PSYCHO-ONCOLOGY CO-OPERATIVE RESEARCH GROUP

Psycho-Oncology Telehealth Recommendations

PoCoG

Psycho-oncology Co-operative Research Group

The Psycho-oncology Telehealth Recommendations were developed by Claire Cooper, Jemma Gilchrist, Lisa Beatty, Laura Kirsten, Louise Sharpe, Nienke Zomerdijk, Maree Grier, Jane Turner, Kim Hobbs, Helen Haydon, Haryana Dhillon, Brian Kelly and Joanne Shaw on behalf of the Psycho-oncology Co-operative Research Group (PoCoG).

We would like to thank the wider PoCoG membership for their input into the recommendations.

PoCoG is supported by Cancer Australia through their Support for Cancer Clinical Trials Funding Scheme. PoCoG is a Centre of The University of Sydney.

SECTION 1

INTRODUCTION

There has been a rapid uptake of telephone and videoconference telehealth by psycho-oncologists across Australia in response to the COVID-19 pandemic [1-3]. Importantly, research shows that telehealth is as effective as face-to-face therapy [4-7]. In addition, there is ample evidence to show that, on average, clients are just as satisfied with telehealth as they are with face-to-face therapy [8].

Psycho-oncologists face challenges such as working with clients experiencing existential issues, and report receiving inadequate training and guidance in addressing these issues via telehealth modalities [9]. Moving forward there are benefits to utilising telehealth distinct from COVID-19 considerations, such as increased access to services for rural and remote clients, or for those who may be too unwell to attend in-person. It is therefore vital to provide guidance on using telehealth for all oncology patient populations in a variety of contexts, which these current recommendations aim to do.

Transferable skills between face-to-face therapy and telehealth

It is important to acknowledge that the core qualities of effective psycho-oncology clinicians such as clinical skillset, empathy, warmth, approachability and applying clinical judgement remain the same despite the modality of therapy. Adaptation of some of these skills, in addition to practical considerations, will be the focus of these recommendations, to ensure optimal benefit to the client and increased confidence in the clinician that they are providing telehealth in the most effective way possible.

Using flexibility and creativity in delivery of telehealth

Clinicians regularly need to pivot during face-to-face therapy if a barrier to treatment becomes apparent. Similarly, using flexibility and creativity during telehealth - especially in the context of a paucity of specific adaption research or guidelines - may assist in providing therapy that is appropriate and nuanced. Careful consideration of first principles of psychological therapy including mechanisms behind why and how evidence-based therapies are effective is important to ensure best-practice in this evolving context.

SECTION 2

PREPARATION FOR TELEHEALTH

2.1 CLIENT SUITABILITY

Clinicians need to use discretion when considering various factors that may impact client suitability for telehealth [3, 10]. The client's context may influence whether telehealth is the most desirable medium for undertaking therapy. As outlined by Haydon et al [3], it is important to consider telehealth in the context of 'what else is available for that person', to ensure the client's context is being considered and that telehealth is the most desirable mode of therapy [3].

For example, cultural and social context is crucial to consider; a need to stay on Country or additional stressors if forced to leave the current environment may render telehealth a particularly appropriate approach, whereas feelings of isolation that may arise especially in emergency situations may indicate that face-to-face options may be optimal.

The Australian Psychological Society (APS) [11] outlines the following factors for consideration when evaluating client suitability:

- Capacity to access technology.
- Form, frequency and degree of symptomatology.
- Extent of psychological distress/crisis.
- Barriers to access the service (i.e., language, physical and visual impairment).
- Risk of harm to self/others.
- Apprehension to using telehealth.
- Quality of social supports.

In addition, Shore et al [10] include the patient's cognitive capacity, history regarding engagement with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behaviour.

While the presence of any of the afore-mentioned factors does not automatically render a client unsuitable for telehealth, they are issues which may require additional consideration, planning, liaison with external parties, and if required, supervision to determine suitability of client before progressing.

Additional psychosocial factors that would be pertinent to consider include health literacy, cultural and linguistically diverse populations, and any other context that may influence the appropriateness of engaging in telehealth.

Further safety considerations are discussed in section 3.1.

2.2 ETHICAL CONSIDERATIONS

Ethical guidelines and codes of conduct are crucial regardless of the mode of therapy. Key telehealth considerations include [3, 11]:

- Ensure the client has consented to using telehealth for their consultation, and is aware of what it entails prior to the session commencing, including any advantages and disadvantages.
- Ensure clients are not disadvantaged by using telehealth.
- Refer to section 2.5 for privacy and security considerations.
- Maintain professional boundaries, and establish out of session communication boundaries (e.g., restricting electronic communication to work hours).

2.3 SETTING UP YOUR SPACE

Physical work space set-up:

- If you are using videoconference to provide telehealth, create a private and comfortable space that is appropriate for the client to see. If you are conducting the session from your home, review what is visible in the background before each day of therapy and ensure that your own privacy is not compromised, e.g., family members walking past the computer.
- Lighting – using a well-lit area will improve the visual quality. Using a ring light can assist, pointing at the clinician (avoid back-lighting as it can cast shadows on the image).
- Set up camera/screen/framing – The camera should be positioned in a way that allows you to comfortably look at the lens while your client is speaking (i.e., sitting approximately .5m from the camera). If you prefer to view the client simultaneously, positioning windows as close to the camera lens as possible will maintain perceived eye contact while viewing the client. Investing in a separate camera (distinct from the camera built into a laptop or computer) can allow flexibility in the angle and distance displayed to the client.
- Audio – Minimise background noise (e.g., mute phones/ alerts including computer alerts) and consider whether use of a headset with built in microphone will enable better sound quality.

Digital space set-up:

- Before commencing telehealth familiarise yourself with hardware and software.
- It can be useful to practise with a colleague when starting out or if you have a change in software.
- Screensharing – edit the screen to reduce distractions and to ensure only appropriate materials are visible. Prior to screensharing ensure email/any personal details are closed and alerts disabled.
- Organise resources that may be required.

For further suggestions, see the Centre for Online Health's 'Quick start to videoconferencing' [13].

2.4 POLICY AND PROCEDURE

When commencing telehealth therapy, make necessary adjustments to your privacy statement and informed consent processes. Train all staff in the use of policies and procedures related to telehealth. Ensure updated consent forms and other necessary documentation is included in record of notes [11].

If you are employed by another person or company, ensure you have familiarised yourself with the telehealth policies and procedures.

Refer to the **APS Telehealth measures guideline** [11] for further details.

2.5 PRIVACY AND SECURITY

- Understand the applicable legal requirements, including jurisdictional differences if conducting telehealth services interstate
- Secure electronic information:
  - Implement security measures to secure electronically-held personal information, including; keeping security software up to date, virus scanning, and using separate devices for business and personal.
  - Engage an information technology (IT) consultant to implement and annually review IT security.
  - Work with clients to protect their own privacy:
    - » Explicitly ask the client if there is anyone in the room with them.
    - » Ensure the session is not able to be recorded by the client (unless mutually agreed upon for specific pre-determined purposes).
    - » If the client is conducting the session out of the house (e.g., in a car or at a park), ensure they have as much privacy as possible/appropriate, and let them know to expect a possible reduction in quality of connection/phone reception.
- If able to choose a telehealth platform – acknowledging that choice, accessibility and competency in desired platforms are not always possible - take a client-centred approach. One which allows client access at no or minimal set-up cost, accessible for clients who may connect through various browsers, devices and platforms, is likely to operate across rural and remote areas of Australia, and is simple for clients to install, access, and operate.
- Take reasonable steps to ensure videoconferencing technology and security, including; strong passwords, secure end-to-end data transfer, regularly updated security measures.

Further information can be found in the APS Telehealth measures guideline [11].

And the Centre for Online Health's 'Security and functionality of common video platforms' Quick guide [13].

2.6 TECHNICAL CONSIDERATIONS

- If the client is using a phone or videoconferencing device, recommend that they sit in a location with good internet connectivity and with a charger nearby as some apps may use power faster than others.
- Prior to the session recommend the client use a laptop or computer, if possible, for increased functionality such as screen-sharing.
- Establish what will happen if internet drops out or is unstable. Inform the client that internet may be impacted by multiple people in the home using devices. Agree on a plan such as the clinician terminating the session if internet is unstable, and using telephone as a back-up option and ensuring the phone is nearby.
- Consider having a set of cue cards on hand for common issues that may arise during videoconference sessions, such as 'I can't hear you', 'turn on computer audio', or 'un-mute' etc.

2.7 PREPARATION INFORMATION FOR THE CLIENT

Preparing the client for what to expect in their telehealth session will likely address any uncertainty about the session and also aid smoother running of processes (e.g., having appropriate access to teleconference apps in advance, on the most suitable device).

If possible, providing the client with an information sheet prior to their initial session that contains basic information and tips will save time during the first session.

There is also research to suggest that a hybrid model of a face-to-face initial session (where possible) followed by subsequent telehealth sessions may enhance relationship development and empathy [2].

For an example telehealth guide for patients attending a video-conference session, see the Centre for Online Health's 'Attending your video consultation' [13]

SECTION 3

CLINICAL AND CULTURAL CONSIDERATIONS

3.1 SAFETY CONSIDERATIONS

3.1i Assessing and managing risk

There are additional risk assessment and management considerations that accompany the use of telehealth. The clinician should be confident in their ability to provide a safe service if the client presents with risk to self or others. Having clarity around processes and expectations will reduce ambiguity of next steps for the therapist and client if risk issues arise.

Aspects for consideration include [10, 11]:

- **Availability of support services/suitability of telehealth** (see also section 2.1 for client suitability)
  - If there are any concerns around client risk based on intake, availability of supports at the client's location (e.g., close liaison/involvement of GP and available crisis services) should be reviewed before considering telehealth. Geographic distance to the nearest emergency medical facility and efficacy of patient's support system should also be considered.
- **Challenges in assessing for risk**
  - Conducting a mental state examination may be more difficult (e.g., subtle non-verbal cues may be missed).
  - The physical distance of a telehealth conversation may elicit more distressing disclosure of risk to self/others.
- **Confidentiality/consent**
  - At the initial session create a contingency plan for managing risk-related situations. Build these risk management procedures into the informed consent process [11]:
    - » Request contact details for the next of kin, as well as GP/psychiatrist if available .
    - » Establish and record the contact details for available crisis services in the clients' local area .
    - » Establish when, how and with whom a crisis plan may be activated. It is helpful to approach this collaboratively with the client. This also needs to be documented and a copy provided to the client.
    - » The consent process should include discussion of the service being discontinued if the patient can no longer be safely managed through telehealth.
    - » Establish a course of action if the internet fails after risk has been established or participation in risk assessment isn't occurring. For example:

Script suggestion

"This is very unlikely to be the case, but if I was concerned about your safety or another person's safety and our internet dropped out or you didn't want to keep talking with me, I have a duty of care to help you just as I would if we were sitting in the same room. If I couldn't reach you on the phone or via videoconference, I would need to contact someone to check on your welfare ***(action dependent on level of risk)"***

Start of session checks:

- Request the client provide their location at the commencement of each session (this may be a quick casual check-in that they are at home, and gain further information if they are not).
- It is not always obvious if anyone else is in the room with client. At the start of a session always check if there is anyone else in the room by asking something like [3]:

Script suggestion

"Do you have space and enough privacy to have a chat today?', or 'are you comfortable enough/ is it appropriate for you to speak with me at the moment?"

