
Rural Telepsychology Services for Children and Adolescents



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Because of the overwhelming maldistribution of mental health specialists in metropolitan areas and the many underserved families living in rural settings, rural areas are natural homes for the use of telemedicine or videoconferencing technology for clinical services. The authors describe telepsychology services for rural clients, placing best psychology practices within the context of broader telemental health services. The goal is to approximate evidence-based child psychotherapy from face-to-face practice using the videoconferencing technology. Telepsychology is illustrated with a case report of a rural Hispanic teen and her family presenting through the teen's primary care clinic. © 2010 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 66:490–501, 2010.

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Technology makes it possible for psychologists to remain at their desk and see clients across the city, the state, the country, or even the world in real time. But, with this extended reach, comes new considerations of best psychology practice. Rural psychologists are particularly interested in using telemedicine or videoconferencing technology for clinical services because of the geographic maldistribution of clients and providers. The overwhelming majority of mental health specialists work in metropolitan areas while many underserved families live in rural and frontier settings. Beyond increasing access to clients living in remote areas, telemedicine can also benefit clients who travel for long periods of time. These include military personnel and clients experiencing challenges in leaving their homes (e.g., the elderly, those with physical disabilities, and those with agoraphobia, driving phobias, social anxiety disorder, and severe depression; Bouchard et al., 2004; Ruskin et al., 2004). There are access challenges in urban areas as well, including the high costs of transportation, limited public transportation, mistrust of professionals outside the immediate neighborhood, and long waitlists for treatment.

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Videoconferencing for mental health services has been referred to by many names including telemental health, telepsychiatry, telepsychology, and behavioral telehealth (Richardson et al., 2009). Telepsychiatry was one of the first telemedicine applications and is by far the most active telemental health application to date. Telepsychiatry focuses on management of psychotropic medication over videoconferencing.

In this article, *telepsychology* will be defined as the use of real-time videoconferencing for the interaction of client and practitioner in the provision of psychology services that are usually delivered in-person. Although important, online counseling, telephone consultation, e-mail correspondence, virtual reality, store-and-forward applications, and other technologies are beyond the scope of this article. Videoconferencing for nonclinical purposes, such as distance education and psychoeducation, are also beyond the article's scope.

Videoconferencing allows the client and the psychologist to talk with and observe nonverbal behavior in real time, approximating the relationship developed in face-to-face traditional therapy. The visual component in videoconferencing creates a social presence that promotes familiarity, connectedness, and comfort discussing complex topics. Mental health professionals report increased feelings of competence and comfort with treatment via videoconferencing as opposed to telephone (Bouchard et al., 2004). Some training programs have also used telepsychiatry to broaden educational opportunities for mental health trainees.

Most often, access to care motivates telepsychology. The burdens of traveling are magnified in mental health care, when regular sessions sustained over a period of time are usually considered necessary for effective care and practitioners are not interchangeable. Technology provides an avenue to increase regular attendance by diminishing the financial and temporal barriers of extensive travel. It can also include community members (e.g., primary care personnel, school personnel, case managers) in the process of evaluation and treatment, depending on the needs and wishes of the family.

Technological advances in personal computer-based videoconferencing systems have made inexpensive, user-friendly, reliable videoconferencing more available and promoted a significant increase in the use of clinical telemedicine. Rural states in particular have benefited from state and federal initiatives to provide inexpensive, high-speed Internet access. Telemedicine has been successfully implemented in innovative venues, such as schools, primary care offices, rural health clinics, and rural outreach centers (Nelson, Barnard, & Cain, 2003).

Beyond increased access, telepsychology may yield some surprising advantages over face-to-face sessions, although these advantages are more hypothesized than researched. In a study of client satisfaction and therapeutic alliance on the Shetland Islands, clients commented that videoconferencing made them less self-conscious, balanced personal attention without being confrontational, and decreased confidentiality concerns as they were seeing someone outside of their relatively isolated community (Simpson, 2001). Furthermore, some researchers have hypothesized that children and adolescents may be more comfortable and accepting of this medium in comparison to adults, because they are more likely to have used interactive video for social, nonclinical applications.

