, therapists had face-to-face assessment or treatment sessions with some clients, met with referring medical personnel and medical clinic staff, and did things that allowed them to get to know the community. It is also unique in that treatment was provided within a context of collaborative care. Most clients were referred by medical providers, clients were physically present at the medical center when they received mental health care (either through videoconferencing or face-to-face), and mental health care was coordinated with and integrated into medical care provided in the rural community. It may be that the findings about learning telemental health reported here are so influenced by this hybrid model that they do not apply to learning telemental health in other settings or with other models of treatment delivery. While this study is a good starting point, future research is clearly needed.

Clinical Implications

An important clinical implication for this study is the need for therapists to be intentional in all aspects of the therapeutic endeavor, including preparation for treatment sessions and their own

therapeutic presence and interactions with clients that follow systemic theories. Being intentional seemed to help the therapists think about their presence in the “therapy room” and be “hypervigilant” to the things they could not see or hear when treating couples, families, and individuals from a systemic lens. This was underscored by the therapist who reported being unaware that a spouse was in the room during a treatment session with a client. Therapists need to think differently about the use of space and communication in treating couples and families. They also need to ask clients specific questions about who is in the room and what is happening outside of their visual awareness. Having clients provide more detail about their experience can begin to overcome the visual and auditory barriers described by our participants.

The results also underscore the need for couple and family therapists to receive systemic-based training and supervision in telemental health. This study revealed the importance of scaffolding student therapists’ experiences by supervisors and trainers who have expertise in systemic-based telemental health. Currently there are little if any guidelines or standards that have been developed describing how one must be trained in this modality. The most recent guidelines from American Association of Marriage and Family Therapy (Caldwell et al., 2017) and American Psychiatric Association and American Telemedicine Association (2018) primarily focus on general practice issues related to ethics and communication on technology issues. The training program from which we drew our participants has developed a specific systemic-based curriculum, nurtured end-user site partners, and provided a set of supervised experiences that provide important scaffolding for training. We believe that these findings underscore how critical it is for therapists to receive training in telemental health from a supervisor or training program that has experience in this modality. This recommendation is in the best interest of both clients and therapists. It is also consistent with the AAMFT Code of Ethics (2015), which states that a clinician can only “commence electronic therapy or supervision after appropriate education, training, or supervised experience”.

Participants in this study described difficulties in working with children from a systemic perspective using telemental health. Most of these difficulties were in instances when parents wanted the therapist to work individually with their children. However, when parents were involved, they could assist in supporting treatment and in intervening on behalf of the therapist. Therapists may need to develop skills in encouraging parents to cofacilitate therapy. With that said, there seemed to be a threshold in which younger children struggled to engage in treatment even with parent’s involvement.

Therapists also struggled to manage conflictual conversations in their work with couples and families via distance technology. In these instances, the therapist had to learn how to establish ground rules for communication in anticipation that these difficult conversations would occur. For example, in supervision we often encourage therapists to designate objects (e.g., a box of facial tissues) at the end-user site as “the floor” to facilitate only one person speaking at a time. Other strategies could include talking with clients about when they could request taking a time out or when they would have the therapist intervene in creative ways. Some of these ways may include remotely increasing the volume of clients’ audio, playing music, or other strategies to get their attention. Our student therapists often had to seek out supervision to develop systemic therapeutic interventions that align with their theory and that could de-escalate couple and family conflict.

Working with families was particularly challenging because one of the limitations of our work in rural clinics was the small room sizes where our clients would gather for treatment. As a result, the therapist was often unable to see more than three people through the camera view, making it difficult to attend to the clients’ visual and auditory cues. One solution was to have the families sit at the back of the room, but this also resulted in an inability to see faces and physical and verbal cues. As technology continues to adapt, we anticipate this may be more possible in the future.

We recognize that COAMFTE guidelines currently restrict training programs from “counting” hours obtained through telemental health toward clinical degree requirements. However, this research emphasizes the importance of systemic-based training in telemental health, and the importance of integrating telemental health training into COAMFTE-accredited training programs. Doing so will (a) better prepare graduates of these programs for the reality of 21st century mental health care and (b) increase opportunities for higher-quality systemic-based research in telemental health. The mental health field is changing rapidly and dramatically, especially with the globalization of the field and with conditions that have dramatic mental health implications, such

as the COVID-19 global pandemic. Conditions such as these demand responsiveness with evidence-based treatments and clinicians trained in their delivery. COAMFTE training programs and MFTs are well positioned to be leaders in addressing these global mental health challenges.

This study also underscores the need for additional research to determine what populations and presenting problems may be contraindicated using this modality. For example, several of the therapists expressed concern that telemental health has limitations in being the primary treatment modality for clients dealing with severe depression or high conflict couples who escalate quickly in session. Future studies are needed to determine whether these conditions and client presentations are not appropriate for telehealth or if they could be addressed by more specific and intentional training.

Our protocol required therapists to supplement distance therapy with face-to-face assessment and/or treatment sessions. Our participants indicated that occasional face-to-face sessions provided an important function in building therapeutic alliance, setting up systemic-based interventions, creating buy-in to this form of treatment, and in building stronger collaborative relationships end user site personnel. Although not stated by our participants, we hypothesize that this may have facilitated therapist comfort and confidence in the model and their ability to assess client nonverbal behavior despite limited access to nonverbal cues through the technology. This, and other characteristics of scaffolding therapist training, will need to be explored through in future studies.

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