The COVID-19 pandemic has altered life globally like no other event in modern history, and psychological service changes to meet the resultant impacts on families have not been assessed in the empirical literature. The purpose of the current study was to examine whether family systems therapists increased their teletherapy use during the pandemic relative to prepandemic usage, and whether projected postpandemic rates would remain at the same level; further, environmental and demographic predictors of these changes were examined. In May 2020, a sample of 626 family systems therapists (58.6% women, 40.6% men; M = 57.4 years old; M years in practice = 25.5) completed a national online study assessing these variables. Results suggested that family systems therapists performed 7.92% of their clinical work using teletherapy before the pandemic and 88.17% during the pandemic. They also projected that they would perform 36.57% of their clinical work using teletherapy after the pandemic. Teletherapy uptake was unrelated to primary practice setting, provider age, gender, race/ethnicity, and practice location (urban/suburban vs. rural) but was higher for family systems therapists who reported increased supportive teletherapy policies and training in their practice setting. Organizational infrastructure and availability of training played an important role in influencing teletherapy uptake during the pandemic. Family systems therapists have a unique opportunity to deploy teletherapy modalities to meet the needs of families during the COVID-19 pandemic, and infrastructure and training to do so may facilitate that work.

Keywords: Teletherapy; COVID-19; Coronavirus; Family Systems; Family Therapy

Fam Proc 61:155–166, 2022
By the middle of March 2020, the World Health Organization (WHO) confirmed that nearly 120,000 people worldwide had contracted the virus and pronounced it a pandemic (WHO, 2020). In accordance with WHO recommendations for interpersonal distancing to try to stem the spread of COVID-19, U.S. institutions and companies transitioned nonessential personnel to working from home (Adalja, Toner, & Inglesby, 2020). The Centers for Disease Control (CDC) recommended that nonessential medical appointments and procedures be postponed indefinitely (CDC, 2020b). Not only has the COVID-19 pandemic brought physical consequences, but it has caused social and emotional sequelae as well (Galea, Merchant, & Lurie, 2020). Concurrent with social isolation has increased stress, which has been linked to increased levels of depression, anxiety, and panic disorder both in the general public (Twenge & Joiner, 2020) and in patients who have already been receiving mental health treatment (Perrin et al., 2020).

**Teletherapy**

Pandemic proscriptions instigated a quick transition from traditional in-person therapy to teletherapy in the first quarter of 2020 (Sammons, VandenBos, & Martin, 2020). Acceptability, efficiency, and effectiveness of teletherapy for the treatment of some of the most commonly occurring mental health conditions (e.g., depression, anxiety, and substance use) have been demonstrated repeatedly (e.g., Adler, Pritchett, Kauth, & Nadorff, 2014; Bennett, Ruggero, Sever, & Yanouri, 2020). However, prepanademic teletherapy utilization comprised merely 7% of therapists’ clinical practice and was predicted by their perceptions of its clinical value and how difficult it would be to use (Pierce, Perrin, & McDonald, 2020a). In the COVID-19 milieu, the research on acceptability, efficacy, and efficiency of teletherapy has become more salient, and research performed during the pandemic found therapists were using teletherapy to provide more than 85% of their services (Pierce, Perrin, & McDonald, 2020b).

Barnwell (2019) asserted that since email, videoconferencing, and electronic medical records are already integrated in most practices, using teletherapy for provision of direct psychological services is a natural progression. Some have opined that the previously slow adoption of teletherapy was due to limited training (Cooper, Campbell, & Smucker Barnwell, 2019), which may have been emphasized by the sudden demand for teletherapy. However, educational, research, and professional entities have heightened efforts to fill this gap by publishing best practice guidelines and handbooks for teletherapy provision and supervision (e.g., APA, 2020; Sahebi, 2020).

While lack of training may have hindered earlier adoption of teletherapy, other likely barriers were federal regulations meant to protect patient privacy (e.g., HIPAA), Medicare and Medicaid reimbursement schedules (APA, 2014; United States Centers for Medicare & Medicaid Services, 2019), and other state and local laws governing the use of teletherapy. Many regulations have been relaxed during the pandemic to better accommodate telehealth (U.S. Department of Health & Human Services’ Office for Civil Rights, 2020). Practices with established teletherapy policies and procedures before the COVID-19 crisis were better equipped to make the transition to 100% teletherapy (Burgoyne & Cohn, 2020). For example, teletherapy use for therapists in Veterans Affairs (VA) medical centers increased by a smaller margin (7×) than the rise in usage for non-VA outpatient clinics (26x), largely due to early integration of telehealth in VA hospitals (Pierce et al., 2020b).