Telepsychology Acceptability

We refer to the broader research concerning the acceptability of telemental health, because little information has been published specific to telepsychology practice

(Hilty et al., 2004, 2009; Myers & Cain, 2008). Across reviews, authors have concluded that telemental health is a reliable means of conducting clinical interviews and noted high levels of clinician and client satisfaction. Preliminary evidence from a literature review suggests that telepsychiatry services are cost effective to clients when factoring in reduced travel requirements, time off work, and childcare needs (Monnier et al., 2003). Beyond financial savings, randomized controlled trials document that telepsychiatry increases access to specialty services and achieves comparable clinical outcomes without compromising client satisfaction or treatment adherence (O'Reilly et al., 2007; Ruskin et al., 2004).

Most studies comparing videoconferencing and face-to-face sessions examine participant satisfaction to some degree. The vast majority of studies report high client and practitioner acceptance and satisfaction across a range of populations and across diagnostic groups. In telepsychology, one study found that all elements of manualized cognitive-behavioral treatment for childhood depression could be implemented over telemedicine without differences in satisfaction or drop out rates in comparison to face-to-face treatment delivery (Nelson, Barnard, & Cain, 2003). High levels of satisfaction have been reported in various groups such as clinician referrers, incarcerated populations, rural clients, geriatric populations, clients with access challenges, inpatient populations, caregiver support groups, and child and adolescent clients and their families (Frueh et al., 2000; Monnier et al., 2003).

Telepsychology Assessment

A growing body of research supports the reliability of psychological assessment via videoconferencing, although large-scale, replicated studies are needed. Studies have demonstrated that telemedicine psychological assessments can be feasible, reliable, and accepted across a variety of patient populations including children and adolescents, general and geriatric adults, forensic settings, American Indian settings, and rural populations (Grady, Myers, & Nelson, 2009). Studies have shown that assessments of obsessive-compulsive disorder, major depression, schizophrenia, alcohol abuse, cognitive impairment/dementia, and forensic competence can be accurately assessed over videoconferencing utilizing standardized assessment scales (e.g., Monnier et al., 2003; Kobak, 2004; Ruskin et al., 2004).

Telepsychology Treatment

Psychology-specific telemedicine guidelines have not been developed, but practitioners can apply extant practice guidelines to telemedicine (Grady, Myers, & Nelson, 2009). Guidelines concerning evidence-based practice and empirically supported treatments may be particularly relevant as therapies are adapted to videoconferencing. As in traditional face-to-face psychological services, psychologists using telemedicine practice a range of theoretical orientations for a variety of patient populations (e.g., supportive, exposure, cognitive behavioral, hypnosis, eye movement desensitization and reprocessing therapy, others; Monnier et al., 2003; Richardson, 2009). Psychotherapy via videoconferencing has included the treatment of attention deficit hyperactivity disorder, bulimia nervosa, panic disorder, agoraphobia, obsessive-compulsive disorder, depression, post-traumatic stress disorder, adjustment disorder, chronic illness, and other conditions (Germain et al., 2009; Hailey et al., 2008). Again, most telepsychology research to date has been positive concerning process and outcome, but larger randomized trials are needed to identify specific advantages and disadvantages compared with traditional psychology

services. Overall, psychotherapy appears to be amenable to videoconferencing, with the majority of literature describing cognitive-behavioral therapy.

Best Practice in Telepsychology Initiation

National and state guidelines for telepsychology are on the horizon. In the absence of telepsychology-specific guidelines, psychologists rely on the American Psychological Association's (APA) ethics code (APA, 2002) that "in those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients, students, research participants, and others from harm." Just as in traditional, face-to-face clinical settings, the core ethical concern *to protect the client* remains paramount for telepsychology (Koocher, 2007; Reed, McLaughlin, & Milholland, 2000).

