Supervision is a core foundation within the field of marriage and family therapy (MFT)/couple and family therapy (CFT) because it guides the personal and professional development of therapists-in-training. Traditionally, case supervision and self-of-the-therapist work has been engaged through in-person individual or group supervision on a campus or at a placement site. A review of training programmes, accredited within the United States by the Commission on
Accreditation for Marriage and Family Therapy Education (COAMFTE), reveals that the majority of programmes are still campus based, with a small percentage of programmes now offered online or in a hybrid format (COAMFTE, 2021). Family therapists have lagged behind other mental health professions in their utilisation of teletherapy and telesupervision (Pickens et al., 2020; Sahebi, 2020; Watters & Northey Jr, 2020). However, for most in-person masters and doctoral CFT programmes, the coronavirus disease 2019 (COVID-19) pandemic necessitated a shift from both in-person therapy and supervision to teletherapy and telesupervision in response to social distancing and shelter-in-place orders. Specifically, the shelter-in-place order in the United States required that, unless deemed essential personnel, citizens were to remain at home and leave only to complete tasks outside of their residence necessary to sustain life and health. This rapid pivot was important to maintain continuity for both clients and supervisees alike during COVID-19 (Simms et al., 2021; Tarlow et al., 2020). It is likely that many CFT programme faculty had difficulty transitioning to these modalities owing to a lack of experience with virtual formats. Managing issues of informed consent, confidentiality, documentation, supervisory alliance, technology, professionalism and all other related procedures requires significant modifications in operating processes when providing virtual therapy and supervision. While the pandemic will eventually diminish, it is presumed that the use of teletherapy and telesupervision will only increase moving forward. This will allow clinical training programmes to reach clients who may not have otherwise been able to access their services, which may be particularly important for disadvantaged and/or low-resourced communities (Augusterfer et al., 2020). It will also expand opportunities for clinical supervisors to provide telesupervision to clinicians working in remote and/or potentially international settings. Goodyear and Rousmaniere (2019) asserted that it will not be long before clinical supervision in various settings is influenced by technology in some form. Consequently, it is important to discuss the benefits, challenges, ethics, repercussions for self-of-the-therapist work and implications for how telesupervision is conducted.

**TELESUPERVISION**

The onset of the pandemic caused universities across the world to shut down and pivot to online education quickly. Digital knowledge and skill sets varied widely among faculty and students, creating a sizeable learning curve for many and increased anxiety in the ability to adequately teach and/or learn effectively in this new modality (Sherbersky et al., 2021). Additionally, university programmes with mental health training ceased in-person therapy and shifted to teletherapy and telesupervision.

**Practitioner points**

- Establishing effective telesupervision requires increased intentionality on part of the supervisor. Authenticity and transparency become more critical in establishing connections and trust with supervisees in an online format.
- Supervisors should collaborate with supervisees to establish processes for the times technology-related problems occur.
- Supervisors must also understand the unique ethical issues that are presented with providing supervision through an online format.
Accredited programmes require a certain number of supervision hours to be based on raw data. Raw data, defined as audio, video or live supervision, is an important part of enhancing CFT supervisee competence. One of the advantages of raw data is that supervisors can provide feedback and suggestions based on observable therapist–client interactions. Raw data collected through asynchronous formats such as video or audio review allow one to watch and re-watch sections of a session, providing the supervisee increased opportunity for self-observation and self-reflection (Topor et al., 2017) while allowing the supervisor to attend to particular behaviours, skills and interactions that occurred during a session. Synchronous formats would include video conferencing programmes (e.g., Zoom) where supervisors and supervisees are interacting in real time (Montalvo, 1973; Nadan et al., 2020). Live supervision is an integral intervention for supervisee development because they get immediate feedback and can implement interventions in real time. Traditionally, feedback in live supervision takes place through a knock on the door, midsession break or a phone call to the therapist in the room, whereas now, live telesupervision occurs via videoconferencing technology.

