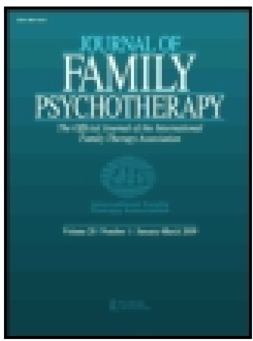

Journal of Family Psychotherapy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wjfp20

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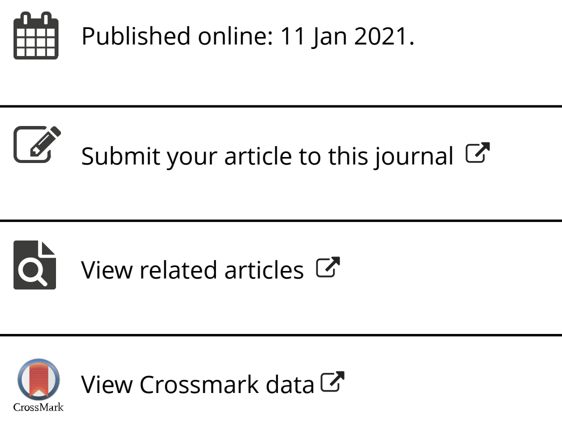
To cite this article: Steve Simms , Pinky Mehta , C. Wayne Jones & Patricia Johnston (2021): A Supervisory Approach to Implementing A Pandemic-Induced, Practice-Based Change to Telehealth, Journal of Family Psychotherapy

To link to this article: https://doi.org/10.1080/2692398X.2020.1865768



Published online: 11 Jan 2021.

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JOURNAL OF FAMILY PSYCHOTHERAPY
https://doi.org/10.1080/2692398X.2020.1865768

A Supervisory Approach to Implementing A Pandemic-Induced, Practice-Based Change to Telehealth

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ABSTRACT

The 2020 COVID-19 pandemic and resulting stay at home orders halted face-to-face in-home therapy for youth at risk of out-of-home placement in Pennsylvania and Delaware. Three family therapy training centers collaborated with state officials managed care organizations, and supervisors to create a two-step process for orchestrating an abrupt, unwanted shift to technology-assisted intensive in-home family therapy. The first step encouraged supervisors to set the stage for this change through an ethics-based lens. The central tenet was to tenaciously advance the wellbeing of the child and their family. The second step encouraged supervisors to remain grounded in the basic principles of treatment and supervision that they followed before telehealth, but with a few adaptations. Three principles are emphasized. Principle one focused on securing clinician commitment to a adapting a family therapy model to a telehealth format. Principle two focused on an unremitting adherence to a preferred family therapy model by using a checklist adapted for technology-based challenges. Finally, principle three focused on fostering professional competence through attending to case conceptualization, supervision-based practice, person-of-the-self challenges, and family-clinician-supervisor isomorphic patterns. Two case examples illustrate the beginning and ending phases of technology-assisted intensive in-home family therapy. Based on feedback from in-home agencies, implementation of these two-steps helped supervisors effectively lead pandemic-induced, practice-based change to a telehealth format with intentionality, conviction, and self-efficacy.

KEYWORDS
Pandemic-induced; practice-based change; technology-assisted intensive in-home family therapy; family systems approach; clinical supervision

Hardship, tragedy, and trauma are ruthlessly rearing their ugly heads through a new conduit, COVID-19, and relying on an ancient forum, worldwide pandemic, to afflict, once again, their menacing presence in the lives of children and their families. This disease's ultimate impact on child development, family life, and our social world is yet to be determined. Mental health professionals using intensive in-home family therapy to thwart out-of-home placement of children at risk from neglect and abuse very recently experienced

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Authors Note We have no known conflicts of interest to disclose.

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an immediate and profound double hit. On or about April 1, 2020, the governors of the Commonwealth of Pennsylvania and the State of Delaware issued respective stay at home orders for their citizenry. The resulting first hit for these professionals was treatment as usual ground to a jolting halt. Like previous historical moments of hardship, tragedy, and trauma, the mental health system found itself paralyzed with uncertainty. Does one wait it out, or does one embrace the challenges of hardship, tragedy, and trauma with intentionality, conviction, and self-efficacy?

