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ORIGINAL PAPER

Towards the Development of Educational Core Competencies for Couple and Family Therapy Technology Practices

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Abstract Rises in technology have created change in the family therapy field. The ethics code and regulatory boards now include areas on technology in family therapy practices. These additions require competency in the area of couple and family therapy technology practices. Previous researchers suggest there is a gap between these competencies needed and the training provided, as well as the research available. Thus, the purpose of this mixed-data survey study was to gain information regarding family therapists' experiences and perceptions of education regarding online family therapy practices. To do this, we administered a survey to family therapists across the United States. Reported, are both quantitative, as well as qualitative findings. The majority of the sample reported that they did not learn about online technologies in clinical practice; however the majority of the participants would like to learn more about couple and family therapy technology practices. The most direct implication of the findings from our study is the need to offer specific education around couple and family therapy technology practices. Suggested core competency areas to cover include theory, research, and practice around technology.

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Introduction

New technological advances have created a space for the valuing and learning of information regarding online clinical practices (Livingstone and Bober 2005). This is leading to a transformation in the family therapy (FT) field. For instance, for the first time in the FT field's primary code of ethics—the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics (2015)—there is an entire section focused on technology (Blumer 2014). The inclusion of this standard is significant as it is through the ethical codes of a professional organization that the standards for what are the expectations regarding competency (Jencius and Sager 2001) are made clear—in this case competency around online therapy and supervisory practices.

What does the AAMFT see as being needed in order to be ethically competent when engaging in couple and family therapy technology (CFTT) practices? In summary, Standard VI: Technology-Assisted Professional Services (AAMFT 2015) calls for FT professionals to: (1) be aware of and compliant with all of the laws related to the delivery of CFTT practices, (2) include in one's written consent the provision of any CFTT services, including the risks, benefits, limitations, and potential issues around confidentiality and security, (3) be able to discern when CFTT services are appropriate and if so determine which kinds are most apt, and (4) participate in CFTT services only upon completion of the appropriate education, training, and/or supervision enabling one to be competent in the providing of such

services, and in a manner that is consistent with current best online practices (Blumer 2014).

A review of the 2015 Association of Marital and Family Therapy Regulatory Board (AMFTRB) Examination in Marital and Family Therapy task and knowledge statements also serves as a further example marking the FT field-based change regarding recognition of CFTT practices, and the need for knowing and learning about such services. Indeed, participants in this examination are now assessed over a number of CFTT areas including: the use of technology in accordance with legal, ethical and professional standards (Task Statement 06.17), the impact of clients' use of resources including online assessments (Knowledge Statement 59), statutes, case law, and regulations related to online practices (Knowledge Statement 62), implications of the use of technology by clinicians and administrative staff (Knowledge Statement 65), ethical considerations in the use of technology by clinicians and administrative staff (Knowledge statement 66), the impact of technology on client systems (Knowledge Statement 67), and the conducting of online therapy (Knowledge Statement 68) (AMFTRB 2015).

Gaps in Couple and Family Therapy Technology Education

The examples presented above mark the need for being competent around CFTT practices (Baltimore 2000). Despite this need, very few clinicians and supervisors are receiving this kind of content in educational venues (Blumer et al. 2014a). For instance, previously between 73 and 82 % of marriage and family therapy (MFT) respondents' reported that cyber topics were not covered in their graduate training (Goldberg et al. 2008). In addition, from 2005 to 2009, a mere 1.2 % of the presentations at annual AAMFT national conferences were devoted to cyber issues (Blumer et al. 2014a).

In addition, FT trainees and professionals alike looking to the literature to learn more about education and training are likely to find little information regarding CFTT educational and training practices (Williams et al. 2013), specifically with regard to the competency areas identified in the AAMFT Code of Ethics (2015) and in the AMFTRB (2015) statements. Indeed, in a content analysis of the top 17 journals of the FT field of the 13,274 articles published between the years 1996 and 2010 only 79 focused on technology and of these a mere 17 articles or 22 % focused on education and training as it relates to online practices (Blumer et al. 2014a). These education and training articles focused on: the ways therapists can use online technologies to augment offline treatment, the use of the Internet as a tool in helping clinicians understand how to learn and implement various modalities and to help clients manage online information and communications in ways that are useful, the Internet as a tool for improving the health and psychological adjustment of clients, the need to be cautious of online misinformation and fraudulence, and the need for attentiveness to cultural considerations inherent within the use of the Internet for oneself and one's clients (Blumer et al. 2014a).