Nadan et al. (2020) described live supervision of teletherapy sessions with the therapist and the clients being visible and audible to one another, while the supervisor and any other supervisees watching are muted with no video but are able to hear and see the therapist working with a client. They suggested there are three primary ways in which supervisors can intervene during live videoconferencing supervision. First, the supervisor is able to talk or text the supervisee during the session to provide interventions and feedback to the therapist. Second, they can ‘enter’ the therapy room by activating their camera and microphone, enabling them to talk directly to the therapist as well as the client(s). Third, the supervisor may choose to have the camera and microphone on during the entirety of the session (Nadan et al., 2020). Most videoconferencing platforms also provide a feature called ‘breakout rooms’ where the therapist, supervisor and other supervisees can sequester themselves away from the client to deliberate about the case. A breakout room is analogous to a knock on the door or a midsession break in traditional live supervision formats. Generally, live supervision sessions have individual or group discussion prior to the session regarding case conceptualisation, any pertinent self-of-the-therapist (Aponte & Kissil, 2014; Simon, 2006) concerns (which are defined and discussed in a later section), identification of what the supervisee needs from the supervision group and conversations regarding interventions. Following a live supervision session, there is a debriefing time where the supervisee and supervisor review the session and discuss the case moving forward. Telesupervision offers a different way to go about this process, but the process in and of itself remains unchanged (Nadan et al., 2020; Sahebi, 2020).

Telesupervision assumes technological competence on the part of the therapist, client and supervisor, and lack of competence can create anxiety in teletherapy and telesupervision. Additionally, internet connections issues due to low bandwidth or bad weather, limitations to internet access or lack of knowledge about or openness to telesupervision can make telesupervision more challenging (Augusterfer et al., 2020). Regarding live supervision specifically, other members of the supervision team are unable to engage in ‘sideways talk’, where they can whisper to one another during the session (Nadan et al., 2020). Although having a group text chain (e.g., WhatsApp) can mitigate some of this, trainees will likely be more selective on what they discuss in the text chain, not to mention that there is a delayed response and it is much more cumbersome to type ideas compared with talking with someone else. Additionally, it can be difficult to assess group dynamics within the supervision team (Nadan et al., 2020).

Although telesupervision has been available for over a decade, many training clinic supervisors resisted this format prior to the COVID-19 pandemic (Sahebi, 2020; Watters & Northey
One reason for hesitance to use telesupervision in training programmes is the potential impact on the supervisory alliance and self-of-the-therapist work.

SUPERVISORY WORKING ALLIANCE

Supervisory working alliances, as defined by Bordin (1983), are relationships built on mutual understanding with goals, tasks and strong emotional bonds between supervisors and their supervisees. Relational therapists typically value in-person supervisory processes, which are an extension of their own clinical training, to achieve this alliance and question if supervisors and supervisees can effectively connect when not in physical proximity with one other (Watters & Northey Jr, 2020). Indeed, a study by Hertlein et al. (2014) found that the majority of relational therapists are reluctant to providing online therapy owing to impact on the therapeutic alliance, a similar construct to the supervisory alliance. Additionally, many supervisors may be digital immigrants born before the widespread use of technology and are less digitally fluent than digital natives, possibly contributing to some of the resistance (Watters & Northey Jr, 2020).

Digital immigrant or not, supervisors are tasked with understanding the process of teletherapy as well as telesupervision. Supervisors must understand policies and procedures for online services as well as be prepared to manage technological issues that arise. However, since telesupervision is relatively new, digital competencies are only recently beginning to emerge, but the focus is on clinical practice rather than supervision (Pote et al., n.d.). While the British Psychological Society has published guidance for clinical supervisors to adapt to digital services (2020), as Sherbersky et al. (2021) note, there are no clear guidelines identifying what digital competencies are needed by supervisors to provide appropriate training of students to work in teletherapy. They further suggest competency guidelines are particularly salient for relational therapists, who must develop complex communication skills to effectively work with multiple clients in the room. This is also true for supervisors working with multiple supervisees in the room. The supervisor’s knowledge and confidence in this area will influence the supervisory alliance, as he or she is able to instil confidence in their supervisees (Sherbersky et al., 2021).

