Ways of working during the COVID-19 crisis

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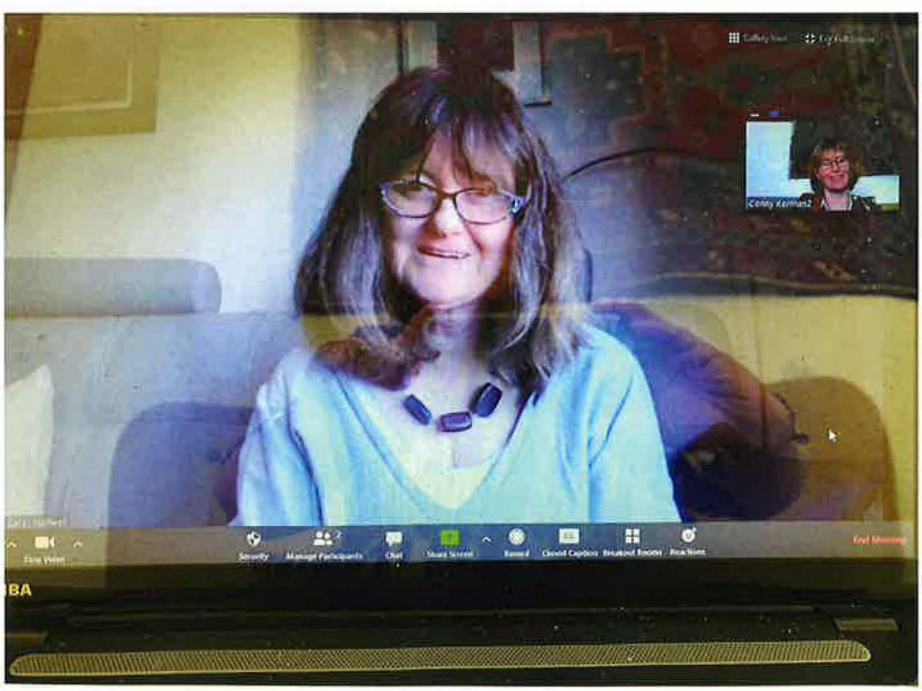
We wrote this blog as an immediate response when COVID-19 led to lockdown. In the two weeks between writing it and sending it to *Context*, much has changed. Many of you have emailed with comments and suggestions based on your own evolving practices. By the time this has been published, it is impossible to know how much of the thinking described below will remain the same and what will have changed. What follows is therefore a punctuation, the capturing of some thoughts at a particular moment in time, full of the mania and fear and anxiety that comes from wanting to do something and not being quite sure what to do.

Remote working in a pandemic

As for many other professions, the COVID-19 coronavirus pandemic has changed the way that systemic practitioners work. With weeks or months of lockdown looming, we cannot practise with families and groups in the ways that have been carefully developed over decades. In just two weeks, all but essential face-to-face contact between psychotherapists and patients and clients has stopped. Crisis mental health services have been set up and reorganised to provide services to those most in need and most at risk and to ensure hospital beds are privileged for COVID patients.

What follows are some ideas we generated, regarding some practicalities of providing systemic psychotherapy remotely via video link. Organisations across health, education, social care and the voluntary sector are using a variety of platforms to enable staff to connect via video conference. At the Tavistock, we are using Zoom via faculty trust accounts and this has been assessed as secure enough to conduct both clinical and training activities. Recent NHS guidance has helpfully emphasised the importance of maintaining a connection with patients over worrying about which platform to use.



Carol (on screen) and Conny (smaller)

Providing medical and general practice consultations online is not new and there has been a certain amount of research into how it is 'different' to face-to-face contacts (Greenhalgh *et al.*, 2016; Greenhalgh *et al.*, 2020; Seuren *et al.*, 2020). Likewise, psychotherapists have been providing a variety of forms of psychotherapy for years (see for example Ragusea & VandeCreek, 2003; McDonald *et al.*, 2019; Roddy *et al.*, 2019). Some systemic practitioners have been providing video-based psychotherapy for years but to date very little has been written about this (Helps, in review). For many systemic practitioners, working using video consultation will be very new. There is a small body of research and practice-based evidence we can draw on to guide our practice in delivering online psychotherapy, which emphasises how online work is different in process and thematically. That body of research informs our thoughts below.

Initial setup for doing systemic psychotherapy work remotely

Moving to online therapeutic work is likely to be more straightforward with families with whom we have an existing therapeutic relationship than those we are starting to work with. But starting off this way, probably after an initial telephone conversation, is not impossible. And obviously it will be unavoidable in the coming months.

