APPENDIX I

PORTFOLIO #4 DENISE: WHEN DISTANCE AND OTHER THERAPISTS GET IN THE WAY

I.1. Relevant History

Denise (a pseudonym), was a 35-year-old single mother of three in receipt of a Disability Pension. She was referred to telepsychology by her case manager for assistance to improve her low self-esteem, poor confidence, poor decision making, and negative self appraisal which occurred in the context of a long history of depression. Her psychiatrist was not confident that she would benefit from CBT. He argued that she was inflexible, unable to reflect on her thoughts and behaviours and had “a challenging personality”. He did not expect that telepsychology would be successful. Although Denise had a complicated presentation, she was considered representative of a long-term, community mental health client, and thus was included in the research.

Denise reported that when she was a child, she was neglected by her depressed mother, emotionally abused by her angry and depressed father, and physically abused by her step-mother, whom she believed was “jealous of her”. She reported frequent episodes of suicidal ideation, made several suicide attempts and had experienced chronic depression since 14 years of age. Denise had lost contact with her biological mother many years earlier. Her current attitude to her father was that she desperately needed him to help her manage her property and her children, but hated when he was around her, and felt afraid of his frequent personal criticism of her.

Many of Denise's most significant acute depressive episodes had occurred in the context of complicated pregnancies and at post-partum. At the time of the intervention she had three children, Susie (12), Steve (10) and Emma (3). Denise's first pregnancy was unplanned, and with a man she described as physically abusive and an alcoholic. Denise had a second child over their ten year relationship, despite their marital problems. Her two eldest children have almost no contact with their father now. Several months after giving birth the first time, Denise made a suicidal overdose attempt and was hospitalised in the Regional Inpatient Unit (IPU) for three weeks. Severe Post Natal Depression (PND), an increasingly aggressive spousal relationship, isolation and a lack of a parental model on which to base her own parenting responses, were identified as contributing factors to her suicidality.

Denise reported that her relationship with her oldest daughter was strained because of the PND she suffered, but it is better now. Denise's daughter had been working with a Child and Adolescent Mental Health (CAMHS) Worker for depression and anger management problems for the last 18 months.

Denise's son, Steve, was diagnosed with Asperger's Syndrome at six years of age. He has minimal support from the Disability Services Commission (DSC) due to his geographical isolation, and because "his needs exceed the referral criteria" for school-based supports. Steve's oppositional and aggressive behaviour was a major challenge for Denise, who admitted that she rarely sticks to behavioural consequences or management plans for any of the children. She reports that all of her children have been non-complaint and aggressive on

regular occasions. Steve and Susie attend four hours of weekend leisure respite on weekends, funded by DSC.

Six years ago, Denise had another episode of PND following the birth of her third child, daughter Emma (currently three years of age). Emma's paternity was unclear for the duration of the pregnancy and shortly after the birth, as Denise had been seeing two different men at the time of conception. Emma's genetically determined father, lived 300 km's away and rarely saw his daughter. Emma was described by Denise as very demanding. Denise felt that there was a constant tug of war between Steve and Emma for her attention. Emma was in subsidised day-care three times per week.

I.2. In-session presentation and clinical issues

Denise frequently articulated a sense of being overwhelmed by her circumstances. She reported that she often lied to cover up her perceived failures and to avoid conflict with, or disappointing, the men in her life. As a consequence of these lies, she then feels resentment and anger and eventually "blows up", causing problems to her children and partner – ultimately feeling extreme guilt and negative self evaluation which results in depression.

Denise described herself as having long term depression, exacerbated by a failure in self confidence, poor decision making and negative thought patterns. She reported being sensitive to criticism from her father (who calls her lazy and stupid if she fails to attend to farm chores), and her ex-partners, who are also critical of her home life. She reported being unable to see a future for herself or

her children at times. She wished she could have a “happy family” that included a loving, supportive partner and happy healthy children, while living in a warm, inviting home, but she feels this is increasingly unlikely to ever happen. She still holds onto the dream of being “rescued” by a man, and does not consider this an unhelpful fantasy. She has expressed homicidal ideation about her children to other health professionals in the past. She denies that this has happened for the last year and is not currently experiencing any such thoughts or feelings. She currently considered the children were protective factors against committing suicide, and she denied any current intent, desire or plan to harm herself or her children.

During the course of working with Denise it became apparent that “I was not alone”. By Session 8, I discovered that in addition to my intervention, Denise had 16 separate organisations or individuals attempting to support her or address her needs. Over the six months of telepsychology, she received calls on a weekly basis from the 24-hour mental health support line, saw the psychiatrist twice and her mental health case manager three times. She attended volunteer alcohol counselling services and a reiki practitioner on a regular basis. She ceased one form of individual counselling two months prior to commencing work with me and also attended couples counselling once over the duration of the research intervention. In addition to what she described as “personal development work” at a community/religious centre, Denise also attended playgroup with her daughter, Emma, twice, attended craft group twice, and the Community Development Group, three times. Denise identified an Asperger’s

Support Group in a town 100 kms away, which she attended once. Denise had participated twice in school-based positive parenting training (1 and 3 years earlier). She had a therapised vocabulary. She was unwilling to formally cease any of these “obligations” and stated that she couldn’t get a job outside of the home because she “didn’t have the time to work”.

Denise presented with depression and Cluster B personality features. She described a recurring pattern of needing to please others in her life, particularly men, at the expense of her own mental well being. She felt unable to assert herself with adults or children in her life, and was unable to establish and maintain behavioural boundaries. She did not trust her own decision-making and sought approval or validation from others. She was often paralysed by anxiety and feared failing to meet other people’s standards or expectations. To reduce or avoid conflict, Denise would neglect herself, if necessary, to complete the tasks she believed were expected of her, or lie to cover up her perceived failures when she was unable to complete a task. This behaviour had fractured her relationships and her current partner complained of an inability to trust her. At various times she has been protective of her children. On one occasion she eventually terminated a relationship (i.e. that which she craves the most) to protect her children from physical and emotional abuse. On other occasions however, she has visualised that the children would be better off dead than with her, when contemplating her own suicide. She is mindful to arrange her life to permit some positive experiences between herself and her children (i.e. she rescheduled one of our appointments to maintain her attendance at playgroup

with her youngest daughter, Emma). However, she could also spend days in bed when she was depressed, leaving meal preparation to her oldest daughter, and be unwilling and unable to take the children to school. She was over-serviced in terms of mental health support, and her compliance to the recommendations made by her support workers was erratic and piecemeal. Her life was punctuated by frequent hospital admissions for being “overwhelmed” and suicidal.

I.3. Intervention

Denise was seen for 11 telepsychology sessions over six months. Ultimately, she replayed many of the problematic interpersonal behaviours with me that she had reported to engage in within her other relationships. Within our sessions, Denise demonstrated passive-aggressiveness; lying to cover up failing to complete planned tasks; avoiding responsibility for her behaviour or emotions, and finally, impulsively terminating our therapy relationship because the session had been challenging to her behavioural and personal inertia.

Initially, I attempted to follow the manualised approach with Denise, and began early sessions with psychoeducation and behavioural activation. These early sessions were difficult for Denise. She struggled with insightful self-reflection and her behaviour was self-sabotaging. She presented with problems of affect regulation and impulsivity, impaired memory and attention, problems with self-perception and interpersonal relations, increased somatisation and impaired systems of meaning – as are typically seen in clients with Borderline

Personality Disorder (Linehan, 1993). These symptoms, in addition to the challenges presented by other supports in her environment, resulted in an abandonment of the manualised CBT approach after three sessions.

Denise failed to complete all assessments as provided to her, despite requests by me to do so. She returned assessments after Sessions 1, 2, 5, 8, 10 and at follow-up. Denise was the first client that was referred to the telepsychology research project, and began before the others. Her failure to complete all the assessments as I had planned was not managed at the far site as effectively as it was with the other clients who were seen over the course of the intervention research. Perhaps the reason that nearly all the telepsychology participants had their assessments administered to them at different times than were planned (or even had some missed) is because the participants started the intervention in a staggered manner. Future telepsychology services might find more consistent assessment results are obtained when every client receives the same instrument at the same time. In this research, the decision to commence therapy from a staggered start was based on ethical concerns, as well as availability of suitable referrals. It was not appropriate to make people wait for appropriate treatment. The lack of control over the administration of assessments, and the need to rely on others at the far site to follow-up on assessments, is also an obvious drawback with telepsychology.

Denise was reminded to complete all assessments at the end of the session by the therapist, but, according to the receptionist, she occasionally left the office without doing so. In face-to-face sessions, the client might have been

able to complete assessments in the same room as the therapist, or the therapist could remind the receptionist that the client would be completing assessments in the waiting room. Such approaches were unable to be implemented, because the room needed to be vacated for the next telepsychology session or for the normal room usage, and the normal showing out/inviting in of clients that occurs between an office and waiting room did not occur. Subsequently, her data set is missing some valuable assessment points. She was assessed after five of the eleven sessions which occurred over a six-month period, and again at three-monthly follow-up.

I observed that, as therapy progressed, there seemed to be an improvement in her mood and capacity for coping at times. Ultimately, however, the gains which seemed to be made in one session appeared to be undermined at the next session. Only very small positive changes were seen in outcome measures and in the qualitative reports from Session 1 to Session 10 overall. In the end, however, based on the follow-up feedback, any small gains that were achieved during the intervention were overshadowed and minimised by the client, after the confrontational group meeting of Session 11(described below), and her subsequent, unexpected, early termination.

On intake, her results on standardised measurements were as follows; State subscale of the State-Trait Anxiety Inventory (STAI-S) = 78%; Trait subscale of STAI (STAI-T) = 84%; and 34 (severe depression) on the Beck Depression Inventory (BDI-II). Denise's scores on the Clinical Outcomes in Routine Evaluation-Outcome Measures (CORE-OM) are presented from baseline

measures at Session 1 to follow-up measures three months after the end of therapy (Table I.1). The developers of the CORE-OM have determined from a national sample of UK community respondents and therapy clients, a number of cut-off scores to differentiate between clinical "caseness" and sub-clinical or non-caseness (Evans et al., 2002) that the clinical cut-off to indicate "caseness" is a score of 10 (1 SD = 5 points). Based on the recommendations from Gray and Mellor-Clark (2007), all of Denise's subscale results, except *Risk* (to self or others), exceeded caseness on all measurement occurrences. Four bands of scores above the clinical cut-off have been established as representative of mild, moderate and severe levels of distress.