The second hit was facing the unnerving challenge to shift to, utilize, and quickly implement technology-assisted intensive in-home family therapy with a challenging clinical population amid a life-threatening, public health crisis. State institutions, managed care organizations, supervisors, and training centers joined together to communicate and share information, make collaborative decisions, and create a cohesive community to support professionals in resuming their commitment to utilize their individual and collective competence in response to this very worrisome and isolating challenge. In this article, we describe how the Ecosystemic Structural Family Therapy Training Consortium worked with our affiliates to navigate an abrupt and unwanted practice-based change. First, we explain how our group encouraged supervisors to set the stage of change through an ethics-based lens. We then describe and illustrate how three key principles … commitment, adherence, and competence … guide our trainers and supervisors to help supervisees launch and implement technology-assisted intensive in-home family therapy.

Crisis-induced, practice-based change: set the stage of change with an ethical perspective

State regulatory agencies and the major organizations representing mental health professional advance codes of ethics universally binding their stakeholders to a deceptively simple clinical obligation. When we ask the question, "what is your basic ethical obligation to clients and their families?," some professionals respond immediately, "First do no harm." This answer implies that "as long as I do no harm, what I do, or, do not do, is not so much the issue." Supervisors should see this automatic, thinking fast reply as, not only faulty, but, also, inaccurate (Kahneman, 2011). In sync with their respective ethics code, supervisors press for supervisees to *advance the wellbeing of the individual* (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2017) and *the family* (American Association of Marriage and Family Therapists, 2015). Should the clinician declare, "I am unsure what to do," the position, first do no harm, is supported, as warranted and essential, until the supervisory team

determines the appropriate course for rendering due care. Should the supervisee fail to find an answer, she is obligated to judiciously secure and facilitate a referral to a qualified colleague.

We postulate that in the early days of the COVID-19 shutdown, some clinicians believed that technology-assisted intensive in-home family therapy is literally impossible. Rather than encouraging supervisors to challenge at once another automatic, fast-thinking clinician-based belief, our group shifted to a thinking slow position (Kahneman, 2011) and reviewed the research literature. This burgeoning database offers affirmative conclusions supporting the efficacy of technology-assisted mental health services including marriage and family therapy (Doss et al., 2017; Reese et al., 2015). Embedded in this literature, however, we discovered an ominous cautionary warning that "technology assisted mental health services may not be appropriate for families challenged by neglect or abuse (Doss et al., 2017, pg. 985)." However, this assertion to date has not been tested.

Pressed by our mission to reduce the risk for children's out-of-home placement, implement this unwanted practice-based change as an ethical mandate, while appreciating the looming presence of a forewarning, we encouraged supervisors to execute technology-assisted intensive in-home family therapy as a clinical and supervisory model. How do clinicians promote the wellbeing of a suffering child and their family through technology-assisted intensive in-home family therapy? How do supervisors promote the wellbeing of a distressed clinician through technology-assisted intensive in-home family therapy? In the next three sections, we explain how supervisors uphold a commitment to family system framework, insist on clinical adherence, and develop competence through supervision that effectively organizes and facilitates an uninvited but ethics driven, obligatory practice-based change.

Principle one for implementing a crisis-inducted practice-based change: commitment to technology-assisted intensive in-home family therapy

Supervisors champion the clinician's commitment to adapting a theoretically coherent, clinically relevant, research and trauma-informed family therapy model (Zur, 2007) to the technology-delivered format. Focusing on three key areas helps. Supervisors begin by drawing the supervisees' attention to how their core beliefs about family aid or hinder the adaptation process. Next, they help them appreciate how their self-perceived role within the family system serves or obstructs the transition. Finally, supervisors always express compassion for supervisees' transition-imposed distress, even when they think it is not necessary, needed, or overdone.

