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# Videconference Grief Group Counseling in Rural Texas: Outcomes, Challenges, and Lessons Learned

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*Disparities in access to mental health care, especially in rural areas, demand continued attention from practitioners, researchers, and community stakeholders. Telehealth, or the use of long distance technology to provide mental health services, is one well-recognized solution for reducing mental health disparities. At the Telehealth Counseling Clinic, advanced doctoral students provide telepsychology services to low-income and uninsured individuals living in a rural region in Texas. In response to an identified community need for grief counseling services, an 8-week grief group utilizing videoconference technology was conducted. This article discusses clinical and methodological challenges and lessons learned that are unique to delivering group counseling services over videoconference technology in a rural area, as well as preliminary data of the group's effectiveness as measured by a satisfaction survey, the Patient Health Questionnaire-9, the CORE-B, and the Complicated Grief Assessment are presented.*

**Keywords:** *grief; rural; telehealth; telepsychology; videoconference group counseling*

Grief counseling, provided one-on-one and in a group setting, is in high demand. Each year, about 2.5 million individuals living in the United States will die (Center for Disease Control and Prevention, 2011; Ghesquiere, Shear, & Duan, 2013). As family members, friends, and acquaintances try to process the death of their loved ones, they

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will experience some form of grief (Shear et al., 2011). Generally, most adults tend to be adept, emotionally and cognitively, at dealing with the death of a loved one, as adults typically have the coping skills necessary to decrease their felt symptoms naturally (Schoenberg, 1980; Tonkins & Lambert, 1996). However, a small minority experience a more chronic grieving process termed “complicated grief” that can develop into serious problems such as depression and anxiety. Complicated grief can cause a significant impairment in one’s work, personal relationships, daily functioning, and thought processes. Affected individuals commonly report finding most things meaningless and constantly yearning for their loved one (Kersting, Braehler, Glaesmer, & Wagner, 2011). If untreated, individuals experiencing complicated grief can experience dysfunctional thoughts, suicidal behaviors, poorer health, and substance abuse (Shear et al., 2011).

Many individuals, especially older adults, seek treatment for grief from their physician, religious leader, or a support group where they can receive emotional and social support from other individuals who also are grieving (Ghesquiere, Shear, & Duan, 2013). The effectiveness of grief support groups is uncertain, as some studies report that they are highly effective (Souter & Moore, 1989; Vachon, Lyall, Rogers, Freedman-Letofsky, & Freedman, 1980; Wilner & Kaltreider, 1988), while other studies indicate that grief groups are not only ineffective (Barrett, 1978; van der Houwen, Stroebe, Schut, Stroebe, & van den Bout, 2010), but also harmful to the individual (Neimeyer, 2000).

While there is a need for rigorous studies exploring the outcome and efficacy of grief groups (Papa & Litz, 2011), there is an even greater need to identify effective psychological resources for individuals who are unable or do not have access to treatment for complicated grief and other mental health issues (Collie et al., 2007; Jaglal et al., 2013; King et al., 2009; Rotondi et al., 2005). Barriers to proper mental health treatment impact roughly 60 million individuals in the United States, or about 19.3% of the population who reside in rural areas (U.S. Census Bureau, 2011). Oftentimes, obstacles such as inadequate housing and transportation, geographic isolation, lack of insurance, and low-socioeconomic status impede rural residents from receiving adequate health care (Bushy, 1998; McCord, Elliott, Brossart, & Castillo, 2012; Stamm et al., 2003; Wagenfeld, 2003). Additionally, health care providers are less likely to work in rural areas, as they face lower compensation, fewer referral sources, and greater ethical risk, such as heightened potential for dual relationships (Hastings & Cohn, 2013; Helbock, Marinelli, & Walls, 2006; McCord et al., 2012). Given these barriers, telehealth has become a well-recognized solution to service delivery in rural areas (Institute of Medicine, 2012). This article details

a telepsychology grief group and discusses the lessons learned through this experience.

