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Teletherapy, the Pandemic, and the Future of Therapy: Reflections from the Editors of the NEJRSP

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David Haddad: There was a series of questions that we had agreed to address, so I thought I'd just read those and then we can open it up to conversation. What are some of the potential challenges with going back to work in person? And on the flip side of that, what are some of the potential opportunities of going back to work in person? What are the components of the therapeutic process that were explored, that we explored during the pandemic, that you want to keep post-vaccination? And what protocols would you like to put in place to determine whether a family should be seen online or in person? So those are four relatively different questions but we can begin anywhere there and see where we end up.

Frank Gomez: One of the things that I was surprised by when this whole thing started was the level of engagement some clients had over telehealth. It was sort of an anxiety-provoking thought that we were to just do that. But at the same time, I can see how that shift back to doing in person can, at least for me, bring up certain things. Like I haven't done a lot of in-person sessions and I'm wondering if that's a thought that is coming up for other people—the sort of anxiety of a second learning curve, as one of the clinicians in the program that I'm from mentioned.

Jackie Gagliardi: I think for me one of the benefits have been that I have seen clients that I ordinarily wouldn't see because of distance. So I feel that has been definitely a good thing. So I've enjoyed seeing clients that I wouldn't necessarily have seen before.

Beverly Ibeh: I feel as though, when working with the family systems, there have been so many advantages of having this tele platform because you get to have an inside look into what is going on behind the scenes with clients you're working with on an ongoing basis, versus inviting the

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family to come for a family session or trying to get a collateral meeting. You have an opportunity to see what the dynamic is in the family and what's being enacted, so you can almost intervene right in those immediate moments. So I think that is something that could be greatly reduced going back to in-person because now we have a format of more individualized services and really being intentional about including the family, whereas via tele we've had kind of an open door to the family system.

David Haddad: I want to go back to what Frank was talking about earlier about how do we determine which families are seen in person and which are not. When I think about the wrap-around services and home-based services is that these are families that we're seeing that are the most at-risk, and so, how do we determine whether they need to be seen face-to-face, because there's some therapeutic benefit or not. Maybe there are protocols that will emerge from that, and maybe that's something we should be asking our membership about because a lot of the folks that are in the organization are part of community mental health, so it just seems like a really interesting question. I don't know what the answer is.

Jeremiah Gibson: Well, right because I think that it's so easy for us to define what we should do based on convenience and I think that that's one of the biggest challenges of going back to in-person work: convenience both to the therapist—I think I've worn real pants to work a dozen times in the last year, and I've seldom had to leave my home—and with clients as well. Like couples for instance with small children: they don't have to find childcare to do sessions. Clients can have intimate, intense conversations from the comfort of their own home. I think one of the challenges is that this capitalist system that therapy exists in has this implicit assumption that convenience is equated to effectiveness. And it's not, obviously. Therapy encourages folks to find change in the counter-intuitive, which takes a ton of work to do. And our own field has also participated in its version of capitalism through the creation of short-term "evidence-based" treatment models and the expansion of psychopharmacology in the last forty years. I think one of the biggest challenges for us is convincing folks that convenience and effectiveness are not the same thing; that at times they're even diametrically opposed. That's a really tough sell in 2021. So I think part of our work in the next six months to twelve months is redefining again: what is the process of therapy?

David Haddad: Right, that's a great question.

Stephen Duclos: I think there's a lot of logistical benefits to telehealth. But I think that there's some problems. You know I think that sometimes small children are getting left out of it. I think that we have some problems with presence and joining with clients—especially clients we've never seen other than on this media. So I think there's logistical stuff that's helpful. But I have a lot of worries, because I don't think it's going back to where we were before. I have worries about not

being present with families. I think that sometimes we're going to have to see families in person. I think the idea of going strictly to a telehealth thing is not going to really work.

