Establishing Therapeutic Alliance in Tele-Mental Health

Brooke A. Finley, PhD, DNP, PMHNP-BC, RN, CARN-AP

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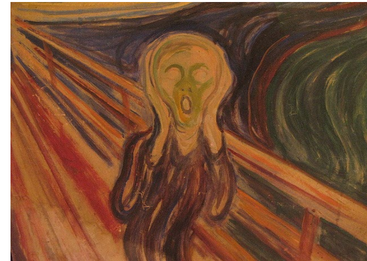
Problem & Context

Mental Health Crisis

- 1 in 5 Americans has a mental health disorder, costing ~$317.6 billion annually (CBHQ, 2015; Insel, 2015)
- Suicide (up 30% since 1999) and opioid overdoses are among the leading causes of death in the U.S. (CDC, 2018a, 2018b)
- Nearly half of those who need mental health care do not receive it (NAMI, 2016; WHO, 2018)
- Global mental health risk increased and overall wellness decreased during COVID-19 pandemic (Aknin, et al., 2022; Moreno, et al., 2020)



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Problem & Context

Virtual Care Revolution

- Telehealth use peaked in April 2020, but the daily utilization is 38x higher than pre COVID baseline (Bestsennyy, et al., 2021)
- Psychiatry utilizes virtual care more than any other specialty as 50-60% of all visits are virtual (Bestsennyy, et al., 2021)
- Telepsychiatry (TP) research basis is nascent beyond showing feasibility, satisfaction, & non-inferior diagnostic accuracy to in-person care (Finley & Shea, 2019; Finley, et al. 2020)

Source: https://www.amnhealthcare.com/siteassets/amn-insights/news-and-features/vcm-blog.jpg?format=webp

Problem & Context

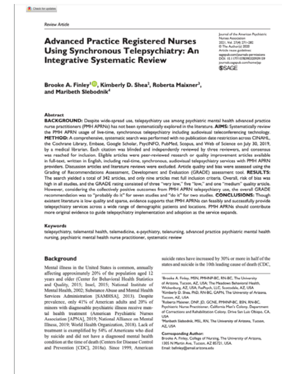
Therapeutic Alliance (TA)

- Conceptualized by Viennese psychoanalyst, Richard Sterba, MD, in the 1930s and is Transdiagnostic variable and quantifiable (Hatcher & Gillaspy, 2006; Rodomonti, et al., 2020)
- Definition: The bond/attachment between provider and patient that allows for an intersubjective sense of collaboration needed for achieving shared goals (Rodomonti, et al., 2020)
- Positive Correlations: Symptom reduction, engagement, patient & provider satisfaction (Lopez, et al., 2019; Simpson, et al., 2020)
- Negative Correlations: suicide, self-harm, treatment drop out, symptom severity (Lopez, et al., 2019; Simpson, et al., 2020)
- Provider characteristics and actions influence TA the most (Del R, et al., 2021)

Source: https://www.aier.org/wp-content/uploads/2020/03/humanconnection-1200x900-cropped.jpg

Problem & Context

Systematic Reviews about TA & TP : What We Know



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Review Article

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Advanced Practice Registered Nurses Using Synchronous Telepsychiatry: An Integrative Systematic Review

Brooke A. Finley[1], Kimberly D. Shea[2], Roberta Maixner[3], and Maribeth Slebodnik[4]

Abstract

BACKGROUND: Despite wide-spread use, telepsychiatry use among psychiatric mental health advanced practice nurse practitioners (PMH APRNs) has not been systematically explored in the literature. **AIMS:** Systematically review the PMH APRN usage of live-time, synchronous telepsychiatry including audiovisual teleconferencing technology. **METHOD:** A comprehensive, systematic search was performed with no publication date restriction across CINAHL, the Cochrane Library, Embase, Google Scholar, PsycINFO, PubMed, Scopus, and Web of Science on July 30, 2019, by a medical librarian. Each citation was blinded and independently reviewed by three reviewers, and consensus was reached for inclusion. Eligible articles were peer-reviewed research or quality improvement articles available in full-text, written in English, including real-time, synchronous, audiovisual telepsychiatry services with PMH APRN providers. Discussion articles and literature reviews were excluded. Article quality and bias were assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) assessment tool. **RESULTS:** The search yielded a total of 342 articles, and only nine articles met full inclusion criteria. Overall, risk of bias was high in all studies, and the GRADE rating consisted of three "very low," five "low," and one "medium" quality article. However, considering the collectively positive outcomes from PMH APRN telepsychiatry use, the overall GRADE recommendation was to "probably do it" for seven studies and "do it" for two studies. **CONCLUSIONS:** Though existent literature is low quality and sparse, evidence supports that PMH APRNs can feasibly and successfully provide telepsychiatry services across a wide range of demographic patients and locations. PMH APRNs should contribute more original evidence to guide telepsychiatry implementation and adoption as the service expands.