**Family Systems**

As governments implemented measures to curtail the spread of the virus, families experienced major shifts in their usual routines (Pietromonaco, 2020). Family systems
researchers have noted how these unique circumstances will provide insights into family adaptation to acute and chronic stressors (Brock & Laifer, 2020). Enforced togetherness may have promoted interpersonal connectedness in some couples and families, while others have experienced increasing conflicts and anxiety with feelings of isolation, old arguments resurfacing, fear related to financial worries and the disease itself, and decreased privacy (Günther-Bel, Vilaregut, Carratala, Torras-Garat, & Pérez-Testor, 2020). In a 59-country study of the pandemic’s effects on well-being, increases in verbal arguments or conflict with other adults in the home were the largest predictor, by far, of increased anxiety and depression (Alzueta et al., 2021) as well as sleep problems (Yuksel et al., 2021). Moreover, there is evidence of increased domestic violence during the pandemic (Mahase, 2020) and qualitative research suggests that the pandemic may have exacerbated risk of intimate partner violence in relationships with a history of abuse (Lyons & Brewer, 2021).

In fact, clinicians have noted marked advantages to teletherapy with couples and families such as improved access in areas with few mental health providers (Doss, Feinberg, Rothman, Roddy, & Comer, 2017). Families with modified work and study hours have more flexibility because of the elimination of transportation concerns and arranging childcare for younger children (Fraenkel & Cho, 2020). Teletherapy has also proven acceptable and effective in treating children and adolescents, as well as adults (Bennett et al., 2020), an important consideration for family systems therapists. Another important benefit is the opportunity to decrease barriers to care for underserved populations (Cooper et al., 2019; Reed, Messler, Coombs, & Quevillon, 2014). This is especially salient in the current health crisis, as racial/ethnic minority families are at greater-than-average risk of contracting COVID-19 and are experiencing more serious health effects (CDC, 2020a).

**Current Study**

The current study focused on changes in teletherapy provision by family systems therapists as a function of the pandemic. Practice settings, institutional policies and training, and practitioner demographic characteristics and therapeutic approaches were examined to determine their potential influences on implementation of teletherapy. These variables were previously found to explain a substantial degree of variance in the use of teletherapy (Pierce, Perrin, Tyler, McKee, & Watson, 2020c). There have been no known studies to date which have assessed how family systems therapists’ usage of teletherapy has changed during the pandemic and what factors may have influenced those changes. It was hypothesized that utilization of teletherapy by family systems therapists would increase during the first few months of the pandemic when compared to prepandemic usage, and that postpandemic teletherapy rates of use would be projected to be higher than prepandemic but lower than during the pandemic. The current study represents a secondary analysis of a study of environmental and demographic predictors of therapists’ use of teletherapy during the COVID-19 pandemic (Pierce et al., 2020c).

**METHOD**

**Procedure**

Study procedures are more fully detailed in the manuscript for the original study (Pierce et al., 2020c). The study was approved by the Virginia Commonwealth University Institutional Review Board. Invitations were emailed between May 11, 2020, and May 25, 2020, to 27,324 potential participants obtained from lists of psychologist newsgroups, social media groups, professional rosters, and directories from counseling centers and mental health clinics. This convenience sample of licensed psychologists was chosen.
because the co-author team was comprised of psychologists who, as a result, had access to professional psychologist directories.

Potential participants received a personalized email with a description of the study’s purpose and an HTML link to the survey. Of these, 14.3% were returned as “undeliverable” and 15.8% of those delivered resulted in participants opening the survey; the overall completed response rate was 11.18%. Those who opened the link were provided a document describing the study, IRB compliance, investigator contact information, and an informed consent form. Eligible participants who consented to participate then answered questionnaire items assessing demographic information, practice characteristics, and use of teletherapy. The eligibility criteria to participate in the overall study were that respondents were (a) currently licensed to practice as a psychologist within the United States, (b) currently practicing as a psychologist by treating clients/patients, and (c) age 18 or older.

Participants

Among the 2,619 participants who completed the survey, a subset of 626 self-identified with a theoretical therapeutic approach as “family systems” and were thus included in the current analyses. Demographic and practice characteristics of the sample appear in Table S1. Participants reported being 58.67 years old on average, with the majority (67.7%) identifying as women and 31.9% identifying as men. There were a greater number of therapists in this sample who identified as women in comparison to demographics reported by APA members, although the average age was similar (58.6% women, 40.6% men; M = 57.4 years old; APA, 2018). The average number of years in practice was 25.5, and most participants reported having an individual practice (58.0%) in a suburban (49.7%) or urban (41.4%) location.

