

# Use of Telepsychiatry in Psychodynamic Psychiatry

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*Abstract:* This article reviews the organization, infrastructure basics, applications, effectiveness, outreach, and implementation barriers related to telepsychiatry. We highlight the tremendous potential and promise that this technology holds and also discuss the importance that telepsychiatry may play in the field of psychodynamic psychiatry. Given the growing effectiveness evidence base for therapy delivered over the Internet, telepsychiatry holds a large unexplored territory to help psychodynamically minded patients connect with psychodynamically oriented psychiatrists. This economically advantageous medium can be utilized to deliver psychodynamically guided approaches to the patient, alone or in combination with pharmacological and other psychosocial interventions. We hope, this article will help psychodynamically trained psychiatrists to consider bridging the gap with the remotely located, chronically mentally ill population which oftentimes has scarcity of resources.

Mental disorders are common (Kessler, Chiu, Demler, & Walters, 2005) and they are associated with high levels of distress, disability, morbidity, and mortality. Many people with these disorders do not have access to mental health services. Many states have substantial health and human service resources in urban centers and relative scarcity of services in rural areas. Such disparities are particularly apparent in the area of mental health services (New Freedom Commission on Mental Health, 2004). It is often difficult to recruit and retain mental health providers to rural and underserved communities. As a result, these communities often suffer from limited access to mental health services. This lack of access can sometimes force patients to travel long distances to obtain mental health services, or forgo such services altogether. Non-mental health providers are also often placed in the position of serving

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patients with severe mental health problems with little or no specialty support. These factors reduce the quality of mental health services available to patients in rural and underserved communities. Access to psychodynamically informed treatments is even scarcer. While it is evident that there has been a decline in psychotherapeutic treatments and increasing reliance on pharmacological management only, the diminishing practice of psychotherapy and in particular psychodynamic psychotherapy can also be attributed to fewer numbers of psychodynamically oriented psychiatrists and their increased concentrations in bigger cities.

A growing body of literature now suggests that use of live, interactive, audio-videoconferencing to provide mental health care has the potential to mitigate the workforce shortage that directly affects access to care, especially in remote and underserved areas (Antonacci, Bloch, Saeed, Yildirim, & Talley, 2008; Saeed, Diamond, & Bloch, 2011). It comes as no surprise that among the general application of these communication technologies to medicine, termed telemedicine, and even more broadly to general health concerns, termed telehealth, that telepsychiatry is one of the largest medical specialty uses (Grigsby et al., 2002; Krupinski et al., 2002). With such an arrangement a provider at a distant location evaluates and treats a patient at their local clinical site via live and interactive video-conferencing. This has been referred to by various terms including tele-behavioral health, telepsychiatry, telemedicine, e-behavioral health, telemental health, e-care, telehealth, and telecare. Telepsychiatry can also be used for consultations between providers, as well as for provider and patient education.

While telemedicine has been variously defined, live interactive two-way audio-video communication, called videoconferencing, is the modality most applicable to medicine and has become synonymous with telemedicine broadly, and telepsychiatry specifically for mental health care.

## TECHNOLOGY BASICS

Telepsychiatry primarily involves interactive audiovisual conferencing systems over high-bandwidth networks. The central component of an interactive telepsychiatry is the codec (coder/decoder), which provides the requisite compression and decompression, and synchronization of audio and video signals. A codec can be a separate device (appliance), but personal computer-based codecs are being increasingly employed as their capabilities improve. A codec is required at both

the patient and consultant ends of the system. A typical telepsychiatry setup also includes a video camera, microphone, speakers (or headset), and one or two displays (monitors) at each end of the system. Often, separate displays or a picture-in-picture (if one display) are used to enable participants to see both outgoing and incoming video. Another consideration is pan-zoom-tilt control of video cameras. This allows the consulting mental health professional to remotely control his or her view of the patient's site or locally control the view that is being transmitted to the patient.

Historically, interactive telepsychiatry applications have used point-to-point network connections, usually as full or fractional T-1 or Integrated Services Digital Network (ISDN) circuits. However, the rapid diffusion of Internet and Ethernet networks has led to the development of videoconferencing systems that can work over these types of networks, namely, Internet Protocol (IP) networks. If the telepsychiatry application uses IP networks, then security must be ensured—this can be accomplished by using encrypted codecs or by setting up a virtual private network (VPN) and/or virtual local area networks (VLAN). The principal advantage of IP networks is that they can be shared by multiple applications, for example Internet access, e-mail, LAN, etc., given that the aforementioned security solutions are employed. This means that the telecommunications (network) costs can be shared, or considered a sunk cost (i.e., not an additional cost to the telepsychiatry application).