Frank Gomez: It's going to be a learning curve. We're doing wellness checks for some of our high-risk cases and one of the things that I've found in my experience is a self-awareness that I did not have as much before when I'm in those in-person sessions. And I think it's going to be time, but for sure there's going to be that moment where we haven't done this in a little bit and it's been all through Zoom...or telehealth. And at the beginning when we were doing telehealth, it was sort of an odd experience and now that is sort of what it is. And I think that there needs to be. I think that we need to account for that shift because it's going to I think kick us in the butt when it takes place fully. So like really taking into account that that shift that is already taking place—and I think some people are being surprised by the shift.

Jeremiah Gibson: Frank, I think you're in a unique position working at the Justice Resource Institute working in an agency and working with people who are new to the field who haven't done face-to-face therapy before. I'm curious how JRI and what you're also hearing other agencies talk about the transition from doing telehealth to face-to-face therapy. What are some of the specific tips and starting places that these agencies are giving to new therapists?

Frank Gomez: Well, I myself have new clinicians that started through doing telehealth. And that in itself was challenging just to maintain a level of normalcy in the training itself and the supervisions and all that. But I think that, in this shift, which is why I keep talking about the second learning curve, they are feeling like they're going to learn again what it is to do outreach work...doing it in person. And sometimes those conversations could be just about how they're presence, what's their presence in the room? That's one layer. The other layer is there's risk in not being able to see someone in person, especially in my team who deals with early psychosis. So there's a lot of guidance around what that looks like and how often should we see a person who might be at-risk in these sort of difficult times.

David Haddad: So based on what you're saying, Frank, I would just think, going back to what protocols I'd like to see. I'd like to see the therapist be able to kind of make a judgment about what's the relative balance between seeing people face-to-face or in person. And then the other point that was sort of coming up earlier was there used to be this conversation many years ago about the clients have to have this kind of skin in the game to kind of benefit. So the idea of driving—I'm not suggesting this happens—but the idea of driving your family to therapy, putting the kids in the car, getting them to the office and having this conversation, it's sort of like we're going to make this work because I'm not going to do this forever. And I think there's some benefit, there's something about that that seems important. I'm sure we can do that online but it seems to me it requires the intention that you're kind of referring to, Frank. So we have to be thoughtful about this.

Stephen Duclos: Yeah, I've been thinking about that a lot in the last year. This is not the same; we're going to have to change how we're doing things. And one of the thoughts I had was that we have to be much more intentional in telehealth than in-person therapy. And at first I wasn't quite sure what that meant. Like, how do you be more intentional? Because, of course, the other thing that happened in the last year is that the demands on our time leaped. So everyone has a waiting list. So if you're working with people who aren't really making much change, you have to start gauging whether and how much more you can do with people if they're not willing to change because of the demands of other people wanting services. So in response, I started becoming way more intentional about what we were going to do and what we were not going to do, and sort of shifting the responsibilities much more so on the clients.

David Haddad: Is that a conversation you had with the clients up front?

Stephen Duclos: Yeah. I started doing it around July. I started having sessions in which: "Look, there's a lot of demands on our time. Let's set up some clear goals for therapy. Let's put some markers in to see how well we're doing." And so we were constantly putting in milestone markers and "what are we going to look for in terms of change, what does change mean for you?" So change became more a part of the conversation. And people weren't changing, that was a conversation too about what was the problem. I think that the intentionality around the structural intentionality of David's idea of bringing all the kids into therapy—you know, we have to do something with the telehealth part to make that much more leveraged in a way so people feel much more responsible about the process. And I have to say that it really helps. And therapy became much briefer and the turnover of cases became much greater in this last year than I've ever experienced before. And I think it's about the idea that, you know: "Ok, if we're going to do this, we're going to do it." Then there's a discussion about why things aren't changing or why they're changing. And also the articulated end-goal is really good and necessary because you have a lot of people waiting to see us in a way that's never happened before. We just don't have the resources, so we have to sort of make some shifts in order to serve a wider population.