Issues of similarity and difference have to be considered first as we move online. This relates to familiarity with technology, to ownership of devices that can handle making video calls, and to having the resources to have data or a WiFi connection. Not all staff or patients have these things. Issues of privilege also quickly emerge when we start to see the intimate details of people's living circumstances. Yesterday, a colleague sat on her bed in her shared flat while we had supervision. Her headphones were clearly irritating her head, as she talked carefully and quietly so that her flatmates did not overhear confidential material. I (Sarah) had the luxury of sitting in my kitchen with a newly bought WIFI booster, safe in the knowledge I could talk freely.

What follows is a series of recommendations based on the evidence and on practice-experiences to date.

Preparation for clinicians

Access and inclusivity: are there any learning, sight, hearing or other issues of disability for staff or patients that need to be taken into account for access?

Risk assess based on what you know: are there any indications that it might not be safe to meet via video (for example, concerns about violence, dissociation)?

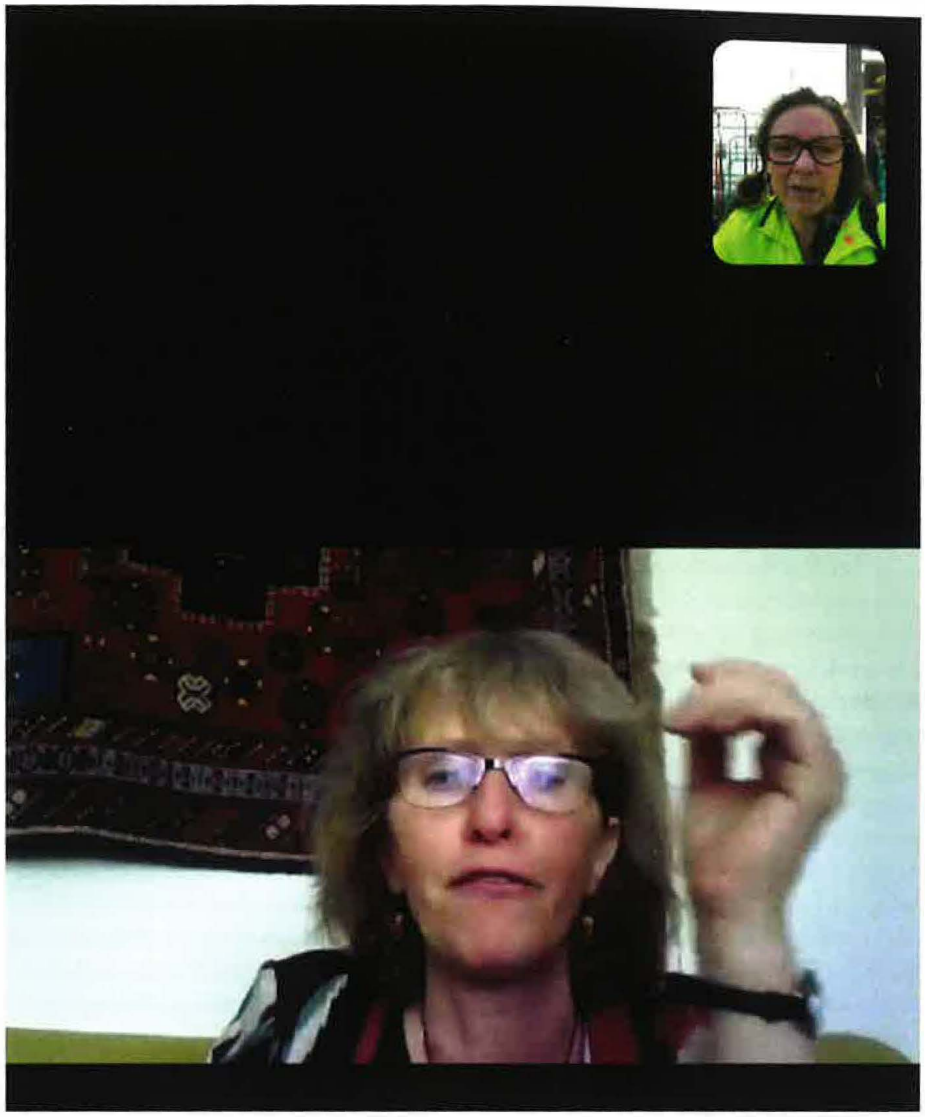
Setting a containing boundary around your workspace, in both practical and psychological terms. Working remotely involves some blurring of boundaries. How can you signify to yourself and those who might be around you at home that you need confidential space and are in work mode. This might involve getting 'dressed' for work, putting up a notice on the door of the room you are working in, wearing headphones to keep the conversations as confidential as possible.