Keywords

telepsychiatry, telemental health, telemedicine, e-psychiatry, telenursing, advanced practice psychiatric mental health nursing, psychiatric mental health nurse practitioner, systematic review

Background

Mental illness in the United States is common, annually affecting approximately 20% of the population aged 12 years and older (Center for Behavioral Health Statistics and Quality, 2015; Insel, 2015; National Institute of Mental Health, 2002; Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Despite prevalence, only 41% of American adults and 20% of minors with diagnosable psychiatric illness receive mental health treatment (American Psychiatric Nurses Association [APNA], 2019; National Alliance on Mental Illness, 2019; World Health Organization, 2018). Lack of treatment is exemplified by 54% of Americans who died by suicide and did not have a diagnosed mental health condition at the time of death (Centers for Disease Control and Prevention [CDC], 2018a). Since 1999, American suicide rates have increased by 30% or more in half of the states and suicide is the 10th leading cause of death (CDC,

[1]Brooke A. Finley, MSN, PMHNP-BC, RN-BC, The University of Arizona, Tucson, AZ, USA; The Meadows Behavioral Health, Wickenburg, AZ, USA; FasPsych, LLC, Scottsdale, AZ, USA
[2]Kimberly D. Shea, PhD, RN-BC, CAPN, The University of Arizona, Tucson, AZ, USA
[3]Roberta Maixner, DNP, JD, GCNE, PMHNP-BC, BSN, RN-BC, Psychiatric Nurse Practitioner, California Men's Colony, Department of Corrections and Rehabilitation Colony, Drive San Luis Obispo, CA, USA
[4]Maribeth Slebodnik, MSL, RN, The University of Arizona, Tucson, AZ, USA

Corresponding Author:
Brooke A. Finley, College of Nursing, The University of Arizona, 1305 N Martin Ave, Tucson, AZ 85721, USA.
Email: bafinley@email.arizona.edu

Cowan, et al., 2019

- Provider = TP gatekeeper
- Non-equivocal experience vs. in-person

Lopez, et al., 2019

- Unclear how TA is mediated by technology
- TA concern among patients and providers
- Providers feel ill-equipped and uncomfortable

Simpson, et al., 2020 & Simpson & Reid, 2014

- In ideal conditions with ideal participants, TA is equivocal across TP vs. in-person treatment
- However, TP providers cite lower TA than patients

Finley, Shea, Maixner, & Slebodnik, 2020

- PMHNPs utilize TP across many settings but there are no studies regarding TA

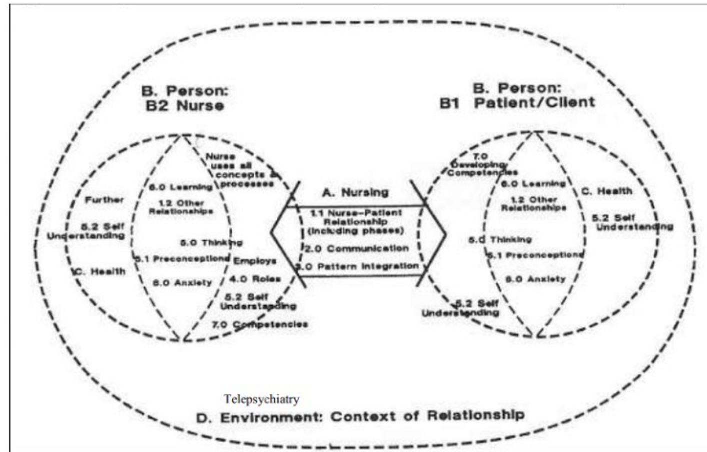
Problem & Context

Psychiatric Mental Health Nurse Practitioners

- PMHNPs- licensed, graduate-prepared nurses who can diagnose and treat mental health conditions with 26 states allowing autonomous practice (AANP, 2019; AANP, 2021b)
- TA is inherent in PMHNP practice (Hartley, et al., 2020; Peplau, 1997)
- Quarter of psychiatric workforce with 15,275 licensed providers (4.7% of all Nurse Practitioners; AANP, 2021a)
- Expected to fill a critical provider gap (16,450 provider paucity by 2030) and more likely to help underserved populations (Beck et al., 2020; Finley, 2019; HHS, 2016, NCBH, 2017)
- Highly underrepresented in the TP literature and generally poor quality (Finley, et al., 2020; Hartley, 2020)

