Utilizing remote technology in managing self-harm and suicidality with refugee trauma clients

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STARTTS Clinical Master Class

My background and current work…

- Counselling in private practice –relationships, chronic or terminal illnesses, palliative care, bereavement incl. through suicide. Previously AOD and gambling addictions as well
- Supervision of practitioners and supervisors
- Training and consultancy for phone and internet based services mostly NFP
- Managing teams in not for profit agencies
- Quality auditing of welfare and NFP services
- Lecturing at different unis/colleges for Bachelors and Masters of Counselling, Psychology and Social Work courses
- Books and chapters in other books about telephone counselling

Identifying clients at risk- no different to f2f

- How well do you already know the person? This might impact your decisions
- If in doubt, err on the side of assuming at risk
- Feeling hopeless e.g. “I just can’t see a way out”
- Feeling helpless e.g. “Nothing’s working and things are completely out of my control”
- Feeling disconnected, isolated or alone
- Displaying apathy e.g. “I just don’t care about anything anymore”
- Displaying rage, anger and/or talking about seeking revenge

And more…

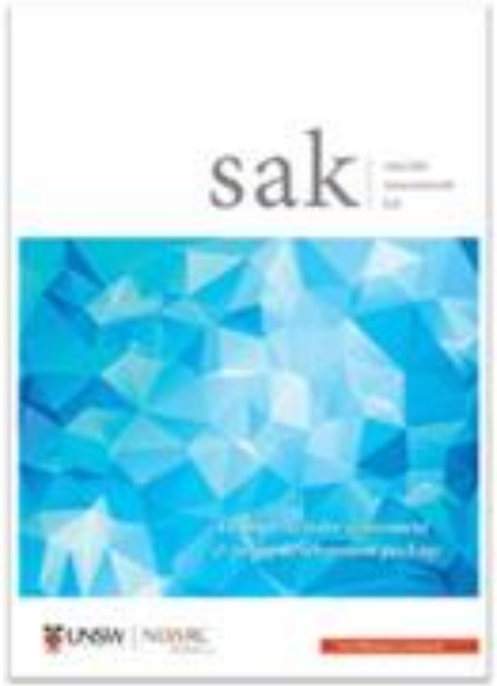
- Impending court hearing or legal proceedings
- Acting recklessly or engaging in risky activities
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Reporting anxiety, agitation, being unable to sleep or sleeping all the time
- Dramatic changes in mood, sometimes to more positive states of mind
- No reason for living, no sense of purpose in life
- Loss of interest and pleasure in all things
- Giving away possessions
- Self-injury

Suicide Prevention

Create a safety contract if you can, in which the client agrees not to kill themselves, trying instead to do some agreed activity to source support or to keep themselves safe

- In a f2f session you might keep the client in your room while you call for emergency support
- In other modes you clearly cannot physically shut the door but you can try to persuade them to allow you to contact an emergency contact or someone else to come to be with them
- If your contract with the client states you can break confidentiality for such purposes without their permission, then you must do so
- Once you have sought help and know it is on its way, you can continue to talk with the client if they are still engaged or, if they break contact, know you have done all you can in your professional boundaries

Suicide risk screeners



Download the complete Suicide Assessment Kit

- Many screeners- free to download and use
- With interpreters, ensure they know before you present them with this what is the nature of the work you are doing
- Remember a screener is not an exact science- it can only be as effective as the client wishes it to be- use your skills and expertise to work out a client's risk and let the documents confirm or guide you

Simple assessment – just ask

Whether on the phone or videoconference if you sense that the client is at risk you must ask directly using words that are clear to the client:

- Do you have a plan to kill yourself?

If the client has no intention they will respond with something like: ‘no, I would not leave my …..’

Or they might say they have thought about it, in which case you ask further questions such as:

- How are you thinking of killing yourself?
- When are you planning to kill yourself?
- Where are you planning to kill yourself?

Simple is effective and not overwhelming for a potentially agitated client

Listen and hear

Practitioner voice and body language

If you become aware a client is potentially suicidal or at risk of self-harm:

- **On the phone** keep your voice calm, warm and firm- you need to sound like you know what you are doing and that can inspire the client to feel safer and less vulnerable or to be less inclined to act
- **On video** be aware of your movements- hold eye contact or look at the camera so if the client looks up they see you looking at them with 100% attention
- **In both modes** let the client know you are making notes of what is being discussed as you have a duty (do you?) to report if you believe they could act further – on video glancing down to write bullet point notes is fine, but not long essays

Client voice and body language

- On videoconference you have some idea if the words match the body language and this can guide how you act but by phone it is much trickier
- How well do you know them? What is their ‘usual’ voice tone and pitch and speed of talking?
- If you do not know them, are their words matching their voice tone and expression?
- Are they agitated or flat? Does this change if you change topic?
- Are they coherent and telling a narrative or are they jumping about?
- What kinds of words do they use? Is this consistent?
- Are they responding to you as you would expect?