Nadan et al. (2020) reported their experiences utilising Zoom for telesupervision at their training clinic in Israel. Owing to the social distancing guidelines implemented in Israel, all supervision and clinical sessions were moved to a virtual format for fourteen supervisors working with twenty-eight supervisees and their clients. Supervisors reported their perception that the supervisory relationship was unchanged by the pivot to telesupervision. Supervisees reported that the safety they felt in supervision remained intact through the transition, and some noted that they felt more secure and less vulnerable receiving supervision online as opposed to being seated face to face with their supervisor. The authors noted that group supervision was also used successfully via Zoom, and supervisors and supervisees alike reported feeling safe and that the new format actually enhanced the group discussions (Nadan et al., 2020). Tarlow et al. (2020) transitioned three doctoral students from in-person supervision to telesupervision and found no differences in supervision satisfaction or supervisory alliance. In a content analysis on the effectiveness of telesupervision, Inman et al. (2019a) found three consistent variables: the effectiveness of supervision, therapist development and the supervisory relationship. Analysis of these studies suggests that telesupervision is at least as effective as in-person supervision and that supervisors and supervisees are able to establish a strong working alliance (Inman et al., 2019a). However, almost all studies utilised a hybrid model where supervisors and supervisees met in-person at some point.
in the supervisory process. In fact, most authors recommended that supervisors and supervisees meet in-person prior to videoconferencing.

The self-of-the-therapist

A component of the supervisory working alliance that has not been examined is the impact of telesupervision on self-of-the-therapist work. Self-of-the-therapist is defined as ‘who the therapist is, their personal characteristics, and the role they play in the delivery of therapy’ (Niño et al., 2015, p. 163). Historically, many CFT training programmes integrate some form of the self-of-the-therapist or personal growth work into their training and/or supervision of clinicians (Simon, 2006). This work generally entails part, or all, of the following: family-of-origin exploration; personal growth/self-of-the-therapist-focused supervision; self-reflection; exploration of beliefs, values and cultural biases; and personal therapy (Aponte & Kissil, 2014; Aponte et al., 2009; Mason et al., 2002; Simon, 2006; von Haenisch, 2011). Self-of-therapist training, therefore, helps the therapist-in-training to connect the self, and to understand the personal aspect of the therapeutic relationship, with the profession.

The goal of personal growth training is to develop more authentic and effective therapists (Aponte & Carol Carlsen, 2009; Aponte & Kissil, 2014; Simon, 2006). Personal growth requires supervisees to be introspective and self-reflective; increase awareness of their thoughts, emotions, behaviours and psychological responses; work through their personal issues; and develop a therapeutic presence (Gehart, 2017; Simms et al., 2021), and requires trust and safety. Small-group and individual supervision is the mechanisms for creating a safe space for this work. Experiential activities have the power to reduce resistance, enhance insight and help clients and supervisees alike to work through unresolved pain and family-of-origin issues (Moreno, 1972). How well the experiential process of self-of-the-therapist work can be adapted to a virtual format remains to be seen, and guiding supervisees through this personal growth process will require creative and adaptive supervision methods (Sahebi, 2020).

Many experiential activities take place during in-person group supervision and utilise relational space and physical positions to engage in the process. For example, family sculptures (Constantine, 1978) are designed to allow participants to create visual, symbolic representations of the internal conceptualisations of relationship maps they have with important family members. A variation on the sculptures described by Constantine (1978) is used with supervisees in the master’s programme where the authors teach. Students are instructed to use furnishings (chairs, lamps, small tables) in the clinic to represent self and family members and are to arrange the furnishings in relation to one another according to his or her view of the family, and to the relationship family members have with one another. While each student starts in one room of the clinic, they may place furnishings anywhere in the clinic. Students will often use children’s chairs to represent family members they perceive have little power. Two chairs placed very closed together may represent enmeshment. A chair placed outside of the room may represent a cut-off family member.

Once completed, students move around their arrangements and make any needed adjustments until it feels right. After all students have finalised their sculptures, the facilitators give each student time to process his or her sculpture with the supervision group. Questions are posed that help each student consider what changes he or she would like to occur and are then encouraged to move the furnishings around to reflect those changes. Each student reflects on how his or her relationships may change because of insights gained through this process. Insights are
gained not only from one's own sculpture but also in experiencing one another's sculptures. This very powerful activity relies on safety, openness, transparency and support from fellow students and faculty.