Given the little previous field-based information regarding CFTT education and training practices, there appear to be knowledge gaps regarding what FTs are learning with regard to CFTT practices, despite some of the expectations around what they should know regarding CFTT practices. Indeed, there is a need for being competent around CFTT practices via training, yet there are no clear guidelines for such training nor are there clear core curricular competency expectations around what trainers should teach with regard to CFTT practices (Baltimore 2000).

Towards the Development of Educational Core Curricular Competencies for CFTT Practices

Despite the shifts in the FT field to focus on competency around CFTT practices there have been no core curricular competencies established around this therapeutic area. Indeed, in both the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE 2005) current version 11 standards and the upcoming 2016 version 12 standards (COAMFTE 2014) there is a lack of focused attention to specific curriculum content regarding CFTT practices. The closest is in version 12 under FCA 8: Contemporary Issues where it is mentioned that students need to develop "competencies in emerging and evolving contemporary challenges, problems, and/or recent developments…This includes such issues as immigration, technology…" (COAMFTE 2014, p. 23). While this is a welcomed call for competencies around technology in FT programming, such competencies have yet to be established in our field making it difficult to address them (Winter and Bamond 2014).

In a related field, counseling psychology, there is also a lack of structured means in graduate programming for training future mental health helping professionals to work in online settings (Mallen et al. 2005). Yet, in this field some training guidelines and related areas of competency regarding online counseling have been acknowledged. Such areas include training aimed at fostering competency around: the technological tools of online counseling, computer-mediated communications, similarities and differences between online and face-to-face (FtF) counseling, practice and supervision of role-played or actual online counseling, training of overt communication of therapeutic emotions like empathy and warmth in online environments,

supporting informal experiences of trainees in various online platforms and related interactions, participation in both FtF and online supervision, exploring and applying knowledge of multicultural issues in online environments, and discernment of online counseling practices across varying populations, state lines, and degrees of accessibility (Mallen et al. 2005).

Much like the developing of core competencies, or "a collection of the basic or minimum skills that each practitioner should possess in order to provide safe and effective care'' (Graves 2005, p. 15), in general, our field has been slower to address what are the necessary skills of our trainees, practitioners, and trainers in comparison to related helping professionals like the medical and psychological fields (Nelson et al. 2007). In this context, it follows that there may be some lag for us in addressing the technological core competencies needed to engage in CFTT practices.

Method

To add to the literature around beginning to establish what are perceived to be some of the educational areas needed in training programs for fostering competency around CFTT practices, and to determine the degree to which FTs believe such education needs to be included in training programs, as well as to examine the interest in gaining such education and/or becoming certified in the practicing of CFTT services we conducted a mixed-data survey study of FTs.

Procedures

This study, which was approved via a university-based Institutional Review Board (#1012-3675), focused upon FTs' perceptions of education and training around CFTT practices. Findings from this study were a part of a larger study focused on perceptions of technological usage of FTs in general (see Blumer and Hertlein, in review; Blumer et al., in revision; Hertlein et al. 2014a, b). Funding for this study was made possible by the Alaska Association for Marriage and Family Therapy (AkAMFT). The participants in this study were FT supervisees, students, faculty, clinicians, and supervisors working in a variety of settings. For a more detailed description of the procedures, see Hertlein et al. (2014a, b).

Instrument

We used a survey to attain mixed-data—that is, incorporating both quantitative and qualitative data. Mixed-data studies are those which attempt to describe trends using standalone statistical-based data, as well as separate rich, thick narrative descriptions in order to better understand the phenomenon of study in two similar yet distinct ways (Blumer et al., in revision). In this way data is obtained that is both complimentary and supportive of the findings attained through each type of data, thereby offering a more comprehensive understanding of the phenomenon of study (Gambrel and Butler 2013).

Our original survey contained 51 items and was divided into separate sections: information about the participant's practice, use of online technologies in clinical practice, use of technologies in supervision, education and training (the focus of the current article), ethical considerations regarding online practices, engagement in online professional networking, and demographic information. The mixed-data survey contained multiple choice items, 6-point Likert scale items, as well as open-ended questions. Quantitative questions included: inquiring as to if participants had received education around CFTT practices and if so in what venues had they received such education, participant interest in learning about CFTT clinical and/or supervisory practices, support for graduate training programs teaching about CFTT clinical and/or supervisory practices, and participant interest in attaining certification in CFTT practices. For a more detailed description of the survey items, see Hertlein et al. (2014a, b).