### **Telehealth Definitions, History, and Future**

Telehealth is defined as “the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, education, and information across distance” (Nickelson, 1998, p. 527). The term telehealth is broad and subsumes many narrower terms like telemedicine and mental health specific terms like telepsychiatry, and telepsychology (Darkins & Cary, 2000). The prefix, *tele-*, is added to many terms to indicate distance. The American Psychological Association prefers the use of the term telepsychology, which is defined as, “the provision of psychological services using telecommunication technologies,” which, “include but are not limited to telephone, mobile devices, interactive videoconferencing, email, chat, text, and Internet (e.g., self-help websites, blogs, and social media),” (American Psychological Association, 2013, p.3). Therefore, grief group counseling services described here are best identified broadly as telehealth services and more specifically as telepsychology services.

There is no way to know for certain when telehealth started. The telegraph and telephone were among the first modalities used to deliver services, but the Internet was the mechanism that caused the exponential growth of telehealth services (Darkins & Cary, 2000; Davidson & Santorelli, 2009; Zundel, 1996). In 2013, 350,000 patients used telehealth and by 2018, seven million individuals are expected to utilize the services. Additionally, telehealth revenue is expected to increase from \$440.6 million in 2013 to \$4.5 billion by 2018 (Roashen, 2013). Telehealth, and videoconference telepsychology services in particular, have been proven to decrease the number of psychiatric hospital admissions as well as the length of stay (Godleski, Darkins, & Peters, 2012). Both meta-analyses and systematic reviews of studies ranging from single-case studies to randomized control trials show positive results in clinical outcomes and patient satisfaction in a variety of settings and applications (Backhaus et al., 2012; Hilty et al., 2013).

### **Tele-Groups**

Group psychotherapy, provided via videoconferencing technologies, has been a useful tool for bridging mental health disparities since its first trial in 1961 (Simpson, 2009; Wittson, Affleck, & Johnson, 1961). Various studies have indicated that the use of technology for group counseling is an effective tool for clinicians to provide high-quality

care to patients in rural communities (Houston, Cooper, & Ford, 2002; Huws, Jones, & Ingledeu, 2001; Page et al., 2000; Wittson et al., 1961; Wittson & Benschoter, 1972). Studies found that Internet-based group treatment has been helpful for individuals because it can allow for greater anonymity, reduces perceived stigmatization, and individuals can stay in their house for treatment (Kenwright, Marks, Gega, & Mataix-Cols, 2004; Luce, Winzelberg, Zabinski, & Osborne, 2003; Papa & Litz, 2011; Ritterband et al., 2003; Wagner, Knaevelsrud, & Maercker, 2005, 2006). Collie et al. (2007) reported that a breast cancer support group effectively reduced clients' depression and posttraumatic stress disorder and found the telepsychology group to be more effective than results of in-person groups.

Studies show that Internet support groups provide group members with 24-hr access to group support and allow members to share their emotions, thoughts, and desires whenever needed. Internet group members can also read and re-read inspirational and helpful posts from other members (Colòn & Friedman, 2003). Haberstroh and Moyer (2012) found that a moderated online support group, for individuals who engage in self-injury, helped participants express their emotions by writing posts, which, along with the support they received from the group, alleviated urges to engage in self-injury. Lastly, Internet groups have been found to provide hope to a broader population and allow for more consistent treatment in multiple populations (Rotondi et al., 2005).

Research also shows that Internet-based groups are not without their challenges. Clients may feel disconnected from other group members, perceive the group as artificial, and have concerns about privacy due to the ability to record or take screenshots of personal information (Kozlowski & Holmes, 2014). Kozlowski and Holmes (2014) reported that the increase in convenience has the potential to reduce engagement in the group. Additionally, this study found that an individual's comfort with technology could impede their willingness to discuss concerns in session, with more technologically savvy individuals having the most reservations and reporting the most suspicion of others and their potential to use technology to manipulate the group (Kozlowski & Holmes, 2014).

The telepsychology group literature demonstrates a range of group configurations with different technology modalities. Studies have used videoconferencing to facilitate a breast cancer survivor group where participants would drive to one of several participating sites, log-in using the clinic's videoconference equipment, and interact with group members through a 4-way split computer screen. (Collie et al., 2007). King et al. (2009) described an Internet based group that provided intense care to opioid dependent patients who joined using personal

computers. Interestingly, the group members could hear all the other group member's voices, but could only see the group facilitator on their screen. The group leader, on the other hand, could see all members through a split screen. Another group provided participants with computers so they could login to a website that contained psychoeducation for persons with Schizophrenia and their families. They provided three therapy groups online that were monitored and managed by a mental health professional: one for family members, one for persons with schizophrenia, and a multifamily group (Rotondi et al., 2005).

