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Case Report

A Case Report of Telehealth Assessment for Adolescent Anxiety, Depression and COVID-Related Grief

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ABSTRACT: Rates of anxiety and depression in children and adolescents have steadily risen over the past decade, and the arrival of COVID-19 exacerbated existing psychological problems for many youth. In the context of these increased rates and the pandemic lockdown, telepsychology, including virtual assessment, evolved as a cornerstone of mental health practice. There are salient benefits to telepsychology, most notably its convenience and accessibility, which have contributed to its expanded application across different types of problems and populations. At the same time, it can pose challenges in acquiring a comprehensive picture of client functioning. This article presents a case study of an adolescent with combined anxiety and depression who was referred for teletherapy during COVID-19, with an emphasis on the assessment intake. Results from a multi-method approach to the assessment are provided along with a brief discussion of treatment and future implications for the practice of telepsychology with youth and families.

Keywords: Telepsychology; Telehealth; Teletherapy; Teleassessment; Adolescent; Anxiety; Depression; Case study

1. Introduction

Assessment and treatment of anxiety and depression in youth are often complex, with the need to examine multiple factors in multiple contexts. Given the overall increase in rates of pediatric anxiety and depression over the past 15 years, this need is all the more pressing. COVID-19 made this more challenging, as the pandemic elicited unique stressors not previously encountered. In response to the COVID-19, telepsychology has become more frequently utilized. We reviewed research literature through the databases of Academic Search Premier, EBSCOhost Nursing, Health and Medical Resources, EBSCOhost Psychology Resources, and Medline. We searched for studies using terms "assessment of child/adolescent anxiety", "assessment of child/adolescent depression", "COVID-19 child or adolescent anxiety/ depression", "virtual/online assessment and therapy for psychiatric/psychological/mental health problems".

1.1. Literature Review

1.1.1. Considerations for Telepsychology Assessment and Therapy

Comprehensive assessment of anxiety and depression in children and adolescents should involve a multi-informant/rater approach, collecting information from the child, parents/guardians, teachers, therapists, and others [1]. Multi-method assessment is considered a gold standard. This includes clinical interviews, such as the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) [2] or the Anxiety Disorders Interview Schedule for Children/Parents (ADIS-C/P) [3]; clinical observations; and the use of rating scales and diagnostic inventories. The latter represents a standard component of assessment, enabling clinicians to gain an understanding of how children's symptoms fit within the context of a standardized set of symptom-based questions. Many scales provide the opportunity for multi-rater/informant assessment because they include self and parent/caregiver forms and, sometimes, a teacher form.

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Virtual assessment of psychological problems using norm-referenced measures can involve different procedures. Some platforms allow clinicians to administer instruments by e-mailing a link, which enables clients to respond to items or questions in a setting of their choice. While this method provides convenience, it may not be suitable for youth since clinicians are not present to ensure measure completion or answer clients' questions. Additionally, asynchronous online administration does not permit immediate follow-up questioning or observation of client reactions, body language, *etc*. In high-risk situations (e.g., suicidal intentions), asynchronous measure completion is likely ill-advised since it does not permit comprehensive risk assessment. For synchronous administration of measures, clinicians share their screen and the client answers items/questions contemporaneously. This allows for follow-up questions as needed and is more appropriate for higher-risk situations, although it does not circumvent difficulties in capturing important non-verbal information. Several anxiety and depression instruments for youth can be administered in this format, including the RCMAS-2 [4], which is suitable for ages 6–19 years, the MASC-2 for ages 8–18 years [5], and the CDI-2 [6] for ages 7–17 years. Some instruments, such as the Beck Youth Inventories [7], for ages 7–18 years, can be used both synchronously and asynchronously.

There has been little research and empirical data to guide psychological teleassessment. Krach et al. [8] reviewed the existing literature on teleassessment as well as recommendations for best practices from professional organizations, test publishers, and government offices. They noted that few instruments meet equivalency standards for adaptation to teleassessment from paper-based or face-to-face versions. Much of the research related to applications, validity, and reliability of teleassessment has involved cognitive and achievement measures. Results indicated that all surveyed test publishers considered it acceptable to adapt face-to-face assessment tools for online use, while professional organizations tended to endorse such adaptations with caution. Lastly, governmental bodies tended to recommend not using adaptations or using them with caution [8].

