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Appreciative Inquiry of a Non-profit Organization Transitioning to Teletherapy

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Appreciative Inquiry of a Non-profit Organization Transitioning to Teletherapy

By

Claudia Herrera

A Dissertation Submitted to Dr. Kiran C. Patel College of Osteopathic Medicine of
Nova Southeastern University in Partial Fulfillment of the requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University

June 2021

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By

Claudia Herrera

June 2021

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Dr. Kiran C. Patel College of Osteopathic Medicine

This dissertation was submitted by Claudia Herrera under the direction of the chair of the dissertation committee listed below. It was submitted to Dr. Kiran C. Patel College of Osteopathic Medicine and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Family Therapy at Nova Southeastern University.

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Abstract

Mental health professionals have been required to make a transition to delivering services using technology during the COVID-19 pandemic. The non-profit agency participating in this study had already listed on its strategic plan the delivery of teletherapy. In 2020, due to the pandemic, the agency decided to expedite the delivery of teletherapy services. This study explored the experiences of the agency's team, to determine what worked well while making this transition, as well as future dreams regarding the delivery of teletherapy. Appreciative inquiry was used as the method of data collection. Findings indicated the agency's clinicians found keeping a positive attitude themselves, receiving support from clients, and equal funding for teletherapy as for in person services on the part of the funders, were key to making the initial transition (Discovery phase); that agency clinicians considered that sustained outreach to both publicize and educate about teletherapy to clients and other community agencies had already proved helpful and is in need of more expansion (Dream phase); and that long term, agency clinicians would like to keep using teletherapy even after the pandemic (Design phase), with improved technology and additional training about teletherapy for both clients and clinicians (Destiny phase). The findings of this study may provide a foundation for other agencies that are in the process of transitioning from in person to virtual services.

Keywords: COVID-19, teletherapy, non-profit agency, appreciative inquiry.

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CHAPTER I: INTRODUCTION

In this chapter, I present the background of the problem starting with the place where I worked as an administrator, supervisor, and clinician during the last six years and where this research on teletherapy was conducted, the Center for Family Services (CFS) of Palm Beach County, Inc., and the circumstances (COVID-19 pandemic) that led to the CFS' transition to teletherapy services. The goal of this chapter is to provide information about the CFS' main funders by presenting a brief description, starting with the Children's Services Council of Palm Beach County, continuing with the State Attorney's Office, the Department of Health, and concluding with the Health Care District. After presenting the main funders, I share my reflections related to the self of the therapist, followed by the purpose of this study and the focus of this study's chapters.

Background of the Problem

The years 2019 and 2020 were important not only for clinicians and the field of family therapy but also for the entire country and world due to the crisis related to the coronavirus disease (COVID-19) which was declared a pandemic by the World Health Organization (2020). This pandemic started in China in 2019 and rapidly moved to other countries such as the USA. In the beginning of 2020, the virus started affecting our citizens' health and the USA economy. The President declared a state of public health emergency, ordering the cancellation of international flights, closing schools and businesses, and encouraging citizens to keep social distance, wear masks, and follow basic hygiene protocols to prevent the spread of the virus.

Starting in 2019, the entire world had been suffering the devastating consequences of the COVID-19 pandemic. According to the Centers for Disease Control and Prevention (2020), many people all over the world died due to COVID-19 crisis. Almost every country is suffering

the sequels of a pandemic that is not only affecting the people's physical and mental health but also the economy, the social interactions, the way businesses deliver services and their future goals. Centers for Disease Control and Prevention (CDC) (2020) estimated that by October 23, 2020 about 222,447 people died in the USA to COVID-19, in Florida 16,267 people died and in Palm Beach County 1,549 people died to COVID-19. Those numbers are alarming and scary. The pandemic caused a dramatic increase in the need for mental health services. For that reason, this is a critical time for the field of family therapy to respond to the needs of our nation and their residents.

Many organizations had to change the way they deliver services to the public due to the severity of this pandemic and to ensure the safety of staff members and clients. In the mental health field, many organizations have been delivering remote or virtual services known as telemental health services, behavioral telehealth, telebehavioral health, distance counseling, online therapy, e-therapy, internet therapy, and teletherapy, among others (Luxton et al., 2016). Those terms are defined in the literature review chapter.

This pandemic brought several changes to the way we (therapists) deliver services. The Health Insurance Portability and Accountability Act (HIPAA) and the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counselors supported the flexibility of confidentiality and approved the expansion of more clinicians (not only licensed clinicians but also registered interns) to deliver teletherapy services, which contributed to the changes the CFS and other local behavioral and mental health organizations adopted to continue with regular operations.

In 2017 the CFS Board of Directors, Executive Team, supervisors, and clinicians revised the Strategic Plan 2017- 2021 including the provision of teletherapy to clients participating in

four programs designed to deliver in person (in office) services. Data from those programs' monthly and annual reports showed high no-show rates for in office appointments due to clients experiencing problems with transportation and childcare services. Teletherapy was in the CFS' radar and with the COVID-19 crisis, the agency had to deliver teletherapy services quickly without having an official implementation plan and all the necessary details in place.

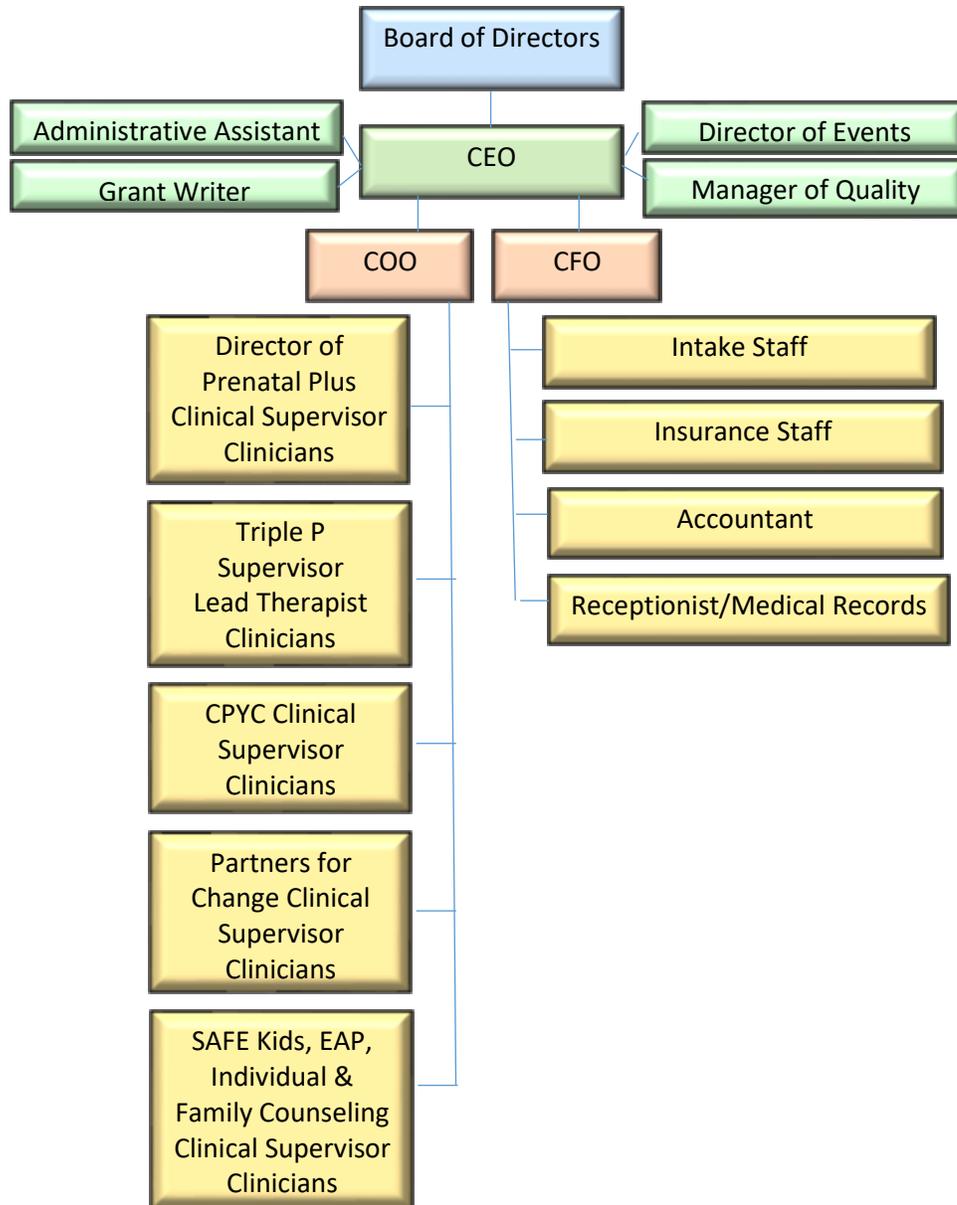
The good news for the CFS and the field of family therapy was that telehealth services were supported by the government. The flexibility of HIPAA rules and the different studies on teletherapy (Barnett & Kolmes, 2016; Hilty et al., 2013; Pruit et al., 2014) supported its use as a viable way to deliver therapy. The CFS started the transition process to teletherapy in March 2019 and the outcomes from the Teletherapy Satisfaction Survey from August 2020 provided a green light to the agency to continue to move forward with the teletherapy initiative. Those results are presented and discussed under the CFS' information.

Center for Family Services of Palm Beach County, Inc. (CFS)

Center for Family Services of Palm Beach County, Inc. (CFS) started providing behavioral health services and education to Palm Beach County residents in 1961 with the mission of “strengthening individuals and families through behavioral health services and education,” (Center for Family Services, n.d. para. 1) based on a culture code that involves teamwork, accountability, leadership, trustworthiness, fairness and continue improvement. CFS' staff members are distributed in different areas as illustrated in Figure 1.

Figure 1

CFS' team



Note. This is a modified version of the CFS’s organizational chart that shows the organizational structure starting with the Board of Directors overseeing the agency’s overall functioning,

following by the Executive Team: CEO, COO, and CFO. The clinical programs are overseeing by the COO.

The CFS' clinicians used to deliver services in-person (face to face) in the office or in the clients' homes or community sites, such as libraries, health clinics, schools, and childcares, among others until March 2020, when COVID-19 changed the way CFS was operating. The agency moved to virtual/remote services with little preparation. It was a moment of a national crisis and the agency needed to adapt to this crisis and continue to support the clients and their families during this difficult time. At that time, I had administrative, supervisory, and clinical roles in the agency that allowed me to consider different angles and perspectives and have different professional experiences during the transition process to teletherapy. I was delivering therapy to clients, facilitating weekly supervision to clinical supervisors, and overseeing the agency's operational activities as the Chief Operating Officer, until October 2020, when I resigned from my position to focus on my private practice.

Part of my responsibilities as a Chief Operating Officer was to ensure the quality of services and programs' operations. For that reason, in August 2020 we conducted the Teletherapy Satisfaction Survey with clinicians and clients' participation with the purpose of monitoring and measuring its efficacy and identifying the areas for improvement. The following information illustrates the survey's outcomes and provides a baseline for the present research.

Teletherapy Satisfaction Surveys

The clinician's survey was intended to measure the therapists' competencies, level of comfort, and comments related to the delivery of teletherapy. The client's satisfaction survey was intended to measure the CFS' clients' perception, level of satisfaction, and comments related to the teletherapy services they started receiving in March 2020. (see Appendices D and E)

The Chief Operating Officer in collaboration with a doctoral level therapist and with the approval of the Executive Team designed the surveys that were delivered throughout Survey Monkey, which is an online survey tool, free, easy to use, and confidential, that allowed the participants to respond anonymously. This tool facilitated the electronic collection and analysis of data by providing visual information in tables and graphs. The surveys measured quantitative and qualitative data.

The participation of clinicians and clients was voluntary. The surveys were distributed to clinicians by the Chief Operating Officer via email and the clients received the surveys from their therapists via e-mail as well. Clinicians had a time frame to respond from August 13, 2020 to August 23, 2020 and the clients from August 14, 2020 to August 28, 2020. The number of clinicians that completed the survey was 20 and the number of clients was 31.

Results from the Clinician's Survey

Times the clinician facilitated teletherapy

According to the data collected, 30% of the CFS' clinicians facilitated teletherapy between 40 and 60 times and 30% more than 100 times. This data indicated that the CFS' clinicians were increasing their experience in facilitating this type of service and getting more comfortable with the delivery of teletherapy.

Clinician's Age

The data gathered showed that 60% of the clinicians were between 25 and 44 years old. Overall, the agency had clinicians that because of the generational circumstances related to use of technology had technological knowledge and skills and were willing to engage in new practices such as virtual therapy.

Professional Licensure

Sixty five percent of the clinicians were registered interns and 35% were licensed therapists. The goal of the agency is to increase the number of licensed clinicians because according to the licensure board only licensed clinicians are approved to deliver teletherapy. During the pandemic, the board and the Department of Health approved the delivery of teletherapy services by registered interns under the supervision of an approved supervisor and with a safety plan in place.

Number of Years Practicing the Profession

Fifty five percent of the clinicians reported that they had been practicing the profession less than 5 years. CFS has new clinicians on board, which represents an opportunity to contribute to the formation of ethical and committed professionals in the field and, at the same time requires more effort from supervisors to provide mentoring and guidance to reduce liability and ensure quality of services. Overall, new clinicians seemed to be eager to learn and that attitude appeared to help with forming and maintaining therapeutic alliances with clients and their families.

Clinician's Perspective about Teletherapy

Ninety percent of the therapists stated that they could schedule/reschedule appointments relatively easily/without significant challenges, which is consistent with one of the benefits of teletherapy in terms of saving time and resources for both clinicians and clients.

Ninety percent of the therapists reported feeling comfortable providing counseling services to clients through teletherapy, which indicates that the clinicians are feeling confident and familiar with delivering teletherapy services. The clinician's confidence could influence the client's level of comfort and confidence engaging in teletherapy services as modeled by the therapists.

Sixty five percent of the therapists felt they had more time to complete paperwork pertinent to clients and cases, meaning that teletherapy helps clinicians to save time (e.g., commuting from work to clients' homes) to dedicate to documentation.

Seventy five percent of the therapists felt prepared to conduct teletherapy, which indicated that therapists felt they had the necessary tools and information to be successful while delivering teletherapy services.

Ninety percent of the therapists felt supported by the supervisor/workplace while providing teletherapy to clients. This is very important for the agency in terms of improving quality of services and customer's satisfaction (including staff and clients).

Sixty percent of the clinicians stated that they received sufficient training to provide teletherapy services. This has been the priority for the CFS' Executive Team and the supervisors to ensure the therapists are successful in what they do. Many of the clinicians have been taking webinars on teletherapy via Relias Training, reading books about teletherapy purchased by the agency and attended online trainings offered by different providers. In July 2020, the agency applied for a grant to cover training expenses for clinicians and supervisors on teletherapy and the response from the funder was pending.

Seventy percent of the clinicians reported to have enough resources to provide to clients via teletherapy. CFS' supervisors and clinicians received frequent messages from 211, Children's Services Council and Nonprofits First, among others, about available resources during the pandemic for clients. Those resources were shared with clients on a regular basis.

Eighty five percent of the clinicians stated that they would like to continue to provide teletherapy services after the pandemic. To do this, the Executive Team encouraged registered interns to become licensed to follow the board's expectations and rules. So far, before the

pandemic, only licensed therapists were approved to facilitate teletherapy, which could limit the availability of services post pandemic, because most of the CFS' therapists are registered interns. The Chief Operating Officer's priority was to hire licensed professionals and that was a challenge because the demand for services during the pandemic was greater than the availability of professionals in the area.

Eighty percent of the clinicians stated that they had a plan in place to assist high risk cases. This was very important because it is an ethical expectation and responsibility for the clinicians to have a plan to ensure the clients' safety and wellbeing.

Ninety five percent of the clinicians stated that their supervisors were available to provide support to them when needed to discuss cases or solve technical issues. Supervisors have been engaging in frequent communication with team members during the pandemic to provide support and prevent burnout and secondary trauma. Clinicians are human beings and some of them have been suffering the consequences of the pandemic directly and indirectly. Moreover, 85% of the clinicians stated that they received support from their colleagues. This was an expected and valued behavior in the CFS. Teamwork was critical to overcome this difficult time and move forward as an agency. Furthermore, 85% of the clinicians mentioned that they received support from the administration. CFS experienced many changes related with new staff working for the agency and others leaving the agency as well as changes in processes linked to the new electronic medical record system and the delivery of teletherapy. CFS' administrative staff's priority was to continue to support the clinical services and work as a team.

Fifty percent of the therapists were neutral about their preferences to facilitate in person services rather than teletherapy. The explanation could be that the therapists were accustomed to see clients face to face and this human contact was missing due to the pandemic. Also, there

were clients that preferred to receive services in person, especially parents looking for therapy for small children. 35% of the therapists disagreed with providing services in person. They preferred to deliver teletherapy services.

Results from the Client's Survey

Location for Teletherapy Visits

According to the data collected on the survey, 87% of the clients engaged in teletherapy services from home. Based on the licensure board, clinicians have the responsibility to verify the client's location at the moment of the teletherapy session to ensure safety in case the client needs to be referred to the hospital due to a high-risk situation that represents danger to the client or others. In those cases, the clinicians need to be familiar with the resources in the area the client is located. Furthermore, the CFS' clinicians' licenses are only valid in Florida and CFS provides services only in Palm Beach County.

Client's Age

Seventy four percent of the clients were within 25 and 44 years old, which matches the age range of the clinicians. This factor can contribute to the alliance between clients and therapist based on age similarities.

Client's Gender

Eighty seven percent of the clients were females, which matches the clinicians' gender as well. Currently about 90% of the clinicians are females. To ensure gender diversity, the agency is making efforts to hire male clinicians that could respond to the unique needs and preferences of male clients.

Client's Ethnicity/Race

Twenty six percent of the clients identified themselves as African American, 16% Caucasians, and 58% Latinx/Hispanic. Those ethnic categories were based on the guidelines

provided by funders. CFS supports and serves every resident in the county regardless of their cultural background. CFS has a diverse team of clinicians that understand the client's cultures, traditions, and beliefs. Currently, the agency has therapists and supervisors with diverse cultural and linguistic backgrounds to respond to the clients' needs.

Client's Perspective About Telehealth Services

Ninety percent of the clients reported that they were able to clearly see the therapist during the visit. The eye contact during therapeutic interactions is critical because that is a demonstration of the therapist interest and respect for the client's narrative. Also, 100% of the clients stated that they were able to clearly hear the therapist during the visit. This is an important piece of active listening to engage the client in the session. Moreover, 100% of the clients reported that they felt understood, heard, and respected during the session. This item indicates that CFS' clinicians have skills to form and maintain strong alliances with clients as demonstrated by the results from the evidence-based practice Partners for Change Outcome Management System (PCOMS), which will be described later in this paper.

Hundred percent of the clients reported that they felt that their private information was protected and safe during the visit. This item reflected how serious CFS is with complying with HIPAA regulations to protect the clients' information as well as its commitment to deliver quality of services.

Seventy four percent of the clients stated that the teletherapy session was as good as a face-to-face visit. This response showed that most of the CFS' clients were comfortable when engaging in teletherapy services, which could be a positive indicator of clients' interest in continuing with teletherapy services after the pandemic.

Seventy four percent of the clients did not feel embarrassed or felt uncomfortable with

the camera and other equipment. In other words, it appeared that clients felt comfortable with using technology to participate in therapy.

Out of the hundred percent (fourteen) of minor clients, 64% (9) stated that their parents liked their participation in teletherapy. This information provided evidence that parents were supporting their children's participation in teletherapy due to their progress in therapy. Also, it appeared that teenagers and older kids preferred to engage in online services (rather than in person services) because many of them felt comfortable with the use of technology. However, some parents requested in person sessions for their younger kids (5 years old and younger) due to their short attention span.

Hundred percent of the clients reported overall satisfaction with using teletherapy. This is promising data for the agency toward the continuation of the delivery of virtual services after the pandemic. Furthermore, 74% of the clients stated that they would like to continue to participate in teletherapy after the pandemic. CFS is currently working on a reopening plan to offer again in-person (in the office or in the community) services for clients that prefer that modality. The agency's goal is to continue to offer teletherapy services to clients that are interested in continuing with that service after the pandemic.

Ninety four percent of the clients reported that they would recommend the agency to a friend or colleague to receive services. This information indicated that many of the CFS' referrals were coming from "word of mouth." Many of the clients are referred to the agency by current or former clients that are satisfied with the services. Also, some clients have been returning to the agency to receive more services when in need. This situation could be a demonstration of the CFS' clients' trust, satisfaction, and loyalty.

Discussion About the Teletherapy Satisfaction Surveys

The results from the Teletherapy Satisfaction Surveys were positive and provided preliminary data to continue with research on this area and the conversations with the funders about the continuity of teletherapy services after the pandemic. Clinicians and clients reported feeling comfortable with participating in teletherapy. Based on this survey, teletherapy offers a variety of benefits related to using resources wisely by saving time in commuting from home to the office, saving money, having the ability to schedule and reschedule sessions efficiently and promptly, feeling safe (prevention of infection) and reducing stress related to leaving pets or children unsupervised at home, among others.