Telemental health guidelines from the American Telemedicine Association (ATA; Grady, Myers, & Nelson, 2009) as well as child telepsychiatry practice parameters (American Academy of Child and Adolescent Psychiatry [AACAP]; Myers & Cain, 2008) can inform "reasonable steps" for telepsychology practice. The broad ATA telemental health guidelines address the overarching question, "*What are the clinical, administrative, and technical effects of providing mental health care via various interactive video technologies in place of traditional face to face care, on the client, their caregivers and the health system?*"

The AACAP telepsychiatry guidelines provide guidance on establishing a telemedicine service and optimizing telemental health services. The following 12 consensus principles for telepsychiatry best practice can be adapted for telepsychology:

1. Determine the need for services and whether telemedicine is an option for meeting that need.
2. Determine whether the service can be sustainable.
3. Determine inclusion and exclusion criteria, the model of care and clinical services offered, and the infrastructure.
4. Determine technological specifications.
5. Establish management strategies for the telepsychiatry service.
6. Develop quality and clinical outcome indicators.
7. Foster rapport, confidence, and collaboration with staff at the client site.
8. Establish informed consent procedures.
9. Arrange the physical setting and establish the virtual relationship to produce an optimal clinical encounter.
10. Determine whether the youth can be interviewed alone, and if not, identify potential alternative means to conduct a mental status examination.
11. Establish procedures for prescribing medications (again, because from a psychiatry perspective; the guidelines could equally be applied to psychotherapy).
12. Inform families about procedures for interim care between telemedicine sessions, including procedures for emergency or urgent care.

Most telepsychology service aims to approximate face-to-face psychology services. This means the client and parent/guardian meet with the psychologist at a frequency similar to onsite visits. Other telemental health models have been proposed but rarely implemented to date, including consultee-centered consultation in which the rural referrer/agency maintain leadership of the youth's care but seeks child mental health

specialist input. The psychologist, rural telemedicine coordinator, and client/family should be informed of the model of care and expectations about whether telepsychology care will be ongoing or transitioned back to the local provider(s). Transparency across participants is very important. The team must also use best clinical judgment concerning whether both new and returning clients will be seen via telemedicine. Because face-to-face services are approximated, staff must agree on procedures around safety concerns, such as suicidal ideation, homicidal intent, or reports of abuse.

An important first step with any outreach service, including telepsychology, is to complete a needs assessment within the rural community to determine perceived interest and availability of psychology services. Ideally, the needs assessment includes candid discussions and meetings across key constituents, including families, local mental health professionals, primary care providers, client advocates, and other community leaders considering telemedicine initiation. This needs assessment slows initial implementation but is a crucial step to building sustainable mental health services. Telemental health services must be perceived as complementing or adding to the community's existing system of care. The needs assessment should thoughtfully consider advantages and disadvantages of telepsychology services from both sides: the rural client side and the telepsychologist side. Advantages for the rural side may include specialist availability, availability to consult with a team, decreased travel demands, less time away from the home community and work, and working with trusted telemedicine coordinators in their home community. There is also some suggestion that videoconferencing at some sites (schools, primary care, other) may decrease stigma associated with seeking mental health services. The advantages for the rural telemedicine site may include faster and more comprehensive services for their constituents (students, clients, others) and ideally, decreased symptoms and more adaptive functioning. Disadvantages may include not knowing what to anticipate over the videoconferencing system as well as initial concerns about the client-psychologist relationship and service quality.

The telepsychologist may provide rural services without the need to spend many hours in the car or on flights. Telepsychology may be an appealing way to expand services to populations without having to be away from competing clinical, research, and teaching responsibilities. Potential disadvantages for the psychologist include already overbooked schedules, concerns about gaining proficiency with the technology, and unknown availability of referral sources in the local setting, such as when the psychologist refers a parent for therapy or a child to crisis management services. There may be initial concerns about developing the relationship with the distant site, defining expectations for both the psychologist and the telemedicine coordinator, and engaging in new telemedicine roles. It is helpful to openly discuss such concerns across the psychologist and rural site ahead of time to implement strong supports and procedures to address concerns ahead of service.