Table I.1. ***Table of Denise's CORE-OM subscale results during intervention and at follow-up with reference to clinical versus subclinical cut-offs (Core Partnership 2007; Evans et al., 2002)***

Subscale (clinical cut-off females)	**Wellbeing (1.77)**	**Problems (1.62)**	**Functioning (1.3)**	**Risk to Self (0.31)**	**Total (1.29)**
Session 1	2.8 *(severe)*	2.6 *(severe)*	2.8 *(severe)*	0.3 *(sub-clin)*	2.3 *(mod-severe)*
Session 2	2.3 *(mod severe)*	2.4 *(mod severe)*	2.5 *(mod severe)*	0.2 *(sub-clin)*	2.4 *(mod severe)*
Session 5	2.7 *(severe)*	2.6 *(severe)*	2.3 *(mod severe)*	0.2 *(sub-clin)*	2.0 *(moderate)*
Session 8	2.5 *(mod severe)*	2.5 *(mod severe)*	2.3 *(mod severe)*	0.2 *(sub-clin)*	2.4 *(mod severe)*
Follow-up	4.0 *(severe)*	2.8 *(severe)*	2.9 *(severe)*	0.1 *(sub-clin)*	3.0 *(severe)*

As can be seen above, Denises's CORE-OM scores never fell below caseness, and, in fact, worsened between Session 8 and follow-up. The CORE-

OM developers suggest that clinically significant change, i.e. change that is in excess of one standard deviation (0.5 points) can be assumed when a client moves from caseness to non-caseness (healthy levels), and reliable statistical change is the movement that may not be explained by chance alone (Core Partnership, 2007). Jacobson and Truax (1991) recommend a cut-off point at two standard deviations from the mean of the functional population, which in the case of the CORE-OM would be the equivalent of 1.0 point difference. Denise's score worsened across levels from low to mild, and by 1.5 points in the *Wellbeing* subscale, and by 0.6 points in the *Functioning* subscale. The factors contributing to the change will be detailed further in the sections below.

Denise's scores on the BSI at baseline suggested that she was struggling with phobic avoidance, which was the only subscale to reach clinical "caseness". Denise indicated low levels on the PST and PSDI, suggesting either that she may have had a "minimising" style when representing her distress, or that she had little insight into her distress. Her scores on depression, anxiety and hostility were surprisingly low (54, 49 and 55, respectively).

As can be seen in Figure G.1, at three months follow-up, Denise scored a large jump in the PST, suggesting that the breadth of symptoms that she endorsed as current concerns had increased substantially, and that she may have been "augmenting" her distress. Her scores on the paranoia subscale exceeded caseness (64), although her phobic avoidance scores had decreased (60). Her score on the psychoticism subscale had also increased to

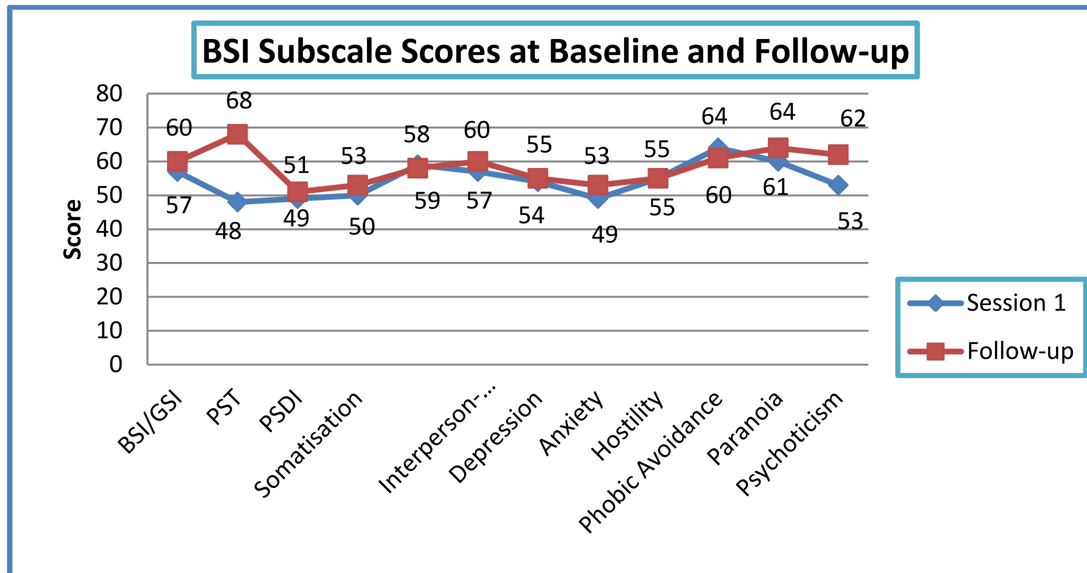

Figure G.1 Denise's Brief Symptom Inventory subscale scores at baseline and follow-up

near caseness, and perhaps this was linked to her paranoia increase, along with increases in interpersonal sensitivity, depression, anxiety and hostility. As shall be detailed later, my impression was that her responses reflected the anger she still felt toward me after she terminated the therapy suddenly.

I.3.1   Relevant Session Events: Session 1

Session 1 began with a thorough history-taking from Denise, and is detailed above. Her initial response to the telepsychology environment gave the impression that she felt self-conscious. It was unclear at the first session whether Denise found it difficult to maintain eye contact with me because she struggled with the social skills to do so, and this would have been typical presentation, or whether she felt uncomfortable with the telepsychology environment, and "looking down the camera". Denise struggled to manipulate

the camera smoothly, after a brief instruction from the receptionist at the far site. After several attempts to alter the size of the image on screen to suit her comfort, Denise asked the receptionist to reset the camera shot to its original size. She was more confident in managing the volume on this and subsequent sessions.

Her ratings of satisfaction indicated that despite the difficulty she had with the technology, she felt she had reasonable levels of comfort, freedom from distractibility with the technology and ease with its use (3/5). Although she did not rate the usefulness of the session or the sound quality highly (2/5) she found the picture clarity good (3/5) and felt that she had control over the session (4/5) (See Figure G.2).

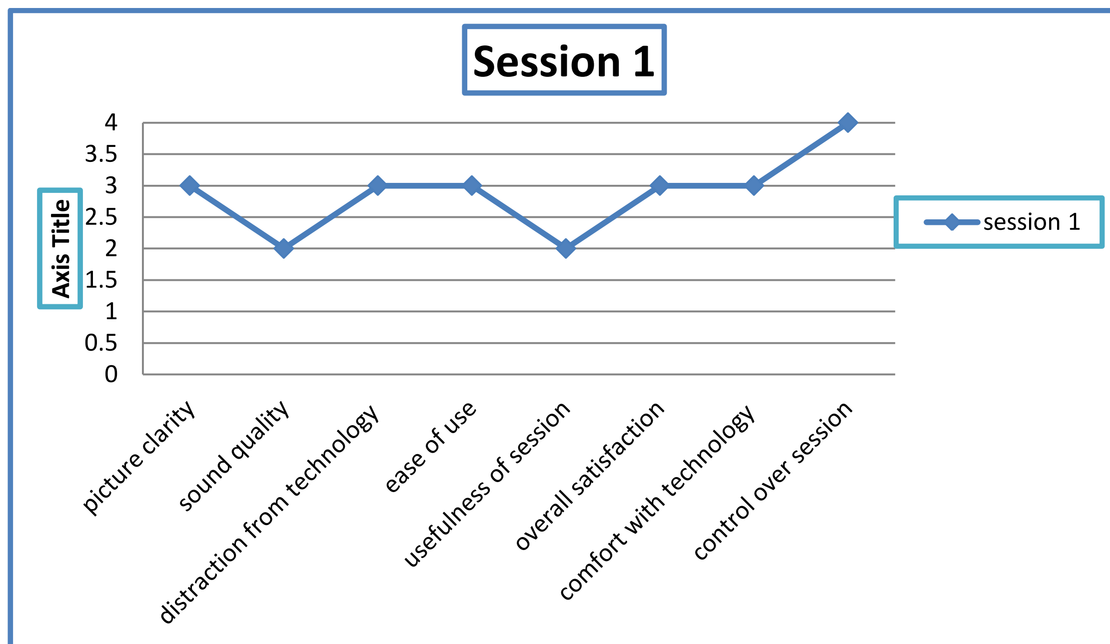

Figure I.2. ***Denise's Satisfaction ratings for Session 1***

Her long answers on the satisfaction questionnaire indicated that;

if given the choice of having either face-to-face or telepsychology (video-therapy) sessions, she would choose face-to-face therapy because face-to-face therapy is...“more personal, felt easier to express things without worrying about how I come across on the TV screen or too loud/soft voice”. In addition, if given the choice of having either telephone or telepsychology (video-therapy) sessions she would choose telepsychology because telepsychology provided...“more connection with the therapist as you can see them as a person and not a voice at the end of the telephone”. These comments support my observation that she seemed self-conscious, but was also valuing the visual context that telepsychology provided. As Denise had weekly telephone mental health support, her preference response was coming from experience. I wondered how effective those weekly telephone sessions were, because of Denise’s feelings.

Denise indicated that using videoconferencing for her therapy sessions made her feel more self-conscious or embarrassed than face-to-face sessions and she rated the control item at the extreme end of (4). She explained the reason for this high score as “I feel like there is more intensive scrutiny of your reactions etc on videoconferencing”. Given Denise’s relatively high score on the paranoia (61), and phobic avoidance (64), subscales on the BSI (outlined above and in Figure 9.1), in addition to her general demeanour and history of being frequently criticised, such a response is not surprising.

Despite her reservations with telepsychology and the therapy thus far, Denise’s final comment about her telepsychology experience was positive. After

the first session she wrote; “I enjoyed it and look forward to the progressive sessions”.

At times, Denise gave the impression that she was listening intently, as if to a television show, rather than engaging with me. As described above (see Figure I.2), it may have been that the sound quality was poor and she had to concentrate to hear me well. Another explanation was that this was due to the artificiality of the interaction for her, or perhaps it was an avoidance strategy to maintain emotional distance. Because she gave the impression of listening, rather than engaging, I noted that I reiterated or paraphrased myself many times, especially in the early psychoeducation-based sessions. During these early sessions, Denise also spoke at the same time as I did (i.e. speaking over the top of me). Reasons for this behaviour may have been 1) to indicate her understanding of my repetitions; 2) because she was unfamiliar with the turn-taking necessity of the technology, or 3) to curtail an uncomfortable discussion.

For the most part, Denise engaged with me adequately during the first session. She was very open about her history, including disclosing her shame about wishing she didn’t have children, her past homicidal and suicidal ideation, and her abusive childhood. Her openness is reflected in the scores I gave her on various subscales of the Agnew Relationship Measure (ARM).

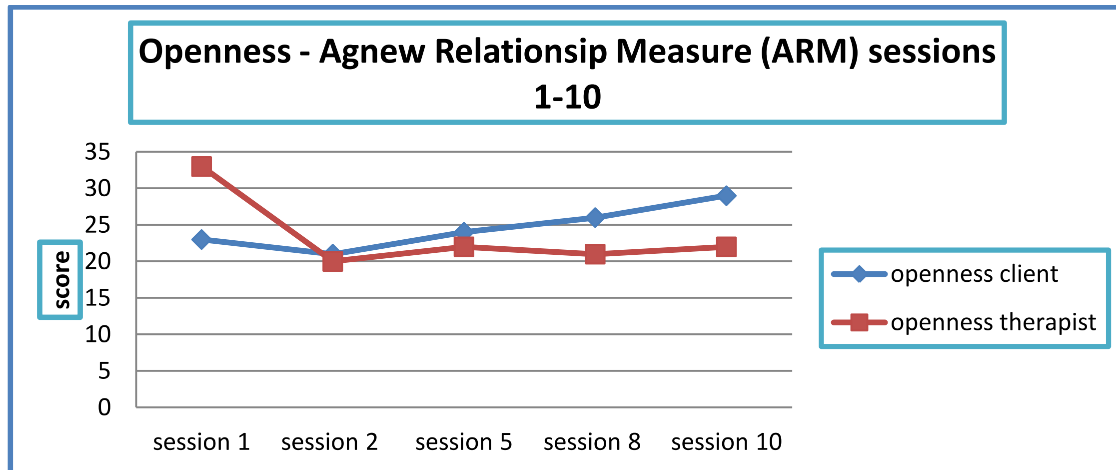

Figure I.3. ***Denise's ratings on the openness subscale of the Agnew Relationship Measure (ARM) for the 5 measurement occurances between Sessions 1-10.***

What is apparent from all the ratings on the ARM (see Figure I.3), is that I rated Denise's connection with me and the therapy process higher than she did at the first session, but from Session 2 on my ratings of her bond, initiative, partnership, openness and my confidence to assist her, decreased to a level below her ratings, and stayed below for the rest of the sessions. This pattern suggests that after our first meeting, I felt a stronger therapeutic alliance, and more positive about the therapy outcome, than Denise did.