Family: resource or barrier

Colapinto (1995) notes that child-focused mental health professionals are vulnerable to simply seeing caregivers as either partners in or barriers to care. Transition-related challenges amplify this risk factor. One view defends the family as an irreplaceable resource. Working from this perspective, clinicians assiduously work to see and access hidden strengths, untapped resources within the caregivers to help them construct a nurturing family life for the child. By inviting the executive subsystem into an equitable partnership, they help free the family of hauntings from the past and promote the parental figures as agents for change in the future. The other view holds families as disaster waiting to happen. Children, hence, must be protected by the professional from the consequences of an irrecoverable collapse of family functioning. In this view, there is a recognition that chronic and unremitting family dysfunction promotes toxic, growth-inhibiting conditions for the child. Here, clinicians see only negative family patterns that are fixed and unchangeable.

Armed with this knowledge, supervisors can expect that some supervisees, overwhelmed by the challenges of a new therapy format, may become captured by this familiar pre-pandemic polarity that derails their commitment to a systemically focused treatment plan (Sadler, 2017). When this occurs, they help supervisees see beyond absolute comparisons. Rather than making stress-fueled quick decisions based on stark and mutually exclusive contrasts such as the caregiver is either a resource or barrier, supervisors help clinicians shirk these dichotomies in favor of attending to complex systemic interpersonal arrangements and context-bound patterns arising in the stress-laden pandemic environment. For example, despite her daughter's recent near-lethal suicide attempt, the caregiver reported her disturbing unilateral decision about the shift to technology-assisted treatment by voicemail, "We don't feel comfortable meeting on the computer. We decided to wait till you can come back to the home." The clinician called her supervisor at once and requested help. She began the conversation with a polarity-driven description, "Doesn't she care about her daughter? The mother is focusing on herself. I may have to report her to Children and Youth." The supervisor began by attending to the human element of this clinical turning point. She stated, "The mom is pulling away from you. This is worrisome. You sound scared." Next, attending to the clinician's focus on the resource-barrier polarity, she used a several questions to shine a light on this complex family-based dilemma. She asked, "What did the family and you discover about the Tamika's suicide attempt?" The clinician responded, "Tamika feels as if she is a burden on her mother. She thinks her mother would be better off with her dead." The supervisor asked, "How did her mother respond to this discovery?" The clinician responded, "She said Tamika is the most important person in her life. If she died, one of the few joys

in life would be lost." The supervisor then said, "I think the mom misses you. Your image on the computer screen may not be enough." After a moment of reflection, the clinician said, "I am ready to make the call." She picked up her cell phone and left the following voice mail message, "Your decision to stop therapy makes sense to me. After Tamika's brush with death, the stress of working in the grocery store during the pandemic, and the computer getting between us, you must feel overwhelmed. You need a break. I would like to sit with your decision for 24 hours. May we speak tomorrow? I would like to share my worry about us pulling away from one another. Please call me back and let me know." The supervisor helped in four ways. She began by acknowledging the truth of the supervisee's distress. She was scared. Next, she drew her attention away from a simplistic duality about a mother to a complex systemic process involving a suffering youth, dislocated mother, and a worried family therapist. Third, she helped the clinician empathically appreciate how telehealth likely fuel the mother's isolation. Finally, by highlighting her strong connection with the family, the clinician determined a way to use strategically use herself through telehealth to introduce some influence on the caregiver's decision-making process.

Professional: collaborator or expert

Blackall et al. (2009) note that clinicians often see themselves as either an expert or collaborator in the care of patients. It is a common arrangement for caregivers to present worrisome child-based mental, emotional, and behavioral symptoms to professionals who readily accept the independent and autonomous responsibility for psychosocial care. In contrast, other professionals respond to caregiver requests for help their child with mental, emotional, or behavioral symptoms as a collaborator seeking a partnership in experimenting with and co-discovering solutions for the family's compelling child-focused puzzle. Again, rather than supporting supervisees embracing a dualistic polarity, we assert that supervisors help clinicians adopt a more systemically complex perspective on their role and function.