Changes to what we can see: Video working might offer a much more visible, mutual and transparent process, as our patients see us as we sit in our kitchens and studies to conduct a session, and this will affect the balance of power in the therapeutic relationship that will need discussion. Think about what's behind you and visible and talk to this different way of being together. Some video packages offer virtual backgrounds so as to create a more neutral-looking space.

How do you usually establish rapport? What will you need to do differently with your usual 'script' in order to establish rapport in this context?

How do you usually use your body? What might you need to do more or less of? Our nods and headshakes have got progressively bigger, my smiles and frowns have become exaggerated so they can be seen on a small screen. Waving, thumbs up and thumbs down has quickly become professional parlance.

Beginnings and endings have a different formality and need specific visual and verbal rituals. If you usually have some physical contact with a family at the start or end of a session – a handshake, a touch on the shoulder – what might be a virtual way of creating this? Likewise in relation to our colleagues, as we feel disconnected sitting at our kitchens or on our sofas, kisses have been blown and hugs



Conny (on screen) and Sarah (smaller)

offered at the end of meetings that would not usually engender such responses.

Issues to discuss with the family

Being more active: The therapist is likely to have to conduct the session in a much more active way than they might usually do – for making explicit who might talk next, setting parameters for who can talk and for how long. Note that you will probably ask more questions in lieu of being able to 'feel' what is going on in the room. Embodied responses might get altered or misread through the screen and might need to be checked.

Initial questions to ask: Is there a safe space to conduct the call? Who else can hear? Who is 'in charge' of the devices on which the call is connected? Is there reliable broadband? Are device chargers at the ready?

Ensure device microphones can pick up all voices. If this is hard – who will be spokesperson? What will that do to the communication?

Using one or multiple devices: Just like a professional team meeting, if family members each have their own device and sufficient broadband capacity, and are able to do so, it seems to work best with everyone on their own separate device, and to manage the session so that everyone can see everyone else's faces.

What to do in case of distress or escalation – establish this as part of the contract very early in the conversation, for every participant. What's the plan if someone decides to hang up?

How issues of risk will be managed – how can this plan be discussed and agreed and shared?

How to ensure voice entitlement for everyone – make use of the 'raise your hand' facilities in some video consultation platforms; develop a virtual talking-stick

What will happen when the call goes 'wonky' – what's the plan if there is lag? We probably all have experiences that are supposed to be synchronous but are anything but, when there is lag in a video call or when the screen temporarily becomes pixelated and then jumps. Naming and agreeing what to do about this is vital.

Length of the session – so far, families seem to like shorter, more frequent sessions. On the Zoom platform, unless you pay for longer sessions, the call 'times out' after 40 minutes, which may be enough for many families and therapists because the concentration required with video is different to that in the room; or you might use the 40 minutes then have a break and team discussion, then reconnect, if necessary.

Drawing and mapping activities – if you usually draw in a session, how might you continue to do so and share your positioning-compass, genogram or whatever with the family, as you proceed? This can be done by simply holding what you have made up to the screen or via 'share screen' if using Zoom. Therapists and families might want to put together a therapy-session box where they keep their own materials, like toys and drawing tools.

How reflecting team conversations might be managed

Family therapists are used to working in teams, whether the team is in the room or behind the screen. Working over video affords the same environment. Social distancing can be achieved by the team each joining via separate screens, and sitting with microphones muted while the family talk with the lead therapist. Then, the reflecting team can talk while the family are muted and listening.

Using Whatsapp to communicate between team members has emerged as helpful. As we sit with microphones and cameras muted, watching and listening to the therapist talk to the family, we have been sending messages via Whatsapp – make short comments on what has been noticed and what we have wondered. We've played around with whether the therapist in the room should read the Whatsapp chain, a bit like having an old fashioned bug in the ear to know something of what is going on from behind the screen.

Topics that have been common in systemic sessions as the pandemic unfolds

- How to address children's worries about the virus – being realistic and hopeful, utilising the many videos, social stories and guides that have been published in recent days
- How to manage when it gets emotionally hot at home
- Building safety and attachment at a time full of fear, loss and disconnection
- Managing teens who don't want to stay in
- Having life and death conversations and talking about advance decision-making.
- What people want to happen if they get very sick
- Getting children to work now that schools are closed
- Enjoying family time (dealing with feelings of guilt about enjoying this time)
- Keeping safe in family situations that are not safe
- Managing issues to do with alcohol and drug consumption, access to illicit drugs or sex
- Dealing with illness in those far away – ways of keeping connected
- Activities outside the house taking account of physical distancing – for example, walking, running or having picnics
- Resetting family rules about chores, screen time etc.
- Contact between parents and non-resident children
- Supporting the facilitation of contact between children in care and families: most contact centres have shut and local authorities are working very hard to find ways of maintaining contact between children and parents.
- Addressing the letter and the spirit of the government lockdown instructions – is it OK to leave the house twice a day if that means a family are less likely to collapse? Or can an older person only walk for ten minutes?
- Giving each other a break, being kind.

