Recommendations for Increasing Rapport and "Telepresence" during Telehealth Interactions with Youth and Families

The University of Hawaii at Manoa, Center for Cognitive Behavioral Therapy
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Background: this document outlines recommendations for increasing rapport and "telepresence" during telehealth interactions with youth and families. These recommendations are chunked into six superordinate categories, as identified by a recent systematic review by Henry, Block, Ciesla, McGown, and Vozenilek (2017) for identifying interpersonal health care provider (HCP) behaviors and attributes related to provider–patient interactions during care in telehealth delivery. After numerous paper identification and data extraction procedures from their final list of 45 articles, Henry et al. identified the six themes outlined below (labeled 1 through 6). Each theme below contains one or more recommendations inferred from the reader of this paper (Nakamura) as well as those accrued through a variety of informal supports (e.g., listserv discussions, expert recommendations from school-based behavioral health providers). The initial stimulus for creating these recommendations was largely the need for telehealth service delivery owing to COVID-19, however, these recommendations are not specific to COVID-19-related services. The recommendations below should be considered within the larger context of at least two limitations. First, the HCPs identified in the Henry et al. (2017) review span a variety of provider roles such as physicians, nurses, and counselors across a variety of settings. Second, the subordinate recommendations placed under the six superordinate themes were generated through clinical judgment. Accordingly, the research-identified themes and subsequent recommendations may or may not be relevant to the reader's profession, training, competencies, and/or setting. Please interpret with caution and consult with your supervisors as necessary.

1. **Preinteractional (Pre) such as attitudes, competencies, and cultural awareness**

   Preinteractional elements are comprised of several different HCP characteristics including beliefs, attitudes, confidence, and cultural competence that precede a positive approach toward working with patients through telehealth.

   Recommendation 1: aim to achieve a positive viewpoint about the benefits of telehealth that can outweigh perceived drawbacks, even before actual service delivery. Acknowledge your own biases and potential discomfort with technology. Be mindful of these issues and consult with your supervisor as needed.

2. **Verbal communication (Verbal) such as behavioral skills, timing, and types of clinician talk**

Research in this area indicated that in telehealth sessions there tends to be less small talk and praise statements, which can damage rapport/alliance. The use of medical jargon can compound these difficulties.

Recommendation 2: continue with check-ins at the beginning of the session and "leave um laughing" strategies at the end of session. As just one example, video games may be particularly reinforcing "Leave um laughing" activities for children and adolescents. While we **do not** recommend engaging with clients in online interactive video games, where both the patient and provider are characters in a larger online world, other interactive games whose participants are limited to the HCP and the client (e.g., those available on www.Kahoot.com) could be helpful rapport-building tools. Online service delivery may also be a wonderful opportunity for youths to demonstrate their mastery of technology to you, and teach the therapist something. As another "Leave um laughing" activity, you may consider having the client teach you about and explore their technological interests through screen-sharing.

Recommendation 3: be mindful to try to maintain the same level of small talk and praise (maybe even more) during the session. As one example, if the youth is comfortable with sharing about some aspect or item of their home life, both the therapist and youth might take turns for engaging in a show and tell for an item in their screen background (or home more broadly).

Recommendation 4: keep language simple and clear. Avoid medical jargon.

NOTE: across recommendations 2, 3, and 4 above, concerning particularly anxious or shy clients, consider sometimes delivery and receipt of "verbal" communication through text/chat features through your online platform.

3. **Nonverbal communication (Non-verbal) such as eye contact, visual cues, and empathetic gestures**

Recommendation 5: maximize non-verbal patterns of communication including eye contact, body positioning, movement, facial gestures, voice quality and vocal tone. When full views are not possible, periodically use non-verbal signals, such as hand gestures, in ways that can be viewed by participants.

Synergistically combine verbal communication recommendations 2, 3, and 4 above with appropriate utilization of visual cues. For example, (a) with very young children, puppets or action figures popping up from different places on the screen can be used to get their attention and explore things through story and narrative. You can also use this as an attention game where they earn points each time they spot the figure. (b) You may use whiteboard features frequently inherent to teleconference platforms (or even typical word processing programs) to create pictures, documents, and games together. (c) Consider also pulling up and sharing from your computer (via screen sharing) relevant

images (e.g., progress ratings graphed over time) and files or websites (e.g., YouTube, Kahoot) that facilitate therapeutic service delivery. As one example of combining recommendations (b) and (c), within WebEx, the therapist may pull up a worksheet and then grant the youth the ability to "annotate" (or the youth may ask "permission to annotate"). Once granted, the youth can color, draw, and write on whatever document the therapist has featured.