Again, supervisors must be prepared to help supervisees appreciate that the pandemic-imposed implementation of technology-assisted intensive in-home family therapy likely exacerbates another clinical challenge. Regardless of their specific family-focused theoretical orientation, clinicians typically enter technology-assisted intensive in-home family therapy with valuable expertise on eliminating or ameliorating compelling child-based symptoms, but, also, important knowledge on how to include caregivers and key persons within their social network in the treatment process (Biglen, 2015; National Research Council & Institute of Medicine, 2009). The drift from a complex systemic focus to artificial, limiting polar frameworks such as expert-collaborator, must be seen as a likely challenge in supervising the transition to technology-

assisted intensive in-home family therapy. For example, Tyrone was hospitalized recently for an acute onset of auditory and visual hallucinations. Discharged with a diagnosis of schizophrenia, the clinician entered each session with the intent to connect mother and son to the treatment process. Thirty seconds into each session, the mother disappeared from the screen and retreated to another room. Tyrone cooperatively engaged with the clinician throughout the remainder of the session.

Consulting with his training group, the clinician not only discovered that Tyrone's mother likely viewed him as the expert, due to contextual variables such as race, education, socioeconomic status assigned to treat her son's schizophrenia, but, also, he inadvertently drifted to this role by giving the client expert-driven recommendations on how to "cope with seeing and hearing things." To shun the limiting expert-collaborator polarity, his training group helped him refocus his attention on the family's broader social system to support the youth's impending transition to college. He decided to enter the next session and state immediately, "Ms. Bertha, I need your help." He then took the position, "I realized it's us against schizophrenia." He linked "creating a team" to helping Tyrone "go to college under the shadow of schizophrenia." He added, "each of us has at least one way we can help." The clinician later reported that the mother participated actively throughout the next session. In this case, the clinician used supervision to help him reconnect to his commitment to implement technology-assisted intensive in-home family therapy by skirting the traps of thinking in polar opposites through addressing how various triangular arrangements may be weaved together to create a nurturing environment for a vulnerable youth navigating a challenging developmental transition.

Principle two for implementing a crisis-inducted practice-based change: model adherence

Thwarting the out-of-home placement of a suffering child presents a complex challenge for intensive in-home family therapy clinicians. Entering a home through technology-assisted means further complicates this process. Although the research-informed supervisor knows that model-specific research linking clinical outcome to clinician adherence rests on equivocal ground (see Blow, 2007), supervisors must confidently argue that adherence to a theoretically coherent, clinically relevant, trauma-/research-informed intensive in-home family therapy model serves several important functions. One, fidelity helps clinicians enter and maintain a focused, intentional position in a new, unfamiliar treatment context. Next, it orients clinicians to link specified model-related mechanisms of change to confidently inspiring hope in an obviously dark, worrisome worldwide crisis. Additionally, intensive in-home family therapy models also offer well established, time-honored strategies and interventions

(Nichols & Schwartz, 1998) that clinicians likely appreciate, and, some rely on. Stated simply, supervisors, as effective leaders, strategically create a process that reinforces adherence. This stokes clinicians' confidence and self-efficacy.

Checklists are critical tools for professionals practicing adherence. Why use a checklist? They are key components to common, best practice standards in the construction, transportation, and energy industries. Research convincingly shows that checklists ensure consistency, completeness, and reduce failure in high stakes professional endeavors (Gwande, 2010). So why not in technology-assisted, intensive, in-home family therapy? Adherence, facilitated, in part, by checklists, helps supervisors and clinicians pragmatically stay connected to their ethical obligation to advance the wellbeing of the child and their family. Supervisors know that when, not if, life-threatening events occur while delivering telehealth, clinicians are judged through the "C student criteria." When assessing complaints, courts and ethics boards organize their decision-making process around the question, "what would have the *average* clinician done?," rather than narrowly shining the spotlight on a tragic clinical outcome and rigid adherence (Zur, 2007). Adherence to a well-accepted, evidence-informed clinical model, not clinical outcome is a pivotal decision-making variable. Adherence though adapting checklists to the existing clinical conditions make an important contribution to supervisors and clinicians meeting their basic ethical obligation.

