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CLINICAL AND ETHICAL CONSIDERATIONS FOR DELIVERING COUPLE AND FAMILY THERAPY VIA TELEHEALTH

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Studies have generally supported telehealth as a feasible, effective, and safe alternative to in-office visits. Telehealth may also be of particular benefit to couples/families interested in relational treatments, as it addresses some of the barriers that may be more prominent for families, such as childcare and scheduling difficulties. Therapists interested in expanding their practice to include telehealth should understand ethical and practical considerations of this modality. This article discusses areas unique to the delivery of telehealth to couples and families. Each broad domain is then elaborated upon with case examples from actual clinical practice and specific recommendations for addressing potential difficulties. Authors recommend further empirical research examining differences in modality outcome, as well as feasibility of the suggestions proposed here.

There are a number of barriers for individuals seeking and engaging in mental healthcare, including practical concerns such as driving distance, cost, and inflexible schedules, as well as psychological barriers such as perceived stigma or safety concerns (Gulliver, Griffiths, & Christensen, 2010; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Some organizations and individual providers have turned to telehealth technologies as a way of decreasing these barriers to care (e.g., Wilson, Onorati, Mishkind, Reger, & Gahm, 2008). Telehealth, by definition, is the provision of healthcare by any telecommunication technology, to include telephone, Internet, email, and others, but the most similar to in-person care is video teleconferencing (VTC). While it is still a burgeoning area of study, research to date has shown that telemental health delivered via VTC does indeed appear to be a viable alternative to in-person care (Backhaus et al., 2012; Hilty et al., 2013).

There is considerably less research addressing the effectiveness of couple or family therapies via telehealth compared to studies of individual therapy. However, a number of case studies and small trials suggest that family therapy via telehealth is well-received by patients and providers and delivers good benefit (Hill, Allman, & Ditzler, 2001; Dausch, Miklowitz, Nagamoto, Adler, & Shore, 2009; Comer et al., 2017). In many of these studies, family therapy was delivered via VTC to a remote clinic, but it is also possible to connect directly with families in their homes. A unique benefit of telehealth for couples and families is that it can connect family members who are physically separated from one another, such as romantic partners in a long-distance relationship (McCoy, Hjelmstad, & Stinson, 2013), or a patient on an inpatient unit whose family members are unable to appear in person (Dausch et al., 2009; Hill et al., 2001). In addition, those seeking specifically couple and family-based treatments may in fact face even greater hurdles to engaging in care

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than individuals, as challenges such as childcare and scheduling become even more difficult when either both partners or all family members must be present for a session. Thus, offering telemental health to couples and families allows us to expand the reach of these important family services.

While couples and families may uniquely stand to benefit from VTC services, there are also unique concerns that accompany this innovative means of service delivery, particularly when it comes to telehealth delivered to families in their homes. As many of these difficulties significantly decline when providers can use VTC to connect to distant clinics, we have chosen to focus on the complexities of in-home VTC delivery. The American Association for Marriage and Family Therapy (AAMFT) has published a best practices guide to online therapy that speaks to many of the ethical and clinical considerations inherent to telehealth in general, such as Internet security, practicing across state lines, and responding to technical difficulties (Caldwell, Bischoff, Derigg-Palumbo, & Liebert, 2017). The current article is intended to complement these guidelines by expanding on common dilemmas and areas of concern that are specific to the delivery of couple and family therapy via home-based VTC.

According to surveys completed in the last several years, many clinicians feel ill-prepared to utilize online technology for couple and family therapy (Blumer, Hertlein, & VandenBosch, 2015). For instance, providers may have concerns about safety above and beyond what is typical for in-person care. Even those who are experienced in using telehealth technologies with individual patients may wonder about the added complexity of managing multiple individuals at a distance, as well as the ways in which the distance between clients and provider (or family members from each other) may impact the family therapy process. Furthermore, providers may worry about how to translate to telehealth some of the administrative and data collection tasks that are relatively easy to perform in-person. The following discussion endeavors to outline some of these areas, roughly categorized into five overarching domains: confidentiality/privacy, safety, managing multiple patients in session, therapy process, and logistics for treatment planning. As ethical and clinical considerations are inexorably intertwined, it should be noted that the clinical and ethical concerns highlighted here are interrelated and not mutually exclusive. Case examples and associated recommendations, drawn from the authors' extensive experience in providing couple and family services via VTC within the Veterans' Affairs (VA) health care system, accompany each domain in an effort to assist clinicians to make informed decisions as they provide therapy. Table 1 provides a summary of these recommendations for easy reference. Finally, please note that the recommendations reflect the views of the authors and not the VA health care system.

