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Psychologists' Experiences Providing Cognitive-Behavioral Therapy (CBT) to Children via Telehealth

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PSYCHOLOGISTS' EXPERIENCES PROVIDING COGNITIVE-BEHAVIORAL THERAPY

(CBT) TO CHILDREN VIA TELEHEALTH

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A DOCTORAL DISSERTATION SUBMITTED

TO THE FACULTY OF

THE GRADUATE STUDIES PROGRAM

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF PSYCHOLOGY

LONG ISLAND UNIVERSITY, POST CAMPUS

AUGUST 2023

MAJOR DIVISION: PSYCHOLOGY

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Abstract

Due to COVID-19, psychologists were forced to rapidly transition to telehealth. While about 1% of American Psychological Association (APA) clinicians used telehealth for most clients pre-pandemic, 92% used telehealth post-pandemic onset (APA, 2020). However, research has not yet thoroughly assessed psychologists' experiences providing child teletherapy. This study fills that gap by exploring psychologists' experiences providing virtual child cognitive-behavioral therapy (CBT). This study is important for teletherapy's potential use for children lacking access to care. Eighteen clinical psychologists who provided CBT to children (ages 7-12) were recruited by sending a flyer to the researcher's graduate program's alumni and training sites, child therapy institutes, private practices, and doctoral programs. Snowball sampling was utilized. Participants were interviewed in four Zoom focus groups of four to six participants each. Auerbach and Silverstein's (2003) grounded theory approach was used. The transcripts were coded for relevant text, repeating ideas, themes, and theoretical constructs. Interrater reliability was assessed and a member check was completed. Six theoretical constructs were identified: 1. Transition to Telehealth Impacts Families' Access to Care – More Positively Than Negatively; 2. Importance of Focusing on Pre-Treatment Considerations When Conducting CBT via Telehealth; 3. Adjusting to Increased Engagement and Management Issues That Arise During Telehealth Treatment; 4. Telehealth Experience has Varied Positive and Negative Impacts on a Case-By-Case Basis on Psychologists and Children; 5. Psychologists' Attitudes Regarding CBT via Telehealth Were Mixed, Though More Positive Than Negative; and 6. CBT via Telehealth for Children is Effective and has a Long-Term Future Beyond the Pandemic. The findings help explain how to effectively provide virtual child CBT and suggest improvements and future research needed.

Psychologists' Experiences Providing Cognitive-Behavioral Therapy (CBT) to Children Via

Telehealth

Shortly after the onset of the COVID-19 pandemic, in April and May of 2020, an APA study conducted on 5,400 participants found 55% of APA member clinicians (individuals with a doctoral degree in psychology or a related field) were seeing fewer patients in general and 64% were receiving fewer patient referrals in general (APA, 2020). This decline in services was likely due to a multitude of factors, including patients'/patients' caregivers' loss of jobs and/or insurance, a need for childcare during school closures, insurance difficulties, and patients moving out of the state they were being provided treatment in prior to the pandemic. The COVID-19 pandemic also caused a major shift in how clinicians practiced. According to this same study, 76% of APA member clinicians were solely providing remote services to patients. Sixteen percent were offering remote services in addition to in-person services. These statistics are in stark contrast to only one percent of APA member clinicians that used remote services for all of their clients before the pandemic (APA, 2020).

Of the APA member clinicians surveyed in April and May of 2020, 76% also reported that treating patients remotely was more challenging than treating patients in-person (APA, 2020). However, clinicians also reported feeling knowledgeable about and confident in their ability to use the technology required for providing remote services. Thus, it is possible that the challenge resided not with the technology itself, but with the adaptation of in-person interventions to telehealth.

Regarding the lack of training and rapidness with which psychologists were expected to transition to telehealth after the onset of the pandemic, Dhara Meghani, PhD, an assistant professor of clinical psychology at the University of San Francisco, stated, **"It's as if the entire**

workforce was trained to drive automobiles and switches to 18-wheelers overnight. You may understand the rules of the road, but you don't know how that applies to the technology you're now using" (Abrams, 2020). According to Schiano and Daniels' (2020) study, 66% of mental health clinicians took merely one week or less to transition to telehealth as a result of the pandemic. This is vastly different from the number of years that mental health clinicians spend training to provide in-person services. Certain aspects of in-person therapy, such as assessment of a client's gait, hygiene, nonverbal cues, and physical well-being, required modifications that may have been neglected during this rapid transition. Further, safety planning with clients similarly required adjustments when moving to telehealth (Abrams, 2020).

Positive Views of the Shift to Telehealth

The California Association of Marriage and Family Therapists (CAMFT) sent a survey via email in June of 2020 to the association's members (licensed marriage and family therapists) concerning the impact the forced move to teletherapy had on their practices and the way they will potentially work in the future (Schiano & Daniels, 2020). The survey, which was completed by about 2,300 mental health providers in California, consisted of 15 multiple-choice and six open-ended questions. The survey results indicated that three months post-transitioning to telehealth, 12% of respondents reported they would prefer to see three quarters to all of their clients virtually after the pandemic is over. Additionally, 20% would prefer to see up to three quarters virtually, 24% would prefer to see half of their patients virtually, and 29% would prefer to see up to one quarter of their patients virtually. Thus, the majority of respondents reported preferring to see at least some portion of their patients virtually, in contrast to only 28% that preferred to use almost no teletherapy when the pandemic is over.

This same survey, through open-ended questions, examined both the positive and negative impacts mental health providers experienced related to the use of teletherapy (Schiano & Daniels, 2020). As for positive impacts, the most commonly cited benefit of teletherapy was the ability for clinicians and patients to remain connected and continue treatment during a difficult time. Another positive impact cited was convenience and flexibility. Clinicians reported that their patients canceled and no-showed less often due to the greater convenience of telehealth. Additionally, greater convenience allowed for increased access to services for patients with disabilities that would have otherwise made it more difficult or impossible for them to utilize in-person services.

In addition to providing a continuation of treatment when in-person mental health services were no longer possible during the pandemic, telehealth could also provide mental health services to individuals in underserved and/or rural communities that ordinarily may not have had access to such services (Gloff et al., 2015; Myers & Comer, 2016; Schiano & Daniels, 2020). Of 46.6 million Americans with a mental health issue, only 42.6% receive treatment (Wilser, 2020). Armstrong et al. (2022) demonstrated the effectiveness of telehealth in decreasing depression severity and improving the ability to reach underserved individuals by examining archival data from 424 rural-residing teletherapy patients receiving teletherapy between 2009 and 2019 in Texas. The study found that clinically significant change was achieved within the first 3-7 sessions, on average.

Compounding the lack of access to mental health services due to geographic boundaries, there is also a dwindling supply of psychiatrists and psychologists, or what is referred to as the aging-out effect. In other words, many of the U.S.'s psychology and psychiatry professionals are reaching retirement age, and the number of professionals entering the field does not compensate

for the amount exiting the field (Gloff et al., 2015; Myers & Comer, 2016). Thus, more than

ever, the fields of psychology and psychiatry need new options for providing mental health

services, and teletherapy could help to fill this gap.

Furthermore, Schiano and Daniels' (2020) survey results indicated that clinicians

perceived increased openness as a result of the switch to teletherapy. Clinicians believed this

increased openness derived from a variety of factors, including the fact that both patient and

clinician were experiencing the same crisis, COVID-19, together. Additionally, appointments

were more casual than usual since they were typically conducted from home, allowing the

clinician to gain, in some cases, a better understanding of patients' contextual/familial issues.

Furthermore, clinicians cited the chat feature on telehealth platforms as a contributor to increased

openness. Patients may be more willing to type something if they do not believe they have

privacy to speak or if they perhaps find it too difficult to say something aloud to the therapist.

The technology could also be used to the clinicians' advantage by easily sending

homework/engaging the patient in virtual therapeutic activities. Additionally, clinicians believed

that the distance created by the computer screen in some cases led their patients to feel a greater

sense of emotional safety.

Negative Impacts of the Shift to Telehealth

In contrast to the abovementioned positive impacts of teletherapy on the therapeutic

process, clinicians from Schiano & Daniels' (2020) survey also reported various negative

impacts. The most commonly reported negative impact was the increased difficulty in

establishing and maintaining therapeutic alliances and rapport. Further, clinicians reported

various technological limitations, including connection issues, glitches, and difficulty reading

patients' nonverbal communication. Clinicians also reported privacy concerns when meeting

with patients virtually. Moreover, therapists reported experiencing Zoom fatigue. Many

therapists indicated that because of Zoom fatigue, they decided to see fewer patients than they

typically would in person. Additionally, they reported feeling less satisfied with their work.

Clinicians also listed effectiveness concerns and some clients' and therapists' unwillingness to

move to telehealth as negative impacts.

Lastly, clinicians reported decreased client engagement, especially when treating

children, as another negative impact of the transition to teletherapy (Schiano & Daniels, 2020).

As the survey responses indicated, children were using screens more than usual during the

pandemic with remote learning, and therapists thus noticed decreased engagement during

sessions after extended periods of screen use during the day. Therapists reported children were

also especially prone to increased distractions such as using other online applications while in

session. Younger child engagement was similarly reported as the most significant barrier to

telehealth in a study examining community mental health clinicians' experiences transitioning to

telehealth (AlRasheed et al., 2022).

Telehealth with Children

It is especially important to study mental health treatment of children due to the

pandemic's large impact on this population's mental health (Leeb et al., 2020; Meherali et al.,

2021). Demonstrating this impact, Leeb et al. (2020) reported that the proportion of mental

health-related emergency department visits in the U.S. for children aged 5-11 and 12-17 years

increased approximately 24% and 31%, respectively, from the onset of the COVID-19 pandemic

to October 2020 in comparison to the same time period in 2019.

Further, Meherali et al. (2021) conducted a systematic review of the current research on

child and adolescent mental health in the context of COVID-19 and past epidemics/pandemics

(Ebola, Equine Influenza, and H1N1 Influenza). The review demonstrated that COVID-19 has significantly impacted the emotional and behavioral experiences of children and adolescents. The review additionally indicated that rates of depression and anxiety within this population are higher as a result of the current pandemic in comparison to pre-pandemic rates. Overall, child and adolescent mental health declines as a result of pandemics have been shown to lead to increased emotional stress, feelings of helplessness, and fear (Meherali et al., 2021).

Due to the COVID-19 pandemic, children have not only been concerned about their physical health, but have also experienced social isolation and drastic changes in their school environments (Leeb et al., 2020). Increased mental health issues amongst this population, in addition to the already existing pressure placed on health care systems during the pandemic, make it even more important to explore new treatment options such as teletherapy (Leeb et al., 2020).

Thus far, children and their caregivers have reported high satisfaction with telehealth services (Dueweke et al., 2020; Gloff et al., 2015; Myers et al., 2017). This provides incentive to further explore teletherapy as a treatment option to utilize post-pandemic. Children may have an advantage over individuals of other ages in regard to being teletherapy patients. Children can be referred to as digital natives, meaning that they have grown up with technology present throughout their lives (Dueweke et al., 2020). Children in particular may easily adapt to a telehealth format due to their familiarity with the technology. In a review of the current literature, Myers et al. (2017) presented multiple studies demonstrating that primary care providers, parents, and youth have endorsed the acceptability of, and satisfaction with, child mental health services provided through videoconferencing. Further, in an article detailing doctoral trainees' experiences transitioning the University at Albany psychological services

training clinic to teletherapy during the COVID-19 pandemic, Scharff et al. (2020) noted that teletherapy provided the unique advantage of being able to see patients in their home environments, allowing therapists to witness family dynamics during remote sessions.

Child treatments clearly include unique challenges that have been particularly impacted by the move to telehealth services, such as parent/family involvement and patient engagement concerns (Dueweke et al., 2020). In a national survey of 250 clinicians providing teletherapy to traumatized children, results demonstrated that caregiver engagement was perceived to be easier via telehealth, in addition to logistical aspects (safety, access, convenience, scheduling, and attendance) of treatment (Baker et al., 2023). On the other hand, rapport building, assessing emotions, having the child feel emotionally supported, maintaining the child's attention, and screen fatigue were all viewed as challenges. These challenges make telehealth treatment of this population particularly important to study.

Recommendations for Child Telehealth Treatment

At the onset of the pandemic, despite the lack of research in the area of telehealth for children, the shift to teletherapy required that recommendations be put forth for practitioners serving this population. For example, Dueweke et al. (2020) outlined recommendations for using telehealth to provide mental health services to children. The authors recommended first orienting the patients and caregivers to telehealth services, including aspects such as billing, insurance, risks, and benefits of the services, as well as obtaining consent for the services. Next, the authors encouraged providers to demonstrate to patients and caregivers how to use the telehealth equipment and to discuss expectations for sessions, including potential distractions in the patients' environments, attire, body positioning, and scheduling. Importantly, it was recommended that providers help patients and caregivers find a private location for sessions,

with caregivers able to access the youth in the event of an emergency. The authors also recommended discussing emergency protocols and the development of routines for transitioning in and out of sessions with patients and caregivers. As for the sessions themselves, the authors recommended using interactive activities with children, frequent breaks, use of physical objects in the child's environment, and adaptation of worksheets and activities for digital use. Lastly, the authors recommended using technology to the provider's advantage, such as by enhancing exposures, gaining access to social context, and using the chat feature on platforms.

Similarly, Jones et al. (2014) emphasized the importance of being interactive in child teletherapy sessions by mailing session materials ahead of time or sharing materials virtually in real time. Other recommendations have focused specifically on youth engagement, encouraging providers to use exaggerated facial expressions and hand gestures, increased use of summary statements to show that the provider is listening, and increased encouragement of verbal confirmations of understanding from patients (Seager van Dyk et al., 2020). Although these recommendations were made early in the pandemic, there were limited applied explanations and examples of digital resources practitioners were able to use in session (Dueweke et al, 2020). Furthermore, there was also limited research about the effects of these recommendations.

CBT for Children

While telehealth treatment of children is an area in need of more research, the research literature on CBT for children is plentiful. CBT has been proven to be efficacious in the treatment of a variety of mental health disorders in children in a multitude of studies and meta-analyses. For example, the literature has supported the use of CBT for children in the treatment of anxiety disorders (Compton et al., 2004; Davis, May, & Whiting, 2011; Ishikawa et al., 2007), depressive disorders (Arnberg & Ost, 2014; Compton et al., 2004; Reinecke, Ryan, & DuBois,

1998), phobias (Davis, May, & Whiting, 2011), trauma symptoms (de Arellano et al., 2014; Dorsey et al., 2017), and externalizing disorders (Battagliese et al., 2015).

Although different CBT interventions exist for specific childhood disorders, commonalities exist across such treatments (Kazdin & Weisz, 2017). For example, CBT interventions are often manualized and include a psychoeducational component, skills building, cognitive restructuring, gradual exposure, relapse prevention plans, structured sessions, use of rewards and contracts, homework, and a fairly small number of sessions. CBT also focuses on specific, present behaviors and thoughts and often includes parental involvement (Kazdin & Weisz, 2017).

Although parental involvement is a commonality across different child-focused CBT treatments, the level and/or type of involvement varies. Depending on the case, the parent may serve as a consultant, a collaborator, or a co-client (Kazdin & Weisz, 2017). Regarding the importance of parent involvement in child CBT treatment, Barnett et al. (2013) points to behavioral parent training (BPT) as the best treatment option for young children with conduct problems, a treatment which primarily involves parents. During BPT, parents are taught effective behavior change strategies and receive feedback via coaching from the therapist (Barnett et al., 2013). In addition, Manassis et al. (2014) examined the effect of different types of parent involvement in CBT for child anxiety on treatment outcomes and found that CBT with emphasis on contingency management and transfer of control better supported long-term maintenance of treatment gains than both CBT with active parental involvement without this emphasis and CBT with low parental involvement.

Researchers have also studied other aspects of the child-focused CBT therapeutic process, such as therapeutic alliance. For example, McLeod et al. (2014) examined the

relationship between therapeutic alliance and client involvement in child CBT for anxiety disorders. The results indicated that a positive change in alliance predicted higher client involvement later in therapy, and a positive change in client involvement also predicted a stronger later alliance. The authors emphasize that further research is needed to determine the specifics of this complex relationship. Given that client involvement and alliance can be potentially impacted by the move to telehealth, it may be even more important now to further examine these processes.

CBT and Telehealth

The most commonly researched theoretical orientation in regard to telehealth thus far has been CBT (Dueweke et al., 2020). For example, empirical studies have been conducted on the use of CBT via telehealth for adults, proving CBT via telehealth to be effective in the treatment of anxiety disorders (Bouchard et al., 2000; Bouchard et al., 2004), obsessive-compulsive disorder (Himle et al., 2006), depressive symptoms (Griffiths et al., 2006), suicidality (Gros et al., 2011a), eating disorders (Simpson et al., 2003; Mitchell et al., 2008), addictive behaviors (Oakes et al., 2008), and posttraumatic stress disorder (Germain et al., 2009; Gros et al., 2011b, Tuerk et al., 2010, Stewart et al., 2020). According to a meta-analysis of randomized control trials comparing CBT via telehealth to in-person CBT, no significant differences were discovered between treatment outcomes at posttreatment, follow-up, or in attrition rates (Lin, Heckman, & Anderson, 2021). CBT interventions are likely easily adaptable to the telehealth format, primarily because of the structure of CBT approaches and the orientation's skill-building focus (Dueweke et al., 2020).