A supervisee announces to her supervisor that creating an enactment promoting parent–child attachment is impossible through telehealth. When working in the home, she describes how she moves about the room directing family member to change seats in order to engage one another differently. She adds, "The way their computer is set up, I only see the parent." The supervisor responded by helping the clinician's acknowledge her above described ethical obligation and commitment to implanting family therapy through telehealth. She then highlighted the truth of the clinician's distress. She stated, "Ok, your in-home check list is DOA. Let's pretend the flight instructor passed out. The mother is the student who must fly plane. You are now the air traffic controller who must coach her to fly the plane. Let's think thru how to communicate the step by step process of creating an enactment." After creating a role-play as outline in principle three, the supervisor stated, "I wrote down every step you told the mother take in connecting with her son. I present you with adapted creating an enactment checklist for telehealth. Let me know how it goes in the next session." The clinician breathes a deep sigh of relief and says, "I will."

Principle three for implementing a crisis-inducted practice-based change: competence

Because competence complements adherence, supervisors acculturate clinicians to regard supervision as a critical experience that enriches professional

growth and development. Establishing and "maintaining high standards of professional competence and integrity" is not only a clinical mandate, but, also, another vital ethical obligation (ethics ref). We encourage supervisors to inspire clinicians to appreciate Blow (2007, p. 308) instructive position, "Models either come alive or die through a therapist." As with adherence, promoting competence through mastering technology-assisted intensive in-home family therapy must take center stage. Lyon et al. (2011) comprehensive review of training methods for mental health clinicians charged with mastering clinical models describe training as a time-consuming, resource-intensive process requiring high levels of trainer-trainee engagement. Rather than reinforcing dependency, the supervisor, as an effective leader, creates a process that reinforces the clinician's habit in adhering to technology-assisted intensive in-home family therapy. To make this happen, supervisors strategically organize the supervision around four critical ingredients: case conceptualization, practice, the person of therapist, and attention to isomorphic patterns.

Systemic case conceptualization

Clinicians must develop a meaningful story with the family to explain how a child's symptoms are evoked and maintained within the context of his or her current relationships (Jones, 2019). This story is what guides practice whether live or through a technology-assisted format. The story is informed by the clinician and supervisor's clinical model, which provides a guide as to which information should be given maximum attention during an assessment. However, case conceptualization is only as good as the data it is based upon. Supervisors must ask themselves, "what does this clinician 'see' when they are with a family?" This is one of the more critical tasks of a systemic supervisor – asking reflective questions that guide clinicians to see family interactions and the spaces between people.

This can be more challenging in technology-assisted in-home family therapy because what can be seen on a screen is more limited than what can be seen live in the home. Clinicians may develop case conceptualizations based only on who they can see on camera, or what they are told by a family member, falling into the trap of overfocusing on content and behavior without context. They succumb to the fallacy of only looking at what can be seen, like the man who lost his keys in a dark alley but insisted only on looking for them on a street where there was a streetlamp. A treatment based on limited data cannot provide a meaningful roadmap for intervention. Systemic supervisors of technology-assisted in-home family therapy must frequently remind clinicians of their limited field of vision, to be mindful of what is not seen, and to help them develop alternative methods for bringing the unseen to the foreground.

Practice

Clinicians practice technology-assisted intensive in-home family therapy through three types of learning activities (Ericsson, 2006). One, they immerse themselves in their work. On the job experience, whether at the beginner, intermediate and advanced practitioner level, is one necessary condition for skill development and the acquisition of competence. Two, deliberately practicing technology-assisted intensive in-home family therapy while receiving supervisory feedback is the next critical condition. Repeated practice and regular feedback in every supervision session must take place. Supervisors construct learning experiences within the supervisee's zone of proximal development (Vygotsky, 1978). Technology-assisted intensive in-home family therapy clinical vignettes strategically constructed around supervisees identified challenges likely evoke opportunist struggles. With focused instruction and immediate feedback, supervisors help them achieve immediate success. Role-plays are an especially useful tool for helping supervisee practice an array of technology-assisted intensive in-home family therapy challenges within a safe, nurturing learning environment. Browning's (2005) informally validated 14 step protocol for creating family-focused role-plays is an excellent resource for supervisors seeking to develop and expand their roleplay facilitating skills.