While telehealth/telepsychology existed prior to 2020, the pandemic ushered in a tremendous expansion of these services. According to research by Schuster et al. conducted before the pandemic with a sample of Austrian therapists, online and hybrid therapy services were perceived as neutral in terms of advantages. In contrast, online-only services were perceived as having more disadvantages and risks [9]. Research done with psychiatrists from India during the pandemic [10] found that the majority of those surveyed perceived telepsychiatry to be advantageous with respect to accessibility of services and decreasing exposure to illness. Disadvantages cited were the possibility of increased doctor shopping among patients and challenges related to crises. In a review of studies focusing on teletherapy [11], Vu noted that available research indicates that teletherapy was equally effective to in-person therapy and is both acceptable and helpful to clients. Overall, the advantages for psychology teleassessment and teletherapy include: (a) minimizing exposure between practitioners and clients; (b) allowance for more convenient scheduling; (c) expanded access to mental health care for those who might have minimal options; (d) increased attendance and adherence to treatment and decreased attrition since travel is not required [12]; and (e) familiarity and preference for this modality. Disadvantages include: (a) potential for less personalized connections due to lack of face-to-face interactions; (b) lack of non-verbal information about clients; this can include aspects of appearance and body language as well as scent (e.g., smell of alcohol) [13]; (c) difficulty managing emergencies and crises [14]; (d) inability to manage clients' environments during assessment and therapy [14]; and (e) technology problems or interruptions. Specific technology problems can include a lack of access to reliable internet connections, which is more prevalent in rural communities; outages or interruptions in connectivity; low quality video and/or audio output; and a lack of synchronization for video and audio transmission [11].

1.1.2. Telepsychology with Adolescent and Child Clients

For many psychological problems, research indicates that teletherapy is equally effective to in-person therapy based on symptom reduction and other outcomes [15,16].

However, there have been no large-scale studies comparing the effectiveness of in-person to teletherapy for children or adolescents. Multiple studies indicated that COVID-19 was associated with higher rates of child and adolescent depression and anxiety symptoms [17,18], and, at the height of the pandemic, telepsychology represented a vital source of social-emotional support for youth. Research conducted during the COVID-19 found that teletherapy was rated as satisfactory and acceptable by both child and adolescent clients and their parents or caregivers [19]. From a clinician's perspective, telepsychology/teletherapy provides the opportunity to observe youth in natural environments, yielding additional insight regarding their everyday functioning. Qualitative research with child clinicians who provided services during COVID-19 [20] indicated several perceived advantages of teletherapy. Two of these involve

convenience and accessibility. Respondents also cited youth preference for, and comfort with, digital technology. For adolescents, telepsychology often represents a less stigmatizing avenue to provide services.

Telepsychology can also present limitations and challenges. Children and adolescents may be distracted by their environment, which can detract from participation. Extra space or materials may be necessary to engage children, and sometimes this warrants involvement from parents or caregivers. Technology glitches can impact the consistency and quality of services, and younger clients might struggle to navigate these. In a qualitative study of child clinicians providing services during COVID-19 [20], respondents expressed concerns about clients' lack of privacy; low access to resources (e.g., suitable devices and private space); and obstacles related to the therapeutic alliance, such as limited interactions with clients and inhibited emotional expression. Respondents also noted that telepsychology might be inappropriate for some clients, such as those who have autism, are suicidal or high-crisis, or have significant trauma-related issues [20]. Other researchers have also highlighted telepsychology's poor fit for youth experiencing more severe mental health difficulties [21]. Telepsychology clinicians might struggle to navigate crises with clients; in-person sessions are likely more suitable for assessing and mitigating higher-risk situations and those where insurance of confidentiality is critical for accurate disclosure [22].