Beyond the adult telehealth literature, few studies had been conducted on CBT via telehealth for children specifically before the pandemic. This is evident when reviewing Gros et

al. (2013)'s meta-analysis of empirical studies on conducting CBT via telehealth, in which only two of the 26 studies reviewed involved interventions for children. Among the few studies that have been conducted examining the efficacy of CBT via telehealth for children was Himle et al.'s (2012) study on comprehensive behavioral intervention for tics (CBIT). The study included 18 children, ages 8-17, who met DSM-IV-TR criteria for chronic tic disorder or Tourette disorder, and the children's parents. The study's results indicated significant improvements in tic behaviors from pre- to post- treatment, with no difference in outcomes between in-person and remote conditions. Additionally, Nelson et al. (2003) conducted a study examining the difference between in-person and remote CBT interventions for children who met the DSM-IV criteria for depression in 28 children from Kansas, ages 8-14, and their parents. The results indicated that individuals receiving treatment via telehealth exhibited a significantly greater rate of decrease in depressive symptoms over time than those receiving in-person treatment. While these results are certainly promising, further research on the efficacy of CBT via telehealth for children is needed.

Castro et al.'s (2022) qualitative study examined the perspectives of youth (*n*=13; ages 8-17), parents (*n*=19), and mental health providers (*n*=4) in an underresourced Latinx community on the use of CBT via telehealth for anxiety during the pandemic. Of the four mental health providers, two were licensed psychologists, one was a licensed marriage and family therapist, and one was a marriage and family therapist associate. The study sampled a mental health program serving a 100% California Medicaid-funded urban, predominantly Latinx, patient population. More detailed demographic information related to the children, parents, and providers was not collected due to privacy concerns. The study's investigators created and used a structured focus group interview guide that was adapted for each type of focus group (youth, parents, or providers). The youth focus groups were asked questions about their experiences in

receiving mental health care via telehealth. The parent groups were asked about their children's experiences in addition to being asked about their own comfort using technology and the perceived strengths, challenges, feasibility, and acceptability regarding telehealth treatment. The provider groups were additionally asked about their own experiences and the strengths, challenges, feasibility, acceptability, and implementation experiences when delivering pediatric anxiety treatment via telehealth. The study investigators provided the following examples of questions asked to the groups, including: "What has been your experience with telehealth?"; "What are some of the things that you like about telehealth?"; and "What are the limitations to telehealth?"

Castro et al. (2022) discovered a variety of themes, one of which was the perceived lack of privacy and safety when conducting teletherapy from home. Identifying an issue that may be particularly prevalent in low-income homes in which families share small spaces or share devices, child participants reported lack of privacy and consequently, less safety in sharing important information. Similarly, providers reported increased challenges establishing privacy during child telehealth sessions. Another limitation mentioned was technological issues. In particular, the children found that the experience was improved when they were comfortable with the technology and parents noted this to be a challenge for them given they did not grow up with widespread use of technology. Providers also mentioned technological issues such as the audio going in and out during session. Further, while some of the children noted greater difficulty forming a close and personal relationship via telehealth, others noted that seeing the providers in their homes allowed them to feel more connected to their provider. Parents and children in this study noted convenience of teletherapy as an advantage. Providers noted issues with maintaining the engagement and attention of the children and parents during sessions. For

example, providers noted that parents were often multi-tasking while sessions were occurring. Providers found that shortening the child session was necessary to address the engagement difficulties of children. Children in this study expressed the importance of rapport and trust being built between the providers and the children. Providers emphasized the importance of setting expectations for parents and children. This may include introducing them to the technology necessary and establishing a private space beforehand. Providers also reported the importance of preparing more structured, engaging session activities to reduce distractions and make the best use of the session time.

Gaps in the Literature

Several studies have been conducted and articles written on the efficacy of child CBT via telehealth and on trainees' (Scharff et al., 2020), therapists' (Schiano & Daniels, 2020), and clients' experiences with the treatment (Dueweke et al., 2020; Gloff et al., 2015; Myers et al., 2017). However, there remain major gaps in the literature; the existing research literature does not address clinical psychologists' (as opposed to other mental health providers') CBT-specific telehealth experiences. Furthermore, the research does not address clinical psychologists' experiences providing CBT to children via telehealth. Research on the topic of CBT via telehealth is generally lacking when compared to the abundance of research on in-person CBT. However, the research is particularly lacking regarding CBT via telehealth for children specifically, especially in light of the prevalence of the treatment and increase in child mental health problems as a result of the pandemic (Leeb et al., 2020; Meherali et al., 2021).

Current Study

The purpose of the current study was to explore the experiences of psychologists in providing CBT via telehealth to children. Specifically, qualitative interview data was used to

generate a theoretical framework regarding how clinicians can effectively provide CBT using this format. Findings from this research can provide an understanding of how clinicians can effectively provide CBT to children via telehealth and aid in identifying areas of CBT via telehealth for children that are still in need of improvement and future research. For example, the current study's findings may be able to shed light on how to effectively adapt key features of child CBT to teletherapy, such as parent/family involvement and patient engagement.

Method

Participants

The researcher recruited 18 clinical psychologists from the U.S. for this study. In order to be included, participants had to have provided or had been currently providing CBT via telehealth to children (ages 7-12) for at least six months. Additionally, participants had to have provided in-person services prior to the onset of the COVID-19 pandemic. See Table 1 for demographic data.

As of when the participants completed the demographic questionnaires, which was between March and April 2023, the clinical psychologists were a mean age of 42.8 years old. On average, the participants had 9.4 years of experience as a practicing licensed psychologist and 3.5 years of experience conducting CBT via telehealth. All of the participants identified as White (100%). Two of the participants identified as Hispanic, Latino/a, or Latinx (11.11%). All but one of the participants were female (94.44%).

Nearly all of the clinical psychologists participating in the study reported treating patients at every age between ages 7 and 12. Further, participants treated children with a variety of diagnoses, the most commonly reported being anxiety disorders (88.89%), ADHD (88.89%), and oppositional defiant disorder (83.33%). As for types of CBT practiced, the large majority

identified practicing exposure therapy (83.33%) and behavioral parent training (88.89%), with some also practicing trauma focused CBT (33.33%) and parent-child interaction therapy (PCIT) (33.33%). Participants also wrote in a variety of other forms of CBT they practiced as indicated in Table 1. All participants reported utilizing videoconferencing technology, and half of the participants also identified utilizing phone call for CBT via telehealth sessions. Additionally, all of the participants reported practicing from home, and the large majority also practice teletherapy in an office setting. Geographically, most of the participants' practices were located in or near New York City. Due to the researcher's recruitment from her university's alumni database, 50% of the participants were Long Island University Post (LIU Post) alumni.

Once interview data had been collected, four of the participants opted to participate in a member check. The four participants were representative of three of the four focus groups. All four of the participants had been providing CBT via telehealth for three years. Three of the participants were practicing in the New York area and one was currently practicing in California as well. These participants were the following ages: 65, 52, 41, and 32 years old.

Table 1

Demographic and Clinical Information for Participants in the Current Study

	Range	*M*	*SD*
Age at Time of Focus Group	32– 65	42.8	9.8
Length of time as practicing licensed clinical psychologist	0.7 – 33	9.4	9.2
Length of time conducting CBT via telehealth	1.5 – 10	3.5	1.8
	n	%	
Racial/ethnic background			
White	17	94.44	
White/Jewish	1	5.56	
Hispanic, Latino/a, or Latinx	2	11.11	
Gender			
Female	17	94.44	
Male	1	5.56	
Age(s) Treated (participants checked all that applied)			

7 years		
8 years	14	77.78
9 years	16	88.89
10 years	16	88.89
11 years	16	88.89
12 years	17	94.44
	18	100
Diagnoses treated (participants checked all that applied)		
Anxiety disorders	16	88.89
Attention-deficit/hyperactivity disorder	16	88.89
Autism spectrum disorder	12	66.67
Depressive disorders	14	77.78
Developmental disabilities	8	44.44
Conduct disorder	2	11.11
Oppositional defiant disorder	15	83.33
Elimination disorders	4	22.22
Feeding and eating disorders	3	16.67
Intellectual disabilities	5	27.78
Motor disorders	2	11.11
Obsessive-Compulsive and related disorders	13	72.22
Trauma- and stressor-related disorders	8	44.44
Substance disorder	2	11.11
Other: Behavioral sleep problems	1	5.56
Types of CBT practiced (participants checked all that applied)		
Exposure therapy	15	83.33
Behavioral parent training	16	88.89
Trauma focused CBT	6	33.33
Parent-child interaction therapy	6	33.33
Other: Acceptance and Commitment Therapy (ACT)	1	5.56
Other: Discoverer, Noticer, Advisor and Values (DNA-V)	1	5.56
Other: CBT for depression	1	5.56
Other: Behavioral therapy	1	5.56
Other: General CBT	1	5.56
Other: CBT for anxiety/depression	1	5.56
Other: Emotion regulation	1	5.56
Other: Trauma Treatment Groups for Students (TTGS)	1	5.56
Method(s) of teletherapy practice (participants checked all that applied)		
Video conferencing	18	100
Phone call	9	50
Participant teletherapy practice setting		

Home	18	100
Office	13	72.22
Geographic location(s) of practice		
Long Island, NY	5	27.78
New York, NY	11	61.11
Westchester, NY	1	5.56
Upstate, NY	1	5.56
New Jersey	4	22.22
Wisconsin	1	5.56
Rhode Island	1	5.56
Greater Boston Area	1	5.56
Maryland	1	5.56
California	1	5.56

Researcher Bias

The researcher recognizes various potential biases she holds related to the current study. For example, the researcher could potentially be biased due to her familiarity with the technology necessary to participate in teletherapy. Due to the fact that the researcher regularly uses various forms of technology, she may be inclined to view the transition to telehealth as easier than an individual unfamiliar or less familiar with such technology. Additionally, the researcher is a novice therapist with about three years of experience providing therapy via telehealth (in both hybrid and solely telehealth settings). Two years of that experience involved solely CBT via telehealth. Further, one year of that experience involved the researcher providing CBT via telehealth to children, specifically. The researcher also volunteered for New York State's Office of Mental Health COVID-19 emotional support helpline at the start of the pandemic. The researcher viewed this helpline as being a positive and deeply beneficial resource to its callers. Thus, due to the researcher's experience providing teletherapy and supportive services during the COVID-19 pandemic, the researcher may be biased toward viewing teletherapy more favorably. Further, the researcher, as a novice therapist, has gained the majority of her clinical experience, especially with children, via telehealth rather than via in-person

services. In order to mitigate the researcher's bias, the researcher ensured the focus group questions were open-ended in nature.

Similar to the researcher, the study's coders are also familiar with the technology necessary to participate in teletherapy and therefore may have viewed the transition to telehealth as being easy as well. However, the study's coders have had more in-person experience than the researcher and more experience with diverse age ranges and theoretical orientations outside of CBT. Therefore, they may not have been as biased in favor of CBT via telehealth for children as the researcher. In order to mitigate the effects of any of the coders' and researcher's biases, the researcher and two coders discussed potential biases before beginning the coding process and during the coding process. The goal of this was to create awareness of these biases among the researcher and coders in order to mitigate them as much as possible.

Design

This study was qualitative in nature in order to gain an understanding of clinical psychologists' experiences providing CBT via telehealth to children. Participants were assigned to four focus groups consisting of four to six participants per group. Each focus group was asked the focus group questions in the same general order. The focus group questions were kept open-ended in order to acquire the psychologists' collective experiences while mitigating the researcher's potential bias. The participants' responses to the researcher's questions served as the study data. This study used Auerbach and Silverstein's (2003) grounded theory to analyze the responses from the focus group participants by extracting relevant text and subsequently organizing into repeating ideas, themes, theoretical constructs, and finally, a theoretical narrative. A member check was completed in order to assess the credibility of the data. Interrater reliability, or Cohen's Kappa, was also assessed.

Procedure

The study was approved by the Long Island University Post Institutional Review Board (IRB). To recruit participants, the researcher posted a recruitment flyer (see Appendix A) on the Association for Behavioral and Cognitive Therapies (ABCT) forum and on various psychologist-populated Facebook groups. The researcher was most successful in recruiting, however, by sending the recruitment flyer to a variety of places, including the researcher's previous training sites, Child Mind Institute and NYU Langone's Child Study Center, local child therapy institutes, private practices, faculty members from clinical psychology doctoral programs in the U.S., and her university's alumni email database. The researcher also recruited through snowball sampling, whereby the researcher encouraged psychologists who volunteered for the study, before their participation, to recommend others who met the inclusion criteria to participate. This variety of methods was used in order to allow for a more representative sample of clinical psychologists since individuals can be a part of the ABCT forum and Facebook groups from any geographic region. However, the large majority of participants' practices were geographically located in the New York area due to the fact that the researcher was most successful in recruiting using the other abovementioned methods.

The researcher explained through the study flyer that the study would explore the participants' experiences providing CBT to children via telehealth. The study flyer also expressed the eligibility criteria, study requirements, and the purpose of the study, which was to help provide an understanding of how clinicians can effectively provide CBT to children via telehealth, identify areas of CBT via telehealth for children that are in need of improvement, and shed light on how to effectively adapt key features of child CBT to teletherapy.

Upon responding to the study flyer, potential participants were assessed to ensure they met eligibility criteria prior to completion of required forms. Eligible participants signed an informed consent form (see Appendix B) prior to participation in the focus groups. Participants also completed a demographic and clinical information form (see Appendix C), a participant contact information form (see Appendix D), and a video recording consent form (see Appendix E). Participants were then assigned to one of four focus groups, each group consisting of four to six participants. Focus groups were used in order to explore the collective experience of the participants. Focus groups were conducted in March and April 2023. By utilizing a group interview format, participants were able to relate to, or conversely, to disagree with, others' responses and speak to experiences they might not have brought up otherwise in an individual interview. Each participant was emailed regarding their availability, and participants were grouped into four focus groups via Zoom based upon availability. The researcher served as the focus group interviewer.

Once in the virtual focus group room, the importance of confidentiality was explained to the group of participants, and they were asked to respect the privacy of other participants and not repeat what was said in the focus group to others. The researcher then reviewed with the participants the purpose of the study prior to beginning the focus group questions. The researcher then asked open-ended questions to explore the participants' collective experiences providing CBT via telehealth to children. The interviews lasted between 29 and 74 minutes ($M = 45.2$, $SD = 19.8$).

The Zoom focus groups were video recorded and transcribed upon completion by the researcher. The researcher and two additional graduate students, who served as coders for the study, then analyzed the transcripts. In accordance with grounded theory's theoretical saturation,

participants/focus groups continued to be added to the study until the researcher was no longer

learning new information about the research concerns from the participants/focus groups.

After the researcher and coders completed the data analysis, a member check was

conducted. Multiple days and time slots were offered to participants. Ultimately, although eight

participants responded to the email regarding the virtual study review, four declined or canceled

to participate due to scheduling conflicts. Four members participated in the member check,

during separate time slots due to varying availability. During the member checks, the researcher

visually presented and reviewed each theoretical construct, theme, and repeating idea. The list of

theoretical constructs, themes, and repeating ideas can be found in Appendix F. The researcher

gave the participants the opportunity to provide feedback and ensure that their ideas had been

accurately represented.

Measures

Demographic and Clinical Information. Prior to participation in the focus groups,

participants completed a demographic and clinical information form (see Appendix C) created by

the researcher, on which they indicated the following: age, racial/ethnic background, gender,

length of time as practicing licensed clinical psychologist, length of time conducting CBT via

telehealth, population(s) treated (including age(s) and diagnoses), type(s) of CBT practiced,

method(s) of teletherapy practice, participant teletherapy practice setting, and geographic

location(s) of practice. Participants also confirmed on this form whether they had provided

and/or were currently providing CBT via telehealth to children (ages 7-12) for at least six

months, and whether they provided in-person services prior to the onset of the COVID-19

pandemic. These eligibility requirements were initially assessed prior to completion of forms.

Focus Group Questions. The focus group questions were used to elicit the collective experiences of the focus groups in providing CBT via telehealth to children. The focus group questions were displayed one at a time on the shared screen by the researcher for easy reference by the participants. The researcher allowed, however, for conversations to develop from each question and for participants to respond to one another.

The following questions were asked in the following order during each focus group to gain a better understanding of the participants' experiences:

- What was your experience like transitioning to providing CBT to children via telehealth? How did you adapt CBT interventions to telehealth?

- What have been some of the advantages/disadvantages of providing CBT to children via telehealth?

- How have you involved caregivers in treatment via telehealth? How is it similar and/or different than involving caregivers in in-person treatment?

- What has been your experience of the effectiveness of CBT via telehealth versus in-person therapy with children?

- What have you found facilitates the work via telehealth and what have you found hinders it?

- Will you continue to provide CBT via telehealth in the future? Why or why not?

Data Analysis

Each focus group was video recorded and transcribed by the researcher. Auerbach and Silverstein's (2003) grounded theory approach was then used to code the transcribed focus group interviews. The researcher recruited two graduate students from the researcher's current internship site to serve as coders. The researcher trained the coders on the Auerbach and

Silverstein coding process by providing them with an in-depth overview of the instructions at each stage of the coding process. The researcher also extracted sample text from the relevant chapters of Auerbach and Silverstein's *Qualitative Data* for each coder to use for practice prior to each respective coding stage. The researcher instructed each coder to extract relevant text, repeating ideas, and themes from the examples and their coding was then compared with the coding done by the authors in the relevant chapters and discussed as a group. The discussion of the examples aided in modeling how the researcher and the coders would achieve consensus at each stage of the coding process. The researcher then instructed each coder to review the relevant chapters from Auerbach and Silverstein's *Qualitative Data* and confirmed that they did so before beginning coding on the current study's data.