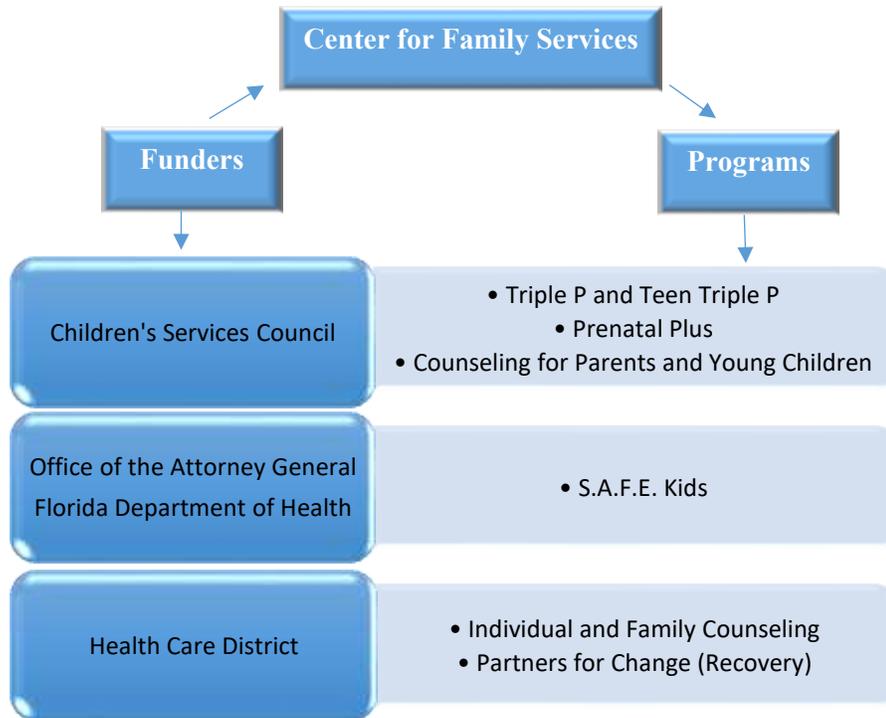
CFS is aware that teletherapy is not the preferred method for every clinician and every client. There are some limitations and challenges related to teletherapy such as the lack of privacy, distractions/concentration problems, interruptions, poor internet connections and technical issues, among others (Barnett & Kolmes, 2016). From the clinical point of view, teletherapy may not be indicated for clients dealing with complex mental conditions that are not appropriate managed as well as clients engaging in high-risk behaviors (Manhal-Baugus, 2001 as cited in Barnett & Kolmes, 2016), clients with concentration/hyperactivity problems, and some young clients (less than 5 years old).

CFS' Main Funders and Programs

CFS receives financial support from dependable funders such as Children's Services Council of Palm Beach County, State Attorney's Office, Department of Health, and Health Care District to continue to operate remotely during the COVID-19 crisis. Figure 2 shows the connection between the funders and the CFS programs.

Figure 2

CFS' Funders and Programs



Note. This figure illustrates the CFS’ main funders and programs in 2020.

The following are brief descriptions of the CFS’s main funders.

Children’s Services Council of Palm Beach County

Children’s Services Council (CSC) of Palm Beach County is an independent special district created by Palm Beach County voters in 1986 to provide funding, services, and research to ensure children’s healthy development and safety. Children’s Services Council has a ten-member council and is funded with property taxes to financially support about 60 programs for children and families in Palm Beach County, including day cares, after school, and summer camp scholarships, as well as services for pregnant women and young children, community initiatives and bridges. (Children’s Services Council of Palm Beach County, n.d.)

CFS is one of the providers for CSC through the Healthy Beginnings System, which support vulnerable groups in our county, such as pregnant women experiencing high risk pregnancies, children 0 to 5 years old, and parents with children 0 to 17 years old. The following is a summary of the three programs offered by CFS to the community funded by CSC as described on the CFS' Client's Services Guide (Revised in 2020).

Tripe P and Teen Triple P. Positive Parenting Program

The Triple P Program is a parenting and family support system designed to prevent, as well as treat, behavioral and emotional problems in children and teenagers (Center for Family Services' Client's Services Guide, 2020). The program was developed by Professor Matt Sanders and his colleagues from the Parenting and Family Support Centre in the School of Psychology at the University of Queensland and is based on over 25 years of research (Markie-Dadds et al., 2013). According to Markie-Dadds et al. (2013) Triple P aims to prevent problems in the family, school, and community before they arise and to create family environments that encourage children to realize their potential. Triple P draws on social learning, cognitive behavioral and developmental theory as well as research into risk factors associated with the development of social and behavioral problems in children. The goal is to equip parents with the skills and confidence they need to be self-sufficient and to be able to manage family issues. CFS has practitioners trained and accredited in several levels of Triple P and provides the program to parents and families in their home, community, and office setting. The Triple P Practitioners provide services in English, Spanish, and Creole.

Prenatal Plus Program

Prenatal Plus is a home visiting program that provides services to at risk pregnant women using a multi-disciplinary team approach. Each pregnant woman is eligible to receive supportive

services from a Care Coordinator/Nurse from Department of Health, a Behavioral Health Practitioner from CFS and a Registered Dietician from Nutritious Lifestyles, Inc. Each member of the team conducts an initial assessment of the pregnant woman and develops an integrated plan of care for ongoing services as needed. Team members work collaboratively to empower women to make lifestyle changes that positively impact their pregnancies and result in healthier infants by using a client-centered approach (Center for Family Services' Client's Services Guide, 2020).

Counseling for Parents and Young Children

Counseling for Parents and Young Children (CPYC) is a mental health counseling program at the Center that provides mobile mental health counseling services to pregnant mothers, children from birth to five years of age, as well as their parents/caretakers. The referrals for the CPYC program come primarily from two agencies: Healthy Mothers/Healthy Babies and Home Safe. In addition to providing mental health services to new and expectant mothers throughout Palm Beach County, the Healthy Beginnings system provides access to healthcare and training in the areas of child development, literacy, and family support. CSC and the CPYC program aim to promote healthy births, reduce abuse and neglect, and support children's readiness to begin kindergarten (Center for Family Services' Client's Services Guide, 2020).

Other funders are the Office of the Attorney General in the State of Florida that approves and oversees the federal Victim of Crime Act (VOCA) grant and the Florida Department of Health that oversees the Sexual Abuse Treatment Programs (SATP) in the State. CFS uses those two grants to provide therapy to Palm Beach County's "victims of crime" (term used by the funder) through the CFS' S.A.F.E. Kids Program.

Office of the Attorney General

The Office of the Attorney General through the Bureau of Advocacy and Grants Management offers the federal Victim of Crime Act (VOCA) grant to community providers to support the emotional and physical needs of survivors of crime in confidential ways. The goal is to support victims of crime with their stabilization after the victimization, understand the criminal justice system, and recover their sense of safety and security.

Florida Department of Health

The Florida Department of Health focus its efforts on improving the Florida residents' health by collaborating with state, county, and local entities. The Division of Children's Medical Services (CMS) is dedicated to serve children with special health care needs through different family-centered programs. The CMS Sexual Abuse Treatment Program (SATP) provides specialized treatment for children victims of sexual abuse to prevent long term psychological effects of sexual abuse victimization, to reduce trauma related to victimization, and support children and families during their healing processes. The referrals to the SATP are coming from the Child Protection Teams, the Department of Children and Families, law enforcement and community agencies. CFS is one of the fourteen SATP providers in the State of Florida.

S.A.F.E. Kids Program. Stop Abuse by Family Empowerment

S.A.F.E. Kids program is the only officially recognized Sexual Abuse Treatment Program (SATP) in Palm Beach County by the Florida Department of Health, Division of Children's Medical Services (CMS). S.A.F.E. Kids provides a needed service in our community by helping adults molested as children, as well as children, their siblings, and parents learn ways to keep themselves safe and find ways to cope effectively with traumatic events. CFS provides therapy and advocacy for children and adults who are victims of sexual abuse, physical abuse,

neglect, domestic violence, human trafficking and/or other crimes. A team of qualified therapists provide comprehensive safety planning as well as various forms of play activities to engage children as young as three in therapeutic services. S.A.F.E. Kids' therapists are trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and receive specialized training in the treatment of sexual abuse. S.A.F.E. Kids partners with local experts in the areas of Play Therapy, Clinical Sexology, and Child & Adolescent Psychiatry to receive specialized training and support the provision of services to this vulnerable population (Center for Family Services' Client's Services Guide, 2020).

Finally, the following is the description of the role of the Health Care District of Palm Beach County as one of the CFS' funders.

Health Care District of Palm Beach County

Health Care District (HCD) of Palm Beach County is an independent taxing district created in 1988 by Palm Beach County Residents and governed by a seven-member Board Commissioners. Its goal is to provide health care services such as: trauma care, school health, health coverage, hospital, nursing care, and primary care clinics. (Health Care District of Palm Beach County, n.d.) The HCD currently funds two CFS' programs: Individual and Family Counseling and Partners for Change (Substance Abuse Treatment Services) Programs that will be described below based on the CFS's Client's Services Guide (Revised in 2020).

Individual and Family Counseling Program

The Individual and Family Counseling Program offers professional and confidential mental health counseling to individuals, families, and children on an outpatient basis to assist with various problems including marital issues, family discord, substance abuse, domestic violence, grief and loss, trauma, depression, anxiety, and life transitions. The program helps

individuals and families build upon their strengths and resources to develop strong social relationships, improve coping skills, lead satisfying and productive lives and gain knowledge of how to access useful community resources. The CFS' therapists are licensed or registered interns with graduate degrees and trained in a variety of therapeutic models (Center for Family Services' Client's Services Guide, 2020).

Partners for Change. Substance Abuse Treatment Services

The Partners for Change (PFC) program is an outpatient psychotherapy service, licensed by the Florida Department of Children and Families to assist adolescents and adults who are experiencing problems with both substance use and co-occurring mental health issues. The program offers confidential therapy by focusing on clients' strengths and assisting clients to achieve their therapeutic goals. This unique approach views clients as valued partners in the change process and offers a systematic real-time outcome measurement process that maximizes effectiveness. CFS' PFC Program provides substance abuse education, crisis intervention, professional consultation, assessments, case management, group, individual, and family therapy aimed at breaking the cycle of addiction. CFS collaborates with community stakeholders such as schools, colleges, universities, clinics, hospitals, law enforcement, state and county probation officers, and traffic schools, among others. The services are provided by multicultural and multilingual licensed and license eligible clinicians (Center for Family Services' Client's Services Guide, 2020).

Program Description for Substance Abuse Services

- Each client receives weekly services for the most part.
- The services include counseling as provided for in subsection 65D-30.010(2), F.A.C. and clinical staff provides those specialized services.

- Services are provided in accordance with the clients' needs as identified in the treatment plans.
- Other areas of focus include: (a) Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making, relationship skills, and symptom management; (b) Training or advising in health and medical issues; (c) Employment or educational support services to assist clients in becoming financially independent.

Partners for Change Program as the other CFS' programs described above use the Partners for Change Outcome Management System (PCOMS) to measure therapeutic outcomes. The following is a brief explanation of this evidence-based practice that add value and quality to the CFS programs.

Partners for Change Outcome Management System (PCOMS)

Partners for Change Outcome Management System (PCOMS) is an evidence-based practice designed to improve outcomes and form strong partnerships with clients. (Better Outcomes Now, n.d.). It was developed by Barry L. Duncan, Psy.D., and was included in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP). CFS has been using PCOMS since 2002 and every year Dr. Duncan facilitates a two-day training for CFS' supervisors and clinicians (Center for Family Services' Client's Services Guide, 2020).

PCOMS uses two, four item scales to solicit clients' feedback regarding factors proven to predict success regardless of treatment model or presenting problem: early progress (using the Outcome Rating Scale, ORS) and the quality of the alliance between therapist and client (using the Session Rating Scale, SRS). PCOMS:

- identifies clients at risk for negative outcome before dropout or treatment failure,
- provides objective, quantifiable data on the effectiveness of providers and systems of care,
- uses measures that are reliable and valid, but feasible for each clinical encounter, and
- provides a mechanism for consumer preferences to guide choice of intervention. (Better Outcomes Now, n.d., para. 2)

With the pandemic, the CFS's clinicians have been engaging clients in the completion of the ORS and SRS remotely. When the clients are unable to complete the tools remotely, the clinicians are collecting the clients' responses verbally and recording the scores in the Better Outcomes Now system to keep track of the clients' progress in therapy. PCOMS has been instrumental in the CFS' successful acquisition of county, state, and federal funds due to the comprehensive and systematic manner to monitor therapeutic outcomes.

Teletherapy in Palm Beach County Non-profit Agencies

The CFS collaborates with referral sources by engaging in outreach efforts and network events with several non-profit agencies in Palm Beach County that provide behavioral health services and education to the residents. The following are the experiences and stories of three non-profit organizations that have been delivering teletherapy services during COVID-19.

Center for Child Counseling

Center for Child Counseling (CCC) was created in 1999 and has been focusing on preventing and healing adverse experiences and toxic stress in children through the ACEs initiative funded by Quantum Foundation. The CCC's mission is "building the foundation for playful, healthful, and hopeful living for children, families and communities" (Center for Child Counseling, 2020, n.p., para. 1).

On the online article written by Jamieson (2020) titled “When Children’s Mental Health Goes Online” and posted on the CCC’s website, where she reported that her agency started the delivery of teletherapy in February 2020 facing some challenges related to the clients not feeling comfortable with the use of technology or problems with the internet, as well as engaging children in play therapy virtually, however, the agency has been mitigating those challenges by providing Home Therapy Play and Tool Kits to develop positive child-caregiver interactions, with the virtual guidance of the therapists. Jamieson (2020) cited the following statement from the CCC’s CEO “our services are more vital now than ever and we have to find ways to provide children with services in an effective, innovative way now that we’re working remotely” (Jamieson, 2020, para. 2).

Regarding teletherapy, L. Scirrotto (personal communication, May 29, 2020), CCC’s Chief Program Officer shared with me her organization’s experience regarding the delivery of virtual services to the community, reporting that her agency started the delivery of teletherapy before the pandemic. According to her, the agency had ten licensed clinicians trained in the Vsee HIPAA compliant platform and were delivering teletherapy services to some clients that had access to technology and the ability to use it to participate in sessions. Scirrotto stated that the teletherapy project was in the initial stage of implementation, which included having the platform running, the clinicians trained in the use of the platform, the clients instructed in the teletherapy process, and the appropriate teletherapy consents and forms with signatures. Scirrotto reported that they were collecting data about the teletherapy services outcomes, opportunities, challenges, and areas for improvement to plan accordingly.

Families First of Palm Beach County

This non-profit agency has been providing services to Palm Beach County residents for 30 years, in the areas of child abuse prevention, health, housing, and behavioral health services. In the online video posted on September 10, 2020, titled “Connectivity through the lens of COVID-19”, Simeus et al. (2020) reported that her agency has been strengthening families through meaningful connections during COVID-19 by using telehealth platforms such as Google Classroom, which is used by the School District to connect with students and their parents. She also stated that her agency is using HIPAA compliant and non-compliant platforms such as Zoom, Vsee, and Google Duo to facilitate family therapy to families that are grieving, as well as the Parent Connect platform to connect parents with one another and teach them parenting skills to enhance the parent-child relationship, address the stigma of mental health, and improve their access to services. (Simeus et al., 2020)

Ruth and Norman Rales Jewish Family Services, Inc. (JFS)

According to the history recorded on the JFS website, the agency was created in 1979 as the first agency of the Jewish Federation of South Palm Beach County and in 2001 became a non-profit agency providing support to individuals with mental illness, developmental disabilities, seniors, students from public schools struggling with depression symptoms, divorced families, families affected by hurricanes, and assisting the Holocaust survivors with meals.

The President and CEO, Hartman (2020) reported on her personal reflections posted on the agency’s website in March 23 that the clinicians from the mental health programs were delivering teletherapy and using tele chat to connect with new and established clients, and the agency continued to accept new clients at that time. She stated that most of the staff members

were working remotely and announced an emergency financial assistance and access to the food pantry to families affected by COVID-19. (Hartman, 2020)

On her last report from July 31, 2020, Hartman updated her agency's information about the increase in services related to the food pantry, the delivery of food for seniors, the emergency financial assistance program and the collaboration with psychiatric residents from FAU to provide mental health services to children and adults affected by COVID-19. JFS also is facilitating virtual support groups to address issues related to bereavement, cancer, caregivers, mindfulness, domestic violence, and employment to mitigate the effects of the pandemic in the community.

The teletherapy experiences of the above non-profit agencies from Palm Beach County are inspirational because they, as well as the CFS, are doing their best to continue to support the residents during the pandemic, providing virtual services and preparing to reopen their offices to provide in-person services to clients that are unable to access virtual services due to the lack of technology, equipment, internet, or clients that do not qualify for teletherapy due to high risk situations or those that prefer in-person services. By comparing the experiences of the above non-profit agencies, I discovered that they were dealing with similar challenges and advantages related to teletherapy that the CFS was experiencing. In this respect, it appears that many non-profit agencies in Palm Beach county are in the preliminary phase of the delivery of teletherapy services. They are learning and adjusting to the process of delivering virtual services.

Self of the Therapist

I started my professional relationship with the Center for Family Services of Palm Beach County, Inc., in 2008 when I began my practicum for the master's program in Marriage and Family Therapy as part of the academic requirement for graduation at Nova Southeastern

University. I completed my practicum in one year and in my opinion, it was the most intense and interesting year of my professional career. I had the opportunity to work with clients with different cultural backgrounds, races, ages, genders, and belief systems. I practiced my clinical skills and learned from my clients' traumatic stories and challenges related to poverty, physical and mental distress, abuse, and violence.

I graduated in 2010 and worked for different organizations until 2014 when I went back to the CFS. During that time, I was pursuing my professional licensure. I worked in the Triple P program funded by Children's Services Council of Palm Beach County to assist parents with parenting skills following an evidence-based curriculum. After a year as a Triple P therapist, I was promoted to a supervisory position in the Integrated Care program where I oversaw a licensed clinician and delivered consultations to clients in two small community clinics as part of a multidisciplinary team of health care providers. The clients ("patients") did not have health insurances or had insurances with limited mental health coverage. The program was funded by a grant that allowed the clients to receive brief free consultations in the clinics' settings. This grant ended in 2015 and that year I was promoted to the Director of Clinical Services position, where I oversaw three programs: S.A.F.E. Kids, Employee Assistance Program (EAP) and Individual and Family Counseling Program.

In July 2019, I was promoted to the Chief Operating Officer position until October 2020, when I transitioned to private practice. My seven-year journey at the CFS was meaningful and productive. I learned and practiced clinical, supervisory, and administrative skills in a multicultural and supportive work environment. I feel privilege and honor by contributing to the CFS with this dissertation project on teletherapy, which is relevant to the Center due to its commitment to serve at risk populations.

This reflection on my professional experience working as a mobile and in-office therapist, led me to be aware of the advantages of delivering in-home and remote services in contrast with in-office services. In-home and remote services, from my perspective, contribute to the reduction of no-show rates and allow the therapist to observe the clients' family environment and social context and understand their experiences and perspectives linked to those environments. Many clients shared with me the benefits of saving time, saving money that otherwise they will spend in childcare, and saving time and money in transportation when attending therapy at home or virtually.

I did not imagine that in 2020 I would be delivering teletherapy services nor that a critical situation such as the pandemic will force the CFS to transition to the delivery of teletherapy services on the spot. This experience taught me at least two relevant lessons: opportunities can come out of crisis and flexibility and adaptability are necessary skills in our field. Therapists have an ethical responsibility to support clients, their families, and the community in moments of crisis, and sometimes we (therapists) need to operate out of our comfort zone.

Purpose of the study

CFS is a non-profit agency with committed and caring clinicians that work very hard to ensure the wellbeing of the Palm Beach County residents. COVID-19 brought many challenges to a health care system that was already overwhelmed by the high demand of therapeutic and social services and the lack of multilingual, specialized, and licensed professionals available to respond to those needs.

The purpose of this study was to explore the experiences of the CFS' staff on what worked well while transitioning to the delivery of teletherapy services during the COVID-19 pandemic, as well as the CFS' team's future dreams regarding the delivery of teletherapy

services. I was interested in learning about the CFS' staff perspectives and reflections on the delivery of virtual services focusing on what was working and how to do more of that to ensure the success of teletherapy in the agency and the community. Furthermore, I was curious about the CFS' team's expectations about teletherapy services in the future and how teletherapy would shape the professional experiences for CFS' clinicians. This study allowed the CFS' team's voices to be heard on what worked when delivering teletherapy services to a community that was affected by the devastating effects of COVID-19.