Jeremiah Gibson: As you're talking, Stephen, I'm thinking about Prochaska's Stages of Change and potentially using that more overtly as a pathway or as a process to determine where clients are —just as an example of some resources we could use to develop some protocols.

David Haddad: It's much more collaborative too, isn't it?

Frank Gomez: I was going to say the same thing.

Stephen Duclos: I think the other thing is that you can start to shift how often you see people based on how well they're doing. Then this opens up space and time for us to have more people.

Beverly Ibeh: I was just going to add to that, in terms of the protocols, but I want to make sure you have a chance to finish your point. I was just thinking in terms of to what your point is about logistics verus case-conceptualization, actually thinking about what are some of the unique needs of the clients and families that we work with. And so, in thinking about this idea of what protocols to put in place to determine whether a family should be seen online or in-person, the first thing that comes to my mind is high-risk, high-stress—these are clients I would really want to come into the office, I would to be leaving their environment, taking some kind of space and respite from the environment that's potentially triggering a lot of the presentation. So really having an idea of risk, clinical conceptualization, even—if we're thinking about from different theoretical standpoints like families that are so enmeshed and have a lot of difficulty really differentiating or giving themselves privacy. You know, there are so many factors that come into place that can really disrupt the therapeutic relationship. So I would be really thinking about those pieces too.

Frank Gomez: Absolutely.

Jackie Gagliardi: I just want to go back to something that Frank had talked about. I surveyed my students—these are my first-year students who have done their practicum online, they've never seen their clients in person, most of them—and they're very comfortable with where they're at and they're not too excited about seeing people in person. And I thought it was just an interesting contrast where, for us, having to switch to online was not as comfortable, and it was very strange and not familiar, and how for them, this is a familiar media and being in person is not. I just thought it was fascinating when I surveyed them and most of them are really comfortable with where they're at and not necessarily excited about seeing people in person.

David Haddad: It just makes me think based on what you're saying that one of the potential opportunities here is that in some ways, comfort gets us into a kind of a position where we're not looking for something different, but the idea that we don't really know, to take a position where we really have to be curious and open to seeing what's the evidence here or what criteria we're using to make that judgment. That's one of the things I find with many students in terms of treatment planning: they can identify what does treatment planning look like, going back to what Stephen was saying—really clear goals that are measurable—and we're not trying to sort of fix everything; we're trying to get the train back on the track here in some ways so families can kind of move on and do what they need to do.

Beverly Ibeh: I'm thinking about, too, the psychological toll of isolation on a lot of trainees and clinicians, and what that's going to look like going back. I mean, to your point about comfort, Jackie, and thinking about people who don't want to go back, I wonder how much of that is the psychological toll of being isolated for some long time and then having to reintegrate back into society. We think about when people have been extracted from society in the system and what that's like to reenter. So I do wonder about the parallel process of both clinicians and clients of that fear, anxiety, and all of those other experiences.

Jeremiah Gibson: Frank, that's why I asked you about how are you noticing that agencies are talking about this, because I think that, Jackie, to your question, agencies are going to take the lead in establishing criteria and protocol for how to get new therapists more comfortable with face-to-face therapy. And if I'm honest, that makes me a bit anxious, because agencies don't have a great track record of making policy decisions that are about the development of a therapist.

Frank Gomez: So I will say this: I agree to that to a certain extent. I think that there is a demand for guidance because we want to catch everyone that is starting in the field and that needs support in knowing what to do in certain situations. What we find is that there's so many variables, including the family's needs, or even in the clinician's needs in providing services. There needs to be...and this is why I love that, David, you said that it's a collaborative process because it really is. And if we are trying to catch the sort of anxieties or problem-solving early before we are...and we are already there; we are doing in-person visits for agencies that continue to do work in telehealth. But I think that it needs to be a collaborative process where you're talking with the families and seeing what will work for them and come from a vulnerable position as a clinician—because everyone is going through the same thing—and talk about what are some of the challenges with providing services a certain way or another. And I love this idea of providing space for families to come to an office outside of that maybe system. I also want to highlight too that sometimes we can't do that. Especially the ones that are engaged in community-based services. We're talking about multi-stress families that maybe can't afford a bus ride.