The qualitative question focused on what participants believed to be the specific content areas necessary in learning about CFTT practices. An open and thematic coding process was used to analyze the responses to the open-ended survey items (Merriam 2002). Through this process, the first and second authors' reviewed the data and identified themes. They then compared themes for agreement and overlap and then compiled a final list of themes. The final list of themes was then reviewed for trustworthiness by one of the authors' graduate students at the time of the study.

Results

Sample

A total of 765 paper surveys were distributed via mail, and of these 101 were returned. These completed paper-based surveys were entered into an online survey tool (QuestionPro®) by a graduate assistant. An additional 126 participants completed the survey via the online survey tool, resulting in a total of 227 licensed marriage and family therapists (LMFTs), and AAMFT clinical members, students, and approved supervisor member participants. The sample was predominately composed of Caucasians ($n = 179$, 79 %), and females ($n = 181$, 79.7 %). The gender of the rest of the participants was male ($n = 46$, 20.3 %) The remaining ethnic and/or racial breakdown of

participants was as follows: 11.1 % identified as mixed ($n = 25$), 5.28 % ($n = 12$) identified as Hispanic/Latin American, 2.27 % ($n = 5$) as African American/Black, 1.7 % ($n = 4$) as Asian American, and the remaining identified as American Indian or Alaskan Native ($n = 2$, .88 %). The age range of participants was between 27 and 81 years, with a mean age of 45.3 years.

A full quarter ($n = 67$, 27.46 %) worked in a university-based graduate program. Another 21.23 % ($n = 48$) worked in a non-profit agency setting. The remaining participants worked in for-profit agencies, medical facilities, employee assistance programs, and other ($n = 37$, 16.37 %). An almost even number of participants worked part-time ($n = 112$, 49.3 %), and full-time ($n = 111$, 48.9 %), and the remainder reported "other" as their employment time status. In terms of the larger contextual setting—48.5 % ($n = 110$) reported being based in an urban practice setting, 39.2 % ($n = 89$) suburban, and 12.3 % ($n = 28$) in a rural setting.

Learning About Online Technologies in Practice

Participants reported their prior educational experiences (or lack thereof) with regard to online technologies in practice (see Table 1). The majority of the sample reported that they did not learn about online technologies in clinical practice ($n = 76$, 24.2 %). When they reported learning about such practices it was primarily through graduate coursework ($n = 51$, 16.24 %), or via continuing education ($n = 51$, 16.24 %), or through the reading of scholarly literature ($n = 55$, 17.52 %). The least common places participants reported learning about online technologies in practice were in the contexts of clinical practice ($n = 36$, 11.46 %), clinical supervision ($n = 21$, 6.69 %, and other (i.e., peer networking, colleagues, on the job, informally, research, etc.) ($n = 24$, 7.64 %).

Participants also shared information regarding the *one* context in which they learned the *most* about online technologies in clinical practice, and reported learning the most information via continuing education ($n = 41$, 18.1 %), followed by graduate coursework ($n = 39$, 17.2 %), and then via the reading of scholarly literature ($n = 26$, 11.5 %). Fewer participants reported learning the most via clinical practice ($n = 19$, 8.4 %), through other venues ($n = 19$, 8.4 %), or in the context of clinical supervision ($n = 5$, 2.2 %).

Support for and Interest in Learning About Online Technologies

Study participants shared their interest in learning more about CFTT practices, as well as their support of graduate training programs including information regarding online technologies in practice and supervision.

Interest in Learning About Online Technologies

The bulk of participants expressed interest in learning more about online technologies in clinical practice to the highest degree ($n = 76$, 33.5 %), most interest ($n = 53$, 23.3 %), or reported a lot of interest (n = 36, 15.9 %). The remaining participants expressed less interest (i.e., $n = 29$, 12.8 % some interest, and $n = 16$, 7 % indicating little interest). Finally, a small percentage of participants, 7.5 % ($n = 17$), reported no interest in learning about online technologies in clinical practice.