PRIVACY AND CONFIDENTIALITY

Concerns about privacy and confidentiality when telemental health is delivered to the home setting are not unique to couple and family therapy, as certainly the reliance on patients to protect their own privacy is true of individual therapy sessions or other in-home activities as well. There are multiple layers to these concerns, as there is confidentiality/privacy with regard to external forces (e.g., electronic communication in general), as well as more internal to the therapy. With regard to privacy/security to outside concerns, as noted in the AAMFT Best Practices for Online Therapy Report, clinicians should be careful to ensure end-to-end encryption, as well as appropriately protected hardware and software in order to secure confidentiality of electronic communications (Caldwell et al., 2017). More inherent to the modality of family therapy, however, is that having multiple members participate means that some common methods for increasing privacy (i.e., the use of headphones) are not as readily available. Furthermore, if individual family members are connecting from different locations, there is the possibility that someone else may be present outside the view of the screen without the other family member's knowledge. Therapists may find themselves concerned about this possibility as well and feel less open in giving feedback or in steering the conversation toward sensitive topics, potentially diluting the therapy as a result.

Case Example

A clinician provided feedback to a couple as part of the assessment and feedback phase of Integrative Behavioral Couple Therapy (Jacobson & Christensen, 1998). The couple was located in their home, seated on the couch in their living room. As part of the informed consent process at

Table 1
Unique Concerns For Couple/Family Telehealth and Associated Recommendations

Consideration	Recommendation
Need for individual assessment for therapy contraindications and safety planning	• Initial in-office visit, if possible • Use progressively more stringent guidelines to collect information given relative risk of case (e.g., partner can utilize headphones to answer clinician questions if there is concern for IPV)
Escalation occurs during session, and provider cannot ensure physical separation to facilitate de-escalation	• Proactively agree to a "time-out" signal at the beginning of therapy • Problem solve how each member of the couple/family will "cool down" out of the presence of others (e.g., walk around the residence, deep breathing)
In-home sessions are interrupted by day-to-day activities	• Discuss with the family the need to attend as if they are "in-office", or create a space for therapy • Discuss possibility of child care, if needed • Gently and assertively draw boundaries that coincide with informed consent discussion at the initiation of services • Return to this informed consent discussion should these boundaries not be upheld
Typical session nonverbal cues are missed via video	• Utilize names more frequently to cue family members • Solicit more verbal feedback than would be typical in-office
Difficulties "joining" with the couple/family	• Initial in-office visit, if possible • Rely more on verbal feedback • In-session practice of skills to help with generalization
Collection of self-report measures, consent forms from different family members	• Send forms via mail, if possible • Visual or verbal collection of measures, in separate phone calls if needed • Electronic collection, if institutional and national regulations do not prohibit it
Referrals for families or couples	• Create a network with local providers • Gather resources for family's local area • Creatively consider referrals (e.g., support groups)

the start of therapy, the couple was informed of the importance of protecting their own privacy by meeting in a private location in their home, free from interruptions. During the assessment, both partners discussed how one partner's strained relationship with her mother-in-law contributed to their overall stress level. The clinician was giving feedback about external stressors that may contribute to their distress when he noticed a woman moving in the background in the room behind the living room. The clinician reported his observation to the couple, who stated that it was fine to continue. Not knowing the identity of the individual, the clinician adjusted his feedback to be more

general, noting that relationships with family members outside of the couple relationship could be a source of stress. At the next session, the clinician again addressed the importance of privacy with the couple. The individual observed during the previous session was not a family member, but a home-help aid, and the couple agreed to schedule their sessions outside of the hours the aid was working and to alert the provider directly if there was any chance of being overheard in the session.

Recommendations

The primary tool at the clinician's disposal when it comes to issues of privacy and confidentiality is informed consent. Stating at the start of therapy that patients are the primary party responsible for protecting their own privacy within the home, and helping them to brainstorm ways of doing so is essential. It is also important to remember that informed consent is an ongoing process, and follow-up conversations may be necessary. Written notice of areas discussed during the consenting process is recommended, as well. The AAMFT Best Practices guide articulates other important areas to address in the informed consent process (Caldwell et al., 2017). It is not uncommon in an in-person setting for a patient to at times give verbal permission for another person to be present for their session, and couple therapists have often dealt with the dilemma of a couple bringing a child into session due to lack of childcare. The presence of other individuals during a session occurring in the patients' home can be addressed in much the same way, through discussing the potential consequences for the therapy (e.g., the presence of a child or other individual may serve an avoidance function), and brainstorming possible solutions to any barriers to privacy (e.g., childcare options). Unlike the in-person setting, however, the clinician can never guarantee complete privacy, as he or she does not have control over the comings and goings of individuals in the patients' home. Often telehealth is being offered because there is no feasible in-person alternative, and so the patients and clinician may jointly decide that the benefits outweigh the privacy risks. Documentation of informed consent around privacy and confidentiality is the best protection for the clinician around any unintended consequences of known or unknown interruptions by outside individuals.