From the current study's transcripts, or raw text, the researcher and two coders each independently extracted text related to the researcher's overarching research concern. This text was labeled the relevant text. From the relevant text, the researcher and coders found repeating ideas, or ideas that were the same or similar across both different group participants and different focus groups. After extracting the repeating ideas, the researcher and coders organized these repeating ideas into common themes. The researcher and coders met to discuss discrepancies and achieve consensus after independently coding at three stages: relevant text, repeating ideas, and themes. Next, the themes were organized by the researcher, in consultation with her dissertation chair. Finally, the theoretical constructs were organized into a theoretical narrative, or a summary of what was discovered about the researcher's research concerns (see Appendix G). The theoretical narrative included both the participants' experiences by utilizing their own words as often as possible, and the researcher's theoretical framework. Participants were then offered the

opportunity to review the themes and theoretical constructs as part of a member check to determine if they felt their subjective experiences had been properly represented.

In order to assess interrater reliability, or Cohen's kappa, two new, independent coders (coder A and coder B) were recruited through the researcher's psychology doctoral program and her current internship to place the themes into theoretical constructs. Cohen's kappa (1960) was calculated to assess interrater reliability between coder A and the master list of constructs (0.73), coder B and the master list of constructs (0.73), and coder A and B with one another (0.67). Overall interrater reliability was determined by calculating the mean of the three abovementioned pairs. The mean was 0.71, which suggested substantial agreement (Cohen, 1960).

Results

Six theoretical constructs were developed from a total of 22 themes (see Table 2). The following constructs were developed from the focus group interviews: 1. Transition to Telehealth Impacts Families' Access to Care – More Positively Than Negatively; 2. Importance of Focusing on Pre-Treatment Considerations When Conducting CBT via Telehealth; 3. Adjusting to Increased Engagement and Management Issues That Arise During Telehealth Treatment; 4. Telehealth Experience has Varied Positive and Negative Impacts on a Case-By-Case Basis on Psychologists and Children; 5. Psychologists' Attitudes Regarding CBT via Telehealth Were Mixed, Though More Positive Than Negative; and 6. CBT via Telehealth for Children is Effective and has a Long-Term Future Beyond the Pandemic. In Table 2 below, these theoretical constructs are represented in capital letters and the themes related to each construct are in bold type. The number and percentage of participants supporting each theoretical construct and theme are also depicted in Table 2.

Table 2

Theoretical Constructs and Themes

	n	*%*
TRANSITION TO TELEHEALTH IMPACTS FAMILIES' ACCESS TO CARE – MORE POSITIVELY THAN NEGATIVELY	16	88.89
Transition to telehealth has a predominantly positive impact on access to care	**16**	**88.89**
Loss of clientele/difficulty accessing families due to transition to telehealth	**5**	**27.78**
Convenience of telehealth can be a disadvantage	**7**	**38.89**
IMPORTANCE OF FOCUSING ON PRE-TREATMENT CONSIDERATIONS WHEN CONDUCTING CBT VIA TELEHEALTH	17	94.44
Negative impacts of telehealth on safety and privacy	**8**	**44.44**
Importance of preparing a conducive therapeutic environment	**5**	**27.78**
Technological hindrances to providing CBT	**13**	**72.22**
Factors that facilitate the transition to telehealth	**13**	**72.22**
ADJUSTING TO INCREASED ENGAGEMENT AND MANAGEMENT ISSUES THAT ARISE DURING TELEHEALTH TREATMENT	18	100
Engagement difficulties via telehealth	**10**	**55.56**
Difficulties with managing telehealth sessions	**13**	**72.22**
Increased creativity needed for telehealth	**16**	**88.89**
Amount of caregiver involvement via telehealth either remained the same or increased in comparison to in-person treatment	**17**	**94.44**
Therapeutic advantages of patient being in their home environment	**11**	**61.11**
TELEHEALTH EXPERIENCE HAS VARIED POSITIVE AND NEGATIVE IMPACTS ON A CASE-BY-CASE BASIS ON PSYCHOLOGISTS AND CHILDREN	16	88.89
Psychologist's telehealth experience generally more positive with older or more advanced children	**5**	**27.78**
Effectiveness depends on the specific child and specific presenting problem(s)	**13**	**72.22**
Telehealth has both positive and negative impacts on psychologists' personal lives	**10**	**55.56**
PSYCHOLOGISTS' ATTITUDES REGARDING CBT VIA TELEHEALTH **WERE MIXED, THOUGH MORE POSITIVE THAN NEGATIVE**	14	77.78
Psychologists' positive experiences with telehealth	**9**	**50**
Psychologists' negative experiences with CBT via telehealth	**7**	**38.89**
In-person therapy is preferable to virtual	**9**	**50**

CBT VIA TELEHEALTH FOR CHILDREN IS EFFECTIVE AND HAS A LONG-TERM FUTURE BEYOND THE PANDEMIC	18	100
CBT via telehealth is effective	**11**	**61.11**
Psychologists and patients will continue to engage in CBT via telehealth	**16**	**88.89**
Long-term considerations regarding the delivery of telehealth services	**10**	**55.56**
Advantage of a hybrid approach	**10**	**55.56**

Note: Theoretical constructs are in capital letters and themes are in bold type

Themes were created from the repeating ideas and relevant text by the researcher and two coders. The repeating ideas categorized under each theme are depicted in Tables H1 through H6 (see Appendix H) in the left column. These repeating ideas were developed from relevant text. Examples of relevant text are listed in the right column next to the repeating ideas under which they are organized. While themes were paraphrases from the original text, repeating ideas were either paraphrases or direct quotes when possible. The relevant text, however, were statements extracted directly from the transcribed focus group interviews.

Transition to Telehealth Impacts Families' Access to Care – More Positively Than Negatively

The first theoretical construct (see Table H1) was supported by three themes that describe the ways in which transitioning to telehealth impacted families' access to mental health care. Participants spoke about the mostly positive impact that telehealth had on the ability to access care. Conversely, participants additionally discussed how the transition to telehealth led to a loss of clientele and increased difficulty accessing some families. Lastly, participants discussed how from their experience, the convenient nature of teletherapy can sometimes bring challenges.

Transition to telehealth has a predominantly positive impact on access to care. The first theme in this theoretical construct describes the participants view on how telehealth impacted families' access to mental health care, mostly in a positive way (see Table H1 – first supporting theme). This theme was discussed by 88.89% (16/18) of the participants and included

six repeating ideas. The majority of participants noted the enormous benefit telehealth provided by increasing access to treatment (Repeating idea #1). Additionally, most participants discussed how the convenience of telehealth allowed some children the opportunity to be in treatment when they otherwise may not have been able to be in treatment (Repeating idea #2). Several participants also described decreased patient tardiness and cancellations due to the telehealth option (Repeating idea #3). A few participants further discussed that telehealth may be the best option for families that do not have access to quality in-person treatment (Repeating idea #4). A few participants also reported having more CBT resources at their disposal than ever before after the transition to telehealth (Repeating idea #5). Lastly, and providing more of a negative outlook, a couple of participants also acknowledged ways in which broadening the geographical access to care could be a disadvantage (Repeating idea #6).

Loss of clientele/difficulty accessing families due to transition to telehealth. The second theme in this construct portrays participants' loss of clientele and difficulty accessing some families as a result of the transition to telehealth (see Table H1 – second supporting theme). This theme was expressed by 27.78% (5/18) of the participants and included two repeating ideas. A few participants reported difficulty accessing underserved families who didn't have access to the technology necessary to engage in telehealth (Repeating idea #1). A couple of participants also expressed losing many patients who were not able to do telehealth (Repeating idea #2). During the member check, two participants expressed being surprised by this loss of clientele.

Convenience of telehealth can be a disadvantage. The third and final theme in this construct describes how participants perceived the convenience of telehealth to be a disadvantage and to present new challenges to treatment (see Table H1 – third supporting theme). This theme

was discussed by 38.89% (7/18) of the participants and included two repeating ideas. A couple

of participants expressed that due to the convenience of telehealth, parents resist the

psychologists' encouragement to transition back to in-person treatment (Repeating idea #1).

Further, several participants reported that the convenience of telehealth can sometimes backfire

and the environment the patient is located in needs to be adjusted (Repeating idea #2).

Importance of Focusing on Pre-Treatment Considerations When Conducting CBT via

Telehealth

The second theoretical construct (see Table H2) was supported by four themes that

encompass the importance the participants placed on taking into consideration factors that may

facilitate and hinder conducting CBT via telehealth before beginning treatment with children and

their caregivers. The participants stressed the significance of considering safety and privacy

when providing treatment to children via telehealth. Furthermore, participants also stressed the

importance of preparing an environment in the patient's home that is conducive to therapy.

Participants also discussed the technological hindrances providers and families face when

providing CBT via telehealth. Lastly, participants identified a variety of factors that may

facilitate the transition to telehealth work.

Negative impacts of telehealth on safety and privacy. The first theme in this construct

describes participants' emphasis on considering the safety and privacy of child patients when

providing CBT via telehealth (see Table H2 – first supporting theme). This theme was discussed

by 44.44% (8/18) of the participants and included two repeating ideas. Some participants

discussed the lack of patient confidentiality/privacy when conducting therapy via telehealth

(Repeating idea #1). A few participants also recognized that some children do not feel they have

a safe space in their home to do therapy (Repeating idea #2).

Importance of preparing a conducive therapeutic environment. The second theme in this construct portrays the participants' considerations of how to prepare an environment in the child patient's home that is conducive to therapy (see Table H2 – second supporting theme). This theme was discussed by 27.78% (5/18) of the participants and included two repeating ideas. Participants discussed the importance of setting up a successful therapeutic environment for the patient in their home (Repeating idea #1), as well as the importance of discussing expectations for telehealth sessions with patients and caregivers before initiating treatment (Repeating idea #2).

Technological hindrances to providing CBT. The third theme in this construct describes the variety of technological hindrances participants identified experiencing when providing CBT via telehealth, all of which can be taken into consideration prior to starting treatment (see Table H2 – third supporting theme). This theme was discussed by 72.22% (13/18) of the participants and included four repeating ideas. Two participants noted patient screen fatigue due to being on screens throughout the day (Repeating idea #1). Half of the participants also discussed various technological problems that hindered the treatment (Repeating Idea #2). Several participants specifically identified internet connectivity problems as being a major barrier to treatment (Repeating Idea #3). Moreover, a few participants noted that the use of technology hindered them from being able to fully physically assess their patients (Repeating Idea #4).

Factors that facilitate the transition to telehealth. The fourth and final theme in this construct describes factors that participants identified as facilitating the transition from in-person to telehealth treatment (see Table H2 – fourth supporting theme). This theme was discussed by 72.22% (13/18) of the participants and included three repeating ideas. A few participants

described children as having the smoothest transition to telehealth since use of technology was so typical for them already (Repeating idea #1). Further, some participants reported the treatment was facilitated by the fact that they had previous experience with telehealth prior to the pandemic and/or used treatments that had a research base regarding telehealth (Repeating idea #2). Several participants also described the transition to telehealth as easier when they had an in-person connection with the patient prior to the transition (Repeating idea #3).

Adjusting to Increased Engagement and Management Issues That Arise During Telehealth Treatment

The third construct (see Table H3) was supported by five themes that describe the adjustments clinical psychologists need/needed to make in response to increased engagement and session management issues during telehealth treatment. Participants elaborated on engagement difficulties and difficulties with managing sessions they faced and/or continue to face when providing CBT via telehealth. Moreover, participants discussed the increased creativity required to engage children via telehealth. Participants also identified maintaining the same amount or increasing the amount of caregiver involvement in treatment via telehealth in response to these issues. Lastly, participants noted the therapeutic advantages that came with patients attending therapy from their home environments, which may combat the abovementioned engagement and management issues.

Engagement difficulties via telehealth. The first theme in this construct describes engagement difficulties the participants encountered when providing CBT via telehealth to children (see Table H3 – first supporting theme). This theme was discussed by 55.56% (10/18) of the participants and included four repeating ideas. Several participants noted that both patients and their parents had more distractions over telehealth than when treatment was in-person

(Repeating idea #1). A few participants also expressed being distracted themselves when providing teletherapy (Repeating idea #2). Further, several participants expressed that children are much more engaged in in-person therapy than teletherapy (Repeating idea #3). Lastly, two participants discussed that how engageable the child is in-person may determine how successful they are in telehealth treatment (Repeating idea #4).

Difficulties with managing telehealth sessions. The second theme in this construct describes difficulties participants identified with managing telehealth CBT sessions (see Table H3 – second supporting theme). This theme was discussed by 72.22% (12/18) of the participants and included four repeating ideas. A few participants reported there is a lot more to manage as the psychologist during telehealth sessions as opposed to in-person sessions, such as management of risk and tantrums (Repeating idea #1). Several participants also expressed issues with managing telehealth session structure (Repeating idea #2). Further, a few participants expressed that they are never certain if the parents will be available to talk when providing treatment via telehealth (Repeating idea #3). One participant noted during the member check, however, that the same was true for them in-person as well, as they were never sure if the parent would bring the child to session and remain there during session. They also reported children would walk away from the screen or exit the telehealth session (Repeating idea #4).

Increased creativity needed for telehealth. The third theme in this construct describes participants' need for increased creativity when providing treatment via telehealth in order to adjust to increased engagement and management issues (see Table H3 – third supporting theme). This theme was depicted by 88.89% (16/18) of the participants and incorporated five repeating ideas. A few participants discussed the need for additional theatrics to engage the children when providing CBT via telehealth (Repeating idea #1). They also reported learning creative ways to

engage the children via telehealth (Repeating idea #2). The majority of participants discussed the incorporation of interactive virtual tools into sessions (Repeating idea #3). A couple of participants also discussed the use of creative at-home rewards (Repeating idea #4) and a few discussed the need for physical tools/prizes (Repeating idea #4).

Amount of caregiver involvement via telehealth either remained the same or increased in comparison to in-person treatment. The fourth theme in this construct describes participants' use of the same or increased amount of caregiver involvement in treatment via telehealth in response to increased engagement and management issues (see Table H3 – fourth supporting theme). This theme was expressed by 94.44% (17/18) of the participants and included three repeating ideas. Several participants expressed involving caregivers via telehealth the same amount as in-person CBT (Repeating idea #1). The majority of participants additionally reported it was easier to involve caregivers in treatment via telehealth versus in-person (Repeating idea #2). Lastly, several participants reported working much more with parents for more of every telehealth session in comparison to in-person sessions (Repeating idea #3).

Therapeutic advantages of child being in their home environment. The fifth and final theme in this construct depicts the therapeutic advantages resulting from the patient being in their home environment for therapy (see Table H3 – fifth supporting theme). This theme was discussed by 61.11% (11/18) of the participants and included three repeating ideas. More than half of the participants reported that being in vivo via telehealth, or in the context where the child's issues exist, was an advantage to treatment, particularly exposure therapy (Repeating idea #1). Several participants similarly reported that it was helpful to have children in their natural environment for sessions, as, among other things, it allowed for increased insight into the child's interests and facilitated coaching the family within the home (Repeating idea #2). Lastly, a few

participants noted gaining increased insight into family dynamics and interactions due to observing the child in their home environment during sessions (Repeating idea #3).

Telehealth Experience has Varied Positive and Negative Impacts on a Case-By-Case Basis on Psychologists and Children The fourth theoretical construct (see Table H4) was supported by three themes that described how participants viewed the experience of providing CBT via telehealth as being specific to the child/provider. Participants found that the telehealth experience depended on the age of the child. Further, they discussed the fact that the effectiveness of CBT via telehealth depended on the specific qualities of the child. Finally, the participants also identified how they were personally impacted by the switch to telehealth.

Psychologist's telehealth experience generally more positive with older or more advanced children. The first theme in this construct describes the participants' view that the experience of CBT via telehealth varied depending on the age of the child in treatment (see Table H4 – first supporting theme). This theme was discussed by 27.78% (5/18) of the participants and included three repeating ideas. A few participants expressed that it was much easier to engage older or more advanced children via telehealth (Repeating idea #1). In a related observation, some participants reported having a hard time working with younger children via telehealth (Repeating idea #2). A few participants also reported the effectiveness of CBT via telehealth depended upon the age of the child being treated (Repeating idea #3).

Effectiveness depends on the specific child and specific presenting problem(s). The second theme in this construct describes participants' perspective that the effectiveness of CBT via telehealth depends on the specific characteristics of the child (see Table H4 – second supporting theme). This theme was discussed by 72.22% (13/18) of the participants and included two repeating ideas. Several participants expressed that providing CBT via telehealth was more

challenging for patients with executive functioning issues and patients on the autism spectrum (Repeating idea #1). Half of the participants also reported that the effectiveness of CBT via telehealth varied on a case by case basis (Repeating idea #2).

Telehealth has both positive and negative impacts on psychologists' personal lives. The third and final theme in this construct depicts the ways in which the psychologists were personally impacted by providing CBT via telehealth (see Table H4 – third supporting theme). This theme was expressed by 55.56% (10/18) of the participants and included three repeating ideas. A few of the participants reported that their self-care was adversely impacted by providing treatment via telehealth (Repeating idea #1). For example, participants reported sitting in front of the screen more and therefore not getting as much movement in, as well as feeling more tired when conducting sessions via telehealth. A couple of the participants also described how their boundaries as a psychologist became less rigid as a result of conducting therapy via telehealth (Repeating idea #2). An additional participant also agreed with this repeating idea during the member check, expressing that she self-discloses more often due to conducting sessions from home. This participant noted that the level of self-disclosure may vary depending on whether the psychologist has a designated office space in their home for sessions or not. Lastly, some participants expressed the benefit of being able to be more flexible as a result of providing teletherapy and having an increased ability to balance their personal lives due to this flexibility (Repeating idea #3).