I decided to use the Appreciative Inquiry (AI) model to explore the CFS' transition to teletherapy because it is a positive, collaborative, constructive, strength-focused, and future-oriented model that aligns with a systematic perspective about organizational change (Cooperrider et al., 2008). This is a model that elicits organizational change by focusing on the human system interactions and collective dreams. AI process consists in the connection between what is working in the organization (Discovery phase), what is the desired future (Dream phase), how to collectively build the organizational architecture (Design phase), and how to find innovative ways for the organization to reach an ideal state (Destiny phase). (Cooperrider et al., 2008)

Focus of Chapters

Chapter I provides the background of the problem in the context of the agency where I worked for the last six years of my professional career, the Center for Family Services (CFS) of Palm Beach County, Inc. I cite and describe the role of the CFS' main funders such as Children's Services Council of Palm Beach County, the Office of the Attorney General, the Florida Department of Health, and the Health Care District of Palm Beach County. Chapter I also includes a section about the self of the therapist where I describe my journey as an administrator,

supervisor, and clinician at the CFS and the lessons I learned when delivering therapy in the office, in the clients' homes, and via teletherapy. The last part of this chapter is dedicated to explaining the purpose and relevance of this study not only for CFS but also for the field of family therapy.

Chapter II presents available literature review on the definition of telehealth, online therapy, telebehavioral health and teletherapy to provide clarification on the use of this term, the use of this modality in the mental health field, and the evolution of teletherapy nationally and locally as well as the use of teletherapy in local non-profit organizations. This chapter also presents the gap in literature related to teletherapy and the need for more research on this topic. Chapter III explains the research methodology which includes a description of the Appreciative Inquiry (AI) methodology as “an organization development process to change management” (Cooperrider et al., 2008) and the 4-D cycle process (Discovery – what is-, Dream – what might be-, Design – how it can be-, and Destiny – what will be-), my role as a researcher, the data collection process, the characteristics of the participants in this study, and the data analysis.

Chapter IV covers the research findings, the data analysis based on the Appreciative Inquiry (AI) methodology, the 4-D cycle process, and the research themes. Chapter V presents the discussion and implications of this study, this researcher's reflections, the strengths and limitations of the study, the clinical implications, the implications for future research and concluding thoughts.

CHAPTER II: LITERATURE REVIEW

In this chapter, I present an overview of virtual or remote therapy, which has different names and similar definitions in the literature. I discuss the benefits and limitations of teletherapy as well as information about the status of teletherapy nationally, in the State of Florida, in Palm Beach County where CFS is located and the experiences of a few non-profit agencies that provide teletherapy in this County. In the last section of this chapter, I discuss information about teletherapy and the field of Marriage and Family Therapy in the context of the pandemic and the temporary changes the licensure board and the Department of Health have been adopting to make possible for clinicians to practice the profession in a safe manner.

Overview of Teletherapy

Definitions

Van Dyk (2014) designed a graph that illustrated the connection between the different terms related to virtual or remote services (Figure 1), where eHealth and telehealth are used interchangeably. According to van Dyk, “semantically, the difference between these two concepts is that eHealth applications are not limited to healthcare over a distance, as is the case with telehealth” (p. 1284). When it comes to mHealth, van Dyk stated that it “refers to e-health applications that are executed with the help of mobile technology.” (p. 1285)

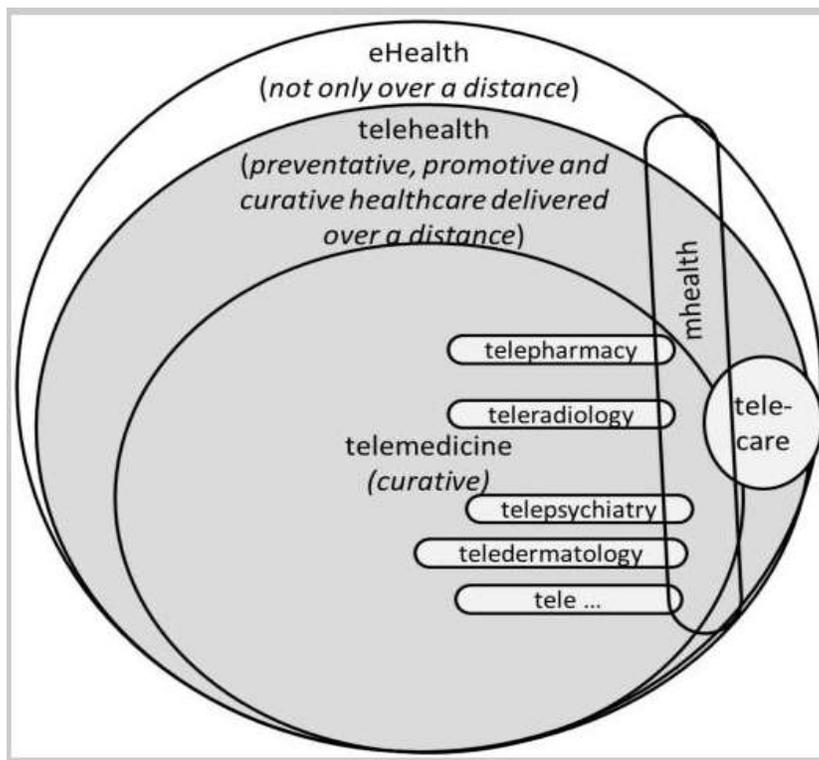
Regarding telehealth, there are different authors that agree with telehealth being an expansion of telemedicine with the difference that telemedicine focuses on the curative part of the treatment while telehealth involves prevention, promotion, and cure. Furthermore, Bashshur et al. (2011) cited Bennet et al., as the pioneers in using the term telehealth in 1978 to extend the scope of telemedicine to activities such as “patient and provider education.” (p. 487)

Regarding telecare, the Telecare Aware Group (2012) provides the following definition: “Telecare is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living,” (para. 1) which due to its preventative nature is part of telehealth.

Figure 3 illustrates the relationship between the different terms used to refer to virtual or remote services in the health and mental fields.

Figure 3

Telehealth terminology



Note. This graph illustrates the relationship between telemedicine, eHealth, telehealth, telecare and mhealth. From van Dyk, L. (2014). A review of telehealth service implementation frameworks. *International Journal of Environmental Research and Public Health*. 11, 1279–1298. doi:10.3390/ijerph110201279

Several authors agree that the term telemedicine involves the use of technology to communicate with clients to deliver health care services. During recent years, the term telehealth has been used broadly to include clinical and non-clinical services. For instance, Chapter 2019-137, Committee Substitute for House Bill No. 23, Section 456.47, Florida Statutes, defines telehealth as

the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. Telehealth does not include audio-only telephone calls, e-mail messages, or fax transmissions. (Florida House of Representatives, 2019, p. 2)

This definition is consistent with the definition provided by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, which defines telehealth as “the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration” (HealthIT.gov, 2020, para. 1).

According to HRSA, the technologies used to delivery health care include “videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications,” (HealthIT.gov, 2020, para. 1) and the applications could be live (synchronous) videoconferencing, where the provider and the client communicate by a two-way audiovisual platform in real time; store-and-forward (asynchronous) videoconferencing which consists in recording the history of a client’s health by a provider to submit it to another provider who usually is a specialist; remote patient monitoring (RPM), also consists in recording health

information by a provider and sharing that recording with another person (usually another provider in a different location) to access that information at a different time; and mobile health (mHealth) which is public health education shared through mobile devices as cited previously.

Regarding the telehealth providers included in the Florida Statutes, the following is the definition:

Telehealth Provider is broadly defined as an individual who provides a health care service using telehealth, which includes, but is not limited to, a licensed physician, podiatrist, optometrist, nurse, nurse practitioner, pharmacist, dentist, chiropractor, acupuncturist, midwife, speech language pathologist, audiologist, occupational therapist, radiological personnel, respiratory therapist, dietician, athletic trainer, orthotist, pedorthist, prosthetist, electrologist, massage therapist, medical physicist, optician, hearing aid specialist, physical therapist, psychologist, clinical social worker, mental health counselor, psychotherapist, marriage and family therapist, behavior analyst, basic or advanced life support service, or air ambulance service. (Ferrante & Lacktman, 2019, para. 2)

When it comes to behavioral and mental health services, the term commonly used is telebehavioral health, which is “the process of providing behavioral therapy or psychotherapy remotely” (WeCounsel, n.d., para. 1). This process usually involves the use of HIPAA compliant platforms for videoconference or messages via text. Other related terms that are used interchangeably are telecounseling, online counseling, online therapy, e-therapy, e-counseling, cyber-counseling, and teletherapy.

According to the Telebehavioral Health Institute (2020), the term telemental health has been replaced recently by the term telebehavioral health by the US Federal Office of Health and

Human Services (HHS) with the intention to de-pathologize and de-stigmatize health care for clients struggling with mental health and/or substance use issues. In this respect, telebehavioral health is defined as “the practice of behavioral health using a telecommunication system to provide clinical services, professional training, administrative and other services at geographically separate sites” (Telebehavioral Health Institute, 2020, para. 2). The virtual services can be delivered in real time via phone, video conference, email, or text message.

In this research I use the term “teletherapy” to refer to the delivery of virtual or remote therapy services because in my opinion it is short, simple, and self-explanatory.

Benefits of Teletherapy

Literature shows that teletherapy could improve clients’ attendance to sessions as well as satisfaction with services, which may reflect positive therapeutic outcomes. According to Pruit et al. (2014), home-based telemental health (HBTMH) treatment has several benefits such as the “reduced travel, less time off work, shorter appointment wait-times, and greater personal control” (Hilty et al., 2007; Simpson et al., 2005, as cited in Pruit et al., 2014, p. 341).

In addition to this, literature demonstrates that the clinicians facilitating teletherapy could observe the clients’ family or social environments, which may enhance the therapeutic alliance and provide valuable information for the treatment process. Pruit et al. (2014) noted that “the capability to view a patient’s environment and personal effects in their home ... may also contribute to rapport and connectedness ... wherein the practitioner gains experiential insight into the day-to-day routines, context, and contingencies operating in the family system” (Reiter, 2000, as cited in Pruit et al., 2014, p. 342).

Moreover, literature shows another benefit of teletherapy for the provider related to physical safety. Pruit et al. (2014) mentioned that “consider that nonfatal, job-related violent

crime perpetrated against mental health professionals by patients occur at a rate of 68.2 per 1,000, approximately four times greater than the rate for non-psychiatrist physicians and approximately three times greater than the rate for nurses” (Anderson & West, 2011; Friedman, 2006, as cited in Pruitt et al., 2014, p. 343). Currently, due to COVID-19, this benefit is relevant to providers and clients to prevent risks of infection and protect their health and wellness.

Hilty et al. (2013) argued that client’s access to care “appears to have been greatly increased, based on the recent decade’s research—with a few exceptions. Patients may have less travel, absence from work, and time waiting, more clinical choice and control, and better outcomes” (p. 451). In other words, clients seemed to experience a variety of advantages when it comes to participating in teletherapy services due to the efficiency and effectiveness of services. Most clients do not like to wait or waste time and resources unnecessarily, for those reasons teletherapy services become easy to access, safe, secure, comfortable, and convenient.

Another factor related to access to care is the difficulties clients are facing when the location to receive teletherapy is out of their vicinity and attending in office services represents an inconvenient due to lack of transportation. This issue is expanded by Benavides-Vaello et al. (2013) when arguing that telehealth

can successfully be implemented for overcoming barriers to adequate services in rural and geographically isolated locations. The benefits of telehealth to the client include reduced travel time and cost, reduced separation of families, and a reduced number of missed appointments. Moreover, the literature supports that rurally located patients express satisfaction with services and a willingness to reuse services. (Benavides-Vaello et al., 2013, p. 113)

This is particularly relevant in Florida, where there are certain rural areas were the

distances are far away from agencies providing behavioral and mental health care services as well as the immigrant populations that due to poverty and resources, lack the ability to own their vehicles in areas where public transportation is not available.

Another important benefit of teletherapy is the reduction of missed appointments. This seems to be linked to the convenience of attending sessions at home, work, or school without spending extra time and efforts traveling from one place to the other.

According to Benavides-Vaello et al. (2013) telehealth has been proving effectiveness across different cultures and populations

The approach is a viable method to increase culturally competent services in rural areas for specialty populations such as Native American Indian Veterans, Chinese Americans, and Latin Americans. These modalities have proven themselves in terms of client and provider acceptance, reliability of assessment data, and feasibility. (Benavides-Vaello et al., 2013, p. 116)

This study is particularly relevant for CFS where a high number of the clients have a cultural background identified by funders as Latinx/Hispanics, farmworkers and immigrants with limited resources and access to care.

In terms of the rapport, connection, and alliance between therapist and client, “research has demonstrated that the therapeutic alliance in psychotherapy via videoconferencing is comparable with the alliance found in in-person treatment. (Cook & Doyle, 2002; Hanley, 2006; Morgan et al., 2008 as cited in Barnett & Kolmes, 2016, p. 57). This information is relevant to the field of family therapy because therapeutic alliance is an important factor that determines positive outcomes from treatment.

Limitations of Teletherapy

Pruit et al. (2014) presented in their research a variety of limitations related to telehealth, one of the most common limitations is “a perceived lack of technical savvy and insufficient experience with computer equipment has been cited by potential HBTMH patients as a reason why they choose to avoid remote care, suggesting that fear about the technological aspects of home-based care” (Shore et al., 2006; Starling & Foley, 2006, as cited in Pruit et al., 2014, p. 341).

This is also true for some clinicians that may experience the same technical limitations as their clients because they were accustomed to deliver in person services with minimal training on technology or not showing interest in using technology. This situation may represent a challenge for the clinician who, due to the pandemic, had to learn not only how to use the technology but also how to teach the clients the use of technology to participate in remote services.

Pruit et al. (2014) cited the results of the study conducted by Brooks et al. (2013) regarding the biggest issues facing the practice of telemental health:

(a) the provision of clinical services via this modality may not be eligible for medical reimbursement; (b) it is unknown how remote services affect and are affected by laws regulating the practice of mental health professionals across state lines (e.g., issues associated with mandatory reporting, duty to warn, etc.); and (c) changes need to be made to liability standards to make this mode of treatment delivery a feasible practice. (Brooks et al., 2013 as cited in Pruit et al., 2014, p. 343)

The reimbursement issue for teletherapy services was also identified in the study conducted by Benavides-Vaello et al. (2013) where the authors noted that “while reimbursement for telehealth services has been implemented through Medicaid, Medicare, and some private

insurance companies, reimbursement is less than that of services provided in face-to-face encounters” (p. 114). Most of the health insurance companies in the nation were covering face to face, in person services for the most part before the pandemic. Some of those insurances covered telephone counseling to manage crisis situations. Due to the pandemic, most of the health insurances expanded the delivery of services to teletherapy with the same reimbursement rate as the face-to-face service, until the pandemic subsides.

Regarding the provision of teletherapy across states, before the pandemic, clinicians needed to be licensed in the state where they were practicing. During the pandemic with the flexibility of rules, clinicians can provide services out of the state; however, there are still some restrictions and requirements depending on the state’s regulations in the field. Moreover, liability continues to be an area of attention due to the complexity of the field of family therapy, the ethical responsibilities, and the current individual, family, and social challenges related to the pandemic.

Barnett and Kolmes (2016) highlighted another limitation of telehealth service related to the absence of visual cues and significant potential for miscommunication, difficulty adequately assessing and diagnosing individuals one does not have the opportunity to observe, and a lack of empirical support for the effectiveness of e-mail as the primary means of providing counseling services. Other concerns include difficulty knowing the identity of the individual one is corresponding with, and whether it is the same individual each time. (Barnett & Kolmes, 2016, p. 57)

The above limitation is more evident when clinicians deliver services via phone, e-mail, or text messages, where it is not possible to see the client’s facial expressions, body language, or

observe evidence that the client is in fact the client enrolled in services. This limitation can represent liability for the clinician and the agency where the clinician practices.

Another limitation related to teletherapy is linked to complex and high-risk cases. According to Barnett and Kolmes (2016) teletherapy is not appropriate “for those clients who suffer from serious mental illness including impairments in reality testing, serious depression and suicidality, and impulse control difficulties such as violence and homicidally” (Manhal-Baugus, 2001, as cited in Barnett & Kolmes, 2016, p. 58).

This is another example of liability for the clinician that delivers teletherapy services due to the limitation in responding to emergency situations across the distance. To reduce or mitigate this risk, the clinician needs to conduct a research of local resources in the client’s area and provide those resources to the client in case of an emergency.

Teletherapy in the USA

According to Doarn (2018) in the 1950s physicians at the University of Nebraska used telemedicine to provide consultation, education, training, and research for the patients between the Nebraska Psychiatric institute and Norfolk State Hospital in Nebraska, using a “two-way closed circuit microwave television,” (p. 1) to facilitate the communication between the sites.

Cecil Wittson was the pioneer of the telemedicine and psychiatric or telepsychiatry based on his work in Nebraska. By 1957, Wittson expanded the telepsychiatry training to Iowa, North and South Dakota – utilizing asynchronous or two-way audio communication. In 1959, asynchronous video improved consultation and therapy processes between the Nebraska Psychiatric Institute and the Nebraska State Hospital in Norfolk. (WeCounsel, n.d.)

Doarn (2018) explained that Wittson’s approach to link medical centers was expanded to

Massachusetts and Arizona in the 1960s and 1970s and continued to grow during the last 60 years to different applications on mobile phones and web-based videoconferencing tools.

The Federal Communications Commission (2013) suggested the year 1996 as the official starting point for teletherapy because the legislation for reimbursement for teletherapy services emerged during that period. Also, in 1996 President Clinton signed the Telecommunication Act, which marked an unprecedented change in the U.S.A law governing communications because it provided guidelines to use technology to deliver treatment and removed economic and legal barriers to its use. (Federal Communications Commission, 2013)

COVID-19 and HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is one of the most important rules in family therapy and in the health care field due to the ethical and legal responsibilities clinicians and health care organizations must ensure confidentiality and privacy of the clients' health information. Due to COVID-19, the U.S Department of Health and Human Services (2020) posted the Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency, providing guidelines on the flexibility with HIPAA rules related to the use of technology and the delivery of telehealth during the pandemic.

The Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) responsible for monitoring the regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), announced in March 2020 that they will not impose penalties to covered health care providers for noncompliance with HIPAA rules if those providers were delivering telehealth services in connection with good faith provision of telehealth during COVID-19. (U.S Department of Health and Human Services, 2020)

Furthermore, this notification allowed the covered health care providers use applications for “video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules,” (para. 6) except for “Facebook Live, Twitch, TikTok, and similar video communication applications” (para. 7). Many behavioral health organizations and clinicians were able to provide telehealth services during the pandemic using the applications they and their clients were able to access following the guidelines from the U.S Department of Health and Human Services feeling confident about not being penalized if not using HIPAA compliant platforms and or not having Business Associate Agreements (BAAs).

Teletherapy in Florida

Lacktman (2016) noted that the Florida’s Agency for Health Care Administration (AHCA) announced the creation in July 2016 of the Florida Telehealth Advisory Council with the purpose of conducting a research on telehealth insurance coverage and provide a report on five areas: the types of healthcare services provided via telehealth; the extent to which telehealth is used by healthcare providers and facilities; the estimated costs and savings to the healthcare system; which healthcare insurers, health maintenance organizations, and managed care organizations cover telehealth services in Florida; and the barriers using, implementing or accessing telehealth. (Lacktman, 2016, p. 1)

Ferrante and Lacktman (2019) cited the Florida Telehealth Advisory Council official report on telehealth that was posted in October 2017 and recommended some changes to the Florida statues and rules for a telehealth bill. This bill created a new section in the Florida statues (Section 456.47) effective on July 1, 2019, which defines telehealth and telehealth providers as well as the practice standards.

One of the practice standards for telehealth services is the provider's duty to practice in a consistent manner with his or her scope of practice and the professional standard "for a health care professional who provides in-person health care services to patients in this state" (p. 3). This is particularly important for family therapists to ensure that the profession has high practice standards regardless of the service is delivered in person or via teletherapy.

Moreover, the Florida Telehealth Advisory Council recommended in 2017 to the Florida statues the increase access to teletherapy by increasing healthcare professionals providing teletherapy. The Florida statues established that "a health insurance policy issued, amended, or renewed on or after July 1, 2018, shall provide coverage for services (excluding Medicare plans) provided via telehealth to the same extent the services are covered if provided in-person. (Florida Telehealth Advisory Council, 2017, p. 11)

This recommendation supports the previous statement about the healthcare professionals providing the same services in-person and via telehealth, which supports a comprehensive delivery of services that favors efficiency, effectiveness, and accountability.

The next recommendation by this Council was related to the reimbursement for services, where "for the purposes of health insurance payment (excluding Medicare plans), payment rates for services provided via telehealth shall be equivalent to the rates for comparable services provided via in-person consultation" (Florida Telehealth Advisory Council, 2017, p. 13).

The goal of this recommendation was to make the reimbursement rate for in-person services equivalent to teletherapy sessions, which in my opinion, encourages family therapists and other healthcare professionals to deliver teletherapy services when appropriate, to increase clients' accessibility to services, especially during emergencies or crisis, while receiving appropriate reimbursement for the delivery of those professional services.