## **BENEFITS AND EFFECTIVENESS OF TELEPSYCHIATRY**

A growing body of literature now suggests that use of telepsychiatry to provide mental health services has the potential to solve the workforce shortage problem that directly affects access to care, especially in remote and underserved areas. Empirical evidence on the use and effectiveness of videoconferencing in providing diagnostic and treatment services in mental health settings that serve child, adolescent, and adult populations has been previously reviewed by our group (Antonacci et al., 2008). While this review of the literature covered a time period of over half a century, we noted that the evidence on effectiveness did not start to emerge until 2000 or later and was relatively weak due to the problems we have discussed previously. The literature on telepsychiatry began with descriptive articles looking at feasibility, acceptance, satisfaction, and cost. There was then movement toward comparing telepsychiatry to services provided face-to-face. In more recent liter-

ature, a few studies that provide the same treatment across the two modalities and measure clinical outcomes have emerged. However, in these studies the treatment tends to be very limited, usually medication management or a short course of CBT. Outcomes appear to be similar as in treatment provided face-to-face. Such studies also show that the acceptance of telepsychiatry is generally good. If there are acceptance problems, it is usually the professional who is reluctant, not the patient or family. Usage is primarily in rural areas or jails, or with underserved subpopulations such as children. While the state of the literature is generally weak, there is more in psychiatry than other medical specialty areas, probably because of the greater reliance on the mental status examination and verbal communication and not on a physical examination. It is also clear that telepsychiatry can make a significant impact on the delivery of mental health care services, particularly to those who have usually received less than adequate care. Services provided via telepsychiatry have been shown to be comparably effective to those delivered in person (Antonacci et al., 2008). Patient access is improved and patient satisfaction is high, with telepsychiatry services (Antonacci et al., 2008) and telemedicine in general (Brown-Connolly, 2002; Gustke, Balch, West, & Rogers, 2000).

In addition to the direct benefits of telepsychiatry to patients and clinicians, there are other benefits that can be expected from implementing telepsychiatry services, including: (1) Reduction of stigma associated with receiving mental health services (Farrell & McKinnon, 2003); (2) Reduction in geographic and socioeconomic health disparities, by improving access to mental health services; (3) Improved consumer convenience by reducing the time and expenses associated with travel which is likely to lead to improved consumer compliance; (4) Reduction in professional isolation and concomitant improvement in recruiting and retaining mental health professionals to live and work in underserved or rural areas (D'Souza, 2000; Haythornthwaite, 2002; Redford & Parkins, 1997; Stamm, 1998); (5) Improved coordination of care across a mental health system; and (6) Improved education of mental health professionals.

## **PSYCHODYNAMIC PSYCHIATRY AND REMOTE DELIVERY OF CARE**

Delivering care remotely has been an ongoing debate and therapists have wondered about this medium since at least the 1950s. In 1951, L. J. Saul reported the first case of telephone use in psychoanalysis and sug-

gested a speakerphone as the closest approximation to in-person sound (Saul, 1951). Multiple publications have discussed the use of telephone in psychoanalysis. However, the model has generated controversy and different viewpoints. Nonetheless, some psychodynamically oriented psychotherapists have expressed hope and enthusiasm since they found that the therapeutic sessions conducted on the telephone were similar to the sessions done in person (Leffert, 2003). Multiple reports have appeared since the 1970s (Robertiello, 1972) about the usage of phone to deliver intensive psychotherapy. The telephone, however, has been primarily used for dealing with crisis or to reach out to a reluctant or bedridden patient. The therapy session over phone has been seen as an extension of transitional space (Aronson, 2000) used for patients too anxious to participate in face-to-face sessions or to prevent premature termination.

With the ongoing development of telepsychiatry, which utilizes very fine audio and video quality, the analyst and the analysand can foster a communication that is much similar to the in-person analytic process. This technology can also help analysts based in the United States and Europe to help patients in far locations including other countries. Also, the virtual space between the analyst and the patient may help expression of intense affects, better exploration of defense mechanisms, thereby, improving alliance development and to deal with the issues related to transference-countertransference. On review of literature measuring therapeutic alliance (TA), studies have overwhelmingly supported the development of TA in psychotherapy via videoconferencing. However, a number of psychologists continue to assume that longer-term, less structured therapeutic approaches such as psychodynamic therapy may be less suitable to be delivered via video conferencing (Simpson & Reid, 2014). These assumptions, however, have not been empirically tested and are not evidence-based.