NOTE: When using video-based applications, be aware that doing so may interfere significantly with internet connectivity and simultaneously using WebEx or Zoom. As such, therapists may consider strategies such as letting the student screen share and show the video from their end (with appropriate parental supervision) so that the internet viewing lag affects only the therapist, or downloading videos or music before the session for subsequent synchronous viewing.

Recommendation 6: be aware of equipment quality and placement. Situate cameras at both sites to allow as much non-verbal communication as possible (balancing visual clarity with full views of each other). Try to situation the camera as stably as possible, in order to avoid the youth playing with and moving the camera around throughout your session.

4. **Relational (Relate) such as rapport and relationship building**

Recommendation 7: as with in-person interactions, express caring, good listening skills, and a strong collaborative stance. Engage in active listening (including for instance, attending, reflection, clarification, summarizing). For example, local community therapists have recently reported that their clients have not necessarily required support to achieve therapeutic goals defined prior to COVID-19 (e.g., in-class academic assignment completion), but instead have been distressed about various social, financial, logistical, or other challenges that they are currently facing. Utilizing active listening skills to acknowledge these challenges could be useful in establishing and maintaining therapeutic alliance.

5. **Environmental (Environ) such as physical surroundings and privacy**

Recommendation 8: assure the patient that privacy and confidentiality extend beyond the transmission of data by making clear that you are not using a shared space (no one is around you or in your background), use head phones, etc.

Similarly, be mindful of the child's physical environment in relation to privacy and confidentiality issues (e.g., does the youth have a sibling that enjoys eavesdropping or thin walls where everything can be heard in the next room over?). Ask the parent to help arrange for a private and confidential space. Be aware that not everyone in the home may even be aware that the youth is receiving therapy services. As one fun but simple activity, the youth could consider hanging a "Do Not Disturb" sign on the outside

of their door during your session. You can also add to this effect by placing a noise machine (or even simply having a music application play) right outside of the youth's door during session.

Also, be mindful about the potentially varying reactions that families may have about having you "inside" their homes. Some clients may enjoy it, but others may really dislike it. From a cross-cultural perspective, for example, Asian families generally are very wary about having outsiders in their homes and doing so implies a deep sense of trust and intimacy families may not be ready for. Along these lines, as you are "entering" their homes, you may consider asking them what their "house rules" are so that you may respect and honor them.

Finally, it might also be a good time to review the limits of confidentiality and privacy.

Recommendation 9: create a calming or reassuring background (e.g., does your background look like your typical office space or provide comfort in some way?). Check to see how you look on the video screen. Adjust lighting, background, clothing so that you communicate warmth and professionalism.

Recommendation 10: keep your environment/background as distraction-free as possible.

NOTE: related to distraction-reduction strategies, some youth may have great difficulties with inattention and hyperactivity/impulsivity. If appropriate, please consider partnering with one or more of the youth's caregivers to help support the youth staying on task during session.

6. **Educational (Edu) such as pre-professional or continuing development and evaluation of interpersonal skills related to provider–patient interactions.**

Recommendation 11: regarding the latter part of this recommendation (i.e., evaluation of interpersonal skills related to provider-patient interactions), collect and review your quick but routine data at the beginning of every TMH session and discuss with participant. For example, this may include a obtaining a youth- and/or parent-reported treatment satisfaction rating ranging from 0 (Not at All Satisfied) to 4 (Very Satisfied) at the end of every therapeutic interaction. Similarly, a therapist may consider the Session Rating Scale from Scott D. Miller for older youth or parents, which assesses a variety of domains such as Relationship (responses ranging from "I did not feel heard, understood, and respected" to "I felt heard, understood, and respected") and Goals and Topics (responses ranging from "We did not work on or talk about what I wanted to work on and talk about" to "We worked on and talked about what I wanted to work on and talk about"). Similarly, therapists may also consider the Child Session Rating Scale from Scott D. Miller which assesses domains such as Listening (responses ranging from "[therapist name] did not always listen to me" to "[therapist name] listened to me") and What We

Did (responses ranging from "I did not like what we did today" to "I liked what we did today"). Track scores over time and discuss with participant no less than monthly or every five sessions, whichever is shorter.

<u>Recommendation 12</u>: this area of study and clinical development warrants future resources and investment.

References

Henry, B. W., Block, D. E., Ciesla, J. R., McGown, B. A., & Vozenilek, J. A. (2017). Clinician behaviors in telehealth care delivery: a systematic review. *Adv in Health Sci Educ, 22,* 869-888. DOI 10.1007/s10459-016-9717-2