Regarding Medicare, the recommendation from the Council to the State of Florida was to “support modifications to Medicare telehealth laws to expand coverage and include store-and-forward modalities as well as remote patient monitoring”, expanding the types of healthcare practitioners covered and revising the geographic requirement, (p. 14) and for Medicaid, their recommendation was to “modify the telehealth fee-for-service rule to include coverage of store-and-forward and remote patient monitoring modalities” in addition to the current live video conferencing modality. (p. 14)

The above modifications related to Medicaid are relevant to family therapist and other healthcare providers when it comes to share confidential information and clients’ records within providers to coordinate treatment and support clients’ care.

Regarding the telehealth standards of care, the Council recommended that “telehealth technologies may be employed for patient care as long as such technologies are used in a manner that is consistent with the standard of care,” (p. 17) which should be the same as the standard for in-person care to ensure professional accountability and quality of services.

In terms of the patient-practitioner relationships and continuity of care, the Council recommended the recognition by the Florida legislature of “the ability for practitioners and patients to establish a relationship through telehealth” and to “encourage efforts for ensuring patient care coordination among treating practitioners” (p. 18). This recommendation is particularly relevant for the field of family therapy due to the importance of therapeutic alliance and rapport in the outcome of treatment as well as ensuring that clients receive the services they need when they are referred to other providers. When it comes to patient consent to participate in telehealth services, the Council recognized the benefits for the patients to know the potential risks and the option of in-person services if necessary. (p. 19)

CFS created an informed consent for teletherapy in March 2020 to address information and risks related to teletherapy services with clients during the initial sessions. So far, the teletherapy consent has been useful to clarify treatment expectations with clients and address solutions to potential problems. (see Appendix C)

Finally, the Council highlighted the technological barriers that not only practitioners but also clients experience in their attempts to engage in telehealth services, including limited access to internet and technology, equipment costs, and secure exchange of clinical information through secure Electronic Medical Records platforms, among others. One of the solutions discussed by the Council on the report, was the federal LIFELINE program in Florida, administered by the Florida Public Service Commission to provide “free or discounted mobile phones to individuals that are eligible and enrolled in certain social services programs” (p. 21).

Technology continues to be an area of attention for CFS’ clinicians and administrators due to the nature of the services that require precautions when it comes to confidentiality and privacy as well as the clients’ limitations to access technology to participate in teletherapy services due to the cost of the equipment, internet services, and the lack of knowledge on how to operate computers and access applications.

Despite of the technology limitations, in Florida telehealth services have been instrumental during Hurricane disasters as indicated by Miller (2017) on her article in Orlando Sentinel, where numerous hospitals in Florida provided free telehealth services to patients during and after the devastating damage of hurricane Irma. Currently with the COVID-19 pandemic, the use of telehealth and teletherapy has been increasing exponentially due to the nature and effects of this crisis, which has been taking the life of many people as well as creating trauma for survivors.

Teletherapy in Florida has been growing and expanding rapidly in 2020 with the pandemic. Many professionals from the fields of health and human/social sciences have been mobilizing efforts to respond to the needs of the community during this crisis. For instance, Norton (2020) reported that a polling survey with Mental Health Counselors in April 2020 showed that 46% of the clinicians were delivering telehealth services only and 14% a combination of in-person and telehealth services. In May 2020, 63% of the clinicians were delivering telehealth services only and 11% were delivering a combination of in-person and telehealth services.

This data shows an increase of clinicians delivering telehealth services by 17% from April to May 2020. Nationally, according to Norton (2020), in April 2020, 65% of the mental health counselors were delivering telehealth services only and 13% were delivering a combination of in-person and telehealth services, in comparison to 43% of the clinicians delivering telehealth services only in May 2020, and 47% delivering a combination of in-person and telehealth services. The national data from May shows a reduction of clinicians delivering telehealth services only and it could be explained by the government and local authorities encouraging businesses and professionals to reopen their service to the public, in states where the pandemic was under control. That was not the case in Florida, where the positive cases of COVID-19 in April 2020 were 498 and in May 2020 were 927. (The New York Times, 2020)

Executive Orders Related to COVID-19

Executive Order number 20-51 was the first order posted on March 1st, 2020 by the Office of the Governor of the State of Florida establishing the COVID-19 response protocol and direction of the public health emergency. On March 21, 2020, the Florida Department of Health posted the Emergency Order number 20-003 to address the suspension of statutes, rules, and

orders due to COVID-19, where encouraged healthcare professionals not licensed in Florida, including marriage and family therapists, to deliver telehealth services in Florida to prepare, respond, and mitigate the effects of COVID-19.

On March 31st, 2020, the Florida Department of Health posted the Emergency Order number 20-004, valid until May 8, 2020, authorizing healthcare practitioners (under section 456.47(1)(b) with clear and active licenses in Florida to utilize audio-only telephone calls in providing health care services to existing patients. Prior to proceeding with audio-only telephone delivery of health care services, telehealth providers shall confirm that other telehealth methods are not available to the patient for treatment by documenting in the patient's medical record: 1) the steps taken to verify the patient's identity; 2) that the telehealth provider is able to currently utilize an available telehealth platform to provide treatment; 3) the name of the telehealth platform; and 4) confirmation that the health care practitioner asked the patient if a smart phone, tablet, desktop, or laptop computer is available for use. (Florida Department of Health, 2020, p. 3)

This Emergency Order provided clear expectations regarding the delivery of teletherapy by family therapists and other professionals to ensure best practices, confidentiality, privacy, platforms, and technology used. CFS' clinicians have been documenting this information in the progress notes recorded in the Electronic Medical Record system, Kipu, as a regular practice to follow this order.

On June 30, 2020, the Florida Department of Health extended the suspension of statutes, rules, and orders due to COVID-19 with the Emergency Order number 20-011 until the expiration of Executive Order number 20-52 (Public Health Emergency due to COVID-19), which was extended until further notice.

Teletherapy and Marriage and Family Therapy

The American Association for Marriage and Family Therapy (AAMFT) (2015) noted in the revised Code of Ethics on the section about releasing confidential information that Marriage and Family Therapist do not release confidential information unless the client provides a written consent. The consent could be also verbal in emergency situations. This section has been instrumental during the pandemic because many clients are unable to meet with clinicians in person to sign documents. In the CFS, clinicians have been collecting verbal consents to release confidential information and documenting the consent from clients in the electronic medical system, since the beginning of the pandemic. The CFS is making efforts to acquire technology that will make possible for clients to sign remotely releases of information forms and other documents, rather than obtaining only verbal consents.

Regarding the sections on maintenance of competency, knowledge of regulatory standards and developing new skills (The American Association for Marriage and Family Therapy, 2015) the AAMFT recommends to clinicians to take measures to learn new developments, clinical skills, and maintain competency in the field through education and supervision that involves ethics, laws, and professional standards. For CFS' clinicians, teletherapy is a new development that started with the pandemic in March 2020 and to gain competency in this area, supervisors and clinicians have been attending trainings and webinars as well as discussing opportunities and challenges during supervision and peer meetings. The transition to teletherapy services is a process that has been improving with time and practice.

The AAMFT Standard VI provides professional services to clients and engage supervisees in supervision using technology. The AAMFT indicated that

marriage and family therapists must: (a) determine that technologically assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology. (The American Association for Marriage and Family Therapy, 2015, p. 8)

COVID-19 triggered the need for teletherapy services in CFS and other national and local organizations in the medical and mental health fields. In the field of Marriage and Family therapists, the AAMFT has been establishing clear ethical guidelines regarding the use of technology to deliver services to clients and supervisees, including the identification of technology that is accessible to clients and supervisees and appropriate to their needs and circumstances, as well as the description of risks related to the use of technology, the importance of ensuring safety during communications that involve technology, and being competent in the use of technology when delivering services to clients or facilitating supervision. All these ethical issues have been discussed and processed in CFS with supervisors and clinicians to make sure the adherence to the AAMFT regulations and best practices. Of course, this is an ongoing process that will improve with time, experience, and more research.

Florida Board of Clinical Social Work, Marriage and Family Therapy & Mental Health Counseling

The Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counselors met in June 2020 to modify the rule 64B4 from the Florida Administrative

Codes due to COVID-19. Some of the modifications were related to allowing registered interns, with a qualified supervisor and a safety plan in place, to facilitate teletherapy during the pandemic to respond to the crisis by providing emotional support to residents in distress. Before the pandemic, only licensed clinicians were approved to facilitate teletherapy. Another modification to this rule was related to the permission for qualified supervisors to conduct supervision sessions via video conference or via telephone when necessary, to ensure the safety of the parties involved. (Florida Board of Clinical Social Work, Marriage and Family Therapy & Mental Health Counselors, 2020)

Before the pandemic, the supervision sessions were facilitated in-person. Those two modifications have been facilitating the delivery of teletherapy services to more community members as well as for the registered interns to continue to collect their client contact hours for their licensure processes. Those modifications also represent some risks for the field related to confidentiality, privacy, problems with technology, and clinical response to high-risk cases virtually.

Moreover, the licensure board published the guidelines on Teletherapy for MFT Associates on March 19, 2020 to clarify some expectations about the clinical practice of teletherapy in Florida. The licensure board stated that

Providers are required to perform within the scope of practice where the provider is located AND where the client is located. For disciplinary purposes, any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. (Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling, 2020, para. 1)

This recommendation is particularly relevant when it comes to safety and the prevention of liability. As discussed previously, clinicians need to take measures to identify the client's location when receiving service to ensure the client's safety, by identifying in advance resources and strategies in case of emergency. At the same time, clinicians should verify the client's identity, age, and location to make sure that privacy is protected.

The licensure board also highlights the requirement of a written informed consent not only for in-person sessions but also for telehealth services where the limitations and expectations on telehealth are explicit, as well as verifying the client's access to technology and the plan to manage problems with technology, if any. The licensure board expects that the clinician keeps documentation in the client's records following the HIPAA confidentiality rules as part of a best practice framework.

Another expectation from the licensure board is related to the clinician's competency and enough knowledge in telehealth, ensuring that the clinician engages in relevant education, training, and supervision that address the use of technology for the delivery of therapeutic services. In this respect, the CFS's supervisors and clinicians have been engaging in online trainings and webinars on teletherapy through Relias Trainings to learn skills and feel more confident when delivering virtual services and more competent when it comes to ethical and legal issues related to teletherapy.

In summary, I presented in this chapter the available literature review on teletherapy and COVID-19. By reading the research, books, articles, blogs, and news on the topic I identified a gap in the literature especially when it comes to research in teletherapy at non-profit organizations dedicated to providing behavioral health services to the community. For that reason, my intention was to contribute to the field of marriage and family therapy, the non-profit

sector, and the CFS with a research study that provides more data related to teletherapy that may be instrumental for the continuation of the delivery of teletherapy services to our community during and after the pandemic.

CHAPTER III: METHODOLOGY

In this chapter, I present and discuss the methodology I selected to conduct this research, starting with the description of the Appreciative Inquiry principles and its cycle model as well as the theoretical foundation of this study, the research design, the self of the researcher, the data collection and analysis, the quality control, and finally a summary.

Qualitative Research

I selected a qualitative research to conduct this study because it allowed me to explore in deep the CFS' staff's experiences related to the transition to the delivery of teletherapy services to Palm Beach County residents during the COVID-19 crisis with the purpose of understanding their perspectives and complexities of their roles during this challenging time. According to Creswell and Poth (2017), a qualitative research

Begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and establishes patterns or themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, a complex description and interpretation of the problem, and its contribution to the literature or a call for change. (Creswell, 2013, p. 44 as cited in Creswell and Poth, 2017, p. 28)

In this research the voices of the CFS's staff were valued and honored as agents of change and support to the members of our community that are struggling with the devastating and traumatic effects of the COVID-19 crisis. This study focused on the CFS's staff's

experiences, emotions, and behaviors related to the transition to the delivery of teletherapy services and to do so, I implemented the Appreciative Inquiry (AI) model, which is a qualitative research approach that focus on the staff and organization's strengths, positive characteristics, achievements, and successes.

Appreciative Inquiry Methodology

With the implementation of the Appreciative Inquiry (AI) strength-based approach in this research, my intention was to explore the experiences of the CFS' team on what worked well and what was positive while transitioning to the delivery of teletherapy services during the COVID-19 pandemic, as well as the CFS's team's future dreams regarding the delivery of teletherapy services in the organization. To accomplish this task, I engaged the CFS' staff members in interviews that involved semi structured questions about their experiences working for CFS during the COVID-19 pandemic and the delivery of teletherapy services, what worked well for the team and what were their dreams and perspectives related to the future of teletherapy in CFS.

The AI model was instrumental in the exploration of opportunities, strengths, dreams, and hopes of the CFS's staff transitioning to teletherapy during the pandemic. The Appreciative Inquiry was developed by David Cooperrider & Suresh Srivastva in the early 1990s and defined by them as "an organization development (OD) process and approach to change management that grows out of social constructionist thought and its applications to management and organizational transformation" (Cooperrider et al., 2008, p. 607).

This is an interesting model because it could be applied to different businesses and incorporates a social constructionist perspective that relates to one of the philosophical lenses in the field of family therapy. In addition to the AI definition, these authors proposed four assumptions linked to the practice of AI. The first assumption is that "inquiry into 'the art of the

possible' in organizational life should begin with appreciation", the second is that "inquiry into what is possible should yield information that is applicable", the third is that "inquiry into what is possible should be provocative", and the fourth is that "inquiry into the human potential of organizational life should be collaborative" (Cooperrider et al., 2008, pp. 658-659).

Based on the AI definition and its assumptions, Cooperrider et al. (2008) designed the 4 D cycle, which is a practical process model to implement AI in organizations, starting with selecting an affirmative topic, following with the Discovery phase (appreciating and valuing), the Dream phase (envisioning), the Design phases (co-constructing the future), and the Destiny phase (learning, empowering, and improvising to sustain the future) as illustrated in Figure 4 Appreciate Inquiry 4-D Cycle. (Cooperrider et al., 2008, p. 670)

Figure 4

Appreciative inquiry 4-D cycle



Note. This figure illustrates the 4-D Cycle and the connection between the positive cores of the AI model. Adapted from Cooperrider, D. L., Whitney, D., & Stavros, J. M., 2008, *Appreciative inquiry handbook: For leaders of change* (2nd ed.). Berrett-Koehler Publishers.

The affirmative topic choice, according to Cooperrider et al. (2008) is identified by the organization as the focus of attention and exploration, something that is relevant and critical to its functioning. Once the affirmative topic is identified, the organization moves to the first D, which is Discovery and “involves valuing those things that are worth valuing,” (p. 680) such as achievements and successes within the organization during its history or between the organization and other organizations in the community. The discovery is possible by team communicating and finding a collaborative meaning to those conversations. After Discovery comes Dream or envision, which “involves passionate thinking, creating a positive image of a desired and preferred future,” (p. 692) based on the stories from the interviews with staff that exemplify the organization’s moments of successes and achievements to imagine the best future.

After Dream comes the Design which “is a provocative and inspiring statement of intention that is grounded in the realities of what has worked in the past combined with what new ideas are envisioned for the future,” (p. 692) co-constructed by the team with an “strategic intent” where the organization identifies what could be repeated in the future. The final D is Destiny, which according to Cooperrider et al. (2008) “once guided by a shared image of what might be, members of the organization find innovative ways to help move the organization closer to the ideal” (p. 700). For this to happen, the team needs to take a collective action with appreciative eyes operating under the rule of not taking things for granted.

Theoretical Foundation

Appreciative Inquiry (AI) is grounded in five principles, according to Cooperrider et al. (2008). The first principle is the constructionist followed by simultaneity, poetic, anticipatory, and positive principles. AI is based on the ideas of social constructionism. Cooperrider et al. (2008) argue that “to be effective as executives, leaders, change agents, and so on, one must be adept in the art of reading, understanding, and analyzing organizations as living, human constructions,” (p. 723) where cooperation and collaboration are key factors to contribute to the organizational change as well as practicing imagination instead of making assumptions, that could lead to biases.

Watkins et al. (2010) cited the definition of social constructionist proposed by Gergen from the Taos Institute (2009) where “Social constructionist dialogues ... concern the processes by which humans generate meaning together. Our focus is on how social groups create and sustain beliefs in the real, the rational, and the good” (para. 1). In other words, the goal is to answer the question how do we know what we know? as proposed by Watkins et al (2010), by exploring personal history and culture, our interpretation of the reality, the nature of our relationships, and the possibility of creating new words, new relationships, and new realities.

The social constructionist perspective offers opportunities for a positive organizational change using framing as explained by Watkins et al. (2010)

since all change processes begin with framing an issue and collecting some data to give us a better understanding of the issue, we become aware that in the very act of doing these preliminary activities, we... are engaging in the process of socially constructing our futures through the choices we make about how to “frame the issue” and the dialogues we have as we make inquiries into those issues. (Watkins et al., 2010, p. 38)

Framing is an intervention many family therapists use to present a more positive perspective about a situation. In organizations, framing also plays a role in the creation of a positive reality and future. Framing is the illustration of the power of words, communication, and meaning in relationships. AI recognizes the power of framing and uses it to guide organizational change.

Moreover, AI is a “philosophy of knowledge” or a way to understand the world. It is a “principle-based intervention theory” that highlights the power of inquiry in the social construction of reality and has “its own philosophy and intervention theory” that could be applied to any organizational process. (Watkins et al. 2010, p. 38)

The principle of simultaneity considers inquiry and change as processes happening simultaneously. According to Cooperrider et al. (2008) “the seeds of change are the things people think and talk about, the things people discover and learn, and the things that inform dialogue and inspire images of the future” (p. 731). This principle suggests that by asking questions the researcher is open to see changes, new possibilities, and potential within the organization.

The poetic principle involves metaphor in the stories that the team members are narrating about their work experiences, creativity, and innovation in the workplace. Cooperrider et al. (2008) stated that “pasts, presents, and futures are endless sources of learning, inspiration, or interpretation” (p. 731). In this statement, these authors are honoring and highlighting the human experience within the organizational system.

The anticipatory principle refers to the “collective imagination” about the future of the organization (Cooperrider et al., 2008) where team members are projecting their expectations, ideas, and hopes for the organization moving forward. The positive principle, as suggested in the

name, is based on formulating positive questions about the organization that will lead to positive outcomes. “Organizations, as human constructions, are largely affirmative systems and thus are responsive to positive thought and positive knowledge,” (Cooperrider et al., 2008) meaning that a positive mindset within the organization could reflect long lasting effects and positive changes.

The AI principles described in this chapter lead to positive changes and a positive image of the organization. Before moving to the next section, I will describe one more factor that characterizes the AI approach, and refers to its difference with the problem-solving approach. As discussed previously, AI focused on what is working well and differs from the traditional problem-solving approach. In the problem-solving process, according to Cooperrider et al. (2008) it is necessary to identify the problem, analyze the causes and possible solutions and implement an action plan or treatment. In AI, it is necessary to appreciate what is good about the organization, envisioning “what might be”, dialoguing “what should be”, and innovating “what would be” (p. 862). The AI perspective is fundamentally different than the problem-solving approach because it starts and stays with a positive framework of organizational change, which makes a big difference in the process and outcome.

Research Design and Appreciative Inquiry

AI is based on the perspective and topic of study in the organization, for instance, focusing on the wisdom and achievements of the organization may set the stage for behaviors that demonstrate those characteristics. The opposite is possible too, focusing on problems may lead to a negative mindset and conversations and realities charged by negative behaviors and attitudes. In summary, organizations may move in the direction of the specific area of study and AI strategically selects what is positive and what works well in the organizations. AI is a strength-based approach to explore change in the organization.

The AI process involves the *positive core* of the organization (Cooperrider et al., 2008) which represents the beginning and the end of the inquiry and includes the organization's resources, strengths, future, and sustainability. According to Cooperrider et al. (2008) the positive core can be expressed in different ways such as achievements and awards, best business practices, positive emotions, products, services or operational strengths, values, strengths of partners and organizational stakeholders, among others.

The AI 4-D cycle "allows the practitioner to access and mobilize the positive core" (Cooperrider et al., 2008, p. 1129). Previously, the AI 4-D cycle was presented as a method with four phases (Discovery, Dream, Design, and Destiny) based on the ideas proposed by Cooperrider et al. (2008). In this section there is an explanation of the application of the 4-D cycle in the study of the CFS transitioning to teletherapy services during COVID-19. The Discovery phase describes the exploration or appreciation of the "what gives life"? what gives meaning to the organization, such as behaviors, actions, practices, processes, and activities the CFS wants to replicate related to teletherapy services. In this phase, the participants shared stories about the CFS at its best. The positive core is represented in this phase by exploring "what gives meaning to the organization" (Cooperrider et al., 2008).

The Dream phase involves a result-oriented vision of the CFS and the team's collaboration to articulate "what might be"? teletherapy in the future. The participants discussed past and present stories about the organization that led to a vision about the preferred future. In this phase, the positive core creates a "result-oriented vision in relation to the discovered potential and questions of higher purpose" (Cooperrider et al., 2008, p. 1136). The Design phase relates to the architecture of CFS that involves the co-construction of the ideal teletherapy service at CFS and "how can it be"? The positive core is represented on the "provocative

propositions of the ideal organization” (Cooperrider et al., 2008, p. 1136). The last phase is the Destiny, “what will be”? teletherapy in the future of CFS, how to sustain the teletherapy services after the pandemic, what else CFS learned about the transition to teletherapy and how CFS’ adjusted and empowered the teams to continue to deliver teletherapy services to the community during the pandemic. This phase engages the capability of the entire system (CFS) toward a better future. The positive core is reflected in this phase by “strengthening the affirmative capability of the whole system” (Cooperrider et al., 2008, p. 1136).