Individual-based self-of-the-therapist interventions may be more adaptable to telesupervision. One intervention, based on the Internal Family Systems model, is the room technique (Schwartz & Sweezy, 2019). When a supervisee is experiencing countertransference with a client, the room technique can be an effective way to mitigate reactivity. To use the room technique, the supervisor guides the trainee to, in their imagination, place the client in a room with a one-way mirror where the trainee is outside the room and looking at the client through the mirror. The supervisor has the trainee imagine the client doing ‘the thing’ that activates the trainee (e.g., being combative, insulting, disengaged or longwinded) and the trainee monitors their emotional reactions. Through mindful awareness, the supervisor helps the supervisee identify their cognitive, emotional and somatic reactions to their client and guides them to become curious and open towards their reaction. Once the supervisee has become mindful of their reactions, they ask those reactions to ‘step back’ so the therapist can be compassionate and open towards the client. Once the supervisee’s personal reactivity has ‘stepped back’, the supervisee goes into the room where their challenging client is waiting for them. Once again, the client does the thing that activates the supervisee, and they monitor their reactivity once again. For most supervisees, their experience is very different the second time around, and they are able to be curious about the client, and they interact with them in a very different way. If, however, there is additional reactivity, the supervisor engages in the same process as before and guides the trainee to be in a mindful state and to separate themselves from their reactivity. This is an intervention that one author (Fitzgerald) has used in supervision and has found to be effective in both in-person and online formats.

Self-of-the-therapist interventions such as the room technique may effectively be done virtually; what may be lost is the group process around self-of-the-therapist work. As scholars have noted regarding teletherapy (Abbass & Elliott, 2020), one of the problems is that valuable non-verbal (i.e., body language) information is lost because generally only supervisee’s head is visible (Duan et al., 2018). It can be extraordinarily difficult to identify how supervisees are reacting to the personal work of their group members. Group supervision is the venue for group members to engage in understanding their own issues but also to work out issues between one another. Unresolved issues between group members can also significantly hamper the personal and professional development of supervisees. The ability to capture the contextual nuances of non-verbal communication in a virtual format will require new supervisory strategies and technologies. Practically speaking, one important strategy to maximise the supervisor’s ability to observe non-verbal communication is to provide information on camera positioning and etiquette to supervisees. Within the telesupervisory relationship, each person’s distance from the camera, positioning within the camera’s view, eye contact with the camera and room lighting all contribute significantly to the way that person is experienced virtually (Inman et al., 2019b; Sahebi, 2020). Supervisors should model appropriate positioning, distance, lighting and eye contact for their supervisees, as well as provide an overview of their expectations to their supervisees at the onset of telesupervision. This seemingly small opening conversation can have a great impact on the supervisor’s ability to identify the supervisee’s reactions and provide helpful nonverbal context throughout the telesupervision sessions.

Finally, supervisors must remain sensitive to individual and group disparities when conducting telesupervision. The universalist mindset resulting from the COVID-19 pandemic declaring ‘we are all in this together’ has the potential to decrease the supervisor’s vigilance to
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attend to issues related to race and ethnicity, socioeconomic status and other relevant cultural dimensions that might have been more easily recognised in pre-pandemic face-to-face settings (Todd & Rastogi, 2014). Supervisors must remain attentive to their own personal experiences and biases related to the COVID-19 pandemic and create safe spaces to broach and work through these topics with their supervisees. Although these conversations may be more challenging in a virtual format, supervisors are encouraged to provide focused time for self-exploration during supervisory meetings. Utilising a culturally informed model of supervision can remind both the supervisor and their supervisees to tune in to the multidimensional and multisystemic aspects of the supervision and therapy process, keep a universalist mentality from contributing to blind spots within the supervisory relationship and strengthen the telesupervisory working alliance (Sahebi, 2020).

ETHICAL CONSIDERATIONS OF TELESUPERVISION

Regardless of method of delivery, clinical supervision is a multi-layered endeavour owing to the supervisor’s responsibility for the quality, professionalism and ethics of both their supervision and their supervisees’ therapy (AAMFT Code of Ethics, 2015; Vaccaro & Lambie, 2007). Telesupervision, with its reliance on technology, adds yet another layer to supervisory ethical concerns that include confidentiality (Hames et al., 2020; Orr, 2010; Wood et al., 2005), informed consent (Abbass et al., 2011; Barnett, 2011; Vaccaro & Lambie, 2007), competency (Barnett, 2011; Barnett & Johnson, 2008; Inman et al., 2019a), regulatory issues (Hames et al., 2020; Orr, 2010; Wood et al., 2005), documentation and record-keeping (Falender & Shafranske, 2004; Orr, 2010) and self-care (Bernard & Goodyear, 2014; Hames et al., 2020). A common belief before the COVID-19 pandemic was that supervisors who were proficient at providing face-to-face supervision were also competent to provide telesupervision; however, it is now clear that the competencies required in face-to-face supervision do not always transfer directly to telesupervision formats (Watters & Northey Jr, 2020). The following discussion explores the ethical challenges of telesupervision that unfold differently than face-to-face supervision.