Measures

Demographics and practice characteristics

Participants reported their current age, years in practice, gender, and race/ethnicity. They were also asked to indicate if their primary practice was located within a rural, suburban, or urban location, the type of setting (e.g., private practice, group practice, and VA medical center), the number of psychologists within their place of practice, their therapeutic orientation (Table S2), and the treatment focus of their setting (e.g., ADHD, anxiety, depression, and obesity). For items assessing therapeutic orientation and setting treatment focus, respondents were asked to select all options that applied.

Use of teletherapy

Actual teletherapy provision was assessed by asking participants, “What percentage of your patient treatment is provided using telepsychology?” where telepsychology was defined as “the use of real-time audio (e.g., telephone) and/or video conferencing technology to provide psychological services.” Participants were instructed to provide answers based on three time points, (a) before the COVID-19 pandemic began in the United States on January 20, 2020, (b) during the COVID-19 pandemic in the United States, and (c) their anticipated use after the COVID-19 pandemic ends in the United States.

Data Analysis

All descriptive statistics and analyses were conducted using IBM SPSS Statistics 26. First, a repeated-measures analysis of variance (ANOVA) was used to examine the effects of time on use of teletherapy. Time (three levels) was included as the sole predictor variable, with percentage of clinical work performed via teletherapy as the outcome variable.
Second, four separate ANOVAs were conducted to test the effects of primary practice setting (the predictor variable) on the four outcome variables of percentage of clinical work performed via teletherapy prepandemic, during the pandemic, projected after the pandemic, and change from prepandemic to during the pandemic, respectively. For these ANOVAs, primary practice settings were excluded if they were selected by fewer than five participants, and those who chose the “other” practice setting were also excluded. Thus, for these ANOVAs only, participants in geriatric facilities, correctional facilities, rehabilitation centers, and residential treatment centers were excluded, as well as those who identified working in “other” practice settings.

Then, two multiple regression analyses were used to predict increases in use of teletherapy during the pandemic relative to before the pandemic. The first regression included predictors comprising participant demographic variables, changes in workplace policies regarding teletherapy provision, changes in workplace teletherapy training, and practice geographical area. Several predictor variables were dichotomized, including gender (1 = woman, 0 = man or transgender or nonbinary), race/ethnicity (1 = White/European American, 0 = racial/ethnic minority), and geographic area type (1 = rural, 0 = suburban/urban). The second regression used workplace treatment foci as predictor variables.

RESULTS

Changes in Teletherapy Use Over Time

The repeated-measures ANOVA showed that percentage of clinical work performed using teletherapy differed significantly by time, $F(2,1250) = 2497.48, p < .001$, partial eta squared $= .80$. Family systems therapists indicated that they performed 7.92% ($SD = 15.71$) of their clinical work using teletherapy before the pandemic, and 88.17% ($SD = 25.79$) during the pandemic. They also projected that they would perform 36.57% ($SD = 27.59$) of their clinical work using teletherapy after the pandemic. These changes demonstrate an over 11-fold increase in percentage use of teletherapy during the pandemic relative to use of teletherapy before the pandemic.

Before the pandemic, 42.5% of family systems therapists indicated that they did not provide any services via teletherapy, and an additional 39.1% reported providing <10% of their clinical work using teletherapy; moreover, only four individuals (0.6%) reported using teletherapy for all of their clinical work. In comparison, only 1.9% of family systems therapists reported that they did not use teletherapy for any clinical work during the pandemic, while 69.3% reported using teletherapy exclusively. Further, only 8.1% projected not using teletherapy for any clinical work after the pandemic had resolved, while 4.3% expected that they would use teletherapy exclusively for clinical work.

Primary Practice Setting

Before the pandemic, percentage use of teletherapy ranged from 3.54% (outpatient treatment facilities) to 9.44% (individual practices), while use during the pandemic ranged from 81.84% (school/university clinics) to 92.84% (group practices). After the pandemic, family systems therapists projected percentage use of teletherapy ranging from 29.47% (school/university clinics) to 44.17% (Veterans Affairs Medical Centers). Four one-way ANOVAs were conducted to compare the percentage of teletherapy use before, during, and after the pandemic, and change in percentage use by primary practice settings (Table 1). None of these ANOVAs were significant, indicating that there were no statistically significant differences in percentage of teletherapy use and change in percentage use based on therapists’ primary practice settings.
Effect of Demographics, Organizational Policies, and Training on Teletherapy Uptake

Results from the first multiple regression (Table 2) indicated that the model predicted a statistically significant amount of change in teletherapy use during the pandemic relative to prepandemic use, $F(6,619) = 7.79, p < .001, R^2 = .07$. Interestingly, none of the demographic predictor variables (provider age, gender, race, and rural practice location) predicted uptake in teletherapy, $ps > .05$. However, changes in policies supporting teletherapy use, $b = 1.72, SE = .63, p = .007$, and increases in teletherapy training, $b = 2.73, SE = .70, p < .001$, were both associated with increased use of teletherapy. These results indicate that for each 1-unit increase in supportive policy changes, teletherapy use increased by 1.72% and increased by 2.73% for each 1-unit increase in teletherapy training changes.