Telepsychologists follow legislative and regulatory requirements at the local, state, and national level. Most states require that telepsychologists are licensed in the state where the client receives service, but psychologists should review state-specific guidelines with their licensure boards. Institutional requirements concerning credentialing at the client site should also be reviewed. Talking with telemental health professionals already in practice and observing telemedicine sessions can socialize the psychologist to these considerations as well as telemedicine practice.

The needs assessment should also clarify *whom* the telepsychology service will serve. Client inclusion and exclusion criteria should be based upon needs of the

referring rural site, the judgment of the telepsychologist, and resources of the client site. The rural site and the telepsychologist may determine if only clients specific to the telemedicine site will be seen or if the site will be open to the broader community-wide population. A key area to discuss with clients/families is the family's right to choose to be seen via telemedicine or to utilize traditional services such as traveling to nontelemedicine clinics.

The sustainability of the telepsychology service over time is a key consideration. The initial focus may be on system-wide cost benefits, including savings for the family and psychologists in decreased travel time and community benefits in increased functioning and decreased need for crisis services. The initial costs associated with starting telemedicine include equipment and software costs, connectivity/line charges, installation costs, costs of remodeling or adding space, personnel costs associated with telemedicine training, costs with adding staff to assist with telemedicine or with changing workflow to meet telemedicine responsibilities, and other costs. Telemedicine bells and whistles can be exciting, but realistic clinical needs should drive technology selection. Standard videoconferencing resolution has improved much in the last five years and is often sufficient for telepsychology. Current standards suggest bandwidths of at least 384 kbits/sec but lower speeds have been shown effective without interfering with rapport. More expensive options, such as high definition, depend on the client population but probably are not necessary for psychology service. This is because psychological practice tends to be history-driven rather than image driven (such as in teledermatology). In addition, very low bandwidth options such as home telehealth units over phone technology may be applicable to meet some telepsychology needs but have not been widely used in clinical telepsychology.

Consider carefully the choice of software, given the expansion of publicly accessible Internet technologies, such as Skype. For telepsychology consultations, serious consideration should be given to privacy and security. Most guidelines recommend use of point-to-point encrypted software to protect privacy.

Also consider treating the telemedicine room as a clinical space, with care taken to ensure the encounter cannot be overheard and that the psychologist is aware of all participants in the room. Key space considerations include the number of people participating in the consult on each side as well as making the room "family friendly." The psychologist side may include individual psychologists or a team and vary by the number of trainees observing. The rural side may involve only the client or involve family, school participants, and other support personnel. Insuring a confidential, client-friendly space is critical to telepsychology success.

Telepsychology procedures should establish who is expected to attend the appointment (client, family members, case managers, other community members) and who is expected to coordinate the appointment at the distant site (school nurse, clinic nurse, other clinic personnel, etc.). Other telemedicine services have described clinics in which no telemedicine coordinator is present and the patient connects directly to the provider. The authors are unaware of any telepsychology programs using this patient only model because of concerns about client needs for assistance related to presenting information, following recommendations, and addressing safety or other emergent concerns. As noted across telemental health guidelines, no absolute exclusionary criteria have been established or supported through research or clinical consensus. As with other emerging fields of practice, psychologists are encouraged to seek out peer guidance to consider best telepsychology practice as unique and complex presentations arise.

Telepsychology for the child and their family almost always involves communication across large systems of care: the specialty mental health system, the school system, the primary care system, the local mental health system, and/or other rural systems. Team building and good communication skills are essential to maintaining these relationships necessary for telemedicine success. Cultural competence related both to rural life and to other cultural considerations are vital to telepsychology service, just as with outreach in general.