The affirmative topic choice is another part of the AI process, which is the “selection of the topic that will become the focus of the intervention” (Cooperrider et al., 2008, p. 1150). In this research study the affirmative topic was the CFS’ transition to teletherapy services. The implementation of the AI 4-D cycle contributed to a systemic understanding of the CFS transition to teletherapy during the pandemic, focusing on achievements, strengths, things that worked well, dreams, and hopes for a future where the CFS team will have more experience and competency in the delivery of teletherapy and more clients will be able to access virtual services and find the help they need.

The AI approach was instrumental in the study of the CFS’ transition to teletherapy services during the pandemic because it facilitated to the CFS’s staff the sharing of their stories and experiences about the transition to teletherapy in a challenging time, where the demanding of services was high, the entire community was under crisis, and many community members were triggered by traumatic events that push them to the limit of desperation and confusion. The CFS’s team’s stories reflected resilience, compassion, commitment, and ethical responsibility to support community members during their journey to heal. The AI approach assisted me with studying the strengths and positive characteristics of the CFS delivering teletherapy services to

the community as well as providing an illustration about the factors that were working well at the CFS with the intention of replicating those in the future.

The data for this research was collected using semi-structure interviews with full time and per diem team members from the CFS. The purpose of the interviews was to explore the team members' experiences about the transition to teletherapy during the pandemic, highlighting achievements and accomplishments related to the support they were providing to the clients and their families. The interview questions were formulated in a way that elicit a deeper understanding of the team members positive behaviors, actions, and attitudes within the team and their dreams about the future of the teletherapy services in the organization. The questions represented the beginning of change for the organization and a way to engage the team members in a reflection about their contribution to the systems (CFS, the clients, the community) and their roles in building a better future for the field of family therapy and the delivery of virtual services.

Self of the Researcher

In the beginning of this study, I presented my reflections about the self of the therapist, based on my clinical and professional experience at CFS during the last six years. In this section, I explain my reflections on the self of the researcher within the context of AI. As I mentioned previously, AI is a collaborative approach and collaboration involves working together to achieve a particular goal. In my opinion, my research approach is collaborative because I value and appreciate the contribution of the team members to make the organization better. The team can build a better organization with the contribution of its participants, focusing on their strengths, values, resiliency, and willingness to do their best. Flexibility and vulnerability are also key elements, in my opinion, to build a strong organization that can adopt changes, face challenges, and move forward, especially in challenging times such as the COVID-19 pandemic.

Respecting and honoring the CFS' staff's stories is critical because every story represents a unique perspective with wisdom coming from learning lessons and meaningful contributions to the past and present of the organization.

Respect also comes from constant self-reflection about my own biases. As a researcher, my intention was to present the data as much accurate and precise as possible and for this to happen, I needed to be aware of my biases and how those shaped the way I saw the CFS and the delivery of teletherapy services to the clients. I tended to see the delivery of teletherapy services as something positive for the agency and the clients; however, I understood that not everybody saw things this way, especially the therapists and/or clients that did not feel comfortable or were not familiar with technology, as well as clients that did not have access to technology or internet services, and therapists and/or clients that preferred in-person encounters rather than virtual sessions.

This reflection illustrates the relativity of things and the importance of perspectives. What is positive for me could not be positive for others. I was aware of differences in perspectives and that data showed organizational changes that could contribute to build a strong agency that will continue to support community members during difficult times. This research was about what was best for the CFS, the staff members, the clients, their families, and the community.

The research integrity was ensured by the researcher engaging in journaling during the entire research project to reflect on biases, assumptions, opinions, feelings, ideas, and experiences that could potentially affect the study. My commitment to this research was to be aware of my biases, and practice vulnerability and flexibility to ensure the integrity of the data and the research.

Qualitative research requires an intentional effort from the researcher to ensure trustworthiness, which according to Harrison et al. (2001) means “the ways we work to meet the criteria of validity, credibility, and believability of our research—as assessed by the academy, our communities, and our participants” (p. 324). This is an important role the researcher must accomplish by making appropriate decisions following the research protocols and ethical responsibilities.

The data I collected involved a process of understanding the meaning of the language the participants used, the interpretation of communication, and the influence of the participants’ experiences described during the interviews. Being aware of these factors helped me as a researcher to self-reflect and monitor my thinking process, attitude, values, and behaviors to avoid the influence on the data. My interactions with colleagues from CFS during the interviews could potentially affect the data, particularly working with a collaborative and relational perspective. For this reason, it was important for me, as researcher, to maintain a non-reactive attitude to ensure the participants’ responses were reliable and valid. After all, the purpose of the AI interviews was to elicit stories and conversations around the organization strengths, achievements, opportunities and dreams about a better future and my role was to honor and respect those stories as a competent and ethical researcher.

Data Collection

Qualitative data collection for this research involved the identification of the participants, the collection of consents to participate in the research and the implementation of the interviews. Data collection requires “working closely with participants and this brings with it the complexities associated with cultural norms, beliefs, values, and behaviors” (Mertens, 2018, p. 2). This situation brought to a light my ethical responsibility as a researcher to pay attention to

my biases and adopt a curious and respectful attitude during the data collection process to ensure validity of the data.

The sampling involved asking each team member working full time and on a per diem basis, delivering teletherapy services at the CFS during the COVID-19 pandemic, about their interest in participating in this research voluntarily. My intention was challenging my assumptions on the topic to be able to understand the team's experiences and stories related to the teletherapy transition CFS experienced and the future of the organization around teletherapy services.

The data collection process followed four steps: (1) approval of this research by the Institutional Review Board for Research with Human Subjects at Nova Southeastern University; (2) participant selection through recruitment and permission e-mail message; (3) obtain a signed informed consent from each participant (see Appendix F); and (4) interview participants utilizing semi-structured questions. (see Appendix G)

Participant Selection

The participants for this study were full time and per diem staff, adults (over 18 years old), from any gender, living in Florida, and fluent in English. The participants represented the clinical area of the agency; however, every staff member was invited to participate. The researcher explained preliminary information to the participants about confidentiality, the purpose, and process of the study as well as the duration of the interviews, which took between 60 and 90 minutes per participant.

Procedures

After obtaining the approval of this research by the Institutional Review Board for Research with Human Subjects at Nova Southeastern University, the researcher selected the

participants using an e-mail message for recruitment and permission. Moving on with the explanation of the consent form and the collection of signatures, before starting the interviews.

The researcher informed to each participant about their voluntary participation in the study and the absence of penalties if they decided to remove their participation at any time during the research process. Participants received a copy of the consent for their records and the researcher kept an encrypted (password protected) copy as well. The researcher informed the participants that they will be able to read the transcripts from their interviews if they were interested in doing so.

The interviews focused on eliciting conversations with the participants about what was working well at the CFS during the transition to the delivery of teletherapy services during the COVID-19 pandemic with the purpose of gaining a deep understanding of their experiences, achievements, successes, and dreams. The researcher formulated open-ended questions following a semi structured interview process. The interviews were recorded and transcribed within a week of each interview.

Interview questions

The interview questions I created for this research were inspired in the following questions suggested by Cooperrider et al. (2008) and the 4-D cycle process: “Imagine your organization five . . . years from now, when everything is just as you always imagined it would be. What has happened? What is different? How have you contributed to this future?” (p. 1168) and the questions my colleague Solomon (2020) used for her dissertation.

Phase I: Discovery

1. What indications do you have that your work is effective?

2. How do you work with complex/at risk cases (suicidal, homicidal, mental conditions) within the teletherapy frame?
3. What do you think attracts clients to the Center for Family Services?

Phase II: Dream

4. Imagine a time in the future where people around the country look at the Center for Family Services as an outstanding non-profit organization delivering high quality of teletherapy services to Palm Beach County residents. In this exciting future, what is different about the Center for Family Services?
5. What are you most proud of having helped the Center for Family Services accomplish?
6. What is sustaining the Center for Family Services dedication to the community?

Phase III: Design

7. What are the areas in which you feel the Center for Family Services' staff could have the most impact in delivering teletherapy services to the Palm Beach County residents during the COVID-19 pandemic?
8. As you reflect on successful ways the Center for Family Services is engage in supporting the community, what initiatives stand out as being exceptionally promising regarding the teletherapy services?
9. What do you consider as indicators that you are doing an excellent job within the community, with clients and their families, and the Center for Family Services?

Phase IV: Destiny

10. What small changes could the Center for Family Services make right now that would encourage other communities, individuals, and families to engage in teletherapy services?

11. How would you personally want to be involved in improving and expanding the teletherapy services at the Center for Family Services?

Data Analysis

The method of this study was AI, which was the guiding model for the research on the CFS' transition to the delivery of teletherapy services during the COVID-19 pandemic, providing structure, validity, and reliability to the study. The purpose of the study was to gain a deeper understanding of the CFS' team's experiences, achievements, and successes during the transition process as well as their dreams for the future of the organization. The AI implied the exploration of the participants' experiences, focusing on strengths and what is working well to co-construct the ideal organization. The CFS' team participated in interviews and conversations about the past, present, and future of the organization and those conversations were categorized using codes to make possible its analysis.

According to Maxwell and Chmiel (2013) "the most widely used categorizing strategy in qualitative data analysis is coding. In coding, the data segments are labeled and grouped by category; they are then examined and compared, both within and between categories" (p. 6). This researcher listened to the recording of the participants' interviews several times to assign codes to the data that facilitated the comparison of the data and the identification of patterns. "Coding categories are a means of sorting the descriptive data you have collected ... so that the material bearing on a given topic can be physically separated from other data" (Bogdan & Biklen, 2003, p. 161 as cited in Maxwell & Chmiel, 2013, p. 6). In other words, this was a process of distinguishing and organizing data to facilitate the contrast, comparison, and connection of the data.

Cooperrider et al. (2008) proposed the identification of “key patterns and/or themes,” (p. 1213) that resulted from the interviews with participants with the intention of analyzing connections between the themes and the impact of those themes on the organization. Cooperrider et al. (2008) highlighted the importance of words and phrases during the interviews because those are not “just semantics, they are essential... because words create worlds” (p. 1219). This statement is supported by the constructivist foundation of the AI approach discussed in previous sections.

In this study, codes were assigned to each interview transcript and each participant. The codes for the interview transcripts were instrumental in the identification of themes and patterns. Those codes were based on the 4-D cycle process. In the initial stage of the data analysis, the researcher listened to the recording to identify broad themes. Then, the researcher used the transcripts to look for themes that may be missed before. If so, the themes were reorganized and adjusted accordingly. The research listened to the recordings and read the transcripts to ensure the accuracy of the data.

The participants’ codes maintained their confidentiality. Each participant had a code, and the data was coded using themes that came from the data collected during the interviews. The researcher’s intention was to identify the themes that illustrated what was working well at the CFS, what things the CFS could do more, and how the CFS’s future looked like. Based on a positive, strength-based perspective, the goal was to identify when, why, and how the CFS was operating at its best and what were the capabilities for the CFS’ to perform well in the future. As a researcher, my mission was to identify positive themes that contributed to the CFS’s success.

The data analysis and transcripts of the interviews were recorded in a Word document. The transcripts of the interviews were conducted using the Otter Pro transcription system.

Quality Control

Standards and Verification

The quality of qualitative research depends on the credibility of the research's outcomes as noted by Birks (2017) in this statement: "regardless of the philosophical and methodological approach used to guide a study, the credibility of outcomes is dependent on the researcher employing measures to ensure quality throughout the entire research process. In other words, you must be able to demonstrate rigor in the conduct of your research" (p. 3). One way that I, as a researcher, demonstrated rigor in this study was by following the requirements of the Institutional Review Board as well as implementing the AI model to fidelity, following the 4-D cycle process, and using reliable and valid data relevant to the study. When the researcher found data that was not related to the topic of study, that data was not used.

Another factor that I took into consideration to ensure the quality of this study was related to the researcher's biases, attitudes, perspectives, motivations, and values. I engaged in self-reflection during the research process to be aware of those biases and prevent those from affecting the data for this study. The researcher respected and honored the themes and patterns coming from the data collected to ensure the credibility of the research.

Confidentiality

The researcher ensured the confidentiality of the information and the participants by keeping encrypted (password protected) signed consent forms and other documentation such as electronic notes, recordings, and transcripts. All information related to this research was encrypted with a lock code and is accessible to me, my dissertation chair, and the staff from the Institutional Review Board. All data related to this study will be destroyed after 36 months from the end of this study.

Ethical Considerations

My responsibility as a researcher was to follow the regulations and guidelines from the Institutional Review Board for Research with Human Subjects at Nova Southeastern University. As a family therapist, I followed the Code of Ethics approved by the American Association for Marriage and Family Therapy (2015), particularly Standard V, “Marriage and family therapists respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research” (p. 6). I communicated regularly with my dissertation chair and committee members to obtain guidance and advice related to this research project to ensure a positive outcome.

Summary

The first three chapters of this qualitative research were the foundation for this study that provided data that can potentially improve the Center for Family Services’ current practices and future projects related to the delivery of teletherapy services to the community. The first chapter contained the background of the problem highlighting the CFS’ transition to the delivery of teletherapy services during a critical time, the pandemic. This chapter also described the CFS’s programs, funders, organizational chart, as well as the self of the therapist and the purpose of this study.

Chapter two presented a description of the literature review related to teletherapy nationally, in Florida, and in Palm Beach County, as well as the regulations and expectations from the AAMFT and the licensure board related to teletherapy. I found a gap in the literature related to the lack of research on teletherapy services delivered by non-profit organizations operating in Palm Beach County. Chapter three was dedicated to the methodology, where I described in detail the Appreciative Inquiry (AI) approach and the 4-D cycle process that guided

the data collection and analysis. I presented my reflections about the self of the researcher and discussed issues related to quality control.

CHAPTER IV: RESEARCH FINDINGS

This qualitative research was based on the appreciative inquiry (AI) design, which allowed me to explore and analyze the experiences of the Center for Family Services' staff during the transition to teletherapy services in a critical time due to the pandemic. The data was collected through 11 semi-structure interview questions with five staff members. The questions were based on the AI 4-D cycle, starting with Discovery, following with Dream and Design, and ending with Destiny. The questions helped me to identify what was working well in the organization, including strengths and positive characteristics, as well as the participants' future dreams regarding the delivery of teletherapy. The data analysis made possible to identify different themes within the organization.

Using the AI design and a positive approach to the organization's transition to teletherapy during the pandemic, provided the participants the opportunity to share their experiences and perspectives. Listening to the participants' comments helped me to identify common themes and gain a better insight about the organization's situation. The identification of common themes was possible by using a descriptive analysis of the data.

The AI' principles of social constructionist, simultaneity, poetic, anticipatory and positive were part of the result process for this study. The social constructionist principle was reflected by the participants and I (former employee) engaging in creative conversations about the CFS's past experiences, present and future opportunities, where the participants used their imagination to make sense of the changes triggered by the pandemic, the transition to teletherapy and the future of the agency after the pandemic. According to Cooperrider et al. (2008) "the questions asked become the material out of which the future is conceived and constructed" (p. 721).

The simultaneity principle was represented in the participants and researcher engaging in conversations guided by questions and answers about the agency's changes due to the pandemic, which assisted with discovering and inspiring the future. Those conversations included the agency's efforts to obtain grants to buy equipment in preparation for future demands related to teletherapy. As per Cooperrider et al. (2008) "the questions set the stage for what is found and what is discovered" (p. 733).

The poetic principle was reflected on the participants narratives about their experiences, struggles, and successes delivering teletherapy, particularly with therapists and clients using for the first time different platforms and technology to participate in therapy. Cooperrider et al. (2008) stated that "pasts, presents, and futures are endless sources of learning, inspiration, or interpretation" (p. 736). The pandemic was the inspiration for the Center to deliver teletherapy services to the community and teletherapy was a source of learning for clients and therapists.

The anticipatory principle was represented by the participants' collective dream about continuing with the delivery of teletherapy services after the pandemic. As Cooperrider et al. (2008) mentioned "the image of the future guides what might be called the current behavior of any organism or organization" (p. 743). In other words, the Center's goal to continue to deliver teletherapy services after the pandemic, guides the staff's current actions.

The positive principle was reflected by the positive questions I formulated for the interviews that led to positive responses and themes as explained in the next sections. Cooperrider et al. (2008) argued that "organizations, as human constructions, are largely affirmative systems and thus are responsive to positive thought and positive knowledge" (p. 749).

Data Analysis

The data analysis involved the use of descriptive analysis of the information discussed during the interviews with the participants. This study focused on the participants' perceptions about the organization's strengths and opportunities. The results of the interviews were presented following the AI 4-D cycle process. Each stage had results that were divided in key themes. Five full time clinicians (from Triple P, Individual and Family Counseling, SAFE Kids, and Partners for Change programs) participated in this study. The interviews were conducted in a week. The participants' ages were within 40 and 60 years old and the average of their work experience was 6 years. Three of the participants had a professional license and two were registered interns. All participants were fluent in English and lived in Palm Beach County, Florida.

The participants were categorized using alphabetical coding to maintain autonomy (Saldaña, 2016). This chapter ends with a summary of the findings and a deeper description of the main theme related to the 4-D cycle process and the input from the participants. The overarching theme (positive core) reflected in the participants' responses was Client's Satisfaction, which refers to the fact that without clients there is not organization. This positive core was present in every AI 4-D cycle phase.

The first phase of the cycle was characterized by the theme Staff's Positive Attitude and Support from Clients and Funders (Discovery Phase), where Client's Satisfaction (positive core) was represented by the therapists' willingness to ensure the clients' safety and the therapists accommodating to their needs and being flexible with the appointment dates and locations. The Outreach and Community Education theme (Dream Phase) incorporated Client's Satisfaction by demonstrating commitment to the clients, providing quality of services, matching their cultures and languages, and honoring diversity.

The Post-pandemic Teletherapy Services theme (Design Phase) incorporates a future where Client's Satisfaction is possible by offering teletherapy as one more option to attend therapy different than in person, in office services, where clients can save time (no need to commute from home to the office) and more clients can attend therapy daily, which mitigates waiting time coming from a period of high demand of services due to the pandemic. The Expanded Teletherapy Training and Technology theme (Destiny Phase) includes Client's Satisfaction by making easier for clients to access services through the provision of appropriate equipment and training to use technology and navigate platforms. The clients' training on teletherapy may increase their familiarity and confidence level with technology and willingness to participate in virtual services.

Table 1 illustrates the themes and subthemes distributed according to the AI 4-D cycle phases, starting with the Discovery phase, which includes, as mentioned above, the theme Staff's Positive Attitude and Support from Clients and Funders, and the subthemes: Safety for High-Risk Clients and Flexibility to deliver teletherapy services. The Dream phase involves the opportunities related to conducting Outreach and Community Education focusing on the Center's programs and services with subthemes such as Commitment, Quality of Services, and Diversity of culture, languages, programs, and funds. The Design phase includes the theme Post-pandemic Teletherapy Services due to the identified advantages of teletherapy for clients and clinicians with subthemes such as the Improved Attendance to therapy, Effective Use of Time for clients and therapists, and Increased Number of Clients receiving services in Palm Beach County and perhaps covering other counties. The Destiny phase shows the theme Expanded Teletherapy Training and Technology by providing the necessary technological equipment and appropriate training for therapists and clients on the teletherapy process. The subthemes for this phase are

Easier Access to Services by adding more HIPAA Compliant Platforms, and Staff and Clients’ Training to provide guidance to clients on how to use the technology, therefore facilitating the clients’ participation in teletherapy as well as to improve staff’s competency when delivering teletherapy services to the community.

Table 1

AI Positive Core, 4-D Cycle Phases, Themes, and Subthemes

Positive Core	Phases	Themes	Subthemes
Client’s Satisfaction	Discovery What gives life?	Staff’s Positive Attitude and Support from Clients and Funders	Safety for High-Risk Clients Flexibility
	Dream What might be?	Outreach and Community Education	Commitment Quality of Services Diversity
	Design How can it be?	Post-pandemic Teletherapy Services	Improved Attendance Effective Use of Time Increased Number of Clients
	Destiny What will be?	Expanded Teletherapy Training and Technology	Easier Access to Services Staff and Clients’ Training

Discovery Phase

Discovery is about appreciating and valuing (Cooperrider et al., 2008). This phase included the participants’ stories related to what was working well in the organization, the achievements, accomplishments, and positive moments that contributed to the organization’s good image, reputation, and success. In this phase the participants shared their perspectives about what they valued about the organization. I formulated three questions to learn about the participants’ perspectives on what was working well in the organization that illustrated the Discovery Phase: 1) What indications do you have that your teletherapy work is effective? 2)

How do you work with complex/at risk cases (suicidal, homicidal, mental conditions) within the teletherapy frame? 3) What do you think attracts clients to the Center for Family Services? The conversations around these questions reflected the theme: Staff's Positive Attitude and Support from Clients and Funders, and the subthemes: Safety for High-Risk Clients and Flexibility to deliver teletherapy services during the pandemic.

