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Rural Telemental Health and Adolescents: Try a Little Shakespeare

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ABSTRACT

Twenty-five percent of Americans live in rural areas, almost all of which are designated as mental health service shortage areas. This designation represents serious problems for adolescents needing help with predictable developmental problems. The project described serves communities without mental health professionals; uses telemental health technology, co-located in rural primary care clinics; and emphasizes communication and coordination among professionals and clients. An example of addressing identity formation in an adolescent experiencing significant family and relational stress is explored, including the resolution of an ongoing friendship problem by using a school assignment, an analysis of Shakespeare's Sonnet 48. Discussion includes safety, immediacy, and using bibliotherapy in telemental health with adolescents, as well as the appropriateness of telemental health for individual and parent-child sessions.

Adolescents show great variability in how they think and feel about themselves related to normal developmental processes. When a child enters puberty, biological changes are significant and signal many other developmental challenges. These challenges center on psychological and societal contexts, including relationships with parents, family, and peers (Brown & Klute, 2003; Erikson, 1968; Schneider, 2014). Challenges also encompass neurocognitive changes signaling an increased capacity for viewing situations from multiple perspectives, including an awareness of situations causing mixed emotions (Burnett, Thompson, Bird, & Blakemore 2011). Emotional changes in boys are not as well studied (Kroger, 2007), but pubertal changes in girls are associated with increases in depressive symptoms (Canals, Vigil-Colet, Chico, & Martí-Henneberg, 2005), self-consciousness (Simmons & Blyth, 2008), parent-adolescent conflict (especially with mothers) (Allison & Schultz, 2004), as well as decreased self-esteem (Feldman, 2010). Although these problems do not affect every adolescent girl, when they do occur, their impacts are notable and distressing for those concerned.

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In addition to physical changes, the influence of family structure, peer relationships and interpersonal issues appear have a greater influence on the development of identity for girls than for boys (Bartoszuk & Pittman, 2010; Cooper & Grotevant, 1987; Pastorino, Dunham, Kidwell, Bacho, & Lamborn, 1997). Whether this is a function of variations in neurocognitive development has yet to be demonstrated, but for girls the ability to identify with others from an emotional standpoint while experiencing personal emotions appears to be a central developmental process (Burnett, Thomson, Bird, & Blakemore, 2011).

Counseling rural adolescents

Often, professional counselors in schools and communities help adolescents navigate changes in significant relationships; however, access to counseling services for rural adolescents is limited. Almost all of rural America meets federal guidelines for mental health shortage areas, meaning that the ratio of population to professional provider exceeds 4,500 to 1 (U.S. Department of Health and Human Services, 2014). Twenty five percent of Americans live in rural settings, yet in general only 10% of the country's health professionals practice in rural settings (Shi, 2012). Whereas counseling help is available in urban settings, rural residents experience longer waiting times, must travel greater distances, and incur greater expense to access mental health care (Davis, Boulger, Hovland, & Hoven, 2007). In addition, children and adolescents in rural settings often experience a lack of school resources, especially counseling, because enrollment and budget constraints often require school counselors to be shared across multiple school districts or to hold multiple roles—counselor and teacher, or counselor and administrator, for example. Traditional private practice models of mental health care are unrealistic in rural settings due to sparse populations and the inability for single, rural communities to support full time practice. In addition, rural residents report a heightened sense of stigma association with mental health visits (Davis et al., 2007), primarily related to rural residents being aware of providers' offices and recognizing vehicles parked in associated parking lots. The closeness touted by rural residents as a feature of their towns can work against seeking help.