An extensive search of recent literature found information on previously established teleconference grief-counseling groups; however, previous groups did not use the same features or structure as the group described in this manuscript. For instance, Jaglal et al. (2013) discussed a similar health education group where the two facilitators were located at one site, and the participants were located in another, separate location; however, one distinguishing feature of this group was that it was facilitated by lay leaders. The pilot project described in this manuscript not only fills a gap in service delivery in the community, but also fills a gap in the current literature and describes a new means by which tele-communications and academic-community partnerships can help reduce mental health disparities in rural communities. This pilot study was designed to understand if group therapy via videoconference technology is an effective and acceptable way to deliver services, while decreasing participants' grief and depression over the course of treatment. Challenges and lessons learned from this pilot study are discussed to inform the future provision of group counseling conducted in rural areas, when using long-distance video technology.

## **Clinic Overview**

Inspired by the results of several community-needs assessments that consistently identified a lack of access to transportation and mental health care as community issues in rural areas of the Brazos Valley Region, Texas, Texas A&M University's School of Public Health and the University's APA-accredited Counseling Psychology program developed the Telehealth Counseling Clinic to provide telepsychology services to rural areas designated as Mental Health Professional Shortage Areas (Health Resources and Service Administration, 2014). The Telehealth Counseling Clinic (TCC) is a psychological service, research, and training clinic where individual, couples, and group counseling services are provided using videoconference and telephone technologies. Services are provided in English and Spanish to individuals ages 13 and up by advanced counseling psychology doctoral students, under the supervision of a licensed psychologist. The group

described here was offered only in English. Located nearly equidistant from the major Texas cities of Austin and Houston, five counties (four rural and one semi-urban) in the Brazos Valley region receive services from the TCC. Counselors come to the main site housed at Texas A&M, which has three rooms equipped with high-definition television screens and Cisco Telepresence SX-20 VC videoconferencing equipment. Clients receive services at one of the five remote sites, which are equipped with technology identical to that used at the main site. Funding for services has been provided through the Health Resources and Services Administration and the Texas Medicaid 1115 Waiver, which works to close gaps in healthcare access through innovative service delivery systems.

### **The Telehealth Counseling Clinic Grief Group**

Upon request from a social services resource coordinator in one of the communities served by the TCC, a 1-day, "Holidays Without You" grief support group was held. This event's attendance, along with the participant's requests for future sessions, identified a need for additional grief counseling opportunities in the community. Two counselors at the TCC sought to fill this need in the community by developing a support and psychoeducational group. Both group leaders had completed doctoral-level coursework in group psychotherapy with one leader having experience facilitating both psychoeducational, evidence-based, and process-oriented groups, including Cognitive Processing Therapy, Meditation for PTSD, and a Vietnam and Korean War process group at a Veteran's Hospital. As the distance between the TCC and the partner clinic is significant, roughly 100 miles, the TCC counselors could not facilitate the group in person. The group, therefore, was designed to operate solely through videoconferencing technologies where the group participants were gathered in the remote site's conference room while the two facilitators were at the TCC. As both facilitators had been providing individual counseling at the TCC previously, they were well-versed in the technology and unique issues related to providing telepsychology services; but, this was the first group established at the TCC, so the group was a new experience for both the facilitators.

All advertisement for the group, as well as all screening and intake procedures, also were conducted using telecommunication technologies. The two counselors made a flyer that described the group and provided TCC's contact information. This flyer was posted at the partner site's waiting room. Additionally, the two facilitators advertised the group at the TCC and asked all counselors to refer any current clients that could benefit from the group. The counselors also spoke

with the partner site's social service resource coordinator, who shared group details with community members. The majority of the referrals received reported learning about the group from the partner clinic's social service resource coordinator.

