

# Considerations, Tips and Thoughts on Video Sessions for Clinicians

## Initial Technological Connecting:

- Always test the connection before the session. My rule is to test 10 minutes before the session: test the link/app, the microphone, and the camera. This leaves enough time to solve any issues.
- If the microphone on the computer doesn't sound great, you can always switch to using the phone for audio (make sure to turn off the audio on the Zoom/app controls- if you are using the phone and have the computer audio on, you will have echo/feedback.). You can do this at any time during the session, if they audio is poor. You can also cut the video and just go to audio if your video is poor/freezing.

## Professionalism

While it could be argued that dress codes, name tags, white coats and titles are all part of enforcing a patriarchal, hierarchical structure, the potential good behind all of these things are that they are proxy indicators for competence, which inspires confidence from those we are serving. Confidence is super important, because it is part of what helps others take our recommendations to heart and is partially responsible for the initial improvements we see after just one therapy session\*.

**Competence**, or the confidence it inspires, is only part of the clinician effectiveness equation, but it is an important one. To that end, if you are at home:

- For the video session, dress in accordance with your organization's dress code, and how you would normally dress in the clinic (at least from the waist up!)
- Test the camera to see how the background looks and adjust accordingly to convey a professional image. We want our background to look like our office would for the patient- no stacked boxes, old movie posters, or untidy counters; avoid showing things in the background that would be distracting or bring attention to you- no Avengers memorabilia ☺. If you'd rather use a virtual background, you can use a photo, (so if you take a picture of your office, you can use it!)

## Initial Therapeutic Connecting

- **Set the foundation:** 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 looking at anything else on your computer, your phone, paperwork, or anything else that draws attention. For sure avoid typing! This would not have been the first bullet if I didn't struggle with this myself; my own attention span has shortened considerably over the last decade, as most of ours has, and I find I have to be very purposeful and willful to stay singularly focused when I am on conference calls, or video calls. One on one video calls are a bit easier, as I am 50% of the interaction, however, I still have to bring myself back to the present at times.
- **Demonstrate attentiveness to other's comfort:** When someone is with us physically, we can assume it was a time that worked for them, and that they are alone. For the video session, it is important to begin by asking if this is still a good time to talk and if they are comfortable. Asking whether they feel they have sufficient privacy is important too.
- **Normalize:** Initiate a conversation about the experience and process of the video session. A good start is to ask what experiences they might have had previously in talking on video. Many people might have had experience with FaceTime, or Skype, and might already have feelings and opinions about it, positive, negative, or both. We can say something like: 'I know it is a bit different, for us to engage in therapy/counseling this way. It can feel pretty odd. What are your thoughts, questions or concerns?' We can also check in at the end, to ask about the experience was for them; what could be done next time differently, to improve the experience, etc.

## Clinical Considerations:

- Remember to **obtain verbal consent** at the beginning of the session (unless your organizations has already integrated virtual sessions into the Consent to Treat, or staff has obtained verbal consent and documented it). Make sure to document this in the EHR. For phrasing for verbal consent, see the 'Nuts and Bolts of Virtual Sessions' document

- **Emergencies:** It may seem like handling emergencies virtually is much different from handling them in person, but it is actually very much the same. Even when someone is in our office/clinic, if they indicate they are acutely suicidal, and our lethality assessment is high (re: with a plan, and with means, history of attempts, etc.) they have to essentially agree to emergency services; if they don't, when the crisis team/police, etc. come to the clinic, our patient will just say they do not feel suicidal, that they are 'fine' now. Much of the work we do when we assess someone as high lethality/risk, is to elicit motivation for them to be hospitalized; we might call it involuntary, but it rarely is: since the information used to commit them comes from them, they have control over whether this happens or not (the exception obviously being someone who is floridly psychotic)

Understanding this, our response virtually to suicidality is essentially the same. We work with them to get a family member on the video, or permission for us to call a family member or friend, we talk to them about hospitalization, we ask them to confirm they are at home if we are calling emergency services to their house, etc.

- **Assessment:** Because almost 100% of the information we use to assess, diagnose, and treat people comes from their self-disclosures, our services are actually less different when delivered virtually, than, for example, medical providers. We've always had to elicit information from patients verbally. What is different, is that because people won't disclose important, or accurate, information if they don't feel we are competent, trustworthy and caring, we likely have to work a bit harder to establish that virtually, especially if it is a first visit.
- **Eye contact:** This is likely something we have already experienced, in Skyping or FaceTiming with family or friends: not breaking eye contact for minutes on end feels like a protracted staring contest! It is one of the reasons why some people feel more nervous on video than in person. When we are with others in person, eye contact is broken many times during conversations, even very connected ones. This happens naturally, so we likely aren't conscious of it. We can purposefully engage in breaking eye contact on video too, to make the conversation feel more natural. Usually the person talking breaks the eye contact, while the person listening continues to keep focused on the other's face. When I am talking, I might look up in thought, down in concentrations, to the side as I'm looking for words. It is likely that other person will pick this up, unconsciously, and

begin mirroring this behavior when they are talking, helping the conversation feel more familiar and natural.

- **Projection (no, not that kind 😊):** For those of you who have been in training videos (or were theatre kids), you know that we have to talk a bit louder, animate our face a bit more, and gesture a little more empathically, to get close to conveying what we would in-person. Some video experts estimate that it is about a 15% increase, to mimic in-person conversation conventions....so up your voice projection, facial expressions and gestures a bit, not too much!

For more detail on these and other empathic communication strategies, see [www.emorrisonconsulting.com](http://www.emorrisonconsulting.com), under the [resources](#) tab.

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