Effect of Treatment Focus on Teletherapy Uptake

Results from the second multiple regression (Table 3) also indicated that the model predicted a statistically significant amount of change in teletherapy use from prepandemic to during the pandemic, $F(55,570) = 2.07, p < .001, R^2 = .17$. Therapists whose primary practices treated relationship issues and women's issues reported the highest increases in teletherapy use during the pandemic relative to before the pandemic. Conversely, those

### Table 1

Percentage Use of Teletherapy by Primary Practice Setting

| Primary Practice Setting                  | % Use before COVID-19 | % Use during COVID-19 | Change in % use during COVID-19 | Projected % use after COVID-19 |
|------------------------------------------|-----------------------|-----------------------|-------------------------------|-------------------------------|
| Omnibus ANOVA p-value                    | 0.203                 | 0.146                 | 0.495                         | 0.123                         |
| Individual practice                      | 9.44                  | 90.41                 | 28.43                         | 37.87                         |
| Group practice                           | 5.58                  | 92.84                 | 26.69                         | 32.28                         |
| Hospital/medical center                  | 8.35                  | 82.44                 | 35.44                         | 43.79                         |
| Outpatient treatment facility            | 3.54                  | 90.31                 | 26.62                         | 30.15                         |
| Academic medical center                  | 7.46                  | 84.18                 | 34.82                         | 42.29                         |
| School/university                        | 4.26                  | 81.84                 | 25.21                         | 29.47                         |
| Veterans Affairs Medical Center          | 7.33                  | 82.67                 | 36.83                         | 44.17                         |

### Table 2

Multiple Regression Testing the Effect of Demographics, Organizational Policies, and Training on Teletherapy Uptake

| Variable                                | B     | SE  | β      | Sig.  |
|-----------------------------------------|-------|-----|--------|-------|
| Age                                     | -.03  | .10 | -.01   | .774  |
| Identifies as woman                     | 3.77  | 2.50| .06    | .131  |
| Identifies as white                     | .94   | 3.99| .01    | .813  |
| Rural location                          | -.54  | 3.95| -.01   | .891  |
| Supportive teletherapy policies         | 1.72**| .63 | .12    | .007  |
| Sufficient teletherapy training         | 2.73***| .70 | .17    | <.001 |
| Constant                                | 70.68***| 7.32| —      | <.001 |

Notes. **p < .01.
***p < .001.

www.FamilyProcess.org
whose primary practices treated physical medicine and rehabilitation, antisocial personality disorder, traumatic brain injury, and family conflict reported the lowest increases in teletherapy uptake.

**DISCUSSION**

The current study is among the first to examine the effects of the COVID-19 pandemic on family systems therapists’ clinical work delivered via teletherapy, as well as predictors of these changes. Results supported hypotheses that family systems therapists would report increased utilization of teletherapy during the first few months of the pandemic in comparison to prepandemic rates, and that projected postpandemic rates would be higher than prepandemic rates but lower than during the pandemic. Secondary analyses showed that teletherapy uptake was unrelated to primary practice setting, age, gender, race/ethnicity, and practice location (urban/suburban vs. rural), but was higher for family systems therapists who reported increased supportive teletherapy policies and training in their practice setting, suggesting that organizational infrastructure and availability of training played an important role in influencing teletherapy uptake during the pandemic.

Perhaps most notably, the current study demonstrates a dramatic, unprecedented shift in family systems therapists’ provision of teletherapy, as rates increased substantially during the first few months of the pandemic. Therapists reported that they had performed 7.92% of their clinical work with teletherapy before the pandemic, and 81.6% noted that they had not used teletherapy at all or used teletherapy for <10% of their clinical work. These are similar to other prepandemic estimates that only about one-fifth of practicing psychologists provided clinical work via teletherapy (Pierce et al., 2020a). In contrast, family systems therapists estimated performing 88.17% of clinical work using teletherapy by the third month of the pandemic, representing an over 11-fold increase relative to before the pandemic. Furthermore, participants predicted that they would perform 36.57% of clinical work using teletherapy after the pandemic had ended, which is a nearly fivefold increase relative to use before the pandemic. These results suggest that participants anticipated long-lasting changes in the provision of services via teletherapy even after pandemic-related concerns are addressed.

