Video Sessions Tips for Clinicians & Other Helping Professionals

Professionalism

How we appear while on video is crucial to setting the tone for our session. While it can be argued that dress codes, name tags, white coats and titles all enforce a patriarchal, hierarchical structure, they also are proxy indicators for competence, which inspires confidence in those we serve. This confidence is critical to the therapeutic relationship. It influences whether patients take recommendations to heart and can be partially responsible for initial improvements in symptoms after just one session. Additionally, the effort we put into how we appear is often interpreted as showing respect to our patients. It indicates that we think the person we are seeing and the service we are providing are important and valuable. To this end, when using a video telehealth platform at home:

- **Dress in accordance with your organization's dress code.** Present with the normal dress for the clinic setting (at least from the waist up!).
- **Test the camera to see how the background looks and adjust accordingly to convey a professional image.** Consider lighting, a plain and tidy background (no stacked boxes, old movie posters, or untidy counters), avoid showing things that would be distracting or call unneeded attention (no Avengers memorabilia or bedroom furniture). Consider using a virtual background and plugging in a photo of your actual office or other therapeutically neutral image.
- **Use a headset and close doors** to preserve confidentiality and minimize interruptions during the session.
- **Find a comfortable place to sit and work** to avoid poor posture or straining to see the camera. Ergonomics are important for sustainably being able to work from home.

The Therapeutic Connection

This is the most important sentence in this document: ***We are unable to listen and communicate skillfully when we are doing something else***. While engaged in video sessions, avoid anything that could potentially distract attention away from the patient. In the clinic setting, we would leave our purse and our personal phone in the other room. We would look away from computer screens and never quickly check

an email when listening to patients. We would never try to multi-task by trying to organize papers or fumble around with items on the table. Of course, this is easier said than done when working from home.

- **Try hiding the view of yourself on the camera.** Most video platforms have the option of hiding yourself from the display. Many people find this incredibly helpful for focusing on the patient during video sessions (and work meetings!). In the office, providers never have an option to see themselves during in-person sessions. This facilitates the "forgetting of oneself", allowing one to enter deeply into listening and engagement with the patient. However, when we can see ourselves, our eyes are drawn to our own image, in some ways to "monitor" how we appear. Even intermittent looking at our own image takes us away mentally from our patients, makes it more likely that we will miss important facial cues, and generally leads us to substandard listening. If the platform being used doesn't allow for removing the self-view (e.g., doxy.me), try a replacing it with another picture of yourself!

- **Sit in a different place for sessions than for administrative work.** Most of us have to look at our computers to do administrative work, so just sitting down at the computer and looking at the screen becomes a behavioral trigger for our minds to start running about the work we need to do. This can spill over into our sessions with patients, even when we know it is time to be fully present for them, as our minds may keep trying to return to work tasks. For this reason, it can be helpful to physically change places when it is time to start seeing patients. You don't have to have a ton of space or rooms at home to make this work. Even just turning your chair to a different side of the table can help tremendously.

I now have a "patient session" chair/computer placement position. When I shift there, my brain is now prompted for patient sessions, not speedy email responding.

When I was seeing patients in the office, I developed a ritual of saying to myself/a higher power, "please let me help this person" while walking to meet a patient. I had done this for so many years, it was automatic. I barely realized it was a ritual until...it was gone. After initiating telehealth sessions, I found myself clicking on a button to begin a session, when I'd barely taken a moment to breathe and get myself present. Once I became aware of my lost ritual, I re-started a slightly different ritual and now I am back to sitting down, taking a deep breath and saying, "please let me be helpful".

- **Develop new prompts and/or new rituals:** Most of us have habitual behaviors we engage in when preparing ourselves for sessions with patients. Whether it is engaging in some positive self-talk, grabbing our favorite notebook, or drinking a glass of water, we engage in behaviors to get us ready for our session. When we make a habitual behavior purposeful, with the intent of connecting to something larger or deeper than our normal "tasking" brain, this is a ritual. Many of our rituals are highly tied to our work environment, so now that our typical work environment has been removed while we are working from home, many of us have also lost our rituals. Taking the intentional time to develop new rituals that can be used in times of telehealth can be a helpful tool for grounding us before entering sessions with patients.