More detailed information can be found in the APS Telehealth measures guideline [11].

3.1ii Violence, abuse and neglect

An increased uptake in telehealth has implications for the safety of current and survivor victims of violence, abuse and neglect, due to increased isolation and fewer opportunities to safely disclose risk [14].

The NSW Department of Health have developed detailed guidance to support health services and practitioners to respond to these increased safety risks, which can be found here: NSW Department of Health – Violence, abuse and neglect and COVID-19 [14].

The NSW Department of Health states that through the guidance outlined above, it "seeks to support health services and pactioners [14]:

- Awareness and understanding of the unique risks to the safety of clients, families and carers where telehealth services are proposed or being delivered
- Develop and implement local health services processes and practices to assess the suitability of telehealth for clients at increased risk of, or experiencing violence, abuse and neglect
- Deliver safe practices for responding to disclosures or suspected domestic and family violence and other forms of violence, abuse and neglect through the delivery of telehealth services

It is important to note that the endorsed NSW Health guidance also states that 'service policy and procedures should generally preference face-to-face service provision rather than telehealth where it is known a client is currently experiencing violence, abuse or neglect or a clinician has identified concerns related to these issues… a blanket exclusion is not recommended as there will be a range of considerations that clinicians and services should consider".

3.2 THE THERAPEUTIC ALLIANCE

Research shows that clients are satisfied with the therapeutic alliance established during telehealth, to the same level as face-to-face and in some cases even higher levels of satisfaction with telehealth [3, 15, 16]. Recommendations for fostering the therapeutic alliance and demonstrating empathy include:

- emphasising verbal and non-verbal gestures
- more frequently clarifying the meaning of clients' facial expressions and body language
- checking with the client about their experience several times during the session
- making eye contact with the camera or if viewing the client image move the screen as close to the camera as possible to mimic eye contact
- active listening – using shorter sentences, pausing, using expressive listening skills
- take care when taking notes – explain at the start of the session that if you are looking down this is what you are doing, and that you are still listening
- be prepared with some comforting statements you can make if the client becomes upset – (see **section 3.7 Comforting a client** for script ideas)

Further information regarding building the therapeutic alliance via telephone is covered in the **next section (3.3)**.

3.3 TELEHEALTH VIA TELEPHONE; UNIQUE CHALLENGES AND OPPORTUNITIES

Conducting telehealth via telephone brings with it the added difficulties of not being able to see how the client is responding during the session; whether this be conducting a mental state examination, noticing the client becoming emotional or picking up on non-verbal cues. Although these aspects can be more challenging to navigate over the phone, there are strategies that can assist:

- Addressing which clients may be more suitable for telephone or videoconference if there is a choice available.
- Openly discussing with the client at the beginning of the session the limitations that can arise, and collaboratively form a plan for dealing with this – for example the clinician may check in during long pauses and ask explicitly what is happening for the client and what they are experiencing from their end;

Script suggestion

"I've noticed you're taking a bit of time after I brought up XXXX, and while I want you to take as much time as you need, I just wanted to check how you're finding what we're discussing?"

- More frequent check ins with the client about their understanding of the content being discussed (noting that you will not be able to see any looks of confusion or disconnectedness);

Script suggestion

"I know the strategy I just described might sound a bit tricky so I wanted to check in with how you're feeling about trying that? Let me know if anything is confusing and we can work through it in another way."

- Ahead of sessions you may be able to mail or email resources/formulation/worksheets (if the client has access to internet) that client and clinician can be referencing at the same time during the phone session.

Opportunity for use of online programs and resources

The online environment can present unique opportunities such as the use of efficacious online support and treatment programs and online resource hubs. Programs and resources listed below might be appropriate to consider depending on the patient's situation and the type of individual psychology treatment they are receiving.

Examples of online support and treatment programs include:

- **MindSpot Clinic –** https://www.mindspot.org.au/ [17] MindSpot describes that it supports Australian adults experiencing stress, anxiety, depression, OCD, PTSD, and chronic pain. All of MindSpot's services are free, confidential, and online, and provide optional access to qualified therapists. Treatment courses are effective and backed by clinical trials.
- **This Way Up –** https://thiswayup.org.au/ [18] This Way Up describes that it develops, tests and releases scientifically-based online programs that help treat anxiety and related mental health conditions. All of their programs are based on the clinically-proven Cognitive Behavioural Therapy (CBT).

An example of an online resource hub includes:

- **Psychology Tools –** https://www.psychologytools.com/ [19] Psychology Tools describes that it has 400+ evidence based resources and tools for professionals to enhance their therapy.

3.4 SCREENING AND OUTCOME MEASURES

The way in which psychological assessments are administered will vary depending on the purpose of the assessment, and the type of telehealth being used (videoconference or telephone).

The most common use of psychological assessment in psycho-oncology is likely to be screening, symptom and outcome monitoring. Options for administering include:

- Emailing prior to session.
- Providing an online option for completing measure (if available).
- If conducting a videoconference session, it may be possible to screen-share the outcome measure and have the client either fill it out on the screen or verbally.
- If conducting telephone session, it is possible to read out the items and complete the answers as the client provides them.

If you are administering the outcome measure over the phone or videoconference and filling in the responses as the client is answering, make allowances for the time this may take depending on the measure and whether you need to read and explain different response options for each item.

For example, if using the Edmonton Symptom Assessment System Revised (ESAS-r) [20, 21], the item responses are all similarly worded ranging from no experience of the symptom (0), to worst possible experience of the symptom (10) which may be relatively efficient for the client to answer. For example:

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness

If, however, you are using a measure that has varied wording for each of the item responses, you may need to allow more time to read these out to the client. For example, the Hospital Anxiety and Depression Scale (HADS): [22]

D	A		D
		I feel tense or 'wound up':	
	3	Most of the time	3
	2	A lot of the time	2
	1	From time to time, occasionally	1
	0	Not at all	0
		I still enjoy the things I used to enjoy:	
0		Definitely as much	
1		Not quite so much	
2		Only a little	
3		Hardly at all	
		I get a sort of frightened feeling as if something awful is about to happen:	
	3	Very definitely and quite badly	3
	2	Yes, but not too badly	2
	1	A little, but it doesn't worry me	1
	0	Not at all	0

3.5 FORMULATION

Considering how to provide the formulation to a client over telehealth is important in ensuring collaboration and engagement with the treatment plan. There are a variety of options depending on the type of telehealth being used (videoconference or telephone), and the extent to which the clinician and client want to/are able to utilise specific videoconference features. The recommended methods of formulation sharing via videoconference and telephone are:

Videoconference	Telephone
Screenshare and whiteboard functions may be available to you to either share a document or to draw in real time with the client's input. It can be helpful to have pre-prepared images/drawings to share during the session.	If the client doesn't have internet access, ask them to have a paper and pencil available during the session and provide a few key words or basic summary ideas they can write down and refer to during treatment (in addition to a verbal discussion of formulation).

In addition, if either of the options outlined above do not suit the clinician or client, alternative options for videoconference and telephone include:

- **Videoconference**
  Writing / drawing the formulation and then taking a photo of / scanning the document and emailing to the client in real-time; apps are available for scanning and emailing documents (review according to the security / privacy section of recommendations).
- **Telephone**
  Emailing formulation documents to the client before or after the session to complement telephone discussion.

It is important to note that if the client is using videoconference on a smart phone, the small screen size will make it difficult to engage with some of the 'videoconference' suggestions and in this instance referring to the 'telephone' suggestions may be most practical.

3.6 WORKING WITH CALD, ABORIGINAL AND TORRES STRAIT ISLANDER, AND VULNERABLE/DISADVANTAGED COMMUNITIES

Working with Aboriginal and Torres Strait Islander Peoples

Reflect on how you will identify if a client is Aboriginal and/or Torres Strait Islander. The only effective and accurate way to do this is to ask "do you identify as Aboriginal and/or Torres Strait Islander?" Providers should consider including this question in the information they collect on all clients at intake [11].

The Australian Psychological Society provides further information and resources relating to the holistic view of health that Aboriginal and Torres Strait Islander people hold, which informs their social and emotional wellbeing [11].

Working with people from rural and remote locations

People in rural and remote Australia face unique stressors compared with Australians living in major cities and regional centres, e.g., financial stress, environmental stressors, lower employment levels, and limited access to a range of services.

The Australian College of Rural and Remote Medicine (ACRRM) [20] created a framework and guidelines which provides detailed clinical aspects of telehealth services relating to:

- Clinical aspects of telehealth services: informing the patient about remote consultations using telehealth services, seeking patient consent, selecting appropriate patients for health care using telehealth services, conducting a remote consultation, skills of practitioners, evaluating the use of telehealth.
- Technical aspects of telehealth services: adequate performance, installation, commissioning and testing, risk management.
- Contextual aspects of telehealth services: management of physical environment, management of business environment, management of logistical environment.

The framework and guidelines can be located here: ACRRM framework and guidelines for telehealth services [23].

Working with people from a CALD background

People from culturally and linguistically diverse (CALD) backgrounds who already have barriers to accessing healthcare such as health literacy issues, may experience worsening of these difficulties with the use of telehealth. Therefore, identifying the need for an interpreter for a person with limited English proficiency or Deaf people is crucial. It is important to note and prepare for potential challenges that can arise with the use of an interpreter who will often be on a separate phone connection.

A detailed guide for working with interpreters in Healthcare Settings has been developed by the Royal Australian College of General Practitioners [RACGP Guide] [24].