Recently, in a randomized controlled trial (RCT), Internet based psychodynamic treatment (IPDT) was found to be equally efficacious to guided internet based cognitive behavior therapy in adult patients with generalized anxiety disorder (Andersson et al., 2012). Additionally, in another RCT that included adult patients with major depressive disorder, a psychodynamically based guided self-help intervention with online therapist contact over 10 weeks was superior to active control which included psycho-education and weekly online contact only (Johansson et al., 2012). Another RCT using Internet delivered affect-phobia therapy, a psychodynamic treatment that emphasizes a strong focus on experience and expression of affect, was found to be efficacious for anxiety and depression among adult patients (Johansson et al., 2013).

Some psychoanalysts may continue to hold negative attitudes toward e-therapy (Wangberg, Gammon, & Spitznogle, 2007) or view inclusion of technology in delivering care as a therapeutic compromise and second to in-person analysis, but the evidence base is growing.

Since telepsychiatry is still in its infancy, providers may have some concerns about issues related to setting boundaries while providing care via videoconferencing. Appropriate boundaries serve multiple roles in achieving therapeutic goals; it is understandable that patients and clinicians may not have a clear expectation in this non-traditional medium. Potential issues may arise from patients being casual during therapy tele-sessions; the issues can be related to time, setting, or therapist. These potential boundary problems are however not uncommon in traditional face-to-face therapy sessions either. Also, they can be managed by structuring the sessions professionally and respecting the timing of sessions. Delivering the tele-sessions in real time much like traditional face-to-face sessions and other precautions like not extending sessions despite ease of telepsychiatry, not providing feedback during nonbusiness hours, maintaining consistent and professional setting, modeling professional self-boundaries, and ensuring confidentiality can help with increasing therapeutic alliance and maximizing clinical outcomes (Drum & Littleton, 2014). Furthermore, in our personal experience, having an electronic intermediary appears to reduce patients' anxiety, and enables them to communicate and reach out more effectively. We have also experienced patients with social anxiety and in the LGBT population communicating more freely over telepsychiatry as compared to face-to-face interactions. Telepsychiatry can reach underserved populations, the incarcerated, may help in providing consistent aftercare to patients who have graduated from intensive therapy, and can help patients who are unable to attend face-to-face sessions due to their physical or mental handicap.

## PSYCHIATRY AND THE MILLENNIAL GENERATION

The millennial generation seems to have a closer relationship with developing technology and its advancement. This generation, in this digitally connected Internet age, travels far and wide with their gadgets. Tele-sessions can increase the appeal of psychodynamic psychotherapy and help the psychodynamically oriented patients in this e-generation.

## USE OF TELEPSYCHIATRY FOR TRAINING IN PSYCHODYNAMIC PSYCHIATRY

Tele-psychodynamic psychotherapy can also be utilized for education of psychiatry trainees. Most psychodynamically oriented professionals are restricted to few areas, which likely has affected the quantity and quality of psychodynamic training among psychiatry residents in the United States. This advancement of the Internet technology can be used for educational, training analysis, and supervision purposes. This will help in expansion of psychodynamic psychiatry as a field and also provide training opportunities for learners in remote locations. Tele-psychiatry can streamline the implementation of training efforts. This can allow training activities to originate from a variety of locations and eliminate the need for trainers to travel to multiple sites to train multiple audiences, or the need to bring distant audiences to a central training site. The provision of telepsychiatry-facilitated training can also allow broader access to the training by the myriad of staff from mental health agencies, mental health centers, hospitals, and private providers, which can also minimize training-related travel costs. Because of the large number of different sites with similar training needs, such training has the added benefit of efficiency since the subject matter can be conveyed consistently from site to site, and questions and comments of the participants and their responses are communicated simultaneously to multiple audiences at the different training sites.

## “CONNECTED HEALTH”—A BROADER CONTEXT OF SERVICES PROVIDED VIA TELEPSYCHIATRY

In today's evolving health care delivery system, it is useful to consider telepsychiatry as a part of a broader “connected health” system with the vision that such a system is available to everyone and that health care is provided at the point-of-convenience. Not only the patient is informed and empowered in such a system, the telehealth applications tend to assure patient compliance, continuing education, ease of access into the health care system, and healthy behaviors. In such a system clinical data are better integrated with longitudinal electronic health records; data are available to patient (personal electronic medical record) and authorized clinical providers; and data and transactions are secure to greatest practical extent. Figure 1 depicts this connected system.