SAFETY

Studies have generally supported telehealth as a feasible, effective, and safe alternative to in-office visits even in more at-risk populations, such as patients diagnosed with Posttraumatic Stress Disorder (PTSD; Morland et al., 2015; Morland, Hynes, Mackintosh, Resick, & Chard, 2011). However, there are unique safety concerns when conducting couple therapy via VTC, most notably concerns about assessment of the typical contraindications designed to address safety for in-person couple therapy (e.g., severe intimate partner violence (IPV), uncontrolled substance abuse or dependence). In-person providers conducting couple therapy, as a best practice, should interview partners separately early in the process (LaTaillade, Epstein, & Werlinich, 2006; Taft, Murphy, & Creech, 2016) in order to assess for safety. This allows for confidential treatment planning should one partner disclose IPV or endorse fear or intimidation from his or her partner. In one's office, providers can be assured that confidentiality can be protected. This allows the clinician to assess for safety without fear of being overheard. By its very nature, the setting of home-based care does not guarantee this, and though individual sessions can be held as part of the assessment process, the clinician cannot ensure confidentiality. Though a partner may leave the room or view of the camera, there may be opportunity for them to hear the endorsements of the other person, and leave the reporter subject to retribution.

Additionally, there are specific considerations for those couples and families that demonstrate the tendency for rapid and severe escalation of conflict. In-office sessions allow for a provider to more readily divert attention from an object of ire (i.e., another family member). It may be more difficult to re-direct when couples and families are in the same room without the clinician present, with the additive factor of close seating to accommodate view for the camera. Similar to concerns regarding confidentiality, providers working with high conflict couples will sometimes ask the couple to physically separate or one member to leave the room to accommodate a "time out" procedure or take a break (Monson & Fredman, 2012). This could be proposed in a telehealth situation,

though the provider will have less control over when the family member returns. In an office, it is typical that opening the office door to the waiting room and inviting the waiting partner back into session serves as that separation. Keeping in mind this distinction and the relative reduction in clinician control, special attention should be paid to safety planning with high conflict couples or families. In the very worst case scenarios, clinicians should verify location of the family in every session in the event that emergency services need to be contacted (Caldwell et al., 2017). Initial contact should include discussion of a crisis management plan so all parties are aware of necessary steps in emergency situations.

Case Example

A clinician seeing a couple for their third treatment session was aware both partners tend to get heated, especially given the difficult presenting problem of previous infidelity by the male partner. The couple presented on time for their home-based session, and partners were asked to take turns showing their weekly questionnaire to the camera for the clinician to note. This questionnaire assesses satisfaction and important occurrences in the last week, a jumping off point for in-session discussion. This week, the female partner checked "yes" next to the question regarding destructive or difficult events, whereas the male partner did not. The clinician then needed to decide how to approach this situation, as it was important to ascertain the nature of this event, and if either partner was feeling frightened or intimidated as a result. The clinician prompted the couple to discuss, as a dyad, the important occurrences of the past week, both positive and negative. In this case, the female partner offered that the couple had an argument two nights previously, in which she had thrown a vase across the room. The male partner laughed and reported he had forgotten about that incident, but that it was "not a big deal." The couple was first educated regarding the problematic nature of this mutual escalation, especially given local law enforcement mandates to universally arrest one member of a couple when called for a domestic dispute. The clinician then spent time assessing each member's perception of the incident, drawing comparisons to the case conceptualization of their negative interaction cycle. Both members of the couple participated in this conversation, claiming some level of ownership over their own behaviors. At one point during this conversation, the female partner experienced intense anger at a response from her partner; she was first directed to speak to the provider in an effort to de-escalate her current emotion. When that was unsuccessful, she requested to "take a walk" around the apartment before returning to session. This was encouraged, and provider spent the intervening minutes asking the male partner to self-soothe with breathing so as not to cover additional content. Once the female partner returned, discussion continued, and a negotiated time-out strategy was crafted in collaboration with the couple. The couple agreed to practice time-outs over the next week. The next week, practice compliance was assessed, and both members of the couple checked "no" for destructive incidents.

Recommendations

This case example is relatively straightforward in comparison to some situations that may arise in the course of conducting couple therapy, especially to the home. For instance, if the female partner had not offered information about the destructive event she endorsed on the self-report, the clinician would need to have clinical judgment regarding discussion of the incident conjointly due to safety concerns. Many have argued that the conjoint treatment of mild IPV is an effective means of intervention for many couples (Taft et al., 2016), though no assumptions should be made regarding aggression. Therefore, if assessment shows history of mild IPV and neither partner endorses fear or intimidation, it is more likely the couple can engage in the conversation detailed above in order to contract for non-aggression and learn skills to prevent this level of escalation.