In terms of interest in learning more about online technology use in supervision, although there was less interest in learning about such technologies in this context, there was still a great deal of interest. Indeed, the majority of participants expressed interest in learning about online technologies in supervision to the highest degree ($n = 50$, 23.92 %), most interest ($n = 48$, 22.97 %), or expressed a lot of interest ($n = 28$, 13.4 %). The remaining participants expressed less interest (i.e., $n = 30$, 14.35 % some interest, and $n = 12$, 5.74 % indicating a little interest) in learning about online technologies in supervision. Finally, just under one-quarter of the participants, 19.62 % ($n = 41$), reported no interest in learning about online technologies in supervision.

Specific Technology-Related Content Areas Necessary in Learning About Online Technologies

Survey participants also responded to an open-ended question regarding what they believe are necessary technology-related content areas that need to be learned with regard to online clinical and/or supervisory practices. Five themes emerged including: (1) ethical and legal concerns regarding online practices, (2) confidentiality and privacy issues in using cyber-based technologies in practice, (3) general information regarding how to conduct clinical and supervisory practices online, (4) precautionary measures of safety and security for usage when engaging in online practices, and (5) evidence-based support for online practices (see list of themes in Table 2).

Ethical and legal concerns regarding online practices were the overwhelmingly predominate areas that participants reported necessary in learning about online technologies in practice. The bulk of participants shared that they needed to learn more about "ethical guidelines" or "ethical procedures" when engaging in online clinical and/or supervisory practices. In terms of legalities, participants reported the need for gaining more information regarding the "statutes and laws regulating practices via cyberspace".

The next major theme focused on confidentiality and privacy issues in CFTT practices. Many participants expressed "general concerns of confidentiality" and needing

Table 1 Frequency of learning about online technologies in practice by setting

Setting	N	%
Did not learn about online technologies in practice	76	24.20
Scholarly literature	55	17.52
Graduate coursework	51	16.24
Continuing education	51	16.24
Clinical practice	36	11.46
Other (e.g., peer networking, colleagues, friends, personal, etc.)	24	7.64
Clinical supervision	21	6.69

Table 2 Specific technology-related content areas necessary in learning about online technologies

Themes
Ethical and legal concerns regarding online practices
Confidentiality and privacy issues in using cyber-based technologies in practice
General information regarding how to conduct clinical and supervisory practices online
Precautionary measures of safety and security for usage when engaging in online practices
Evidence-based support for online practices

to gain more information regarding how to "safeguard client confidentiality". Several participants were concerned with client "privacy protection" and learning more about "HIPAA [Health Insurance Portability and Accountability Act] compliant technology."

Another common theme was that of needing to learn more about how to conduct clinical and supervisory practices online. Thematically the "how to" of conducting online practices manifested itself in several ways. First, some participants reported the need to know more about the actual "nuts and bolts" of how to engage in online technological practices as was reflected in statements like "I would want to learn about how to use the programs used in the [online] process" and wanting to know more about "its application". Second, some participants reported learning more about the forms of online technologies that were available for use in conducting supervision and/or clinical practices as a necessity. For instance, participants expressed that knowing more about their technological "options" for online practices and specifically learning more about how to use certain technologies like "texting" and/or "online video chatting (Skype™, etc.)" was essential. Third, and finally, participants reported a need for knowing more about how to develop a "therapeutic relationship online", including how to "assess" and "communicate and read non-verbal language/emotions through the screen".

Another theme revolved around participants needing to learn more about precautionary measures they can take to safeguard client safety and security when engaging in online practices. For instance, participants reported the need to learn about "cyber safety in practice", "malpractice risks", and "liability issues". They also noted the importance of learning more about cautionary measures in terms of considerations on the part of the clinician and client. As captured in the following participant statement regarding what they believed they needed to learn more about specifically, which was "how to ensure that the appropriate precautions on both ends of the cyber connection are made."

The fifth and final theme was that of participants need to learn more about the evidence-based support for online practices. This theme was noted by participants to a lesser degree than the previously introduced themes, however, when noted it was done so with a high degree of consistency. Participants repeatedly shared needing more specific education around the "outcome effectiveness of cyber based treatments." Similarly, yet even more specifically, other participants shared that they would "like to [know] if using cyber-based technologies were more effective than in-person supervision" or said similarly provide instructional materials that "convince me that such technologies are effective generally and are as or more effective than face-to-face therapy."