I.3.2. Relevant Session Events: Session 2

Session 2 began positively with Denise attending on time and groomed. She had a visible injection site wound in her elbow which was visible to me on the monitor. On enquiry, Denise advised that she had received a blood test from her GP to test for hypothyroid to explain her fatigue and anergia. She presented as mildly dysthymic with deliberate, effortful speech at times, sad affect, and

down-turned, defeated posture. She reported feeling positive about our first session and felt confident to proceed with the intervention.

The agenda of this session was to clarify her risk management plan and identify goals and plans for the rest of the intervention, and to discuss the costs and benefits of change. This therapeutic activity followed the manual, at this stage. In order to complete the goal-writing exercise, Denise dictated her responses to me and I wrote a copy of them down on my worksheet template. I suggested that Denise speak with the clinic receptionist and ask them to fax me a copy of her goals. Denise was supposed to have written these goals before the session began, but she sheepishly confessed that "she didn't have time to do them". With minimal prompting Denise's initial goals were as follows: 1) to be more confident in her parenting; and 2) to feel happier.

When I asked her to expand on this and to explain how she would know if she had achieved her goals, it became apparent that parenting problems were the most typical way that Denise criticised herself. Denise seemed to believe that, if she could manage her kids better, she would be happier in all aspects. To that end, she demonstrated fairly limited insight into the extent of her negative self-talk and unrealistic beliefs that had nothing to do with her parenting but were extremely destructive to her self-esteem. Initially, she only formulated goals to address her parenting and had to be pushed to bring some change focus onto herself. I was becoming aware that Denise's therapised vocabulary may have masked how little she understood, or considered, about herself and her own behaviour's contribution to problems in her life. This speculation was further

borne out by the example she provided of her responses to tantrum and disobedience by her son, Steve.

With some suggestions and behavioural guidance from me, Denise was ultimately able to identify the following goals for intervention – and they are presented in the order in which she wrote (and prioritised?) them;

1. “to increase consistency in my parenting strategies”;
2. “to reduce Steve’s current bad behaviour (to 0 instances of refusal per day; to 0 instances of aggression per day)”;
3. “increase instances of Steve’s good behaviour (as evidence by me being able to give at least 5 compliments per day)”;
4. “to challenge my negative thoughts (to reduce the frequency of my own negative thoughts by recording and challenging my thoughts to demonstrate a reducing frequency, and increase my positive self talk – as evidence by a positive SUDS rating >5)”;
5. “to increase the number of pleasurable activities I engage in for myself (3 per week) to feel happier and more relaxed”;
6. “To increase time for myself (by prioritising my needs as much as those of the children) to repair my health for at least 30 mins per day of quiet (and/or alone) time”.

My impression was that if we hadn’t spent a long time on developing the last three goals, Denise would have focussed all her attention on “fixing the children”, and not recognised that the focus of the intervention was on her. I observed that Denise frequently used blame and refocussing to avoid dealing

with, or being responsible for, her own behaviour or emotional response. It was this aspect of her interaction style which changed my assessment of her in terms of our alliance (See Figure I.4. below).

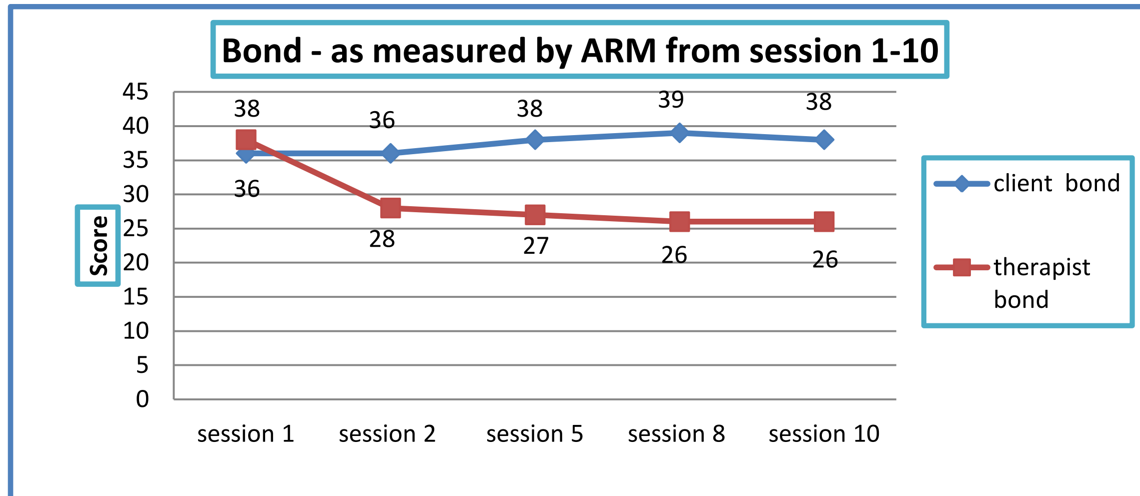

Figure I.4 ***Denise's ratings on the bond subscale of the Agnew Relationship Measure (ARM) for the 5 measurement occurances between Sessions 1-10.***

As can be seen above, my ratings of bond dropped by 10 points between Session 1 and 2, and was 8 points lower in Session 2, than Denise's rating of the same session. Similar large drops in my (therapist) ratings from Session 1 to Session 2 can be seen on all subscale measures (See Figure I.5 below). These drops in rating appear large, but I am unsure as to why they fell so dramatically. The session progressed adequately, though a little ponderously, and the videoconferencing technology was not distracting.

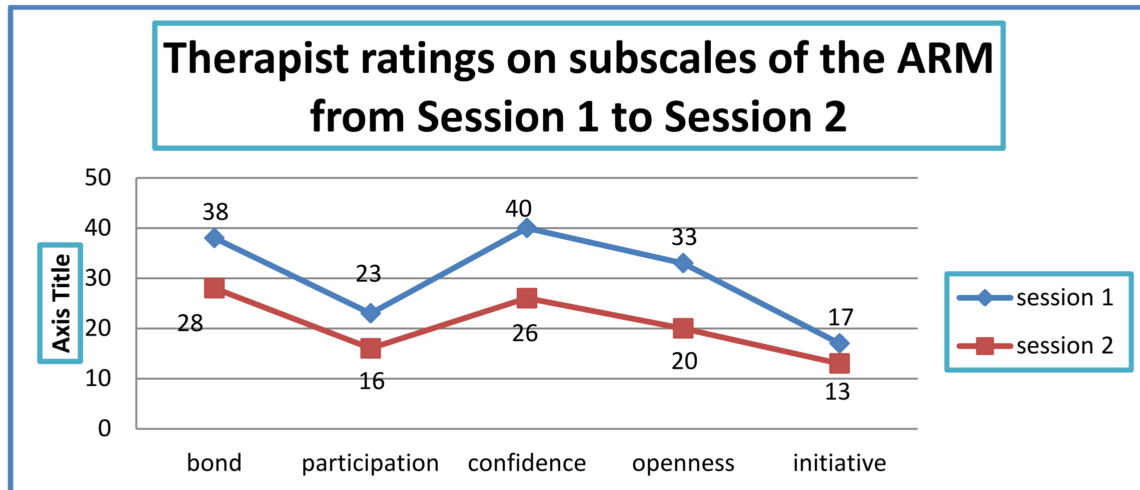

Figure I.5. ***Therapist ratings of all subscales of the ARM comparing Session 1 to Session 2 ratings.***

Denise's scores on the measures of anxiety and depression (the STAI and the BDI-II) also fell between the end of Session 1 and the end of Session 2; both from high and severe levels, respectively, to moderate levels for both (see Figure I.6). Given that "therapy" per se had yet to occur, this drop is difficult to explain. Perhaps the act of describing her problems in a supportive, encouraging environment was sufficient to offer some emotional relief. Research has demonstrated that assessment itself can sometimes be considered therapeutic. Tang and DeRubeis (1999) identified that many CBT patients experienced sudden and large symptom improvements during a single between-session interval, known as "sudden gains", and quantitised a "sudden gain" as being a 7-point reduction on the Beck Depression Inventory-II (BDI-II). Although Denise's BDI-II score change met this criteria, the change was not sustained over the course of the intervention, nor was it significant in relation to the mean change, where mean scores on the BDI-II were 32 (SD = 3.36).

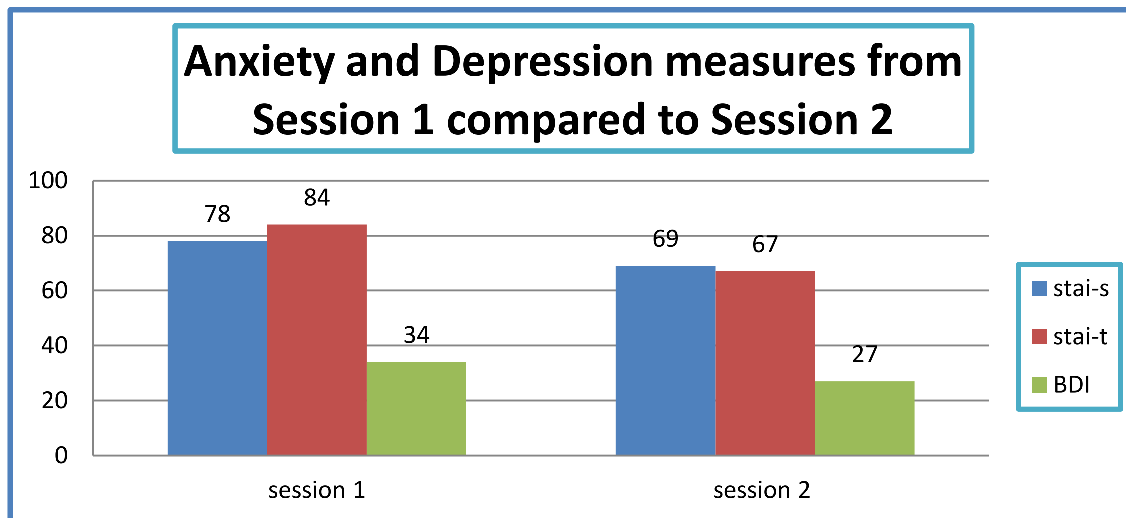

Figure I.6. ***Denise's BDI-II and STAI ratings from Session 1 to Session 2.***

Denise's ratings of satisfaction improved from Session 1 to Session 2 on a number of items including sound quality, session usefulness and overall satisfaction with telepsychology. Her ratings decreased, relative to session 1, on picture quality and control over the session. She wrote long responses which indicated that, though she still considered face-to face therapy better than telepsychology because it was "more personal", when compared to telephone therapy, she prefered being able to "see the other person's face" in telepsychology. Compared to Session 1, Denise rated her self-consciousness lower (3) than she did at Session 1 (4), but stated that this was when "looking at faces" she preferred to have "eye contact that I feel comfortable with". She indicated in her final comment about telepsychology that she was "getting more comfortable with it".