Discovery Phase Theme: Staff's Positive Attitude and Support from Clients and Funders. This theme came out from the interviews with participants as demonstration of the strengths and possibilities for the Center. The Center for Family Services' positive feedback from clients and funders relates to the highly qualified professionals that are accountable, involved, client-centered, trauma-informed, and resilient. During COVID-19 pandemic, the Center's staff has been supporting the community with affordable services available to residents of the county regardless of their ability to pay for services. The Center has a diverse group of professionals with different cultural backgrounds, languages, demographics, and areas of expertise. The Center's staff reported feeling proud of being a community support during the pandemic by contributing to the mental health of the clients and their families. The participants in this study shared several successes and achievements during their interviews that are described below.

The following transcript excerpts illustrate the participants' comments about the importance of the staff's positive attitude and the support the agency receives from clients and funders. Many of the participants reported during the interviews the benefits of receiving positive feedback from clients about the services they receive, which is reflected on the agency's outcomes measurements and effectiveness of services through tools such as post assessments, surveys, client satisfaction questionnaires, and PCOMS (Outcome Rating Scales and Session

Rating Scales). Moreover, funders are demonstrating a level of trust to the Center year after year by allocating funds to continue to offer programs and services to the community based on positive outcomes. Therefore, clients' positive feedback is linked to the Center's ability to secure funds to operate. The Center's staff members mentioned during the interviews that receiving positive feedback from clients and financial support from funders are indicators of an excellent job.

Staff's positive attitude refers to the ability to adapt to changes related to the pandemic and willingness to try something new, which is the delivery of teletherapy services. The positive feedback from clients and financial support from funders, refer to the comments that clients are posting on social media and documenting through satisfaction surveys about the services they receive at the Center, as well as the funders' willingness to continue to support the Center's programs and services. The Center applies annually for funds and part of the application process is demonstrating positive outcomes and clients' therapeutic progress. The Center keeps track of programs' outcomes using PCOMS as an evidenced-based practice supporting the therapeutic work and quality of services. The following is a transcript excerpt that reflects the importance of this theme for the Center.

Participant B: We have high quality professionals, and maybe the most important thing is the unconditional positive regard and the empathy that professionals have here... When you go into Google and search, you can see that a lot of people who have said good things about the Center is because of the professionals working here. We are very empathetic toward families and we are utilizing an unconditional positive regard approach.

I think one of the reasons we keep going is because the different sponsors we have. They see that people are being helped and they have good reports of how they have been helped. So that way they can continue contributing to our Center with money and the resources.

This excerpt shows evidence of the Center's staff involvement with the community and the empathy that professionals are demonstrating to clients which is a key factor in receiving positive feedback from them. This participant also highlighted the funder's support to the programs and their important role in making possible for the Center to continue to provide services to the community, especially to clients that are unable to pay for services.

During the pandemic, funders such as Children's Services Council, the State Attorney's Office and Health Care District authorized the Center to switch from in person therapy to teletherapy receiving the same reimbursement rate. This decision helped the Center to continue to pay salaries and cover operational expenses that otherwise will affect the financial stability of the organization. According to Benavides-Vaello et al. (2013) "while reimbursement for telehealth services has been implemented through Medicaid, Medicare, and some private insurance companies, reimbursement is less than that of services provided in face-to-face encounters" (p. 114). Luckily for the Center this was not the situation because the pandemic was a call for the stakeholders to join efforts and collaborate to mitigate the crisis.

Discover Phase Subtheme 1: Safety for High-Risk Clients. The participants in this study reported that they were following the agency's protocols the same way they did it in in-person sessions to ensure the safety of clients experiencing high risk situations such as suicidal or homicidal ideation, self-harm behaviors, or chronic mental health conditions that required psychiatric medication. Ensuring the clients' safety is an ethical responsibility that is taken seriously at the Center given the nature of the organization, the complexity of the clients'

circumstances (substance abuse, trauma, and chronic mental conditions, among others), and the COVID-19 crisis. Literature shows “the inappropriateness of using tele-mental health across large distances for those clients who suffer from serious mental illness including impairments in reality testing, serious depression and suicidality, and impulse control difficulties such as violence and homicidality” (Manhal-Baugus, 2001 as cited in Barnett & Kolmes, 2016, p. 58). During the pandemic, the Center’s clinicians did not have the option to meet with clients in person due to the risk of COVID-19 infection so supervisors, clinicians, clients, family members, and local hospitals collaborated to support each other, as evidenced by the following transcript excerpts.

Participant C: It makes it a little harder because the person is not actually in front of you, but I still do the same thing which is assess for suicidal, homicidal, or mental condition, for the severity of it, and then I apply my intervention, or maybe recommend a referral to a higher level of care.

This participant acknowledged the challenge of managing high risk cases via teletherapy “because the person is not actually in front of you” and described the steps to ensure the client’s safety including assessment, severity, intervention, and referral. Another participant described her experience with a high-risk case that involved a minor.

Participant B: The child was cutting herself and the mother reported that to me. She sent me a text message with the picture of the girl... cutting herself, so I immediately called and have both parties involved, mother and daughter... As we were doing teletherapy, the mother walked into the room, took the shaving racers... we did the safety plan... and the daughter agreed... to sleep with her mother that night and they were going to the hospital first thing in the morning.

This excerpt highlighted the importance for the therapist to involve the child's parent in the safety plan process. The collaboration between the therapist and the family members was key to ensure the client's wellbeing. The therapist and this family members used technology to communicate promptly and manage a high-risk situation via teletherapy, considering that the pandemic limited their ability to meet in person.

This subtheme demonstrated that it was possible to manage emergencies and crisis via teletherapy contrary to what the literature showed. Perhaps because the pandemic changed the way our community approaches the delivery of mental health services, where the goal is to support our residents with the available resources, and it appears that the Center's clinicians are committed to that goal. The ability to successfully manage high-risk cases via teletherapy is related to the next subtheme, which is flexibility, because the pandemic is bringing changes to the field and the organization and new stressors to clients. Coping with changes and stressors requires a level of flexibility to adapt and survive.

Discovery Phase Subtheme 2: Flexibility. Flexibility from my perspective is linked to adaptability to changes. The pandemic put a proof the therapists' ability to deal with uncertainty and learn new ways to facilitate therapy, such as teletherapy, using the available resources (platform, computers, and phones), following the agency's protocols, attending to the client's needs, and understanding that due to the pandemic, clients are in distress and some of them are experiencing trauma symptoms and high levels of stress. The following excerpt illustrates this subtheme:

Participant D: Teletherapy has been effective for allowing the clients to have the flexibility to participate in therapy with the pandemic...It allows families to have the benefit of

teletherapy, to accommodate them with their schedule... and for the therapists...it gives them the opportunity to save time.

For this participant flexibility benefits the clients because they can work around their schedules to attend therapy services during the pandemic. For the therapists, flexibility is an advantage because they can save time by arranging their appointments around their clients' availability. In the Design phase, I will expand on the topic related to the benefits of teletherapy following the lead of some of the participants that highlighted this theme as relevant to the "architecture" of the Center.

Discovery Phase: Summary. The above transcript excerpts illustrated "what gives meaning to the organization" (Cooperrider et al., 2008). According to the staff members that participated in the interview, the staff' positive attitude and support received from clients and funders. The Center depends in part from grants and funds to operate. Some staff members mentioned during the interview, the importance of receiving financial support from funders to continue to provide services to clients that do not have health insurances or clients that have limited access to behavioral health services.

The staff's positive attitude and support from clients and funders illustrated by the above excerpt are important aspects of the Discovery phase because those aspect show what is working well in the agency and set the expectations for the agency's future. This phase is connected to the Dream phase because the staff's positive attitude contributes to make meaningful connections and form strong alliances with potential clients, referral sources, and funders that are willing to support the Center's programs.

Dream Phase

This phase represents the envision of new opportunities, a desired and preferred future (Cooperrider et al., 2008). Three questions were formulated to the participants to elicit reflections and share their hopes on how the future would look like based on their perspectives. The questions that allowed me to learn about the staff members' dreams about the organization were: 1) Imagine a time in the future where people around the country look at the Center for Family Services as an outstanding non-profit organization delivering high quality of teletherapy services to Palm Beach County residents. In this exciting future, what is different about the Center for Family Services? 2) What are you most proud of having helped the Center for Family Services accomplish? 3) What is sustaining the Center for Family Services dedication to the community? The theme I identified for this phase, based on the interviews with participants was: Outreach and Community Education and the subthemes were: Commitment, Quality of Services, and Diversity.

Dream Phase Theme: Outreach and Community Education. The Center's staff highlighted the collaboration between colleagues from different fields, the collaboration from clients that are loyal to the Center and refer other people (worth of mouth), and the collaboration between the Center and other community agencies as relevant factors that represent opportunities for the Center moving forward with the teletherapy services. Those collaborations, according to the participants, are main sources of support for the Center to become a stronger and exceptional non-profit organization in Palm Beach County delivering teletherapy services.

One of the main activities the Center's staff engages regularly is conducting outreach in the community with the purpose of educating the community on the available programs and resources. The Center's staff participates on community events, fairs, network meetings, parents'

meetings with the intention of reaching community members in need of support. The following are some transcript excerpts that illustrate this theme.

Participant A: We are doing virtual outreach in different organizations with different population such as in schools...I have been reaching out to schools and doctors and every person I know and offering the services, because I know the needs that they have right now...

Participant B: Doing outreach in the community. I do visit different places such as schools, daycares, churches so they can hear and understand and become more aware about the services that we provide at the Center.

The above excerpts illustrate the relevance of conducting outreach in the community to educate potential clients and providers. The Center's goal is to contribute to the behavioral health and education of the residents, and this is possible by collaborating and cooperating with other community organizations. One part of the equation is to receive funds and the other part is to provide services to clients.

Dream Phase Subtheme 1: Commitment. Some of the participants highlighted the important role the Center is playing in a community with high demands for mental health services, especially during the pandemic, and how the staff's devotion to do their best and the desire to provide high quality of services made a difference when it comes to conduct outreach in the community and increase referrals from sources that trust the Center's mission. The following transcripts excerpts illustrate the relevance of this subtheme for the Center.

Participant D: I think... the commitment to provide the services to the community (is sustaining the CFS' dedication to the community). This is a community in need of mental health services.

During the interview, this participant mentioned the “compassion that the therapists have for the clients” as a factor that reflect the organization’s commitment to support the needs of the community. She also stated that she felt proud of participating in the development of the culture code for the organization the year before the pandemic, which seemed to be a demonstration of her dedication and support to the organization’s mission and values.

Participant A: I have been working the extra mile with my clients during the pandemic situation... the outcomes of my program are excellent, and I am doing the best of my ability.

This participant reported during the interview the difficulties she experienced to engage clients in teletherapy services because teletherapy was new to them and some of her clients were hesitant. This participant explained during the interview that despite of the challenges engaging clients in teletherapy she successfully facilitated teletherapy sessions and her program had positive outcomes. This participant’s positive attitude (“working the extra mile”) exemplifies her commitment to her clients, her program, and the organization, which is linked to high quality of services as discussed under the next subtheme.

Dream Phase Subtheme 2: Quality of Services. Quality, from my perspective, involves the desire and intention to deliver the best mental health service possible for the community. Quality is linked to the above subtheme about commitment, because, when the staff members are dedicated to a cause the results of their actions are reflected in client’s satisfaction and ultimately in the improvement of the community’s mental health. The following transcript excerpts illustrate this subtheme.

Participant D stated “I think that the CFS provides quality services to the community” and Participant B supported this comment by mentioning “at this point, I will say continue delivering high quality services for clients and contributing with doing outreach in the

community”. It appears that positive outcomes from the outreach efforts are related to having a good image and reputation in the community. The Center’s good image in the county is connected to the commitment from staff, the high quality of services, and the cultural diversity of staff and clients.

Dream Phase Subtheme 3: Diversity. Diversity at the Center refers to the clients’ and therapists’ different cultural and linguistic backgrounds as well as the Center’s different programs, specialties, and funders. Currently the Center has clients and therapist that identify as Latinx/Hispanic, Haitian, African American, and Caucasian (those racial categories are suggested by the funders for reporting purposes). The Center also has different programs for diverse populations based on their needs such as children 0-5 years old, pregnant women, clients dealing with substance abuse, parents, clients that were sexually abused and other “victims of crime” (this is a term suggested by the funder). Furthermore, the Center receives financial support from different funders such as Children’s Services Council, the State Attorney’s Office, the Department of Health, and the Health Care District, among others (described in the literature review chapter).

Another way the Center is diverse is related to the therapists and supervisor areas of expertise and training. The Center’s clinicians are trained in different therapeutic models such as Solution Focused Brief Therapy (SFBT), Narrative Therapy, Cognitive Behavioral Therapy (CBT), Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), and Trauma-Focused Therapy. Some therapists are National Certified Counselors, and others have certifications in specific areas such as Trauma Therapy, TF-CBT, and Eye Movement Desensitization and Reprocessing (EMDR), among others. The dream of the participants is to continue to be diverse and expand the horizon to more cultures, languages, programs, and specialties within the field.

The following excerpt demonstrates the dream about diversity described by some of the participants.

Participant C: I think the Center would have maybe more therapists to specialize in different types of interventions, and maybe speak other languages as well, because that is our clientele. We just keep getting people from different cultures and different languages that just come and accommodating them would be the goal.

This participant expanded the diversity topic by sharing her thoughts about the characteristic that sustains the Center's dedication to the community. The following is the excerpt.

Participant C: I think it is the therapists. It is the employees who are as diverse as the people in the community that has been sustaining the Center.

The Center's therapists reflect the clients' demographic characteristics related to diversity, cultures, and languages and it contributes to the Center's success in the outreach and networking efforts. The Center has therapists representing diverse racial and ethnic groups such as "Latinx/Hispanic, African American, Haitian, and White/Caucasians" (categories suggested by the funders) which helps to build rapport with the clients and deliver services in their native languages (Spanish, Portuguese, Haitian Creole, and English). Sharing the clients' cultures and languages may contribute to the clients' sense of belonging, familiarity, and connection with the therapists. Diversity improves the credibility and dependability that the Center projects to the community, which is related to the Center's sustainability, as demonstrated during the pandemic, especially with the high level of referrals in the Prenatal Plus Program, where pregnant women receive multidisciplinary support (counseling, nutrition, and nurses) to deliver healthy babies and ensure their newborns' wellbeing.

The pandemic supported the beginning of teletherapy services at the Center. Before the pandemic, the Center offered in person (in office) and home visits options. Currently, the Center continues to offer in person (in office), home visits plus teletherapy. Adding one more option (teletherapy) can count as the Center diversification of its portfolio of services.

Dream Phase: Summary. This phase is a “result-oriented vision” of the organizational best future (Cooperrider et al., 2008) and the above examples demonstrated the importance of outreach by collaborating, cooperating, and connecting with professionals, clients, community organizations, and funders. The Dream phase illustrates a systemic perspective where the Center for Family Services plays a relevant job in ensuring the mental health of the community before and during the pandemic. The participants’ dream is to continue to conduct outreach to educate the community about the Center’s services and programs. During the pandemic, the participants stated that outreach was relevant to inform the community members about the teletherapy services.

The Dream phase is connected to the Design phase because when the Center recruits and engages clients in services it is contributing to the mental health wellness of the community and funders appreciate that the financial resources are spent in responding to the needs of the residents. With the pandemic, the Center acknowledged the importance of delivering services being mindful of the clients’, therapists’, and other staff members’ safety and comfort. For that reason, teletherapy is playing a critical role in keeping everybody safe and comfortable while participating in therapy. The Design phase describes the advantages related to teletherapy as perceived by the participants.

Design Phase

This phase involved the co-construction of the future of the organization based on past success and new opportunities (Cooperrider et al., 2008). Design requires planning and the implementation of strategies that contribute to organizational improvement. To explore this phase, I formulated three questions to the participants: 1) What are the areas in which you feel the Center for Family Services' staff could have the most impact in delivering teletherapy services to the Palm Beach County residents during the COVID-19 pandemic? 2) As you reflect on successful ways the Center for Family Services is engage in supporting the community, what initiatives stand out as being exceptionally promising regarding the teletherapy services? 3) What do you consider as indicators that you are doing an excellent job within the community, with clients and their families, and the Center for Family Services? The theme identified for this last phase was Post-pandemic Teletherapy Services with the subthemes: Improved Attendance to Therapy, Effective Use of Time for clients and therapists, and Increased Number of Clients Receiving Services in Palm Beach County and perhaps covering other counties.

Design Phase Theme: Post-pandemic Teletherapy Services. The results from the interviews with staff reflected the theme of continuing with the delivery of teletherapy services after the pandemic based on positive outcomes the participants noticed related to saving time (clients and therapists), reducing no show rates, and convenience for clients without transportation, among others. The Center's staff members that participated in the interview hoped and dreamed with a future where teletherapy will continue to be available for the community, after the pandemic. The following are some transcripts excerpts relevant to this theme and subthemes.

Design Phase Subtheme 1: Improved Attendance to Therapy. As mentioned previously, many of the therapists that participated in this study highlighted the benefits of improving attendance to sessions due to teletherapy, in terms of achieving consistency and therapeutic progress, which is reflected in meaningful changes in the clients' lives, and positive outcomes for the programs and the organization. Improved attendance to therapy is consistent with literature. For instance, Hilty et al. (2007) and Simpson et al. (2005) as cited in Pruit et al. (2014) argued that "one of the principal benefits of Home-based Telemental Health is its potential to improve treatment attendance and satisfaction which can lead to more positive treatment outcomes" (p. 341). The following is a transcript excerpt that illustrates this subtheme.

Participant C: Teletherapy promises to keep client's appointments on time...it reduces the no show rates, and it is proved to be very convenient for clients because they do not have to leave their houses.

This participant mentioned during the interview that she experienced many advantaged related to teletherapy especially the reduction of no-show rates and clients being on time for their sessions. This participant stated that her clients found teletherapy a convenient option for them to attend therapy because they could do it form the comfort of their homes. This subtheme is related to the next subthemes related to clients and therapists saving time, and more clients being able to receive services because of teletherapy.

Design Phase Subtheme 2: Effective Use of Time. Effective use of time refers to the increased number of activities the therapists and clients can do in a day because they are saving time by engaging in teletherapy and not commuting from home to the office and vice versa. If clients and therapists can use their time effectively (when participating in teletherapy), the

quality and quantity of their daily activities could potentially increase. The following transcripts excerpts illustrate this subtheme.

Participant B: For therapist will be saving time... with less travel time, there is ... more time for the therapists to complete their paperwork and the agency's requirements.

The above participant stated that therapists can use the time that they are not commuting to the office or the clients' homes to complete progress notes and documentation. This is an important topic because the Center's therapists usually face the challenge of balancing the clinical and administrative responsibilities. The Center's clinical supervisors have been discussing with their teams some viable ways to complete documentation on time and following the funders' requirements to reduce liability and ensure quality.

Participant E: I do not have a many missed sessions, because, if I call them (clients) at one o'clock and they do not answer on their scheduled time and they call me at three, and I do not have a client at that time, I am like "well, let's do it now". And then we are still able to complete the session on the same day, even if it is at a different time, or if a client is running late, it is fine because it is from home... it is easier to be more flexible.

Many of the therapists that participated in this study mentioned the advantages of rescheduling clients within the same day because of teletherapy. In the past, when clients were attending therapy in the office, some of them were unable to reschedule sessions the same day because of travel time. With teletherapy, sometimes clients are attending teletherapy from their cars or during work or school breaks and they as the therapists appreciate the flexibility they have because of the teletherapy services.

Design Phase Subtheme 3: Increased Number of Clients Receiving Services. The results of the interviews with the Center's therapists reflected that teletherapy helps to increase

the number of clients receiving services every day, week, and month and this is explained by the therapists' ability to reschedule sessions within the same day, the possibility to save travel time, and the convenience of participating from home. During the pandemic, many people have been concerned about health issues due to COVID-19 infection. Other people have been suffering financial problems due to the loss of jobs or reduction of work hours. For those families with children, there are adding responsibilities related to supervise the children's attendance to virtual classes and monitoring their homework. With teletherapy many of those challenges and concerns are mitigated which creates opportunities for the Center to serve a higher number of clients. The following transcript excerpt illustrates this subtheme.

Participant B: We (therapist) will be able to serve more clients in on single day... we could probably serve more than one county because the clients do not have to drive all the way here. A lot of times, they do not have a car to drive to the agency or commute to whatever location... it can be promising that they still can receive the services without having to move out of their comfort zone.

The above participants highlighted the advantages of teletherapy related to clients and therapists saving time therefore being able to spend time efficiently and perhaps providing services to more clients even from other counties. This participants' comments are consistent with the literature review on teletherapy were "patients may have less travel, absence from work, and time waiting, more clinical choice and control, and better outcomes" (Hilty et al., 2013, p. 451).

