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## Using Person-Centered Scheduling with Geriatric Patients to Reduce Anxiety with Telepsychiatry

Jody Long

*Jacksonville State University, jlong12@jsu.edu*

Patricia A. Wilkerson

*Arkansas State University - Main Campus*

Evi Taylor

*Arkansas State University - Main Campus*

John Hall

*Arkansas State University - Main Campus*

Christopher Peters

*Arkansas State University - Main Campus*

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*Arkansas State University*

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## Using Person-Centered Scheduling with Geriatric Patients to Reduce Anxiety with Telepsychiatry

Jody G. Long

*Jacksonville State University*

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John H. Hall

Christopher Peters

*Arkansas State University*

**Abstract.** This study explored using person-centered scheduling with telepsychiatry for rural community geriatric patients. Quantitative research approaches were used to determine the level of satisfaction participants experienced with person-centered scheduling and geriatric telepsychiatry. Quantitative data were collected by using the Zung Self-Rating Anxiety Scale (SAS) before scheduling the first appointment and to assess the intervention's effectiveness after the telepsychiatry session. Person-centered telepsychiatry scheduling decreased geriatric patients' anxiety as evidenced by Zung SAS scores. Conclusion: Older adult patients saw telepsychiatry as a viable means of treatment. Future research with geriatrics from different regions is needed. Implications and future directions include exploring patient responses from different regions such as rural areas vs. urban metropolitan areas. Qualitative data from different age categories, 65 to 75 and over 75 may yield different perspectives. The results of this study are consistent with the benefits of person-centered approaches and the benefits of telepsychiatry.

**Keywords:** person-centered scheduling, geriatrics, telepsychiatry

In the United States, it has been estimated that half the population now suffers from some form of mental illness. An increasing number of these individuals reside in rural areas (Mackie, 2015; Malhotra, Chakrabarti & Shah, 2013) where there are fewer mental health practitioners providing specialty care (Lokkerbol et al., 2014; Noe et al., 2011). Furthermore, the high cost of mental health services in rural communities is problematic for many residents. Limited or no access to psychiatric services in these areas has become a critical problem in the United States (Hilty et al., 2015). For instance, the lack of treatment providers in rural communities has led to under-treatment, resulting in negative consequences such as higher incidents of suicide, increased hospital emergency room use, hospitalizations, and mental institution placements (Long, Sakauye, Chisty, & Upton, 2016; Ruskin et al., 2004; Moak & Borson, 2000).

These negative consequences are especially problematic with the geriatric population given that 20% of the elderly have been diagnosed with a mental disorder (Thakur & Blazer, 2008). Older adults who suffer from mental illnesses in rural areas that are not located near specialized care or mental health service providers present a unique healthcare delivery challenge (Amirasadri, Burns, Pizzuti, & Arfken, 2017; Shore, 2013). Approximately one-half of the elderly reported missing appointments due to having transportation issues (Syed, Gerber, & Sharp, 2013). Additional barriers associated with obtaining appropriate treatment include inability to drive, and limited financial recourses. Therefore, there is a significant need to provide

accessible mental health services for older adults in rural communities (Moore et al., 2016; Conn, Madan, Lam, Patterson, & Skirten, 2013).

Telemedicine may be one solution for these problems. It has been used since the late 1950s to provide patient care and education to those who are not able to easily access practitioners' offices (Moore et al., 2016; Rohland, Saleh, Rohrer & Romitti, 2000). With the most recent advances in telemedicine and availability of technology, telepsychiatry has become a reasonable means for rural residents faced with limited access and inability to connect with academic psychiatry centers and medical facilities in urban areas (Noe et al., 2011; Tang, Chiu, Woo, Hjelm, & Hui, 2001).

Telepsychiatry is a mode of delivery used in the diagnosis and treatment of patients separated from psychiatrists by distance that has proven to be an effective manner of meeting patients' mental health needs (Helm et al., 2016; Fortney et al., 2013; Kuo, Ma, Lee, & Bourne, 2001) and overcoming the previously noted barriers. It also has promise for dealing with the growing scarcity of psychiatry and mental health services for the elderly.

