Key skills for developing a strong therapeutic alliance in videotherapy

Extracted from:

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TABLE 1 Key skills for developing a strong therapeutic alliance in videotherapy

Key skills for developing a strong therapeutic alliance in videotherapy	Key reference
Providing a rationale for videotherapy: When explaining the transition to virtual sessions, psychotherapists can introduce videotherapy as part of their overarching commitment to provide the highest quality individualised, secure psychotherapy care. This can either be discussed in-person, or via email or telephone.	
Technical induction to videotherapy: Some clients will need to be 'walked through' the technology first, as a means of building confidence with the videoconferencing platforms being used. Contingency plans should also be put in place, so that a secondary videoconferencing platform and/or telephone can be utilised when any difficulties arise. Therapists can also briefly describe the security and confidentiality standards associated with the platform, and provide an opportunity for clients to express any concerns or ask questions. Time should also be provided within sessions for questions regarding the use of videoconferencing. Provision of a short information sheet with simple details on getting the most out of videotherapy, can provide reassurance and allay anxieties.	
Therapeutic induction to videotherapy: Where possible, offer an in-person session prior to starting videotherapy in order to allay concerns and initiate rapport—It should be noted that in reality this option is generally only taken up by a minority of clients. Information sheets (and Consent forms) can be provided in advance to explain the process and provide back-up forms of contact in case of technology or internet failure.	(Bischoff, Hollist, Smith, & Flack, 2004; Manchanda & McLaren, 1998).
Risk management: A collaborative risk-management plan should be developed and put in writing to ensure that steps are in place for ensuring patient safety. This may include changes associated with steps needed to organise hospitalisation in the case of suicidality or medical instability (e.g., in severe eating disorders and substance misuse). It may also include making sure that the client is in a safe space during the videotherapy session (e.g., not in a situation of acute domestic violence risk that may be triggered by the session)	
Communication enhancement (human): Expression of empathy and warmth can be conveyed more 'actively' through more regular checking-in to facilitate attunement to clients' emotional responses; 'leaning in' to the screen, intentionally using body posture, facial expressions, voice tone and body gestures. The dialogue can be slowed down through increased paraphrasing, summarising, and turn-taking. Therapists may also enquire more regularly to elucidate meanings associated with facial expressions and body movements/position.	(Bischoff, Hollist, Smith, & Flack, 2004; Himle et al., 2006; Lozano et al., 2015; Richardson, 2012; Simpson, 2009; Simpson, Richardson, & Reid, 2016; Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010).
Communication enhancement (technology): Exploration of feelings of safety and intimacy associated with location and size of self-other images on the screen, level of eye-contact, and experimenting with sitting closer to or further from the camera. For example, by placing the picture of the client in the top half of their screen near to the camera, it may be easier to create an experience of 'virtual eye contact', thus creating a greater sense of connection. Clients who find connection and intimacy confronting can be encouraged to 'play' with the technology, to experiment with size and location of images and sound, and to zoom the therapist in and out, in order to develop a sense of internal comfort and connection	(Simpson & Francesco, 2020)
Therapists can monitor and adjust their verbal and nonverbal responses through self-monitoring via the 'P in P' function (i.e., the self-image that appears on the screen). Clients can also utilise this function to attain valuable information regarding their own communication, or it can be switch off if preferred.	(Bouchard et al., 2004)
Sharing control: Clients have been reported to be more active in videoconference sessions, which may be linked to the democratising effect of being situated in their own 'territory' with responsibility for their own remote control and screen	(Day & Schneider, 2002; Simpson et al., 2003).
Maintaining boundaries: Maintain therapeutic boundaries through (1) establishing a therapeutic contract, clarifying time and financial and confidentiality commitments; (2) not accepting social media invitations from clients and maintaining a professional tone and manner in both video- and text based (e.g., emails and SMS) engagements; (3) where possible, maintaining consistency and predictability by keeping sessions to a regular time and ensuring that they begin on-time;	(Simpson, Richardson, & Reid, 2016)

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TABLE 1 (Continued)

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(4) dressing professionally, as in an in-person setting; (5) ensuring sessions take place in a private space, with minimal background noise.	
Session preparation: Therapists tend to spend more time in preparation for videoconferencing sessions, which may play a role in enhancing quality and effectiveness.	(e.g., Richardson, 2012; Simpson, Deans, & Brebner, 2001)
Advanced skills: Once psychotherapists develop a preliminary level of competence with the technology, videotherapy can offer multifarious opportunities for working and connecting in creative ways, such as through uploading drawings or using the 'whiteboard' facility to develop collaborative formulations and can even be adapted for experiential techniques such as chairwork and imagery rescripting. Further, incorporating avatar technology into videotherapy can provide a blank canvas or 'virtual world', which provides a setting through which client and therapist can co-create and connect. This provides further opportunity for therapist and client to deepen their understanding of the client's inner world	(e.g., Simpson & Francesco, 2020)
COVID-specific etiquette: There is a COVID-specific etiquette emerging, or at least an etiquette necessary in these unusual conditions to support privacy for client and therapist. Most of our clients are in self-isolation at home, with other family or household members sharing a confined space throughout the day making physical privacy during sessions unrealistic.	
Creating a therapeutic space: Clients working from home may need to develop a sense of separation from their 'workspace' whilst engaging in their therapy session. If a laptop or telephone is being used, suggest moving from the home office to another location, to create a more personal therapeutic space. Conversely, therapists working from home may need to ensure a sense of being in a 'workspace' at home that is separate from their personal or family space. Clients undertaking sessions from work, for examples, frontline healthworkers who may undertake videotherapy from a hospital setting, should be encouraged to ensure that access to the telehealth technology is in a private, bookable space to ensure that work does not impinge on the session, and that they are free to undertake the session without the wearing of a face mask. It may also be helpful to ensure that the session occurs at the end of a shift rather than during a shift-break given the potential for a session to be distressing.	
Privacy: The mute function can assist in maintaining privacy by blocking out background conversations or noise. Both therapists and clients can be encouraged to use headphones or earplugs to ensure that other family members cannot overhear or impinge on the therapeutic conversation. App-based artificial backdrops provide protection against seeing each other's homes, particularly when the only feasible space for a session is in a bedroom or other private space. This can operate functionally to screen out the home environment but may also be a form of self-expression through the images chosen.	(Lustgarten, Garrison, Sinnard, & Flynn, 2020).
Social scheduling: Where possible, sessions can be timed to take place during periods of reduced demands around childcare (e.g., evening clinics).	(Lustgarten, Garrison, Sinnard, & Flynn, 2020).
Security: Psychotherapists turning to videotherapy for the first time, or using it for the first time from home, should familiarise themselves with the security settings within their videoconferencing platform, to ensure that calls are secure, confidential and password protected.	(Lustgarten, Garrison, Sinnard, & Flynn, 2020).
Therapist self-care: Supervision via videotherapy is a critical part of providing a therapeutic service at this time. Unusually, both therapist and client are experiencing the COVID pandemic which affords potentially greater opportunities for empathy but also potentially for boundary violations. "Zoom fatigue" has recently entered into our lexicon. Already we are recognising that there is an additional cognitive load of interacting through virtual means for extended periods. It is important that therapists build in breaks to their videotherapy sessions to minimise burnout	(Sander & Bauman, 2020)