Address person of the therapist challenges

Supervisors strive to craft an emotionally meaningful supervisory relationship. Within this context, supervisees reach deep within themselves to use all parts of "who they are today" to the benefit of their clients. By practicing curiosity, compassion, and consistency in all aspects of the therapeutic process – relationship building, assessment, and intervention, supervisors assist the person of the therapist, i.e., clinician, to capitalize on the fullest use of their personal selves, especially, emotional vulnerabilities (Aponte & Kissel, 2016). When selectively using all aspects of the self, professionals must give attention to their signature themes. We all carry within ourselves a mantra, which is the driver for all emotional and relational functioning throughout our lives. Additionally, these signature themes may also be comprised of other personal issues or derivative themes. Connection to these signature and derivative themes is central to the clinician's ability to make connections with their clients' struggles. Supervision is used as a learning experience in which supervisees' practice using signature themes as valuable resources to effectively empathize and differentiate from their clients.

For example, Xavier and his family were referred to in-home services due to psychiatric hospitalization for suicidal ideations and depression. The clinician sought out supervision requesting a "new clinician" for Xavier stating, "I can't get him to talk. I just do not think I am a good fit for this client. He would do

better with a more experienced male therapist, who has experience, who can do telehealth better than me." By creating a nurturing holding container in supervision, the supervisor and clinician turned to the clinician's signature themes of "low self-worth," as well as, her derivative theme of "unintentionally withdrawing from relationships," as a valuable recourse to reengage the caregivers into treatment.

Upon further discussion and examination of the family's history and role-plays in supervision, the clinician was able enter into the next technology-assisted intensive in-home family therapy session stating "your son has this crazy idea that he is a burden on your family and that you would be free from this burden if he were dead." The clinician was able to use her signature and derivative themes to understand her reactivity to Xavier's unresponsiveness and use it to deepen her relationship with the family and support the family in creating opportunities to be physically and emotionally present in session in order to advance Xavier's self-worth.

Attend to isomorphic family-therapist patterns

Patterns in families can have a strong gravitational pull, organizing the behavior of not only family members, but, also, clinicians who are working with them. Isomorphism refers to a replication of a positive or negative emotional process, thinking process or interactional pattern across relationships. The most common isomorphic traps clinicians face include falling into family triangles or coalitions, taking over for an overwhelmed parent, and leaving important people out of treatment (Jones, 2019). Since it occurs out of consciousness, systemically oriented supervisors are always on the look-out for clinicians falling into isomorphic patterns with families. They know that it is not possible for therapists to entirely avoid these traps, because they are human and family patterns are powerful.

A major strategy used by supervisors to identify isomorphic patterns is videotape review. This allows clinicians to see themselves in interactions with families, and to step back and reflect on the process. When a clinician is unaware and replicating a negative isomorphic pattern with the family, they become a homeostatic mechanism, unwittingly reinforcing, and maintaining the family's maladaptive patterns. This runs afoul of the ethical standard referred to at the beginning of this paper. That is, clinicians must advance the well-being of the child and family. When proactive, clinicians and their supervisors use this concept of isomorphism to identify how their attitudes and actions affect the family's interactions with one another and their parenting behavior. They ask, 1) "Am I relating in a deficit-based way, thus reinforcing or setting in motion critical, disempowering interactions in the family?" or 2) "Am I relating supportively in a way that is empowering, engendering more strength-based parenting and collaborative intra-familial interactions?"

This concept can also be used to identify how the family's attitudes and actions are carried by the clinicians into their relationships with their team partners and the supervisor.

Here is an example of how isomorphism may present itself in technology-assisted intensive, in-home family therapy. Bill, the clinician, was working with the Stevenson family for about 3 weeks, but in every telehealth session, only the mother was on camera. She seemed to love talking to Bill and telling him about the crisis of the day. Although her husband of 17 years was in the same room, and she often complained about him, she nor the therapist invited him to join into the conversation. The negative isomorphic pattern was that mother always leaves her husband out because she believes he is an incompetent parent. Yet she often complained about needing help from him with their aggressive adolescent son. Because Bill could not see the father on camera, the father rarely spoke and deferred to his wife, the clinician began to share in the mother's belief about her husband. Now Bill was maintaining the systemic problem. When the supervisor reviewed a videotape of a telehealth session, she immediately noticed the father's absence and inquired about it. The clinician was surprised with himself that he had not noticed and had not been more proactive at engaging the father. The supervisor was supportive, normalizing and reminding him that this is the power of patterns in families and it must be respected as such.