Results from the current study also highlight the efforts of family systems therapists to meet the needs of the general public in the context of the pandemic. This is not only important given the documentation of increased symptoms of anxiety and depression in individuals (e.g., Perrin et al., 2020; Twenge & Joiner, 2020) but is also highly relevant for

### Table 3

| Variable                               | B     | SE   | β    | Sig.  |
|----------------------------------------|-------|------|------|-------|
| Antisocial personality                 | -12.56* | 5.99 | -0.10 | .036  |
| Family conflict                        | -7.20*  | 2.97 | -0.12 | .016  |
| Physical medicine and rehabilitation   | -15.31*** | 5.38 | -0.13 | .005  |
| Relationship issues                    | 12.39*** | 3.25 | 0.19  | <.001 |
| Traumatic brain injury                 | -10.61*  | 4.54 | -0.11 | .020  |
| Women’s issues                         | 8.27**   | 2.99 | 0.13  | .006  |

*Notes. Although 55 treatment foci were included as predictors, for simplicity, only significant effects are presented.

***p < .001.

**p < .01.

*p < .05.

_Fam. Proc., Vol. 61, March, 2022_
families who have experienced unprecedented disruptions to home and work life, increased conflicts, and decreased family functioning (Günther-Bel et al., 2020). Teletherapy allows family systems therapists to treat these difficulties while following social distancing mandates. Teletherapy also allows for increased access to care for individuals in rural areas (Nelson & Bui, 2010) and individuals in other underserved populations (Cooper et al., 2019; Reed et al., 2014). It may also increase access for couples and families who would need to arrange transportation or childcare.

Overall, no differences were found in percentage of teletherapy use and change in percentage use based on family systems therapists’ primary practice settings. This suggests that therapists across multiple practice settings experienced similar abilities to introduce or increase teletherapy use during the pandemic. There were no significant differences by primary practice setting in family systems therapists’ projected use of teletherapy after the pandemic, suggesting that changes in uptake were projected to occur on a wide scale. Interestingly, these results are inconsistent with prepandemic research indicating that therapists were more likely to use teletherapy if their primary practice setting was a VA Medical Center, individual private practice, or group practice (Pierce et al., 2020b). It could be that family systems therapists in other settings (e.g., academic medical centers and schools/universities) did not experience the same barriers to teletherapy uptake as other therapists did before the pandemic. Additionally, although therapists in settings like VA Medical Centers may have benefited from the teletherapy and telemedicine infrastructure that was already in place (e.g., Caver et al., 2020), it could be that other practice settings with fewer barriers to uptake (such as less complex infrastructure or more rapid administrative action) may have allowed them to transition more rapidly.

Teletherapy use was not significantly related to therapists’ age, gender, race/ethnicity, and practice location. This is partially consistent with previous prepandemic findings (Pierce et al., 2020b) that teletherapy use was not associated with age, gender, or race/ethnicity, although it was associated with rural practice location. However, this is inconsistent with findings from the original larger sample (Pierce et al., 2020c), which demonstrated that therapists who identified as women and those in nonrural practice settings reported increased teletherapy use. These results suggest that teletherapy was consistently adopted by family systems therapists during the pandemic regardless of these demographic and practice characteristics. This is a somewhat surprising finding, as initial rates of COVID-19 cases tended to be higher in more densely populated states (CDC, 2020a), and rural providers have historically been less likely to provide teletherapy services (Pierce et al., 2020b). This may indicate that demand for family systems therapists’ teletherapy services increased consistently across multiple types of communities. Alternatively, it could be that in rural areas increased teletherapy availability in order to improve access to care for couples and families in urban and suburban areas.

Changes in policies supporting the use of teletherapy and increases in teletherapy training were both associated with increased use of teletherapy during the pandemic relative to before the pandemic, consistent with previous research (Pierce et al., 2020b, 2020c). Previously, perceived ease of teletherapy use was identified as a significant barrier or facilitator of uptake (Pierce et al., 2020a); certainly, it seems possible that both policies and training could impact therapists’ ability to easily and efficiently transition to teletherapy use. In addition to changes that were implemented on a national scale, such as privacy and security regulations (APA, 2014), these results highlight the important role that organizational support and training for teletherapy use has played in the rapid adoption of teletherapy among family systems therapists during the pandemic.

Lastly, the current study examined treatment foci that were associated with increased or decreased teletherapy use during the pandemic. Family systems therapists whose primary practices treated relationship issues and women’s issues reported the highest

www.FamilyProcess.org
increases in teletherapy. This could indicate that therapists perceive that these therapeu-
tic issues may be particularly amenable to being adapted to teletherapy. It could also be
that family systems therapists experienced greater demands for teletherapy use with
these issues during the pandemic, which would be consistent with reports of increased
conflict in the home (Günther-Bel et al., 2020) and its impact on health (Alzueta et al.,
2021; Yuksel et al., 2021). Patients seeking therapy for women’s issues may also have
higher need for teletherapy services, particularly as women tend to provide the bulk of
childcare (Bianchi, Sayer, Milkie, & Robinson, 2012), and teletherapy may have facilitated
access to care for working parents while many schools and daycares were closed.