Psychologists' Attitudes Regarding CBT via Telehealth Were Mixed, Though More Positive Than Negative

The fifth theoretical construct (see Table H5) was supported by three themes that portray the participants' varying attitudes regarding CBT via telehealth. While some participants

identified having a positive experience with telehealth, others described their negative

experiences with CBT via telehealth and their preference for in-person therapy.

Psychologists' positive experiences with telehealth. The first theme in this construct

expresses the positive experiences that some participants had with providing CBT via telehealth

to children (see Table H5 – first supporting theme). This theme was discussed by 50% (9/18) of

the participants and included three repeating ideas. A few of the participants identified their

experience with CBT via telehealth as being largely positive (Repeating idea #1). Further, a few

expressed that providing CBT via telehealth to children went better than they expected

(Repeating idea #2). They also expressed that providing CBT via telehealth became easier over

time (Repeating idea #3).

Psychologists' negative experiences with CBT via telehealth. The second theme in this

construct describes the negative opinions some of the participants had on providing CBT via

telehealth to children (see Table H5 – second supporting theme). This theme was discussed by

38.89% (7/18) of the participants and included three repeating ideas. A couple of the participants

expressed uncertainty as to whether the treatment they were providing was actually CBT when

provided via telehealth (Repeating idea #1). Moreover, a few of the participants expressed their

opinion that CBT via telehealth was less effective than in-person CBT for children (Repeating

idea #2). A few of the participants additionally expressed that the transition to telehealth was

very difficult for them (Repeating idea #3).

In-person therapy is preferable to virtual. The third and final theme in this construct

portrays the belief expressed by some participants that in-person therapy is preferable to therapy

via telehealth (see Table H5 – third supporting theme). This theme was discussed by 50% (9/18)

of the participants and included three repeating ideas. During the member check, one participant

expressed she was surprised that a preference for in-person therapy for children was not unanimous. A few participants expressed that if it is not a necessity for them to provide CBT via telehealth to children, then they do not do it (Repeating idea #1). Further, two participants expressed that there is no replacement for the in-person therapy experience (Repeating idea #2). Lastly, some participants portrayed a different feel to therapy in person versus via telehealth (Repeating idea #3).

CBT via Telehealth for Children is Effective and has a Long-Term Future Beyond the Pandemic

The sixth and final theoretical construct (see Table H6) was supported by four themes that depict the participants' beliefs that CBT via telehealth for children is effective and has a long-term future beyond the pandemic. Participants discussed their current use of CBT via telehealth for children and their plans to continue its use in the future. They additionally identified long-term considerations regarding telehealth. Further, they described the advantage of utilizing at least some telehealth, or a hybrid approach. Lastly, participants discussed their belief that CBT via telehealth for children is as effective as, or in some cases more effective than, in-person treatment.

CBT via telehealth is effective. The first theme in this construct describes the participants' view of CBT via telehealth as an effective form of treatment (see Table H6 – fourth supporting theme). This theme was discussed by 61.11% (11/18) of the participants and included three repeating ideas. Several participants expressed their belief that the effectiveness of CBT via telehealth remained the same as in-person CBT for children (Repeating idea #1). Several also expressed that therapeutic work was still being done and progress was still apparent via

telehealth (Repeating idea #2). Lastly, a few participants expressed that in some ways, CBT via telehealth was more effective than in-person CBT.

Psychologists and patients will continue to engage in CBT via telehealth. The second theme in this theoretical construct describes participants continued use of CBT via telehealth for children post-pandemic (see Table H6 – first supporting theme). This theme was discussed by 88.89% (16/18) of the participants and included four repeating ideas. Several participants expressed their belief that telehealth is here to stay in the future (Repeating idea #1). The majority also expressed they will definitely continue to provide CBT via telehealth to children (Repeating idea #2). Further, some participants reported that the large majority of their patients continue to use telehealth today (Repeating idea #3). Lastly, a few participants expressed that families/patients prefer telehealth to in-person treatment (Repeating idea #4).

Long-term considerations regarding the delivery of telehealth services. The third theme in this construct describes the participants' considerations for the future of telehealth (see Table H6 – second supporting theme). This theme was portrayed by 55.56% (10/18) of the participants and included four repeating ideas. A few of the participants expressed their belief that only licensing issues are stopping psychologists from realizing the long-term potential benefits of telehealth (Repeating idea #1). A couple of participants also expressed the importance of teletherapy being covered by insurance in the same way that in-person therapy is covered (Repeating idea #2). Additionally, some participants expressed their belief that the potential of CBT via telehealth has not yet been fully tapped into and there is much more that can be done with telehealth in the future (Repeating idea #3). A couple of participants also identified ways in which the adaptations they made when providing CBT via telehealth have impacted their post-

COVID work and how they may be utilizing these adaptations in in-person therapy (Repeating idea #4).

Advantage of a hybrid approach. The fourth and final theme in this construct describes the participants' view of hybrid work as an advantage (see Table H6 – third supporting theme). This theme was expressed by 55.56% (10/18) of the participants and included two repeating ideas. Several participants expressed the need for a hybrid model to remain in the future (Repeating idea #1). Several also identified the flexibility that a hybrid model allows, including the option for their telehealth patients to come in person (Repeating idea #2).

Member Check

During each member check conducted with the four participants who opted to review the study's results, the participants unanimously agreed that their ideas were accurately represented. In addition to the more specific comments previously mentioned, participants also made more general comments during the member check. For example, one participant commented that the results pointed to an overwhelmingly positive experience with telehealth. Additionally, one participant pointed to potential future research such as examining the key factors of therapy itself or the psychologists themselves that lead to different opinions amongst providers about telehealth. One participant also commented that some of the factors to consider that hindered telehealth may also have presented difficulties in-person and therefore represent challenges with working with children generally rather than providing therapy via telehealth. Moreover, a participant questioned whether focus group dynamics may have swayed participants' opinions.

Discussion

The current study's purpose was to explore clinical psychologists' experiences in providing CBT via telehealth to children. To the researcher's knowledge, this is the first

qualitative study to explore experiences providing CBT via telehealth to children, exclusively from clinical psychologists' perspectives. Six theoretical constructs were developed based on the focus group interviews with the participating clinical psychologists: 1. Transition to Telehealth Impacts Families' Access to Care – More Positively Than Negatively; 2. Importance of Focusing on Pre-Treatment Considerations When Conducting CBT via Telehealth; 3. Adjusting to Increased Engagement and Management Issues That Arise During Telehealth Treatment; 4. Telehealth Experience has Varied Positive and Negative Impacts on a Case-By-Case Basis on Psychologists and Children; 5. Psychologists' Attitudes Regarding CBT via Telehealth Were Mixed, Though More Positive Than Negative; and 6. CBT via Telehealth for Children is Effective and has a Long-Term Future Beyond the Pandemic. The researcher supported the constructs created with existing research where possible, as well as existing telehealth recommendations.

Theoretical Framework

1st Theoretical Construct: Transition to Telehealth Impacts Families' Access to Care – More Positively Than Negatively

The first construct theorizes that the transition to telehealth impacted families' ability to access mental health care. The large majority of participants noted a variety of positive impacts that telehealth had on access to care, including an increase in accessibility for families. They noted that the convenience of telehealth facilitated some children being in treatment who normally would not have been able to be in treatment for a variety of reasons. One participant explained:

> I have a patient right now who is in more after school activities than I've ever heard of in my life. And I think if we didn't have the option to do telehealth, really having therapy

would be really challenging for him just in terms of logistically being able to come into

the office. And this is someone though who also can engage virtually really well. So I

think it facilitates him being in treatment period. Because I don't know if he would be

able to be in treatment if he didn't have the telehealth option.

This is supported by research in which parents and child patients indicated that the increased

convenience provided by telehealth was an advantage (Castro et al., 2022). For example,

licensed marriage and family therapists have indicated that telehealth allows for patients with

disabilities, who would otherwise have difficulty accessing or be unable to access in-person

services, to obtain mental health services (Schiano & Daniels, 2020). Moreover, literature has

indicated telehealth enabled individuals in underserved and/or rural communities who ordinarily

may not have had access to become engaged in treatment (Gloff et al., 2015; Myers & Comer,

2016; Schiano & Daniels, 2020).

Further, several participants in the present study reported that having the option of

telehealth led to decreased tardiness and cancellations, which was also cited as a benefit of

teletherapy by licensed marriage and family therapists in Schiano and Daniels' (2020) study. One

participant in the present study explained, "Virtually everybody is on time and if they're a minute

or two late that's the latest they are and very few cancellations, very few no shows so I feel like it

just made it possible." Although increased convenience was largely positive, participants also

noted the shortcomings of increased convenience. For example, a couple of the participants

noted that some parents resisted the encouragement to return to in-person due to the convenience

of telehealth. Additionally, several participants noted that increased convenience led families to

join sessions from public places or environments that were not conducive to therapy. One

participant noted:

So they were able to do it in the car during you know, right after soccer practice.

Nobody's in the right frame of mind after soccer practice to sit and do therapy, you know,

so 'Oh, no, it's fine.' And after a while it was it's not fine.

A few of the participants noted that although there may be doubts about the effectiveness of CBT via telehealth, it may be the best option for families that are unable to access quality in-person evidence-based treatment. One participant explained, "we have to balance that it still may be better than having no access or not being able to make a session." In addition to increased access to care, a few of the participants perceived there to be more CBT resources easily accessible to them than ever before as a result of the telehealth transition, referencing an "overwhelming amount of resources and worksheets and protocols and videos."

Although the transition to telehealth was reported by the majority of participants to have led to an increase in accessibility, there were also some disadvantages and exceptions to this. For example, a couple of the participants noted that broader geographical access to care can lead clinicians to treat patients who are geographically far from them, in areas with which they are unfamiliar. This becomes a disadvantage when, as participants stated, the patient needs to be referred to other providers and the psychologist is unfamiliar with providers in the area. Further, if the patient would benefit from a transition to in-person work, this may not be an option. As one participant explained:

…the advantage of having the teletherapy essentially gave us the opportunity to access a broader range of families who maybe were a little further away. What I'm finding now with the disadvantage of that is that people are still accessing locations that are pretty far and so if you did want to convert to in-person sessions, or you're like, 'look, this is not going to work via telehealth,' you've now done an evaluation, potentially started to

establish rapport, and then really ultimately you're maybe suggesting like 'you really

need to see somebody closer to home.'… so you end up stuck: do you keep them and do

like subpar therapy, or do you insist and hold onto them until they find someone else?

A few of the participants also noted that although accessibility increased for some

because of transitioning to telehealth, the same was not true for underserved families who did not

have access to the necessary technology for telehealth. One participant reported they needed to

"be able to get them hotspots or iPads or ways to even just access the session." Several

participants noted that their patients were unable to do telehealth and they therefore lost clientele.

This is consistent with the research indicating that a majority of APA member clinicians were

seeing fewer patients and receiving fewer patient referrals immediately after the onset of the

pandemic (APA, 2020).

2nd Theoretical Construct: Importance of Focusing on Pre-Treatment Considerations

When Conducting CBT via Telehealth

The second construct theorized that in order to optimize the effectiveness of CBT via

telehealth for children, it is important to consider factors that facilitate and hinder the treatment

before beginning. In particular, several participants acknowledged the significance of safety and

privacy when providing treatment via telehealth and the general lack of confidentiality that

existed via telehealth. A few of the participants also recognized that the transition to providing

therapy in the child's home led to concerns about whether the child has a safe space within this

environment to engage in therapy. These privacy considerations are prevalent throughout the

existing literature (Castro et al., 2022; Schiano & Daniels, 2020). Castro et al. (2022) notes this

issue may be particularly relevant for patients in low-income homes who share small spaces.

An additional hindrance to providing CBT via telehealth noted by the majority of participants was technological issues. This included problems related to the technology or platform itself, such as internet connectivity issues, and other barriers created by technology. One participant noted her frustration with internet connectivity issues by stating, "when someone is in the middle of something and freezes. It's just like, 'Oh, you gotta be kidding.'" Other participants noted issues such as poor audio or video quality and background noise. Two participants also reported issues related to a patient or caregivers' audio being muted when another individual was speaking due to the nature of the telehealth platform. One participant explained, "the way audio works on computers where one person like Zoom if one person is talking it like mutes everybody else and so it just creates some of these awkward, awkward situations." These technological hindrances are referenced throughout the research literature by mental health providers (Castro et al., 2022; Schiano & Daniels, 2020). A couple of the participants also noticed that patient screen fatigue impacted sessions, which is supported by reports of community mental health clinicians (AlRasheed et al., 2022) and mental health clinicians providing teletherapy to child who had experienced trauma (Baker et al., 2023) in the existing research as well. A few of the present study's participants additionally reported that the use of telehealth prevented them from being able to fully assess the child physically. This hindrance is supported by Abrams' (2020) article, in which it was suggested that assessment of a client's gait, hygiene, nonverbal cues, and physical well-being may have been neglected when transitioning rapidly to telehealth. For example, one participant in the present study commented on being unaware of a patient's odor prior to it being addressed by the patient's teachers. Similarly, another participant noted being unable to tell that a patient had lost weight and

developed an eating disorder. In order to address this, the participant noted that in the future she, "always found reasons" and "initiated ways to see their full body, at least once in a while."

Considering these hindrances, some participants noted the importance of preparing a conducive environment for the child at the therapy's outset. One participant noted that one of her child patients and a caregiver needed to set up the patient's therapy environment in a similar way to the in-person therapy room for the child to remain engaged. A couple of the participants also referenced the importance of discussing telehealth expectations with children and caregivers at the start of treatment. This is supported by Dueweke et al.'s (2020) recommendations for telehealth regarding orienting families to telehealth services beforehand. This includes an overview of the services themselves, information on the telehealth platform, expectations for sessions, addressing of potential distractions, plans for transitioning in and out of sessions, and plans for emergencies. Mental health providers in Castro et al.'s (2022) study also supported the importance of setting expectations at the outset of treatment.

Regarding factors that facilitated the transition, a few participants noted that children adapted to the telehealth platform most easily in comparison to patients of other ages due to their familiarity with technology. This may be due to the fact that children are digital natives (Dueweke et al., 2020), or have grown up with pervasive technology (Castro et al., 2022). Similarly, a few participants who themselves had previous experience with telehealth, or who were using forms of CBT such as PCIT that already had an existing research base regarding its use via telehealth, found the transition to be easier. Lastly, several participants noted that the transition was facilitated when an in-person connection existed with the child before the transition, rather than the treatment starting via telehealth. One participant stated:

I know during the pandemic, a lot of us might have started with somebody during the

pandemic and it was so much harder to create that relationship here as opposed to

working with somebody in person and then we have to go online. Even now when it's

every once in a while, we can make that work because we have that relationship but

starting out with a pandemic and meeting them online and continuing therapy online I

think it was much harder to create an appropriate therapeutic relationship or an effective,

at least for me, an effective one.

This idea is supported by Schiano and Daniels' (2020) most commonly reported negative impact

of teletherapy by licensed and marriage family therapists: increased difficulty establishing and

maintaining therapeutic alliances and rapport. Similarly, Baker et al.'s (2023) survey of mental

health clinicians who provided teletherapy to children who had experienced trauma indicated

rapport building as a challenge via telehealth and Castro et al.'s (2022) study revealed that

parents reported greater difficulty forming close relationships between provider and patient via

telehealth. Based on the research and present study, it appears to be helpful when an in-person

connection is made to facilitate the telehealth treatment, or, according to the child patients that

participated in Castro et al.'s (2022) study, that focus be placed on rapport and trust building

before beginning treatment.

Similarly, an applicable theory to this construct is Edward Bordin's working alliance

model. Bordin believed that the alliance between therapist and patient, consisting of agreement

on treatment goals, agreement on tasks, and development of a personal bond, was key to

successful therapy (Fernandes, 2022). This theory confirms the importance that participants in

the present study suggested placing on pre-treatment considerations, especially having an in-

person connection.

3rd Theoretical Construct: Adjusting to Increased Engagement and Management Issues That Arise During Telehealth Treatment

The third theoretical construct, which was discussed by every participant, theorized that during the course of treatment, there was a need for clinical psychologists to adjust to increased engagement and management issues. Participants posited that there were increased engagement difficulties and distractions via telehealth for the patients, parents, and psychologists, which is also suggested by the existing research literature on clinicians providing teletherapy to children who experienced trauma (Baker et al., 2023), mental health providers (Castro et al., 2022), and licensed marriage and family therapists (Schiano & Daniels, 2020). Several participants noted that the engagement of children in person was much higher than their engagement via telehealth. One participant explained:

> …I'm noticing that children are, have consistently been really distracted. Even children who, when I previously saw them in the office had much better like attention spans with me, they're holding like two or three screens at once. They've got me on the iPad, and they're on their phones at the same time and, you know, they're insisting that they can maintain a good attention. It's really hard to, to manage that the way I manage it in the office.

A couple of the participants noted that the child's engageability in person may determine their success via telehealth. For example, one participant noted, "For the vast majority of kids that have a harder time engaging over telehealth are kids that I don't find all that engageable in person either and need more like parent and caregiver based work anyway."