This RACGP guide identifies practice points for clinicians working with interpreters in healthcare settings, for example:

- Clinicians inform interpreters on the nature of the consultation prior to its commencement, where possible, recognising the need to assist the interpreter to prepare for the information that may need to be interpreted.
- Clinicians introduce the interpreter to the person and explain the role of the interpreter as a non-clinical member of the healthcare team, who is tasked with facilitating effective communication in the clinical consultation through accurate interpretation, is bound by confidentiality and maintains impartiality.
- When working with a telephone interpreter, clinicians use a speakerphone or a hands-free telephone.
- When working with a telephone or video interpreter, clinicians interact directly with the person, ensure they manage turn-taking, and use adequate descriptive language.
- Clinicians speak clearly, use plain English and explain complex concepts and terminology to enhance the person's understanding.
- Clinicians speak at a reasonable speed, with appropriate pauses and avoiding overlapping speech, so as to enable the interpreter to interpret.
- In a multidisciplinary team consultation, clinicians ensure adequate speech rate, pauses and turn taking for all parties to facilitate good quality and accurate conveyance of messages to the person.

While not all interpreter services have the capacity to offer three-way videoconferencing, this RACGP document [Telephone consultations with patients requiring an interpreter] [24] describes a possible workaround. Through using an interpreter service such as the Australian Government's Translation and Interpreting Service (TIS) an audio call can be established between the interpreter, client and clinician, and then a separate videoconference with the client would be set up which is kept on mute. This allows the clinician to have a visual connection with the client, but the interpreter will only have audio.

3.7 COMFORTING A CLIENT

The physical distance involved in telehealth sessions may make comforting a client more difficult due to a) potentially missing cues of client discomfort/emotion, for example eyes welling up with tears, and b) reduced options for comforting the client.

Suggestions for addressing these issues via videoconference and telephone include:

Videoconference

Some clients may feel more exposed to becoming emotional during a videoconference call due to the remote nature of the session and the personal isolation, in addition to being confronted with seeing their own emotion and reactions on a screen.

One way to address this is to discuss and normalise at the commencement of therapy the 'unusual' nature of telehealth session in this regard, and to reassure the client that they are safe and encouraged to experience and display any emotions that arise - and that the clinician is able to support them through this.

Some platforms also have functionality to allow the minimisation of your own screen, which the client (and clinician if preferred) can use to provide a more naturalistic feel of looking at one another only.

Script suggestion

"Clients sometimes mention to me that it can feel a bit awkward to get upset and cry when they're sitting on their own in a room and watching themselves on the screen. I wanted to bring this up in case this happens for you too, and to let you know that it is completely normal and understandable to feel this way.

I'm here to support you just as if we were in the same room, and at any point just stop me if you want to grab some tissues or anything else to make you feel comfortable. If you're feeling thrown by watching yourself you could try minimising the visual screen of yourself so that you can focus on the image of me if that helps."

Telephone

It can be difficult to identify when a client is becoming upset on the telephone due to the absence of visual cues. Phone consultations rely on non-verbal cues such as pace, pause and tone. It may be useful to be especially mindful of long pauses from the client during discussions of emotional or difficult content, and to openly check in with them at these times.

A list of quick guides for telehealth covering several of the topics in this section can be found at the Centre for Online Health's 'Quick guides for telehealth' [13].

SECTION 4

THERAPEUTIC ADAPTATIONS

The way in which therapy can best be adapted to telehealth will depend on what type of telehealth is being used (telephone or videoconference), what type of therapeutic modality is being utilised (e.g., CBT and ACT), as well as specific client and clinician preferences.

Despite these variations, there are common considerations when implementing telehealth therapy across contexts; such as ensuring props and resources are prepared ahead of time (by both clinician and client), consideration on how resources will be shared, and any additional digital considerations if conducting videoconference telehealth.

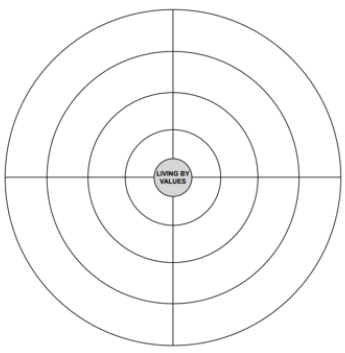
The following examples of adaptations for ACT and CBT demonstrate how these considerations may practically be implemented.

4.1 ACCEPTANCE AND COMMITMENT THERAPY (ACT)

When engaging in telehealth psycho-oncology sessions from an Acceptance and Commitment Therapy (ACT) approach, the following examples outline how various tools, metaphors, props and written material may be presented via telehealth.

Thick dark marker – bold images for holding up to camera

Making bold lines/shapes to be held up to the camera will be more clearly visible to the client than normal pen and paper or thin print worksheets. For example, if you are doing values work and are wanting to use a 'Bull's eye' target, you may trace around this worksheet in thick marker to make the key aspects more pronounced.

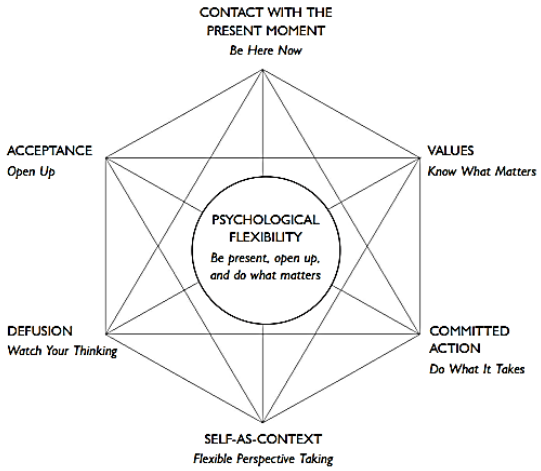


Simplifying visual resources

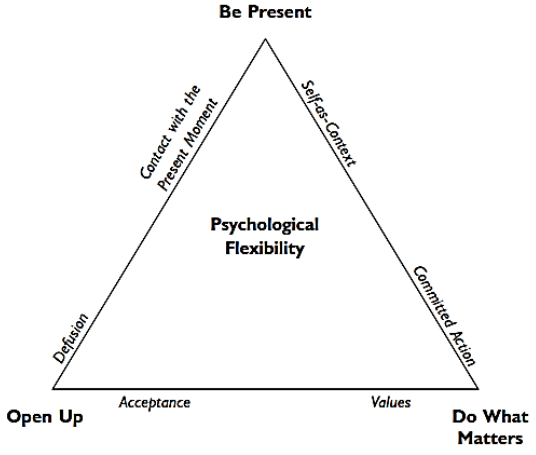
Hand-writing images/concepts and holding them up to the camera can be time consuming depending on the topic, so considering how some techniques and tasks can be modified or simplified may assist with keeping the exercise timely.

For example, rather than using a detailed Hexaflex (below, top), it may be more realistic to draw a basic version of the Triflex (below) and annotate or explain the components relevant to that session (a detailed version can be emailed to the client if appropriate) [25].

Detailed Hexaflex



Simplified Triflex



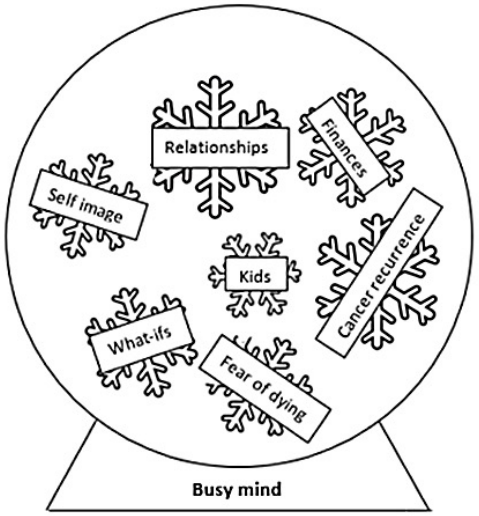
Props

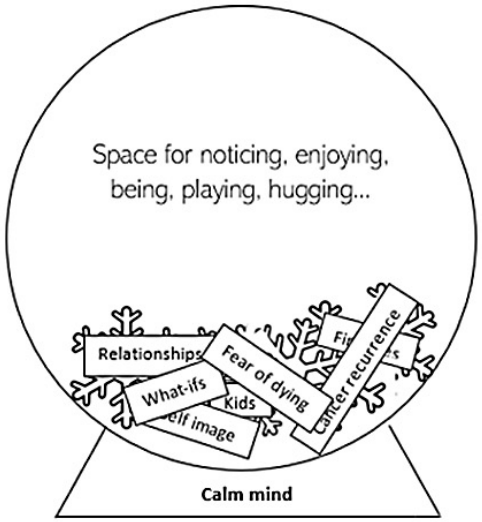
If you are planning to use a metaphor, decide whether you need a prop on hand before the session, and how you will use the prop so that it is visible to the client. For example, the 'snow globe' metaphor uses a shaken snow globe to represent a busy and agitated mind and the gradual settling of the snow represents a calming of the mind and thoughts.

Using a real snow globe to demonstrate the metaphor rather than just verbally describing it may enhance the client's understanding of or engagement with the metaphor.

If you anticipate using a prop, ensure that it is easily accessible so that you do not have to leave your chair/turn your back or lean across the camera/rummage on your desk to access it.

To further enhance the exercise for the client, if the prop is something common that the client would likely have available to them at home, before the session ask them to have it on hand so that they are able to enact the metaphor for themselves at the same time as you demonstrate and explain.





Screen-sharing

If you are conducting a videoconference session, you may consider utilising screen-sharing technology to play videos or cartoons explaining metaphors, such as 'leaves on a stream' [26] to describe the observations of thoughts and allowing them to flow freely.

Or if you are using the snow globe metaphor from the previous 'props' section and you don't have a snow globe available, you may consider screen sharing an image to demonstrate the concept, or with blank spaces for the client to fill in their own challenges during the session using an 'annotate' function during screenshare (if available on platform).

Describing metaphors via telephone

When describing metaphors via a telephone session with a client, considering ways to enhance client engagement and understanding of the metaphor without any visual cues or props is important. Take for example the 'passengers on a bus' metaphor which has previously been used in psycho-oncology research in the context of patients labelling passengers as persistently challenging thoughts, feelings, and memories/ images about cancer [27].

Rather than simply describing the metaphor, asking the client to draw or write down basic components of what is being discussed may assist them to remember and connect with the pertinent concepts (detailed handout/worksheet can be emailed or posted following the session to supplement their notes).

Script suggestion

"I'm going to ask you to grab paper and a pen and in a very basic form try and draw and write down what I'm describing to you – it doesn't have to be realistic (I'm no artist myself!) and no one else will see it, this is just for you to refer to later. Does that sound okay? We're going to start by drawing a bus which can be a rectangle with 4 circles underneath…"

Continue with simple descriptions of drawing 3-4 passengers (stick figures are fine) and ask the client to label the passengers with a challenging thought, feeling, memory or emotion (discuss this with the client in as much detail as they need to come up with labels).

Then describe the metaphor to the client; that the client (driver) can decide where the bus is heading (values-based living). Discuss with the client where it is that they would like to be heading that aligns with their values. When the driver is heading towards where they want to go, the passengers are likely to be loud, rude and distracting because they want to go in another direction. If the driver goes where the passengers want, they quieten down somewhat, but the driver is no longer heading in the values-based direction.