Telepsychology Administration

A telemedicine “champion” is a central element that leads to clinic success or failure. The champion serves as the bridge among the telepsychologist, the rural site, and the patients and is commonly identified as the “telemedicine coordinator” or “telemedicine presenter.” The champion takes responsibility assisting with the service from promoting the service, scheduling the consult, compiling intake packets, socializing the client and family to telepsychology, utilizing the technology, assisting during the consultation, and helping the family follow-up on recommendations. The champion requires the support of upper-level administrators in completing these many tasks, with an understanding of the outreach benefits. Training all telemedicine coordinators around technology (e.g., *what to do if the technology fails?*) as well as mental health topics (e.g., *what should the client and family expect in the first meeting with a psychologist?*) is strongly encouraged.

The telepsychologist should carefully consider the intake information needed and HIPAA-compliant means to acquire the information in time for the first appointment. The telepsychologist and rural sites determine ahead of time the location of the medical record and how the telemedicine service may interact with electronic health records. Just as with onsite rural outreach, telepsychology programs have used varied initial funding, including institutional seed money, community and foundational support, state grants, and federal funding, billing, and contractual agreements. Contractual agreements may be developed between the rural site and the psychologist to cover both psychologist time as well as related costs (e.g., line charges, office management). A growing number of third-party insurers also reimburse telemedicine services, including Medicare, the majority of state Medicaid policies, and many private insurers. Approximately a half dozen states have legislative requirements that telemedicine services be reimbursed as face-to-face benefits.

Case Illustration

Presenting Problem and Client Description

“Jana” is a 14-year-old Hispanic girl presenting at a rural telemedicine clinic located at her primary care clinic. She was referred to the telepsychology clinic by her rural primary care provider (PCP) after her mother reported increasing arguments regarding household rules and resulting stress across the family. She is the oldest of six siblings and lives with her parents, siblings, and grandmother. As a freshman, she is doing well academically, and her school personnel report no behavior problems. Her parents report that Jana has always been strong-willed, but her behavior has become of increased concern as “she just won’t take no for an answer.” Jana’s mother reports that Jana has approximately one outburst per week that may last from 10 minutes to 2 hours, and she is concerned that the tantrums are becoming

more frequent. She reports that the outbursts involve “screaming at them” and refusing to comply with requests; the outbursts do not involve physical aggression or property destruction. Jana’s mother is worried that “all her little brothers and sisters are going to start acting the same way too.”

Jana is seen in a primary care clinic room that is large enough to accommodate Jana, her mother, her younger sister, and the telemedicine coordinator. It would be large enough to include other family members or community participants if needed. Close to the therapy room is a fax machine, which facilitates distributing questionnaires, handouts, and therapy activities. The videoconferencing equipment is a standard room-based unit with a large monitor on a mobile cart. Although the telemedicine system includes a digital stethoscope and exam camera, these more expensive attachments are not necessary for the telepsychology visits. The high-definition unit runs at 384 kb/s using encrypted, secure software. The camera is placed strategically to see Jana seated at the small table in the room and the lighting allows the therapist to easily see her facial expressions. The telepsychologist uses a smaller computer-based camera with videoconferencing software.

Although the family was disinclined to drive 6 hours for weekly psychotherapy sessions around these moderately intense symptoms, they were willing to meet weekly in their primary care clinic. The telepsychology clinic, thus, helps catch the teen early and, it is hoped, facilitates an early intervention before family conflict worsens and before the conflict precipitates poor teen choices. The PCP identified the increasing family conflict seen in clinic visits, but did not have the time and resources within the clinic or within the local community to provide positive parenting strategies for this “strong willed” teen. The availability of services at the primary care office was particularly appealing as there was little stigma or concern with being identified by other rural community members as visiting the mental health center.

Jana and her mother learned of telemedicine through the rural telemedicine coordinator, Carla. A speech therapist, Carla is the rural site champion and has completed telemedicine trainings about the technology and about mental health clinics. She schedules Jana’s appointments through the medical center telemedicine scheduler. The scheduler coordinates the rural site and the telepsychologist availability, in addition to the availability of the telemedicine equipment and rooms. Before the appointment, Carla explained to Jana and her mother what to expect in the telepsychology visit and helped the family complete the paperwork, including consent to treatment, registration form, insurance information, HIPAA-related Notice of Privacy, history intake form, the Behavior Assessment System for Children (BASC), and a narrative description of Jana. Because Jana’s mother completed the forms in Spanish, Carla asked her if she would prefer a medical interpreter for the telemedicine visit, but Jana’s mother felt proficient to participate without the additional interpreter assistance.