Participant E: I think that because we have spent a year conducting teletherapy... it would be most convenient to continue delivering those types of services for the clients who are not able to leave their houses or who have difficulty with transportation... I have had so many

positive encounters throughout this year, and I would like to continue (delivering teletherapy) even after the pandemic.

The above participant made an important point regarding some clients facing difficulties attending in person sessions due to transportation issues, childcare problems, or medical conditions (related and unrelated to COVID-19) and the convenience of being able to use teletherapy services if needed. This statement is consistent with literature because it “establishes that telehealth can successfully be implemented for overcoming barriers to adequate services in rural and geographically isolated locations. The benefits of telehealth to the client include reduced travel time and cost, reduced separation of families, and a reduced number of missed appointments” (Benavides-Vaello et al., 2013, p. 113).

The Dream phase was characterized by outreach and community education and this phase demonstrated the benefits of teletherapy for clients and therapists. Part of the outreach and education efforts is to show the community members that teletherapy is a convenient and safe option to access therapy services during the pandemic. The goal is for the community members to make educated decisions about accessing therapy. The Design phase is based on evidence that teletherapy is working for many clients and therapists.

Design Phase: Summary. The ideal organizational design (Cooperrider et al., 2008) for the Center’s staff members could be co-constructed based on the continuation of teletherapy services due to the benefits of teletherapy and the experience obtained during the last year and feedback provided by clients, staff members, funders, and community members. The Design of the Center, based on the interviews, involves the awareness of the things that are working well within the organization to repeat those in the future.

The Design phase showed the interest of the participants in continuing with the delivery of teletherapy services based on their successful experiences so far. This phase is related to the Destiny phase because the participants recognized that providing training to clients and therapist, as well as improving technology and offer appropriate equipment to clients, could make possible the expansion of teletherapy services to more clients that otherwise will not consider this option.

Destiny Phase

This is the last phase of the cycle, which refers to those innovative ideas from staff members that make possible for the organization to get closer to the ideal way of functioning (Cooperrider et al., 2008). This phase is about ensuring the sustainability of the organization and envisioning what will be the ideal Center for Family Services and the role that the staff members will play of making that possible. I formulated two questions to the staff members that allowed me to have a better idea about the destiny of the organization: 1) What small changes could the Center for Family Services make right now that would encourage other communities, individuals, and families to engage in teletherapy services? and 2) How would you personally want to be involved in improving and expanding the teletherapy services at the Center for Family Services? The results of the interviews with staff members reflected the theme Expanded Teletherapy Training and Technology and the subthemes: Easier Access to Services and Staff and Clients' Training.

Destiny Phase Theme: Expanded Teletherapy Training and Technology. Some of the innovative ways that the participants shared with me during the interviews were the improvement of clients' accessibility to teletherapy services characterized by facilitating training for clients and therapists on teletherapy and technology, as well as adding more HIPAA compliant platforms that clients can access with the equipment they have. This theme illustrates

how the agency could be in the future from the perspective of the staff members that participated in the interviews. Some participants highlighted the need of more professional training on teletherapy so the therapists can feel more competent, comfortable, and familiar with the delivery of virtual services. The following are some transcription excerpts relevant to this theme.

Destiny Phase Subtheme 1: Staff and Clients' Training. Before the pandemic started in March 2020, the Center's therapists and supervisors did not receive a formal training about teletherapy. After March 2020, the clinicians started learning about teletherapy by attending webinars throughout the Relias Training website and other online courses offered by different providers specialized in teletherapy. The training for the clients has been facilitated by their therapists, who before the initial sessions are communicating with their clients to guide them during the intake process, the teletherapy agreement, policy, and rules as well as the HIPAA compliant platform (Kipu) and the equipment that is compatible with the platform. According to the therapist interviewed for this study, when their clients are not able to access the platform, the therapists offered them other temporary options such as using other HIPAA compliant platforms and sometimes participating in sessions via phone (as the last resort and only during the pandemic).

Participant A: Get more training and get the best resources to make this virtual experience for the client as real as possible.

This participant highlighted the need of training for therapists and clients on teletherapy and technology to be familiar with the process and feel more comfortable when engaging in virtual services.

Participant B: Being patient, being flexible with them (clients), understanding their abilities, so they do not feel discouraged by utilizing teletherapy. Helping them to understand

that one thing is to sign consents and another thing is to do the session and walking them (clients) through that process.

This participant referred to clients with “low level of literacy and low level of technology knowledge” and the benefits of guiding them through the teletherapy process by explaining the process step by step to create a safe environment when the clients feel comfortable with using technology to participate in therapy. Based on the conversations with the therapists I arrived at the conclusion that clients feel comfortable participating in teletherapy when the therapists feel comfortable with facilitating teletherapy. Therapists can teach clients how to use the platform only when they (therapists) know how to use it and how to solve technical problems or access technical assistance when needed. After a year of the Center’s therapists facilitating teletherapy, it appears, based on the interviews, that there is a level of confidence and comfort with using technology as described by the following participant.

Participant D: More professional development (for therapist), using different platforms that are HIPAA compliant ... so that would be something that would be very helpful. Having different platforms that would be user friendly for the clients.

Participant A: We have been attending different webinars, trainings, and presentations for clinicians to be able to offer the best teletherapy services to the clients, because this was basically something new for everybody, and took the society by surprise.

The above participants’ comments align with literature regarding the importance for clients to feel comfortable with technology to engage in teletherapy services as discussed by Shore et al. (2006) and Starling and Foley (200b) as cited in Pruit et al. (2016) “a perceived lack of technical savvy and insufficient experience with computer equipment has been cited by

potential Home-based Telemental Health patients as a reason why they choose to avoid remote care” (p. 341). This topic is expanded under the next subtheme about easier access to services.

Destiny Phase Subtheme 2: Easier Access to Services. During the last year, the Center has been learning ways to engage clients in teletherapy by making easier for them to access the HIPAA compliant platform by providing clear instructions during intake sessions and for those clients that are unable to access online services (due to the lack of internet connection or equipment) offering the phone sessions. The Center also has been searching for financial resources to buy appropriate equipment that therapists and clients can use to participate in teletherapy. This is a process that take time and resources and the Center is diligently working on it. The following is a transcript excerpt that illustrates the importance of this subtheme for the future of teletherapy in the Center.

Participant B: Help clients that are illiterate to be able to sign consents electronically. So, the Center has one platform... and the client must follow certain steps to sign consents... if the Center can find a way to make it easier for those clients that cannot read or write or that are not technology savvy...I think we will be able to have more families engaging in services.

This participant referred to clients that have difficulties accessing teletherapy services due to language comprehension issues and the lack of technology knowledge. For this participant, teletherapy should be an option that anyone could access regardless of the educational level or ability to navigate technology. This participant also mentioned the benefits of adding more HIPAA compliant platforms that clients can use because using only one platform (Kipu) may limit the clients’ ability to participate in teletherapy due to the equipment incompatibility and platform complexity.

Participant D: The agency is working right now on the technology aspect. So, we are working on getting some iPads, some tables that we can provide to the clients, so they would have equipment... to do teletherapy.

This participant mentioned the Center's efforts to acquire more equipment for clients to participate in teletherapy. According to this participant, the agency has been searching for grants that fund equipment for clients, to reduce the barriers to access services during the pandemic. The technological limitation of teletherapy was discussed in the literature chapter of this study, where I identified that "a perceived lack of technical savvy and insufficient experience with computer equipment has been cited by potential Home-Based Telemental Health Treatment patients as a reason why they choose to avoid remote care" (Pruit et al., 2014, p. 341).

The above participants shared their perspectives about training and technology as critical factors to ensure the continuity of teletherapy services for the community after the pandemic. Bridging the gap of access to technology could be the key for the expansion of teletherapy services in the county. This statement is consistent with literature when it comes to the therapists' "knowledge about various technology requirements for providing telemental health services to include hardware, software, type of Internet connection, privacy safeguards, and security precautions needed to help ensure each client's privacy is protected" (Barnett & Kolmes, 2016, p. 56).

Destiny Phase. Summary. The above transcript excerpts demonstrated innovative ways to sustain and improve the contribution of the Center to the community mental health. The ideal organization, according to the participants, involves continuous improvement regarding professional development, competency in the delivery of teletherapy, improvement of technology, education and support to clients that have limited knowledge of technology, and the

continuation of the delivery of teletherapy after the pandemic in conjunction with in-person services, maintaining a broad spectrum of services and accessibility to a culturally diverse community.

The continuation of teletherapy services in conjunction with face-to-face services to keep the services broad and inclusive seemed to be the collective goal for the Center. Some of the participants in this study mentioned that small children (5 years old and less) and clients attending psychiatric services seemed to prefer to attend in person services due to a short attention span, behavioral issues, or mental health conditions that limit the clients' ability to use technology. A therapist stated that she provides in person services the same day the psychiatrist sees clients, that way the clients can keep both appointments (therapy and psychiatric visit) the same day, which seemed to be convenient for clients.

Moreover, Participant B stated that "after session three (Triple P), I know for sure we have to meet in person... we cannot continue doing this over the phone... it can be because of the children's behaviors at home or other times they tend to be more visual, like in person, where they have to see what is going on in order to engage". This statement illustrates the benefits of in person sessions in some cases. Furthermore, Participant C mentioned "I would like for the Center to continue providing telehealth services in conjunction with face-to-face services, so clients will have access to therapy," which suggests that the combination of in person and teletherapy services could be a "plus for the agency and for other agencies" as stated by Participant D.

Summary of the Research Findings

This research journey started with my curiosity in exploring the transition to teletherapy at the Center for Family Services during the pandemic. I engaged in face-to-face individual conversations with five therapists to identify what was working at the Center and what were their

dreams about teletherapy. After the interviews, the process continued with the analysis and identification of themes and subthemes based on the AI 4-D cycle phases. The first phase, Discovery was characterized by the theme Staff's Positive Attitude and Support from Clients and Funders, with the subthemes: Safety for High-Risk Clients and Flexibility to deliver teletherapy services. This phase provided clarity about the Center's alignment of strengths that made the system's weaknesses irrelevant. (Cooperrider et al., 2008)

The next phase was Dream, which described the Center's possibilities for the future and growth, inspired by the Discovery phase. This phase unfolded the importance of conducting Outreach and Community Education regarding the Center's programs and services, including subthemes such as Commitment to the community and the organization, Quality of Services, and Diversity of culture, languages, programs, and funds. Once the collective dream was identified, the process continued with the Design phase, which challenged the organization to move from the present to the future.

The Design phase included the theme Post-pandemic Teletherapy Services where I discussed the advantages of teletherapy for clients and clinicians based on the interviews, which was consistent with literature and the results from the Teletherapy Satisfaction Surveys conducted but the Center in August 2020. The subthemes for this phase were Improved Attendance to therapy (reduction of no shows) in comparison to in person therapy, Effective Use of Time by clients and therapists mostly because of the elimination of travel time, and Increased Number of Clients receiving services in Palm Beach County, which is linked to saving time and resources, and teletherapy seeing as a convenient and safe option.

The Destiny phase came from the collection of the team's creative ideas from the Discovery, Dream, and Design phases. The Destiny phase challenged the organization to adapt

and sustain changes in the future envisioned by a collective dream (Cooperrider et al., 2008).

This phase included the theme Expanded Teletherapy Training and Technology by responding to the technological need of the Center and the community, including the provision of appropriate equipment and teletherapy training for therapists and clients, with subthemes such as Easier Access to Services by adding more HIPAA Compliant Platforms, and Staff and Clients' Training including the provision of detailed instructions for clients on how to use technology and access the platforms and professional training on teletherapy for staff to improve competency and ethical and legal compliance.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THE STUDY

This research had its origin in the need to support our community with mental health services during the pandemic. The purpose was to explore what worked well during the Center's transition to the delivery of teletherapy services as well as the agency's staff member's future dreams related to the delivery of teletherapy services to the community. The AI model and the 4-D cycle guided the exploration of this research question and subsequent findings.

Teletherapy was a new way to deliver services for the CFS until March 2020 when the pandemic started. Before the pandemic, I (in my role as a Chief Operating Officer) attended different trainings on teletherapy and contacted leaders from local organization that were facilitating teletherapy to learn from their experiences and tailor a plan to deliver teletherapy at the Center. We were making preliminary steps toward the delivery of teletherapy (doing research and gathering information) when the pandemic happened, and the agency needed to speed up the process of delivering teletherapy services. There were many loose pieces such as deciding what platform to use, training the therapists on the use of technology, having appropriate technology to facilitate teletherapy, educating the clients on the use of technology to access services, funding for teletherapy, and clarity related to legal and ethical issues related to teletherapy, among others. We learned by practicing, facilitating the services, communicating with other providers and funders, and receiving training on the topic.

The findings of this research are consistent with literature, the experiences from other providers, and the Center's staff members' positive attitude to try a new option to deliver therapy (teletherapy) and adapt to changes. Teletherapy can be a successful method to deliver services if the providers and the clients are comfortable with its use. Regarding the outreach efforts and community education, other local providers shared with us their experiences about clients not

attending in person therapy because they were afraid of having health issues related to the pandemic, or their lives and routines changed due to the need of working from home and their children attending classes online and not finding time to attend therapy, or clients not having the appropriate equipment or technology knowledge to access teletherapy services. In those situations, conducting outreach was critical for clients to access mental health services and for the agency to be able to function and survive the crisis.

The teletherapy benefits is another factor that is supported by literature and by the findings of this research. The Teletherapy Satisfaction Survey conducted with therapists and clients in August 2020 showed positive results related to teletherapy as well as the results from the interviews conducted in this research study and the positive experiences other providers shared during meetings and trainings about the delivery of teletherapy during the pandemic. The pandemic is not over yet and nobody knows when it will be over, meaning that the Center's staff's future goal is to continue with the delivery of teletherapy services incorporating improvements in the areas of training on technology use for staff members and clients as well as providing appropriate and reliable equipment to therapists and clients to access the HIPAA compliant platforms for videoconferences and to sign intake forms and other consent forms. Technology is an area that represents challenges and limitations according to literature because it is linked to financial resources, training, and level of comfort from providers and clients.

In this chapter I discuss my reflections as a researcher. I present the strengths and limitations of this study as well as the clinical implications for Marriage and Family Therapists and for future research studies. The final section of this chapter includes concluding thoughts.

Researcher's Reflection

The idea to conduct this research study came from a conversation I had with the Center's Executive Team two years ago, when discussing the implementation of the agency's strategic plan. This conversation happened before the pandemic. It took me a year to complete preliminary courses at the University before starting this project. When I started working on the research proposal the pandemic happened and the agency had to make a quick transition to teletherapy. At that time, I was part of the Center's Executive Team and had the opportunity to lead the transition process in collaboration with other colleagues and clinicians. The initial steps were difficult because some of the staff members suffered the direct impact of the pandemic (they got infected, or their family members were sick).

The agency had an influx of referrals due to community members struggling with depression, anxiety, stress, and trauma symptoms. The clinicians were overwhelmed and displaying compassion fatigue and burnout symptoms. It took intentionality, strategy, and leadership to adapt to the new norm and make the transition possible. The staff faced different challenges related to the use of available technology, learning how to use the new electronic medical records system (Kipu), educating the clients on the use of technology and platforms, coordinating the billing process of teletherapy services with the funders, keeping updated information about the professional laws and regulations related to teletherapy, and attending trainings related to teletherapy, among others.

In October 2020, I resigned from my position at the Center to start my private practice. From that time until now, I continued to work on this research study, this time as an external observer. Conducting the interviews and engaging in conversations with my colleagues gave me a better idea about the progress of the teletherapy services at the Center. The data collection was

an interesting process that involved curiosity from my part and an effort to stay neutral and separate my biases and beliefs from the participants' views and perspectives. Journaling was a tool that helped me to be aware of my biases and gave me clarity about my role as a researcher.

The conversations with my former colleagues gave me a new perspective about their level of commitment to the Center, their passion to serve the community, their level of resiliency and determination to move forward despite of the challenges. The participants in this research study seemed to feel proud of being part of a team that collaborated to deliver teletherapy services without having a precise or concrete road map as evidenced by their comments during the interviews. The Center's staff were willing to take the risk to deliver teletherapy due to the community need and the need of the agency to continue to operate. The teletherapy outcomes so far seemed to be positive and the staff appeared to be interested in continuing to support the teletherapy initiative after the pandemic.

Based on the literature on the teletherapy topic, the conversations with my colleagues, and my reflections as a former employee of the Center, the results of the 4 D cycle process seemed to be viable to create organizational change at the Center around teletherapy. As discussed previously, the affirmative topic choice for this study was the CFS's transition to teletherapy and the positive core was Client's Satisfaction, theme that was present in every phase of the AI process. The Discovery phase showed the Center's strengths and positive characteristics related to having staff members that display a positive attitude during difficult times such as the pandemic and the clients and funders willingness to support the Center's services and programs by collaborating and working as a team. The Dream phase demonstrated that conducting outreach and community education were key factors to sustain the teletherapy initiative in the future.

The Design phase presented the opportunities of the continuation of teletherapy services for the agency, the staff, the clients, and the community when it comes to safety, convenience, and effective use of resources, among others. The last phase, Destiny showed the vision of a future in which the Center could improve the quality of teletherapy services by providing training and education on how to use technology and platforms, as well as providing appropriate equipment to staff and clients to make teletherapy a positive experience for the involved parties. The future of teletherapy for the participants in this research is moving toward the expansion of the services (reaching more clients and maybe other counties) and the combination of teletherapy with in-person services to respond to the needs and preferences of the community.

Strengths and Limitations of the Study

Strengths

This research is relevant to the community because literature is limited when it comes to studies related to the delivery of teletherapy services by non-profit organizations dedicated to ensuring the mental health of the population. This research study is a contribution to my professional field with a topic (teletherapy) that is relevant during crises such as the pandemic. It was interesting to interview my colleagues and learn their perspectives and experiences related to the delivery of teletherapy. It was interesting to facilitate the co-construction of meaning based on the participants' stories and experiences.

This study could serve as a framework to other non-profit organizations dedicated to ensuring the mental health of the community, that are in the transition process to deliver teletherapy services or would like to start that process in the future. The data documented in this study could facilitate the teletherapy process for other organizations that would like to offer

teletherapy services to their clients and would like to make a plan that includes challenges, opportunities, areas for improvement, and achievements.

The Appreciative Inquiry (AI) model made possible to follow a strength-based perspective that contributed to the identification of positive experiences that the Center had, including successes, achievements, opportunities, accomplishments, and possibilities. The participants had the opportunity to reflect on their contributions to the agency, their hopes, dreams, innovative ideas, creativity, and ideal image of the agency. The Center's staff members demonstrated in their comments the desired to participate in the improvement of the processes, so the organization continue to move forward and become stronger.

This research study could be instrumental for organizations that are implementing changes during crisis. The Center needed to adapt to rapid changes due to the pandemic to continue to exist and support a community that was experiencing trauma due to the loss of lives, health, jobs, housing, routines, and financial stability, among others. The Center faced challenges at different levels, including the staff members suffering the consequences of the pandemic directly (getting infected with COVID-19, the loss of family members, changes in their routines, and taking care of their children's school responsibilities, among others) and yet it was able to join efforts and collaborate as a team, demonstrating resiliency, adopting positive attitudes and perspectives, and being resourceful to face the challenges. It was an interesting process of teamwork, adaptation to rapid changes, and determination to move forward.

Limitations

I interviewed five staff members working for the Center for Family Services and the details of the interviews provided relevant information about teletherapy services during the pandemic; however, the number of participants does not represent the entire population.

Moreover, the agency's characteristics do not reflect the characteristics of other local agencies providing similar services. This study has limitations related to the agency's geographical location, the clients, and staff's demographic information as well as diversity and cultural differences.

Clinical Implications

Teletherapy is in high demand during the pandemic. Clients, clinicians, and staff members would like to stay safe and healthy. The Center has been facilitating teletherapy for a year and there are areas that need further work to ensure professional competency and client's comfort. Literature shows benefits linked to the delivery of teletherapy services such as the reduction of no shows, effective use of time (less travel time, less waiting), comfort, safety, ability to reschedule sessions for the same day, and serving more clients, among others. There are also limitations related to teletherapy such as the lack of technology knowledge or equipment, the lack of internet services or connectivity problems, issues related to confidentiality, the difficulties observing nonverbal communication, challenges related to ensuring the safety of high-risk clients, and difficulty engaging small children in the therapeutic process, and fatigue related to the use of the computer for long periods of time, among others.

This research study is relevant to the field of Marriage and Family Therapy because offers a strength-based framework to approach the delivery of teletherapy services. This study illustrates the transition to teletherapy services in a nonprofit agency that due to the pandemic had to develop resiliency by learning how to adapt quickly to changes and solve problems to the best of its ability with the available resources. The pandemic has been bringing challenges and opportunities to the field. This is a period of transitions and adaptations that have profound implications in the way we will practice our profession in the future. The pandemic and the

changes in the way we (clinicians) deliver services represent opportunities for growth in our field.