Given the rise of telepsychology during COVID-19, it is important to consider assessment within this context. Much of the psychological assessment that occurred during the pandemic was done virtually. For some youth, such assessment did not represent a shift from previous procedures. For example, several longitudinal studies examining anxiety and depression in children and/or adolescents utilized the same online measures across time points, including during the pandemic [23,24]. However, many large-scale studies and reviews of youth mental health during the pandemic did not describe specific considerations related to teleassessment.

Since 2020, research on teleassessment has somewhat increased. For example, remote communication assessments have been conducted with some success [25,26]. Some studies indicate that teleassessment for autism can be as effective as in-person [27]. It is important to note, however, that there has been no research focusing on the validity or reliability of teleassessment for youth anxiety or depression or comparing the effectiveness of in-person *vs.* teleassessment for these problems.

1.1.3. General Concerns Related to Telepsychology

It is clear that COVID-19 has generated a new era in telepsychology, one that is here to stay. Benefits such as increased accessibility and convenience are applicable across multiple client populations. While these advantages are salient, many families still lack access to the most suitable types of technology. Potential threats to privacy and confidentiality represent a primary ethical concern in telepsychology; these must be weighed in consideration of other benefits and drawbacks [21]. During telepsychology, nuances related to client body language, facial expressions, *etc*. might be difficult to discern, making the assessment of functioning more challenging and potentially interfering with clinicians responding to clients with appropriate therapeutic techniques [22]. Specifically, regarding teleassessment, there is some research supporting its use. For example, Van Ballegooijen et al. [28] conducted a systematic review of online measures to assess psychological disorders. They found evidence of adequate psychometric properties, but only covered measures used with adults. They also noted the continuing dearth of information about psychological teleassessment.

2. Method

2.1. Case Study

In considering the context of the rise of telepsychology and the importance of sound assessment and intervention for youth mental health problems, we present a case study of an adolescent client engaged in telehealth services during the pandemic. Some elements of the case have been slightly altered to protect confidentiality. This case demonstrates a multifaceted approach to the assessment of anxiety and depression and highlights key issues and challenges.

2.2. Procedures

2.2.1. General Clinic Procedures

Our community-based training clinic is led by doctoral psychology students who work with child, adolescent, and/or adult clients under the supervision of licensed faculty psychologists. Both assessment and therapy services are provided free of charge. When prospective clients or parents/guardians contact our clinic, a phone screen is conducted by one of our trained clinic assistants. This screen consists of a set of questions that ask about background, history, and symptoms

or difficulties being experienced. The clinic assistants also ask questions related to potential risk. Since clinicians are students and not licensed professionals, our clinic does not accept court-ordered referrals or clients with high suicidal risk, serious risk of hurting others, significant substance abuse problems, or more serious problems, such as schizophrenia.

2.2.2. Research Ethics and Consent

In addition to the above, clinic assistants explain basic operational policies and procedures, including scheduling, privacy, confidentiality, *etc*. Due to the training and research nature of the clinic, clinic assistants and clinicians explain informed consent and assent to clients and their parents or guardians, in the case of minors under 18 years of age. Assent is explained to clients who are minors. For consent and assent, clients are informed that non-identifiable data from their psychological services may be used for research purposes, and this is described in all forms. In the current case, the parent and client gave consent and assent after these explanations. Consent and assent were obtained through encrypted e-mail communication and reviewed during the first appointment. Copies of the consent and assent forms are stored securely in the clinic's database. The IRB of the University where the clinic is located provided approval for the research.

2.2.3. Telehealth Services During the Pandemic

Following the closure of the university due to COVID-19, we transitioned to teletherapy for our clinic. After considering different options, we adopted a HIPAA-compliant Zoom platform. Beginning in summer 2020, all client sessions, including intake sessions, were conducted via Zoom. All doctoral clinicians and supervisors completed training in the provision of telehealth/teletherapy, including ethical and legal issues related to this service.

3. Results

3.1. Client Background and History

The intake was conducted over multiple Zoom sessions with RB, age 14 years, and her mother, Mrs. K. Background information about RB is summarized in Table 1 below:

Table 1. Summary of Client Background Information.