Although telepsychiatry is predicted to have an increasing place in providing care (Mackie, 2015; Noe et al., 2011; Thakur & Blazer, 2008), it is not without problems. Many elderly people are resistant to technology and thus use these innovations less frequently. Wu, Damnee, Kerherve, Ware, and Rigaud (2015) report that only 8.4% of older adults use the internet compared to 100% born after 1990. The lack of exposure to technology often results in increased discomfort, anxiety and fear, or a lack of interest. They may lack technology skills due to a combination of lack of preparation, education, and experience (Conn et al., 2013; Lokkerbol et al., 2014).

Anxiety can be a major issue. It contributes to decreased quality of life (Sarma & Byrne, 2014). It is seen more frequently in older adults especially those with chronic medical conditions and is correlated with increased disability (Levine, Richardson, Granieri, & Reid, 2014). Because of the overall increased incidence of anxiety with new technologies among older adults (Wu et al., 2015), telepsychiatry may be intimidating for them. Shore (2013) found that patients' level of comfort with telepsychiatry is directly related to their past experience with technology, age, and education.

Such anxiety of course tends to reduce treatment acceptability, which in turn can significantly impact geriatric patients' use of needed psychiatric services. Familiarity with technology is critical to the success of telepsychiatry in this population.

Due to the importance of geriatric patients' level of anxiety for treatment acceptability, adherence success with this population lies with creating a warm, empathic, understanding atmosphere during telepsychiatry sessions (Hilty et al., 2015). One viable method for creating this conducive environment is through the use of person-centered scheduling whereby patients scheduled for appointments meet with a practitioner to introduce them to telepsychiatry procedures. Person-centered approaches are driven by the needs and desires of the individual and support informed decision making (Sundar, Fox, and Phillips, 2014). According to Carl Rogers, the founder of Person-Centered Therapy, unconditional positive acceptance, congruence, and

empathy are key elements in therapeutic work using a person-centered approach (Téllez, & Pérez).

Person-centered scheduling has been used as a technique to schedule appointments, build therapeutic alliances, and improve patient acceptability and compliance (McNeil, Gormley, & Binder, 2013; Long, Sakauye, Chisty, & Upton, 2016). This method embraces the concepts of compassion, genuineness, empathic understanding, and unconditional positive regard when scheduling telepsychiatry sessions. Person-centered scheduling provides a more optimistic and warm use of awareness to counter patients' uncertainty with telepsychiatry (Paige & Mansell, 2013; McNeil et al., 2013). It seems to be less anxiety provoking compared to more mechanistic methods of scheduling appointments.

The work of several authors has pointed to this idea, although little research specific to person-centered scheduling and rural geriatrics patients' experiences with telepsychiatry has been conducted. Malhotra, et al., (2013) noted the need to explore telepsychiatry patient interactions with geriatric patients.

Thakur & Blazer (2008) identified the need to examine rural geriatric patients' perspectives regarding telepsychiatry including comfort, clinical processes, clinical developments, therapeutic alliance, and elder care. Other studies have found elderly patients' reluctance with telemedicine and rural patients' resistance to telepsychiatry (Ruskin et al., 2004; Bratton & Short, 2001). Research has also investigated the acceptability of telepsychiatry with rural populations, cultural aspects, and challenges (Malhotra et al., 2013; Rohland et al., 2000; Thakur & Blazer, 2008).

While telepsychiatry has great promise to serve older adults, its application may still be problematic in practice. Studies investigating telepsychiatry with older adults have revealed the previously described concerns associated with creating or intensifying anxiety (Levine, Richardson, Granieri, & Reid, 2014).

To bridge this gap, tailored training (e.g., person-centered scheduling) has been cited as the best way to approach geriatrics regarding technology and telepsychiatry. Adequate training, support, and individualized accommodations tend to have a positive influence on older adults' ability to adapt to new technologies. Given the significance of geriatric patients' anxiety and the limited research specific to person-centered scheduling, we explored the use of this method as a treatment for reducing it. We hypothesized that a treatment consisting of person-centered scheduling would generate a more supportive environment in this population compared to those who simply received telepsychiatry. We looked at self-ratings of anxiety in these patients.