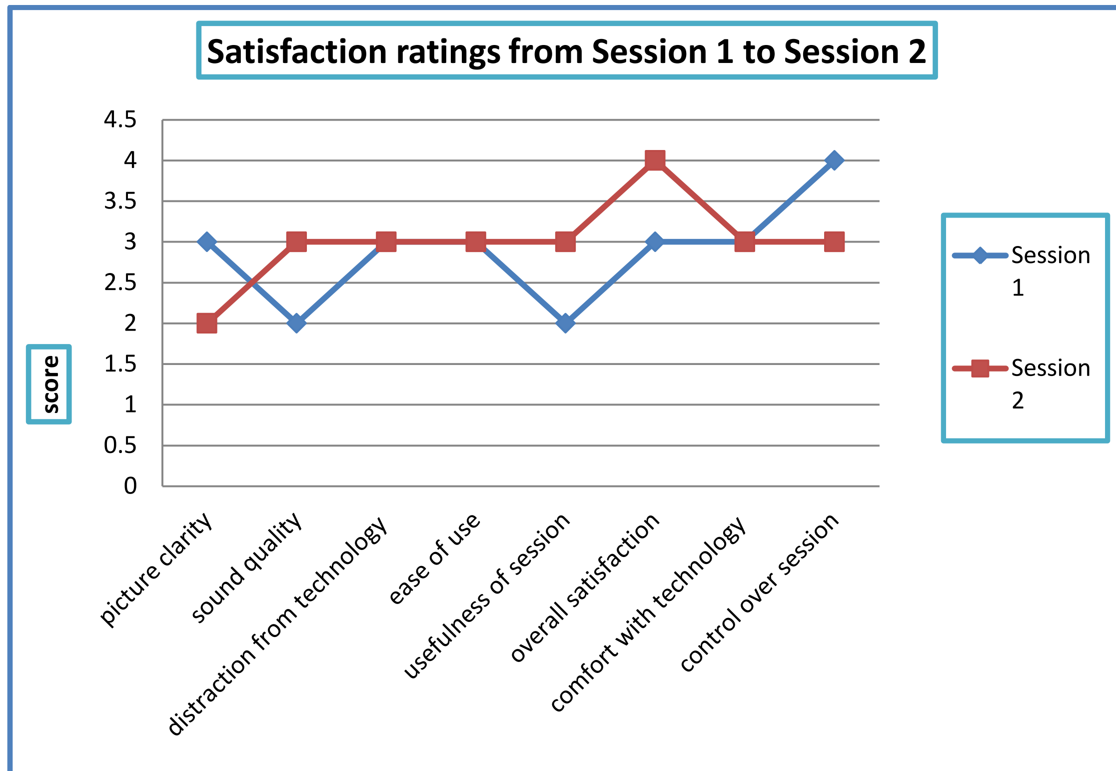

Figure I.7 ***Denise's satisfaction rating changes from Session 1 to Session 2.***

One of the treatment issues that seemed particular to this client in this telepsychology environment was due to the manualised CBT format that the treatment intervention initially took. The manualised CBT process, conducted at a distance, allowed for Denise to literally "hide behind a book". The room in which telepsychology was conducted consisted of a chair at a large desk facing the screen (not unlike a classroom); the participant manual appeared to almost represent a textbook, and the guided exercises were inside, like mini school assignments. During sessions, Denise took many notes and flicked through the manual pages, despite the engagement being a collaborative, as opposed to didactic, one. To some extent, this may have also triggered a response pattern

she had played out with perceived authority figures in her past, i.e. another "teacher" telling her what to think, do and feel. Sitting at a desk with a book to use as a "prop", being able to avert her eyes from the screen, and having to manage the remote for the teleconference, gave Denise objects and behaviours that maintained emotional distance. My impression was that this was an effective strategy to avoid reflection and cognitive or behaviour change, whilst maintaining her avoidance of conflict and responsibility to change her own situation. She could be seen to be "doing the right thing", being busy, but not actually doing anything to alter her situation. It was because of these types of impressions and observations of Denise's subsequent behaviours that I considered Denise to present with more Cluster B personality features, rather than the dependent or avoidant personality features of Cluster C type disorders. These observations are probably also what contributed to my reduced ratings of Denise's initiative (See Figure G.8), confidence (Figure G.9) and participation (Figure G.10) below that were taken at Session 2.

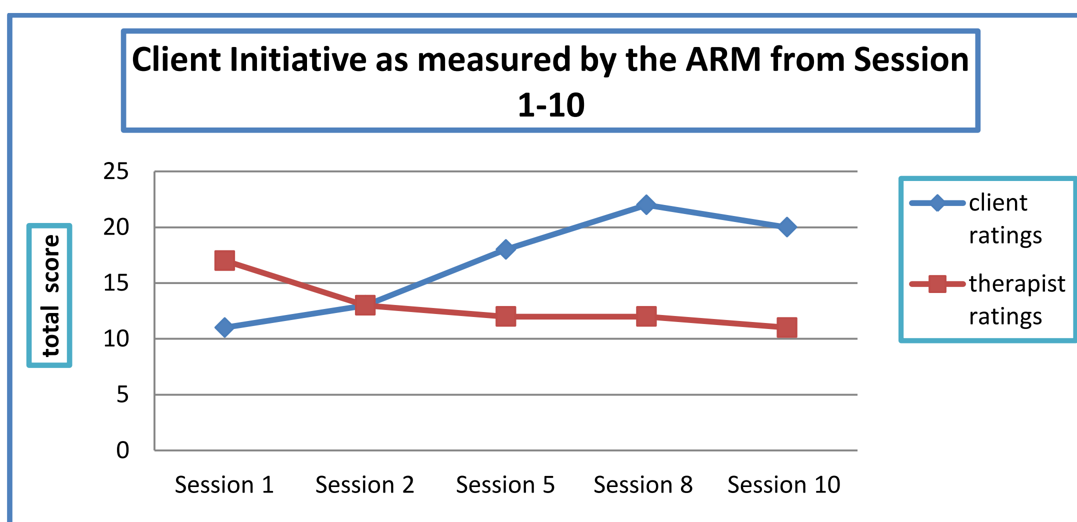

Figure I.8. ***Denise's ratings on the initiative subscale of the Agnew Relationship Measure (ARM) for the 5 measurement occurances between Sessions 1-10.***

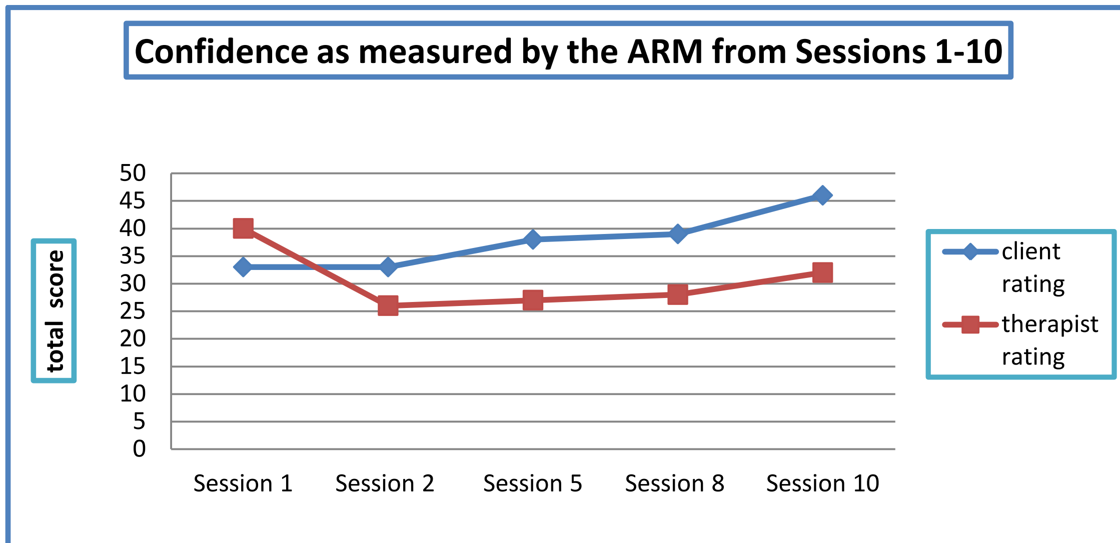

Figure I.9. ***Denise's ratings on the confidence subscale of the Agnew Relationship Measure (ARM) for the 5 measurement occurances between Sessions 1-10.***

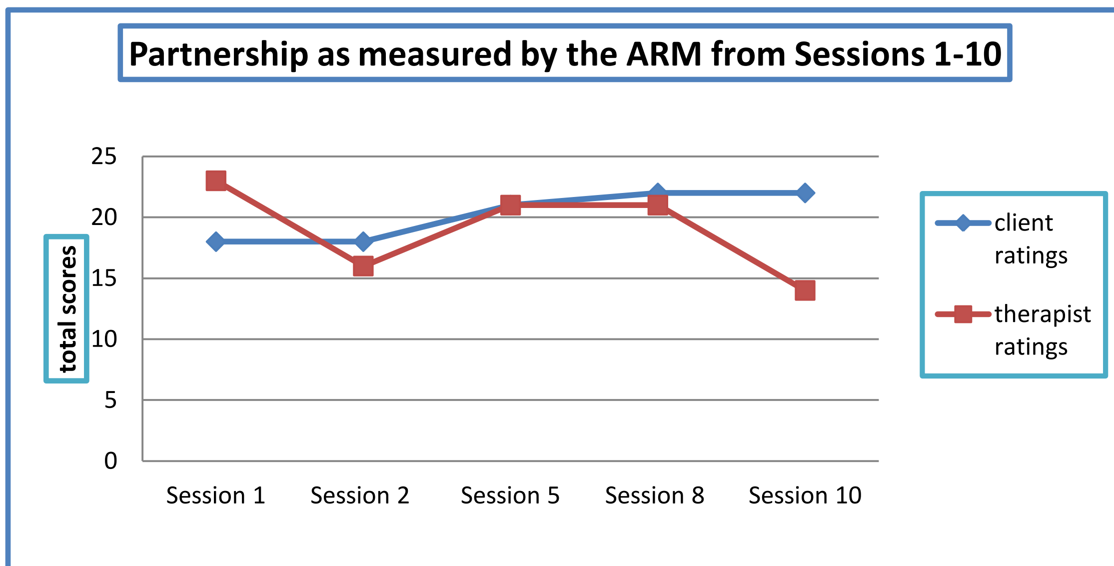

Figure I.10. ***Denise's ratings on the partnership subscale of the Agnew Relationship Measure (ARM) for the 5 measurement occurances between Sessions 1-10.***

I.3.3. Relevent Session Events – Session 3-5

Denise appeared on screen at Session 3 looking fatigued and sad. She expressed feelings of helplessness and low motivation, and was overwhelmed by issues at home related to chores, parenting, and good nutrition, yet she stated that she was not feeling very depressed. Unexpectedly, going on previous

behaviour, Denise completed her homework from the manual which was a decisional balance sheet for implementing change. Denise explained that the long-term benefits of making changes to her home routine and her own self-esteem would have positive benefits, however could see short-term discomfort associated with attempting to set limits on Steve's behaviour, and seemed ambivalent about her confidence to implement these strategies. My role in this session was to reinforce her positive choices, encourage her to take a problem-solving approach, and focus on small achievable goals.