Race and Ethnicity	**Black and Latina**
Socioeconomic Background of Family	Lower-middle
Type of Community	Metropolitan-suburban (about 15 miles or 24 km outside of a major city)
Languages Spoken	English and Spanish
Family Composition	Adolescent client, mom, younger brother (age 10), stepfather passed away from COVID several months prior.
Medical and Health Information	Good physical health; No acute or chronic health conditions; No known allergies; No medications
Sleeping and Eating	The client reported difficulties falling and staying asleep almost every night. The client had difficulty specifying the quantity of nightly sleep, but estimated 4–5 h per night. Client reported reduced appetite and some weight loss within the past year; amount not specified
Daily Activities	The client attended high school and left home before 7 a.m. to get to school, arriving home at 3:15 p.m. Missed several school days per month due to anxiety.

Mrs. K referred RB due to concerns about mood and grief, as well as COVID-19-related anxiety. At this time, RB was in ninth grade and had returned to in-person education. Her stepfather had passed away several months prior due to COVID-19. Mrs. K noted that RB became more withdrawn as her husband became sicker. However, RB did not directly communicate her feelings of loss or sadness. Mrs. K and RB both described their relationship as agreeable, though not particularly close. RB indicated she had a positive relationship with her stepfather. She was closer to him than her biological father, with whom she had minimal contact.

RB described liking school in general, but she had "hated" remote learning. She reported having friends, though not any close ones. RB did not see peers in person during the pandemic and felt isolated. Both RB and Mrs. K described her as having anxiety, which often impacted her functioning, even before COVID-19. For example, RB was interested in the arts, but she had not done any extracurricular activities because she felt nervous about being around kids she didn't know. She also experienced panic symptoms several times a week, consisting of a pounding heart, sweating, and

thoughts about people in her life dying. Mrs. K described her daughter as a good student who typically earned A's and B's. RB reported plans to attend college, but she was unsure of what she wanted to study.

3.2. Observations

During intake and beginning treatment sessions, RB often did not want to appear on camera. When she did, she usually participated in therapy from bed. RB often appeared and sounded fatigued. The clinician also noted that RB's speech volume was low, making it difficult for her to be heard. Her responses to questions were brief, and she did not elaborate on them. RB responded affirmatively when asked about experiencing low energy and concentration problems. The clinician observed that RB was often irritable about responding to questions. RB's therapeutic engagement, including the use of a camera, was an initial treatment target. Through shaping and reinforcement, the clinician was able to increase RB's participation in therapy and camera time gradually.

3.3. Results from Standardized Measures

RB and Mrs. K were administered the MASC-2 and CDI-2. Results are presented in Tables 2 and 3 below. These scores showed that RB and her mother rated her similarly with respect to depression symptoms. Since RB refused to answer about thoughts/intentions related to suicide, it was not possible to obtain a total score and several other CDI scores. Based upon clinician follow-up questions, RB admitted to passive suicidal ideation on an intermittent basis. RB rated herself higher for anxiety symptoms on the MASC-2 compared to her mother. It is important to note that discrepancies between parent and child ratings on such measures are not uncommon [29]. RB's MASC-2 yielded an Anxiety Probability Score in the High Range, while her mother's was in the Borderline range, suggesting a strong likelihood that she was experiencing one or more anxiety disorders.

Table 2. Scores from the Multidimensional Anxiety Scale for Children-Second Edition.

Name of Scale/Subscale	Self T Score	Description/ Guideline	Parent T Score	Description/ Guideline
Total MASC-2 Score	75	Very Elevated	70	Very Elevated
Anxiety Scale: Separation Anxiety/Phobias	70	Very Elevated	64	Slightly Elevated
Anxiety Scale: GAD Index	74	Very Elevated	65	Elevated
Anxiety Scale: Social Anxiety-Total	72	Very Elevated	65	Elevated
Humiliation/Rejection	70	Very Elevated	64	Slightly Elevated
Performance Fears	74	Very Elevated	66	Elevated
Obsessions & Compulsions	67	Elevated	63	Slightly Elevated
Physical Symptoms	77	Very Elevated	70	Very Elevated
Panic	78	Very Elevated	71	Very Elevated
Tense/Restless	76	Very Elevated	73	Very Elevated
Harm Avoidance	65	Elevated	65	Elevated

Table 3. Scores from the Children's Depression Inventory-Second Edition Self (CDI-2).