In response to a critical shortage of rural counselors, the Center for Rural Mental Health Studies (CRMHS) at the University of Minnesota Medical School, Duluth has developed a telemental health project, which now serves 12 rural Minnesota communities with populations between 300 and 3,500 people. Sites are based in primary health care clinics, with referrals initiated by family physicians and nurse practitioners. Clients are seen via secure televideo connections in the primary care clinic, often in examination/consultation rooms. Integrated, shared, or co-located services such as these allow

for coordination of care and a safer handoff of clients among professionals. Responsibility for the client and his or her records remains with the primary care provider. Written consultation notes are submitted to the client's clinic record, with copies of each note mailed to the client within 24 hr of service. The hub of the project is located in an urban setting, and staffed by licensed mental health providers. None of the CRMHS sites has community-based mental health providers available to them, and some sites are over 200 miles from mental health professionals, making telemental health services a valuable alternative (Davis et al., 2007).

Indirect, distance, and televideo or telemental health counseling

Distance and indirect counseling have been practiced for decades (Rosenfield, 2003; Rosenfield & Smillie, 1998). Freud notably conducted indirect sessions by letter in 1897 with the father of Little Hans (Stuart, 2007). Although privacy was a problem, direct, short wave radios were used in Australia, Canada, and territorial Alaska for emergency purposes in the mid-20th century. In addition, telephones have been used for counseling for the past 50 years (Reese, Conoley, & Brossart, 2006). The first forays into mental health care via internet connections occurred during the 1980s (Skinner & Zack, 2004), starting with email and mental health chat rooms.

Using remote technology carries obvious concerns about safety, confidentiality, and privacy, and the lack of fully encrypted platforms reduced the adoption and regulation of distance or televideo counseling (Mallen & Vogel, 2005). Internet-based systems are now capable of being fully encrypted on both sending and receiving ends making them privacy compliant. Internet face-to-face sessions can be conducted using camera systems capable of remote panning and zooming, which give great flexibility for viewing (e.g., Tandberg or Polycom systems). However, purchasing this equipment (often costing thousands of dollars per unit) has proved prohibitive for many sites. As encryption and high definition screens have become readily available in other platforms, our telemental health service has transitioned to portable and less expensive Apple Macintosh computers, which since late 2010 run encrypted Face Time programs for sessions. The built in cameras transmit in high definition, but panning and zooming are not available. Although Skype and Google Hangout are often used for video conferencing, encryption is a major concern and we have chosen not to adopt those platforms.

In the past decade, the CRMHS has provided services to 2,100 clients in over 5,800 sessions. Our clients seem comfortable with each system as reflected by patient satisfaction questionnaires showing 90% or greater high satisfaction. About 10% of our visits are with school age or adolescent clients. As would be expected, many of the presenting problems in this age group

stem from developmental challenges as they intersect with uncontrollable life circumstances.

The following case illustration and discussion demonstrate interactions between a counselor and adolescent via secure telemental health connections over a 5-year period. Sessions were intermittent and initiated by the adolescent and/or her mother via their primary care practitioner. Sessions focused primarily on coping with mood instability as well as relational changes during adolescence. In the discussion following the case, many of the questions posed about use of technology and the process of counseling are addressed. Many of the client's concerns centered on some of the predictable developmental concerns of adolescent girls: biological changes, friendships, and relationships with parents. A key component of the case presentations is a demonstration of spontaneous use of a high school English assignment in helping an adolescent understand painful, one-sided changes in an important peer relationship. The client's essay on a Shakespearian sonnet reflects her ability to analyze changes in a best-friend relationship from multiple emotional perspectives, described by Burnett et al. (2011) as a key developmental process in girls.

Case

Kate, now 19, was referred to our telemental health consultation practice as a 13-year-old. Her primary care provider was concerned about a prior diagnosis of depression, which was treated with fluoxetine without obvious benefit. Kate was quiet and almost shut down. Her mother noticed these changes and pressed the primary care physician for counseling. A diagnostic assessment performed at the time suggested dysthymia, now identified in the *DSM-5* as persistent depressive disorder (American Psychiatric Association, 2013).