A few of the participants additionally noted increased difficulty managing telehealth sessions and reported it can "get chaotic pretty quickly." They found that there was more to

manage during telehealth sessions and that there were more issues with managing the session structure in particular. One example of how they adapted to this was to shorten sessions, a strategy supported by mental health providers in the existing research (Castro et al., 2022). Further, a few participants reported more uncertainty as to whether parents would be available to talk during session via telehealth. They also reported having to handle children walking away from the screen or exiting the session, issues that did not exist in person.

In response to these engagement and management issues, the large majority of participants reported making adjustments such as increasing creativity used during sessions. A few participants noted being more theatrical during sessions to keep children engaged. One participant reported feeling as if she was "performing all day." This idea is supported by Seager van Dyk et al.'s (2020) recommendation for providers to use exaggerated facial expressions and hand gestures. Some of the participants also reported learning new, creative ways to engage the children and incorporate interactive virtual tools such as online games, worksheets, virtual whiteboards, and PowerPoints. The importance of these creative techniques was supported by mental health providers in Castro et al.'s (2022) study's emphasis on the importance of preparing more structured, engaging session activities to reduce distractions and Dueweke et al. (2020)'s suggestion to adapt worksheets and interactive activities for digital use. These engaging interactive virtual tools are also supported in the literature by Jones et al. (2014), in which, similar to participants' experiences, it was suggested to mail session materials ahead of time or share materials virtually in real time. One participant in the present study explained, "There was more effort put into planning and ensuring that the session could be effective and engaging for them." A few of the participants found they needed physical tools/prizes they normally had access to in person in order to engage patients. A couple of the participants filled this gap by

creating at-home rewards. This is supported by a conceptual article of recommendations that suggests using physical objects in the child's environment (Dueweke et al., 2020). Participants also responded to these issues by involving caregivers. Several participants noted high caregiver involvement in person, and reported the same amount of caregiver involvement via telehealth. However, the majority of participants noted an increased ease of getting caregivers involved via telehealth and reported working with caregivers for more of each session via telehealth, a concept supported by Baker et al.'s (2023) survey results, which indicated that mental health clinicians providing teletherapy to children who experienced trauma found it easier to involve caregivers via telehealth. One participant in the present study expressed that telehealth "allows for maybe parents that weren't so engaged or weren't able to come to sessions that are now able to do that."

Lastly, although in some cases being in the home environment led to increased difficulties with engagement and managing sessions, the majority of participants also noted using the patient's home environment to their advantage. More than half of the participants discussed how being "in vivo" could be helpful to treatment, especially exposure therapy. One participant explained, "The chance to do telehealth allowed me to actually do exposures in the environment where kids really were experiencing their feared stimuli so that was a really positive experience about providing telehealth." This is supported by Dueweke et al.'s (2020) recommendation of using telehealth to the provider's advantage by enhancing exposures. Many of the participants also generally found it helpful to see the child's home environment and gain insight into family dynamics. Participants gained more information than they would have had otherwise by witnessing the child in their natural environment. This is supported by the existing research's findings that sessions conducted from home allowed for better understanding of children's

contextual issues and family dynamics by psychology doctoral trainees (Scharff et al., 2020) and licensed marriage and family therapists (Schiano & Daniels, 2020). It is also supported by Dueweke et al.'s (2020) suggestion to gain access into the social context in which the child is living by conducting sessions via telehealth.

4th Theoretical Construct: Telehealth Experience has Varied Positive and Negative Impacts on a Case-By-Case Basis on Psychologists and Children

The fourth construct theorizes that there are specific factors, for both the child and the psychologist, that impact the telehealth experience. Regarding the child, several participants noted the telehealth experience depended on the child's age, with it being much easier to engage older children and more difficult to work with the younger children. Existing research suggests that sustained attention rapidly develops up until age 10, at which point it plateaus (Betts et al., 2006). This supports the abovementioned idea that older children are easier to engage via telehealth, as younger children are still developing their ability to maintain attention on a task such as therapy. Further supporting the idea that older children are easier to engage is Jean Piaget's cognitive developmental theory. According to Piaget's theory, children ages 7 through 11, which encompasses most of the ages of patients in the current study, are in the concrete operational stage, whereas children 12 and above are in the formal operational stage. Thus, although children in the concrete operational stage may be able to think logically about concrete events, they may struggle to understand abstract or hypothetical concepts, an understanding that Piaget theorized begins at age 12. In the formal operational stage, children are better able to engage in long-term planning as well as examine possible outcomes and consequence of actions. Further, children in this stage of development are theorized to have improved problem-solving abilities and are able to engage in metacognition, or thinking about their own and other's

thoughts (McLeod, 2018). These developments that are made in the formal operational stage would likely be very beneficial to the therapeutic process, and it therefore makes sense that psychologists would find it easier to work with older, or more advanced, children based on this theory. The idea of younger child engagement being a significant barrier to telehealth was also reflected in AlRasheed's et al. (2022) study of community mental health clinicians. In addition to age, the majority of the present study's participants also suggested that effectiveness depended on the child's characteristics and thus varied on a case by case basis. Several participants noted the increased difficulty of treating children with executive functioning issues and children on the autism spectrum via telehealth.

Regarding the psychologist, a few participants noted their self-care was adversely impacted by telehealth. One participant noted, "I found at the end of the day, I needed a nap, it was exhausting." Similarly, another participant referenced their own "Zoom fatigue," which is supported by Schiano and Daniels' (2020) findings. A couple of the present study's participants specifically referenced a loosening of boundaries, in that they were revealing more of their personal lives to families by conducting sessions from home. According to Castro et al. (2022)'s study, which indicated that children found that seeing providers in homes allowed for increased connectedness to the provider, this may actually be an advantage. Some of the current study's participants also reported they were also able to be more flexible with their schedules and fit more patients into their day. In some cases, this flexibility was noted to be beneficial by helping them to balance their lives in the same way it was helpful with respect to the personal lives and schedules of patients. For instance, participants reported the flexibility "reduces my burnout," and others referenced specific personal benefits to them such as being able to care for their own children at home. On the other hand, one participant noted that increased flexibility allowed him

to fit more patients into his day, which "raised questions" for him "around boundaries" that he "didn't have to address before."

5th Theoretical Construct: Psychologists' Attitudes Regarding CBT via Telehealth Were Mixed, Though More Positive Than Negative

The fifth theoretical construct posits that psychologists' attitudes vary regarding the experience of providing CBT via telehealth. Half of the participants noted the experience to be positive. They reported that the treatment went better than they would have anticipated and that it became easier for them over time. On the other hand, several participants portrayed negative experiences with CBT via telehealth for children, expressing that the transition was difficult, which makes sense given that 66% of mental health clinicians took merely one week or less to make the transition (Schiano & Daniels, 2020). A few participants also expressed that CBT via telehealth was less effective than in-person CBT, which is supported by other clinicians' beliefs reported in existing research (Schiano & Daniels, 2020). In fact, two of the participants in the present study questioned whether the CBT they were providing via telehealth was actually CBT. One participant explained, "I feel like I was modifying interventions to the point where it was not clear if it was like actual CBT. It just kind of became something like new. And usually not as effective."

Lastly, many participants, including some who were in favor of the long-term use of CBT, reported that there was no replacement for the in-person therapeutic experience. This is reflected in the research indicating clinicians' decreased satisfaction with telehealth work (Schiano & Daniels, 2020). For a few of the present study's participants, telehealth remained a last resort for treatment and in-person therapy was preferred. One participant stated, "If I don't have to do it, I don't do it." One reason cited by participants for this preference was the different

"feel" that therapy had in-person versus via telehealth. One participant described this by stating,

"The intuition we have in just getting somebody's feelings or getting what they're not saying,

and just getting their mood even if they're not expressing it. That was definitely diminished."

6th Theoretical Construct: CBT via Telehealth for Children is Effective and has a Long-Term Future Beyond the Pandemic

The sixth and final theoretical construct theorizes that CBT via telehealth for children is

effective and has a long-term future beyond the duration of the pandemic. Every participant

expressed this during the focus groups, regardless of their attitude toward telehealth.

The majority of participants discussed their belief that CBT via telehealth is effective. Several

participants noted that the effectiveness was the same as in-person CBT and that adequate work

was being done and progress was being made. The maintenance of effectiveness of CBT via

telehealth for children is recorded in limited existing research (Himle et al., 2012). A few

participants expressed the belief that telehealth was actually more effective in some

circumstances, which is supported by Nelson et al.'s (2003) study which found that children

diagnosed with depression exhibited a significantly greater rate of decrease in symptoms over

time when treated via telehealth rather than in-person. Licensed marriage and family therapists

from Schiano and Daniels' (2020) study cited increased client openness due to the transition to

telehealth, potentially resulting from the distance created by the computer screen leading to

increased emotional safety. Exemplifying this, one participant from the present study explained:

> … I can think of two socially anxious kids that I worked with where it felt like once we
>
> switched to virtual, I hit the jackpot. Like they turned their camera off and just like felt
>
> like they were chatting, chatting, chatting and telling me all sorts of things that I had
>
> never heard before. Mostly, I think because they didn't have to look at themselves and

maybe didn't have to you know, they were in their own house and in their own bed and in

their own environment in a way that probably made them feel pretty comfortable.

The theme that CBT via telehealth is effective aids in explaining the participants' unanimous

view that it has a definite future. Participants expressed the belief that telehealth is here to stay as

a treatment option and that they would continue to provide CBT via telehealth. This is reflected

in the existing research by the fact that the large majority of mental health providers continued to

use telehealth for their patients after the pandemic (APA, 2020; Schiano & Daniels, 2020).

Mental health providers also have largely indicated a preference for using at least some

telehealth in the future for their patients (Schiano & Daniels, 2020). A few participants in the

present study also expressed that the large majority of patients continue to use and, in some

cases, prefer telehealth. Existing literature supports this preference, indicating that children and

caregivers reported high satisfaction with telehealth services (Dueweke et al., 2020; Gloff et al.,

2015; Myers et al., 2017).

Considering the acceptability and persistence of telehealth, the majority of participants in

the present study discussed some long-term considerations regarding telehealth as well. For

example, a few participants discussed licensing issues and how PSYPACT, which "opens up a

lot of doors to practice in other states," has begun to address these issues. One participant stated,

"now your license is what's stopping you and nothing else." Further, a couple of participants

discussed their hope that teletherapy would be covered by insurance in the same way that in-

person therapy is covered. They additionally noted ways in which the adaptations they made for

telehealth have impacted their post-COVID work. For example, a couple of participants

mentioned continuing to use some of the tools or strategies they used via telehealth with their in-

person child patients. Moreover, some participants expressed an optimistic belief that CBT via

telehealth has even greater potential that has not yet been realized. One participant explained, "I think the potential is not even fully tapped into."

Lastly, regarding the future, the majority of participants discussed their insistence that a hybrid model remain an option in the future. One participant stated, "I think you'd be silly to not include that as a hybrid at minimum for yourself." Participants discussed how increased flexibility and the option to come in person when needed can be a major advantage.

Clinical Implications

The results of the present study engender various recommendations that address areas of CBT via telehealth for children in need of improvement and facilitate the adaptation of features of child CBT to telehealth, all with the objective of providing effective treatment. See Appendix I for a table of recommendations for providers, families, and systems. One such recommendation would be to increase training on providing CBT via telehealth. Many participants noted a difficult transition to telehealth, which, amongst a multitude of reasons, was partially due to a lack of experience in providing CBT via telehealth prior to the pandemic. Participants who had used telehealth prior to the pandemic reported an easier experience. Due to the prevalence of telehealth and its promising future, it is vital that training programs incorporate mandatory telehealth training into their curriculum. For those who are in the field and no longer in training, practices would benefit from providing and/or requiring participation in extensive didactics and continuing education courses dedicated to the topic of providing telehealth to children and families. More specifically, clinicians would benefit from didactics and courses on the specific telehealth platforms their practices use in order to ensure they are taking full advantage of the platform's features. Practices may also benefit from gauging the perspectives of families and providers in order to assess the aspects of their experiences of CBT via telehealth that can be

improved upon. They may do so by regularly incorporating a feedback questionnaire into their practice.

Another recommendation based on this study's participants' experiences would be for providers to address factors hindering CBT via telehealth before beginning treatment in order to optimize treatment effectiveness. This would include addressing key aspects of treatment with children and caregivers beforehand such as safety and privacy issues, expectations for treatment, the logistics of the telehealth platform, information on the technology being used, and the conduciveness of the therapeutic environment at home. It is also recommended that a caregiver be nearby when therapy is being conducted in the event that assistance is needed with managing the session. Moreover, providers may take the recommendation of one of the participants into consideration, and periodically and innocuously during treatment have the patient show their full body on screen in order to assess for any changes in their physical well-being. Providers may also benefit from frequently asking caregiver(s) about other information that is usually assessed in person, such as hygiene. Considering the abundance of engagement issues reported by participants, providers and psychology practices would benefit from continuing to create interactive virtual tools and/or adapting in-person resources for virtual use. In some cases, it may be necessary for materials to be mailed to families ahead of time.

Further addressing engagement issues, providers may provide children and caregivers with an overview of the session schedule beforehand, ensuring that breaks and time to speak with the caregiver(s) are scheduled ahead of time. By doing so, the provider can ensure that the caregiver(s) will be available to speak, which was an uncertainty mentioned by participants. This will also serve to set expectations for the family as to the session structure. Providers may also

find it helpful to recommend to caregiver(s) that they limit their child's screen use on the day therapy is conducted in order to reduce the probability of screen fatigue during the session.

Additionally, some participants noted their self-care was adversely impacted by telehealth, which could be due to their reported loosening of boundaries. It is essential that providers and practices more generally maintain the same schedule for seeing patients that they maintained in-person. This means ensuring that the provider is not fitting in additional patients due to their ability to be flexible. This may ultimately lead to clinician burnout and less effective care.

Participants also suggested that the transition was easier when there was an in-person connection between provider and patient. Thus, it is recommended that, when possible, providers meet their patients in-person initially before the transition. When this is not possible, it is essential that providers put more time and energy into rapport building than they would in person.

On a broader scale, it is important that insurance companies and licensing rules continue to progress in the same direction as telehealth. Further, in order to increase access to services, it is essential that families in underserved areas have access to technological devices necessary for telehealth. Providers should assess the technological needs of families beforehand and guide them on how to access the necessary technology. For example, children may be eligible to receive such a device from the Department of Education. Or, as a likely more ambitious recommendation, perhaps insurance companies could pick up at least part of this cost.

Study Limitations

Several limitations are important to acknowledge when considering this study's results. These limitations include the sample size ($n=18$), the fact that the majority of the participants

practice in or near New York, and the relatively ethnically homogenous sample. The study may

therefore not represent the full spectrum of psychologists' experiences across the United States.

The researcher also noticed very few participants acknowledged difficulty accessing families

lacking access to technology. There was also little mention of the participants themselves, and/or

the sites they work at, lacking access to resources. This suggests that the participants may treat a

relatively socioeconomically homogenous population. More generally, the researcher also did

not gather information regarding the settings participants worked and/or currently work in, which

may impact their access to resources. Also, half of the participants recruited were LIU Post

alumni and thus have similar training. Thus, they may have viewed the experience through a

similar lens. Additionally, the present study focused on children between ages 7 and 12 and it is

therefore unknown if the results can be generalized to virtual CBT with adolescents or parents of

children younger than 7 years.

Further, while conducting interviews in focus groups has advantages, there is also the

limitation that participants may be hesitant to express contrary opinions to the rest of the group

or may be swayed by the other members' opinions. This may apply specifically to the present

study's focus groups since some of the participants within the focus groups knew each other due

to attending the same graduate program or through work experience. While on the one hand this

may have increased comfort levels, it may have also reduced the likelihood that they would

express contrary opinions to their colleagues. Additionally, on several occasions during the focus

groups, participants reported they generally agreed with what others had said or did not wish to

repeat what others said and instead added additional opinions. Similarly, some participants

nodded in response to other participants' comments rather than voicing agreement. In these

cases, it is possible some of their opinions, because they were expressed nonverbally were not transcribed, or were not coded as relevant text due to the vagueness of the statements.

Hypotheses and Directions for Future Research

The present study suggests several hypotheses and directions for future research. Many participants noted the impact that the transition to telehealth had on families' access to care, in some cases making it more difficult to access families. It is hypothesized that if increased resources were provided to both patients and providers (e.g., access to, and information on how to use, technology/telehealth platforms and access to digital CBT resources such as worksheets and activities), then psychologists would view CBT via telehealth more favorably. Future research can examine the difference in clinicians' attitudes toward telehealth between those providing services in underserved areas and those providing services in areas with an abundance of resources.

Many participants also identified the importance of focusing on pre-treatment considerations, such as facilitating and hindering factors to telehealth treatment. It is hypothesized that if psychologists spend more time addressing pre-treatment considerations, then CBT via telehealth may be viewed more favorably, in terms of the overall experience and effectiveness, by providers. Future research may examine the impact that each factor has on providers' attitudes toward therapy. It may also be beneficial to study the most productive way to implement these improvements and train providers/trainees in how to implement these changes. Further, it would be helpful for future research to examine CBT via telehealth experiences from the perspectives of child patients and caregivers, just as psychologists' perspectives were examined in the present study, in order to gain further information regarding improvements to be made before beginning treatment.

The present study's participants also highlighted increased engagement issues that arise during telehealth treatment. It is hypothesized that if psychologists spend more time focusing on and addressing engagement difficulties during CBT via telehealth treatment, then these psychologists will have a more favorable outlook on CBT via telehealth.