The telepsychologist began the initial visit acknowledging that the videoconferencing may take a little time to get used to and encouraged the family to share their thoughts about meeting over videoconferencing. The telepsychologist used the camera to scan both her room, to show Jana who was present, and Jana’s room, to make sure she was aware of everyone in the room. Jana and her family had used Skype videoconferencing at home to talk with relatives and appeared comfortable with the technology. The telepsychologist reviewed that only she could see the family and only they could see her; no one else has access to the encrypted, secure visit.

Just as in the face-to-face setting, initial discussion included what to expect during evaluation. The telepsychologist reviewed introductory topics including

confidentiality and its limits around safety and abuse. Although coordinator Carla does not sit in sessions, she is available throughout the interaction in the event the telepsychologist needs assistance with emergency concerns or more general help such as faxing forms or asking for help from the rural primary care clinic. The telepsychologist was sensitive to rapport building over telemedicine. Time was taken to discuss the telepsychologist's location some 6 hours away at the academic medical center as well as good-natured conversation around the client wearing a sweatshirt with the logo of a "rival" state university.

The telepsychologist had frequent check-ins with the family about their experience of the new technology. Jana's mother reported "getting used to seeing herself on screen." Jana appeared to like seeing herself on camera, smiling often, and commenting on the picture-in-picture function on screen. The telepsychologist was careful to maintain eye contact and to minimize looking down at notes. Both Jana and her mother appeared to have no difficulty describing their perspectives over the videoconferencing system, frequently smiling when describing positive family events, such as a recent school carnival, and becoming more serious when describing "yelling at each other" when Jana was asked to clean her room.

In light of Jana's developmental level, appropriate affect, and comfort with the technology, time was divided between seeing Jana and her mother together and then talking with each alone, again approximating the psychologist face-to-face intakes. Carla helped make sure privacy was observed when Jana and when her mother took turns, directing the other to the waiting room during the respective portions of the interview.

Case Formulation

The initial diagnosis was parent-child relational problem, with rule-out diagnoses of disruptive disorders and depressive disorders. The videoconferencing medium itself did not disrupt the diagnostic process. The rural PCP provided valuable input concerning Jana's development, current health, and academic progress. In particular, Jana was born almost 2 months premature but the PCP reported no concern with long-term developmental delays. The PCP also supported the family description of Jana's good physical health and no recent changes in mood, eating, energy, or sleep that might accompany depression. The PCP confirmed that no other family member had presented to the clinic with mental health symptoms and that there was no known history of mental health disorders.

Both the parent and the teacher BASC ratings were unremarkable, with few elevations above same-age peers. Table 1 presents the *t* scores ($M = 50$, $SD = 10$) for the parents' and teacher's BASC on Jana. This was helpful information for Jana's mother as it helped put Jana's behaviors within the range of peer behaviors. The parents did report "at risk" scores related to externalizing problems, which fit with their description of increasing concern about Jana's outbursts.

Table 1
Behavior Assessment System for Children (BASC) Scores at Intake

BASC <i>t</i> -scores	Parent report	Teacher report
Externalizing problems total	67	43
Internalizing problems total	52	55
Adaptive skills total	53	51

Course of Treatment

Treatment focused on three related areas: positive parenting strategies, anger management strategies, and adaptive parent-child communication strategies. Therapy goals and activities approximated face-to-face therapy. Jana's mother mentioned several times that "Jana's our first teenager" and suggested that she and Jana's father were interested in learning how to support Jana as she progressed through adolescence and to increase harmony within the family.

