



Early use of telepsychotherapy in resident continuity clinics—our experience and a review of literature

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Abstract: Telepsychotherapy is an underutilized tool in training programs, and use of telepsychiatry often occurs in the later years of residency. This study evaluates the feasibility of early exposure to telepsychotherapy in residency continuity clinics and reviews the existing literature on the use of telemedicine in the training of psychiatrists. Feedback from the participating residents and patients was used to determine the benefit of such a training curriculum. The results of the feedback and evidence from the review of literature indicate that the early use of telepsychotherapy should be employed in psychiatric training.

Keywords: Telepsychotherapy; telepsychiatry; telemedicine; residency; education

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Introduction

Telepsychiatry refers to the provision of psychiatric care via video-based conferencing. It is widely adopted given its potential to extend care to underserved areas and those with limited access to mental health services. Research demonstrates a high rate of satisfaction with telepsychiatry both among patients and providers but also admits the need for consistency in accessing competency with the use of technology to ensure quality of care (1-7). Telepsychiatry is not inferior to the traditional approach in terms of reliability and allows for significant time and cost savings (8-12). Studies also show that telepsychiatry can be successfully applied in psychotherapy (13).

The field of psychiatry is rapidly evolving, but training in telepsychiatry is not currently a requirement in most US residency programs, and where available it is usually introduced in the final year of training (14,15). The difficulty in establishing early exposure to telepsychiatry may be linked to a lack of an ability to measure a training physician's skills in performing distance therapy (1). We

evaluated the feasibility of early training in telepsychiatry in resident continuity clinics and focused on the delivery of telepsychotherapy. To our knowledge, no studies of a similar design have been conducted to-date.

Methods

All patients receiving supportive or psychodynamic therapy with access to a smartphone or an Internet-connected computing device of two psychiatry residents in their post-graduate year (PGY)-2 and PGY-3 were asked to participate in telepsychotherapy. Four patients (three with major depressive disorder and anxiety disorder and one with schizoaffective disorder) volunteered and underwent telepsychotherapy using a secure cloud-based video communications service. The volunteer patients cited their distance from the clinic as the primary reason for favoring telepsychotherapy. The residents and patients were instructed on the technical aspects of the software.

The study protocol was by the Health Insurance Portability and Accountability Act (HIPAA) regulations.

The patients received five or more standard in-person psychotherapy sessions before engaging in telepsychotherapy. Throughout the therapy, patients could choose between in-person or remote sessions at each encounter. They each received fourteen non-consecutive sessions of psychodynamic or supportive psychotherapy.

Study participants were instructed to use their devices (laptops, iPads, smartphones) in their home while residents used secure computers at the clinic. The interviews were not synchronously supervised. Cases were individually discussed with preceptors during long-term supervision sessions following the protocol used with in-person psychotherapy cases. The residents later evaluated their experience in the form of an unstructured narrative. The Institutional Review Board determined that these evaluations were not considered research on human subjects and, therefore, required no formal approval.

Results

The patients remained psychiatrically stable and did not require hospitalization. All involved residents completed the evaluation. The unstructured narrative ensured that resident feedback was not limited to preconceived parameters.

The quality of video and sound allowed for adequate patient-provider communication. Minor technical difficulties such as poor connection or a short loss of connection were sometimes experienced but did not affect patient care. No concerns about patient confidentiality or general privacy were voiced by the residents, patients, or training supervisors.

Even though patient satisfaction with the use of telepsychiatry was not a targeted outcome in this study, there was overall positive feedback from all the study participants. This was consistent with the high level of satisfaction reported by the resident physicians. The discussion of cases with supervisors after the session is the standard practice of the continuity clinic and a lack of experience or supervision during the sessions was not cited as a barrier to successful provision of telepsychotherapy. Exposure to the technological aspects of telepsychotherapy and the new communication style associated with it was regarded as a benefit.

As perceived by the supervising attendings, the quality of psychiatric care was no different from that provided in regular office settings, and there was no compromise in the ability of the residents to empathize and relate to the

patients. It was reported that non-verbal cue interpretation did not differ from in-person scenarios. The residents appreciated the flexibility associated with telepsychiatry, which allowed for a stable schedule and continuous care. Thus, patients scheduled for office visits often requested telepsychotherapy under circumstances of illness, last-minute commitment changes, or lack of transportation. Compared to the standard visit, remote sessions also seemed to better align with patient schedules. This reduced the number of no-shows and maintained continuity of care, thereby increasing overall satisfaction with the therapeutic alliance and the quality of services provided. As the study progressed, the residents observed an increase in the frequency of telepsychotherapy being chosen by patients.