Case studies in supervision: technology-assisted intensive in-home family therapy with symptomatic youth and their families

We begin this clinical application section by calling the reader's attention to another crucial isomorphic process. At one level, supervisors assist clinicians in approaching each technology-assisted intensive in-home family therapy session by focusing on their ethical obligations, commitment to a systemic perspective, adherence to a family therapy model, and professional competence. At the next level, supervisors use this approach for organizing supervision around the supervisor–supervisee relationship and their interactional process. Supervisors attend to their ethical obligations including the supervisee, commit to advancing a systemic perspective in the clinical and supervisory contexts, adhere to a systems-based clinical and a supervisory model, and promote professional growth and development, not only with the supervisee, but, also, their self. Two case studies illustrate beginning with and terminating technology-assisted intensive in-home family therapy.

Beginning with technology-assisted intensive in-home family therapy

The supervisor and supervisee studied a comprehensive referral packet summarized as follows. Jacob, age 12, and his family, were referred 2 weeks after

the COVID-19 pandemic-imposed stay at home order. In 2019, Jacob was hospitalized twice though a local inpatient psychiatric service for aggression directed toward family members and property destruction in the home. He lives in a single-parent household with his biological mother, and, two siblings, Elijah, 15 years old, and, sister, Rachel, 5 years old. His mother is employed as an essential worker for the federal government. Jacob's father resides in the same neighborhood but is sporadically involved in his life. Mother reports a history of domestic violence between Jacob's father and her. Elijah's and Rachel's fathers are not involved in their lives. The mother describes the family's neighborhood as "not safe." She requires the children to remain at home until she returns from work. In her absence, Elijah, the oldest, oversees the household and serves as her emissary to the children's school. Her request for service was "to get Jacob's behavior's in order." She agreed to technology-assisted intensive in-home family therapy.

The supervisor organized this beginning technology-assisted intensive in-home family therapy conversation around a series of open-ended questions. The first question, "Entering the home through technology, what is your most pressing area of focus?," triggered a thoughtful conversation around the clinician's ethical obligation to Jacob and his family. Another question, "What are the connections between Jacob's symptoms, his life with a stressed mom, and a violent neighborhood?," prompted a lively conversation around her commitment to a systemic understanding of this child presenting symptoms embedded within a highly stressed and likely faltering executive subsystem and community. She next inquired about how Ecosystemic Structural Family Therapy (ESFT; Lindblad-Goldberg & Northey, 2013; Simms & Hawkins, 2015; Jones, 2019), the agency's chosen family therapy clinical model, "guided her to build a relationship with each family member by way of technology?" The supervisee attentively linked several facets of the model to the presenting clinical challenge.

The supervisor summarized and supported this seasoned supervisee's plan for session one. She said, "Valerie, I think you are entering your first ever technology assisted session focused and intentional." First, I like that you want to assess the child's and family's safety in the home and community. This attention to wellbeing is excellent. Next, your take that Jacob's presenting symptoms are connected to the impact of a caregiver parenting alone under the threat of illness and community violence is a great systemic hypothesis. Your plan to join with each family member around the reframe, "starting to look like it might be us creating a team against it," helps you stick with the model (adhere). At this point, the supervisor was tempted to confidently summarize, "I think you are ready!," and end their conversation. Recalling her recent self-challenge to "trust her gut more often," she then paused to deliberately ponder the supervisee's earlier comment, "Don't worry about me! I think technology assisted therapy will be better for this family." The

supervisor stated, "Before we wrap up, I want to ask you about the smile that came to your face when you said you would rather use technology rather than go to their home. That is confusing. I thought you loved working with families in their home." After a deafening silence, the supervisee disclosed, "That neighborhood scares me." First, the supervisor utilized the remaining time to help the supervisee consider how acknowledging her reality-based fear may assist her in joining with this mother and developing a "us versus it" reframe. Next, she made a supervision note to broach in future supervisory sessions how this understandable fear of community violence remained hidden during their longtime relationship.