Jeremiah Gibson: I'm really glad you brought that last point up, Frank, because I think that privilege is an undiscussed factor in this conversation and I want to make sure that we recognize that telehealth is also useful for folks that, like you were saying, don't have the money to get on the bus or don't have consistent transportation access to get from their house to a client.

David Haddad: I want to sort of highlight that not only is it a question of privilege, but it's also a reflection of what reimbursement rates the agencies get. Being someone who ran and was directing an agency, they get paid so little; it's a reflection of how much we value our work in our country. So in some ways it's like organizations are advocating for increasing just the basic rates for paying people to work with the most vulnerable of our population. It's in some ways appalling.

Jackie Gagliardi: Something came to mind as we were talking about this. I wonder, during the pandemic, how many people who don't have computers, who don't have that privilege, ending up not getting the services that they needed more than other people.

Stephen Duclos: With aging people in particular, one of the things that we were finding, just in my own community, is that one of the first questions that are asked when you go to get a vaccination is: what's your email? Now in my community there are home-bound people, there are people who are quite old in their 80s and 90s who are still living independently, and they don't have a computer and they don't have an email. So now what? My wife's been going around finding

people who are home-bound and making sure they get vaccinated because, well, how do you get vaccinated? You have to go online. You can make a phone call, but sometimes that's not terribly useful either, and of course, you have to find the phone call by going online and finding the phone number. So I think that there's a whole aging population as well that has a problem with the use of computers. One other thing: I read Ishiguro's novel Klara and the Sun recently about a artificial friend who's narrating…

David Haddad: Oh yeah, I saw that reviewed.

Stephen Duclos: And I kept thinking...the artificial friend was programmed to observe and be empathic. And I was thinking that the artificial friend is sort of like what we're doing now. We're kind of online, we"re being empathic. Now, I don't necessarily want us to be thought of as an artificial friend. I think that being in person kind of breaks that down a bit. And so I think there's lots of technological stuff going on here that have been hidden for a long time that are coming to the fore. I think insurance companies would love the idea of us doing telehealth because they could make more productivity demands, and then we become like Ishiguro's artificial friend. And we don't get to sort of direct things in another way.

David Haddad: I actually read this study—just to highlight, Stephen, what you're saying—about where working with elders in a community, they put these dogs—it was clearly a robotic dog—and every morning, when the client woke up they go to the dog and the dog would open his eyes and say, "How are you this morning?" And would ask a series of questions. And even though the person knew this was artificial they responded, and they said openly that they felt better just being able to have someone respond.

Stephen Duclos: Well, I don't want to be an artificial dog, and I don't really like dogs and I like real people, and this technology has logistical power to it.

David Haddad: Maybe it's connected though, as you're saying, though, that we're artificial but there's something that triggers people to get back into the office; there's something that we recognize as a key or a clue that requires a face-to-face of some kind—some protocol that emerges from that.

Stephen Duclos: I don't think we know what that is yet.

David Haddad: I agree.

Stephen Duclos: I think we have pre-COVID psychotherapy, we have COVID psychotherapy, and we have post-COVID psychotherapy. And I think we've kind of figured out a lot of the logistics and some of the possibilities of telehealth, but I don't think we've really figured out how to sort of meld the telehealth and the in-person therapy in a post-COVID...whatever that is.

David Haddad: Good point.

Stephen Duclos: And I don't think there's any way of knowing that until we actually do it.

Frank Gomez: It's approaching.