Hildegard Peplau
Source: https://nurseslabs.com/wp-content/uploads/2014/08/Hildegard-Peplau-213x300.png

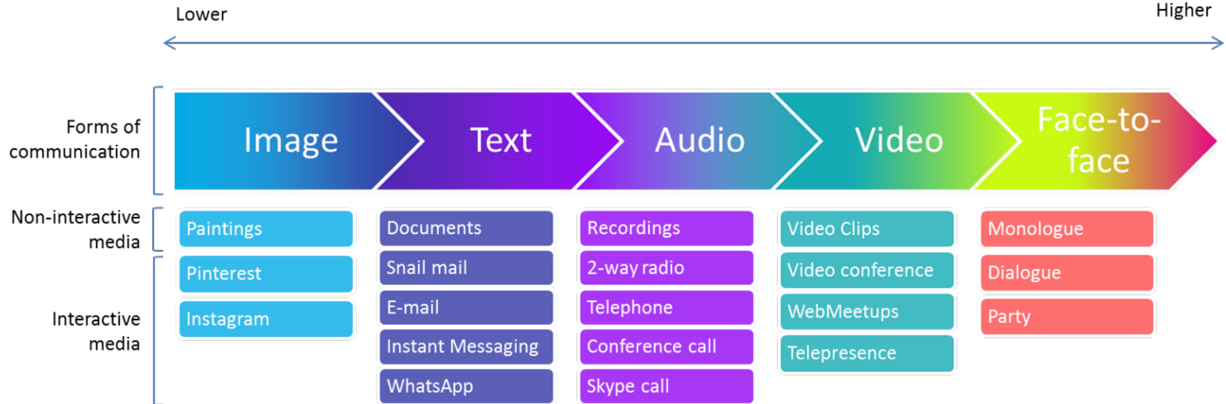
Interpersonal Relations Theory (IRT)



Adapted from Forchuk & Reynolds (2001)

- Created in the 1950s as original nursing knowledge and challenged biomedicalization and depersonalization (Peplau, 1997)
- Bidirectional transformative process made healing interpersonal
- Change occurs through helping someone finish developmental tasks within a therapeutic relationship to get needs met- main nursing process is observation, then relational intervention using many nursing roles
- TA is central to the process and phases of the relationship: orientation, working, termination

Media Richness Theory (MRT)



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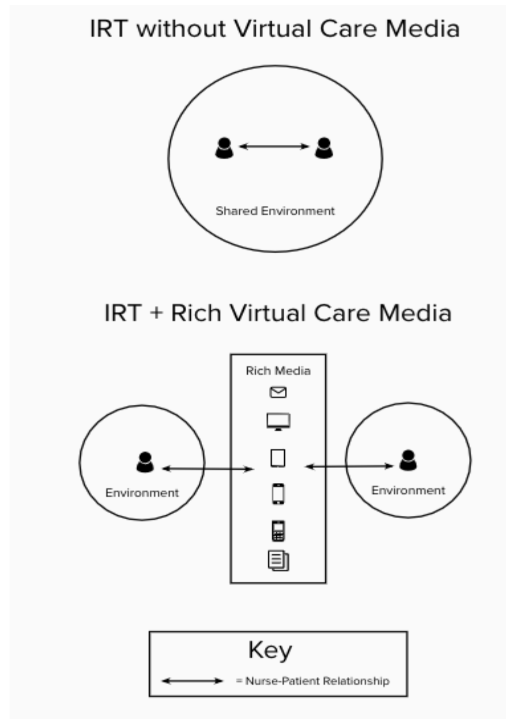
- MRT was an organizational theory developed in the 1980s by Richard Daft and Robert Lengel (Ishii, et al., 2019)
- Media can be ranked according to their effectiveness for resolving communication ambiguity(Ishii, et al., 2019)
- Characterized by cue availability, multiplicity, personalization, expression, and bidirectional feedback to complete a task, conceptualized as “richness” (Dennis & Kinney, 1998; Kahai & Cooper, 2003)

Modified Theoretical Framework



Finley, B.A., Shea, K.D., Gallagher, S.P., Palitsky, R., & Gauvin, J. (*in review*). A theoretical framework for conducting research regarding psychiatric mental health nursing virtual care.