Proactively Address the Challenges of Video in the Session:

Video sessions are, at least in most settings and in this capacity, new for all of us. There are many adjustments and barriers to troubleshoot, whether it is internet connections and hotspots, not having the appropriate technology, or difficulty with finding a private space. Often providers and patient's alike feel as though they don't have the tech-skills necessary to seamlessly log on and get through a video session while maintaining their composure. This adds to anxiety and feelings of inadequacy at both ends. Here are some helpful ideas on how to address the added difficulties brought about by video sessions:

- **Acknowledge and validate the "newness" of the method of service for patients.** Initiate a conversation about the experience of using video sessions, eliciting any feelings around possible concern, frustration, or discomfort. A good way to start is to ask if the patient has previous experience with using video chat technologies, such as FaceTime or Skype. Then, elicit their opinions about their previous experiences, both the positive and the negative. It can be helpful to name the seemingly abrupt change in the way services are provided by saying something like: *"I know it is different for us to engage in therapy/counseling this way. It can feel pretty odd or unconventional. What are your thoughts, questions, or concerns about us using video chat to have our sessions?"* It is also a good idea to check in at the end of the first few sessions to ask about how the experience has been for them, what can be done differently for the session to run smoother and how the experience can be improved.

- **Attend to privacy issues.** Privacy is different than confidentiality. Privacy is modulated by how someone feels in regard to their own boundaries and comfort levels. Confidentiality is typically a legal definition of how information is shared and maintained. Although we may not be able to fix someone's feelings of discomfort or lack of sufficient privacy, we can ask how they feel about it, acknowledge the challenges, and try to problem solve to meet the patients' privacy preferences when possible. For example, by asking them what they do feel comfortable talking about and when, or if there are any themes or issues they wouldn't want someone to potentially overhear.

> *I was shocked when I did my first telehealth therapy session as a patient to find that I was nervous about talking about my husband and children, in case they could hear me-- and I have an*

- **Vary your eye contact.** In in-person conversations, eye contact is broken frequently. Even in conversations when we are deeply connected, our eye gaze shifts, but it happens naturally and unconsciously so we usually don't realize it. For example, in sessions with patients, we look at them, they look at us, we look to the side in thought, they look down when they cry. It doesn't interfere with our ability to listen empathically and it is one of the norms of in-person conversations. When we move to video, we tend to stop doing this. It is part of what sometimes makes our Skype or FaceTime sessions feel odd – like a protracted staring contest! It is also one of the reasons why some people feel more nervous on video than in person – we feel like we can't look away! However, in video sessions with patients this dynamic can be overcome by purposefully breaking eye contact to make the conversation feel more natural. We can still look up in thought, down in concentrations, and to the side while we are looking for words. The patient will likewise mirror these behaviors unconsciously, helping the conversation feel more familiar and natural.

- **Lean into the patient's home environment.** Being able to see our patients in their homes is an amazing opportunity that most clinicians do not have on a daily basis in the clinic setting. If we pretend that it is "treatment as usual", we miss an opportunity to enrich our understanding of our patients' strengths, challenges and how their social/emotional environment impacts them. To this end, don't miss opportunities to offer observations or to ask patients about their home environments while doing telehealth.

I recently had an adolescent patient show me around her room, sparking an important conversation about her relationship with her brother. Likewise, a colleague of mine had a patient show her his lovingly tended rose garden. On the other hand, however, I also heard one of my patients yelling at her children in session and was able to gently ask about it, which prompted an important exchange about anger in my patient's home and its impact on

- **Acknowledge your own home environment when it makes sense.** As clinicians, we never want to draw focus to ourselves. We want to present ourselves with a sense of neutrality and an appearance that inspires trust and confidence. However, in current work-from-home settings, if we don't acknowledge our own home environment, it can feel a bit ingenuine. While a dog barking is much more innocuous than a parent's alcoholism, for example, not acknowledging both can send the message that we are not going to talk about what is really happening. If our home life intrudes into our session in the form of a crying baby or if a patient notices a quilt on the wall behind us, we can just acknowledge, as a fellow human, the reality of where we are. For those of us who were trained to veer strictly away from self-disclosures, this can feel uncomfortable at first. But, when addressed tactfully, it can help us develop deeper, human to human, helping relationships with those we serve.

There was a time where I would immediately mute the phone if my dog barked, or one of my kids squealed, just hoping no one heard. Now I realize that such behavior can replicate unhealthy family systems, where everyone hears or sees something, and no one talks about

- **Avoid charting simultaneously during the session.** Many of us who work in the clinic setting are used to doing some quick, simultaneous, charting during sessions, but this is more complicated when doing video-telehealth. Patients can't see everything we are doing on the other side of the screen to know that we are simply jotting down some notes about the session. They may think we are answering someone else's email, working on a personal project, or otherwise distracted from their session. It goes without saying that this can be incredibly damaging to the therapeutic relationship and intervention process.

For these reasons, sparingly engage in simultaneous charting during video sessions. It is also not for beginners. Being able to type and actively listen is a skill that must be developed over time and even more challenging while navigating the new reality of video visits. With all that, it is important to mention to the patient if we are hoping to chart a bit during the beginning of the session and ask permission. We can say something like, "*Would it be okay with you if I take some notes down about what you are saying during the first few minutes of our session? This is so I can make sure I remember the important things you say".* Remember, it is best practice to only chart down some initial information, not during the entire session, and to actively turn away from typing once the information has been noted – and certainly when patients are sharing strong emotional content.