## **Method**

### **Participants**

A convenience sample of 100 (N = 100) newly admitted geriatric patients at outpatient programs located at critical access hospitals in the Southeast U. S. participated in the study over a twelve-month period in 2014-2015. These hospitals are located in rural areas, have 25 or fewer

beds and provide 24 hour emergency service (DeShazo & Parker, 2016). The mean age of the participants was 68.22 (3.32) at pre-treatment. Eighty-eight percent were female and 12% were male. All participants had DSM-5 (American Psychiatric Association, 2013) diagnosis. Specifically, 88% (n = 44) had a diagnosis of Major Depressive Disorder and 12% (n = 6) had a diagnosis of Bipolar I Disorder.

## **Setting**

Five hospitals located in rural areas in the Southeast U. S. that had an existing partnership with the university medical school and were located in a large regional city served as the setting for the study. The university medical school psychiatric department provided the Scheduled Telepsychiatry services. The same psychiatrist who was licensed in each state where the critical access hospital was located was assigned to the program. Another psychiatrist was available in case the primary psychiatrist was not. The psychiatrist was available one day a week for assessments, medication management, treatment team meetings, supervision and other staff needs. Having a consistent psychiatrist for each patient was extremely beneficial. Documentation was promptly uploaded with the hospitals' medical records.

On-demand telepsychiatry was available for emergent patient situations. This typically included assessment of suicidal, homicidal, violent, psychotic, manic, depressed and severely anxious patients.

## **Measures**

The Zung Self-Rating Anxiety Scale (SAS) (Zung, 1971; Ramirez & Lukenbill, 2008) is a 20-item self-report rating scale developed to measure anxiety levels based on scores in four subtests/domains: (a) Cognitive, (b) Autonomic, (c) Motor, and (d) Central Nervous System symptoms. The items are scored on a Likert-type scale ranging from 1 – 4 (i.e., 1 = “a little of the time,” 2 = “some of the time,” 3 = “good part of the time,” and 4 = “most of the time”). The total raw scores range from 20 – 80. The Anxiety Index Score (AIX) is used to determine the clinical interpretation of one's level of anxiety within the following ranges: 20-44 normal range; 45 – 59 mild to moderate; 60 – 74 marked to severe; and 75 – 80 extreme (Ramirez & Lukenbill, 2008). The SAS is reported to have good internal consistency with a Cronbach's alpha of .82 and fair concurrent validity. There is evidence to show the SAS distinguished between clinical and non-clinical groups and between individuals diagnosed with anxiety disorders and other conditions (e. g., Dunstan, Scott, & Todd, 2017).

## **Procedure**

Following Institutional Review Board (IRB) approval, telepsychiatry appointments were scheduled by the university medical school's psychiatric department. Newly admitted geriatric psychiatric patients during the first six months of the study were assigned to the telepsychiatry group (n = 50) and were asked to complete the SAS. These participants received telepsychiatry, but did not obtain person-centered scheduling. The control group patients were informed of the telepsychiatry sessions but were given only a brief explanation of them.

Newly admitted patients from the next six months of the study were assigned to the person-centered scheduling group ( $n = 50$ ) and asked to complete the SAS prior to the first telepsychiatry session. After treatment, all patients again completed the SAS. Gender demographics were identical for both groups.

## **Treatment**

A quasi-experimental pre-posttest control group design was utilized. At the beginning of treatment participants ( $n = 50$ ) were seen every 2 weeks but could also be seen in a crisis situation through telepsychiatry. Telepsychiatry sessions were scheduled at least once a month. The treatment consisted of a mental health clinician (e.g., Clinical Psychologist, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, or Registered Nurse) meeting with each participant and explaining person-centered scheduling. The control group patients were escorted to the telepsychiatry treatment room. They were assisted to a comfortable chair and the clinician connected the computer to the psychiatrist. The patient would notify the clinician when the session was completed.