Name of Scale	Self T Score	Percentile	Classification	Parent T Score	Percentile	Classification
*TOTAL SCORE	N/A	N/A	N/A	70	95th	Very Elevated
*EMOTIONAL PROBLEMS	N/A	N/A	N/A	71	96th	Very Elevated
Negative Mood/ Physical Symptoms	71	96th	Very Elevated	N/A		
*Negative Self-Esteem	N/A	N/A	N/A	N/A		
FUNCTIONAL PROBLEMS	75	97th	Very Elevated	70	95th	Very Elevated
Ineffectiveness	77	98th	Very Elevated	N/A		
Interpersonal Problems	69	95th	Elevated	N/A		

*For the CDI-2 critical item most directly related to suicidal intention and/or ideation, R indicated that she did not want to answer. As a result, RB's self-report scores for some scales and subscales could not be computed, and these are denoted by not applicable "N/A". The CDI parent form does not contain subscales as the self-report form does; these are also marked as N/A.

Additionally, Mrs. K completed the COVID-19 Exposure and Family Impacts Scale (CEFIS) [30] to better understand the impact of COVID-19 on various life areas. Mrs. K rated her overall level of COVID-19 distress at seven out of ten (ten indicating "extreme distress") and rated her children's level of distress at eight out of ten.

3.4. Diagnostic Impressions

Overall, the results from the combined assessment tools (e.g., observations, interviewing, standardized measures) indicated that RB was experiencing significant anxiety and depression as well as grief, interfering with her everyday functioning. The clinician diagnosed RB with major depressive disorder based on predominantly sad and irritable mood, which had been present for several months; her hypersomnia; reported and observed fatigue and lack of energy; slow motor movements; and difficulties with conversation. Additionally, RB experienced some degree of suicidal ideation, though she refused to answer the suicide-related item on the CDI-2. Although RB's presenting concerns involved grief, based on the intake, her difficulties extended beyond typical grief symptoms. RB also received a diagnosis of unspecified anxiety disorder, given her experiences with excessive worry, avoidance, and panic over a prolonged period, including before the pandemic. Her difficulties were exacerbated by remote education, isolation, health fears, and the loss of her stepfather, who had been a stabilizing force in her life. Intervention for RB involved a combination of behavioral strategies, such as formation of SMART goals, behavioral activation and shaping to engage her in specific activities (e.g., turning camera on); cognitive-behavioral therapy to change unhealthy thought patterns; and some mindfulness and acceptance and commitment therapy (ACT) strategies Overall, it was challenging to engage RB in treatment due to her fatigue, but she did have a period of responding positively to shaping and positive reinforcement (e.g., praise) to increase her camera usage. The clinician completed a CBT intervention, the Panic Stations [31], with RB; this helps clients understand physical, cognitive, and behavioral components of their anxiety and teaches them specific coping strategies. RB expressed some interest in ACT strategies, such as choosing values and mindful grounding techniques. The challenge for both the CBT and ACT strategies was that RB did not practice them independently outside of therapy.

4. Discussion

The multiple, unique challenges associated with COVID-19 generated adverse effects for youth, many of which continue to interfere with their everyday functioning. Studies have documented increased rates of mental health problems during the pandemic. Further, research has found that youth who already experienced risk factors pre-pandemic showed worse functioning during COVID-19 [32]. The case of RB demonstrates the intersection of such risk factors with COVID-specific adversities, since she had pre-existing anxiety and faced not only the isolation and loss of social interactions typical of the pandemic, but also the death of her stepfather.