However, should there be nonverbal indication that the female partner may be uncomfortable discussing the incident with the partner present, one of several avenues is recommended. First, if possible, it may be helpful to have the couple attend an in-office session where confidentiality can be assured with physical separation. It must be acknowledged that often telehealth into the home is conducted due to the distance between provider and couple/family, or other logistical reasons. It may be possible to schedule one in-person session if safety is a major concern. This will allow safety planning with the victimized partner. Second, it may be beneficial to ask one partner to leave the room, and the remaining partner to utilize headphones to answer yes or no questions. In this way,

confidentiality can be assured even if the other partner is listening to the content of the conversation. This same strategy should be used for the other partner, as well, in order to maintain equity.

Should a couple become highly conflictual during session, it may be worthwhile to proactively and collaboratively agree to time-out signals for the clinician as part of the no-aggression contract. So, for instance, if the clinician makes the "T" signal with his or her hands, it means the couple must cease all communication in that moment. This recommendation is in service of the technological difficulties that occur with loud background noise; the couple may not hear or may not want to hear the clinician verbally signal a time-out. Finally, it may be helpful to explicitly discuss how each member of the couple will "cool down" postsession. Clinicians in-person may recommend that couples not discuss the in-office session, or use of soothing music on their drive home to help with the high levels of remaining emotion. As a couple being seen in the home has no commute, there is a risk that the altercation may continue without the clinician's presence. While clinicians should discuss this with the couple and help them with skills to prevent this, it may be helpful to have each member of the couple brainstorm how to soothe after particularly difficult sessions prior to engaging again with their partner.

One overarching question that may come up for the reader with regard to safety is whether there are times when this modality is contraindicated above and beyond those contraindications already in place for couple or family therapy. In general, we would argue that the same exclusions as in-person couple/family therapy apply (e.g., severe IPV, untreated substance abuse or psychotic disorders in one or more family members, untreated high suicide risk in one or more family members). There is not research to date to suggest that more stringent exclusion criteria are necessary. That said, there may be times where it becomes clear that the couple or family is not able to uphold the boundaries set by the clinician to ensure safety (e.g., if a family member refuses to allow for a confidential and private individual session to assess IPV or refuses to call the clinician back after dropping hints about suicidality) and the clinician may decide that VTC is not the best option. There may also be other instances where the provider is not comfortable with the family being seen unless a particular family member is also being seen individually in person. For example, a family member with an eating disorder or self-harm behaviors that may be difficult to adequately observe in session might also be required to see a nurse at the local clinic for check ins. Always, the clinician should use their clinical judgment and consult with other providers about safety concerns and feel free to request in person sessions or refer to outside providers when necessary to ensure safety. The present article is only a brief overview, but continued discussion and research should occur in order to better understand the range of concerns with safety, couples/families, and VTC.

MANAGING MULTIPLE PATIENTS IN SESSION

Inherent to the process of doing couple or family therapy, sessions include multiple participants. While this is a characteristic of both in-person and telehealth sessions, there are unique concerns in conducting a multi-patient session via telehealth. For instance, in-person therapy simply requires space and seating to accommodate participants, while in virtual modalities one must be concerned with lighting, sound, and visual contact with each individual. For instance, conducting family therapy with four people becomes challenging in simple logistical terms: how will two adults and two adolescents fit on camera, and does their home environment allow for that close of quarters? With the additional possibility of intense emotional content in session, how will the proximity between participants impact the environment of session? Another consideration is the decreased utility of a clinician's use of body language to indicate the target of their questions, or to use body language to "block" problematic interactions (e.g., moving his or her chair in the room, waving arms). While these non-verbal actions can still be witnessed on the patient-side of the screen, the absence of a physical presence could reduce their effectiveness, especially in heated situations. Additionally, the technology itself may create the interruption. Clinicians who have utilized VTC in any modality are likely familiar with the sudden loss of signal that arises when device batteries have not been charged, or the Internet goes into outage.

An additional complication that arises when conducting couple or family therapy into the home is the potential for blurred boundaries between the day-to-day operations of the household and the therapy session. For example, although meeting via VTC to the home may make it easier

for parents to participate in couple therapy, it may also increase the likelihood of interruptions from children during session. As noted in the discussion of confidentiality, patients may not have adequate space to accommodate complete privacy during session, and clinicians may experience interruptions from family members walking through the room, children crying or seeking parental attention, or other disruptions. Alternatively, distractions may originate from the patients themselves. Past examples have included one half of the couple requesting to continue with session despite their partner cooking breakfast off-screen, though within hearing distance. Additionally, it may be more tempting for non-prescribed absences from session to occur due to the familiar surroundings of home. While a couple may be less likely to present to session in-person if one member declines to attend, there could be a greater likelihood for one partner to attend virtual sessions without the other. However, there may also be greater opportunity for a clinician or partner to coax the absent member to attend if they are elsewhere in the home, with the caveat that it is clinically indicated (i.e., not reinforcing of problematic patterns within the relationship).