Individuals who called the TCC about the group were provided details and asked if they would like to enroll in the group by first completing a 10–15 min phone screening, per clinic policy, which ensures the individual is appropriate for telepsychology services. Exclusionary criteria for the clinic include severe, active suicidal or homicidal ideation and unmedicated, active psychosis. Participants deemed appropriate were scheduled for an hour-long intake session, conducted via videoconference technology, which determined the individual's fit for the group. The intake session asked participants to detail their experience with grief, coping skills/strategies, and their goals or reasons for joining the group to ensure each group member in fact had presenting concerns consistent with the purpose of the group. Additionally, the intake session asked participants to discuss how they typically conduct themselves in a group setting, in order to exclude members who may be disruptive to group cohesion or progress. Determining group fit is a balancing act in an underserved area where denying someone access to the group likely means that the interested individual will have no other feasible options for obtaining services. In the present case, all individuals who completed the intake session did not demonstrate any red flags indicating a poor fit for the group.

From the 10 names referred, 6 completed a phone screening, 4 attended their intake interview, and 4 participated in the group. Of these four participants, all were women, three were African American and one was Caucasian, all lived in the same rural county, and all members had recently experienced the death of a loved one. Two of the women were receiving individual counseling both prior to and during the group and the other two women only received group counseling. The women's ages ranged from 45 to 61 years. All participants remained in the group for the entire 8 weeks.

*Group procedures.* Prior to their intake, each group member was asked to complete the TCC's intake paperwork package, which includes the clinic's consent form, a HIPAA form, a history questionnaire, the Patient Health Questionnaire (PHQ), and the Clinical Outcomes in Routine Evaluation–Form B (CORE–B). The PHQ is a diagnostic instrument for eight common mental disorders based on *Diagnostic and Statistical Manual of Mental Disorders–IV (DSM–IV)* criteria, including major depressive disorder, panic disorder, other anxiety disorder, and bulimia nervosa (Spitzer, Kroenke, & Williams, 1999). The CORE–B is an 18-item self-report measure developed specifically

for use in tracking a client's progression through therapy and has 5 domains: Well-being, Problems, Risk, Functioning, and Global Distress (Evans et al., 2002).

During each member's intake interview, one of the co-counselors verbally administered the Complicated Grief Assessment as part of a semi-structured interview. Follow up questions were asked to gather more information about the potential member. The Complicated Grief Assessment was developed to assess an individual's chronic symptoms of grief. The self-report measure assesses 4 domains of complicated grief: level of yearning for the deceased, degree of social, occupational, and daily functioning impairment, depression symptoms, and duration of symptoms (Prigerson & Maciejewski, 2015). In the subsequent weeks, each member was asked to complete a CORE-B and PHQ-9 at the end of each session. The PHQ-9 is a self-report questionnaire that reflects the *DSM-IV* criteria specific to depressive disorders. The members completed the Complicated Grief Assessment at the end of the fifth session and at their termination session. All members also completed a satisfaction survey at the termination session. The satisfaction survey was created by TCC staff and is a 21-item questionnaire that assesses the participant's comfort with the technology, counseling, and their counselor, as well as their overall evaluation of the services they received. All assessments were collected by the remote site's staff and were kept until the group's conclusion. Counselors did not receive the assessments until the group terminated.

This grief group was designed to meet for 8 weeks and was provided in a psycho-educational and support group format aimed at exploring the traditional five stages of grief. Aside from the obvious differences in the setup due to the use of technology, the content and structure of the group could be replicated in an in-person group. During the first session, introductions, purpose and objectives, guidelines and confidentiality were discussed. Specifically, while facilitators are bound legally and ethically to maintain confidentiality, members only are bound ethically; however, the importance of maintaining confidentiality in a small, rural town was emphasized. In the second group meeting, all 5 Kübler-Ross stages of grief (Kübler-Ross, Wessler, & Avioli, 1972) were introduced and briefly explained. A handout was given on the stages and members were encouraged to explore and share what stage they believed they were in. Each subsequent week, the counselors provided information on the week's stage of grief; for example, Week 3 discussed denial and isolation, and then asked the group members to share their own experiences in that particular stage. Time was allotted for the members to reflect on their reactions to learning about the five stages and their own experiences in each. The final week allowed the group members to conclude their experience by reflecting on the group

process, completing the final assessments, and counselors providing referrals for any additional services needed.