A key conflict in the family concerned Jana's parents establishing the rule that she could not attend all Quinceañera parties, one of Jana's most sought-after activities with her friends. Quinceañera is a coming of age ceremony held on a girl's fifteenth birthday, comparable to a "Sweet Sixteen" celebration. The positive parenting strategy was increasing praise and positive attention when Jana followed rules around party attendance. For example, her parents praised her and drove her to a party after they set the expectation that she could go after she cleaned her room. A difficult area with the family was consistency in the contingency system with not only the mother and father but also the grandmother, who is living in the household. On one occasion, the father set the rule that Jana could not attend a party because of competing family demands. After Jana's hour-long yelling about not getting to go, her grandmother "took Jana's side" and her parents then allowed her to attend the party. The telepsychologist discussed with Jana's mother how this would increase the likelihood that Jana will "throw a fit" in the future to get her way. Although the family was encouraged to attend a group telemedicine session to discuss household rules together, both Jana's father and grandmother did not attend because of conflicting work demands and, to some extent, caution from the grandmother in seeking family-wide intervention via telemedicine or in person.

Luckily, Jana also wanted to decrease fights with her parents about attending the dances. She responded well to relaxation strategies as part of anger management. Relaxation strategies, including deep breathing, progressive muscle relaxation, and imagery, were framed as a way to calm her body across situations. Jana was interested in learning how athletes practice relaxation strategies, and she applied the relaxation strategies to stay calm during her volleyball matches. Handouts about relaxation were faxed ahead of time so that Jana and the therapist would have the same materials. Jana also taught her younger sister about deep breathing during an early session. Jana learned and practiced the strategies over the videoconferencing system, particularly because the rural clinic room was a quiet space.

Finally, the telepsychology sessions addressed parent-child communication. The telepsychologist worked with Jana and her mother to ask and respond to questions in constructive ways. Jana's mother shared the rationale and approach for good communication strategies with Jana's father. Jana's main question was, "*Why can't I attend every party?*" Although she did not agree with her parents' rationale, she did decrease outbursts when her parents set clear limits on the number of parties she could attend, the specific ones she could attend, and their expectations of her. In-session activities included Jana and her mother practicing disagreements without yelling, using attacking language, or disengaging from the discussion.

Outcome and Prognosis

To date, Jana and her mother have attended eight sessions over 4 months via videoconferencing and now attend once a month. Jana's mother and teacher completed the BASC at the end of 4 months of therapy, and Jana fell within the

nonclinical range on all areas, reflecting more adaptive functioning at home. Therapy focuses on ongoing use of the parenting, anger management, and communication skills. Prognosis is good but will depend on consistent use of these adaptive skills over time and across family members. The telepsychologist has set the expectation that the family may attend “booster sessions” as new challenges arise with parenting their teenager.

Clinical Practices and Summary

Jana’s case was an ideal referral for telepsychology and illustrates its potential benefits and challenges. It uses technology to bridge the gap between a motivated teen and her family, on the one side, and a psychologist experienced in using research-supported therapies for youth, on the other. The therapeutic success with Jana and her family encouraged the rural primary care office to expand referral to the telepsychologist clinic for internalizing and externalizing disorders. The telepsychologist and the rural clinic have been successful in completing third payer reimbursement, and this has further encouraged the growing telepsychology practice. As the telepsychology clinic has grown, new challenges arise related to recruiting additional psychologists to meet increasing clinic interest. Referrals have expanded from not only the rural primary care practice but also Jana’s school. The case was also an excellent training opportunity for the psychology graduate students participating in the telepsychologist’s service.

One lesson from Jana’s case is that telepsychology sessions face the same successes and challenges as the face-to-face sessions. Key challenges are as follows: completing all the required paperwork, building rapport with both parent and child, tailoring strategies for the individual client and family needs, and encouraging sustained practice of therapy strategies at home and across family members.

Existing technology makes it possible for Jana to be easily treated at the primary care clinic, hospital, school, church, home, or other sites. Although videoconferencing units were used in this case, cell phone, Internet, and other options increase the potential to see the client almost any place at any time. Technologies will continue to expand outreach options but the increased access also brings new psychologist responsibilities in insuring effective, evidence-based psychological treatments across rural settings.

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