Kate's family situation was far from ideal. Her mother, Marie, experienced persistent mental health problems after the birth of her second child when Kate was almost 5 years of age. Marie's illness subsequently included multiple hospitalizations for therapy and medication adjustment. Kate's father suffered from untreated alcoholism. During Marie's initial years of treatment, Kate and her father managed the household, including cooking, cleaning, and caring for Kate's younger sibling. Marie slept between 18 and 20 hr per day. The role reversal between Kate and her mother continued throughout Kate's childhood and adolescence, even after the mother's mental health improved. Kate's only relief from household duties was when she was able to attend school or play with her friend Elena at Elena's home. She often expressed the desire to be Elena's sister—to live with Elena and her family permanently. Conflict with her mother resulted in sadness, irritability, and a persistent

sense of hopelessness for Kate, which gradually escalated until Kate experienced puberty.

Individual counseling focused on helping Kate overcome depressive thoughts and feelings. Eventually, Kate's therapy included sessions shared with her parents focused on restoring more appropriate roles in the family as well as establishing predictable, consistent parenting. The goal was to relieve Kate of the adult burdens she had prematurely accepted and to afford her the opportunity to be more actively cared for by her parents. As a result of this intervention, much of the conflict in Kate's family subsided.

Although individual and shared counseling sessions for Kate helped restore balance in family relationships, Kate was aware that her friendship with Elena was changing. At first, she blamed her mother for interfering in their relationship, but over time, it was clear that the paths of both girls diverged after puberty. Elena became sexually active and Kate did not. Elena's school performance dropped, whereas Kate's improved. Elena found ways to humiliate Kate at school in front of mutual friends or to "dump" her in social situations. Kate would often remark on the shared promise, made in fourth grade, that she and Elena would be "friends forever." When it became apparent that Elena had forgotten the promise, Kate struggled with the cruelty of a one-sided commitment. She would often remark that Elena promised to be her friend forever and that a promise is a promise. With continued individual counseling, she was able to examine her expectations of others, especially Elena. But a lingering wound and a sense of being abused by her friend persisted. It wasn't until her English teacher started a unit on William Shakespeare's Sonnets that Kate gained deeper insight into her loss. She was assigned Sonnet 48 for analysis.

> How careful was I when I took my way,
> Each trifle under truest bars to thrust,
> That to my use it might unused stay
> From hands of falsehood, in sure wards of trust!
> But thou, to whom my jewels trifles are,
> Most worthy comfort, now my greatest grief,
> Thou best of dearest, and mine only care,
> Art left the prey of every vulgar thief.
> Thee have I not locked up in any chest,
> Save where thou art not, though I feel thou art,
> Within the gentle closure of my breast,
> From whence at pleasure thou mayst come and part;
> And even thence thou wilt be stol'n I fear,
> For truth proves thievish for a prize so dear. (William Shakespeare, 1609)

Kate remarked on the assignment in one of her individual sessions, reading the poem aloud and with encouragement, sharing her analysis. She was first dismissive of her own thinking about the sonnet, but was willing to

explore it in the context of her friendship with Elena. The exploration consumed the counseling hour, and at a follow-up session, Kate talked about her relief in letting go of a one-sided relationship. The discussion with Kate about her interpretation of the sonnet was insightful and full of reference to her lost relationship with the friend of her younger life, Elena. Kate's reflections on her own growth and the falsehood of her friend's early promises incorporated not only Shakespeare's meaning, but an acknowledgement that as people grow and develop their relationships change. She was also able to contrast the sweet naiveté of childhood promises with more adult perspectives, concluding that there are joys and sorrows in relationships, from which she is not immune. She acknowledged the one-sided nature of her valued relationship with Elena.

Kate could also relate Sonnet 48 to other promises broken: her mother's mental illness and her father's alcoholism and their collective impact on her childhood. As she compared her family to friends' families, she became more aware of what she had lacked as a child: engaged and involved parents, for example. She became aware of the role reversal she experienced and the associated loss of her early childhood freedoms. Although illness absorbed her mother's time, her father's work and alcoholism interfered with closeness among family members. It wasn't until they were in a counseling session that her father could even say aloud that he loved Kate. Kate was able to speak about her losses and the confusion she experienced in dealing with the truth of her life in and out of her family, including the prize of her love which was not valued or understood by others.