While no emergency situations emerged during the group, emergency procedure protocol of the TCC included stopping the group, having one facilitator call the service coordinator at the remote site, and having the member in distress escorted to the emergency room, which is connected to the clinic building. The local mental health authority and/or police would be utilized in the event an involuntary hospitalization was needed. Given that the counselors had conducted individual videoconference counseling sessions, they were familiar with following such emergency procedures and remote site staff also were trained. During the course of the group, technological problems, or instances of lag, freezing, or disconnection did not occur; however, had this occurred, the procedure for individual sessions is to switch to a phone session or reschedule. As phone sessions would not have been feasible in a group setting, had there been issues with technology, the discussion would have been paused and the group would have been rescheduled for the following week.

*Pilot data, and information.* At intake, the average PHQ score across the four individuals was 1.67 ( $SD = 1.53$ ). This indicates that on average individuals were reporting minimal symptoms. The average PHQ-9 score at termination was 2.0 ( $SD = 3.46$ ). This indicates that individuals, on average, were reporting minimal symptoms. The average intake CORE-B scores in each of the subsections were as follows: well-being (.917); functioning (.499); problems (.776); risk (0.0); total score (.628). At termination, the CORE-B scores were: well-being (1.00); functioning (.290); problems (1.209); risk (0.0); total score (.720). At both administrations of the CORE-B, all clients' scores fell below the gender-normed, clinical cut-off scores for symptom severity. At intake, none of the group members met criteria for complicated grief based on each member's self-reports on the Complicated Grief Assessment. This provided an interesting consideration for the facilitators. On one hand, as clinicians, the facilitators felt there was value and benefit for the group members, regardless of whether or not the members met criteria for complicated grief. As researchers, the facilitators were cognizant that this may reveal limited results in the realm of statistical significance. Had the group met criteria for complicated grief, it is likely this would have led to different results, both at baseline (higher symptomology reports), and at termination (statistically significant reduction in symptomology) and would be an important topic for future study. As the group progressed, the members' self-reports on the assessment at week 5 and at termination indicated they were not experiencing any complicated grief symptoms, thus indicating a

congruency between the three administrations. Given that none of the group members endorsed symptoms of complicated grief, there were no group differences on assessments among group members who had prior individual therapy experience and those who did not.

The satisfaction surveys showed the majority of participants agreed or strongly agreed with questions under the domains of their overall telepsychology experience, interactions with the remote site, and ratings of their facilitators. It is worth noting that one group member's satisfaction survey was not included in the results, as it is believed their survey is invalid as it appeared they did not understand the directions and indiscriminately circled all items with the right most option, giving all 4s or 0s, which was inconsistent with her self-report of being satisfied with the group. It was not possible to follow-up with that group member after termination to verify these inconsistencies. Additionally, all valid surveys showed that group members agreed/strongly agreed they would have gone without services if the group had not been offered by TCC. All clients believed the care they received was just as good as face-to-face services and said they would recommend TCC's services to others. They also all agreed that telehealth was more convenient than traveling to the nearest mental health provider, which was located approximately 45 min away from the rural community.

## DISCUSSION

While the quantitative results from the grief group are formative at best due to the low sample size, it is important to note that the participants were satisfied with the grief counseling via telehealth and said they would have gone completely without services had telehealth not been available. While the results from this pilot study have limited generalizability to other samples, the results of this pilot project are valuable because they show that grief counseling can be delivered through telehealth and that in many cases, rural clients will not receive services if telehealth is not available. To describe how this grief counseling model can be replicated in other remote settings via telehealth, we illustrate some of the challenges encountered and lessons learned through the pilot study.

### **Challenges and Lessons Learned From Using Telehealth for Group Counseling**

Both facilitators had prior knowledge and familiarity with videoconference technology prior to the grief group because they had provided individual therapy using telehealth previously. However, the

grief group provided a new experience for them to use this technology in a group setting. Additionally, two of the group members had previously been seen on an individual basis through telehealth while the other two members had no prior experience with telehealth technology. The general familiarity with videoconference technology helped reduce problems experienced by the group as most individuals were comfortable with the service modality. For the members who did not have previous experience, the facilitators acknowledged the differences between videoconferencing and in-person groups, such as the aspect of eye contact. That is, the facilitators maintain eye contact with the members' eye level on the television screen; however since the camera is overhead, it can appear as though the facilitators are looking down. This was explained explicitly so as to minimize any confusion or to detract from developing rapport.