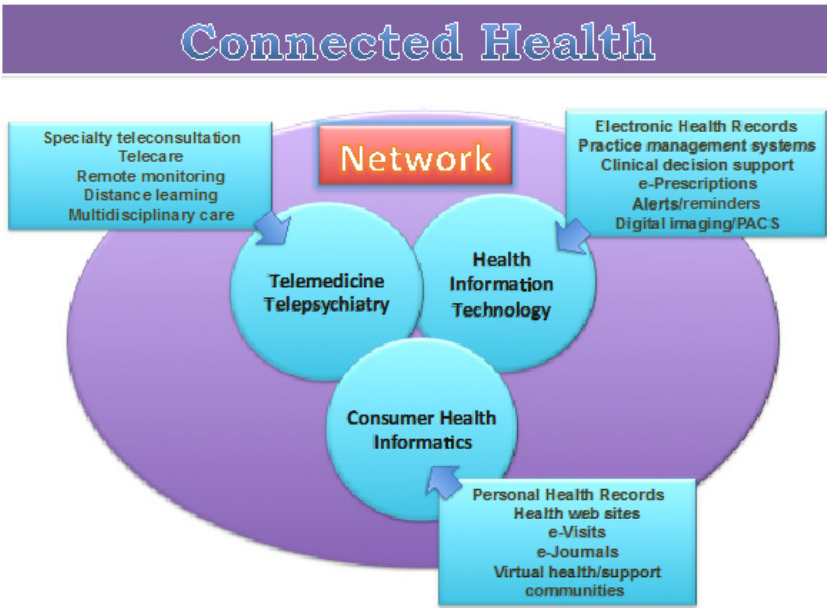


FIGURE 1.

### SETTING UP A TELEPSYCHIATRY SERVICE: WHERE TO START?

Setting up a telepsychiatry service requires systematic attention to several details. Here is a simplified step-by-step approach:

1. The first step, as in setting up any clinical service, is doing a need assessment for the service. This covers three questions: is the telepsychiatry service needed, is it feasible, and is it sustainable.
2. Determine specifically which partnerships are going to be put together to implement and sustain the telepsychiatry service. In essence, this includes partnership at the site(s) where the patients are going to be located at and the partnerships on the providers' sites (e.g. practice groups, academic practices, employed providers, etc.).
3. Detailed assessment of what the existing technological, organizational, and programmatic infrastructure is, both at the patient site and at the provider site.



4. Identifying equipment and network infrastructure that will be needed for the telepsychiatry service, both at the patient site and at the provider site.
5. Establish the model of care (e.g., direct care, patient-centered consultation, provider-focused consultation, or hybrid).
6. Establish specific protocols, clinic policies and procedures. It is usually helpful to have an "operation manual" that contains all such information. Such a manual also contains information regarding the following:
  - Available providers
  - Technical and user support
  - Protected health information (PHI) transfer/medical record (MR) creation
  - F/U to referring provider
  - Scheduling/presentation protocol
  - Training of users
  - Call center
7. Establish timeline for going live and identify a work group or "steering committee" that will meet periodically to oversee a smooth implementation, identify and work out problems, revise protocols, and report data.
8. Do a small-scale trial run before going live.
9. Go live.

### **POTENTIAL BARRIERS TO THE WIDESPREAD USE OF TELEPSYCHIATRY**

Although telepsychiatry offers a tremendous promise, implementation has been neither widespread nor easy to achieve. Several potential barriers to the diffusion of telepsychiatry have been identified. Some of the barriers are associated with the acceptance of any new technology and practice in health care. Usual impediments include cost issues, resistance to change by individuals or organizations, and technological illiteracy. In addition, several legal, regulatory, and technical factors further hinder the implementation of telemedicine in general. Common potential barriers to the dispersion of telepsychiatry are as follows:

## **Integrating Technology and Evidence into Practice**

As identified by us previously (McGinty, Saeed, Simmons, & Yildirim, 2006), physicians and other providers do not always have easy access to timely, relevant evidence-based information and, when they do have such information, there are other challenges with integrating the information into their routine practice such as time constraints and demands of their work environments including the complexity of large health care organizations and access to technical support. Two studies from Michigan found that after controlling for other barriers such as reimbursement and regulatory issues, providers are the most significant initial gatekeepers affecting the use of telehealth. Therefore, they recommended that telemedicine project managers must keep providers' needs, such as ease of use and incentives, in mind when designing a telemedicine system (Coleman, 2002).