Supervisors are responsible for maintaining the confidentiality of their supervisees and their supervisees’ clients (AAMFT Code of Ethics, 2015). Telesupervision takes place in cyberspace where there are no 100% guarantees of privacy, and therefore, the threat of unauthorised access to confidential material is increased (Inman et al., 2019a; McAdams & Wyatt, 2010; Vaccaro & Lambie, 2007; Wood et al., 2005). However, as in therapy, video-conferencing platforms are vulnerable to unauthorised access unless they are equipped with appropriate security protocols (Abbass et al., 2011; Inman et al., 2019a, 2019b). Unlike providing therapy services, though, supervisors often supervise by viewing recorded therapy sessions. Although a very useful mode of supervision, it could constitute a potential threat to confidentiality unless the videos are stored, maintained and viewed in secure physical and electronic settings (Abbass et al., 2011; Hames et al., 2020). In addition, when telesupervision entails the transmission of documentation or other materials for review, there exists a potential risk of breaching client confidentiality (Abbass et al., 2011; Wood et al., 2005). Even with the use of encryption software, there is still the risk that a person other than the supervisor might retrieve the communication and documents (Orr, 2010). The use of HIPPA (Health Insurance Portability and Accountability Act of 1996; USA)-compliant websites or cloud storage sites that allow documents to be securely accessed by authorised individuals could be a better choice for the sharing of supervision materials. Other recommendations for addressing email confidentiality include disclaimers on emails stating that
it is of a confidential nature (Morissette et al., 2012), clear and documented agreements between supervisor and supervisee about how these issues will be handled and development of a standard operating procedure (Inman et al., 2019a; Orr, 2010). Additional suggested protocols for maintaining confidentiality while engaging in telesupervision include ensuring that supervisor and supervisee’s physical space is private, with reduced potential for interruptions or being overheard (Hames et al., 2020), and refraining from the use of identifying client information when discussing cases online or engaging in electronic communication (Abbass et al., 2011; Wood et al., 2005).

The utilisation of telesupervision also has ethical implications for the supervisors’ informed consent or supervision contract (Barnett & Molzon, 2014), as well as the supervisee’s informed consent for therapy (Wood et al., 2005). Recommendations for supervisors’ contracts include an agreement of how to maintain privacy while online; policies for confidentiality, security and encryption for the period of the contract and an agreement of whether sessions are audio or videotaped, how they will be stored securely, how long they will be kept and what they will be used for (Orr, 2010). The supervisee must also inform their clients that they are engaging in telesupervision and of the risk to confidentiality that may entail (Barnett, 2011; Vaccaro & Lambie, 2007; Wood et al., 2005). Furthermore, the client should be informed that their information may be transmitted electronically to the supervisor (Vaccaro & Lambie, 2007), and if therapy recordings are being utilised, clients must be informed of the video conference process in plain language (Abbass et al., 2011).

Supervisors are expected to oversee supervisees’ competence and professionalism (AAMFT Code of Ethics, 2015). They are also expected to possess competence in the clinical areas to be supervised and in the practice of clinical supervision (Barnett, 2011; Barnett & Johnson, 2008; Sahebi, 2020). Therefore, supervisors must be competent in the technology, practice and ethics associated with providing clinical services online in order to supervise ethically, particularly if they are also supervising therapists engaged in providing teletherapy services (Barnett, 2011). Suggestions for helping supervisors ensure that they are practicing telesupervision ethically include reviewing the code of ethics (Morissette et al., 2012), training in technology for both supervisor and supervisee (Tarlow et al., 2020; Vaccaro & Lambie, 2007), developing protocols and back-up plans in case of technological failure (Hames et al., 2020; Vaccaro & Lambie, 2007), routinely reviewing guidelines and updates from software providers (Abbass et al., 2011) and regularly updating virus scan programmes (Wood et al., 2005). An upside of telesupervision is the increased availability of and access to supervisors with specific therapeutic expertise, which has the potential to enhance supervisee training and competence (Watters & Northey Jr, 2020).