Beverly Ibeh: I'm excited to go back to the process of having a container, an emotional container, for a lot of kids. I've had the experience of working with kid clients in which they can just easily turn away from tele. Or, you know, they're staring at their show and I'm like, "It's like I'm not even here. Are we doing therapy?" And it's just a lot easier for them to just run off and not be so engaged, or flick the camera up like we talked about last time. Or adolescent clients that are more resistant. So I do think going back in person and having that structure and containment in a room with a clinician on a weekly basis provides that emotional safety to be vulnerable and to really dive into the benefits of therapy, as opposed to just turning on your computer 'cause mom said so.

Jeremiah Gibson: Well, and Bev, I was also thinking about something you said earlier regarding some of the criteria you were talking about: the family structure and the enmeshment, the "fusedness" of a family. I'm also thinking about this in terms of the intersection of professional work on top of the administrative work, the childrearing, and the general politics that come into that. Boundaries have gotten really blurred, and when people have a designated space and time to explore themselves and the dynamic of their relationship that's separate from work, separate from the administrative tasks at home, they can—at least in theory—engage in a therapeutic and self-explorative process in different and deeper ways, and can also be more intentional about transitioning in and out of the therapeutic space. I'd love to read research, or to have someone do research that talks with clients about how they notice that they're able to engage in the therapeutic process differently in teletherapy versus in live spaces. And it'll be interesting to do that research post-COVID. So any PhD students who are reading students, you're welcome: I just gave you your dissertation.

Jackie Gagliardi: So there's always guidelines: the insurance company has guidelines, the DSM...but we really don't have guidelines for when it might be beneficial for telehealth and when it might be beneficial to see people in person. And I'm just wondering: who makes those guidelines?

Stephen Duclos: We do.

Jackie Gagliardi: One of the things I was thinking about is actually to do a survey and reach out to people and ask: what kind of guidelines do you think we, you know, might create? And just look at them because there are no guidelines.

David Haddad: Well, I was saying that tongue-in-cheek. I think the guidelines emerge from kind of a financial policy. So if you didn't need insurance, or before there was insurance, you just saw the clients—and if there was the capacity to see them online then you would do it because you make the decisions.

Jackie Gagliardi: But now most insurance companies are fine with telehealth so that's not so much an issue as it was pre-COVID. But I just think it's interesting...I was just thinking, like: "Who would make the guidelines, you know? You would create them?"

David Haddad: Well, it would emerge from the research. That's the way science works. Someone will do a study, and then that will become policy, and then that policy will be in place until something new comes along that says, "No, we shouldn't do that."

Jackie Gagliardi: Ok, but say we don't want to do the research or by the time the research is done—you know, especially if it's a longer study—it'll be a year, two years. One of the things with this journal that we're trying to create is the voice of the readers. So I'm just wondering how the readers would respond? What would they see as some guidelines?

David Haddad: Ken Gergen talks about future-forming research, research that's guided for what you want, what you're looking for, versus research that looks back. So maybe we're doing some future-forming research. I'm realizing our time is about up for what we had marked for this, if we wanted to have some sort of kind of closing for this. I feel like we could've gone on like this for a long time. I can't imagine our colleagues would find an opportunity to talk about policy or pedagogy. Equally kind of engaging.

Stephen Duclos: I think we need to invite our readers to think about the future of psychotherapy and create it—not necessarily based on research that might have...but based on what's going on with them.

Jackie Gagliardi: Right, and their experiences and their wisdom.

Frank Gomez: I would second that. There's an energy to family therapy that right now, it's sort of in a weird place—at least for me as a practitioner. I think even in this conversation there's a lot of energy that's coming up in what we're talking about, and I think that it's something that's across the board for people that are engaging in therapy, on both sides.

Jeremiah Gibson: And I really like the way that we moved our conversation from what the potential concerns are to these are potential questions we need to be asking. And Jackie, you're right: doing the research is going to take a lot of work, and I hope there are folks who are reading this—be they dissertation/PhD students, be they other therapists who are willing to take on the mantle.