Support for Graduate Programs Teaching About Online Technologies

The majority of participants expressed a high degree of support for graduate programs teaching about the use of online technologies in clinical practice ($n = 87$, 38.3 %), followed by expressing most interest ($n = 54$, 23.8 %), and then a lot of interest ($n = 36$, 15.9 %). Fewer participants expressed some interest ($n = 30$, 13.2 %), or little interest ($n = 11$, 4.8 %). Very few participants, (n = 9, 4 %), reported no interest at all in graduate programs teaching about CFTT practices.

In general, there was less interest in graduate programs teaching about online supervision in comparison to online

therapy. The majority of participants reported the most support for graduate programs teaching about the use of online technologies in supervision ($n = 51$, 24.4 %), followed by expressing a high degree of interest ($n = 49$, 23.44 %), and then a lot of interest ($n = 37$, 17.7 %). Fewer participants expressed some interest ($n = 27$, 12.92 %), or little interest (n = 9, 4.31 %). Finally, several participants, ($n = 36$, 17.22 %), expressed no interest at all in graduate programs teaching about the use of online technologies in supervision.

Interest in Certification in Online Clinical Practices

Participants reported on their interest level in gaining certification to specialize in online clinical practices. The bulk of participants were polarized on their interest regarding specialization in online clinical practices; 49 (21.6 %) reported a high degree of interest and 52 (22.9 %) reported no interest at all in becoming certified to specialize in online practices. The remaining participants reported having little interest ($n = 42$, 18.5 %), a lot of interest ($n = 32$, 14.1 %), the most degree of interest ($n = 30$, 13.2 %), or some interest ($n = 21$, 9.3 %).

Discussion and Implications

Our finding that the majority of our sample reported that they did not learn about online technologies in clinical practice is consistent with the previous research (Goldberg et al. 2008). When participants did report learning about CFTT practices it was in the context of graduate schooling, via continuing education or through the reading of scholarly literature. They also shared that of the contexts in which they learned the most information had been gained via continuing education, followed by graduate coursework and then scholarly literature.

Even though participants are not having much opportunity to learn about CFTT practices; they have a very high interest in doing so, particularly online clinical practices. Given the changes in the AAMFT Code of Ethics and the national AMFTRB licensure exam, it appears that it is virtually required for people to do so. So this is a good match between what the field is valuing and what participants are valuing. But, where, when, will, and what should they be learning with regard to CFTT practices?

In the current study, the place where people are learning about CFTT practices is during graduate training and there is a very high degree of support for graduate programs teaching about the use of online technologies in clinical practice. So, it follows that during graduate schooling is when we should be training FTs in the area of online therapy. This is also ideal timing in the context of the previous literature that has demonstrated that training around online counseling should begin as early as possible as frequently experienced providers are less likely to acclimate themselves to the new mode of service delivery (Mallen et al. 2005).

Training Implications: Identification of the CFTT Core Competencies

The most direct implication of the findings from our study is to offer specific education around CFTT practices in graduate coursework in particular, but also in continuing education opportunities as well as in the literature (Blumer et al. 2014b). Offering such information in the literature was also the same conclusion reached by Blumer et al. (2014a) in their content analysis of attention to technology in the top FT journals. Indeed, in their analysis an implication was that there needs to be more written scholarly attention to the training and teaching of CFTT practices (Blumer et al. 2014a). We propose three areas of core competencies in CFTT education: competencies in theory, research, and practice.

Core Competencies with Regard to Theory

With regard to theory, FTs should have familiarity with theories and frameworks that explain the impact of technology on couple and family life. For instance, the Couple and Family Technology (CFT) framework identifies specific characteristics of technology and new media and their influence on the processes and structure of couple and family relationships (see Hertlein 2012; Hertlein and Blumer 2013) and its framework is both relevant and flexible enough to be applied to the way that technology influences the nature of clinical relationships (see Blumer 2014; Blumer, in press). This theory is drawn from theories in other disciplines such as domestication theory (Haddon 2006), the structural-functionalist perspective (Johnson 1971), interaction-constructionist perspective (Berger and Kellner 1970), and the family ecology perspective (Granic et al. 2003), to name a few (Hertlein 2012). Understanding each of these theories will illuminate the varied ways in which technology can play a role in system dynamics and problem generation/maintenance.