Through having a drawn image/written descriptions, the client is able to refer back to something tangible and review the meaning behind the metaphor for them.

Additional considerations for conducting ACT based sessions via telehealth include:

- Distractions and frustrations that the client may be experiencing in their at-home environment can be used as in situ opportunities for mindfulness/acceptance practice. This may be the lead-in to introducing a metaphor or simply explaining how it can be easy to get 'hooked' on things like distractions, and explore how the client feels when becoming 'hooked'.
- Most experiential exercises within the ACT framework are translatable to telehealth. Some are more difficult and may need to be reconsidered if they are not eliciting the intended goal, such as the 'eyes on' activity [28] due to difficulty with the gaze being at the computer screen or camera. Have a pre-prepared list of experiential exercises that fit the same function as ones that may not be working for you or the client via telehealth (e.g. The Big Book of ACT Metaphors).

Card sorting

Using a set of cards that describe various values/attributes/principles and asking clients to sort them into piles relating to their relative importance allows the client to clarify which values are most important to them. This also allows them to see any discrepancies in time spent on lower importance values, and goal setting around re-prioritisation of time and attention.

In face-to-face therapy the cards would be sorted by the client into piles, such as 'very important', 'quite important' and 'not so important'. A select number of cards of key importance from the 'very important' pile may then be discussed in greater detail during the session. Administration via telehealth is not always recommended, unless one of the following methods of administration is available to both client and clinician via videoconferencing:

- Searching online for web-based programs or apps that provide online versions of the card sort activity.
- Screen sharing the cards during a videoconference call and colour-coding according to the three categories (e.g., highlighting the text of each card one of three colours depending on which category the client wants to place them in).

If videoconference is not available and there is a particular indication that the client may benefit from card sorting value work via telephone, the following administration method may be considered however it is important to note that this method can be time consuming:

- Via telephone the clinician could read out each card text one at a time and mark down which category the client would put the card in. The psychologist would then share which cards were placed in the highest category of importance by the client for further discussion and goal setting

4.2 COGNITIVE BEHAVIOURAL THERAPY (CBT)

The cognitive and behavioural elements of Cognitive Behavioural Therapy (CBT) can be approached in various ways via telehealth, dependent on whether videoconference or telephone is being utilised:

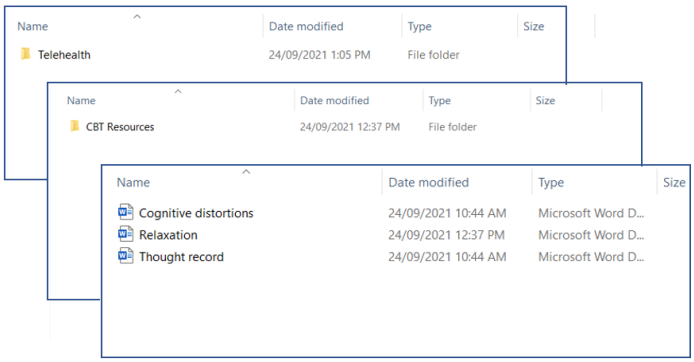
4.2i Cognitive components

Cognitive restructuring may be aided by worksheets and other written/illustrated resources. As mentioned in earlier sections of these recommendations, there are various ways to share these resources and collaborate with the client:

- Emailing resources/worksheets prior to the session, during or after.
- Writing/drawing descriptions and examples and holding up to the camera.
- Posting resources ahead of a telephone session
- Providing websites containing worksheets if internet available to client.

Screen-sharing

When screen-sharing, it can be effective to create a distinct folder for telehealth so that you can quickly locate commonly used resources without inadvertently showing the client other documents in the process:



- Simplifying worksheets to be either held up to the camera or described to the client can be an effective way to keep the client engaged. More detailed worksheets can then be emailed or posted after the session for homework.
  For example:

Cognitive restructuring

There are countless readily available cognitive restructuring worksheets online, and while some have extensive descriptions and tables for documenting thoughts, they may be cumbersome when trying to describe over videoconference or telephone.

Locating simplified worksheets may enable you to either hold them up to a camera, or screen-share and complete them together online, or simply describe them over the telephone for a client to write down basic headings.

There is also the option to email or post more detailed worksheets for the client to complete in between sessions once they understand the concept. An example of headings in a simplified cognitive restructuring worksheet may be:

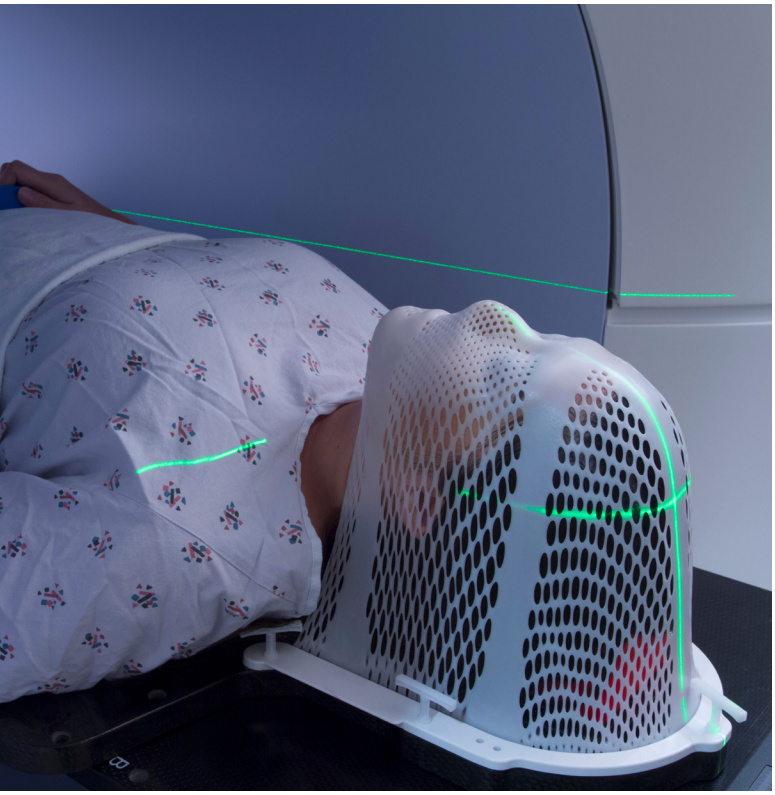
- What I'm thinking.
- Facts supporting the thought.
- Facts contradicting the thought.
- Based on evidence or opinion?

4.2ii Behavioural components – Case studies

Common behavioural components of CBT include exposure therapy, behavioural activation, and relaxation training / breathing exercises. The following section provides case studies outlining clinical examples of how various behavioural components may be adapted for telehealth (assuming existing clinical judgement and knowledge in face-to-face therapy).

CASE STUDY 1

RADIATION MASK ANXIETY



This case study assumes existing clinical knowledge and judgement

Background

Stephen is a 54 year-old man, diagnosed with a tonsil cancer. He has a treatment of combined radiotherapy and chemotherapy. He is fearful of the impact of treatment and whether he will be able to manage pain and the NG tube/ PEG feed that he has been told may be required. Stephen lives alone, is a fork-lift driver and has few supports. He was referred by his radiation oncologist because, when informed about needing the mask for treatment, he became angry, overwhelmed and started to speak about refusing treatment. He is due to have the mask made in coming days and is avoiding coming in for his medical appointments. He refuses a video-consultation (although is familiar with it from his medical appointments) but agrees to a phone session.

Considering the therapeutic approach

It can, of course, be a challenge to develop rapport with patients in Stephen's position, even when you are able to see them face to face. Video-consult would be preferable, so see if you can find a way to problem-solve that. However, if refusal continues and we do not know why he has refused video-consult, it is potentially a barrier indicating that he is not fully engaged in the recommendation to see a psychologist or convinced of any value.

On the phone, especially, it will be helpful to be clear and direct about why he has been referred and the way in which you can help. Be prepared to have less time to work on an intervention because of the reluctance, as well as the short time frame.

Stephen has told you that his main fear is of being trapped in the mask - he hasn't seen one yet. He has a history of trauma (you don't know the details) but he says he "doesn't like being held down". He gets tense, anxious and thinks he will want to "tear the thing off".

Given the client's background it would be important for the clinician to explore with the patient whether he has used medication before to help with anxiety, and whether this is something he wants to discuss with his doctor. In a face-to-face appointment, you may choose to show him the mask, introduce him to the team, take him into the radiotherapy treatment space, explain how he is in contact with the team via camera/microphone etc; but not all of these options will be available to you to demonstrate.

It is likely that you will take a CBT approach here with a combination of education, procedural knowledge, cognitive therapy, acute anxiety management and systematic de-sensitisation to the sensations of the mask.

RADIATION MASK ANXIETY

continued

Telehealth treatment considerations

Consider having some contemporary pictures available that you can ask him to look at (e.g. of a mask where the person can see that it has holes/mesh; where they can see that treatment rooms are large). He may be willing to do that on his phone while speaking to you on speaker phone, or if he is next to a computer. This helps to elicit the concerns/beliefs that he would mention face to face e.g. "I can't do that", "It's bolted down", "that's better than I thought, I assumed it was made of Perspex", "so they can see me?", and "can they tell if I'm breathing?".

Although you can't de-sensitise in the treatment environment, you can explain that people are often confronted by the idea of the mask but the vast majority can adjust to it. He has a history of trauma so you will need to acknowledge this and be aware of severe symptoms that he may experience, but engender an approach of self-efficacy. The aim is not necessarily to be completely calm and for the treatment not to bother him, but to find ways to make it tolerable and 'do-able'. In other words, set expectations so he is not thinking he has to be "fine with it" in order to do it!

Explain how, as humans, it is natural not to like the sensation of feeling trapped and we will feel we need to escape. However, in this situation, what he really wants is to stay, to not run, so we have to show his brain that it's safe and he's 'got this'. Normally, we would do that with the actual mask, but we can't so we find other, creative ways to allow his brain to get used to the feeling of having his face covered and even to have tightness and restriction.

We will be doing that with a four-pronged approach.

1. Getting Stephen used to something covering and even restricting his face.
2. Gentle, supportive self-talk with the attitude that he can do this.
3. Breathing and softening tense muscles so he is more comfortable and calm when he is in the treatment room.
4. Distraction such as music/podcasts, mindfulness etc playing in the room.

Ask him to take notes if that is possible for him. You might choose to e-mail him some summary points after the call so he is clear on the steps and strategies he can draw upon.