Another telesupervision ethical challenge is that of jurisdiction (Inman et al., 2019b; Vaccaro & Lambie, 2007; Wood et al., 2005). Supervisors may be required to have a licence in the supervisee’s state (Inman et al., 2019a; McAdams & Wyatt, 2010; Wood et al., 2005), or it may be that supervision hours acquired through telesupervision may not be approved to count towards a supervisee’s required supervision hours for licensure (Inman et al., 2019a; Tarlow et al., 2020; Wood et al., 2005). In addition, the supervisor should verify that, if the supervisee is providing teletherapy, they are licensed in the jurisdiction in which they are providing services (Orr, 2010). If the supervisor is working within a training setting, recommendations are that they should also check their regulatory codes and accreditation bodies to ensure there are no special restrictions on supervisees’ practicum supervision experiences (Hames et al., 2020). Although jurisdictional issues must be properly attended, the possibilities for providing supervision to clinicians located in underserved and unreached communities around the world through telesupervision is exciting. Duan et al. (2018) discussed their experiences of supervisors in the United States providing supervision to Chinese clinicians, providing much-needed mental health services in China.
Although many challenges were encountered, the authors noted the success and wonderful multicultural learning experiences that this setup presented for the supervisors and supervisees involved.

Family therapists and therapists-in-training are generally relational people who value contact with others. This contact is experienced differently in online settings. Nadan et al. (2020) noted the challenges of the extended, focused screen time associated with telesupervision. For supervisors providing live supervision, intense divided attention was necessary to stay attentive to the session being supervised, communicating with the supervisees as needed, engaging with an observing supervision group and collaborating with any co-supervisors. Supervisors noted the high level of fatigue that came from orchestrating all of these activities via a computer screen. Supervisors need to be aware of the potential for this fatigue and provide necessary breaks to help keep themselves and their trainees engaged in the supervision process in order to provide the best learning environment possible (Nadan et al., 2020).

Finally, ethical supervision is supervision that monitors psychological wellness, self-care, distress and burnout, as well as concerns around professional competence of supervisees, regardless of the mode of delivery (Bernard & Goodyear, 2014). Supervisees, by definition, have a relative lack of clinical experience, and Tarlow et al. (2020) suggest that, paired with clinical responsibilities, this makes them more vulnerable to secondary traumatic stress and burnout. In addition, researchers are predicting a rise in mental health issues, including anxiety and depression, substance use, loneliness and domestic violence, in the general population as a result of the fear and social isolation surrounding the COVID-19 pandemic (Galea et al., 2020). These factors taken in conjunction may indicate an increased need currently for supervisory focus and monitoring of clinician self-care. Simms et al. (2021) reported the need for supervisors to always show compassion for their supervisees’ distress over pandemic-related and transition-to-telesupervision-related distress, regardless of the supervisor’s own perception of that distress. Galea and colleagues also suggest that digital technologies have the potential to bridge social distance, particularly when the contact involves voice and/or video. Telesupervision entailing video conferencing and incorporating an intentional focus on self-awareness and understanding may be an important component in reducing social isolation and positively impacting supervisees’ self-care.

CONCLUSIONS

There are numerous benefits to telesupervision including increased scheduling flexibility, reaching trainees where supervision would not be otherwise possible and supervisee self-of-the-therapist work, and these benefits can benefit both masters and doctoral CFT programmes. There are, however, some downfalls to telesupervision, including issues related to identifying group dynamics and establishing safety to engage in self-of-the-therapist, possible environmental influences (e.g., distractions such as children, partners, surfing the internet) and confidentiality issues. Given the strengths and limitations of telesupervision, training programmes should be intentional in determining whether to implement as an alternative to in-person supervision or an adjunctive form, particularly programmes that place a strong emphasis on self-of-the-therapist. Furthermore, the discipline should develop technical competency guidelines for telesupervision (Sherbersky et al., 2021). Should programmes want to implement telesupervision and also focus on self-of-the-therapist, then we recommend having in-person supervision first to establish rapport and familiarity and then shifting to telesupervision.
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H.G., C.H., P.R., M.J. and M.F. each wrote a section of the manuscript. H.G. and P.S. were in charge of manuscript revisions and submitting the manuscript. P.S. assisted with each of the manuscript sections. C.H., P.R. and M.F. assisted with some of the revisions.

CONFLICT OF INTEREST
The authors declare that there are no conflicts of interest.

ETHICS STATEMENT
The authors followed university and ethical guidelines in the preparation of this manuscript. Furthermore, as far as all authors are aware, no part of this manuscript infringes in any way on the copyright of other manuscripts.

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