In contrast, physical medicine and rehabilitation, antisocial personality disorder, traum-
atic brain injury, and family conflict were associated with the lowest increases in
teletherapy uptake. Physical medicine and rehabilitation as well as traumatic brain injury
may be perceived by family systems therapists as less adaptable to teletherapy, possibly
because of the need to coordinate psychotherapy with medical services like examinations
or physical therapy, which are likely to be provided in-person. Yet, the benefits of home-
based teletherapy interventions have been documented for some time in this literature,
including patient groups such family caregivers of persons with traumatic spinal cord
injuries (Elliott, Brossart, Berry, & Fine, 2008), families of adolescents with traumatic
brain injuries (Wade, Carey, & Wolfe, 2006), and individuals with multiple sclerosis (Ehde
et al., 2015). Further, those who have severe physical impairments that require routine
assistance with essential activities of daily living may be in relationships that are vulnera-
ble to pressures, neglect, and abuse that may occur under times of duress, warranting clin-
ical attention from the treating therapists. Therapists in these settings are aware of these
clinical issues and presumably, of the research supporting the use of telehealth in working
with these individuals in the home. The reasons, then, for the lower rate of teletherapy
use among family systems therapists in these settings may merit further investigation.

Mental health providers may be reluctant to treat antisocial personality disorder via
teletherapy because of perceived safety concerns, or because of a perception that treat-
ment may not be easily adaptable to teletherapy. This may also be the case for family con-
flict: while family systems therapists may feel comfortable adapting couples therapy or
therapy for relationship issues to teletherapy, conducting teletherapy with more than two
patients at a time (as might occur with therapy for family conflict) might prove to be pro-
hibitive, particularly if childcare or supervision is needed for other children in the home at
the same time. This finding was consistent with a small qualitative study of mental
healthcare providers in the Netherlands, who identified that family therapy, in addition
to the treatment of psychotic symptoms, severe anxiety, trauma, or individuals in crisis,
was less suited to online modalities (Feijt et al., 2020). Family systems therapists may also
feel reluctant to address family conflict via teletherapy because of safety issues, such as
the duty to assess and report child abuse or suicidality in minor patients. There may also
have been concerns on the part of therapists as to liability or licensure issues related to
providing services to families whose members live in different states. Provider concerns
related to family therapy via teletherapy and possible adaptations are discussed in recent
commentary (Burgoyne & Cohn, 2020).

Limitations and Future Directions

The current study has a number of important limitations which should be taken into
account. First, because of the observational design used, no causal inferences should be
made about patterns relating to teletherapy use. It was not possible to determine whether
differences existed between therapists who completed the survey and those who chose not
to participate or did not complete the questionnaires. In the subset of data used in the

Fam. Proc., Vol. 61, March, 2022
current study, there were small numbers of family systems therapists practicing in geriatric facilities, correctional facilities, rehabilitation centers, and residential treatment centers. Therapists in these settings may also have had fewer opportunities to use teletherapy, as patients in these facilities often reside on site. Because of the small numbers of therapists in these settings, they were excluded from the analysis of primary practice setting, which could potentially obscure differences that might have been detectable with a larger sample.

The data in the current study were collected in May 2020 during the initial wave of the COVID-19 pandemic. Additional research is needed to determine whether these patterns of teletherapy use have persisted as social distancing practices in many states have continued throughout the first quarter of 2021. Teletherapy use by family systems therapists may have continued to increase even in excess of the percentage reported here, as many patients may have perceived that they could no longer wait to initiate therapy. This could also impact the projected use of teletherapy after the pandemic, as family systems therapists, their practice settings, and patients may be more amenable to teletherapy use in the future with increased use and familiarity/perceived ease of use while the pandemic continues. Relatedly, because many future policy changes (or lack of changes) regarding the practice of teletherapy are not yet known, such as changes to privacy or security regulations, therapists’ predictions of postpandemic teletherapy use may change over time. Moreover, because participants in the current study were asked to project current use at some point in the future, in contrast to observed past time points (prepandemic and during the pandemic), there is likely to have been systematic error introduced in therapists’ projections that did not exist for the two earlier time points.

CONFLICT OF INTERESTS

The authors report no conflict of interests related to the submission of this manuscript.