### **Reimbursement**

Medicare reimbursement for telemedicine started in 1999, and some of the original limitations in the payment scheme have been addressed (American Telemedicine Association, 2003; Puskin, 1999). Many state Medicaid programs, and many third-party payers, provide reimbursement for telehealth services, with similar limitations as seen with the Medicare program. A "fee-for-service" approach is used for payment that reimburses the consulting physician or mental health professional for their time. Reimbursement in telepsychiatry is typically provided for a diagnostic interview, pharmacologic management, and individual psychotherapy provided by psychiatrists and clinical psychologists (American Psychiatric Association [APA], 1998). Services provided by other mental health providers are not currently covered in most states. However, social workers and other mental health providers practicing in Utah are currently being reimbursed for their services (Centers for Medicare and Medicaid Services [CMMS], 2005). The American Psychiatric Association's Resource Document on Telepsychiatry via Videoconferencing (APA, 1998) has two suggestions regarding this issue. First, reimbursement for telepsychiatry services should follow customary charges for the delivery of the appropriate CPT code(s). Second, a structure for reimbursement of collateral charges, such as technician and line time, should be identified.

## Impacting Practice Behavior

Sustained change in workplace behaviors requires a restructuring of the flow of daily work so that routine procedures make it natural for the clinician to give care in the new way. If the goal of the organization is to promote the use of telepsychiatry, then telepsychiatry must be integrated with the current process of delivering patient care. For successful implementation, both providers and consumers must see this method as an approach to treatment that is likely to increase the possibility of a successful outcome, increase access, or enhance quality. For the change in practice behavior to occur, intention to change must be combined with the necessary skill, and the environmental constraints must be removed (Fishbein, 1995).

## Licensure

For a physician to conduct a telemedicine consultation with a facility in another state, that physician must be licensed by both states' licensing boards. Likewise, nurses and other allied health professionals have similar state licensing constraints. Three potential solutions have been suggested (Sanders, 1993) including:

1. Establishing a national licensing system.
2. Assigning the responsibility of care to the referring physician, with the consulting physician's opinions as "recommendations only."
3. Determining that the patient is being "electronically transmitted" to the consultant's state.

## Privacy, Security, and HIPPA

Kumekawa (2001) has discussed privacy considerations that are unique to telepsychiatry. These include the potential for nonclinical technical and administrative personnel to view telepsychiatry transactions and the off-camera presence of other clinical personnel. The increased use of IP videoconferencing over public networks also creates the potential for unauthorized access to PHI. Technological solutions, such as in-codec encryption and virtual private networks, will need to be implemented to address these issues. Once these technological

solutions are developed and implemented, providers will need to be trained regarding the storage and retrieval of data; medico-legal; and ethical issues related to maintaining patient privacy.

## **Infrastructure**

The costs associated with the infrastructure development and maintenance are typically non-reimbursable at the current time. There are cases where reimbursement is obtained either from individual contracts, from managed care, from third party payers in a few states, and from Medicaid and Medicare in limited situations. Clearly, there is a need to identify a structure for reimbursement of collateral charges, such as technician and line time. The U.S. Federal Communications Commission's (FCC) Universal Service Fund (USF) subsidies can reduce the cost of telepsychiatry network connections. The USF was implemented to increase the diffusion of high bandwidth telecommunications to rural schools, libraries, and health care providers. The funding for the USF is generated from fees paid by telecommunications providers. However, the USF mechanism is not being widely used for several reasons, including a cumbersome application process, limitations on eligible facilities and locations, and questions regarding the actual costs to the provider (Puskin, 2001). Individual states have also developed various funding streams to support telemedicine.

## **CONCLUSION**

The potential for telepsychiatry to improve access to adequate mental health care is becoming more evident. The current technology is adequate for most uses and continued advances are in progress. There are numerous applications already defined and more are ripe for exploration. Barriers to implementation are primarily of the human variety and will require a combination of consumer, provider, and governmental advocacy to overcome. Telepsychiatry can be effectively used to bridge the psychodynamically oriented mental health providers with the population who would significantly benefit from psychodynamic interventions or its combination with other treatments. The use of technology has brought down the costs of electronically delivered care besides making the communication easy and accessible. The advancement in technology over the years has connected the majority of the American

population and the Internet has had significant effect of increasing users' social networking. Given the challenges associated with disparity in access to psychiatric care, telepsychiatry can help connect with the rural American, terminally ill, bedridden, and the patients who may benefit from psychodynamic awareness.

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