You could ask him to go through the exercise below with you on the phone, or choose the first few steps he can practice and build (though you might need to move rapidly and have sessions in successive days). You may also encourage the client to have a support person with them if there are any concerns about their ability to negotiate the session.

You may try:

Use of a loose covering:

1	Ask him to lie down, and place a small dry cloth (e.g. tea towel, face cloth/flannel) gently over his face. (If lying down for the following task is too much, you can do all of this sitting up and him holding the cloth, or leaning back against something and work up to lying down).
2	Eyes closed (if acceptable; most people prefer this, but make sure you ask). He can notice sensations of cloth and his ability to continue to breathe despite face covered
3	Ask client to: • Relax shoulders so they sink into the couch/bed. • Place hands on the diaphragm so he can feel his breathing low and slow. • Use the self-talk strategies (keep as simple as needed).
4	When client can do this (use subjective units of distress or whatever your normal procedure is), increase weight/density of the cloth (terry towelling e.g.) and size (tea towel, bath towel, folded bath towel to give weight etc.).
5	It can be helpful for the client to try making the cloth wet. This adds density and a sense of more difficulty breathing. Again, start with light material and move to thick towel.
6	When client becomes used to the weight of the towel and this slight restriction of breathing (he has been using his other techniques to cope as you go along) – move to the idea of restriction; described on the next page.

RADIATION MASK ANXIETY

continued

Use of a restricted covering:

1	Ask client to choose fabric that can wrap around head and be tucked in either side, so there is slight pressure. All he has to do to cease it, is to sit up, or to pull the cloth away. He has control. Client could repeat this step with it more firmly attached (e.g. wrapped around the back; using pegs to fix at the side).
2	Some people have anxiety triggered by the 'click' of the mask being fixed into place. You may want to ask the client to click his fingers to get used to the idea of the mask fixing into place, and that he is still safe. Encourage self-talk such as "I'm safe", "I'm doing the treatment that counts", "every second is closer to this being done", or "ok good, I've started, soon I will be one more down".
3	Ask client to practice various types of breathing (e.g. in through the nose - out through the mouth, in and out through the nose, and in and out through the mouth). This provides options as we don't know what will be more comfortable/easy; nose or mouth – so encourage him to be able to use either/both. Remind him to keep relaxing shoulders when he is lying down. If shoulders and back muscles tense, the body moves up from the bed slightly, and the sensation of feeling trapped can be worse as the mask feels tighter. Trying phrasing this as "allow your body to sink" or "feel your shoulders flop back onto the bed".

The safety and personal-control aspects of the treatment can be emphasised. The client may feel trapped, but they are not. Remind them that during the actual radiation session there is a button to cease the machine, and staff are watching closely.

People can actually move through this exercise rapidly. No matter how much time you have between the intervention and treatment, encourage practice, however silly it feels to them.

As you move through each step, you will have been adjusting and problem-solving according to his sensations, cognitions, concerns and barriers. As you finish that initial contact, explain to Stephen that, as he went through the exercise, there would have been times he felt uncomfortable. There were times he felt he couldn't get enough air, there were times his mind wanted to tell him to escape. But he did it etc. While this is not the same as being in treatment, the sensations are a bit different to wearing a mask, there are more things that are the same.

After the first session, ask Stephen to work out a play list of music and audio books etc., that he can use in the room. Don't pre-judge this. Sometimes we are surprised by people whom we assume would shun mindfulness meditation or self-soothing strategies and they fully embrace it. If people choose the same play list/meditation; they can find it helpful as an indicator of when the treatment will end (e.g. 2 songs in, they know they are half-way). Some people like to record in a voice memo someone they love and care about encouraging them.

Hopefully, you will have the opportunity for a second session where you can 'fine-tune' which cognitive and self-soothing strategies to use. Grounding exercises using senses (e.g. noise) can be helpful but it depends on the person and their history; some are more triggered by this and using some senses is fruitless. If there are no holes in the mask cut for eyes and the ceiling is blank, using '5 things you can see' is unhelpful!

The safety and personal-control aspects of the treatment can be emphasised. He may feel trapped, but he is not. Remind him that he has a button to cease the machine. Staff are watching. Educate him about the environment. Some people like to count, they know that, for example, there are five longer noises and the treatment is over once the last one, for a count of 20, has ended. The staff will come in and they will release the mask immediately. This is where you use your knowledge from the actual treatment he is having. Discuss what he has used for other procedures (e.g. relaxing his arm for a vaccination).

Of course, you will liaise with the team in the way you normally would about this client and his emotional challenges and needs from them. It may be possible to have holes cut for eyes/mouth but not always as they can affect the structure and stability of the mask. Just don't forget to talk to treating staff as you normally would.

Remember, as it would be at your cancer centre, his adjustment is a work in progress. You can have brief telephone (or video if he has changed his mind) contact to adjust aspects of the treatment that were easier or more difficult than he thought. The important thing is to make familiar to the patient the things that are familiar to us, that we take for granted. On phone, or video-consult, this involves "painting a picture" and reassuring that, even though this is not the usual way of helping them, it will work and they will find this easier.

CASE STUDY 2

RESUMING EXERCISE

This case study assumes existing clinical knowledge and judgement

Background

Lily is 54 years old and has completed surgery (unilateral mastectomy with implant reconstruction), chemotherapy and radiotherapy for an early breast cancer. She is continuing endocrine therapy (an AI). Lily has an anxious disposition and experienced two panic attacks during her treatment; one when she was first diagnosed and one following an admission for febrile neutropenia during chemotherapy. She responded well to psychoeducation and anxiety management strategies at that time. Although she is determined to continue with her endocrine therapy, she is bothered by hot flushes, pain in her joints, poor sleep and weight gain. She has not exercised since before her diagnosis (when she used to go for the occasional walk with her friend) but has recently joined a breast cancer-specific exercise program and feels motivated to improve her exercise. When she has tried walking, she has felt uncomfortable, hot, worried she would have a panic attack and so sore the following morning that she felt like crying. As a result, Lily is avoiding exercise and is increasingly anxious about weight gain and any impact that inactivity may have on her risk of recurrence and overall health.

Usual treatment considerations

In a face-to-face context, the intervention for Lily could fit with a CBT approach. This would involve, for example, presenting a formulation followed by psycho-education, anxiety and panic management strategies, cognitive therapy to elicit and manage unhelpful thinking and graded exposure to re-introduce exercise.

With resources to hand in sessions, Lily could be provided with a written formulation diagram, which was developed with her in session, handouts to consolidate her psycho-education, thought recording resources and handouts on common thinking errors for homework and review and then a “stepladder” drawing in which the graded steps she will be working on are developed together and problem-solved.

As per your normal treatment approach, it is likely you will have already discussed the use of SUDS recording, or 70% guidelines (i.e. moving to the next step when they are 70% confident they can achieve it). Re-engaging in exercise is likely to be confronting for Lily and encouragement, support and attunement to any fear-related hesitancy or avoidance will be important. We know that, in graded exposure, steps often need to be adjusted as people gain insight into their confidence, ability and barriers to change. This is a work in progress and is underpinned by trust and encouragement.

RESUMING EXERCISE

continued

Telehealth treatment considerations

In a video-conference, it can be harder to notice subtle emotional reactions. To have all those resources available for review and to be astute about subtle indications that could undermine Lily's progress in treatment. Being organised will help.

Having the forms that you often use for thought recording, for example, allows you to screen share and talk through the kinds of thoughts that she would record. For graded exposure, have an exposure "stepladder" diagram to hand (a printed copy you can show to the camera or screen share) so she is rapidly able to see that the goals will move from steps that may result in very low subjective units of distress, to low, medium, high and very high.

Screen sharing can be a barrier to rapport in some instances. You will need to explore the set-up of the video-conferencing software you are using. If you are screen-sharing a document, for example, then that may take up a lot of the screen (or all the screen) and you may not be able to see the emotional reaction of the person as you move through the information.

For example, the normal clues you would get from Lily as you move through potential graded exposure steps would not be as overt. The ability to adjust your steps based on non-verbal feedback, such as how comfortable she appears, if she loses eye contact, if she is breathing faster, or has tears welling in her eyes would be undermined.

For Lily's situation, you could show the stepladder on screen. Once you have shown the stepladder and explained the concept, return to the face-to-face screen and continue to fill out the steps. Remember you will have already worked out what makes the pain/heat/anxiety etc. better or worse so you can decide which 'levers' to change when. The following example is a basic idea.

Perhaps the stepladder looks something like this:

1	Choose simple exercise clothes and shoes and wear them at home so you become familiar with them (e.g., you are not constantly adjusting them, feeling self-conscious or are too hot).
2	Complete a basic stretching routine, slowly and gently for 10 minutes, become familiar with movement that you control at a pace you control.
3	Go for a 10-minute walk outside. Choose a cooler time of day and a flat route. You may want to have a bench where you can stop if you feel like it.
4	Go for a 20-minute walk outside following the steps above.

As you build in your steps, make sure that you are writing them down. It might be helpful to have an A4 whiteboard so that you can send a scan/photo once it is complete and you and the client have that for reference when they record their attempts and SUDS.

If the client becomes distressed, it can be more of a challenge to comfort them and display confidence, collaboration and support. Acknowledge that "it's hard when we are not in the same room", "I can see you're upset, you've got this though", "it's OK, when we think about new steps and challenges, lots of people feel apprehensive, teary", "we will just take our time – you have control", and "you look like you're about to cry…is that step a bit too much to bear? Remember you can adjust the steps in the ladder".

Key Messages

- Spend some time organising common resources so you have them to hand, e.g. resources from This Way Up and Psychology Tools [18,19].
- If you use handouts, have them ready to e-mail or in clear enough ink to show on screen.
- Consider using a simple A4 whiteboard to show diagrams and ideas quickly to the camera.
- Investigate other resources such as tablets or 'paper-feel' tablets where you can rapidly e-mail drawings to people (they can also convert handwriting to text).
- Keep checking back in with the person if you are screen-sharing.

CASE STUDY 3

DYSPNOEA

This case study assumes existing clinical knowledge and judgement

Background

Ivy is a 78 year-old woman with metastatic lung cancer. She lives alone although her son and daughter-in-law visit, bring her meals, do her washing and shopping. She has carers come in to assist her to shower three times per week. Her main issue is that she is feeling breathless on exertion, and this is leading to heightened anxiety (although not panic). She is not on oxygen at this stage (although she has been told this will be a recommendation in the near future).

Ivy finds herself doing less and less, she is cancelling the carers at times (as she finds the effort of a shower too confronting) and feels most comfortable in her bed. However, she finds herself with too much time to think, especially about the end of life and how she "will suffocate".