Practitioners' fears and beliefs

- Explore your own fears or beliefs about suicide – be clear about what is your 'stuff' and what is not. If these get in the way you will experience countertransference and be pre-occupied with that instead of serving the client's needs
- Or, worse, you will project your beliefs onto the client – indicated by:
- Clients say they are feeling 'guilty' for mentioning suicide
- Clients wish to end the session abruptly
- Clients disengage from the service

Transference and countertransference in remote modes

- NO difference to face to face if you are skilled at using the modes and are self aware
- Think how you detect transference and countertransference f2f- why would it be different using videoconferencing?
- On the phone you have to work much harder to have a skilled therapy session. There is no difference to how you might experience countertransference
- Transference manifests similarly to f2f so if you have clear boundaries eg about your availability, your role with the client and if you hear the client's emotions clearly and challenge inappropriate expression, then you are as aware as you can be of their transference

Practitioner confidence

- Practitioners sometimes report that when there is no visual contact they second guess themselves, particularly if they do not have a well-established relationship with the client
- Practitioners who have not received *specific training* in using phone or videoconference platforms for counselling, report feeling less comfortable with the modes in order to develop an effective online therapeutic alliance
- A hypervigilant or anxious client will ‘sense’ practitioner hesitation or discomfort without knowing what exactly they are sensing- can lead to lack of confidence in the practitioner or to the client making incorrect assumptions about their own mental health

Phone and videoconference are equally effective as long as…

- The practitioner is confident in all three modes, f2f, phone and videoconference
- The practitioner is self aware and self reflective
- The practitioner has been trained in all three modes
- Their supervisor also has experience of the three modes

- Often the phone is the least ‘comfortable’ mode because practitioners feel hampered by the lack of visual cues- if this applies to you, don’t use it for therapy

How times have changed!

- Phone in 1993

‘Telephone counselling cannot be considered true counselling as there is no eye contact and physical presence’ correspondence with British Association for Counselling and Psychotherapy

- Internet counselling started a few years later and the phone was somewhat sidelined- no more concerns about validity of counselling!
- Privacy - end to end encryption is enough in Australia and Zoom, WhatsApp and Messenger all provide this. WeChat does not use this so always check the app status before engaging if privacy is a concern

Phone and internet work: common challenges– and opportunities

Poor connections

Background noises- interruptions, safety, confidentiality

Location for the session

Unclear boundaries – must be clear, expressed and held

Leaving the session

Emergency contact verification- are phone and email sufficient?

Intake assessment challenges

Interpreters should be in same mode if possible

Is all admin electronic? Privacy and client data

Leaving the ‘room’

- Phone and videoconference counselling have the disadvantage that when the session ends the client does not have to physically leave and travel somewhere else and re-engage with their life
- If you deem that a client is not at risk as the session ends, it is important to finish the session in an ‘up’ phase – no long summaries of all the discussion points, reinforce any goals *gently*
- Set/reinforce clear boundaries for future contact or between session contact
- Reiterate the safety plan as the final thing that they leave with

Helping clients

- Phone and internet work often require more directive interventions than face to face – ask the direct questions and be prepared to provide follow up referrals or advocacy as appropriate
- Informed consent is essential before the first session to avoid practitioner challenges later on
- Safety plans or contracts developed in a phone or internet session must be provided to the client as soon as the session ends – text or email or…?
- Confirmation of receipt and agreement of contracts or plans (signed or oral confirmation or..?) must be obtained for practitioner records and to demonstrate the 'seriousness' with which the practitioner is taking the sessions – can be reassuring for client
- Contact emergency contact with the knowledge, if not consent, of the client
- Follow up with client as agreed in plan/contract

Modalities online and by phone

- Person centred focus so the client feels important, validated and valued
- Rogers' unconditional positive regard, empathy and congruence are really important
- Allow lots of narrative processing if they wish to talk
- Do not 'teach' though on video you can share screen with some material if you wish; phone you have to talk it all through in a non-psychoeducation way

- The most successful phone sessions are those that seem to the client to be like a 'chat'- they are not as simple as a chat for the practitioner!

Practitioner support- BSR

- Breathers many small things that can be done daily whenever a stressful situation is encountered – a mindful focussed quick something eg breathing exercises, a scream (into a pillow?!), a short walk
- Sustainers may require planning but are a longer term 'build' for resilience eg social activities with friends, gardening, writing about your feelings, visiting a place that is special for you or is different from usual
- Restorers Supervision!!!!!! your own therapy, meditation, spiritual beliefs and rituals, yoga, regular massage
- 'Breathers and Sustainers fill our cup from outside while Restorers fill our cup from within'

Phone and videoconference are here to stay!

- COVID-19 has advanced practitioner use of different technologies far quicker than would have otherwise happened
- Not every practitioner is effective in all modes
- Do not work in a mode that doesn't fit with you – you will be more likely to misinterpret or overreact to situations
- The phone is the most tricky mode of all – lack of visuals requires different kinds of listening and focus from the practitioner
- Seek training to be effective in phone and videoconference- using these for therapeutic purposes is very different from using them for social activities

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