Case Example

A scheduled appointment with a couple on their fourth conjoint session began with only the female partner present. Uncertain of the reasons of the male partner's absence, the clinician prompted the partner to explain. She stated he had reported "not feeling it today" and had withdrawn to their bedroom rather than attend session. As part of the assessment process and feedback, the clinician had determined the couple's tendency for mutual withdrawal rather than approach in conflict. As the clinician had already discussed the importance of both member's attendance in the initial session so as to avoid unbalancing the therapeutic relationship, the clinician worked with the partner to ascertain whether she was comfortable approaching the male partner with a request to attend. In this example, the male partner agreed to attend once his partner asked, and time was spent debriefing the preceding events and the interaction that led to his reentry into session. The couple was again reminded of the necessity of both members' attendance, and their ability to disrupt the typical problematic pattern with a new type of interaction (i.e., female partner's willingness to approach instead of avoid) was applauded. Had the male partner continued to decline participation in the session, therapy could not have proceeded any further, and a check-in call to assess for safety and rationale for attendance would have been completed.

Recommendations

Some of the aforementioned difficulties can be addressed with limit setting as part of the informed consent process. It is recommended that the clinician discuss, from the outset of therapy, that participants treat the session as much like an in-person session as possible. This discussion should occur collaboratively and with sensitivity. In the case of the partner cooking breakfast, session one should have included a discussion of the ability of the participants to choose when they begin session, also with a reminder that session will end on time no matter when it began. If this discussion occurred early, a gentle reminder may be all that is necessary when the situation arises. This is similar to patient late arrival in-person; the applicable tenet is that the agreed upon session length (e.g., one hour, half hour, ninety minutes) is the couple's time to maximize should they choose to do so. Conversely, the example of one person declining to attend session may be more clinically nuanced if it is a family of four, for instance. Using clinical judgment, it will be important to determine if continuing session with the remaining members of the family will serve as a chance to shore up other family subsystems, or if it will further alienate the absent member. It is certainly recommended that follow-up with the absent person occur when possible in order to discuss the salient concerns, including safety.

With regard to the logistical concerns, like lighting, space, and noise, the foremost recommendation is flexibility and assertiveness on the part of the clinician. If family members are utilizing a laptop or tablet rather than a desktop to attend session, there may be greater ability to use a different room or setting in the home to assure privacy or accommodate more people. Similarly, it may benefit the clinician to have a discussion in which a family member is strategically assigned the task of ensuring the technology is charged to reduce the chance of signal loss. Additionally, some technology does allow for use of multiple devices, which may be an option if there are multiple family members to accommodate. Clinicians should not hesitate to open a problem-solving discussion in

this situation, as it is crucial that each person be seen on the screen, due to non-verbal cues being essential to assessment of relational dynamics. Clinicians should also collaborate with family members as the need arises to decide on clinician cues, as they may need to be more explicit. For example, clinician use of his or her hands as a "time out" signal could be useful to interrupt problematic interactions or counter loud background noise; this will be more effective if it is defined and discussed with the family proactively so that all participants comprehend its meaning. The clinician is also encouraged to use couple or family member names to explicitly designate a person they wish to answer certain questions. In-person, non-verbal signals like head nods or open palms may be easier to interpret.

Distractions and interruptions should also be addressed collaboratively and assertively, as they arise. If children are present in the home, do schedules allow for session to occur during naptime? Is it possible to enlist a neighbor or other family member to watch the child for an hour during the session? Opening a problem-solving discussion to the participants may allow for a fruitful assessment or skills practice opportunity. For instance, therapy goals around parental boundaries and limit setting can be addressed with in-session coaching on how best to set limits with other family members about the session timeframe. Finally, should the technology create difficulties with sound or background noise, it may be helpful to mute the sound from VTC and utilize speakerphone on both ends. Best practices also include discussion of alternative arrangements should technology fail (Caldwell et al., 2017).