Recordings sessions

Recording our work when communicating via video needs ongoing discussion. We are in the most part used to being in control of making the recording, and now families might have the possibility to record. Different video platforms have different settings regarding who can record. Even if there has been careful prior agreement about why the sessions are to be recorded, this can often be forgotten about and needs further discussion about how and why the recording is being made (this will differ for different actors), how the recording will be stored and who it will be shared with.

The benefits of having a recording are many. Having a recording of the session might be very helpful for patients with additional needs, those who want or need time to process the information discussed or who want to share a session with a person who could not join. It will of course also help if the therapist, whether trainee or qualified, has naturally occurring material that they can discuss during supervision.

Sending therapeutic letters by email has so far proven useful and well received as a way of recording some reflections and ideas for sessions. It also serves to show that we are keeping people in mind between the contacts. Some teenagers have asked for a list of questions in advance of a video conversation,

which takes some careful and tentative planning. Over the past weeks, our trusts have swiftly issued governance guidelines to ensure that confidentiality and safety can be maintained while working remotely.

Looking after ourselves

COVID-19 is a personal as well as a global challenge. Many of us will be affected as we or those we love become ill. It is vital that we look after ourselves, and supervision is a key part of this. Giving and receiving supervision via video link is very common and generally effective (Pennington, Patton *et al.*, 2003). Working remotely seems much more exhausting, partly because of the new and anxiety-filled context and partly because we lack the embodied, intra-active, felt experience of the other, on which we rely so heavily. We will need to develop ways of bringing to language this aspect of our practice and of giving voice to our behind-the-remote-screen feelings.

Further steps in making remote ways of working work

As experts in patterns of communication, we already know that the frame of the conversation will affect how we present ourselves (Goffman, 1956). We know that all communication is a complex social interaction that is particularly intense in the doctor/therapist -relationship (Iedema *et al.*, 2019). When our usual channels of information change, there will undoubtedly be miscommunication and misattunement. We already work with feedback, and we are used to reviewing and revising and checking back. These well-honed skills will be crucial in this time of rapid change.

We don't yet know what the mental health and relational implications of COVID-19 will be. A recent review by the National Elf Service (2020) unsurprisingly suggests that quarantine can have a range of negative impacts on mental health. We know from our own lives that anxiety has increased as our world temporarily closes in, as exams are cancelled, as routine health appointments are postponed, as we can't get to see or indeed hug those we hold dear. We don't yet know whether mental health service use will increase, remain static or decrease as the pandemic evolves. We don't know if family communications problems will intensify or whether, in this time of crisis, people will find different ways of being with each other and managing strong emotions. There are anecdotal newspaper reports that domestic violence is increasing. It seems likely that where there was risk before, this will still be present. Above all, we need to ensure that ordinary distress in the face of this extraordinary situation does not get pathologised.

We don't yet know how families will cope with online service delivery. Not all therapists or patients will find a fit with online therapeutic intervention. Issues of high risk, dissociation, and difficulties using technology are just some of the known barriers. This list will undoubtedly be refined in coming weeks and months. Likewise, we can't yet know what the clinical, practical and ethical issues of working in this new way will be. It is equally possible that some patients, including families and groups from more marginalised communities, or those where there is a person with an autism spectrum condition, might even find online access more flexible and indeed beneficial (Benford & Standen, 2009).

Not all families will want to engage in remote video sessions. Despite the barrier of the screen, an unusual intimacy can be experienced which leads to conversations feeling 'too' intense, leading to a switch to just using audio channels. Again, regular discussion of what is working and what is tricky is vital.

An online way of working will rapidly become ordinary practice. For psychotherapeutic services and specifically within the systemic discipline, future trainees will be taught about the ethics and practice of using telehealth care to provide systemic psychotherapy training and service delivery. Current trainees and clinicians are therefore at the forefront of developing models of what works safely. This new way of working will have a huge impact for the future, for research and practice.

Coda

In the past two weeks we have been amazed at community, at the ways in which professionals have shared, pulled together, looked out for and looked after each other. We have also become aware of how people have such individual ways of coping in a crisis and how fear can lead to certainty and a need for control. Despite our love of the not-knowing and the tentative, there are times when we all want to know what to do and how to be. It is very hard to remain curious, to breathe, to step back and step away in order to keep going. And doing these things will certainly help. Stay well and stay safe. Physical distancing does not mean that you can't make contact and connection. Be creative and look after yourselves and each other.

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