*Paperwork and group attention.* One challenge that emerged as an issue prior to the start of the group was how paperwork was going to be handled. In an effort to reduce the administrative burden on the unpaid, remote site staff person, the facilitators dropped off all the necessary paperwork in folder separated by each session so that the completed assessments could be filled out weekly and then collected after the group terminated. This resulted in the dynamic of clients starting to fill out paperwork at the beginning of the session instead of when the session was over. Since there was no paid support staff at the remote site that could handle the demand of administering and collecting the paperwork on a weekly basis, it was up to the facilitators to try and control this dynamic from a distance. The facilitators did their best to redirect individual members and the group as a whole as necessary. The facilitators addressed this issue more in early sessions, but without much improvement seen from session to session. This is something that the facilitators believe would have been easier to manage had the group been in person.

### **Room Layout**

At the start of the group, the tables and chairs were set up like a classroom, where all group members were sitting behind a desk facing the TV screen and looking at the facilitators. However, after two sessions, the group expressed an interest in rearranging their chairs in a circle to resemble a more traditional group feel. Both the facilitators and group members remarked that this was a crucial point in the group, which allowed the group members to feel more comfortable and took away the teacher-student feel. At the last session, the clinicians checked in with the group to understand how the group

process experience was for each member. All members agreed that by circling their chairs they were able to engage better and reported almost forgetting that the facilitators were there. Additionally, most, if not all, group members indicated they would have liked it if there was at least some in-person contact with the facilitators, preferably the first session. They indicated that while this did not impede their abilities to open up, it would have helped speed up the process.

Many lessons were learned by establishing and conducting the first videoconference group at the TCC. In future videoconference groups, many protocols will stay the same, while trying to incorporate the valuable lessons learned. For example, the group will be encouraged to set the room up in a circular fashion prior to the start of the first session. Taking into consideration the feedback received, the facilitators have discussed the possibility of having the first session conducted with one leader physically at the remote site and the other facilitator connecting over videoconference. While this prevents the group from being solely video-based, if the capabilities and resources are available, this is something that could be beneficial for group cohesion. Certainly though, there are many professionals performing telehealth services who are unable to drive to meet their clients and it is believed that quality work can be accomplished without this initial in-person contact.

### **Challenges and Lessons Learned From Working in a Rural Area**

The fact that this group was conducted in a rural setting identified various strengths and limitations of this group and subsequent pilot research. First, as is true in many rural communities, the citizens of the town all know each other in some manner. One member stated that her favorite part of living in their town is the sense of community they have. She said that she loves that people are friends with their neighbors and that help always is provided to a citizen in need. This level of familiarity helped facilitate a sense of unity in the group and helped the members feel comfortable from the beginning. Likewise, their familiarity with each other helped the members highlight each other's strengths, their progress, and their potential, as they have witnessed each other's entire grief process even prior to the start of the group.

*Familiarity among members.* With increased familiarity, comes decreased anonymity—a dynamic that can prevent individuals from seeking mental health treatment entirely and in this case seemed to prevent authenticity within the group (Smalley & Warren, 2012). While their closeness helped foster positive exchanges between the members, it also created a barrier that kept the group from exploring the issues

at a deeper level. Group members seemed cautious about detailing their feelings of anger and depression, as well as their experience with the “bargaining” phase. Members seemed to either lessen their pain or intensify their struggle, depending on the other member’s previous responses. Overall, members seemed to especially censor themselves with regards to religion, as they seemingly did not want to portray a lack of faith or trust in the Lord. Future group leaders should be aware of the potential for censorship and equip themselves on how to address it in a culturally sensitive manner.