Participants additionally expressed that the experience and effectiveness of telehealth varies depending on the age and specific characteristics of the child, such as diagnosis. It is thus hypothesized that psychologists who tailor their CBT via telehealth treatments to the age and specific characteristics of their patients will have a more favorable perspective than those who do not make individualized adjustments. Further, some participants suggested that telehealth had both positive and negative impacts on their own personal lives. It is hypothesized that if increased time is spent on clinicians' self-care activities when providing teletherapy, then these clinicians may report a more positive experience with CBT via telehealth.

Overall, participants agreed unanimously that child CBT via telehealth has a long-term future, while expressing varying attitudes regarding their experiences with telehealth. In addition to the suggestions presented above, future research may also continue to examine psychologists' experiences and attitudes toward CBT via telehealth in order to assess how their attitudes change with time and, hopefully, improvements in the field. Moreover, although not examined in the present study, it would be useful for future research to continue to compare the treatment outcomes for children who participated in in-person CBT with children who participated in CBT via telehealth, as well as how adjustments in telehealth treatment may impact the outcomes.

Final Thoughts

This study explored clinical psychologists' experiences providing CBT via telehealth to children. Given the study's implications that telehealth is here to stay and that there are some

distinct advantages that have surfaced in a relatively short sample period, the researcher hopes this study will encourage others to continue studying this topic. The researcher hopes that with increased investigation in this area, providers will have an increased understanding regarding adaptations that can facilitate child teletherapy, will be able to improve upon existing practices and overcome the current challenges, and will thus be able to effectively utilize CBT via telehealth for children in the future.

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Appendix A

Recruitment Flyer

Have you provided Cognitive Behavioral Therapy (CBT) via telehealth to children?

Take part in a brief study exploring clinical psychologists' experiences providing CBT via telehealth to children.

Eligibility:
- Clinical psychologist in the U.S.
- Have provided and/or are providing CBT via telehealth to children (ages 7-12) for at least six months
- Have provided in-person services prior to the onset of the COVID-19 pandemic.

Requirements:
- Complete demographic and clinical information form, and contact information form (~20 min)
- Participate in 60-90 min focus group via Zoom

Research purpose:
- Help provide an understanding of how clinicians can effectively provide CBT to children via telehealth, identify areas of CBT via telehealth for children that are in need of improvement, and shed light on how to effectively adapt key features of child CBT to teletherapy.

Contact student investigator, Carly Apar, at carly.apar@my.liu.edu for more information.

Appendix B

Informed Consent

LONG ISLAND UNIVERSITY
INSTITUTIONAL REVIEW BOARD (IRB)

RESEARCH PARTICIPANT INFORMED CONSENT FORM

Study Title: Psychologists' Experiences Providing Cognitive-Behavioral Therapy (CBT) to Children Via Telehealth

Faculty Investigator: Hilary Vidair, Ph.D.
Associate Professor of Psychology
Clinical Psychology Doctoral Program
Long Island University, Post Campus
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516-299-3630

Student Investigator: Carly Apar, M.S.
Clinical Psychology Doctoral Program
Carly.apar@my.liu.edu
516-491-1639

You are being asked to join a research study. Participation in this study is voluntary. Even if you decide to join now, you can change your mind later.

1. **Why is this research being done?**
   This research is being done to explore the experiences of psychologists providing CBT via telehealth to children. The research will help provide an understanding of how clinicians can effectively provide CBT to children using this format, identify areas of CBT via telehealth for children that are still in need of improvement, and shed light on how to effectively adapt key features of child CBT to teletherapy.

   Clinical psychologists in the United States providing CBT to children (ages 7-12) will be recruited for this study. In order to be included, potential participants must have provided in-person services prior to the onset of the COVID-19 pandemic. Additionally, potential participants must have provided or be providing CBT via telehealth for at least six months. We anticipate that about 17-24 people will take part in this study.

2.   What will happen if you join this study?
If you agree to be in this study, we will ask you to do the following things:
- Complete a demographic and clinical information form, and contact information form
- Provide your availability via email for scheduling of a focus group via Zoom
- Partake in an approximately 60 to 90-minute focus group via Zoom about your experiences providing CBT via telehealth to children
- Participate with other psychologists in an optional virtual review of the study's results in order to determine if you feel your subjective experience has been properly represented and/or if you believe information should be added that is missing but important

Video recordings:
As part of this research, we are requesting your permission to create and use a video recording of the focus group that will be transcribed for study purposes. The video recording will not be used for advertising or non-study related purposes.

You should know that:
- You may request that the video recording be stopped at any time.
- If you agree to allow the video recording and then change your mind, you may ask us to destroy that recording. If the recording has had all identifiers removed, we may not be able to do this.
- We will only use the video recording for the purposes of this research.
- The video recording will be transcribed by the student investigator (Carly Apar) who will keep all data confidential.

How long will you be in the study?
Participation in the study will take approximately 60-90 minutes for the virtual focus group. If you choose to participate in the virtual study review, the review will be approximately 60 minutes.

4.   What are the risks or discomforts of the study?

When participating in the virtual focus group, while it will be emphasized, confidentiality cannot be ensured. Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of focus groups prevents the researchers from guaranteeing confidentiality. The researchers would like to remind participants to respect the privacy of your fellow participants and not repeat what is said in the focus group to others.

The risks associated with participation in this study are no greater than those encountered in daily life. You may get tired or bored when we are asking you questions. You do not have to answer any question you do not want to answer.

Although your IP Address will not be stored in the survey results, there is always the possibility of tampering from an outside source when using the Internet for collecting

information. While the confidentiality of your responses will be protected once the data is downloaded from the Internet, there is always the possibility of hacking or other security breaches that could threaten the confidentiality of your responses.

Although any identifiers will be removed from the video recording and transcription, the information will not be used or distributed for future research studies.

5.   Are there benefits to being in the study?

Although there is no direct benefit to you from being in this study, it is reasonable to expect that the results may provide information of value for providing CBT via telehealth to children.

6.   What are your options if you do not want to be in the study?
Your participation in this study is entirely voluntary. You choose whether to participate, refuse to participate, or withdraw from this study. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled.

7.   Will it cost you anything to be in this study?
No.

8.   Will you be paid if you join this study?
No.

9.   Can you leave the study early?
- You can agree to be in the study now and change your mind later, without any penalty or loss of benefits.
- If you wish to stop, please tell us right away.
- If you want to withdraw from the study, please contact the student investigator: Carly Apar at 516-491-1639 or carly.apar@my.liu.edu.

10.   How will the confidentiality of your data be protected?
Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Long Island University Institutional Review Board and officials from government agencies such as the National Institutes of Health and the Office for Human Research Protections. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

Your identity as a participant will remain confidential. This consent form and the contact information form are the only documents identifying you as a participant in this study. Your name will not be included in any other forms, transcriptions, etc. All data will be

stored on a password protected hard drive. The hard drive will be stored in a locked drawer in the primary investigator's home. Data will be stored for six years after the completion of the study before being destroyed. Data collected will be destroyed at the end of six years. Results will largely be reported in the aggregate, though some specific quotes from individual interviews will be reported in a de-identified manner.

11.   What other things should you know about this research study?

What is the Institutional Review Board (IRB) and how does it protect you?
This study has been reviewed by an Institutional Review Board (IRB), a group of people that reviews human research studies. The IRB can help you if you have questions about your rights as a research participant or if you have other questions, concerns or complaints about this research study. You may contact the IRB at osp@liu.edu.

What should you do if you have questions about the study?
Contact the student investigator (Carly Apar at 516-491-1639 or carly.apar@my.liu.edu) or the faculty investigator (Hilary Vidair at 516-299-3630 or hilary.vidair@liu.edu). If you wish, you may contact the faculty investigator by letter. The address is on page one of this consent form. If you cannot reach the investigators or wish to talk to someone else, contact the IRB office at osp@liu.edu. You can ask questions about this research study now or at any time during the study. If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Institutional Review Board at Long Island University at osp@liu.edu.

12.   What does your signature on this consent form mean?
Your signature on this form means that: You understand the information given to you in this form, you accept the provisions in the form, and you agree to join the study. You will not give up any legal rights by signing this consent form.

WE WILL GIVE YOU A COPY OF THIS SIGNED AND DATED CONSENT FORM

_____
_____
Signature of Participant   (Print Name)
           Date/Time

_____
_____
Signature of Person Obtaining Consent   (Print Name)
           Date/Time

NOTE: A COPY OF THE SIGNED, DATED CONSENT FORM MUST BE KEPT BY THE PRINCIPAL INVESTIGATOR; A COPY MUST BE GIVEN TO THE PARTICIPANT.

Appendix C

Participant Demographic and Clinical Information Form

Carly Apar, M.S.
Long Island University Post
Doctoral Program in Psychology
Carly.apar@my.liu.edu
(516) 491-1639

Participant Demographic and Clinical Information Form

Today's Date: _____

Age: _____

Racial/ethnic background: Please check all that apply.

☐ White

☐ Black or African American

☐ American Indian or Alaskan Native

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

☐ Other: _____

Do you identify as Hispanic, Latino/a, or Latinx?

☐ Yes

☐ No

Gender: _____

Length of time as practicing licensed clinical psychologist: _____

Length of time conducting CBT via telehealth: _____

Have you provided and/or are you currently providing CBT via telehealth to children (ages 7-12) for at least six months?

☐ Yes

☐ No

Did you provide in-person services prior to the onset of the COVID-19 pandemic?

☐ Yes

☐ No

Population(s) treated (check all that apply):

Ages

    ☐ 7 years   ☐ 9 years   ☐ 11 years

    ☐ 8 years   ☐ 10 years   ☐ 12 years

Diagnoses treated in your practice:

    ☐ Anxiety disorders

    ☐ Attention-deficit/hyperactivity disorder

    ☐ Autism spectrum disorder

    ☐ Depressive disorders

    ☐ Developmental disabilities

    ☐ Conduct Disorder

    ☐ Oppositional Defiant Disorder

    ☐ Elimination disorders

    ☐ Feeding and eating disorders

    ☐ Intellectual disabilities

    ☐ Motor disorders

    ☐ Obsessive-compulsive and related disorders

    ☐ Trauma- and stressor-related disorders

    ☐ Substance disorder

☐ Other: _____

_____

Type(s) of CBT practiced (check all that apply):

☐ Exposure therapy

☐ Behavioral parent training

☐ Trauma focused CBT

☐ Parent-child interaction therapy

☐ Other: _____

_____

Method(s) of teletherapy practice (check all that apply):

☐ Video conferencing

☐ Phone call

☐ Other: _____

_____

Participant teletherapy practice setting:

☐ Home

☐ Office

☐ Other: _____

_____

Geographic location(s) of practice:

_____

_____

Appendix D

Participant Contact Information Form

Carly Apar, M.S.
Long Island University Post
Doctoral Program in Psychology
Carly.apar@my.liu.edu
(516) 491-1639

Participant Contact Information Form

Participant Name: _____

                         First   Last

Participant Phone Number: _____

Participant Email Address: _____

Appendix E

Participant Video Recording Consent Form

<u>**Video Recording Consent Form**</u>

As part of this research, we are requesting your permission to create and use video recordings. Any video recording of the Zoom focus group will not be used for advertising or non-study related purposes.

You should know that:
- You may request that the recording be stopped at any time.
- If you agree to allow the video recording and then change your mind, you may ask us to destroy that imaging/recording. If the imaging/recording has had all identifiers removed, we may not be able to do this.
- We will only use these video recordings for the purposes of this research.
- The audio recording will be transcribed by the student investigator, Carly Apar, who will keep all data confidential.

_____I **agree** to allow the study to make and use photographs/video recordings/audio recordings of me (or the participant I represent) for the purpose of this study.

_____   _____
Participant Signature   Date
(or Legally Authorized Representative Signature, if applicable)

Appendix F

Final List of Constructs, Themes, and Repeating Ideas

Each theoretical construct, theme, and repeating idea listed below is followed by a number in parentheses that represents the number of participants that endorsed it. Theoretical constructs are represented in capital letters, themes are bolded, and repeating ideas are in regular print.

1) TRANSITION TO TELEHEALTH IMPACTS FAMILIES' ACCESS TO CARE – MORE POSITIVELY THAN NEGATIVELY (16)
    1. **Transition to telehealth has a predominantly positive impact on access to care (16)**
       The accessibility that it allows it kind of makes you wonder why didn't we do it? (10)
       Convenience facilitates the child being in treatment, period (12)
       Decreased tardiness/cancellations with telehealth option (6)
       May be the best option for families that do not have access to quality in-person evidence-based treatment (3)
       More CBT resources available than ever before after transition to telehealth (3)
       Broader geographical access to care can also be a disadvantage (2)

    2. **Loss of clientele/difficulty accessing families due to transition to telehealth (5)**
       Difficulty accessing underserved families who didn't have access to necessary technology (3)
       I lost a lot of clients who just weren't able to do telehealth (2)

    3. **Convenience of telehealth can be a disadvantage (7)**
       Parents resisting push to coming to the office because of convenience of telehealth (2)
       Convenience can backfire and environment of therapy needs to be adjusted (6)

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2) IMPORTANCE OF FOCUSING ON PRE-TREATMENT CONSIDERATIONS WHEN CONDUCTING CBT VIA TELEHEALTH (17)
    1. **Negative impacts of telehealth on safety and privacy (8)**
       Lack of patient confidentiality/privacy via telehealth (5)
       Some kids don't feel like they can have a safe space in their own home to do therapy (4)

    2. **Importance of preparing a conducive therapeutic environment (5)**
       Setting up a successful environment for patients (5)
       Discussing expectations for telehealth sessions with patients and caregivers before initiating treatment (2)

    3. **Technological hindrances to providing CBT (13)**
       Patient screen fatigue from being on the computer all day (2)

Technological factors were a big hindrance (9)
Barriers created by internet connectivity problems (6)
Inability to fully assess patient physically (4)

4. **Factors that facilitate the transition to telehealth (13)**
Smoothest transition for children because use of technology was so typical for them (4)
Psychologist had previous experience with telehealth/research base (4)
Easier transition to telehealth when there was an in-person connection (6)

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3) ADJUSTING TO INCREASED ENGAGEMENT AND MANAGEMENT ISSUES THAT ARISE DURING TELEHEALTH TREATMENT (18)
1. **Engagement difficulties via telehealth (10)**
Patients and parents have more distractions over telehealth (6)
Distracting for the psychologist (3)
It's quite amazing how much more engaged they are in person versus telehealth (7)
Child's engageability in-person may determine success via telehealth (2)

2. **Difficulties with managing telehealth sessions (13)**
A lot more to manage during telehealth sessions (3)
Issues with managing telehealth session structure (7)
I never know if the parent is going to be available to talk (4)
Children walking away from the screen/exiting the session (5)

3. **Increased creativity needed for telehealth (16)**
Need for additional theatrics when providing CBT via telehealth (3)
Learning creative ways to engage the children via telehealth (5)
Incorporating interactive virtual tools (11)
Use of creative at-home rewards (2)
Need for physical tools/prizes (5)

4. **Amount of caregiver involvement via telehealth either remained the same or increased in comparison to in-person treatment (17)**
Same amount of caregiver involvement via telehealth (6)
Easier to get caregivers involved in treatment over telehealth (13)
Working a lot more with parents for a lot more of every session via telehealth (7)

5. **Therapeutic advantages of child being in their home environment (11)**
Being able to be in vivo was an advantage (10)
Helpful to have children in their natural environment (7)
Insight into family dynamics/interactions within the home environment (3)

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4) TELEHEALTH EXPERIENCE HAS VARIED POSITIVE AND NEGATIVE IMPACTS ON A CASE-BY-CASE BASIS ON PSYCHOLOGISTS AND CHILDREN (16)

    1. Psychologist's telehealth experience generally more positive with older or more advanced children (5)
Much easier to engage the older or more advanced children via telehealth (3)
Hard time working with younger children via telehealth (5)
Telehealth effectiveness depended upon the age of the child (3)

    2. Effectiveness depends on the specific child and specific presenting problem(s) (13)
CBT via telehealth more challenging for children with executive functioning issues and children on autism spectrum (8)
CBT via telehealth effectiveness on a case by case basis (9)

    3. Telehealth has both positive and negative impacts on psychologists' personal lives (10)
Psychologist's self-care was adversely affected doing telehealth (4)
Loosening of psychologist's boundaries (2)
More flexibility as a clinician and helps balance my life (5)

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5) PSYCHOLOGISTS' ATTITUDES REGARDING CBT VIA TELEHEALTH WERE MIXED, THOUGH MORE POSITIVE THAN NEGATIVE (14)

    1. Psychologists' positive experiences with telehealth (9)
My experience was largely positive (3)
It went better than I would have expected (3)
Providing CBT via telehealth got a lot easier over time (4)

    2. Psychologists' negative experiences with CBT via telehealth (7)
Not clear if it's actual CBT (2)
CBT via telehealth less effective than in-person (4)
The transition to telehealth was very difficult (4)

    3. In-person therapy is preferable to virtual (9)
If I don't have to do it, I don't do it (3)
Nothing replaces the in-person experience (2)
Therapy has a different feel in-person (5)

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6) CBT VIA TELEHEALTH FOR CHILDREN HAS A LONG-TERM FUTURE BEYOND THE PANDEMIC (18)

    1. CBT via telehealth is effective (11)
Effectiveness remained the same (8)
Work was still being done and progress was still being made (6)
Telehealth more effective in some ways (3)

2. **Psychologists and patients will continue to engage in CBT via telehealth (16)**
   Telehealth is here to stay (7)
   I will absolutely continue to provide CBT via telehealth (13)
   Large majority of patients continue to use telehealth (5)
   Families/patients prefer telehealth (4)

3. **Long-term considerations regarding the delivery of telehealth services (10)**
   Now your license is what's stopping you and nothing else (4)
   Importance of teletherapy being covered by insurance in the same way that in-person is covered (2)
   Potential of CBT via telehealth not even fully tapped into yet (5)
   Telehealth adaptations impacted post-COVID work (2)

4. **Advantage of a hybrid approach (10)**
   Hybrid model needs to stick around (8)
   Allowing for flexibility and option to come in person (6)

Appendix G

Theoretical Narrative

The purpose of this study was to explore clinical psychologists' experiences providing CBT via telehealth to children. By doing so, the study aimed to generate an understanding of how clinicians can effectively provide CBT using telehealth, aid in identifying areas of CBT via telehealth for children that are still in need of improvement, and identify how to effectively adapt child CBT to teletherapy. The following theoretical narrative portrays the experiences of the psychologists who participated in the study, based on theoretical constructs, themes, and repeating ideas. Theoretical constructs are displayed in parentheses in all capital letters, themes are expressed in parentheses in italics, and repeating ideas are in parentheses in plain text.