Significance & Innovation

- First study to explore PMHNP therapeutic alliance when using TP (Finley, et al., 2020; Hartley, et al., 2020)
- Focuses on one of the major contributions to TA, which is individual provider
- Providers are the gate keepers to virtual care, so understanding PMHNPs can expand access to TP
- Generate new knowledge to inform research, education, and practice
- Creates a PMHNP virtual care framework and there are none currently (van Dyk, 2014)
- Supports generating nursing science and PMHNP practice as a independent specialty

Study Aims

- **Objective:** The proposed research study aims to fill a gap in the literature by phenomenologically understanding how PMHNPs experience TA in the TP environment.

- **Aim1:** Using phenomenology-type individual interviews, explore how PMHNPs experience TA when using TP.
- **Aim2:** Describe the experienced TA barriers and facilitators among PMHNPs utilizing TP.

Recruitment Procedures

Convenient, non-probabilistic, purposive sampling across three online domains will be utilized for study recruitment and was dependent on data saturation, 3-30 qualifying PMHNPs will be included (Creswell & Clark, 2018; Englander, 2012). Data saturation is considered reached when no new themes are found (Englander, 2012)

1. PMHNP participants were recruited online (invitation posted on APNA board, writer's LinkedIn, PMHNP Facebook Groups)
2. Participant answers inclusion/exclusion criteria: PMHNP, speak English fluently, and have practiced telepsychiatry (e.g., telehealth, telenursing, tele-mental health, telemedicine, virtual care) in the past 12 months. Specifically, this research pertains to telepsychiatry that is synchronous (e.g., in live time) and audiovisual (e.g., camera and microphone) in nature.
3. Participant signed digital consents
4. If meeting inclusion criteria and signed consent, potential participants provided contact information including full legal name, phone number, and email along with the state they primarily practice in as a PMHNP and demographics were collected via HIPAA compliant survey software sent in an email via SurveyMonkey and stored in a secure database, and participants' datasets will be de-identified for security
5. Investigator checked for active PMHNP licensure in public state online license review
6. Investigator contacted participant to schedule interview
7. After interviews were completed, the participant may have an electronic gift card sent to them with a value up to $25.

Interview Procedures

1. Semi-structured interviews with the primary investigator lasted approximately 40-70minutes (Englander, 2012)
2. Interviews will be semi-structured and begin with the respective open-ended question based on telepsychiatry role: “Can you please describe your experiences building a healing relationship with your patients when using telepsychiatry…” (Englander, 2012)
3. After the interview is complete, the participate will receive an electronic gift card with a value up to from a vendor of their choosing within two weeks of completing the interview
4. Professional, HIPAA-compliant transcription

Methods: Husserl Phenomenology

1. The foundation of Husserl phenomenology starts with phenomenological reduction whereas the researcher eliminates preconceived notions to uncover the subjects' temporal, spatial, corporeal, and relational life worlds
2. Process begins with immersion- investigator must “unknow” by identifying their assumptions and biases prior to analysis
3. Familiarization with data through reading/re-reading transcription prior to analysis and logging initial impression
4. Bracketing approach to help with identifying biases and allow for ‘intuitive seeing’
5. Process of induction and deductive of phenomenological thematic analysis for categories
6. Use of in-vivo coding
7. Refine and review coding in an iterative process
8. Ongoing analysis until theme/code findings are saturated
9. Utilize collaborative research for confirmability
10. Create a final report of findings
11. Compare findings to the extant literature

(Koch, 1995; Laverty, 2003; Munhall, 2012)