Core Competencies with Regard to Research

We believe as trainers considering implementing what we believe to be the cornerstone of the educational core competencies around CFTT practices it is important that one makes use of the current research in the emerging field of CFT Studies (Hertlein and Blumer 2013). Core competencies in the area of research would be developing

knowledge of the literature highlighting the evidence-based support for online practices. For example, there is effectiveness research supporting the practicing of online (web-based or telemental health) treatments for mental health disorders such as anxiety, panic, obsessive–compulsive, depression, and some addictions (Carlbring et al. 2005; Hailey et al. 2008; Mackinnon et al. 2008; Robinson and Serfaty 2001; Spek et al. 2007; Wiersma et al. 2011; Wootton et al. 2011). There are also settings, populations, and circumstances in which the use of online clinical practices may have advantages over FtF clinical practices. Some such advantages include providing access to clients in remote geographical areas, the ready availability of specialists through the Internet, opening up of more providers to families, ability to time-shift sessions to a convenient private part of the day, and the availability of services to those who are differently able and may not be able to readily access an onsite therapist via their physical location (Sussman 1998).

Core Competencies with Regard to Clinical Practice

From the qualitative data in the present study, core competencies for clinical practice when educating around online technologies include: ethical and legal concerns regarding online practice, confidentiality and privacy practices when utilizing online technologies in practice, general information regarding the nuts and bolts of how to conduct CFTT practices, the precautionary measures of security and safety when participating in CFTT practices, and the evidence-based support for CFTT practices (Blumer et al. 2014b). In addition, as there was a higher degree of interest in online treatment service delivery than online supervisory practices, master's-level training programs may elect to focus more on online clinical therapy rather than online supervisory engagement. This latter implication may be a product of the setting in which the bulk of participants resided—master's level FT programs. These findings could be different if the bulk of FT programs were doctoral in nature.

In addition, evidence-based online therapy modalities are being developed, of which FTs could be trained to implement, and subsequently use in working with clients. The therapist-assisted Internet cognitive behavioral therapy (TAICBT) service is one such modality which has been effectively implemented in working with clients experiencing depression and anxiety (Hadjistavropoulos et al. 2011). TAICBT provides clients with psycho-educational information and cognitive behavior therapy (CBT) treatment material geared toward a specific disorder or symptom (Hadjistavropoulos et al. 2011). The materials are presented in a structured modularized format, between four to twelve modules, using various multimedia features, such as text or video (Hadjistavropoulos et al. 2011). To facilitate learning, clients work on offline assignments following the completion of each module. TAICBT also involves an identified therapist, who provides support, encouragement, and directs therapeutic activities remotely (Hadjistavropoulos et al. 2011). Contact happens about once a week by e-mail or telephone. So far, randomized controlled trials have shown TAICBT to have better outcomes than clients on a waiting list and those that participate in discussion groups (Hadjistavropoulos et al. 2011). In a different study, Cuijpers et al. (2010) found that TAICBT provides client outcomes comparable to best practice CBT offered FtF.

Core competencies in clinical practice can be taught via vignettes and case studies focused on helping trainees work through common online issues related to ethics, legality, technology, and the developing of an online therapeutic alliance (Blumer et al. 2014a).

Offering education and training around CFTT practices would also be in alignment with the current AAMFT Code of Ethics and Standard VI: Technology-Assisted Professional Services (AAMFT 2015), and would help prepare students for those knowledge and tasks statements they are to be examined on via the AMFTRB before becoming licensed.

Limitations

One limitation of this study was the sample. A sample with a greater number of participants might have yielded somewhat different results. We feel fairly confident, however, that our sample is representative of a larger sample because our sample shared similar characteristics to the practice patterns described by Northey (2002). A second limitation was that we did not specifically ask the participants to identify "core competencies" of FT training related to technology—rather, we generated the core competencies based on the data of what was known about technology in an FT's practice and what was not known and still needs attention.

Future Directions

This article, which presents the identified educational needs related to CFFT practices, serves as a first step into the conversation of what elements are critical in helping FTs understand and better manage the presence of technology in practice. The next steps will be to refine these competencies through incorporating them into training programs, workshops, and journal publications and subsequently evaluating their utility in clinical practice. Further, given our polarized finding regarding interest in specializing in online clinical practices via certification, more research of FTs aimed at exploring the pros and cons of such

certification, as well as the perceived advantages versus disadvantages around such certification, might be helpful in assisting FT programs in implementing greater inclusivity of CFTT practices into training.

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