Part of the session agenda, as per the manual, was to review Denise's time management by (i) looking at her current activity schedule, and (ii) identifying where changes or refinements could be made. The review included looking at how to schedule pleasant activities in to her days, in addition to scheduling mastery activities to enhance her sense of accomplishment

Denise seemed to struggle to manage what little time she had to herself by over committing to personal development activities (e.g. 12 Steps House, Carer's support group, Asperger's support group, etc.,) and to her children's after school activities (e.g. picking up and dropping off between dancing and sport). She seemed more willing to give up her own support activities (i.e. reducing her CAMHS respite appointments) than limiting the kid's activities or allowing others to help her. The consequence was that the children were demanding and she felt resentful and angry toward them, so much so that she would punish them inconsistently and harshly at times.

Denise described feeling resentful of her children monopolising her time and giving her no rest, despite options for respite being available to Denise. She described a circle of jealousy, attention-seeking, rejection, anger and resentment as occurring between herself, Emma and Susie. This circle is interspersed with Steve's behavioural outbursts and inability for Denise to ever have the sense that she is reconciled (forgiven?) with Steve, due to his emotional distance. When I suggested that Denise spend time recruiting and reinforcing Susie to assist with the care of Emma, she seemed reluctant, due to the amount of effort and lack of time to reinforce Susie with what she wants most of all; namely, her mother's undivided attention.

My observations during the session were that Denise was an agreeable, but not entirely convincing, participant in the telepsychology therapy and her own change process. I felt that she would benefit from taking time to reaffirm her beliefs about her decision to change, and realistically appraise her commitment to the effort involved.

Session 4 was when the extent of Denise's self-sabotaging behaviour and misplaced anger started to become apparent. Denise appeared dishevelled and ungroomed, with obvious signs of reduced self-care including no make-up, greasy hair and wearing a stained old t-shirt. This dishevelment was apparent without need for a camera close-up, but I did so anyway. She looked fatigued, often rubbing her eyes and wringing her hands through her hair. Her eye contact with me was poor, but I could not determine if this was due to her physical agitation, usual avoidance, or feelings of guilt. She blamed her tiredness on

Emma's poor sleep and her clinginess. She complained irritably and frequently that "Emma had given her a migraine", and she felt unable to concentrate.

Denise advised me that she had attended counselling at the 12 steps programme already that morning. She reported that she had tried to end her counselling sessions there, but felt she had been coerced to keep future appointments. She reported that this made her feel guilty and stressed, as she was trying to reduce her burden of appointments, but was unable to be assertive with the counsellor.

She reported that the children were not going to bed until 9:30pm, after which time she was too exhausted to attend to her own homework commitments. She was getting behind on housework, and was feeling overwhelmed by the amount of chores she needed to do, especially while the children were causing her frustration by "constantly wanting her attention".

As far as she was concerned her children were the cause of her difficulties and they "were not being fair" to her. Finally, she disclosed that she had not taken her antidepressant medication for seven days. When I prompted, she conceded that perhaps some of her current negative mood state and failure to cope may have been attributable to this absence of medication. Denise did not seem to consider her own behaviour was implicated in her current mood state. Her perspective seemed to be that her children, her counsellor and I, should know that we were all preventing her from doing something she wanted to do and just stop. Her statements belied her childlike way of viewing the situation, and the lack of responsibility she took for dealing with her problems. It became

apparent quickly that Denise was not happy to be at telepsychology when she stated after 20 minutes, “everyone is always telling me what to do” and that she could not finish the session. I encouraged her to stay, but she insisted with irritation that her headache was too bad, and she terminated the session abruptly. I was left with an impression of witnessing a child’s tantrum.

Session 5 was missed for five weeks in a row. I was advised by the Community Mental Health Team (CMHT) that Denise’s grandmother had died two weeks earlier and Denise had travelled with her children to Perth for the funeral. She attended telepsychology five weeks after Session 4.

Denise described strong feelings of sadness and loss associated with the death of her grandmother, but while she was emotionally affected by her retelling of her relationship with her grandmother, she did not become tearful or excessively emotional, but appeared to be regulating her feelings in an appropriate manner. I zoomed in on her face to monitor her expressions and was able to see damp eyes, but no tears. I made comment to Denise about her self-control, and Denise agreed that she was managing herself better. She acknowledged that getting too emotional didn’t help her or the children.

She reported having spent much of the week in bed with a cold. Emma had been sick also. This period of time had provided Denise a chance to “rest”, as well as grieve privately, while the children were at school. Having Steve back in a school routine appeared also to have settled his angry outbursts and she recognised the importance of routine for him.

Being in Perth for the funeral and spending time with her extended family had been difficult. Denise had resigned herself to have no more contact with her extended family – and she was currently still very angry with her father for trying to control her at her grandmother's funeral. She gave the following example; she had wanted the children to place some flowers on their nanna's closed casket and Denise's father would not allow this. He also put limits on how long Denise was allowed to sit with her grandmother (who had an open casket at Denise's aunt's home) even though Denise arrived on the day of the cremation, and other family members had been able to tend to her grandmother for five preceding days. She recognised that being told to "do as you're told" was disrespectful of her needs and her as an adult. She had told her father to back off and her reasons for wanting to spend longer with her grandmother, and believed she had been assertive with him. Her cousins commented to her at the time that they had never seen her stand up to her Dad like that before. She felt glad to have stood her ground, but sorry she let him bully her into not allowing the children to say goodbye (Susie was also close to her great grandma).

On the basis of her account of the positive parenting behaviours, good decision making, supportive self-statements and assertiveness that she described, I modelled a negative thought-challenging exercise, related to her doubts associated with these unfamiliar behaviours. She felt pleased about her achievements, despite feeling sad.

Denise was administered the Session 5 assessment packages that did not contain the BDI-II or STAI questionnaires. She completed a CORE-OM, ARM

and Satisfaction Survey only. Her results compared to Session 1 on the CORE-OM indicated very little change, other than slight, non-significant reductions (i.e. “worse” performance) in all subscale scores (see Figure I.11).

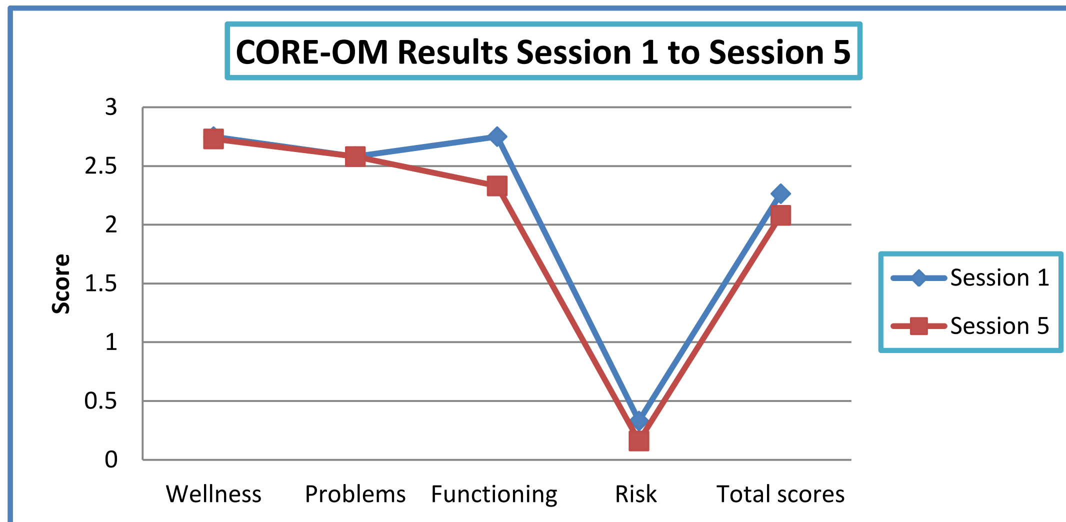

Figure I.11. Comparison of clients ratings on the subscales of the CORE-OM at Session 1 and Session 5

The comparison of total scores on the Agnew Relationship Measure (ARM) in Session 5, demonstrated equivalent non-significant improvements overall between the client and therapist. This result suggests that positive changes to the relationship were experienced similarly by Denise and I, although at a lower scoring range for the therapist. With regard to the ARM subscale scores, Denise and I were in agreement regarding the level of “partnership” at Session 5, but I continued to rate her lower than she rated herself on bond, initiative, confidence and openness (Figure 1.12).

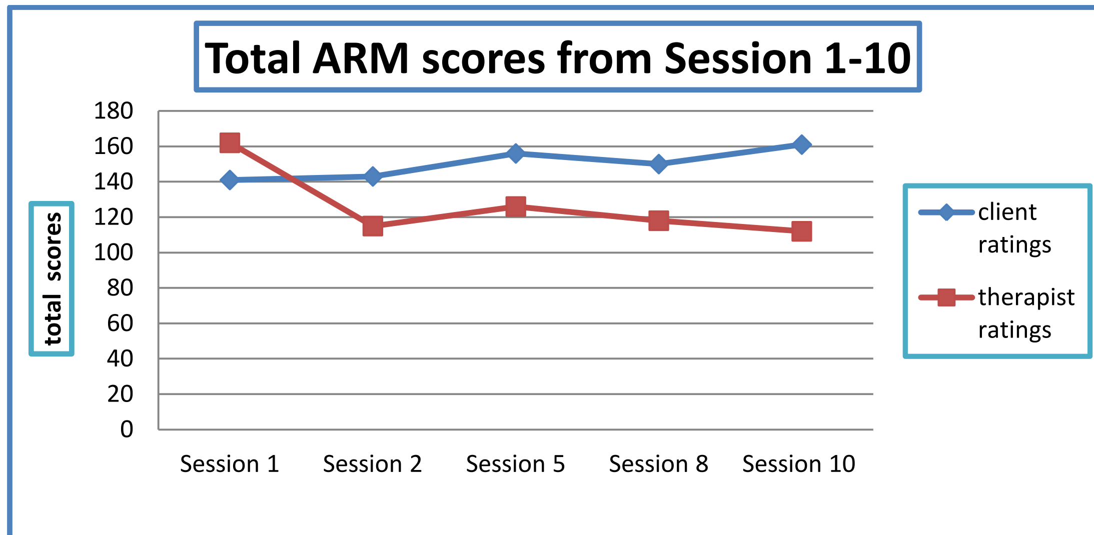

Figure I.12 Total Agnew Relationship Scores for all Sessions comparing therapist and client ratings.

I.3.4. Relevant Session Events – Sessions 6-8

Sessions 6 to 8 were marked by the features of chaotic emotional dysregulation and dyscopia in Denise. These three sessions represented a real challenge to distance telepsychology. Their hallmark features of "client-in-crisis" provided circumstances which could not be managed alone by me (the near-site therapist). Responsible client management required the involvement of staff at the far site to manage risk and contain the client appropriately.

Denise presented at Session 6 (two weeks later than planned) as very depressed. She had not been sleeping, was still sick with a cold, and was still grieving her grandmother's death. Exacerbating her grief were ongoing parenting problems with her children, and with her own father, who was expressing suicidal thoughts as well. Denice's recent telephone contact with her father had revealed that he was expressing thoughts that he wished he were

dead, as he could not see any purpose in his own life, now that his mother had died.