This became a different sort of treasure for her. As Kate has improved, her parents were focusing more energy on their own mental health as well as the well-being of both children. This has afforded Kate an opportunity to move forward with the challenges of young adulthood, leaving much of the emotional pain of childhood in its past contexts. She now realizes that as the child of her family circumstances, she was more vulnerable to misunderstanding or misinterpreting relationships. She is developing the wisdom to pursue healthy, engaged relationships rather than relying on fantasies about what her early relationships were meant to be. She has confronted divergent perceptions of her friendship with Elena and has found resolution in knowing that like her, Elena has developed and changed from the fourth grade girl she used to be.

Discussion

One of the concerns that some counselors have raised about telemental health counseling is whether client experiences are equivalent to more traditional, face to face counseling sessions. Is it possible to read client cues and respond appropriately? Does the technology interfere with exploration of

problems? How do older children and adolescents respond to sessions conducted in this way? Is it possible to conduct family counseling sessions using this technology? Can sessions be immediate and incorporate creative approaches to therapy? What avenues for spontaneity exist in these sessions?

Kate's case is presented to give a context for some of the questions posed, especially those related to counseling in telemental health settings, including the process itself. First, it is clear that Kate was able to develop a therapeutic alliance with her telemental health counselor, and that the counselor was able to expand the alliance to include family sessions using the technology. It is of interest that the absence of a physically present counselor appeared to increase the amount of emotional and physical support offered to Kate by each of her parents. All three unexpectedly commented on this phenomenon. While absolutely limiting the counselor's use of close gestures, the telemental health sessions allowed Kate and her parents to rely on each other for comfort. Unlike Kate and her parents, some clients may need gentle nudging to offer comfort to each other in joint sessions, and certainly these suggestions can be made in telemental health sessions as they are in face-to-face sessions.

A concern about the use of technology in counseling focuses on whether a camera and monitor interfere with the counseling process. We have found that technology "disappears" within the first few minutes of a session when counselor and client begin to work together to address problems. Counselors and clients alike have noticed this. Although a physically and emotionally present counselor is viewed as important, the quality of physical presence may be less important than hearing or being heard and seeing or being seen.

As a practitioner who has counseled clients via secure video connections in small primary care clinics for a decade, I would also like to comment on the intimacy of counseling adolescents using this technology. Kate, in particular, found it helpful to have me "at a distance." By that, she meant that she did not have to worry about how her revelations impacted me, because I wasn't physically present in the room except via a television screen. She once told me she felt safe to tell me things, because she knew she would never see me in her town or worry about who would know she was being seen by a counselor. Other telemental health clients have commented on how easy it is to disclose concerns to a less dimensional helper, than one who is physically present in the room. One client stated, "I feel safer telling you these things, knowing you aren't really here." These comments suggest that immediacy and its attendant effects can be experienced without a bodily presence.

It is a fact that as a whole, we are more connected to our technology, and perhaps telemental health counseling reflects the ability to connect technology and helping without risking casual encounters in unexpected settings in one's community, thereby helping to promote disclosure in sessions and reduce stigma. There appears to be ease in relating to a televised person,

which notably includes clients having complete control of the counseling space, including the on–off button. Not one of our clients has ever stormed out of a room or pushed the button to disconnect from a session. Ethical guidelines of the American Counseling Association (2014) acknowledge principles specifically associated with distance counseling, emphasizing the limitations of the counseling relationship conducted electronically. The benefits of counseling delivered at a distance need further exploration. In our project, one benefit is access for those who would be unable to easily receive the assistance of a professional counselor. At some future point, perceived sense of comfort and control might be of interest from a research perspective.

Another concern relates to whether there are opportunities for spontaneity or creativity in telemental health sessions, especially since the session is structured by the equipment used. It has been our experience that clients often bring or make reference to catalysts in their sessions—these can be music, pictures, poems, and stories, for example.