The study's participants expressed that the transition to telehealth impacted families' access to mental health care (TRANSITION TO TELEHEALTH IMPACTS FAMILIES' ACCESS TO CARE – MORE POSITIVELY THAN NEGATIVELY). Participants largely found the impact on accessibility (*Transition to telehealth has a predominantly positive impact on access to care*), to be an advantage (The accessibility that it allows it kind of makes you wonder why didn't we do it?). The convenience telehealth offered allowed children to be in treatment who may not normally have been able to access treatment for a variety of reasons (Convenience facilitates the child being in treatment, period). Similarly, a few participants acknowledged that regardless of the effectiveness of CBT via telehealth, this treatment modality may be the best or only option for families without access to quality in-person treatment (May be the best option for families that do not have access to in-person evidence-based treatment). Several participants also found that the increased convenience telehealth offered led to decreased patient tardiness/cancellations (Decreased tardiness/cancellations with telehealth option). The

telehealth option not only increased access to treatment, but a few of the participants also experienced it increasing access to treatment resources (More CBT resources available than ever before after transition to telehealth).

However, participants also found that increased accessibility has some disadvantages. A couple of the participants realized that reaching patients geographically farther away can lead to an inability to transition to in-person treatment if needed, and/or difficulty providing referrals due to lack of knowledge about the patient's geographical area (Broader geographical access to care can also be a disadvantage). Further, a few of the participants acknowledged that in some cases, such as underserved families who lack access to technology (Difficulty accessing underserved families who didn't have access to necessary technology), the transition to telehealth negatively impacted access to care (*Loss of clientele/difficulty accessing families due to transition to telehealth).* Additionally, a couple of participants rapidly lost a significant portion of their patients who could not make the transition (I lost a lot of clients who just weren't able to do telehealth). Moreover, several participants found that the convenience offered by telehealth can sometimes lead to challenges (*Convenience of telehealth can be a disadvantage).* A couple of participants noticed some parents resisted returning to in-person sessions due to telehealth's convenience, despite encouragement from the psychologists (Parents resist push to coming to the office because of convenience of telehealth). Several participants also experienced patients joining sessions from public places or environments not conducive to therapy as a result of the convenient nature of telehealth (Convenience can backfire and environment of therapy needs to be adjusted).

Reflecting on their own transition experiences, participants discussed the importance of considering factors that facilitate or hinder treatment at the treatment outset (IMPORTANCE OF

FOCUSING ON PRE-TREATMENT CONSIDERATIONS WHEN CONDUCTING CBT VIA TELEHEALTH). One such consideration was the safety and privacy of patients (*Negative impacts of telehealth on safety and privacy),* which several participants believed was lacking via telehealth (Lack of patient confidentiality/privacy via telehealth). Some participants found that children sometimes did not feel safe to conduct therapy in their homes due to their fear of others in the home overhearing (Some kids don't feel like they can have a safe space in their own home to do therapy). Technological hindrances such as audio or video problems (Technological factors were a big hindrance) also impeded the CBT (*Technological hindrances to providing CBT).* In particular, several participants experienced internet connectivity issues disturbing their sessions (Barriers created by internet connectivity problems). A couple of participants also noticed patient screen fatigue during sessions due to patients using technology all day (Patient screen fatigue from being on the computer all day). Further, conducting teletherapy only allowed participants to partially view children's physical appearances, leading them to sometimes miss important information such as weight loss, hygiene issues, or tics.

In response to some of these hindrances, some participants suggested considering preparing a conducive therapeutic environment before beginning treatment (*Importance of preparing a conducive therapeutic environment).* They stressed the importance of setting up a successful environment for the child in their home before treatment (Setting up a successful environment for patients) and discussing telehealth expectations with families at the outset (Discussing expectations for telehealth sessions with patients and caregivers before initiating treatment).

In terms of factors that facilitated the transition (*Factors that facilitate the transition to telehealth),* a few of the participants found that children transitioned very easily due to their

familiarity with technology (Smoothest transition for children because use of technology was so typical for them). Similarly, a few participants who had previous experience with telehealth or were aware of the telehealth research base for a particular treatment experienced an easier transition (Psychologist had previous experience with telehealth/research base). Further, the transition was facilitated by an existing in-person relationship with the patient before moving to telehealth (Easier transition to telehealth when there was an in-person connection).

During treatment, participants expressed making adjustments in response to increased engagement and session management issues (ADJUSTING TO INCREASED ENGAGEMENT AND MANAGEMENT ISSUES THAT ARISE DURING TELEHEALTH TREATMENT). Regarding engagement issues (*Engagement difficulties via telehealth)*, several participants found children to be much more engaged in person (It's quite amazing how much more engaged they are in person versus telehealth). They also found that distractions were more prevalent via telehealth for children and parents (Patients and parents have more distractions over telehealth), as well as for themselves (Distracting for the psychologist). A couple of participants posited that the child's in-person engageability may predict their ability to engage successfully via telehealth (Child's engageability in-person may determine success via telehealth). Similar to engagement issues, telehealth session management issues (*Difficulties with managing telehealth sessions)* also seemed to increase (A lot more to manage during telehealth sessions). In particular, not being able to be in person with the patients led to more difficulty managing session structure (Issues with managing telehealth session structure). In some cases, children would walk away from the screen or exit the platform (Children walking away from the screen/exiting the session). Without the structure of in-person sessions, a few of the participants also never knew if the

parent(s) would be able to join a session (I never know if the parent is going to be available to talk).

In response to these engagement and management issues, the large majority of participants stressed the importance of creativity (*Increased creativity needed for telehealth*). For instance, a few participants found they were more theatrical via telehealth to keep the children engaged (Need for additional theatrics when providing CBT via telehealth). They learned new ways of engaging the children through telehealth (Learning creative ways to engage the children via telehealth) such as utilizing interactive virtual tools like worksheets, whiteboards, and videos (Incorporating interactive virtual tools). They also found that they needed physical tools/prizes that they had access to in person (Need for physical tools/prizes) and in response to this, took advantage of at-home rewards (Use of creative at-home rewards). Nearly all of the participants also stressed the importance of caregiver involvement via telehealth due to engagement difficulties (*Amount of caregiver involvement via telehealth either remained the same or increased in comparison to in-person treatment*). In several cases, participants already had parents very involved in-person and therefore reported no change in involvement via telehealth (Same amount of caregiver involvement via telehealth). The majority noticed that it was easier to get caregivers involved in treatment due to telehealth's convenience and flexibility (Easier to get caregivers involved in treatment over telehealth). Several participants leaned into working with parents for more of every session due to the children's difficulty engaging (Working a lot more with parents for a lot more of every session via telehealth).

The majority of participants also expressed how the child being in their home environment could combat some of the abovementioned issues (*Therapeutic advantages of child being in their home environment*). Several participants found it helpful to have children in their

home environments (helpful to have children in their natural environment), and to be able to witness interactions with family members they normally wouldn't have seen in the office (Insight into family dynamics/interactions within the home environment). They also found that in some cases, such as in exposure therapy, it was an advantage to be able to treat the child in vivo (Being able to be in vivo was an advantage) rather than recreating the context in the office.

Although general facilitating and hindering factors, adjustments, disadvantages, and advantages have been mentioned, the large majority of participants noted that there are specific factors, to both the children and providers, that impact the telehealth experience (TELEHEALTH EXPERIENCE HAS VARIED POSITIVE AND NEGATIVE IMPACTS ON A CASE-BY-CASE BASIS ON PSYCHOLOGISTS AND CHILDREN). Some participants found that the telehealth experience (*Psychologist's telehealth experience generally more positive with older or more advanced children)* and effectiveness (Telehealth effectiveness depended upon the age of the child) varied depending on the child's age, with it being easier to engage the older children (Much easier to engage the older or more advanced children via telehealth) and more difficult with younger children (Hard time working with younger children via telehealth). The majority also noticed effectiveness depended on the child's characteristics (*Effectiveness depends on the specific child and specific presenting problem(s))*, and could therefore only be evaluated on a case by case basis (CBT via telehealth effectiveness on a case by case basis). For example, several participants found telehealth more challenging for children with executive functioning issues and children on the autism spectrum (CBT via telehealth more challenging for children with executive functioning issues and children on autism spectrum). Regarding personal factors for the psychologist (*Telehealth has both positive and negative impacts on psychologists' personal lives)*, a few of the participants reported that their self-care was negatively impacted by

telehealth (Psychologist's self-care was adversely affected doing telehealth). They also noticed they loosened their boundaries (Loosening of psychologist's boundaries) by revealing more of their personal lives while conducting therapy from home and fitting more patients into their schedule due to increased flexibility. Flexibility also worked to their advantage in some cases, however, as some were better able to balance their personal lives as a result (More flexibility as a clinician and helps balance my life). Thus flexibility seemed to work as an advantage or disadvantage depending on how the psychologist used it.

Considering the varying impact telehealth had on psychologists themselves and treatment, it is no surprise that participants' attitudes regarding CBT via telehealth varied (PSYCHOLOGISTS' ATTITUDES REGARDING CBT VIA TELEHEALTH WERE MIXED, THOUGH MORE POSITIVE THAN NEGATIVE). For many, the experience was largely positive (*Psychologists' positive experiences with telehealth;* My experience was largely positive). A few participants found that telehealth went better than anticipated (It went better than I would have expected). A few also thought it became easier with time (Providing CBT via telehealth got a lot easier over time), likely due to the adjustments made. On the other hand, several participants had negative attitudes toward CBT via telehealth (*Psychologists' negative experiences with CBT via telehealth).* A few participants found the transition to be very difficult (The transition to telehealth was very difficult) and found it ultimately less effective than in-person treatment (CBT via telehealth less effective than in-person). A couple of participants were uncertain whether the treatment was still CBT due to the barriers and adjustments made (Not clear if it's actual CBT). Consequently, half of the participants preferred in-person therapy, even some that had a positive outlook on CBT via telehealth (*In-person therapy is preferable to virtual).* Additionally, a few of the participants viewed telehealth as a last resort (If I don't have

to do it, I don't do it) and found the in-person experience to be irreplaceable (Nothing replaces the in-person experience). One reason for this was the different feel that therapy has in-person (Therapy has a different feel in-person).

Despite varying attitudes, participants overwhelmingly agreed that CBT via telehealth for children has a long-term future (CBT VIA TELEHEALTH FOR CHILDREN IS EFFECTIVE AND HAS A LONG-TERM FUTURE BEYOND THE PANDEMIC). The majority of participants expressed their belief that CBT via telehealth is effective (*CBT via telehealth is effective*), which undoubtedly contributes to their belief in the necessity of continuing to offer telehealth as an option in the future (Telehealth is here to stay). Several participants reported that CBT was just as effective via telehealth as in-person therapy (Effectiveness remained the same) and that therapeutic work and treatment progress were continuing via telehealth (Work was still being done and progress was still being made). A few even noted telehealth to be more effective in some cases (Telehealth more effective in some ways), such as for socially anxious children. The majority of participants reported continuing to use telehealth for child patients (*Psychologists and patients will continue to engage in CBT via telehealth*) and indicated they plan to continue using it in the future (I will absolutely continue to provide CBT via telehealth). They reported that the large majority of the patients in their practices continue to use telehealth, despite having the in-person option (Large majority of patients continue to use telehealth), and some of them even prefer it (Families/patients prefer telehealth).

Taking into account their belief that telehealth will remain as a treatment option, the majority of participants articulated some long-term considerations regarding telehealth (*Long-term considerations regarding the delivery of telehealth services*). For example, a few participants discussed licensing barriers and how PSYPACT may address the need for treating

patients in multiple states (Now your license is what's stopping you and nothing else). They also

would like to see insurance cover teletherapy in the future in the same way as in-person sessions

(Importance of teletherapy being covered by insurance in the same way that in-person is

covered). They also argue that telehealth's potential has not yet been fully realized, implying

even more future benefits of telehealth (Potential of CBT via telehealth not even fully tapped

into yet). A couple of participants noted that telehealth not only has a permanent spot in the

future of therapy, but it has also impacted how psychologists work in-person (Telehealth

adaptations impacted post-COVID work). At the very least, the majority of participants

emphasized the importance of a hybrid approach (*Advantage of a hybrid approach).* The

flexibility that a hybrid approach offers (Allowing for flexibility and option to come in person)

makes it a non-negotiable for the future (Hybrid model needs to stick around).

Appendix H

Theoretical Constructs, Themes, Repeating Ideas, and Relevant Text Examples

Tables

Table H1

1st Theoretical Construct: Transition to Telehealth Impacts Families' Access to Care – More

Positively Than Negatively

Repeating Idea	Relevant Text Example
1st THEORETICAL CONSTRUCT: **TRANSITION TO TELEHEALTH IMPACTS FAMILIES' ACCESS TO CARE – MORE POSITIVELY THAN NEGATIVELY**	
1st Supporting Theme: **Transition to telehealth has a predominantly positive impact on access to care**	
The accessibility that it allows it kind of makes you wonder why didn't we do it?	"You'd be really limiting yourself as a clinician, as well as like, you know, limiting access to care for people if you only stick with in-person."
Convenience facilitates the child being in treatment, period	"I have a patient right now who is in more after school activities than I've ever heard of in my life. And I think if we didn't have the option to do telehealth, really having therapy would be really challenging for him just in terms of logistically being able to come into the office. And this is someone though who also can engage virtually really well. So I think it facilitates him being in treatment period. Because I don't know if he would be able to be in treatment if he didn't have the telehealth option."
Decreased tardiness/cancellations with telehealth option	"Virtually everybody is on time and if they're a minute or two late that's the latest they are and very few cancellations, very few no shows so I feel like it just made it possible."
May be the best option for families that do not have access to quality in-person evidence-based treatment	"So I think about is it the best kind of treatment without really thinking about like, well, what else are they going to get? You know, so they might not get the best. You know, just because I've sent them somewhere around the corner from their home doesn't mean that they're actually in treatment. So I appreciate the reminder that maybe it's better."
More CBT resources available than ever before after transition to telehealth	"I think when we all first switched to telehealth there was like an overwhelming amount of resources and worksheets and protocols and videos that we could all use with children and so in some ways I found I had more resources than ever before."

Broader geographical access to care can also be a disadvantage	"If you then also want to make a referral to other providers if you're seeing them at a distance like I had like a temporary licensure in Massachusetts for a bit and then I was referring the child to someone else, I just didn't have the network up there. Like I referred them to I think it was Boston Children's. So I mean, I just but I didn't know like any sort of people in practice. So that was that was hard."

2nd Supporting Theme:
Loss of clientele/difficulty accessing families due to transition to telehealth

Repeating Idea	Relevant Text Example
Difficulty accessing underserved families who didn't have access to necessary technology	"I also work with a lot of underserved populations who didn't have access to the technology that was needed at first and so we had to find some workarounds to be able to get them hotspots or iPads or ways to even just access the session."
I lost a lot of clients who just weren't able to do telehealth	"I lost a lot of clients who just weren't able to do telehealth I think that's important to mention. And I don't know if they returned to treatment with somebody else in the future."

3rd Supporting Theme:
Convenience of telehealth can be a disadvantage

Repeating Idea	Relevant Text Example
Parents resisting push to coming to the office because of convenience of telehealth	"Sometimes I felt families were hesitant to give up a virtual appointment because of the convenience of it and encouraging them to resume in-person treatment could be a bit of a push."
Convenience can backfire and environment of therapy needs to be adjusted	"I have had that come up so often where they like pick up and they're in the car and I'm like, 'I'm sorry, like, we can't have therapy like this, like this just doesn't work like this.' But it's challenging, because then it's like well do you cancel the session? Do you reschedule this? There's just like so much like logistics that then come into it. But you just can't do therapy while someone's like in the car in the back, mom's interjecting, dad's interjecting, the little sibling's interjecting, it just doesn't work."

Table H2

2nd Theoretical Construct: Importance of Focusing on Pre-Treatment Considerations When

Conducting CBT via Telehealth

2nd THEORETICAL CONSTRUCT:

IMPORTANCE OF FOCUSING ON PRE-TREATMENT CONSIDERATIONS WHEN CONDUCTING CBT VIA TELEHEALTH

1st Supporting Theme:
Negative impacts of telehealth on safety and privacy

Repeating Idea	Relevant Text Example
Lack of patient confidentiality/privacy via telehealth	"I think that there are some potential risks to privacy, not just from the online space, but in terms of who's in the room and you know, sometimes you're having conversation you don't realize that the parent was actually you know, preparing dinner in the background the whole time. And that can be a challenge."
Some kids don't feel like they can have a safe space in their own home to do therapy	"Something that I have found hinders it, though, is that some kids don't feel like they can have a safe space in their own home to do therapy, for fear that a family member will overhear them."