Due to these family pressures, Denise had neglected her self-care, and close-up examination revealed she was unkempt, dirty looking and told me that she had not showered for three days. She had felt unable to get to the chemist and so had run out of her medication 5 days earlier. She complained of ongoing headaches, fatigue, lack of motivation, anergia, increased tearfulness, forgetfulness, and indecision. Denise stated that she felt as if her life would never improve, that she was a failure for being unable to cope and couldn't see a positive future for herself. In contrast to past episodes of suicidal ideation, she felt that that her children would be better off without her, whereas in the past, she expressed ideation that they too would be better off dead. She denied any thoughts to harm the children, but was ambivalent about her own desire to live. On exploration, she had no current means, plan or intent to act on her feelings of hopelessness, however her past suicide attempts had been impulsive. Of concern was the fact that she had few supports around her because her regular CMHT case manager was away for 8 more weeks, and Denise and Steve were unwilling to see Jo, the case manager's locum.

This session's therapeutic agenda had to be abandoned, due to Denise's presentation and her low suicidal risk presentation. Following some supportive counselling, positive reinforcement and problem solving, with Denise's permission, I called reception and asked the Triage Officer (T/O) at the Clinic to come on the screen. With Denise waiting in reception, I briefly provided a verbal

handover to the Triage Officer, outlining my concerns for Denise's vulnerability to escalation of risk to herself and past history of ideation to harm the children. These concerns included her current suicidal ambivalence, her poor cognitive coping strategies and emotional dysregulation, and the lack of respite from childcare until the weekend, her lack of adequate social support, her unwillingness to access locum case management support at present, her potential to neglect the care of the children, and having no current medication.

The T/O and I invited Denise back to the telepsychology room and requested the T/O follow-up for; 1) immediate recommencement of antidepressant medication (ADM); 2) referral to telephone support overnight and weekend 3) T/O to contact Disability Service Commission after the weekend to arrange respite for Steve; 3) to increase weekend activity support via "Strive" for Sally and Steve, and 4) Family and Children's Services to be contacted for long-term assistance for Steve.

Session 7 began after a two-week delay. Denise had been admitted to the Regional Hospital Psychiatric Unit for one week, earlier on, for respite and because of her increasing suicidal ideation and inability to cope. She reported having ongoing depressed mood, as a consequence of parenting difficulties, and being criticised by her partner and father about her parenting, her incompetence to manage her own property, her failing self-care and her "unattractive appearance". Although she had seen her psychiatrist twice, she had still not filled her prescriptions. This presentation prompted a discussion about priorities (for herself and medication) and her goals for therapy.

Denise then read out her list of goals that she had developed for herself while in hospital the previous week. These included improving her assertiveness and boundaries with others; coping with conflict instead of avoiding it; taking more responsibility and owning her own decisions; overcoming inertia; reducing comfort eating; being a more consistent parent; facing painful issues instead of giving up or running away; not settling for relationships to avoid loneliness. She clutched her list tightly and struggled to direct her gaze to me.

With prompting, she then disclosed a full account of all the parties involved in her mental health care: 1) Sally and Steve's school counsellor; 2) a 12-Steps coach/counsellor ; 3) a Reiki counsellor; 4) two different Child and Adolescent Mental Health Team (CAMHS) case managers; 5) a specialist "Triple-P" school psychologist; 6) triage officer at Regional Community Mental Health Team (CMHT); 7) her CMHT psychiatrist; 8) the local playgroup leader; 9) a Tendercare relationships counsellor; 10) a subsidised private psychologist at SW Counselling Service; 11) peer support from the local craft group; 12) peer support from committee members of the Local Community Development Committee of which she was also a member; 13) at least weekly contact from the local 24/7 telephone and psychiatric triage service; 14) her case manager from Department for Community Development/ Family & Children's Services; 15) and me, providing telepsychology.

Although I had previously asked Denise to list all of her helpers, she had never done so as clearly or as completely as she did during this session. My

impression was that her guard was down, and she was unable to recall what she had previously told me, so she told me everything.

On the basis of this list and her self-expressed goal to create stronger boundaries and build assertiveness, I suggested paring down her commitments and activities to two or three core services (such as the CMHT, CAMHS and DCD). Although Denise verbally agreed with this, her body language on screen was avoidant and passive. She then stated that she “felt obliged to people” and so continued with all her services and supports, even when she did not wish to, or felt them to be demanding or unhelpful. She did this to avoid what she believed would be interpersonal conflict. The result of this avoidance was that she continued to behave in ways she believed others wanted, over-committed herself, felt resentful and overwhelmed, failed to make that commitment, then, feeling guilty and worthless, failed others as well. She then became more depressed, guilty and avoidant, and the cycle continued.

Given the myriad of health professionals involved with Denise and her family, it was determined, in consultation with her Community Mental Health Case Manager, a family systems approach was to be taken. This approach was to include a shared agenda and goals between professionals, while also culling extraneous or overlapping professional involvement, and encouraging Denise to prioritise intervention and take back control over the kind of help she received

The choice to take this approach was well supported, conceptually, by all professionals involved with Denise, and one that was agreed to be necessary to reduce overlap and conflicting agendas. However, it soon became apparent that

the other professionals involved assumed that I would take responsibility for managing this family system, as they appeared to be reluctant to take responsibility in a practical, as opposed to titular, capacity. As the telepsychologist, and a “long-distance professional”, assuming this role was a challenge, however, one that in the short term appeared necessary.

On two occasions, for example, I explicitly requested the case manager to take on this role more prominently. On both occasions he was either unable to make contact with other professionals/participants or was diverted from the task due to other commitments. It was also observed that the community clinic overall was understaffed and many case managers also performed additional roles, including duty officer, emergency authorised practitioner on outreach cases with the police, and hospital locum mental health nurses. Ultimately, the needs of the telepsychology practitioner were possibly placed even further down a collegial priority list than they might have been, had I been practicing on the site. Similarly, rescheduling sessions to accommodate the on-site staff was also not possible, due to the availability of the room at the far site, and the technology at the home site.

In an attempt to manage Denise’s treatment in an ethically responsible fashion, reduce time wasted on case management duties, as opposed to therapeutic engagements, and reduce the degree to which the client was playing professionals against one-another, I was required to take a more significant case leadership role initially (and, ultimately, at the end of my relationship with her). Such a role is not well suited to a long-distance placement, nor was it a role that I

believed was the best use of my time, nor the intention of the telepsychology intervention. But, in order to facilitate a “hand-over” of this responsibility, I believed it was necessary to create the connections between the various stakeholders, model appropriate task allocation and information sharing, and work from a problem-solving perspective to enhance the potential for the case manger to take over the practical, therapeutic ‘management” responsibility for the client. I did this in a number of ways. For example, to maintain the professional delineation between myself as therapist, and not case manager, when I spoke with individuals I ensured that all further contact was directed to the case manager, and that all interactions I had were immediately fed back to the case manager – who then maintained his role as central point of contact. Of course, such a feedback system is by no means a simple one, nor is it equally reciprocal. Being located at a distance meant repeated phone calls from me to services for information and then cross-checking once different versions appeared. Ultimately, however, despite this increased cohesiveness in the therapeutic and support agenda between mental health professionals, Denise’s behaviour indicated that she was unwilling to honestly let go of services, despite verbalising a desire to. This behaviour became strongly evident in Session 8.

Session 8 began as earlier ones had. Disappointingly, Denise did not complete the monitoring homework which would have anchored the session to working on thought-challenging of Denise’s own mood state. For this particular client, the emphasis on between-session homework of the CBT manual being used and the model overall was not helpful. Significant behavioural and

personality issues interfered with in-session agenda setting and meeting the explicit goals of the manual, and the client never completed cognitive homework tasks or behavioural experimentation, as planned in session. An increasingly dialectical approach was implemented in sessions, with this client which included many techniques of interpersonal therapy and refocussing on the development of therapeutic trust and relationship.

She attended Session 8 feeling depressed, and was focussed on everyone else causing her problems. She felt her children were “pushing her”, her father was criticising her, and her partner was neglecting her. She was unable to talk about herself without blaming someone else for her feelings. She demonstrated once more, that she was unable to grasp the key concept of CBT; namely, that her own thoughts and beliefs contributed to her emotional experience. Denise preferred to believe that she was a victim of her emotions and circumstances, and deep down, believed that someone would rescue her from her life one day. She reported feeling pressured by her Reiki counsellor to attend sessions twice weekly at $25 per session, and by her peer support counsellor at the local community outreach centre to maintain her “voluntary work” three times per week.

After talking through her thinking errors and challenging some of her negative self ruminations, we conducted some interpersonal role-playing. She began in a ruminatory cycle, where she returned to using negative self-talk about her lack of assertiveness and inability to say no – a strong fantasy to “be rescued’ was elicited.

Through a problem-solving strategy, we identified that she felt she would benefit from role playing and scripting refusals. This process proved difficult process because, as she rehearsed her role played “speeches”, I would attempt to give feedback. However, on this transmission there was a slight sound delay which gave the impression of an echo. The delay meant that both parties talked over each other, often resulting in missed initial or termination statements, or no sound, and repetition was required. The fluency of the rehearsed role-play scripts was reduced, and may have impacted on her confidence with saying them at a later date. Denise reported at the next session that she had struggled with implementing these scripts, and failed to conduct her assigned behavioural experiment, despite seeming moderately fluent in sessions and comfortable with practising them at home for later use. With regard to her satisfaction with telepsychology, Denise rated the picture clarity and sound quality at 3/5, and the other factors (including overall comfort, freedom from distractibility, and ease of use etc.) at 4/5. This reduced sound quality rating would seem to be borne out by the in-therapy experience described above. Her comments on the satisfaction survey were that, regarding her comfort with telepsychology, “I am used to it now and don't feel as nervous, anxious as I used to be” . In contrast to previous choices, she indicated that she would actually prefer telepsychology to face-to-face sessions, because she preferred the distance between herself and the therapist (i.e. “you know the therapist is a long way away and not next to you”). At her final comment about telepsychology, Denise stated that she “felt very positive – like something was achieved for me”.

At Session 8, her results on the Beck Depression Inventory were moderate (33), and the State (70) and Trait (69) Anxiety Inventory (STAI) were moderate also (See Figure G.13). These results suggested almost a return to her Session 1 results, particularly in terms of depression.