Implications for Future Research

The literature review showed gaps in the delivery of teletherapy services by non-profit organizations that provide mental health services. Future research that involves other organizations providing teletherapy services to other populations will be relevant to expand the knowledge and perspectives in this area. Contrasting those studies may contribute to a comprehensive understanding of the effectiveness and limitations of the delivery of teletherapy services to the community, as well as the exploration of what is working well about teletherapy services in other agencies. Other studies on this topic may contribute to the expansion of the current research, for instance, studies using different research methods, models, contexts, or themes. This research study could be the baseline for other studies that could expand on the topic of teletherapy and Marriage and Family Therapy. Further research on how to engage in teletherapy clients with limited knowledge and resources may be useful, as well as research on professional training and clinical competency when delivering teletherapy.

Concluding Thoughts

This study is a contribution to the Center for Family Services' efforts to continue with the transition to the delivery of teletherapy services during and after the pandemic. This is the first qualitative study conducted at the Center on this topic and the results could provide a better idea about the Center staff's strengths, achievements, successes, opportunities, hopes, and dreams. This study is also a contribution to the literature on the topic of teletherapy and a guide to other researchers interested in exploring this topic further.

This research answered the question on what worked well at the Center while transitioning to the delivery of teletherapy services during the pandemic, as well as the agency's team's future dreams regarding the delivery of teletherapy services. The findings of this study are the foundation to other agencies that are in the process of transitioning from in person to virtual services. This research study showed that the staff's positive attitudes and the support provided by clients and funders helped the organization to have a smooth transition to teletherapy services. According to the participants in this study, the Center for Family Services has been engaging in outreach efforts and community education to promote programs and services in the community.

The collaboration with funders and other community organizations has been instrumental in the transition to teletherapy, as per the participants in this study. The participants expressed their interest in continuing with the delivery of teletherapy after the pandemic based on the benefits of teletherapy reported by therapists and clients. The participants also highlighted the opportunities for the agency regarding the improvement of teletherapy services, particularly in the areas of training for staff and clients on technology and different platforms. The overarching theme in this study research was Client's Satisfaction, which was at the center of every phase of the AI process. Client's Satisfaction seemed to be the goal of the Center and teletherapy represented a viable option for clients to increase access to services and improve their wellbeing, especially during the pandemic when the demand of services was very high.

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Appendices

Appendix A: Site Approval Letter



CENTER FOR FAMILY SERVICES
OF PALM BEACH COUNTY, INC.

4101 Parker Ave | West Palm Beach, FL 33406
888.616.1222 | ctfam.org

SITE APPROVAL LETTER

August 2020

Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314-7796

To whom it may concern:

This letter acknowledges that I have received a request from Claudia Herrera, LMFT to conduct a research project as part of her dissertation requirements on teletherapy at the Center for Family Services of Palm Beach County and I approve this research to be conducted at our facility.

Once the Nova Southeastern University's Institutional Review Board/NSE IRB has approved the proposed research project, the agency will provide access for the approved research project. If we have any concerns or need additional information, we will contact the Nova Southeastern University's IRB at (954) 262-5369 or irb@nova.edu.

Sincerely,

Fabiana DesRosiers, Ph.D.
Chief Executive Officer
(561) 616 1222
fdesrosiers@ctfam.org

Strengthening individuals and families through behavioral health and education services.



Appendix B: CFS’ Teletherapy Policy

P&P #:

DEPARTMENT Counseling Programs	BOARD REVISION DATE March 23, 2020
REFERENCE TO STANDARDS	POLICY DEVELOPED BY: Executive Team

TELETHERAPY

Policy

The agency’s intent is to find ways to improve client access to affordable, high quality services. Teletherapy can be a means to overcome barriers which preclude or hinder delivery of services. *Teletherapy* refers to online, technology-driven therapeutic services (e.g., video, chat, etc.) and telephone counseling, and to be effective both the agency and client must have the technological capabilities in place. However, the State of Florida licensing board for clinicians narrows the definition further so that telephone counseling alone does not qualify for “teletherapy”. When teletherapy is feasible, funder-authorized, and can be delivered confidentially and securely with HIPAA-compliant components, services will be considered and approved by the Executive Team and Board of Directors. This policy provides the guidelines for the agency’s staff when teletherapy has been approved.

Confidentiality and Security Considerations

Technology offers the opportunity to increase client access to therapeutic services; however, there are added risks to confidentiality and security. The HIPAA guidelines on telemedicine are contained within the HIPAA Security Rule and stipulate:

1. Only authorized users should have access to electronic protected health information (ePHI).
2. A system of secure communication should be implemented to protect the integrity of ePHI.
3. A system of monitoring communications containing ePHI should be implemented to prevent accidental or malicious breaches.

Confidentiality regarding ePHI means that data or information is not made available or disclosed to unauthorized persons or processes. *Security* or *security measures* are terms that encompass all the administrative, physical, and technical safeguards in an information system.

Therapists should make reasonable effort to understand cultural, linguistic, socioeconomic, and other individual characteristics (e.g., medical status, psychiatric stability, physical/cognitive disability, personal preferences), may affect effective use of teletherapy.

In addition, it is incumbent on the therapist to engage in a continual assessment of the appropriateness of providing teletherapy throughout the duration of the service delivery. If a client, for example, experiences recurrent challenges which cannot be resolved with reasonable corrective action, teletherapy may need to cease and in-person services begun. Moreover, therapists are encouraged to reflect on multicultural considerations and how best to manage any emergency that may arise during the provision of teletherapy.

Therapists should carefully assess the remote environment in which services will be provided, to determine what impact, if any, there might be to the efficacy, privacy and/or safety of the proposed intervention offered via technology. Assessment may include a discussion of the remote environment and the client's situation within the home, the availability of emergency or technical personnel or supports, risk of distractions, potential for privacy breaches or any other impediments that may affect the effective delivery of services. Along this line, therapists are encouraged to discuss fully with the clients their role in ensuring that sessions are not interrupted and that the setting is comfortable and conducive to making progress to maximize the impact of the service provided since the therapist will not be able to control those factors remotely.

Therapists are urged to monitor and regularly assess the progress of their client when offering teletherapy to determine if it is still appropriate and beneficial to the client. If there is a significant change in the client or in the therapeutic interaction to cause concern, therapists should make reasonable effort to take appropriate steps to adjust and reassess the appropriateness of the services delivered via telephone. Where it is believed that continuing to provide remote services is no longer beneficial or presents a risk to a client's emotional or physical well-being, therapists are encouraged to discuss the case with the supervisor, thoroughly discuss these concerns with the client, appropriately terminate their remote services with adequate notice and refer or offer any needed alternative services to the client.

The Center's staff is responsible for disclosing and discussing teletherapy risks with the client ("client" regarding authorizations also refers to their caregivers or guardians) and the measures taken to mitigate them.

Administrative Considerations

To deliver teletherapy the agency must have all client intake forms completed and consent to provide therapy via online platforms and other forms of technology. Existing clients – those who have already completed the client intake paperwork – will only need to consent to receive teletherapy (**Informed Consent Form**). New clients will also need to review and agree to the client intake forms (**Attestation Statement Form**).

Informed Consent and Attestation Statement Forms

1. New and established clients will sign and return the **Informed Consent Form**.

2. New clients sign and return the **Attestation Statement Form** which is an acknowledgement that the client has received and read the following forms:
 - a. Service Payment Agreement
 - b. Client Information Form
 - c. Statement of Client Rights, Responsibilities and Consent for Treatment
 - d. Appointment Agreement
 - e. Behavior Management Policy
 - f. Acknowledgement of Receipt of Client Services Guide
 - g. Authorization for Release of Protected Health Information (if needed)
3. New clients in Children's Services Council (CSC) programs will receive additional required forms.

Service Delivery

1. The agency's Chief Operating Officer, in discussion with Program Directors/Supervisors, will determine if therapists will need to work from the office or have the option of working remotely from home.
2. Both client receiving services and therapist delivering them are in the state of Florida at the time of service.
3. Full-time therapists facilitating teletherapy from home will document the sessions in the electronic health records system within 24 hours, according to the agency's standards.
4. Therapist should use the appropriate code (teletherapy) when documenting in the electronic health records to ensure accuracy in reports and reimbursement.
5. Full-time therapists should complete at least 40 hours of work when working from home, as if they were in the office conducting regular business.
6. Therapists that do not have work cellphone can use their personal phones, using *67 to keep their numbers private. At the therapists' discretion, audio for videoconferencing may be accessed via their cellphones rather than their computer's microphone for better quality communication.
7. Teletherapy depends on reliable, secure internet connectivity and technical hardware requirements (e.g., webcam, microphone). The therapist must ensure the client is capable of effective teletherapy. A test call is recommended in advance. Only HIPAA-compliant, agency-approved, audio and video apps may be used which provide end-to-end call encryption.
8. The therapists should ensure that the teletherapy session will be confidential, by coordinating in advance with the client the time of the call and suggesting to the client that they find a private place during the session (where others cannot hear the conversation).
9. The therapists should remind the clients that the teletherapy session may not be recorded.
10. The therapists should find a private place to facilitate teletherapy to clients. At all times, the environment (e.g., setting, background noise) must be professional.
11. If the session involves a minor, the therapist should discuss with the caregiver the importance of ensuring privacy for the minor client during the session.

Assessment Tools

Therapists can assist clients with completing the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) tools remotely if clients have access to computer/laptop/internet. Otherwise, therapists will use the Partner for Change Outcome Management System (PCOMS) oral version (scripts) of the measures.

Billing***Documentation***

Therapists will write on the progress note that client participated in a teletherapy session. The program code, time, and duration will be recorded for billing purposes, among others.

Payment

If clients must pay any fee for services and to do so, they should be transferred to the intake staff who will collect the payment (credit card) by phone before the teletherapy session is facilitated.

Clinical Supervision

Clinical supervision meetings can be conducted by telephone and audio/videoconferencing when obstacles prevent in person meetings. To preserve client confidentiality, the participants should be in a private setting.

Appendix C: Informed Consent for Teletherapy

Informed Consent for Teletherapy

I hereby voluntarily consent to engage in teletherapy, which is a form of psychotherapy provided via internet technology, which can include consultation, treatment, transfer of protected health information, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Limitations on Confidentiality

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client/legal guardian of client, need to be a resident of Florida.
2. I, the client/legal guardian of client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during my therapy session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the Consent for Treatment form I signed when beginning therapy with the Center for Family Services of Palm Beach County, Inc.
4. I understand that there are risks and consequences when participating in teletherapy. These risks may include but are not limited to, the possibility that despite the best efforts of my therapist to ensure high encryption and secure technology the transmission of my information could be disrupted or distorted by technical failures or the transmission of my information could be interrupted by unauthorized persons.
5. Technology can be unreliable at times. There is a risk that services could be disrupted or distorted by unforeseen technical problems.
6. I understand that teletherapy based services and care may not be as complete as face-to-face services that take place in a private setting office.
7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.
8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I need to call 911 or proceed to the nearest hospital emergency room for help.
9. I understand that there is a risk of being overheard by anyone near me if I am not in a private location while participating in teletherapy.
10. I am responsible for:

- Providing the necessary computer, telecommunications equipment, and internet access for my teletherapy sessions.
 - Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
11. The psychological treatment provider is responsible for utilizing secure teletherapy telecommunications equipment and provide psychotherapy in a confidential setting.

Duration of Consent

I understand my consent for treatment is freely given and may be withdrawn at any time. In cases of shared parental custody for treatment on a minor, I understand it is the right and responsibility of the custodial parent to advise the non-custodial parent of the child’s treatment and the non-custodial parent has the right to withdraw consent at any time.

Legal Guardian (if child is client)

I do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my legal consent to the treatment and services mentioned in this form.

Client’s Signature

Date

Client’s Parent or Legal guardian’s Signature

Date

Therapist’s Signature

Date

This form was adapted from the Informed Consent for Teletherapy form used at Gulf Coast Children’s Advocacy Center, 2020.

Appendix D: Teletherapy Clinicians' Satisfaction Survey

Center for Family Services of Palm Beach County, Inc.**Date:** _____

Please place a check mark on your answer.

1. Please tell us how many times you have facilitated telehealth sessions.

- >20
- 20-40
- 40-60
- <100

2. Please place a check mark by your age group.

- > 24
- 25 – 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 or older

3. Please identify your level of professional licensure

- Registered intern
- Licensed professional (LMHC, LCSW, LMFT)

4. Please identify the number of years in practice as a mental health professional.

- >5 years
- 6-10 years
- 11-15 years
- 16 and more

5. Thinking about the telehealth services you provided, how would you rate the following?

- 5 -Strongly agree
- 4 -Agree
- 3 -Neither agree nor disagree
- 2 -Disagree
- 1 -Strongly disagree

- I could schedule/reschedule clients relatively easily/without significant challenges.
- I felt comfortable providing counseling services to my clients through telehealth.
- I felt I had more time to complete paperwork pertinent to clients and cases.
- I felt prepared to conduct telehealth services.
- I felt supported by my supervisor/workplace in my needs while providing telehealth services to my clients.
- I felt sufficient training was provided to conduct services through telehealth.
- I had sufficient resources to provide to clients via telehealth.
- I would like to continue providing services via telehealth once the pandemic has subsided.
- I had a plan in place for high-risk cases.
- My supervisor was available when I needed to discuss cases or solve technical issues.
- I received support from my colleagues.
- I received support from the administration.
- I would prefer to facilitate in person services rather than teletherapy.

6. Please provide any additional comments or suggestions about your experience conducting counseling services via telehealth. (has it been challenging, stress-free, any complications and/or successes?) Please explain.

We appreciate your comments. Thank you for your participation!

Appendix E: Teletherapy Clients' Satisfaction Survey

Center for Family Services of Palm Beach County, Inc.**Date:** _____

We are interested in learning more about your experience with teletherapy so far. The information that you provide will help us to make improvements in this method of bringing mental care to you and others who may not otherwise receive it.

You are not required to answer any question that makes you feel uncomfortable. Your individual answers and comments will not be shared with anyone. If you choose not to answer any questions, you will still receive services.

1. Please tell us where you usually have your telehealth visits. Please select all the options that apply to you.

- Home
- Workplace
- Automobile
- Public setting (library, restaurant, café, school)
- Open place (park, pool, beach)

2. Please place a check by your age group.

- Less than 12
- 12 - 17
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 or older

3. Gender

- Female
- Male
- Other
- Prefer not to disclose

4. Ethnicity/Race

- Black
- White
- Latino/Hispanic

- Asian/Pacific
- Mixed
- Other

5. Thinking about the telehealth services you received, how would you rate the following?

5 -Strongly agree

4 -Agree

3 -Neither agree nor disagree

2 -Disagree

1 -Strongly disagree

- I could clearly see the therapist during the visit.
- I could clearly hear the therapist during the visit.
- I felt understood, heard, and respected during the visit.
- I felt my private information was protected and safe during the visit.
- The telehealth visit was as good as a face-to-face visit.
- The camera and other equipment embarrassed me or made me feel uncomfortable.
- I would have to miss school/work to see the therapist if it were not for telehealth.
- It is financially hard for me to get myself or my family members to counseling sessions at the Center.
- I would not attend therapy if it were not for telehealth services.
- My parents like it that I use telehealth (for minor clients only).
- Overall, I am satisfied with using telehealth.
- I would like to continue to participate in telehealth once the pandemic has subsided.
- I would prefer to attend in person sessions instead of telehealth.

6. Please provide any additional comments or suggestions about your experience with telehealth. (has it been beneficial, helpful, or not?) Please explain.

We appreciate your comments. Thank you for your participation!

Appendix F: Consent Form for Participants in the Study

General Informed Consent Form
NSU Consent to be in a Research Study Entitled

Appreciative Inquiry of a Non-profit Organization Transitioning to Teletherapy

Who is doing this research study?

College: Nova Southeastern University, Dr. Kiran C. Patel College of Osteopathic Medicine, Department of Family Therapy.

Principal Investigator: Claudia Herrera, LMFT, CFLE
Nova Southeastern University
3301 College Avenue
Fort Lauderdale, Florida 33314

Faculty Advisor/Dissertation Chair: Anne H. Rambo, PhD, LMFT
Nova Southeastern University
3301 College Avenue
Fort Lauderdale, Florida 33314

Site Information: Center for Family Services of Palm Beach County, Inc.
4101 Parker Avenue
West Palm Beach, Florida 33405

Funding: Unfunded

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this research study is to understand what is working at the Center for Family Services while transitioning to the delivery of teletherapy services during COVID-19 and how the Center can be a model for other community agencies delivering mental and behavioral health services. The purpose of this research study is to add more information to the available literature in the field by exploring the experiences of the Center's staff members.

Why are you asking me to be in this research study?

You are being asked to be in this research study because you are a member of the Center for Family Services' team. This study will include between 5 to 10 people, over the age of 18, living in Florida, full time and per diem employees working for the Center.

What will I be doing if I agree to be in this research study?

This research study will include a face-to-face interview (one session) that will take between 60 to 90 minutes. The interview will be conducted outside the participant's working hours, and in an external location agreed upon by the researcher and the participant which offers confidentiality. The interview will not be conducted onsite. The interview will be with the researcher Claudia

Herrera. During the interview you will be asked to reflect on your experiences, strengths, and team's accomplishment with working at the Center for Family Services.

Research Study Procedures

Eligible participants must be full time or per diem, English speaking-employees at the Center for Family Services, 18 years old, living in Florida. Once the consent form is signed, the researcher will schedule a face-to-face interview (only one session) that will take between 60 to 90 minutes. After the interview, the participant will receive an encrypted transcript. The participant will be asked to review the transcript to ensure accuracy.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life. Participation in this research study in no way impacts employment at the Center for Family Services.

What happens if I do not want to be in this research study?

You have the right to leave this research study at any time or refuse to be in it. If you decide to leave or you do not want to be in the study anymore, you will not get any penalty or lose any services you have a right to get. If you choose to stop being in the study before it is over, any information about you that was collected **before** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigator. You may be asked to sign a new Informed Consent Form if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study. We hope the information learned from this study will provide a further understanding of the role of the Center for Family Services' staff in improving the mental health of our residents by providing teletherapy services during the pandemic.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. Each interview will be conducted privately, outside the regular working hours, and each participant identifying information will remain confidential. This data will be available to the researcher, the Institutional Review Board, and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely behind a locked office door and filing cabinet. All computer documents will be password protected. All data will be kept for 36 months from the end of the study and destroyed after that time by erasing the encrypted hard drive.

Will there be any Audio or Video Recording?

This research study involves audio and/or video recording. This recording will be available to the researcher, the Institutional Review Board, and other representatives of this institution, and any of the people who gave the researcher money to do the study (if applicable). The recording will be kept, stored, and destroyed as stated in the section above. Because what is in the recording could be used to find out that it is you, it is not possible to be sure that the recording will always be kept confidential. The researcher will try to keep anyone not working on the research from listening to or viewing the recording.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:

Claudia Herrera, LMFT, CFLE can be reached at 561 506 8581, that will be readily available during and after normal work hours.

Research Participants Rights

For questions/concerns regarding your research rights, please contact:

Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

All space below was intentionally left blank.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant

Signature of Participant

Date

Printed Name of Person Obtaining
Consent and Authorization

Signature of Person Obtaining Consent &
Authorization

Date

Appendix G: Interview Questions

Phase I: Discovery

1. What indications do you have that your teletherapy work is effective?
2. How do you work with complex/at risk cases (suicidal, homicidal, mental conditions) within the teletherapy frame?
3. What do you think attracts clients to the Center for Family Services?

Phase II: Dream

4. Imagine a time in the future where people around the country look at the Center for Family Services as an outstanding non-profit organization delivering high quality of teletherapy services to Palm Beach County residents. In this exciting future, what is different about the Center for Family Services?
5. What are you most proud of having helped the Center for Family Services accomplish?
6. What is sustaining the Center for Family Services dedication to the community?

Phase III: Design

7. What are the areas in which you feel the Center for Family Services' staff could have the most impact in delivering teletherapy services to the Palm Beach County residents during the COVID-19 pandemic?
8. As you reflect on successful ways the Center for Family Services is engage in supporting the community, what initiatives stand out as being exceptionally promising regarding the teletherapy services?
9. What do you consider as indicators that you are doing an excellent job within the community, with clients and their families, and the Center for Family Services?

Phase IV: Destiny

10. What small changes could the Center for Family Services make right now that would encourage other communities, individuals, and families to engage in teletherapy services?

11. How would you personally want to be involved in improving and expanding the teletherapy services at the Center for Family Services?

Biographical Sketch

Claudia Herrera was born in Colombia, South America and moved to the United States in 2000. She received a Bachelor of Science in Social Work and a Post-graduate degree in Occupational Health in Colombia. She earned her Master of Science in Marriage and Family Therapy from Nova Southeastern University in 2010. Claudia became a licensed clinician in Florida in 2015 and decided to pursue her PhD. in Family Therapy at Nova Southeastern University. Claudia has administrative, leadership, supervisory, and clinical experience working from a systemic, relational, strength-based, trauma-informed perspectives. Claudia was an intern at the Center for Family Services of Palm Beach County, Inc., during her master's program. After graduation she worked for the Center as a Triple P therapist and continued to move forward with her career at the Center as a Clinical Supervisor, Director of Clinical Services, and Chief Operating Officer. In 2020, Claudia resigned from her position at the Center to open her private practice in Florida.