Ensuring Quality

- **Rigor:** Researcher is the tool. Self-reflection is critical along with honest objectivity. e.g., reflection or bias prior to starting. Bracketing throughout the data collection. Daily journaling for day-to-day.
- **Credibility:** confidence gained from collecting quality data and analyzing it appropriately in ways that make sense and are believable. Sample is appropriate. e.g, Experienced interviewer with past experience (Finley & Sheppard, 2017). Confirming interview information in vivo. Collaboration with fellow researchers. Logical code explanation. Literature comparison.
- **Dependability:** accounting for instability and promoting reliability, minimizes inconsistencies that can arise during data collection, related primarily to the interviewer's skill and interviewee selection. e.g, Appropriate researcher background. Ongoing collaboration. Daily journaling.
- **Confirmability:** degree where the results can be confirmed by others who add their unique perspectives and strengths to the study. e.g., Research team collaboration, data audits during research process, comparison with extant literature
- **Transferability:** the extent to which findings can be transferred to other populations and settings. e.g., demographic information provided, cultural and contextual information, generalizability discussed

(Graneheim & Lundman, 2004; Lincoln & Guba, 1985; Munhall, 2012; Trochim, et al., 2016; Vaismoradi, et al., 2013)

Data Analysis

1. Transcripts were uploaded into a secure qualitative analysis tool MAXQDA Analytics Pro software, for secure, cloud-based storage (VERBI GmbH, 2020)
2. Interview transcripts were thematically analyzed using a Husslerian qualitative approach (Munhall, 2012)
3. Descriptive statistics will be collected and complied

Retrieved from: https://www.maxqda.com/blogpost/just-released-maxqda-2018

Results: Participant Sample

Characteristic	Individual Responses (N=17)
Age (in years)	Individual: 30,31,33,34,39,40,41,44,47,48,50,57,59,66,66,67,75 Mean: 45.2 years Median: 47 years Range: 30-75= 45 years
Years in PMHMP Practice	Individual: 1,1,1,3,3,4,6,6,6,8,9,10,16,20,20,30,40 Mean: 10.8 years Median: 6 years Range: 1- 40= 39 years
Years Practicing Tele-Mental Health	Individual: 1,1,1,1,2,2,2,2,2,2,2,3,3,3,5,5,7 Mean: 2.6 years Median: 2 Range: 1-7= 6 years
Highest Level of Clinical Education	Master of Science in Nursing (MSN): 9 Doctorate of Nursing Practice (DNP): 4 Post-Masters PMHNP Certificate: 4 Additional Graduate Education (PhD): 3
States Licenses Held	Arizona (3), Arkansas (1), California (1), Connecticut (2), Florida (1), Kentucky (1), Illinois (1), Louisiana (1), Maryland (2), Michigan (1), Minnesota (1), Nebraska (1), Nevada (1), New Jersey (1), New York (1), North Carolina (1), North Dakota (1), Ohio (1), Pennsylvania (1), South Carolina (1), South Dakota (1), Virginia (1), Washington State (1), Wisconsin (1), Wyoming (1)

Results: Participant Sample

	Category Type, n (N=17)
Ethnicity	Caucasian: 14 (biracial, n= 2) Black/African American: 3, (biracial= 1) Hispanic or Latino: 1 (biracial, n= 1) Asian or Pacific Islander: 1
Biological Sex	Female: 17
Gender Identity	Cis-Female: 17
Relationship Status	Married: 10 Divorced: 5 Single, never married: 2
Employee Status	Fulltime (40+hours/week): 13 Part-time (0 to <40 hours/week): 4
Care Setting	Outpatient: 16 Residential: 1
Self-reported Specializations	Rural: 6 Pediatric-Focus: 5 Psychotherapy: 3
Primary Employment Setting	Private Practice: 8 Community Mental Health: 4 Academic: 3 Military: 1 Correctional: 1
Employer Structure	For-profit: 11 Non-profit (501c): 5 Military: 1

Results: Thematic Analysis

1,426 individual codes

16 respective subthemes were discovered

Five major themes

Theme 0: Skills are Skills

Theme 1: There is No Place Like Home…

or Tele-Mental Health in the Wild

Theme 2: Virtual Divide or Digital Connection

Theme 3: Individual Patient & Provider Considerations

Theme 4: Provider Ambivalence

Theme 0: Skills are Skills (n= 280 codes)

Subthemes:

1. **Listening**
2. **Psychotherapy**
3. **Observation**
4. **Therapeutic Techniques**
5. **Measurements**