The residents indicated that this early exposure to telepsychiatry was an exciting and positive experience that benefited their training and strengthened their interest in this type of psychiatric care. They also expressed a desire to continue using telepsychiatry in their residency and formal practice.

Discussion

The use of telemedicine in psychiatry is widely introduced in modern practice due to its effectiveness, potential to address the disparities in access to care, reduce costs and supply comfort to patients (1-5,8-12). Other medical specialties have also addressed the need to educate residents in the use of telemedicine in various clinical settings (16-22). The experience of these studies has been equivocal, with no negative impact reported by the physicians in training, but some reservations expressed by the supervisors and attending physicians. The use of telepsychiatry in pediatric emergency rooms resulted in an overall positive impact in regards to call burden for the residents, hinting at the importance of early incorporation of telehealth training (23).

The patients in our study were volunteers, and therefore, interested in and comfortable with the use of technology. This familiarity resulted in the observed effect of continuous patient compliance and interaction with the resident. The patients also received at least 5 in-person sessions thereby developing baseline rapport, which then translated to the teletherapy session. Our supervisors did not express any discomfort

Despite publications on telepsychiatry competencies, life-long learning, and continuing medical education credits, residents receive little or no formal exposure to telepsychiatry during their training (14,15,24-26). In a

survey of 183 psychiatry training programs, the response rate was only 25% (n=46) of which 21 programs reported resident involvement in telepsychiatry in some fashion while only 12 programs offered a formalized curriculum (27). A formalized training regimen has not yet been standardized. Hilty *et al.* have designed a framework for training and education in telepsychiatry (25). In their study, the focus is on the competencies of the electronic practice of psychiatry in general, but psychotherapy is not explicitly addressed. Several other studies on telepsychiatry also do not directly address the delivery of therapy using telemedicine (14,28-31).

There are a few reports on the utilization of telepsychotherapy specifically for resident education (32,33). DeGaetano *et al.* reported that 40% of the resident interactions involved some psychotherapy using telemedicine. The researchers report that residents were more comfortable with medical management and patient evaluations compared to therapy. However, the study admits that the residents had less experience with therapy in general. Mahoney *et al.* reported positive feedback from residents and educators in the use of technology in psychotherapy training.

The goal of our study was to assess the feasibility of conducting telepsychotherapy early in residency training and use technology to make our residents more comfortable with therapy in general. Our residents showed that the opportunity to conduct remote psychotherapy increased their interest in the evolving practice of telepsychiatry and therapy. Also, the experience of performing telepsychotherapy in the context of a training program increased resident readiness to use the modality and the software. In line with previously published data, our resident and supervisor feedback confirmed the conclusions by Glover *et al.* that there is a gap between exposure to telemedicine and the interest endorsed by resident physicians (34).

Although there are some reports of how telepsychiatry is implemented in resident training, there is no uniform consensus, and therefore, the use of telepsychotherapy in resident continuity clinics has not been explicitly explored. According to the recent review by Kocsis *et al.* (13), telepsychotherapy may be useful for a wide range of patients and may offer an innovative way of forming therapeutic relationships. It allows for an intimate dialogue, unique observations (i.e., patient's home environment), and maybe preferred by patients with anxiety, PTSD, and paranoia (35).

The impact of telepsychiatry in the doctor-patient relationship is currently under debate (8). The resident

psychiatrists involved in our study reported increased strength of the therapeutic alliance, which could be explained by reduction in patient stress level and perception of improved control over their lives due to the flexibility attributed to the use of technology. This flexibility in turn translated into more consistent follow-up, improved continuity of care, and a stable schedule for both patients and providers.

The lack of experience did not seem to pose a barrier to the successful implementation of telepsychotherapy at the resident clinic; therefore, early introduction of telepsychotherapy in training is feasible. Residents and medical students have uniformly responded favorably to the use of this technology in practice, and the educational experience has been reported to be rewarding when coupled with appropriate supervision (36,37).

Our study suggests that tele psychotherapy can be effectively used by residents in the continuity clinic starting as early as the second year of training. Supervisors in our program did not identify any patient-care related challenges. We attributed this level of comfort to an understanding of technology, and the lack of access to mental health in our community needing the use of telepsychotherapy. Our findings call for the modification of the existing residency curriculum to prepare the new generation of psychiatrists for the growing demand for mental health services. A survey of the extent of telepsychiatry in the American residency programs demonstrated interest in designing a formalized and standardized telepsychiatry curriculum (38), and we illustrate a trend in that direction (27,39). As shown in our study, use of telepsychotherapy in continuity clinics has the potential to create a more longitudinal educational experience and increase opportunities for residents to be active participants in therapy sessions. More extensive studies are needed to explore the nuances of the resident experience further and devise the framework for a telepsychotherapy curriculum.

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Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all

aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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