THERAPY PROCESS

While there are many logistical concerns that arise when doing therapy virtually, in general, most therapeutic-specific factors mirror in-person encounters, with some adjustments (Gros et al., 2013). Available research indicates that in the case of many evidenced-based treatments, VTC is non-inferior to in-office care for individuals and groups for a range of disorders (Bakke, Mitchell, Wonderlich, & Erickson, 2001; Bouchard et al., 2004; Carlson et al., 2012; Germain, Machand, Bouchard, Drouin, & Guay, 2009), even in randomized clinical trials (Morland et al., 2011, 2015; Strachan et al., 2012). More specifically, a therapist is generally able to use the techniques of a given protocol or orientation without too many adjustments in VTC-delivered care. However, it would be a major misstep to ignore process elements of completing couple and family therapy via VTC. As already discussed, working with multiple people simultaneously allows for interactional observations, leading to richer data than one might receive in individual therapy. This is an area in which telehealth may hinder clinicians, as subtler interactional cues could be missed (e.g., glances between participants, actions taking place below the field of view). Furthermore, therapies that encourage a deepening or heightening of primary emotions (e.g., Emotion Focused Couple Therapy, Integrative Behavioral Couple Therapy) often require the clinician to notice and create awareness around the presence of vulnerable emotions such as loneliness or abandonment (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000; Johnson & Brubacher, 2016). One way a clinician can identify the presence of these emotions is through cues such as body language, facial expression, or early signals of affect (e.g., eyes filling with tears). These cues could be more difficult to perceive over a screen, especially given any other logistical concerns previously noted such as lighting or distance.

Another consideration is the possible impediment to the process of *joining* with a couple or family. Joining has multiple definitions depending on the orientation of the therapist; it is defined here as the process by which the therapist builds a therapeutic alliance with the family, sometimes through emulation of speech patterns or verbiage (Minuchin, 1974). VTC may not affect verbally based strategies for joining with the family; however, methods dependent on non-verbal communication could be less impactful. For instance, in structural family therapy, physical distance from different participants (including the therapist) can signal temporary alliances designed to impact the family structure (Minuchin, 1974). Therefore, interventions such as moving a chair to be closer to one family member would not translate well to VTC-delivered therapy. Additionally, there is mixed evidence with regard to therapeutic alliance and VTC. Some studies suggest therapeutic alliance could be less robust than in-person encounters (Glueckauf et al., 2002; Greene et al., 2010),; however, ratings of alliance in the latter study were high in both modalities and appeared non-

impactful on study outcomes. Conversely, other studies examining individual or group therapy have not found differences in working alliance scores or group cohesion (Gros et al., 2013; Morland et al., 2011).

It should also be noted some advocates in the field argue that in-home, in-person interventions better serve at-risk families, facilitating quicker assessment and joining (Christensen, 1995; Reiter, 2000). These in-person, home-based visits are counterbalanced by logistical difficulties such as expense, or provider safety and comfort, (Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012). It is unclear whether the benefits of in-home, in-person visits on joining with the family extend to VTC sessions, or if distance therapy would negate the added benefits.

Case Example

A family of four was referred to a family clinic for psychoeducation and intervention around the mother's experience of Posttraumatic Stress Disorder. Due to the distance from the clinic and difficulties scheduling around the two adolescents' school schedules, it was decided that home-based telehealth might be optimal. The provider spoke with the mother to ascertain if the first two sessions, framed as assessment sessions, could be done in-person. This afforded the opportunity for the family and provider to meet one another prior to moving to VTC. This held several benefits including giving the clinician the chance to observe and learn family dynamics (e.g., the cues that can be missed in VTC), allowing the family to become familiar with the clinician's style, and facilitating a joining process that could then translate to virtual sessions. In this case, it was possible for the family to travel to the clinic and spend about an hour and a half completing measures, participating in interactional tasks, and orienting to family therapy. The family voiced their readiness for continued care, and felt comfortable moving to VTC with the provider following the second session.

Recommendations

As illustrated in the previous example, couples, families, and providers may benefit from one or more in-person session if at all possible. There are several possible benefits to this method. One, it could assist with providing the clinician interactional data that is harder to discern through VTC, such as the subtle cues mentioned earlier. Secondly, in-person visits may help counteract impact on therapeutic alliance or the joining process, as evidence regarding VTC's impact on these factors is mixed. Finally, it may increase participants' levels of comfort with the provider, especially if there are hesitancies regarding the technology. It is acknowledged, however, that telehealth via VTC was conceived as a way to prevent burdensome travel and accessibility issues, and that this recommendation may not be feasible in many cases.

Another strategy to offset the problem of missed cues may be to depend more on verbal feedback than may be used in a face-to-face session. Questions such as "what are you feeling?", "what is coming up for you right now?", or "what thoughts are you having?" are likely regularly used in order to understand emotional experiences and cognitions in-person. In VTC, it may behoove the provider to increase his or her frequency of inquiries of this nature. This could reduce the amount the provider and participants rely on non-verbal cues. Balance should be a key goal with this recommendation, as it is still preferable to slow down interactions and allow space for participants to interact differently with one another and with their emotions (Johnson & Brubacher, 2016).