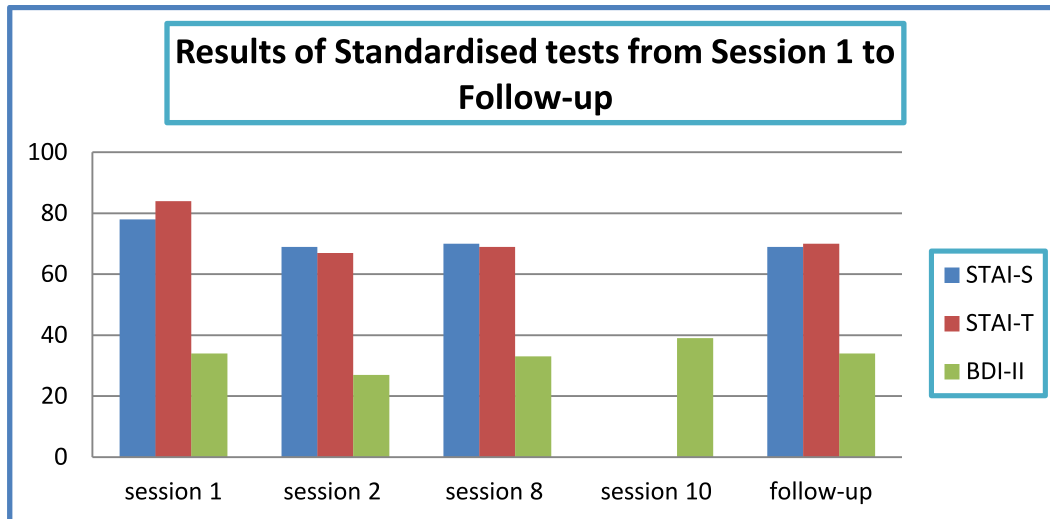

Figure I.13. ***Total results from BDI-II and STAI-S and STAI-T for all Sessions.***

As demonstrated in Table I.1., Denise's CORE-OM scores remained at moderately severe range (2.3-2.5) for all subscales except risk (0.2 = sub-clinical), with a worse score (2.4) for total overall score, compared to Session 1 (2.3). Overall, the results suggested that Denise was not improving from the telepsychology intervention and my behavioural observations and field-notes supported this.

Session notes indicated the I felt increasingly frustrated by the repetition of Denise's focus on an inappropriate content area (i.e. parenting issues which were also being addressed by a CAMHS worker) and crisis management issues

(i.e. which were being addressed by a Disability Services Worker and CMHT Case Manager), despite my agreement with the client to focus on her self-management issues. Increasingly, the sessions had an external focus (i.e. home, children, work, income), and externalised focus of blame, rather than an internal focus on her reactions to these stressors. Using the manual as an anchor, I attempted to meet the needs of Denise, even if they differed from the manual. This might account for why the partnership was, at times, rated closely between Denise and I. From my perspective, the quality of the alliance diminished overall, but from the client's perspective, the alliance continued to slowly improve. This result could be viewed as a positive outcome, in that, despite changes in appraisal of alliance by me, as the therapist, the client did not recognise this and her appraisal remained positive.

I.3.5. Relevant Session Events: Sessions 9-11

Session 9 began with Denise appearing distressed and fatigued. She had avoidant and erratic eye contact with me, was wringing her hair and she appeared to have neglected her self-care again. She began quoting terminology (i.e. "I have toxic shame") she had acquired from listening to "12 steps" coaching tapes at her "volunteer work". Her negative ideation was themed around her being a bad mother, with her evidence being the unhappiness or uncontrollability of her children. She was unwilling to implement any of the rehearsed assertiveness strategies that were discussed in the last session, and she had not followed up with other suggestions.

Toward the last quarter of the session, Denise reported she was experiencing a return of passive suicidal ideation (e.g. “I have a crappy life...what’s the point…I can’t deal with my problems…I believes that I am going to ruin my children...maybe I’d be better off dead”). She then disclosed that she had been erratic about taking her antidepressant medication, had been tearful every day, was depressed, angry with herself and her children, felt unable to cope, and was not sleeping. Because of her in-session breakdown and the need for her to be psychiatrically triaged, the session was concluded with calling the Triage Officer to come in for a handover and problem-solving session to engage with local emergency support services.

Session 10 commenced with Denise appearing dishevelled, unkempt, tearful, but also minimally reactive from the outset. I felt it necessary to maintain a close-up image on the screen to monitor her emotional expressions. She reported that she had taken one sleeping tablet overnight because she had been unable to sleep, but was also feeling distressed and hopeless for the future. Following her session the previous week, Denise enlisted her father to help her care for her home and the children, and he stayed with her for six days. His alleged criticism of her, combined with her own negative self appraisal, increased her low mood and feelings of hopelessness. Her beliefs about her low self-worth were reinforced when no-one remembered her birthday, until the evening. When her father was reminded about her birthday Denise reported that he made the comment that “he knew something was wrong because he called me passive aggressive all day”.

Denise's passive suicidal thoughts, helplessness and hopelessness remained prominent throughout the session, despite Denise recounting the options that numerous professionals had suggested to her to support or assist her to make changes to her emotional state or physical situation. Denise then stated that she felt that "no one was helping her". When I asked her to expand on this belief, and to describe what she believed had failed to be done for her, Denise changed her complaint. She then stated that there were "too many people telling her what to do", no-one was listening to her and she felt unable to say no to any of those involved in her care.

In an effort to unify the many helping participants, and reality test Denise's beliefs and expectations for help, while also "keeping her honest" about what she had been telling different helpers about her problems, I solicited Denise's agreement to have a group teleconference. I suggested that in terms of shared agenda, the meeting could include the CMHT Triage Officer, her CAMHS case worker, her psychiatrist and myself. One of the aims of the group meeting was to enlist the Triage Officer as case manager and liaison for all other services. Moreover, having a shared treatment plan with clear limits for service would also encourage Denise to take responsibility for taking action, because all other helpers would know what role they played in the larger integrated support package. Denise agreed to trialling this and the Triage Officer was brought into the session to arrange a date for our group session.

Denise did not complete the STAI included in her assessment package. Her scores on the BDI-II indicated no change from Session 1 scores. No CORE-

OM ratings were made. With regard to her ratings on the Agnew Relationship Measure, it appeared that as Denise felt more confident about her progress and the bond, the therapist-rated confidence to assist the client, the bond and partnership between them, and the degree of client intiative, lower each time (see Figure I. 14).

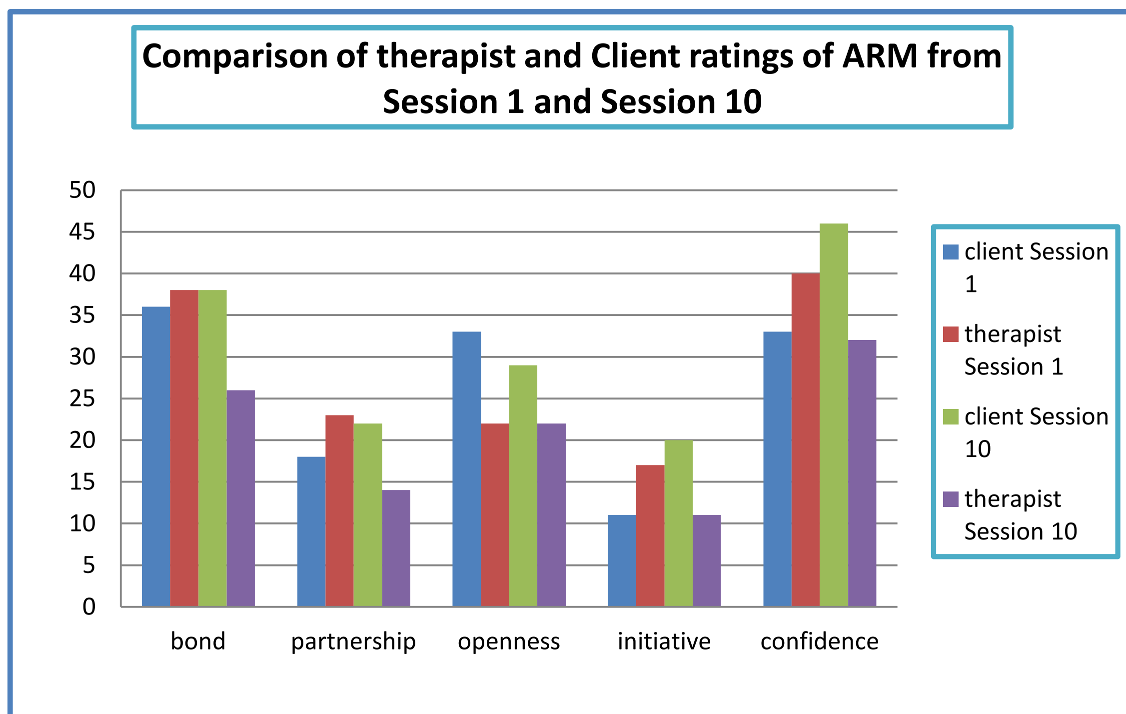

Figure I.14. ***Comparison of client and therapist ratings on subscales of the ARM from Session 1 and Session 10.***

I.3.6 Relevant Session Events – Session 11

At the 11th session, a CAMHS worker and case manager attended at the distant site (the psychiatrist was informed of the meeting but was unable to attend) along with Denise, and I was at the home site. Because three people were on screen at the distant site, and the camera was unable to be moved remotely from the home site, it was difficult for me at the home site to see facial

expressions or fine motor movement easily. It was also difficult to interpret client discomfort physically. In addition, this particular client worked hard to avoid conflict and often minimised her negative emotions or thoughts, so her verbal communications were not necessarily honest reflections of her true feelings.

I was much more involved in leading the discussion, despite my request to not have the lead role, and was perceived to be instigating the change. The discussion tended to feel one-sided from my perspective. However, with little leadership from the far site, I was able to elicit Denise's concerns and, with direct questioning of the other staff present, all parties agreed to the observation that 1) Denise would benefit from limiting her contact with some services she felt were peripheral to her needs, and that ground services would assist her to do so if she required it; and 2) Denise was a little vague, although emphasised that her main problems related to her parenting skills (which could be assisted more consistently by the CAMHS worker – who also offered to visit her at home) and social concerns, such as finances and respite options (which the case manager agreed to assist with more), thereby freeing up her therapy time for herself, so that her negative self talk, self esteem issues and interpersonal issues could be targeted by therapy. Denise agreed that this plan seemed to better meet her needs and, at the end of the meeting, stated she was pleased with the outcome.

The next day, the Community Team received a fax from the Overnight Emergency helpline that Denise wanted no further contact from any member of community mental health. We were effectively "sacked".

It is possible that, had I better been able to distinguish her reactions during the discussion, I may have assumed a less directive (less confrontational?) approach. However, I am not entirely convinced that this would have been the case. There was a sense of distance between the home site and the far site, because of the need for a wide angle that captured all the participants. The wide angle may have influenced my body language to be more exaggerated and my language to be more directive, to compensate for this perceived distance, even though the far site would not necessarily have experienced the same level of distance, as they would have seen only a single talking head. It may also have been that she perceived that she was being given an ultimatum. After 10 sessions where the same issues were raised by Denise, despite having multiple solutions and problem-solving around them, and opportunities to change identified but not accepting them, there seemed little benefit to continuing with therapy anyway.

The initial aim of the group meeting was to give Denise the support to cease contact temporarily, and hopefully reduce her feelings of being overwhelmed, with those services seen by all community mental health participants to be peripheral to meeting her psychosocial needs (i.e. like her reiki counsellor, psychic, volunteer 12-steps counselling/work). The irony was, in fact, that she did do exactly what we asked her to do – namely, cut out contact with over-servicing helpers. What was unexpected was that she chose to get rid of the one service that was united in meeting her needs.

While reflecting on the consequences of this final session, I wondered if the choice Denise made demonstrated the impact of her personality features – namely, being unable to reflect on self, being reactive to limit setting, perceiving that being controlled results in devaluation of the other? Or did she simply chose to get rid of the service that was pressuring her the most on that day? Did she genuinely believe they had nothing to offer her? At follow-up four months later, Denise still felt that therapy had been unhelpful, however, she remained positive about videoconferencing. One can speculate that, while I, as therapist, remained a two-dimensional image, I was not threatening. Once a meeting included real people in her space, and I was perceived as the driving force behind the challenge, I became three dimensional and, therefore, present and threatening.