Telehealth logistical considerations

At first, Ivy only agrees to a telephone consultation on her land line as she is not confident with technology. When you first speak to her, you can determine if she has a smart phone, tablet etc and if someone can help her follow a link to use a video-call.

On the first telephone consult, you can explain the link between breathlessness from exertion and anxiety. Ivy can then appreciate how, when she tries to do too much of a task at once (gets out of bed, walks to the bathroom with the carer, gets undressed, has a shower and all the micro-steps that are involved in this experience) that this is overwhelming oxygen demand. Her body then lacks oxygen, she experiences symptoms of oxygen deprivation, becomes anxious about the sensations that creates and this exacerbates the loss of oxygen and escalates symptoms of anxiety.

You can describe how the body will use more energy (and, therefore, oxygen) to stand than it does to sit and lying down will use less again. There is enormous value in learning to break tasks down and take rests and pauses. You can emphasise the importance of her stopping and 're-charging' between each step. Waiting until her breath is stable and she feels sufficiently calm and confident for the next step. This includes using calming self-talk and pursed lips breathing. People often benefit from an electric fan gently blowing across their face to increase the perception of air flow.

Again, it is probably going to be helpful if you have the benefit of a video-consult at some point. For a person with Ivy's fears, we know that a part of the intervention will be about the details of pacing herself and ensuring that her environment is understood and optimized for energy conservation and breaking tasks into smaller units.

Telehealth treatment considerations

It is recommended that sufficient caution be exercised to ensure the safety of a person with dyspnoea prior to the pacing task outlined below. The therapist should consider the person's current medical condition, which may require consulting with their medical team, having the client reviewed by a physiotherapist or encouraging the client to have a support person with them if there are any concerns about

DYSPNOEA

continued

their ability to negotiate the task safely. Careful questioning about what the client has been able to do in the recent should be used to guide any specific behavioural steps, and it is important to establish with the client that they are confident (at least 70%) that they could achieve each step in any pacing plan. It is always better to start with a smaller goal if in any doubt that the activity would be safe and use the smaller step as a behavioural experiment to ensure that the person can manage the prescribed activity.

Let's assume that, for the next session, Ivy has worked out how to access the video-call on her phone. However, when you call, she is lying on her bed, propped up on pillows. It does provide an excellent opportunity for you to move through a pacing task with her. If she has a smartphone and it is light enough to take with her, you can coach her through the following steps:

1 You can review her understanding of pacing from the last session, and problem-solve what has worked and not worked. Has she realised the relative effort of laying down, sitting and standing?

2 Explain that the speed at which she is getting out of bed and straight into an activity may be exhausting. Linked to expectations of how she used to do things.

3 Introduce cognitive work regarding how thoughts can escalate distress. Establish exactly what she is fearful will happen.

4 Practice sitting exercises which will first involve the client progressing through the following movements:

- Sit up.
- Move her legs so she is sitting on the edge of the bed.
- Carry out shoulder shrugs, gentle arm movements, crossing and uncrossing legs while remaining seated.

5 If the client tolerates step 4 well, it may be suitable for them to progress to getting out of bed (assuming prior medical team consultation and appropriate reviews / supports have been considered).

The activity would be broken into micro-steps, and after each step encourage the client to settle, breathe, and re-set:

- While sitting on the edge of the bed, stand by using her arms for support and then stop for a break.
- Then gently move on (e.g., to the kitchen).
- She may need to stop on the way, holding onto something (this can be a pre-prepared area for a rest stop).
- When she gets to her location (e.g., kitchen to make a tea), she may hold onto the bench and re-set before she refills the kettle etc.

6 If possible, the client can then gradually return to their starting position in bed and settling, then allowing for a discussion of the thoughts arising if the shortness of breath is present, perhaps revisiting behavioural techniques, relaxation or cognitive re-structuring as appropriate. Explicitly ask about whether the feared outcome occurred, and if not, what Ivy could learn from that.

This detailed pacing approach can also provide an opportunity to discuss the client's environment as she moves through it (she will be describing it or you can see it). This allows for the delivery of therapy in 'real time' – the psychologist can also be discussing her thoughts, ideas, beliefs and fears concurrently.

You can discuss how moving out of her comfort zone can be done in small steps and she does not need to avoid change because of fear of overwhelm. But also, doing what counts, however new and challenging, will bring with it uncomfortable thoughts, feelings and sensations.

Flexibility In telehealth

The intervention can address both her breathlessness and her existential distress and fear about her illness trajectory and end of life. The connection, whether by telephone or video, allows a descriptive window into her immediate challenges. It allows you to appreciate details and to build trust as she is speaking to you from her actual environment and is likely to notice and report thoughts and feelings as she experiences them. It is important to note that the use of CBT or ACT components should be guided by the evidence base for the particular client presentation / context that is being addressed.

CASE STUDY 4

PALLIATIVE CARE

This case study assumes existing clinical knowledge and judgement

Background

Nur is a 43 year old man who is in the end stage of his treatment for colon cancer. He is married to Indarie and they have two children – aged 3 years and 10 months. He was given his diagnosis on the morning of the day their second child was born. In the days after the birth, he had further tests and widespread metastatic disease was evident. He then progressed through treatment and is likely to have weeks to short months left of his life.

Nur has had multiple admissions (for bowel obstructions, diarrhoea related to his immunotherapy and pain). They have said that they want to see you as a couple, but presently, Nur is in hospital and his wife is at home with the children.

Telehealth logistical considerations

When these types of referrals arise, it can be an excellent opportunity to have both people on a video-call, even if they are not in the same space. In the past, you may have done this via telephone, but the typical arrangement was to try to get partners into a face-to-face session.

One of the benefits of video-call is the flexibility it affords if people cannot easily get away from work, or do not drive, do not have easy access to flexible child-care etc. When the session is arranged, you can typically send links to more than one person (e.g you could run a whole family session like this).

Telehealth treatment considerations

Session 1

Indarie joins the call first, flustered and apologises for not being with Nur in-person – she wanted to be but did not have a person to take care of the children.

When Nur joins Indarie in the call, it becomes clear that they are emotionally distant from each other. She has been pre-occupied with all the needs of the children, breast feeding, night waking and so on. She feels guilty, exhausted, torn about the needs of Nur and the children. Nur feels sad, lost, helpless to be able to support her, grieving the end of his life, the impact on the family and not seeing his children grow. She has to leave the call early and he tells you that they have not been intimate since before the baby was born, she is no longer affectionate and they can't talk about it.

Towards the end of the 40 minute session, you notice that Nur is struggling. He is tired, eyes are drooping, he is uncomfortable in his chair and moves off screen as he moves his body. You both agree to end the session and he is going to request his break-through medications.

It can be helpful with patients with advanced disease to check if they need to do anything regarding analgesia (in consultation with their doctor) prior to commencing the session.

You suggest that for the next session they try to see if they can both be in his hospital room, on one device. If the tablet is too heavy, see if they can use a laptop and whether there is better timing for him that you could arrange for fatigue/pain etc.

PALLIATIVE CARE

continued

One of the useful (though ethically challenging) aspects of video-calls with people in different places is that the technology means that they may join the call at different times (or choose to). This does happen in face-to-face appointments too of course.

Remember that, if you feel it will be an issue (such as with separated parents who are acrimonious and likely to want to de-brief to you about the other before a family session) that you have control of when you admit them from the virtual waiting room into the session.

In normal circumstances, you would not choose to take one parent and all the children from the waiting room and then get the other parent later (who is likely to feel aggrieved, excluded and de-valued) so be careful with the messages you send via video-call if all people are not present on the one device. Be aware of when and how you let participants join and how to summarise if one is late etc., so trust is not eroded.

Session 2

For the second session with Nur and Indarie, they are in one room. Originally, he is a chair next to the bed and she is on a plastic seat. She is half off-screen and she says that's fine because it's 'about Nur anyway'. This is a good opportunity to signal that they both matter and to create a feeling of connection between you all. Have a look at the room (just ask them to move the screen around). You could suggest that, if comfortable he gets into the bed and Indarie sits in the chair (she might also choose to sit on the bed, don't push it, give her control – just as you would face-to-face).

Have a brief talk about fatigue; if he holds the tablet he's going to get fatigued. Can we prop it up? Can Indarie hold it? Do they have another computer? Use a pillow on the little table over the bed, make the bottom of the bed into a "V" so his knees can support the screen.

These adjustments matter because they create opportunity for less distraction with pain, fatigue or moving off screen. If you notice discomfort during the session, ask them to move position, be flexible. Sometimes people (including us) forget that screens move!

As the session continues, both Nur and Indarie express their grief, love and sadness. They are actually very open with each other and can see each other's point of view, wanting to protect one another but they can't. They both start to cry; she's still on the chair.

In a face-to-face consult, they may choose to hug, hold hands etc. Sometimes we might prompt that if we can see they want to. That can feel awkward to them on screen, so more prompting might be necessary; "you can hop up on the bed if you like", "don't worry about me or the screen, just move it", or "you look like you want to have a cuddle and a cry, you do that". Just like in session, people will show emotion and then contain themselves after a time. So allow space and opportunity for that.

As you would in a face-to-face consult of an inpatient, be mindful of attention, pain, discomfort and privacy. You may see eye contact be lost, are aware there is a 'side-bar' discussion, or the person needs to use the pan or bathroom. It's harder for us to notice these cues.

Benefits and Challenges of Telehealth

The purpose of this case study is to illustrate how being on a screen can have benefits as well as challenges in this inpatient or end of life setting. The flexibility (e.g., to have consults at palliative care units, homes etc when people are too ill or at end of life to come to an appointment) is very helpful. But you will need to overcome some issues such as social cues for comfort, privacy and screen-related fatigue. Sometimes, nursing or medical staff (or visitors) come into the room and do not realise, or respect, that a session is in place. You may not realise at first either!

If the patient does not know what to say, you may need to ask them to turn the screen so that you can tell the person who has come into the room what is happening. Most are very respectful and come back. If that isn't possible, quickly say to the patient that you will stay in the meeting, they can leave and then press the link to re-join (just as you might leave the room in a medical inpatient consult that couldn't be delayed).

Check your software for how this works, if the link can only be used once etc. Of course, if they need to use the bathroom or adjust a catheter position or dressing etc, you can do this too to maintain dignity.

This case study introduces two people but the strategies described here are a springboard to ways of approaching larger groups or family counselling.

PALLIATIVE CARE

continued

You may have family members all on screens, in dyads or individually. This is incredibly useful if family are prevented from being together geographically or because of infection risk etc. The same cues about comfort can be used. In these types of situations, however, you will need to set a plan or agenda as you would in a face-to-face meeting; why you are meeting, how people can contribute and how you will intervene if, for example, conflict is escalating, people are not listening to one another. If you do not set the scene as a professional appointment with some families, they can use the forum as a catalyst for airing grievances or shouting etc.