Finally, in line with the research finding that the presence of a provider in-home may facilitate more rapid therapeutic alliance and generalization, in-session practice via VTC may assist in more natural skills practice, as has been suggested in some VTC-delivered parenting interventions (Mogil et al., 2015). More specifically, if couples or families have already practiced a skill in their home in session, it may feel more natural to use again at a later time. This argument would be logical given the construct of context-dependent learning, in which a person's ability to recall and use information is improved when the environment is the same as when it was encoded (i.e., skills learned and practiced in the home environment should be easier to remember and use in the same environment, or context). This is in direct contrast to skills taught during in-office visits; often participants report difficulty implementing these skills in their home environment. This idea is theoretical in nature, and could benefit from further study.

LOGISTICS FOR TREATMENT PLANNING

The final unique area for telehealth with couples and families into the home is not negligible, and represents one of the most common challenges for conducting VTC: logistics to assist with treatment planning. In particular, we will address concerns about the use of measurement-based treatment, connecting with family members across state lines, and the ability to refer patients to other resources when needed.

Self-report measures serve as one component of a multi-modal approach to assessment and treatment. However, due to the geographical difference inherent in therapy using VTC, a clinician cannot simply collect measures when the couple arrives to session. There are several avenues to consider, including mail, e-mail/electronic collection, and in-session collection through verbal or visual means. All of these methods have their benefits and drawbacks. For instance, measures can be mailed to the couple/family with a self-addressed envelope. Family members can then be guaranteed a little more confidentiality than with some of the other methods, as each family member can place their measures in a separate envelope and seal it before sending. However, this method allows for what could be a significant time delay in sending and collecting of measures, as well as a dependence on the couple or family's ability to maintain and return the measures requested. Should the measures be lost in the mail or misplaced within the family, it would take additional time to send another copy.

With regard to e-mail or electronic collections, institutional and federal/state regulations (e.g., Health Insurance Portability and Accountability Act (HIPAA) must be considered. In the VA system, for example, Veterans have access to a program that allows for secure messaging and attachments to those messages. This is an encrypted system, whereas traditional e-mail is not likely to ensure encryption. In VA, however, Veterans would be responsible for uploading the documents, which may also threaten confidentiality for any additional family members, such as his or her partner.

Finally, verbal or visual (i.e., each member of the family holding up their own self-report measures to the screen) collection during the session could be used. This may be the most effective means of confidentially collecting information in real-time for use in the session. However, it could be vulnerable to provider error in coding, and takes time out of session for the provider to notate and score any measures. For any of these methods, without further research, it cannot be guaranteed that reliability and validity integrity would remain intact.

Another logistical consideration that may arise is when a family member who wishes to be included in treatment is located in a different state than the clinician's practice. As noted earlier, one of the unique benefits of telehealth is that it can connect family members at a distance who may benefit from family therapy (e.g., long-distance romantic relationships). However, the provider must consider the ethical and legal implications of practicing across state lines.

Lastly, difficulties arise in ensuring appropriate referral sources for telehealth couples and families. It is not uncommon for a couple or family therapist to recommend individual treatment when the needs of the individual cannot adequately be address in couple therapy. Likewise, new information may arise during assessment or treatment that leads the clinician to determine that couple/family therapy or VTC is contraindicated. The challenge specific to telehealth is that the clinician may be unfamiliar with resources near the patient's location or there may be a dearth of choices for the family and their mental health needs. Particularly in rural communities, mental health provider shortages are well documented, (Jameson & Blank, 2007) and are just one reason telehealth is so essential to provide access. When a couple or family is in dire need of assistance, and their circumstances change or represent a contraindication for work in this modality, providers often feel helpless to connect with appropriate resources.

Case Example

A couple was scheduled with a clinician for an initial evaluation session in 2 weeks. Following confirmation of the appointment via phone, the clinician sent the couple two copies of an intake packet, including separate envelopes for each packet, and a self-addressed envelope for the return of everything. The clinician asked the couple to fill out the packets as soon as possible and mail them back in preparation for the first session. The couple did this, and the clinician noted there

were no endorsements of IPV for either member. In the initial appointment, the couple was again explicitly asked about any history of violence, which was denied; similarly it was denied in individual interviews. When the assessment phase was complete, the couple was asked to track their satisfaction levels and any occurrence of destructive events on a weekly questionnaire. Because this self-report is brief (5 items), sessions began with each member of the couple verbally reciting the scores from the measure and discussing any changes that occurred from week to week.