I.3.7. Discussion and Conclusions

In this particular case, my overall perception of the impact of telepsychology was to increase distance (or reduce a sense of physical presence), an impact that was particularly apparent when trying to share information about Denise in a rapid and informal way with the other workers involved in her care. Clarifying impressions and attempting to untangle her splitting of relationships took longer, because she was able to capitalise on the technology to maintain separation between practitioners. It was fortunate that, as the participant-researcher, I was able to adjust to her needs and monitor her

progress in an ethically responsible manner, particularly in light of the ultimate early termination by the client.

In addition to the process issues regarding the integration of multiple stakeholders to provide consistent intervention, the nature of the CBT intervention chosen for the project also proved unhelpful for this particular client. CBT consists of a psychoeducational component, is based on learning principles, and has less of an emphasis on the therapeutic relationship than other more insight-oriented therapies. To that extent it would seem well-suited to this client. However, the co-occurrence of Cluster B personality features, in particular, emotional dysregulation and dependent interpersonal styles, frequent presentation in psychosocial crisis, cognitive inflexibility, and questionable insight, made her a poor candidate for a CBT intervention. The model and style of therapy offered to this kind of client group is as important as the mode of delivery. Clients with interpersonal problems and emotional dysregulation experience notoriously poor clinical outcomes in straightforward CBT treatment but may benefit from more directive interventions which also address the longstanding and entrenched nature of their difficulties (e.g. schema-focused therapy, CAT, DBT, mentalisation etc). CBT can also support the expression of 'avoidance' behaviours, as it does not allow a great deal of space for exploring the therapeutic relationship. After attempting to stick closely to the manual through the first four sessions, a less structured approach which incorporated some of the manual's CBT strategies and techniques, along with aspects of dialectical behaviour therapy, interpersonal therapy and supportive counselling

was required to respond to Denise's chaotic presenting problems. The aim of this new approach was to reduce avoidance opportunities and to commence intervention that enhanced mentalisation so that personal reflection might be better accomplished by the client.

It is unclear the extent to which a blurry picture may have also created a quality of distance and unreality that made emotional disconnection easier to maintain. Previous researchers have recognised the influence of larger bandwidth to improve picture quality (e.g. see Hilty, Marks, Urness et al., 2004) and therefore enhance the quality of therapeutic interactions. Videoconferencing may use different types of technology (e.g. personal computer units, dual 32" monitor units or low bandwidth portable videophones) with different levels of bandwidth (Hilty, Nesbitt, et al., 2002).

In Western Australia, state government health department sites can connect either via ISDN line or IP address and use a minimum transmission speed of 128 kbps, but can go as high as 512 kbps on IP connections. As transmission speed increases on ISDN, the cost associated with the call also increases. This project used 256 kbps transmission bandwidth on ISDN line, resulting in approximately 80% quality of television broadcast. Although ISDN calls are made on a dedicated line, visible variations in the definition of the picture are still visible due to issues with the service provider. On certain days, poor picture quality made observing and confronting some of her interpersonal and personality features (e.g. manipulation, splitting, deceit, alternation between extremes of devaluation and idealisation, strong dependency on others,

emotional instability, frantic efforts to avoid real and imagined rejection/abandonment, chronic feelings of emptiness, inappropriate anger) challenging. These personality and interpersonal features were both observed and inferred from, behaviours. On the screen, these features were indicated by physical changes to her expression, demeanour and body language. Some examples included 1) an inability to experience feelings without defensive reactions, such as dissociation, acting out and projection; 2) fear and helplessness when confronted with feelings; 3) poor control over affective expression; and 4) facial expressions suggestive of a disconnection between affect and stimuli (Hawker, 2001).

My personal clinical experience is that it is much easier to observe and confront typical Cluster B behaviours in-person, than it is by videoconferencing. Video therapy offers more opportunity for avoidance, which is difficult to deal with when your client is continually disrupting sessions and attending chaotically. Studies also show that an avoidant coping style can be a negative predictor of change (Hayes, Wilson, Gifford, Follette & Strosahl, 1996). From a practice point of view, telepsychology may require therapists to be even more explicit about their boundaries and the limits of their service. This is a phenomenon which will actually be of benefit when working with clients presenting with Cluster B personality features. However, drop-outs may be more frequent, as some clients with similar personality features do not respond well to boundaries, regardless of the setting.

It is possible that some clients who are very avoidant are more likely to engage in video therapy treatment than in-person, because of the personal space and control they have in this setting. To that end, it may be that a combination of the two modes of treatment delivery could provide a balance. Further study is required with this particular patient group to elucidate the optimal management conditions. In this case, frequent missed appointments were a hallmark feature of this client's presentation. The lack of notice was very disruptive and wasteful of my time. Unlike practicing from your own office, this transmission occurred at a third-party site, so the opportunity to continue with other work was limited when the client did not attend. In order to assist this client to stay in counselling, she claimed she needed morning appointments – then claimed attending them placed too much pressure on her in the mornings. In this instance, telepsychology may have enhanced her ability to avoid. These passive-aggressive strategies feel "slipperier" to manage via telepsychology than they do in face-to face settings.

The technical aspects of the therapy seemed to interfere in many ways. Picture quality made identifying behavioural cues more difficult and increased a sense of distance, as opposed to social presence, in the interactions with this client. On many occasions the therapist and the client "spoke over" the top of each other, i.e. they spoke at the same time, which resulted in either a loss of sound or confusion which preceded requests for repetition. On some days, the issue of sound echo was also greater than on others; slower sound echo interrupted the flow of speech, and gave more opportunities for "talking over"

each other. In a related event, the relaxation session felt very “distant”, in the sense that I experienced it as more artificial than in a traditional therapy office/session. Denise appeared to struggle with the exercise, and seemed unable to immerse herself in the process, due to sitting in an office space at a desk. I also could not monitor breathing and facial tension easily either and found it difficult to see her fully, because Denise was unable to use the remote control smoothly enough to alter the camera point-of-view (POV), and the picture quality was too grainy. In addition, the quality of TV vocal sound did not sound as relaxing a tone as it does when in a non-televised setting.

Over the course of intervention, her results on the BDI-II did not change, starting at the severe level (score Session 1 = 34) and ending at the severe level (Follow-up =34), with a brief categorical drop at Session 2 to 27 (moderate). Her results on the State-Trait Anxiety Inventory reduced only moderately from the 94th percentile to the 87th percentile, with minimal percentile change in the middle of the assessment period.

Denise commenced therapy with no elevations in subscale scores on the Brief Symptom Inventory (BSI) indicative of caseness, other than for phobic anxiety (PHOB). This symptom reflects a persistent fear response of an irrational and disproportionate nature to a specific person, place, object, or situation. This symptom profile was evident in Denise’s persistent attempts to avoid interpersonal conflict with authority figures and her avoidance of decision-making and responsibility. At follow-up, Denise had increased her ratings from Session 1 of psychotocism [PSY] (i.e. symptoms of mental confusion and delusions),

paranoia [PAR] (disordered thinking, projection, hostility, suspiciousness, grandiosity and delusions), interpersonal sensitivity [I-S] (reflecting feelings of uneasiness and marked discomfort when interacting with others, as well as feelings of personal inadequacy and inferiority, especially compared with others), anxiety [ANX] and somatisation [SOM] (bodily related distress such as headaches and pain; it also includes gastrointestinal, respiratory, and cardiovascular complaints and complaints of sleeping problems) in addition to the global indices GSI and PST. Only paranoia and PST indicated scores >63 (and, therefore, caseness), however, the degree of elevation on the PST scores compared to baseline scores at Session 1, suggested that her scores on the BSI are open to interpretation.

One possibility was that, following her perceived negative experience of therapy, she might have been exaggerating her levels of distress at follow-up. The PST subscale score is a coarse indicator of whether the client is attempting to misrepresent her status (Derogatis & Savitz, in Maruish, 1999), and scores of 70 and above are highly suggestive of psychiatric status. Denise scored 68 on PST at follow-up, and 48 at Session 1. A second hypothesis is that Denise underrepresented her level of distress at Session 1 and her scores at follow-up more accurately represented her genuine distress levels. It is interesting to note that her GSI score, reflecting both the number of endorsed symptoms in addition to the level of intensity of symptoms, was similar at both assessment times, differing only by two points.

The results on the subscales of the Agnew Therapeutic Alliance Scale were collected on five assessment occasions. The deviations in score patterns suggest interesting clinical moments that the client overall rated positively and relatively consistently. At the first session the bond between client and therapist was rated highly and similarly. All other subscales (i.e. partnership, confidence, initiative and openness) were rated higher by the therapist than by the client. This rating may have reflected the observation I made during the first session that Denise presented as open about the extent of problems and concerns, even disclosing past homicidal ideation, and expressed desire to change and relief at being listened to. My ratings on all subsequent subscales demonstrated a significant drop in scores, and this may have been related to my impression that Denise was not as committed to engaging in therapy as she had initially presented (i.e. notes indicate that the client had failed to complete homework assigned on three occasions, had cancelled five times with little notice, had presented in distress, failed to implement recommendations and ceased medication against advice).

When reviewing the ratings of satisfaction, the follow-up session had the lowest ratings on average. On the satisfaction questionnaire, the lowest rating (1) was achieved for the item that assessed whether the sessions were useful overall. Further comment from Denise at the follow-up confirmed that she felt very negative about the content of the sessions, did not feel listened to or supported by me, despite not having reflected these negative feelings during the course of the intervention. Overall, Denise's comments regarding telepsychology

were positive, and extra comments indicated that she felt she was able to present the same information she would have in person, and was comfortable in her ability to talk over the teleconference. It is interesting to note that, after the group session, Denise rated that she was moderately distracted (2) by the technology, found the session not useful (1), was unsatisfied overall (2) and felt she had little control over the session(2), despite sound and picture quality being adequate. The client continued to rate the telepsychology experience features positively, despite feeling very negative toward the therapist and the content of the final session.

A number of technical issues occurred with this client, that, when compared to other clients, seemed to affect the quality of the therapeutic interaction to a much greater extent. This difference in alliance development is hypothesised to be either because 1) the client presented with personality features that made her a challenge to work with, and particularly in the context of attempting to implement a time limited, problem limited CBT intervention; or 2) that the quality of the therapeutic relationship was poor and facilitated an insufficient bond between the therapist and client with which to overcome the technical challenges.

In terms of intervention with Denise, the distance and lack of local knowledge made it difficult to work directly with other service providers to co-ordinate intervention goals. In this particular case, liaison with local providers might have circumvented the client's tendency to avoidance and splitting between services. As I began to coordinate the intervention, this change

resulted in increased suicidal ideation and self harming threats by Denise, as pressure increased for her to be personally accountable for marshalling her own mental health support. By encouraging Denise to make decisions regarding her care, and then to be accountable for acting on help that was offered, she was increasingly having to reflect on herself and her genuine needs. This self reflection was challenging and frequently negative, which increased her suicidal ideation, and which, in turn, increased the likelihood of hospitalisation (as her personal circumstances tended to force this step). Subsequently, external services tended to then back off, and she was given respite from having to take responsibility for her support needs. In the context of community mental health service provision, it is both ethically responsible and professionally facilitative to participate in information sharing between various service providers – even when your goals for intervention may be different from those of other service providers.