Certainly, bibliotherapy or therapy incorporating art forms is not new. A search of the U.S. National Library of Medicine using www.PubMed.org revealed 438 scholarly articles about the use of books in treating children, adolescents, and adults for various medical and mental health conditions, with the oldest citation dating from 1945 (Schenk, 1945). A similar search of ERIC (www.ERIC.ed.gov) showed 633 manuscripts about the use of literature in therapy, with 362 listed as peer reviewed. Materials in bibliotherapy can be self-assigned, encouraged by a therapist, or a mutual exploration involving client(s) and counselor. Bibliotherapy has never been seen as setting specific, hence its broad use from individuals to groups, including classrooms. There is no reason why it is inappropriate in telemental health sessions.

What seems relevant in the case of Kate, was her willingness to explore her school essay on Sonnet 48. As counselors, we need to be aware of everyday occurrences outside of therapy sessions and try to use these as opportunities when they are presented in sessions. For example, Kate's teacher made the assignment, and Kate brought her personal interpretation of the sonnet to her counseling session, which occurred shortly after she had finished writing her essay. Was Kate's interpretation of Sonnet 48 accurate? The answer is, for her, it was. It seemed an explanation for the pain and loss in her life, helping to remove the sense of complete responsibility for a changed friendship from Kate's young shoulders. Would her explanation of the sonnet pass muster with a Shakespeare scholar? Perhaps not, but that is not the point. We need to value what clients bring to session, explore the meaning of those contributions, and be open to poetry, art, and literature as expression of emotional states. What her analysis demonstrates is the willingness to identify with the topic, experience the topic emotionally, and develop insight about her situation. These three processes are the hallmark of bibliotherapy, whether self-generated or assigned by a therapist (Sumara, 1998; Zaccaria & Moses, 1978). Lastly, there is

the issue of predictable concerns of adolescents experiencing puberty. Counseling, because of its emphasis on human development, seems an appropriate frame of reference for several problems Kate experienced in her family and in her friendships. Her depressive symptoms and conflict with her mother served as triggers for help-seeking by her parents, and although distressing to those involved, for the most part can be considered expected outcomes of developmental striving. For example, research (Canals et al., 2005; Feldman, 2010; Newman & Newman, 2011; Richard & Schneider, 2005) describes exactly the problems Kate experienced as common at the onset of puberty for girls: conflict and distancing from her mother, increased depressive symptoms, self-consciousness, and changed peer relationships. One of the more difficult challenges, especially during late childhood and adolescence, is coping with changes in friendships. A best friend forever in childhood may become a source of frustration and pain later, as individual experiences and directions diverge (Allison & Schultz, 2004; Kroger, 2006).

Being able to help Kate see herself as experiencing things that others have experienced allowed her and her parents to normalize her situation, with the exception of the unfortunate mental health problems of her parents. The more she accepted her own development striving, the more she was able to detach from her parents' difficulties. Treating Kate's problems as pathology did not appear appropriate and is the most likely explanation for the failure of medication therapy.

In conclusion, examination of Kate's case in relation to the literature shows that counseling proceeded in a way that would be expected for the developmental problems she confronted. Her focal concerns included friendships, family, and her future and are congruent with the developmental concerns of many adolescents (girls in particular) as they work toward distinct identities. For girls, family relationships provide a primary context for identify formation (Bartoszuk & Pittman, 2010). It is understood that counseling sessions rely on the problems clients are willing to discuss, and Kate's problems aligned with problems considered important to adolescents struggling to discover identities (Bartoszuk & Pittman, 2010; Erikson, 1968). The telemental health technology did not appear to interfere with process or outcome. It allowed for safety and spontaneity (in the use of poetry) and incorporated multiple family members as appropriate. Telemental health counseling continues to be a valuable asset in rural communities, especially when it can be integrated into settings in which individuals and families generally receive care, which in this case was the local primary care clinic.

Notes on contributor

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