The negative impact of their familiarity was seen again in the referral process. This group interviewed several individuals who, after completing a screening interview, withdrew from the group due to a variety of reasons. Many of the individuals stated that they reflected on the group and realized that they were agreeing to participate as a favor to someone else. Future groups should be mindful of dual relationships and their role in the group dynamic. Group leaders can help lessen the impact of dual relationships by directly addressing this concern at the beginning of the group so to maintain the group’s confidentiality without impacting their pre-established relationships.

*Anonymity.* The lack of anonymity within the group was intensified as this study only advertised at the remote site and in the TCC clinic. Group leaders originally planned to advertise through various resources but opted out of doing so as they received ample referrals from these two sources. Future groups could benefit from advertising to the greater public through ads on the local radio stations, in the local newspapers, and in the local stores. Likewise, future groups could benefit from advertising in nearby towns so to decrease the familiarity.

*Religion.* Religion is an influential, deep-rooted force in rural American culture, which can provide resources and connection and promote positive outcomes (Aten, Hall, Weaver, Mangis, & Campbell, 2012; Gill, Barrio Minton, & Myers, 2010). However, religious beliefs, especially fundamentalist beliefs, have been known to create potential therapeutic challenges (Aten, Mangis, & Campbell, 2010). This study found that religion, specifically Christianity, was a common value for all four of the members in the group. In each member’s individual screening appointments, they all identified their faith in God as a source of strength during their grieving periods. Each woman took time during this intake session to share personal stories of how the Holy Spirit helped them find the strength and courage to move on with their lives. It was evident in the first meeting that their faith and religious beliefs were unifying factors for the women. Throughout each session,

the members would share Bible verses, inspirational stories, and affirmations with each other. This use of religion as a coping mechanism is well-documented in the literature as various studies have found that churches tend to increase their congregant's psychological, as well as their physical, well-being through their prevention and treatment-focused groups, which include support groups (Blank, Mahmood, Fox, & Guterbock, 2002; Eng, Hatch, & Callan, 1985; Hatch & Derthick, 1992). Additionally, studies have found that churches, especially those in rural Black communities, are effective mediums for psychological health as they implement the use of social support, which is based on common views regarding one's mental health (Blank et al., 2002; Durlak, 1979; Harris, 1985).

While a group's shared spirituality can help unite a group, it can also create a barrier either between the members themselves or between the members and their group leaders. Psychologists are required ethically, according to the American Psychological Association (APA), to respect clients' religious beliefs and values as they help shape clients' thoughts, emotions, and behaviors (APA, 1990). Future group leaders should therefore inquire about a potential group member's religious/spiritual views during the screening interview. The group leaders of this study, for example, asked each member what role religion had in their life and asked how they interact with individuals of different faiths. Questions such as these can help group leaders prepare for the impact religion will have in their group.

It is suggested that group leaders address religious/spiritual beliefs in the first session and ask the group to determine what role religion can play in the group. That is, the group leaders should ask the members if they will be open to talking about religion and incorporating it into the process or if they would like to ban the topic due to discomfort. Should the group decide to incorporate religion into their meetings the group leaders should make efforts to become familiar with the member's beliefs, values, and practices (American Psychological Association, 1990). Lastly, APA suggests that psychologists consult with community spiritual leaders and include them when it would be therapeutically relevant and helpful.

### **Methodological Challenges and Lessons Learned**

While there were no statistically significant decreases in symptoms shown in this pilot study, there are multiple variables that could account for these results. First, the group had a very small sample size. Second, half of the group members had previously received counseling services at the TCC and therefore had worked through a significant

part of their grief. Third, all of the group members were involved heavily in their church and reported gaining a significant source of strength from their faith in their grieving process, although at times this seemed to hinder open dialogue and abilities to process. Specifically, individuals tended to refrain from discussing their experiences with anger or bargaining as this was deemed to be “questioning God’s plan.” Lastly, data were not collected and scored until after termination. This meant that it was not until after the group was over and assessments were scored that it became evident group members may not have fully understood the questions or given their full attention towards the task based on incongruent and inconsistent response patterns. The intention of not looking at the data until the completion of the study was to reduce the burden on remote site staff to fax additional paperwork each week, as well as to keep group leaders blind to assessment responses until the completion of the group. In future groups, data will be scored after each session and issues will be addressed at subsequent sessions.