Assessments, Screenings, and Emergencies:

Formal assessments are a core component of our work in behavioral health. Screenings, likewise, are a critical component of working in a telehealth setting, but typically administered by someone besides the behavioral health clinician. They are designed to be exactly what they say they are – a screening – provided to a large portion (if not the entire clinic) population. Emergencies are inevitable. Emergencies don't stop now that patients are at home and we are still ethically and legally responsible to respond competently. Below are some tips for getting through these complicated aspects of virtual work.

- **Avoid the trap of going through a long, formal assessment in the first video session**. Even in person, formal assessments are the kryptonite of therapy. Long, formal assessment are almost always driven by payers, systems, grants, self-protection, tradition or habit – rarely by what is best for the patient. Formal assessments are, by definition, our agenda, not the patient's, and are characterized by closed and narrow questions, discouraging meaningful self-disclosure. Furthermore, research has shown that when the first visit is primarily formal assessments (and patients must return for treatment to begin) the dropout rate is over 75%. During the first visit, the primary task is to build initial rapport, trust, establish empathy and inspire confidence that change is possible. All of this is more challenging by video, as we have lost our ability to walk side by side with patients into our office while engaging in connecting talk, or use our non-verbal cues and body language to reflect closeness, emotional support, interest and compassion. For this reason, it is even more important to avoid formal assessments in the first

video session. The good news is that we will almost always get the information we need when we simply sit back and ask open ended questions, listen closely, reflect back, and listen some more. If there are a few important un-answered questions (around suicide risk, substance use and safety in the home) as we approach the end of the session, we can say something like: "*Thank you so much for sharing all of this with me. Before we talk about our plan moving forward, I wanted to ask about a few things I haven't heard you talk about yet….*"

- **Avoid administering screenings.** Screenings, by definition, are for large swaths of the population to stratify needs for population health interventions. If a patient is already at a behavioral health appointment, they are already a part of a vetted/stratified subgroup. In the clinic setting, we know that screenings are typically built into PCP visits and administered in the waiting room or by medical assistants. It would be duplicative for behavioral health providers to repeat them. The exception to this is when PHQ-9s or other measurement-based tools are used by behavioral health providers to measure treatment efficacy and progress. For example, they can be used at session 4, since we know 80% of improvements for most patients happen in the first 4 sessions. They can be administered again at termination, to measure progress at closure. In these instances, the questionnaire is not being used to screen, but rather as a treatment tool.
- **Handling emergencies over telehealth is very similar to in-person.** It may seem like handling emergencies virtually is categorically different from handling them in person, but it is actually very similar. When someone is in our office and acutely suicidal or our lethality assessment is high (re: with a plan, means, history of attempts, etc.) we proceed by discussing with them the need for emergency services. If they don't agree to voluntarily seeking a higher level of care, the local crisis team or police come to the clinic. There is no need to overthink the response to suicidal statements over telehealth - it is essentially the same. The only main difference is that, if possible, we would want to work with them to get a family member on the video, or permission for us to call a family member or friend. We would want to talk to them about voluntary hospitalization and ask them to again confirm their location in case we need to call emergency services to their house. Here are some additional resources about managing suicidality virtually, and here for managing IPV virtually.

Sharing Education Materials and Resources:

When initially transitioning to telehealth, many clinicians felt paralyzed - as if they could not do the same quality of work or have access to the same resources as when they were in the office. However, quite quickly, clinicians figured out ways around this and even found that telehealth offered some significant benefits when it came to sharing psychoeducational material in particular. Here are some ideas to try out in session:

- **Screen-share with patients** to show them psychoeducational material. That way, clinicians and patients can look and read through material together and explore content during the session as they go.
- **Use a whiteboard to write out material** and direct the camera to show the contents. This can be particularly helpful for clinicians who are still in in their office environment, but seeing patients virtually. They may still have access to white boards or large easels of note paper to write out in real-time certain notes or dynamics that they want to illustrate to patients.
- **Email patients follow up information.** As long as we have explained the risks of electronic communication and the patient consents, we can ethically and legally email materials to patients. This can be super helpful because, although screen-sharing allows patients to view material in real-time and discuss in session, email gives them something they can refer back to in between sessions. Even better – when we email patients electronic copies of documents, they are less likely to get lost or promptly discarded on the way out of a session.

Thank you to Lizzie Horevitz, Phd, LCSW and Erica Palmer, LCSW for their contributions. For more detail on these and other empathic communication strategies, see www.emorrisonconsulting.com, under the resources tab.

Feel free to share, attribution is appreciated but not necessary. If you'd like a Word version of this, to alter and edit, please email me at: elizabeth@emorrisonconconsulting.com

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