The treatment group received each of these steps plus the person-centered scheduling. Typically, clients received telepsychiatry every two weeks when first starting outpatient treatment. The treatment focus was on establishing a therapeutic alliance (e.g., displaying warmth, empathy, genuineness, and unconditional positive regard) in an attempt to decrease the participant's anxiety and discomfort associated with telepsychiatry. Person-centered scheduling consisted of 11 steps which focused on increasing participants' understanding and awareness of telepsychiatry and decreasing their anxiety, insecurity, and worry associated with this modality (see Table 1).

## **Results**

A mixed factorial analysis of variance (ANOVA) indicated a significant interaction,  $F(1, 98) = 44.77, p < .001$ , partial  $\eta^2 = 3.14$ . Planned comparisons indicated that while both the person-centered scheduling ( $t = 24.69, p < .001$ , Cohen's  $d = 2.13$ ) and telepsychiatry ( $t = 6.71, p < .001$ , Cohen's  $d = 0.79$ ) conditions resulted in significantly lower anxiety, the person-centered scheduling group ( $M = 45.46, SD = 6.91$ ) had significantly lower anxiety than the telepsychiatry group ( $M = 51.98, SD = 8.96, t = 4.08, p < .001$ , Cohen's  $d = 0.81$ ) (see Figure 1).

## **Discussion**

A significant number of geriatric patients live in rural isolated areas. They face diverse hardships including financial stress, family discord, domestic situations, lack of transportation and access to healthcare. Physicians, nurses, and social workers are in short supply (Daley, 2015).

Because of the various needs of the rural geriatric population, the one-size-fits-all model of in person service does not work well. However, social workers can empower clients no matter the rural setting.

Strong relationships with rural patients are difficult to establish. Clinicians need to know them as individual and learn their culture. Not all rural towns and communities are the same. Hence, social workers must adapt mental health practices to each rural community. The geriatric population in the rural community continues to grow. This growth is accompanied by common challenges for the rural community: Nicotine use, obesity, chronic health problems, avoidance of seeing physicians, poverty and mental health issues. As discussed, geriatric patients prefer to retain the older methods of doing tasks and follow old established customs and patterns.

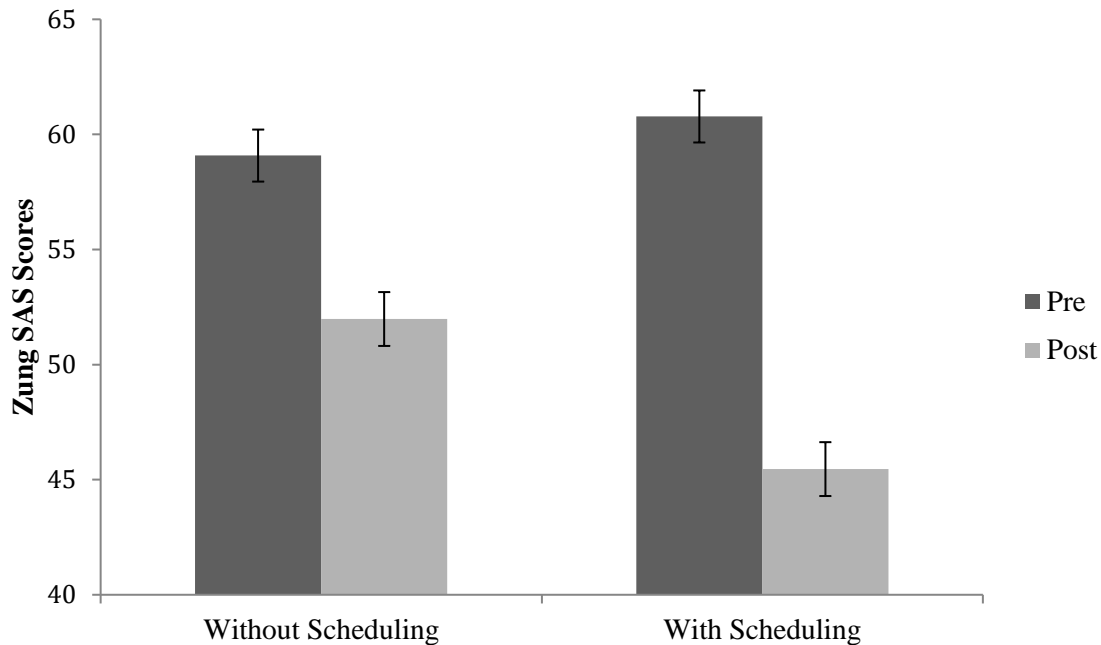
Table 1.