Recommendations

It is recommended that if the couple/family cannot attend a first session in-person, that initial measures be sent via mail. Subsequent assessment, however, may be subject to clinical judgment about couples based on their history and presentation. In the case example, the couple was repeatedly assessed for safety concerns prior to deciding how to collect measures. It was their repeated denials around this area of concern, and their openness to discussing their satisfaction levels that led to verbal collection, which may represent the least confidential of the options. Alternatively, maximum confidentiality may be obtained from mail, though with the trade-off of time and additional effort. Couples in which the dynamics of power and control appear salient may result in clinician use of mail in order to protect the confidentiality of both members. It is also recommended that visual collection, where each member of the couple holds their answers to the screen, or verbal collection utilizing headphones be used as a standby in these cases should mail prove inefficient. As indicated previously, electronic means are subject to institutional and national regulations, but may represent a future method as encryption software becomes more widely available. Each clinician must develop his or her own system in an effort to streamline multimodal assessment at a distance.

When it comes to including family members that are located out of state in a therapy session, as noted in the AAMFT guidelines, it is imperative that the clinician is aware of state licensing and applicable mental health laws for the location of everyone who would be present on the video conference (Caldwell et al., 2017). The clinician would be wise to also consult his or her own licensing board to determine the legality of practicing with an out-of-state individual. As may add an administrative burden for the clinician, some may decide that it is not practically feasible to offer to include out-of-state family members.

With regard to the concern about referring individuals or families for concurrent or postfamily therapy, it is recommended that clinicians seek connection with any providers in the local area of the patients, regardless of discipline. This connection may assist with forming a network. While some providers may be more forthcoming or available to assist telemental health clinicians than others, it is worthwhile to gather information about resources in order to best serve the needs of the family. Particularly in rural areas, a clinician may need to be creative about what referrals will work and for whom. For instance, while individual psychotherapy may not be available widely without insurance, some organizations are more likely to have support groups that can be beneficial and provide at least some level of support until other arrangements can be made. Internet searches for resources can yield an impressive number of results. In service of building a network and for good customer service, an e-mail or phone call to confirm the availability of certain services may help to avoid providing the family with additional roadblocks to assistance.

FUTURE DIRECTIONS

This article is meant to spark further discussion about the unique concerns regarding the use of in-home VTC for services with couple and families. While some small trials and case examples form the basis of the extant literature, there are several areas unexplored outside of individual or team-based procedures. However, a dialogue can be considered a step forward, with hope that these initial recommendations will assist with problem-solving for clinicians, as well as helping to identify future directions of empirical study. The more narrow scope of this article was chosen based on the additional considerations of couple/family therapy in comparison to individual or group therapy, and the additive complexities of completing therapy in a person's home. In addition, while other technologies exist to conduct psychotherapy online, VTC in particular was chosen due to its burgeoning use in systems such as Veteran Affairs. That said, some of the considerations and recommendations noted here may be generalizable to other forms of online therapy.

A fundamental area for future study is in attrition and engagement with family services via VTC. Does this modality do as it is designed, and overcome barriers associated with couple and family care? Individual and group modalities appear to have attrition comparable to in-person visits (Greene et al., 2010) in addition to lower cost (Morland et al., 2015) for clinics, but differences between session attendance via VTC and in-person therapy for couples and families should be examined.

With regard to confidentiality and safety, many of the recommendations in this article center on proactive discussions with families regarding emergency situations, informed consent, and alternatives, similarly to the report on best practices (Caldwell et al., 2017). It is hoped that providers adhering to best practices will experience more comfort using the modality. However, additional evidence that couple/family therapy via VTC is safe, effective, and cost-reducing, similar to the evidence suggesting positive outcomes with individuals and groups (Backhaus et al., 2012; Hilty et al., 2013), may facilitate more widespread use. Thus, research is needed to assess both safety and therapeutic outcomes.

Finally, as a logical extension to the discussion about joining, it would be worthwhile to determine if there are identifiable differences in rapport, or working alliance with couples or families and their providers (e.g., is the joining process made more difficult because of the virtual nature of the interaction). Future research should examine these factors to clarify the relationship between the joining process and the use of VTC for couple/family therapy into the home.

As these suggestions are just a few of an array of remaining inquiries, one final recommendation may be made. Many couple and family providers are blazing these trails alone or with the benefit of only a few team members. As technology continues to evolve and integrate further into families' daily interactions, clinicians will benefit from any "lessons learned," both in conceptualizing the impact of inclusion of technology on relationships, as well as conducting therapy through the modality of VTC (Hertlein & Blumer, 2014). One additional possibility is that a structure in which providers conducting this kind of work can share their insights, lessons learned, and queries with one another could assist in bridging the knowledge gap. It is foreseeable that a connected network of professionals can help one another problem solve, while also pinpointing other important aspects about the modality not considered here.

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