We know that being behind a screen can be disinhibiting for some. They say things they would not normally say in ways they would not choose if they were face-to-face. In a high-conflict family, be aware of this. Conversely, some people find it easier to be assertive or to express how they really feel if the person is not in front of them and they will not be alone together after the appointment.

This can provide opportunity for safe expression and conversation about tender issues (e.g. for an adult child to tell their parents that they wish to die in hospital and not be cared for at home by their mum). Issues that may have been avoided can feel more contained with the distance that screens provide.

Accommodating Children in Telehealth

Children can pose their own hurdles; decide how you will manage the situation if children are involved. On screens children can get easily distracted. They look away or, intentionally or unintentionally, move the screen (especially if on a phone) so you cannot see their face/are looking up their nose etc. Some don't listen, or interrupt others that are present (climb on a parent for a cuddle, ask for food, whisper comments or questions etc). Some children, especially with behavioural or attentional issues, go to the bathroom and attempt to bring the screen with them (!), burp, yawn, swear, leave or all of the above.

Finding that balance between children feeling included and feeling targeted is a challenge in some situations and the parents are likely to look to you for a plan of action. It helps to speak to parents first so you know the likely issues and to keep interactions with children involved short. An appointment at 4pm with a hungry, tired 13-year-old is asking for trouble, especially when the normal cues of a professional appointment are not there.

Simple advice to parents such as allowing them to get changed into comfy clothes, not coming straight into an appointment, having food or drink ready for the likely 'hangry' child, explaining to them what is happening prior (who they are seeing and why), how long they will be there and the basics of what is expected can help. Some children, especially with sensory issues, are more settled with fidget toys and so on, so be clear with parents that flexibility works well for rapport.

Key Messages

- Telehealth is a very useful tool in family and end of life situations.
- It provides opportunities that were very difficult to create previously.
- Don't shy away from using the tool because you feel you have less control over the environment.
- Video can be useful as people are more relaxed, more flexible and less stressed by other issues (racing for the appointment, parking, school pick-up, pain, fatigue etc).
- Planning helps, encouraging people to be relaxed and comfortable is important and setting the scene for this as a normal appointment creates some expectations and boundaries with individuals or families that are likely to be challenging.
- Be prepared for a wide range of individual reactions when people are together as a group. As with any group, there are multiple dynamics to balance.

4.3 OTHER THERAPEUTIC MODALITIES

In addition to CBT and ACT, clinicians may practice across a range of therapeutic modalities such as schema therapy and trauma-focused CBT for example. It is important for clinicians to investigate how to best adapt the therapeutic modality they intend to use, to a telehealth format. This includes considering whether there are any contra-indications for the client being treated under a particular modality via telehealth, and reviewing any available evidence base.

Gerber et al [29] consider trauma-informed virtual care to ensure the fostering of safe and collaborative interactions between patients and healthcare team.

They refer to applying principles of trauma-informed care to telehealth according to the Substance Abuse and Mental Health Service Administration (SAMHSA).

These include:

Safety

For example verifying patient location and contact information at the commencement of an encounter, and ensuring a secure and private environment.

Trustworthiness and transparency

For example alerting the patient to possible ambient noises, and sitting far enough from the screen that the patient can see body language.

Peer support

Consider referring to telehealth groups/providing information on virtual peer support.

Collaboration and mutuality

Collaboratively identify and develop session agenda and goals.

Empowerment, voice, and choice

Follow patient preferences regarding extent of the visit.

Cultural, historical, and gender issues

Use gender-affirming language (including patient's pronouns), consider social determinant of health during the visit, seek ways to make telehealth accessible to those who lack resources.

There has also been some research conducted into the efficacy of imagery rescripting (as a therapeutic technique within schema therapy) via telehealth. Paulik et al [30] looked at clinical concerns, benefits and recommendations relating to the use of imagery rescripting via telehealth. The outcomes of this study were that the delivery of imagery rescripting via telehealth was no less effective than face-to-face delivery, however that telehealth may not be viable in some situations due to lockdown related restraints such as thin walls, or for people with some complex disorders.

The researchers found that clients with dissociative identity disorder and to a lesser extent borderline personality disorder were less open to undertaking imagery rescripting via telehealth.

SECTION 5

SPECIFIC CLIENT CONSIDERATIONS

5.1 WORKING WITH CLIENTS IN PALLIATIVE CARE

The use of telehealth in palliative care may in some cases provide a continuity of care between a patient and clinician when the patient is no longer well enough to attend the hospital, and can reduce the discomfort of travel as well as reduce exposure to disease in a hospital setting [31, 32]. Family members may be able to be involved in the telehealth session with the patient at home. This would require considerations such as placing a phone on loud speaker or being mindful of where the camera is facing during a videoconference session, depending on patient preference (noting that it is always important for the clinician to know who is in the room and part of the session).

There is also evidence that Dignity Therapy conducted via telehealth is feasible and acceptable, and may provide a service to people who would otherwise miss out on the therapy [33].

Self-care for clinicians doing psycho-oncology work via telehealth is important **(see self-care section)**, but this may be amplified in palliative care settings.

5.2 AGE SPECIFIC CONSIDERATIONS (ADOLESCENT AND YOUNG ADULT/OLDER ADULT)

Working with an adolescent and young adult (AYA) and older adult population brings with it unique considerations, however on the whole many of the topics mentioned throughout these recommendations are still applicable, for example: setting up the space, privacy/security, technical consideration, risk assessment, the therapeutic alliance, cultural considerations, comforting a client etc. Specific factors to consider that are unique to the AYA and older adult population are outlined below.

Adolescent and Young Adult (AYA) telehealth considerations

It is possible to successfully undertake clinical interactions with young people and their families using telehealth [34]. Furthermore, telehealth may provide additional benefits to the AYA population such as greater access to psychological services to patients who reside far from the hospital, and AYAs may access telehealth even if they are unwilling to engage in face-to-face, thus providing an added layer of potential therapeutic engagement and benefit [35]. Sansom-Daly et al [35] documented factors that assist in successful engagement with young people and families via telehealth, some of which included:

- **Ongoing evaluation of telehealth over time**
  AYA preferences for videoconference vs telephone connection are variable and may change over time – therefore it is important to explicitly 'check in' on how they are finding the telehealth model.
- **Risk management**
  Adequate risk screening is important prior to first session and at each online session, including collecting contact details of home/next-of-kin, and/or GP.
- **Therapeutic strategies**
  Naming/exploring setting as a means to learn more about the client in the context of their geography, family/home situations, everyday life.

  Flexible use of online tools, e.g. collaborative exercises during session using screen-share – ensure familiarity prior to use.

Further recommendations are made by the American Telemedicine Association [36] in relation to working with children, including:

- Consider developmental status of youth (such as motor functioning, speech and language capabilities, and relatedness).
- When legally required, families need to be informed when a telehealth appointment is scheduled for their child.

- The room at the client's end should be large enough to include the youth and a parent plus one or two other individuals (as appropriate/necessary), and for the camera to be able to observe all involved if possible.

- A table for the child to draw/play at as well as age appropriate toys to occupy the child and allow assessment of skills should be available.

- Further tips for working with children and AYA are suggested in the **'Accommodating children in telehealth'** section of Case study 4.

Older adult telehealth considerations

As with other populations, telehealth may afford older adults more accessible and convenient access to psychology health care depending on their location and situation. There often exists a common misconception that older adults don't have the same interest in or ability to access technology platforms. The American Psychological Association show data suggesting this is in-fact not the case, with most older adults having access to a computer, smart phone or tablet with internet access [37].

Specific consideration should be given, however, to ways to reduce limitations and barriers, and to increase reach of telehealth to older adults. The following considerations should be considered when working with older adults via telehealth: [36, 38]

- **Sensory deficits:** understanding whether there are any sensory deficits, particularly visual and auditory is important, as these can impair the ability to engage fully with videoconference.
  - **Adaptations:** If required, support from a health worker or family caregiver may be beneficial, as well as adapting communication strategies/style and acoustic arrangements of teleconsult room would be helpful. Any strategies to enhance audio and video quality are important.
- **Communication style** should be appropriate for a client who may be finding it difficult to adapt to technology.
  - **Adaptations:** slowing things down and ensuring explanations are clear, as well as frequent checking on client understanding and comfort levels with the telehealth interaction
- **Family meetings** may be appropriate where family members or the patient live in rural or remote places. It can also be beneficial in aiding multidisciplinary meetings with GPs and specialists, assisting a coordinated management approach to patient care
- **Cognitive impairment/legal/consent and capacity issues:** many older adults experience some expected cognitive decline such as slower speed of processing or slight decline in episodic memory, which should not prevent use of telehealth. Some older adults may have a higher level of cognitive impairment, however, including dementia. Cognitive status needs to be considered before engaging in telehealth, and factors taken into account such as whether adequate support can be provided to assist with the telehealth process if required. In addition, legal issues and capacity and consent issues need to be considered on an individual basis
  - **Adaptations:**
    - Compensatory strategies such as making notes or using reminders, including reminders for telehealth appointment times. Written notes may include instructions on how to launch the telehealth application.
    - Adults with mild dementia may still be able to use telehealth with the assistance of a family member or health professional to set up the session

The American Psychological Association provides further strategies and adaptations for supporting older adults using telehealth [37]:

- Don't assume older adults aren't interested in telehealth

- Prior to the appointment, consider a phone call to talk through the telehealth (including 'how-to'), and provide written instructions for using telehealth – using concise language, larger font size, and screen shots of each step of the process

- Consider visual presentation modifications, such as increasing the display illumination

- Auditory enhancements may also assist the process, including adjust volume settings, use of headset

- Ensure your background is not 'busy' – a plain backdrop will assist an older adult with visual challenges to better focus on the clinician

- Check if the patient needs breaks during the session to stretch. Encourage them to use anything in session that helps with their physical comfort such as a comfortable chair

- Provide an end-of-session summary of goals and exercises for next session

- Directly acknowledge that telehealth sessions can start off feeling awkward and tricky, and that most people find this

SECTION 6

CLINICIAN SELF-CARE

Mental health clinicians carry unique occupational vulnerabilities inherent to the profession [39, 40], however telehealth can bring an additional physical and emotional strain, including increased fatigue, that warrants a focus on self-care [41].