Terminating treatment through technology-assisted intensive in-home family therapy

Families likely experience the ending of a close, nurturing, therapeutic relationship as hard. For example, Kazak et al. (2004) showed that the discharge from intensive oncology care to an annual outpatient visit was a significant traumatic event for many caregivers of childhood cancer survivors. Although most intensive in-home family therapy models address discharge planning across all phases of treatment, as this treatment-related event approaches, clinicians must work strategically with families on a transition plan. This plan typically punctuates progress, anticipates triggers that activate "old" family interaction patterns, and empowers the caregivers to create a supportive alliance with professional and nonprofessional members of their community that support the "new" more adaptive family interaction patterns. The following summary prepares the reader to follow the final case study.

Malcom, age 13, is the adoptive son in a remarried family. His adoptive father brought three children (16, 13, and 9) to this family. The children's mother suffered a tragic death from cancer. His adoptive mother brought one child, age 17, to this new family. The caregivers place family life as their number one value and priority. The adoptive parents are devoted members of a local church. Their Christian faith advocates for the adoption of "disadvantaged children."

In preparing for discharge, the supervisory team agreed that several important treatment goals were achieved. First, an adult leadership subsystem was formed based on caregiver's cultural and religious belief systems. Next, each family member and Malcom established a secure attachment. Finally, the caregiver's worked with the children in a developmentally appropriate way to create family-based roles, rules, and boundaries leading to a nurturing child-focused family environment. The clinician then proposed a transition plan. She would first deliver to their home, hand paints and paper, and, then lead an exercise. She would direct each family member to connect their

handprints to one another to visually signify “family.” She would instruct them to leave a space on the sheet to give a handprint of caregiver’s waving goodbye to the clinician. She would conclude the session by inquiring how the family wanted to use this print.

The supervisor paused, then asked, “How does you leading this activity reinforce the caregiver’s leadership role at discharge?” She responded hesitantly, “I guess it does not.” As the supervisor began asking the next question, “How does you leading the …,” the supervisee exclaimed, “I get it! I get it! They need to lead, and I need to follow.” The supervisory team then role played a caregiver-clinician conversation around the question, “Dad, mom, what do you need from me to create a remembrance project of our work?” The clinician concluded the role play by saying to the caregivers, “I think you got this. I will observe by computer but mute my audio. You got this.” The supervisor responded with a smile and thumbs up.” Technology-assisted intensive in-home family therapy was a perfect venue for highlighting both the caregiver’s and clinician's growing competence at critical therapeutic juncture.

Conclusion

After reading this paper, what does the supervisor take to the next supervisory encounter with a clinician facing a pandemic-imposed, unwanted practice-based change? Regardless of their specific family therapy model or orientation, they always help the clinician launch and implement technology-assisted intensive in-home family therapy through an ethics-based lens. Next, they utilize three key principles. One, advance a commitment to a systemic perspective. Two, promote adherence to a theoretically coherent, clinically relevant, trauma-informed, research-informed family therapy model. Finally, nurture professional competence though developing systemic conceptualizations, orchestrating practice through role-plays, helping clinicians capitalize on their person of the therapist challenges, and attending to isomorphic patterns. Finally, this paper illustrates how two supervisors helped two supervisees begin and terminate with technology-assisted intensive in-home family therapy. With these guidelines, suggestions, and examples, readers may consider how to apply this process to their own work with families, supervisees, and communities of care.

Supervisors further assist by drawing supervisees’ attention to how, as Simon (2006) describes, their personal belief system, world view, and assigned or adopted family therapy model converge. The supervisors and supervisees must recommit to their relationship to, not only, helping caregivers forge a nurturing environment for the suffering child, but, also, create a nurturing supervisory environment promoting the clinician’s own wellbeing, growth, and development. Connecting this idea with the concept of isomorphism

discussed in principle three is useful. These two ideas shape a philosophical congruence between personal and professional worldviews engendering a deep commitment, an *esprit de corps*, to their ethical obligation of providing due care.

They must help their supervisees resist the human inclination to push past pain of the past and remain in the present to explore how the supervisee's experience with hardship, tragedy, and trauma influences their beliefs about families.

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