2nd Supporting Theme:
Importance of preparing a conducive therapeutic environment

Repeating Idea	Relevant Text Example
Setting up a successful environment for patients	"I had a kid who literally I hadn't seen her in a while, mom calls. And it took her 10 minutes to get on the Zoom and you know, I ask her why. And she was like, 'Well, I had to set it up like your office,' you know, and it was adorable. So she kind of knew that she couldn't sit there and speak."
Discussing expectations for telehealth sessions with patients and caregivers before initiating treatment	"What often facilitated that was again, like a lot of discussion with parents about how you would set your like how you wanted them to talk about you and how the you know it would be set up and also helping parents to understand the expectations like just like I wouldn't have a very active clinical first appointment with the kid if they came to my office. In my first virtual appointment, we're probably going to watch a lot of videos and play some games and that's probably going to be it because I want them to want to come on to the screen the next time they see me you know."

3rd Supporting Theme:
Technological hindrances to providing CBT

Repeating Idea	Relevant Text Example
Patient screen fatigue from being on the computer all day	"I think the only times it was an issue were my kids who were like fatigued from being on

	the computer all day. And so those were the cases where I was really struggling and frustrated and trying to see if we can get them in in person."
Technological factors were a big hindrance	"This may be obvious, but good, working technology certainly facilitates telehealth practice – it can be a bit challenging, frustrating, etc. when, on occasion, the sound quality or video quality is poor, it can negatively impact the flow of the session, etc. These technical aspects both facilitate and hinder telehealth practice. In addition, background noise and/or setting where the patient may be doing the session, for example if it is outdoors, can be problematic as well."
Barriers created by internet connectivity problems	"Bad internet connection, and that happens not so much when I'm working from the office in the city, but when I'm working from home, it really gets frustrating. Or theirs, you know, when someone is in the middle of something and freezes. It's just like, 'Oh, you gotta be kidding.'"
Inability to fully assess patient physically	"Turns out that she (patient) developed an eating disorder where I didn't know you know, forehead doesn't lose weight. I really didn't know and then what I learned from it moving forward after that, is I always on the telehealth I always found reasons and I initiated ways to see their full body, at least once in a while. Just you know, show me how tall you are. Show me how you run compared to your parents and like I use examples of that just like occasions of that you just get to see them. So this was for me that is a more striking omission on my part that I didn't even think about that really taught me a valuable lesson."
4th Supporting Theme: **Factors that facilitate the transition to telehealth**	
Smoothest transition for children because use of technology was so typical for them	"I also see teens and adults and the kids were the absolute easiest to transition to telehealth. It was so typical for them. I mean, they were doing this for school. They're already oriented. They've grown up being on video chat. So for them it was really I think the smoothest transition."

Psychologist had previous experience with telehealth/research base	"I actually was one of the people when I was previously at [a child study center], one of the people who saw the most telehealth like prior to the pandemic so like the platform, all of that wasn't really much of a switch to me because there were a lot of parents that would see me on their lunch break and I do a lot of PMT."
Easier transition to telehealth when there was an in-person connection	"I would say that it complements the fact that in person sessions are occurring most of the time and I think it's easier to transition to some telehealth when there's also that in-person connection."

Table H3

3rd Theoretical Construct: Adjusting to Increased Engagement and Management Issues That

Arise During Telehealth Treatment

3rd THEORETICAL CONSTRUCT: **ADJUSTING TO INCREASED ENGAGEMENT AND MANAGEMENT ISSUES THAT ARISE DURING TELEHEALTH TREATMENT**	
1st Supporting Theme: **Engagement difficulties via telehealth**	
Repeating Idea	Relevant Text Example
Patients and parents have more distractions over telehealth	"But then when it comes to in terms of the children being engaged, I'm noticing that children are, have consistently been really distracted. Even children who, when I previously saw them in the office had much better like attention spans with me, they're holding like two or three screens at once. They've got me on the iPad, and they're on their phones at the same time and, you know, they're insisting that they can maintain a good attention. It's really hard to, to manage that the way I manage it in the office."
Distracting for the psychologist	"Now I'm engaging in multiple screens and I have all these different things going on and it just I found that to be very difficult and distracting and inappropriate during the session."
It's quite amazing how much more engaged they are in person versus telehealth	"There are some kids that I have found wow, like it's quite amazing how much more engaged they are in person versus telehealth."
Child's engageability in-person may determine success via telehealth	"For the vast majority of kids that have a harder time engaging over telehealth are kids that I don't find all

| | that engageable in person either and need more like parent and caregiver based work anyway. So to me that doesn't feel like super weighty." |

2nd Supporting Theme:
Difficulties with managing telehealth sessions

Repeating Idea	Relevant Text Example
A lot more to manage during telehealth sessions	"It feels as a therapist that there's a lot more you need to try to contain."
Issues with managing telehealth session structure	"It can get chaotic pretty quickly because there's some safety assessments where like, you know, the laptop is being passed to the child who's telling me and we're going through a safety assessment and then the parents like enter the room suddenly and they're like, can we talk to you for a minute and kind of just take the laptop and it's more, as an environment, it's a little bit more chaotic versus an office where you could you know, kind of direct who you speak to when and how you structure things, I think more effectively."
I never know if the parent is going to be available to talk	"I just feel more so now that I never know if the parent is gonna be available to talk sometimes. And whereas again before when they were just in person, I found more often I like was like, okay, parents are going to drop them off. I can take them in for a couple of minutes. Whereas now it just it feels like just generally so much more fluid."
Children walking away from the screen/exiting the session	"Because I would have kids that after five or 10 minutes they would just walk away, they were done, who had previously sat with me for 45 minutes doing a lot more hands on stuff. That still remains a challenge with some of the kids I see."

3rd Supporting Theme:
Increased creativity needed for telehealth

Repeating Idea	Relevant Text Example
Need for additional theatrics when providing CBT via telehealth	"I definitely felt like I was I was performing all day. It was like a lot of theatrics and a lot of keeping things moving and joking and falling out of my chair doing all kinds of reenactments of what ADHD is, it felt like I was, it was like a constant movement."
Learning creative ways to engage the children via telehealth	"There was more effort put into planning and ensuring that the session could be effective and engaging for them."
Incorporating interactive virtual tools	"One of the things that I find facilitates work via telehealth is having either engaging in some sort of if we're doing any rapport building activity or an in-session reward, doing an online game that people had mentioned or utilizing, like taking any worksheets or

	other things that I may have done in person and translating those to a PowerPoint or something that we can do together. Showing videos, just using those sort of like interactive resources it can help rather than just acting like okay, you're just sitting here and I'm sitting here."
Use of creative at-home rewards	"It was great that I had reinforcers that I'd never had before where like they could immediately go and do something in their house they wanted to do or you know, like that. Didn't have to wait to go home to do that type of thing. "
Need for physical tools/prizes	"…definitely easier to be able to give stickers and bells and whistles and have some toys in the office to help them engage…"

4th Supporting Theme:
Amount of caregiver involvement via telehealth either remained the same or increased in comparison to in-person treatment

Repeating Idea	Relevant Text Example
Same amount of caregiver involvement via telehealth	"I tend to do more collaborative work with parents, so parents were a part of the sessions just as much as they are, you know, in person."
Easier to get caregivers involved in treatment over telehealth	"It's so nice that we can have a session at noon on a Wednesday while they're at work. And, you know, one parent can join from one place and one parent can join from the other. And I think that just allows for maybe parents that weren't so engaged or weren't able to come to sessions that are now able to do that. So I think that's a big advantage of that."
Working a lot more with parents for a lot more of every session via telehealth	"The interventions themselves like I found myself modifying a lot of things and working a lot more with parents for a lot more of every session."

5th Supporting Theme:
Therapeutic advantages of child being in their home environment

Repeating Idea	Relevant Text Example
Being able to be in vivo was an advantage	"I predominantly treat anxiety and OCD and so I'm predominately using exposure-based treatment. And so a lot of times I found that, you know, we were creating exposures when we were in person that were analogues to what the patient was experiencing at home. The chance to do telehealth allowed me to actually do exposures in the environment where kids really were experiencing their feared stimuli so that was a really positive experience about providing telehealth."
Helpful to have children in their natural environment	"…being able to just like see so much more. I feel like it gave a lot of really good insight into some of the

	things that like parents were talking about, that they were seeing at home that maybe we weren't seeing in the office."
Insight into family dynamics/interactions within the home environment	"And then you get to see things you wouldn't normally see and you can bring the sister in for a minute and you could bring the mom in for a minute and logistically it ended up making a lot of things easier."

Table H4

4th Theoretical Construct: Telehealth Experience has Varied Positive and Negative Impacts on a

Case-By-Case Basis on Psychologists and Children

4th THEORETICAL CONSTRUCT: TELEHEALTH EXPERIENCE HAS VARIED POSITIVE AND NEGATIVE IMPACTS ON A CASE-BY-CASE BASIS ON PSYCHOLOGISTS AND CHILDREN	
1st Supporting Theme: **Psychologist's telehealth experience generally more positive with older or more advanced children**	
Repeating Idea	Relevant Text Example
Much easier to engage the older or more advanced children via telehealth	"I felt like with the older kiddos, it was much easier to engage them and I feel like they were also just more used to that kind of communication with folks because they FaceTime their friends and whatnot."
Hard time working with younger children via telehealth	"But when working with the very young children, I had a very hard time because we're very hands on and even if I asked for them to have the same kind of games and whatnot or, you know, 'show me what you have around and let's work with that,' they had a lot more difficulty relating to what I was doing or understanding what I was saying or trying to get across."
Telehealth effectiveness depended upon the age of the child	"And a lot of the interventions I've found difficult it really depended upon the age."
2nd Supporting Theme: **Effectiveness depends on the specific child and specific presenting problem(s)**	
Repeating Idea	Relevant Text Example
CBT via telehealth more challenging for children with executive functioning issues and children on autism spectrum	"For others, especially ones that I see that are on like the autism spectrum and ADHD, I have switched back to in person with them because I feel like I've made progress a lot quicker in person with those kids."
CBT via telehealth effectiveness on a case by case basis	"It's really case specific as to whether or not it's going to be as effective."
3rd Supporting Theme:	

Telehealth has both positive and negative impacts on psychologists' personal lives	
Repeating Idea	Relevant Text Example
Psychologist's self-care was adversely affected doing telehealth	"I found at the end of the day, I needed a nap, it was exhausting. I think the brain gets different signals than before so I think I found it just very tiring."
Loosening of psychologist's boundaries	"I don't know if this is a disadvantage or an advantage probably dependent on the moment, but I did find that I was often offering more about my own state and personal being in the area where I am and things like that then I typically would be in the office, right like I don't have like in an office like any pictures of my family or anything like that."
More flexibility as a clinician and helps balance my life	"It's nice to have my week sort of, I'm able to sort of balance my own life in the way that I want and it gives me more flexibility just as a clinician and reduces my burnout."

Table H5

5th Theoretical Construct: Psychologists' Attitudes Regarding CBT via Telehealth Were Mixed,

Though More Positive Than Negative

5th THEORETICAL CONSTRUCT: **PSYCHOLOGISTS' ATTITUDES REGARDING CBT VIA TELEHEALTH WERE MIXED, THOUGH MORE POSITIVE THAN NEGATIVE**	
1st Supporting Theme: **Psychologists' positive experiences with telehealth**	
Repeating Idea	Relevant Text Example
My experience was largely positive	"I think my experience was largely positive."
It went better than I would have expected	"I thought the transition worked better, went better, than I would have expected. Right pre COVID, you would have asked me if I you know what I thought about telehealth, I would have said 'well, probably it wouldn't work as well as in person.' But I found, to my surprise, that it worked, you know, nearly as well."
Providing CBT via telehealth got a lot easier over time	"Now I feel like things have gotten a lot easier."
2nd Supporting Theme: **Psychologists' negative experiences with CBT via telehealth**	
Repeating Idea	Relevant Text Example
Not clear if it's actual CBT	"I feel like I was modifying interventions to the point where it was not clear if it was like actual CBT. It just kind of became something like new. And usually not as effective."

CBT via telehealth less effective than in-person	"Even with the older ones that I work with, it is so much better and so much more effective in person than it is via telehealth, like by leaps and bounds."
The transition to telehealth was very difficult	"I transitioned relatively abruptly due to the pandemic. I found it very difficult."
3rd Supporting Theme: **In-person therapy is preferable to virtual**	
Repeating Idea	Relevant Text Example
If I don't have to do it, I don't do it	"But I did transition back to in person as fast as I could and nowadays I hardly see kids on Zoom. Hardly. Like if I don't have to do it, I don't do it."
Nothing replaces the in-person experience	"There is no replacement I think to be in the same space with another person."
Therapy has a different feel in-person	"The intuition we have in just getting somebody's feelings or getting what they're not saying, and just getting their mood even if they're not expressing it. That was definitely diminished."

Table H6

6th Theoretical Construct: CBT via Telehealth for Children is Effective and has a Long-Term

Future Beyond the Pandemic

6th THEORETICAL CONSTRUCT: **CBT VIA TELEHEALTH FOR CHILDREN IS EFFECTIVE AND HAS A LONG-TERM FUTURE BEYOND THE PANDEMIC**	
1st Supporting Theme: **CBT via telehealth is effective**	
Repeating Idea	Relevant Text Example
Effectiveness remained the same	"I think the effectiveness has been maintained across telehealth versus in-person."
Work was still being done and progress was still being made	"I would venture to guess that you know, whatever studies come out, it's going to find that the work was still being done and progress was still being made and, and kids and families were getting better and even during such a stressful time."
Telehealth more effective in some ways	"I don't do a ton of work with socially anxious kids, but I can think of two socially anxious kids that I worked with where it felt like once we switched to virtual, I hit the jackpot. Like they turned their camera off and just like felt like they were chatting, chatting, chatting and telling me all sorts of things that I had never heard before. Mostly, I think because they didn't have to look at themselves and maybe didn't have to you know, they were in their own

	house and in their own bed and in their own environment in a way that probably made them feel pretty comfortable."

2nd Supporting Theme:
Psychologists and patients will continue to engage in CBT via telehealth

Repeating Idea	Relevant Text Example
Telehealth is here to stay	"I think that it's here to stay. It's very positive, I think for our field."
I will absolutely continue to provide CBT via telehealth	"It will definitely remain an option for my clients, whether for all of their sessions, for just those sessions where they have a conflict with traveling or are sick, or any other as needed reason."
Large majority of patients continue to use telehealth	"Even though, I'm in my office, and I will see zero patients in person today, or tomorrow, or Wednesday. I think I have one on Thursday. So maybe all week I'll have one in-person session and the rest of the load is telehealth for a variety of reasons."
Families/patients prefer telehealth	"It's been interesting to see that people prefer it."

3rd Supporting Theme:
Long-term considerations regarding the delivery of telehealth services

Repeating Idea	Relevant Text Example
Now your license is what's stopping you and nothing else	"I acquired like the licensing through PSYPACT. So if they are in a PSYPACT state or even if they're traveling within state but are too far away from the office, like all of a sudden, you know switching to virtual which in the past might have sounded like 'oh, like we don't really do that.' All of a sudden it's like oh yes, we very much do that. And it's not a problem to have an appointment in that format anymore."
Importance of teletherapy being covered by insurance in the same way that in-person is covered	"I'm very involved in legislation regarding psychologists in New York State and so there's a very big push to have this covered in the same way that in-person is covered."
Potential of CBT via telehealth not even fully tapped into yet	"And I think the potential is not even fully tapped into"
Telehealth adaptations impacted post-COVID work	"And now coming out of telehealth, I find that that's how I'm structuring my in-person sessions with kids as well. So I think it was a really nice takeaway on how to do more of the, like I said, the [behavior therapy]."

4th Supporting Theme:
Advantage of a hybrid approach

Repeating Idea	Relevant Text Example
Hybrid model needs to stick around	"I think that definitely some kind of hybrid needs to stick around."
Allowing for flexibility and option to come in person	"…allows for flexibility if either of those are not working, like if we're starting in telehealth and that's not working out, at least there is the option to come in person. Like, 'I

do have in person days. I think this is what we need to do for the betterment of our treatment. Let's shift to those in-person days.'"

Appendix I

Recommendations for Future of CBT via Telehealth for Children

Recommendations for Future of CBT via Telehealth for Children

Provider Recommendations	Family Recommendations	Systems Recommendations
Address safety and privacy issues before treatment	Limit child's screen use during the day before therapy	Didactics on providing CBT via telehealth to children
Set expectations for treatment at outset of teletherapy	Discuss conduciveness of therapeutic environment with provider before treatment	Continuing education courses on working with children and families via telehealth
Provide information on telehealth platform and technology to families before treatment	Remain nearby during sessions	Incorporate CBT via telehealth training into training programs' curriculums
Incorporate feedback questionnaires for families and providers into practices		Incorporate feedback questionnaires for families and providers into practices
Adapt in-person resources for virtual use		Adapt in-person resources for virtual use
Assess patient's full body on screen/ask caregivers information assessed in person (i.e. hygiene)		Insurance companies and licensing rules progress in same direction as telehealth
Mail materials to families		Increase access to technology in underserved areas (i.e. through Department of Education or insurance companies)
Provide schedule of therapy before session		Create interactive virtual tools
Maintain same schedule/caseload per day via telehealth as in-person		

Meet child in-person before
transition

Increase time and energy spent on
rapport building

Assess families' access to
technology and provide guidance
on ways to access technology