While none of the group members endorsed complicated grief, two of the members did report experiencing symptoms of depression. However, their depression fluctuated throughout the duration of the group and did not attain statistically significant decreases. The group as a whole saw increases in their psychological functioning as measured by the CORE-B. This may indicate that while the group members did not attribute improvements directly to the group itself, they may have felt more comfortable reporting more innocuous changes, such as physical improvements, than ones directly related to their bereavement and mood.

One significant methodological limitation of this study is the small sample size. A single case design with multiple, pre-treatment baseline administrations of the assessments would likely be more sensitive to detecting change attributable to the group intervention. Additionally, using a single-case design can eliminate the ethical issues related to having a waitlist control group as each individual can serve as their own control group through the use of multiple baselines (Kazdin, 2011). Moreover, all of the group members knew at least one other member before beginning the grief group. This might have influenced the degree to which individuals openly disclosed struggling with feelings of depression and grief since the clinic is located in a small, rural area and group members mentioned being mindful of the limitations of confidentiality in group settings.

As future groups are developed at the TCC, the facilitators will be more mindful in the structuring of the group, including taking into account dual relationships. With regards to assessments, there will be stronger norms set to fill out paperwork at the end so as to limit distractions. The facilitators have agreed that checking over the assessments

each week will help prevent invalid data and responses, as opposed to checking and entering the data after termination. Additionally, the use of a more psychometrically sound grief assessment will be used in future grief groups to ensure that variable of interest is measured accurately.

### **Future Directions for Telehealth Group Work**

The Association for Specialists in Group Work (2007) states in the Best Practice Guidelines, that group workers are “aware of and responsive to technological changes as they affect society and the profession” (Association for Specialists in Group Work, 2007, p. 115). However, more qualitative, quantitative, and phenomenological studies are needed to develop best practices specific to service delivery using technology. Based on the clinical experience of the group discussed here, the following are proposed as best practices for group counseling conducted using videoconference technology.

1. *Create an atmosphere conducive to group cohesion.* Meeting with individuals from a distance naturally creates barriers for connection and steps should be taken to minimize the impact of using technology for services delivery. For example, arrange chairs in a circle when clients are in the same room. Adjust camera angles for optimal eye contact. And as much as is feasible, use the best connection speeds and the highest quality video and audio equipment to ensure all group members can see and hear each other clearly.
2. *Directly address implications of technology on group dynamics.* Using technology to conduct group counseling can affect the group dynamics both positively and negatively. Talk about variations in eye contact caused by using videoconferencing equipment. When services are provided using a personal computer, address with the group how members have additional ways to project a positive impression compared to meeting in person (i.e., adjusting the backdrop visible within the camera frame, looking good from the neck up, etc.). Facilitate discussion on the positive benefits such as convenience and access to previously inaccessible services. Some participants may feel safer disclosing deeper material due to the distance or feel more comfortable with the indirect eye contact afforded by videoconferencing equipment.
3. *Know and discuss special considerations to confidentiality and security.* Clinicians must also be able to describe security of data and video transmission in a way clients can understand. The group should set norms and rules that ban recording or taking screen shots when services are offered over personal computers and warned that other clients do not have the same responsibilities for confidentiality and data security as do group leaders. Group norms should be established regarding posting about group experiences on social media sites and blogs and provide examples of how to post about personal group experiences/revelations without violating any other group members' privacy (i.e., “Got the opportunity today to really rethink how I view loss.”).

4. *Develop long-distance data collection methods.* Special consideration is needed when collecting data from a distance and solutions must be tailored uniquely to each group format. Care should be taken to ensure transmitted data stays secure and confidential, using encryption tools when necessary. To propel the field forward, data on group counseling interventions using technology must be collected and findings and lessons learned disseminated.

Given the integration of technology into our everyday lives, telehealth may expand beyond just being a solution for reducing disparities and become the preferred method of treatment. Therefore, clinicians must strive for competence in providing such services and research must attempt to explain and predict the benefits and challenges such technology presents. The pilot data from this group indicate that group counseling for grief can be conducted successfully using long-distance videoconference technology. Group members, all of whom reported they would have gone without services if not for the telehealth group, agreed that the service was as good as face-to-face service and that the group helped them deal more effectively with their problems.

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