COPYRIGHT STATEMENT

Since Dr. Perrin and Dr. McKee are employees of the U.S. Government and contributed to the manuscript “The COVID-19 Pandemic’s Influence on Family Systems Therapists’ Provision of Teletherapy” as part of their official duties, the work is not subject to U.S. copyright.

DISCLAIMER

The contents of this manuscript do not represent the views of the U.S. Department of Veterans Affairs or the U.S. Government.

REFERENCES

Adalja, A. A., Toner, E., & Inglesby, T. (2020). Priorities for the US health community responding to COVID-19. Journal of the American Medical Association, 323, 1343–1344. https://doi.org/10.1001/jama.2020.3413.
Adler, G., Pritchett, L. R., Kauth, M. R., & Nadorff, D. (2014). A pilot project to improve access to telespsychotherapy at rural clinics. Teledmedicine and e-Health, 20, 83–85. https://doi.org/10.1089/tmj.2013.0085.
Alzueta, E., Perrin, P. B., Baker, F., Caffarra, S., Ramos-Usuga, D., Yuksel, D. et al. (2021). How the COVID-19 pandemic has changed our lives: A study of psychological correlates across 59 countries. Journal of Clinical Psychology, 77, 556–570. https://doi.org/10.1002/jclp.23082.
American Psychological Association (2014). Practitioner pointer: Does the use of Skype raise HIPAA compliance issues?. Retrieved from https://www.apaservices.org/practice/update/2014/04-24/skype-hipaa.
American Psychological Association (2020). Telepsychotherapy. American Psychological Association. Retrieved from https://www.apa.org/members/your-growth/practice-management/telepsychotherapy.

Barnwell, S. S. (2019). A telepsychology primer. Journal of Health Service Psychology, 45, 48–56. https://doi.org/10.1007/BF03544680.

Bennett, C. B., Ruggiero, C. J., Sever, A. C., & Yanouri, L. (2020). eHealth to redress psychotherapy access barriers both new and old: A review of reviews and meta-analyses. Journal of Psychotherapy Integration, 30, 188–207. https://doi.org/10.1037/int0000217.

Bianchi, S. M., Sayer, L. C., Milkie, M. A., & Robinson, J. P. (2012). Housework: Who did, does or will do it, and how much does it matter? Social Forces, 91, 55–63. https://doi.org/10.1083/sfsos120.

Brock, R. L., & Laifer, L. M. (2020). Family science in the context of the COVID-19 pandemic: Solutions and new directions. Family Process, 59, 1007–1017. https://doi.org/10.1111/famp.12582.

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

Caver, K. A., Shearer, E. M., Burks, D. J., Perry, K., Paul, N. F., McGinn, M. M. et al. (2020). Telemental health training in the veterans administration puget sound health care system. Journal of Clinical Psychology, 76, 1108–1124. https://doi.org/10.1002/jcpl.22797.

Centers for Disease Control and Prevention (2020). Resources for clinics and healthcare facilities. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html.

Centers for Disease Control and Prevention (2020a, February 11). Coronavirus disease 2019 (COVID-19). Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

Cooper, S. E., Campbell, L. F., & Smucker Barnwell, S. (2019). Telepsychology: A primer for counseling psychologists. The Counseling Psychologist, 47, 1074–1114. https://doi.org/10.1177/00110000198985276.

Doss, B. D., Feinberg, L. K., Rothman, K., Roddy, M. K., & Comer, J. S. (2017). Using technology to enhance and expand interventions for couples and families: Conceptual and methodological considerations. Journal of Family Psychology, 31, 983–993. https://doi.org/10.1037/famp0000349.

Ehde, D. M., Elzea, J. L., Verrall, A. M., Gibbons, L. E., Smith, A. E., & Amtmann, D. (2015). Efficacy of a telephone-delivered self-management intervention for persons with multiple sclerosis: A randomized controlled trial with a one-year follow-up. Archives of Physical Medicine and Rehabilitation, 96, 1945–1958.e2. https://doi.org/10.1016/j.apmr.2015.07.015.

Elliott, T., Brossart, D., Berry, J. W., & Fine, P. R. (2008). Problem-solving training via videoconferencing for family caregivers of persons with spinal cord injuries: A randomized controlled trial. Behaviour Research and Therapy, 46, 1220–1229. https://doi.org/10.1016/j.brat.2008.08.004.

Feijt, M., de Kort, Y., Bierbooms, J., Westerink, J., & IJsselsteijn, W. (2020). Mental health care goes online: Practitioners’ experiences of providing mental health care during the COVID-19 pandemic. Cyberpsychology, Behavior, and Social Networking, 23, 860–864. https://doi.org/10.1089/cyber.2020.0370.