*Person-centered scheduling steps.*

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1. The participant completed the Zung Self-Rating Anxiety Scale (SAS) before and then after the telepsychiatry session. The clinician assessed the degree of the participant's apprehension.
  2. The clinician met with the participant to provide an overview of the telepsychiatry session in an effort to decrease their apprehension, anxiety, and discomfort toward telepsychiatry.
  3. The clinician established a therapeutic alliance with the participant by displaying warmth, empathy, genuineness, and unconditional positive regard and by assuring them that telepsychiatry was an effective treatment.
  4. The clinician showed the participant the telepsychiatry room, which contained a pleasing décor and warm inviting chair, as opposed to a sterile atmosphere.
  5. The clinician empowered the participant by encouraging them to engage in the scheduling process and to voice their views of telepsychiatry.
  6. The clinician therapeutically focused on positive communication and support to disclose the participant's concerns.
  7. The process established a sense of partnership with the participant and telepsychiatry.
  8. The clinician escorted the participant to the telepsychiatry session and remained with them until the session began.
  9. The clinician instructed the participant that if problems occurred, they were available in the adjacent room.
  10. The participant's potential anxiety, fear, and concerns associated with the first telepsychiatry session were addressed by the clinician.
  11. Each scheduling session ended with the clinician highlighting the benefits of having the participant's psychiatric needs met (e.g., treating insomnia, anxiety, depression, and mood swings).
-





*Figure 1.* Mean (SE) pre and post anxiety scores for the telepsychiatry groups without and with person-centered scheduling.

They also tend to see important the personal style of social interactions and trusting outsiders from a close-knit community. Due to these needs, professional newcomers to the rural community need to individualize care. Person-centered scheduling meets these identified needs. It allows social workers to adapt standard psychiatry practice to engage the rural geriatric patient. It is predicated on establishing empathy and rapport. Once trust is created, adherence increases with medical protocols. This is critical for the rural resident who may have spent his or her entire life in the same community and relying on the same type of interactions.

Person-centered scheduling in combination telepsychiatry has the ability to bring mental health care to geriatric rural patients and increase the range of services available to them. It allows them to meet with a psychiatrist who otherwise may not have been available. Furthermore, this treatment modality holds the potential to solve significant problems associated with geriatric patients' mental illness (Malhotra et al., 2013). Telepsychiatry is not limited to emergencies and is convenient for both patients and practitioners.

The results obtained from this study reveal that while both the person-centered scheduling and telepsychiatry significantly lowered anxiety, the patients who also received person-centered scheduling had significantly lower anxiety than those who just received telepsychiatry alone. These results are consistent with the benefits of person-centered approaches: lower levels of anxiety, possibly comfort with using technology, and increased treatment acceptability and adherence.

## Study Weakness

This study is exploratory and not definitive. Generalizations cannot be made beyond the scope of the area under study in the clinic represented in the mostly female population attending the telemedicine clinic. The participants were a convenience sample as well. Replicating this study with a larger sample would increase the generalizability of the results.

Lastly, acknowledging that anxiety levels can be influenced in the therapeutic outcomes of elderly who participate in telepsychiatry is significant but these results might not be generalizable to rural elderly may possibly limit the generalizability of rural elderly whose diagnoses are beyond the usual scope of telemedicine psychiatry. Still, this study and its outcomes may contribute to explaining person-centered scheduling to offset the level of anxiety for the respective population under study. Additional research should explore other telemedicine disciplines with geriatric patients in rural versus urban settings.

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