1. “The approach I always take is to really try to listen to what their concerns are”- #05
2. “I don’t necessarily always need their verbal input. I can also see what’s going on”- #15
3. “I used to work with EMDR and IFS and am able to do both of those, um, virtually with people”. -#24
4. “You use techniques that build the therapeutic alliance by focusing on, you know, what the person’s main concerns are…”- #32
5. “I'm a huge objective, metrics person. I love my PHQ and GAD's and ISI's. Um, love them. I love to track them, um. Yeah, which is very hard and Telehealth, but again that grooming, appearance, um, plus what you get on the objective measures and then subjectively, what they tell you makes a full, um, assessment, right?”- #09

Theme 1: There is No Place Like Home… or Tele-Mental Health in the Wild (n=456)

Subthemes:

1. **Distractions & Hyperfocus**
2. **No Place Like Home**
3. **Curating the Virtual Frame**

1. "When I'm with my patient, I'm with my patient and nothing else matters."- #05; "I actually made a shirt that says, ' Don't shrink and drive' because I've had [laughter] so many people, I swear to God, I give all the shirt out for you. It's hysterical. It looks like the, yeah, it's a don't drink and drive home. I've had so many patients actively driving, and I'm like, "Are you driving a car right now?", and sometimes, I'm treating them for ADD and they're like, "Yeah", and I'm like, "Oh, no.", I need you to pull to the side of the road somewhere safe, that you're not going to get mugged or robbed. And I've had literally, like police knocking on their window, asking if they were okay, and they're like, 'Yeah, just talking to my psychiatrist.', and I'm like, 'Not a doctor, but thank you', you know." -#09
2. "When you do a Telehealth visit, it's almost like you have an additional component of a mental status exam in that you can see the environment that they're in which is kind of cool. Um, like, if I see the room is messy, and mom is yelling in the background, I would hold off on starting a stimulant. I think I would focus more on like, how do we do some environmental interventions first, like, you know, can we carve out 30 minutes of your day? -#13
3. "People are trying to get a bunch of things done and fit it into their lives, but I think there's definitely feedback that there's needs to be a time to preserve the interaction and the connection, and make sure it's private and it's your time and we're together focusing on each other, you know"- #18

Theme 2: Virtual Divide or Digital Connection (n=172)

Subthemes:

1. **Energy & Presence**
2. **Different Connection**
3. **It’s Not Real**
4. **Transactional De-personalization**

1. “You know, I felt it was really that rapport building that instant connectivity in the environment that you're giving someone. And they read us, you know what, you know that, I mean the patient's read our attitude too, and I think sometimes, the, you know, our non-judgmental attitude that we wanna bring out. I don't know how much of that is really getting conveyed in, in, you know, they're not seeing a whole lot of our nonverbal cues either. So I think that's kind of, kind of goes both ways.”- #12; “I don't really have an ulterior motive other than, you know, to get them better, but like I think that's what's been helping in those aspects is just really trying to listen to them and then, just being authentic and truly caring about their well-being, and I feel like no matter if it's television or telemedicine or in person, they can just sense on that”- #05
2. “I find that Telehealth for me, personally, takes a little bit longer for me to have that good report where I can, you know, sometimes we use a lot of that nonverbal communication to, to, to sometimes, you know, funnel in and ask more questions. #12
3. “It's very interesting to just know that they are the only see you as someone that's in the screens, but then they know that you exist, if you've been in the same space, you know, if you been in the same spaces than before versus. Yeah. So if you've only seen them in Tele, they, they yeah the that I don't know if they believe you're a real person”. -#12
4. “I feel like that was completely transactional and I feel like because that was completely virtual, like there was no option for in-person, I do feel like I- like they probably did just consider me a floating, a floating head like I kind of could have been anyone, uhm, really. And I don't think they would have minded, just kind of based on what the private practice was like and it was very, it was very transactional. #07
5. I know I'm just at the moment I feel like a little picture on your screen, but I'm actually a real person, you know. #35

Theme 3: Individual Patient & Provider Considerations (n=315)

Subthemes:

1. **Clear Preferences**
2. **Clinically Appropriate vs. Inappropriate Patients**