Fraenkel, P., & Cho, W. L. (2020). Reaching up, down, in, and around: Couple and family coping during the coronavirus pandemic. Family Process, 59, 847–864. https://doi.org/10.1111/famp.12570.

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. JAMA Internal Medicine, 180, 817. https://doi.org/10.1001/jama.2020.1562.

Günther-Bel, C., Vilaregut, A., Carratala, E., Torras-Garat, S., & Pérez-Testor, C. (2020). A mixed-method study of individual, couple and parental functioning during the state-regulated COVID-19 lockdown in Spain. Family Process, 59, 1060–1079. https://doi.org/10.1111/famp.12585.

Lyons, M., & Brewg, G. (2021). Experiences of intimate partner violence during lockdown and the COVID-19 pandemic. Journal of Family Violence. Advance online publication. https://doi.org/10.1007/s10896-021-00260-x.

Mahase, E. (2020). Covid-19: EU states report 60% rise in emergency calls about domestic violence. British Medical Journal (Online), 369, m1872. https://doi.org/10.1136/bmj.m1872.

Nelson, E. L., & Bui, T. (2010). Rural telepsychology services for children and adolescents. Journal of Clinical Psychology, 66(5), 490–501. https://doi.org/10.1002/jclp.20682.

Perrin, B. S., Rybarczyk, B. D., Pierce, B. S., Jones, H. A., Shaffer, C., & Islam, L. (2020). Rapid telepsychology deployment during the COVID-19 pandemic: A special issue commentary and lessons from primary care psychology training. Journal of Clinical Psychology, 76, 1173–1185. https://doi.org/10.1002/jclp.22969.

Pierce, B. S., Perrin, P. B., & McDonald, S. D. (2020a). Path analytic modeling of psychologists’ openness to performing clinical work with telepsychology: A national study. Journal of Clinical Psychology, 76, 1135–1150. https://doi.org/10.1002/jclp.22851.

Pierce, B. S., Perrin, P. B., & McDonald, S. D. (2020b). Demographic, organizational, and clinical practice predictors of U. S. psychologists’ use of telepsychology. Professional Psychology: Research and Practice, 51, 184–193.

Pierce, B. S., Perrin, P. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2020c). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in U.S. mental health care delivery. American Psychology, 76, 14–25. https://doi.org/10.1037/amp0000722.

Fam. Proc., Vol. 61, March, 2022
Pietromonaco, P. (2020, April 28). Pandemic effects on marriage and relationships. Association for Psychological Science. Retrieved from https://www.newswise.com/coronavirus/pandemic-effects-on-marriage-and-relationships.

Reed, R. N., Messler, E. C., Coombs, T. E., & Quevillon, R. P. (2014). Social media use and the acceptability of telepsychological services in rural populations. *Journal of Rural Mental Health, 38*, 2–8. https://doi.org/10.1037/rmh0000007.

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

Sammons, M. T., VandenBos, G. R., & Martin, J. N. (2020). Psychological practice and the COVID-19 crisis: A rapid response survey. *Journal of Health Service Psychology, 46*, 51–57. https://doi.org/10.1007/s42843-020-00013-2.

Twenge, J. M., & Joiner, T. E. (2020). U.S. Census Bureau-assessed prevalence of anxiety and depressive symptoms in 2019 and during the 2020 COVID-19 pandemic. *Depression and Anxiety, 37*(10), 954–956. https://doi.org/10.1002/da.23077.

United States Centers for Medicare and Medicaid Services (2019). *Telemedicine*.

United States Department of Health and Human Services’ Office for Civil Rights (2020). OCR eases HIPAA telehealth enforcement for COVID-19 emergency. Retrieved from https://www.aha.org/news/headline/2020-03-18-ocr-eases-hipaa-telehealth-enforcement-covid-19-emergency.

Wade, S. L., Carey, J., & Wolfe, C. R. (2006). The efficacy of an online cognitive–behavioral family intervention in improving child behavior and social competence. *Rehabilitation Psychology, 51*, 179–189. https://doi.org/10.1037/0090-5550.51.3.179.

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

Yuksel, D., McKee, G. B., Perrin, P. B., Alzueta, E., Caffarra, S., Ramos-Usuga, D. et al. (2021). Sleeping when the world locks down: Predictors of sleep health during the COVID-19 pandemic across 59 countries. *Sleep Health, 7*, 134–142. https://doi.org/10.1016/j.sleh.2020.12.008.

**SUPPORTING INFORMATION**

Additional Supporting Information may be found in the online version of this article:

*Table S1*. Summary of Participant Characteristics.

*Table S2*. Summary of Participant Therapeutic Orientations.

www.FamilyProcess.org