Hoffman (2021) [40] suggests the following self-care considerations for telehealth specific stressors:

Challenges	Suggestions
Increased fatigue	Schedule additional breaks during the day
Working remotely can add to isolation from colleagues who may normally provide social support and the chance to discussion clinical challenges	Schedule consultation time with colleagues
Working long hours	Spending quality time with family members or others who live in the same house

Other self-care tips include [42]:

- maintaining awareness of stressors
- maintain participation in supervision
- taking care of yourself – including a focus on sleep, exercise, nutrition, meaningful relationships and leisure time
- developing and working toward specific personal goals to give priority to your own mental and physical health
- engaging in mindfulness

Closing Statement

These recommendations were developed in Australia on the background of rapidly evolving COVID-19 regulations and restrictions but are based on best available evidence. Despite subsequent easing of restrictions, there is a continued emphasis on developing the capabilities of health providers to enable ongoing provision of high quality, effective telehealth services. The ability to provide nuanced best-practice psycho-oncology therapy via videoconference and telephone will ensure greater reach and flexibility of services to clients who may otherwise have been unable to access services.

Telehealth remains a crucial and ever-growing component of the Australian healthcare system, and it is hoped that these recommendations will aid clinicians in providing the best possible care to clients impacted by cancer.

REFERENCES

1. Hale M, Brennan L. *Why have psychologists been slow to adopt telehealth?* InPsych, 2020. 42(3).
2. Spelten, E. R., Hardman, R. N., Pike, K. E., Yuen, E. Y., & Wilson, C. *Best practice in the implementation of telehealth-based supportive cancer care: Using research evidence and discipline-based guidance*. Patient education and counseling, 2021. 104(11), 2682-2699.
3. Haydon HM, Smith AC, Snoswell CL, Thomas EE, Caffery LJ. *Addressing concerns and adapting psychological techniques for videoconsultations: a practical guide*. Clinical Psychologist, 2021. 25(2):179-86.
4. Backhaus A, Agha Z, Maglione ML, Repp A, Ross B, Zuest D, Rice-Thorp NM, Lohr J, Thorp SR. *Videoconferencing psychotherapy: a systematic review*. Psychological services, 2012. 9(2):111.
5. Hilty DM, Ferrer DC, Parish MB, Johnston B, Callahan EJ, Yellowlees PM. *The effectiveness of telemental health: a 2013 review*. Telemedicine and e-Health, 2013. 19(6):444-54.
6. Osenbach JE, O'Brien KM, Mishkind M, Smolenski DJ. *Synchronous telehealth technologies in psychotherapy for depression: A meta-analysis*. Depression and Anxiety, 2013. 30(11):1058-67.
7. Snoswell CL, Chelberg G, De Guzman KR, Haydon HH, Thomas EE, Caffery LJ, Smith AC. *The clinical effectiveness of telehealth: a systematic review of meta-analyses from 2010 to 2019*. Journal of Telemedicine and Telecare, 2021. Jun 29:1357633X211022907.
8. Jenkins-Guarnieri MA, Pruitt LD, Luxton DD, Johnson K. *Patient perceptions of telemental health: Systematic review of direct comparisons to in-person psychotherapeutic treatments.* Telemedicine and e-Health, 2015. 21(8):652-60.
9. Butt Z, Kirsten L, Beatty L, Kelly B, Dhillon H, Shaw JM. *Barriers and enablers to implementing telehealth consultations in psycho-oncology*. Psycho-Oncology, 2022. Apr 23.
10. Shore JH, Yellowlees P, Caudill R, Johnston B, Turvey C, Mishkind M, Krupinski E, Myers K, Shore P, Kaftarian E, Hilty D. *Best practices in videoconferencing-based telemental health*. Telemedicine and e-Health, 2018. 24(11):827-32.
11. Australian Psychological Society (APS). *Telehealth measures to improve access to psychological services for rural and remote patients under the Better Access initiative - Considerations for providers*. 2017. Retreived December 6, 2022 from https://psychology.org.au/getmedia/4dd9dd91-1617-421b-928c-531d019f05c2/22aps-telehealth-providers-p1.pdf
12. Joint Task Force for the Development of Telepsychology Guidelines for Psychologists. *Guidelines for the practice of telepsychology*, 2013. American Psychologist, 68 (9), 791-800.
13. Caffery, L., Hobson, G., Mothershaw, A., Haydon, H.M., Snoswell, C.L., Thomas, E., Zurynski, Y., Smith, K., Clay, C. Smith, A.C. *Quick guides for telehealth*. Available from: https://coh.centre.uq.edu.au/quick-guides-telehealth. Published 21 April 2020. Accessed 10th Nov 2021.
14. *NSW Department of Health, Violence, abuse and neglect and COVID-19 - Telehealth*. Available online at https://www.health.nsw.gov.au/Infectious/covid-19/pages/violence-abuse-neglect.aspx#telehealth. Accessed 10th Nov, 2021.
15. Watts S, Marchand A, Bouchard S, Gosselin P, Langlois F, Belleville G, Dugas MJ. *Telepsychotherapy for generalized anxiety disorder: Impact on the working alliance.* Journal of Psychotherapy Integration, 2020. 30(2):208.
16. Simpson SG, Reid CL. *Therapeutic alliance in videoconferencing psychotherapy: A review. Australian Journal of Rural Health*, 2014. 22(6):280-99.
17. MindSpot [Internet]. *What MindSpot Offers*. Accessed December 6, 2022 from http://mindspot.org.au/
18. This Way Up [Internet]. *What we do*. Accessed December 6, 2022 from http://thiswayup.org.au/
19. Psych Tools. [internet]. *Feel prepared to deliver effective therapy*. Accessed December 6, 2022 from http://www.psychologytools.com/
20. Bruera, E. and S. MacDonald, *Clinical Audit in Palliative Care. Audit methods: the Edmonton Symptom Assessment System*, 1993: p. 61-77.
21. Watanabe SM, Nekolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. *A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients*. Journal of pain and symptom management, 2011. 1;41(2):456-68.
22. Zigmond AS, Snaith RP. *The hospital anxiety and depression scale*. Acta psychiatrica scandinavica, 1983. 67(6):361-70.
23. Australian College of Rural & Remote Medicine. *ACRRM framework and guideliens for telehealth services*, 2020. Available online at https://www.acrrm.org.au/docs/default-source/all-files/telehealth-framework-and-guidelines.pdf?sfvrsn=ec0eda85_2. Accessed 10th Nov, 2021.

REFERENCES

24. Royal Australian College of General Practitioners. *Guide for clinicians working with interpreters in healthcare settings*, 2019. Available online at https://culturaldiversityhealth.org.au/wp-content/uploads/2019/10/Guide-for-clinicians-working-with-interpreters-in-healthcare-settings-Jan2019.pdf. Accessed 10th Nov, 2021.

25. Harris R. Getting unstuck in ACT: *A clinician's guide to overcoming common obstacles in acceptance and commitment therapy*. New Harbinger Publications; 2013. p30-31.

26. Harris R. ACT made simple: An easy-to-read primer on acceptance and commitment therapy. New Harbinger Publications; 2019.

27. Arch JJ, Mitchell JL. *An Acceptance and Commitment Therapy (ACT) group intervention for cancer survivors experiencing anxiety at re-entry*. Psycho-Oncology, 2016. 25(5):610-5.

28. Smith BP, Coe E, Meyer EC. *Acceptance and Commitment Therapy delivered via telehealth for the treatment of co-occurring depression, PTSD, and nicotine use in a male veteran. Clinical Case Studies*, 2021. 20(1):75-91.

29. Gerber MR, Elisseou S, Sager ZS, Keith JA. *Trauma-informed telehealth in the COVID-19 era and beyond. Federal Practitioner*, 2020. 37(7):302.

30. Paulik G, Maloney G, Arntz A, Bachrach N, Koppeschaar A, McEvoy P. *Delivering imagery rescripting via telehealth: clinical concerns, benefits, and recommendations. Current psychiatry reports*, 2021. 23(5):1-0.

31. Haydon HM, Snoswell CL, Thomas EE, Broadbent A, Caffery LJ, Brydon JA, Smith AC. *Enhancing a community palliative care service with telehealth leads to efficiency gains and improves job satisfaction*. Journal of Telemedicine and Telecare, 2021. 27(10):625-30.

32. Chávarri-Guerra Y, Ramos-López WA, Covarrubias-Gómez A, Sánchez-Román S, Quiroz-Friedman P, Alcocer-Castillejos N, del Pilar Milke-García M, Carrillo-Soto M, Morales-Alfaro A, Medina-Palma M, Aguilar-Velazco JC. *Providing supportive and palliative care using telemedicine for patients with advanced cancer during the COVID-19 pandemic in Mexico.* The oncologist, 2021. 26(3):e512-5.

33. Bentley B, O'Connor M, Williams A, Breen LJ. *Dignity therapy online: Piloting an online psychosocial intervention for people with terminal illness*. Digital health, 2020. Sep;6:2055207620958527.

34. Sansom-Daly UM, Bradford N. *Grappling with the "human" problem hiding behind the technology: telehealth during and beyond COVID-19*. Psycho-oncology, 2020. 29(9):1404.

35. Sansom-Daly UM, Wakefield CE, McGill BC, Patterson P. *Ethical and clinical challenges delivering group-based cognitive-behavioural therapy to adolescents and young adults with cancer using videoconferencing technology*. Australian Psychologist, 2015. 50(4):271-8.

36. Grady B, Myers KM, Nelson EL, Belz N, Bennett L, Carnahan L, Decker VB, Holden D, Perry G, Rosenthal L, Rowe N. *Evidence-based practice for telemental health*. Telemedicine and e-Health, 2011. 17(2):131-48.

37. American Psychological Association. *How to provide telehealth to older adults*, 2020. Available online at https://www.apaservices.org/practice/clinic/telehealth-older-adults. Accessed 11th Nov, 2021.

38. Sivakumar PT, Mukku SS, Kar N, Manjunatha N, Phutane VH, Sinha P, Kumar CN, Math SB. *Geriatric telepsychiatry: Promoting access to geriatric mental health care beyond the physical barriers*. Indian Journal of Psychological Medicine, 2020. 42(5_suppl):41S-6S.

39. Rokach A, Boulazreg S. *The COVID-19 era: How therapists can diminish burnout symptoms through self-care*. Current Psychology, 2020. 31:1-8.

40. Hoffman L. *Existential – humanistic therapy and disaster response: Lessons from the COVID-19 pandemic*. Journal of Humanistic Psychology, 2021. 61(1):33-54.

41. Sampaio M, Navarro Haro MV, De Sousa B, Vieira Melo W, Hoffman HG. *Therapists make the switch to telepsychology to safely continue treating their patients during the COVID-19 pandemic. Virtual reality telepsychology may be next*. Frontiers in virtual reality, 2021. 5;1:576421.

42. American Psychological Association.*Tips for Self-Care*, 2010. Accessed May 20, 2020 from https://www.apaservices.org/practice/ce/self-care/acca-promoting.