1. "I think that that is like a function of age, like, that mostly, my older patients say, say that they feel like they know me better in person. Uhm, I think it's because, you know, that's what they're used to. You know, we're- younger people are used to FaceTiming and used to, you know, used to the virtual, virtual world, and, I think, they have a better understanding about virtual health care, whereas the older patients I just don't- I just- it's brand new. So, I feel like they just, you know, are kind of wary of it. So, I think that's a function- that's more so a function of age, and I also do think there is something to be said for meeting people in person. You know, that's always going to be a little bit different. But, I found that, you know, like I said before, like, getting to alliance, I think, can still happen with telepsychiatry. I think just sometimes, it might go a little bit slower than if it was all in-person." -#07
2. "I'll say also another issue um, that I've come up with, with telemedicine, especially those new patients that you haven't seen in office and it's strictly tele is when they're not stable. Um, you have to trust that where they're at, is where they're telling you they're at. So when you need, we have somebody that is in crisis. Your hands are kind of tied and we have a situation yesterday. We need... I mean he called and said he was gonna kill the... his supervisor. Um, he said he was going to, he got fired from his job was gonna go get revenge on them. We called 911. They transfer the 311. We don't know where the pace is. You know, what's going on. We have an address at home address where he said he's at. Three hours later. He's calling us back and you know, yelling about where's his help? So he was obviously not the right state of mind to go and, and get himself where he needed to be and we couldn't guarantee his safety. So things like that um, are definitely problematic." -#11

Theme 4: Provider Ambivalence (n=203).

Subthemes:

1. **Convenience is a Double-Edged Sword**
2. **Straddling the Divide**

1. “Service is available via Telehealth. And parents don't have to leave their job, they don't have to uhm, you know, leave the home, or they have, you know, infants or babies or other people that they care for in the home that they just can't leave.” -#15; “I think that you come into the office hands-down, creates that mo-more of an incentive to get better.”- #11 & “Yeah, you're not just, you’re not just online refilling your prescription for, you know, your antidepressant know you, it's behavioral activation. Like you have to get dressed, you have to go to your appointment in order to get those tickets, this medication. Um, there's more in somebody’s intentionality”. -#13
2. “So it's a, that's it, it's, it's it's a blessing, when we're using it appropriately, right? It's a, it's a blessing to be able to reach people wherever they are. And I've had some that, in rural areas that, there's no way that you could get to them, right? It's a blessing. And I think that we should use it, as such, but I don't think that we should, um, depend on either, everything in person or everything Telehealth, you know, I think that it should be, um, an option for both the patient and the provider.”-#09; “I think that in-person is, you know, huge...hugely wonderful but I don't think that this has been like a complete bust, you know, with the Zoom shift because a lot of people can't travel.” -#32

Discussion

- Overall, PMHNPs felt that they could establish TA with patients using classic PMHNP interpersonal skills
- Building TA over TP but usually this took longer than in-person and was of a lower intensity and quality and required modified patient engagement and communication with more 3rd party reliance
- The patient's TP environment could lend more information than in-person appointments alone and altered TA interventions and care
- PMHNPs experienced impairments in TA compared to in-person care, often linking this with limitations of sensory media and interpersonal experiences of depersonalization, objectification, and lack of 'full picture'
- TP allowed for new avenues for transference and countertransference with shifted power dynamics
- Individual provider and patient clinical and comfort considerations impact TA

Strengths & Limitations

Strengths

- Sample was reflective of the PMHNP field demographics and COVID-19 adoption (Phoenix, 2019)
- Highly diverse sample regarding age, geography, specialization
- High quality analysis

Limitations

- No male participants nor non-binary participants
- Only one clinical setting was not outpatient
- Half of states not represented
- Average TP practice length was 2.6 years

Conclusions

- PMHNPs are able to build TA over TP, though it is experienced differently than in-person care and is met with ambivalence
- Relationship-mediating technological richness alters patient observation, which affects the entire relationship and respective PMHNP TA and care
- TP care can be unparalleled regarding convenience and provide novel patient information, impacting TA
- Most PMHNPs experienced that a combination of TP and in-person care was optimal for building TA and gathering a full clinical picture of a patient
- Individual factors and preferences must be considered when using TP as this may impair or foster TA

Value & Future Research Potential

1. Generates more questions about TA facilitating regarding media choices and digital TA-techniques
2. Opens new avenues for exploring the psychodynamics of TP care
3. Contributes new knowledge for the profession adapt for a digital future with higher practice and educational standards
4. Enhances education for PMHNPs about facilitating and impairing TA factors with TP, enhancing quality of care
5. Provides a new PMHNP virtual care framework and there are none currently (van Dyk, 2014)
6. Supports PMHNP practice as a independent specialty with nursing-specific knowledge

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Questions/Comments?