The case of RB illustrates several important points related to telepsychology for youth with anxiety and/or depression. First, while multimodal, comprehensive assessment is considered the gold standard, best practices for teleassessment have not been fully established. We recommend that clinicians continue to use norm-referenced measures, especially those with a history of computerized administration. If reliability and validity have not yet been well-established for online measures, it is important to recognize these limitations and report them in the results. When utilizing online self-report or parent-report instruments, clinicians should be prepared to conduct follow-up questioning and/or guide respondents if they have queries about particular items.

Second, RB's case shows that significant gaps remain with respect to culturally responsive telepsychology practices [33]. In considering RB's identity as a Latina/Black female with multiple risk factors, the clinician did not apply a specific model of cultural adaptation; however, she accounted for cultural and family values, including familism, respect for authority, and an emphasis on family hierarchy. While there was distance in the maternal-client relationship, RB showed reverence for her mother and acknowledged her authority and sacrifices for the family. The clinician validated these elements throughout therapy. While these steps are valuable, gaps in best practice remain. Recommendations to address these gaps include: empirically evaluating telepsychology interventions with diverse youth; providing skills and support to trainees in culturally responsive telepsychology; and focusing on best dissemination practices among diverse populations while accounting for existing healthcare disparities [33].

Third, RB's case illustrates both the advantages and challenges in utilizing telepsychology. The use of Zoom enabled RB to receive therapy, which wouldn't have been accessible otherwise, but it presented challenges in gaining comprehensive information about her functioning. For example, RB's reluctance to appear on camera made it difficult to observe facial expressions, body language, and home functioning, which, in turn, limited assessment of the nature

and degree of her symptoms. Simultaneously, this refusal was a manifestation of her struggles and became a treatment target. Even when clients do appear on camera, some symptoms might be harder to observe. This speaks to the need to develop and evaluate structured protocols for teleassessment/therapy that are sensitive to verbal and non-verbal communication and manifestation of particular psychological symptoms. Additionally, clinicians need to consider client age, developmental level, attention span, and other factors that influence engagement. Other factors that might influence teletherapy include space and privacy; clients' preparedness to transition into teletherapy from other activities; and ensuring adequate time and resources for reflection [34]. These factors are particularly relevant for child and adolescent clients, who, compared to adults, likely have less control over their setting and require more guidance and structure to process cognitive and emotional content from teletherapy.

Lastly, the case of RB underscores the need to consider high-risk telepsychology situations carefully. There is a strong need for effective practices that can be conducted virtually, including the evaluation of symptom clusters; individual characteristics; and situational risk factors such as bullying, home or school disciplinary actions, relationship breakups, and academic failure [35]. For telehealth, it is vital to document both the client's and caregiver's location and contact information, both legally and ethically. This was consistently done for RB. It is also crucial to obtain information about protective factors; psychological diagnoses; treatment history; and current and past suicidal thoughts, ideation, attempts, and plans. For RB, some of this information was obtained; however, her reluctance to discuss her experiences was a limitation.

5. Conclusions

In conclusion, the context of COVID and its aftermath are unique in their impact on children's lives. Increases in youth mental health problems and the concomitant rise of telepsychology call for the development of evidence-based protocols for online assessment and therapy. The case of RB demonstrates both advantages and challenges of telepsychology for youth experiencing anxiety and depression. Based on this case, we recommend that clinicians continue to use thorough, multimodal, and multi-informant assessments, including norm-referenced instruments, for diagnosis and treatment, while taking into account the potential limitations of telepsychology discussed above.

Author Contributions

Conceptualization: A.G.; Methodology: A.G. and K.C.; Software: Not applicable; Validation: A.G.; Formal Analysis: A.G. and K.C.; Investigation: A.G., K.C. and D.C.; Resources: A.G.; Data Curation: A.G. and K.C.; Writing—Original Draft: A.G., K.C. and D.C.; Writing—Reviewing and Editing: A.G.; Visualization: A.G.; Supervision: A.G.; Project Administration: A.G.; Funding Acquisition: Not applicable.

Ethics Statement

The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Institutional Review Board of Kean University (# FWA00012551; 16 September 2025).

Informed Consent Statement

Informed consent was obtained from all participants involved in this study.

Data Availability Statement

Not applicable.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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