My Tele Health story with comments on technology and tips for practitioners

Jo Grimwade

Preamble

Soon after completing my honours in psychology in 1979, I was appointed to the role of Psychologist, Grade 1, at the Telecom Australia Research Laboratories. My task was to use social psychological experimental method to try to understand what might be causing on a lower rate of uptake of teleconferencing technology in industry. There began forty years of experience in working with teleconferencing and its many technologies and devices. I was in this role for fifteen months and then moved to clinical Master's studies. I was back at the Research Laboratories at the end of the year doing a study of blind users of telephone teleconferencing and how it added to enjoyment in their lives.

The experiments involved corralling six participants into group problem-solving tasks that were relatively easy, moderately easy, and very difficult. The participants would be in one of three technological arrangements: connected by telephone only, or in two sub-groups of three, connected by audio only or video and audio. The aim was to discern the factors that were disturbing or enhancing levels of communication. The design was complex, and the number of groups was insufficient to demonstrate an effect, but I also kept notes of the interactions.

Ultimately, the experiment was designed to understand the psychological factors that might make teleconferencing a less attractive alternative to face-to-face meeting. I studied the available literature and it was hypothesized by some that the lower level of non-verbal exchange lowered the effectiveness and/or reduced comfort with the technology. A sociological explanation was that travelling to another city for a face-to-face meeting had many perks associated with it regarding accommodation, meals, other activities, or just the opportunity for unhappy spouses to be away from home. Back then, it was already clear that teleconferencing, whether by multiple telephones or by conference room to conference room, was cheaper than having many of the meeting travel to a shared location.

One of the great privileges of that year was to participate in an international teleconference involving sixteen countries and forty sites, world-wide. The video was black and white and slow-screen. Slow screen video is transmitted line by line such that the image is built up by a spot of light travelling slowly across the monitor and replacing the previous image with the new image. Each new screen took about five minutes to complete, while the former image slowly was replaced at the top and disappeared at the bottom of the screen.

Each place was invited to display what might ordinarily be happening in their home country at the time of the conference. Generated from the USA, we could see afternoon tea and in the UK we could see morning tea. In Japan there was a huge number of business suits sitting in neat rows, with the speakers down the front having cups of tea. The twelve or so Australians in a similar time zone (12 midnight) to the Japanese were drinking red wine on this Friday night! There were talks given from various sites, all of which acknowledged the momentousness of the occasion and reported what their site was doing in teleconferencing research. These were almost all technological discussions, but one UK site and the Melbourne site reported on psychological research. It was momentous! But nothing world shaking was reported; it was the event itself.

One of the phenomena I noticed in our group was the focus on the screen and how the international images of each site were slowly constructed in front of us. It was the screen that seemed to be most important. I reflected upon this and noticed the same phenomenon

in the group to group experimental conferences. Those in the telephone conferences would report sort of network of connections in their mind and allocated places to each of the voices which did not bear any connection to the physical location, unless a Research Lab participant knew the actual location of another Lab participant in the building. In the sub-group conferences, the attention of the participants went toward the other conference room at the cost of using local group members to solve the puzzles. I came to call this end-stuck. This phenomenon reduced the size of the group to a maximum of four at any one time reduced effectiveness for the difficult task, but facilitated effectiveness for the simple task. This was an experiential observation not an empirical finding, as the *n* was too small.

When I studied the group of blind people, who were facilitated by a very warm and gracious Social Worker, using telephone conferencing, this same phenomenon was on show. The participants would say that they had become better listeners than talkers when using the technology: that is, they wanted to get from the conference the thoughts of others. This had the effect of sometimes there being no speaking at all and required the Social Worker to direct questions to specific persons to encourage speaking.

For this project, I had use of a portable telephone conferencing “bridge” borrowed from my former Telecom colleagues. “Bridge” was to me a rather strange metaphor for a piece of multi-port telecommunications electronics. The highlight of this project was bringing together my wife’s mother’s surviving siblings together online for their last ever meeting, prior to Christmas, 1983. The surviving uncle got frustrated with his sisters all talking at once and left abruptly. The one remaining employed person had to leave to attend to her business. But the four others chatted on for an extended period; I left, as did my wife, and they continued for an unknown period of time. Some took to the multi-voice chatter with ease, while others found the whole event confusing and exhausting.

At Deakin University, I helped set up telephone tutorials for remote students and presented to the International Distance Education conference at La Trobe University (Grimwade, 1985). I had already moved to work as a clinical child psychologist, but this set of experiences seemed to be relevant from time to time.

When I worked in Albury Wodonga, I had occasion to use telephone conferencing and wanted to have supervision by video conferencing from Melbourne or Sydney, but the costs were prohibitive. Similarly, when I worked in Adelaide and travelled to the Riverland, my suggestion to teleconference was rejected on the grounds of cost of the technology, even though I could demonstrate that the costs of travel, time, and accommodation exceeded quite quickly the costs of purchasing the technology.

In 1992, back in Melbourne, an international child mental health forum occurred using telephone conferencing and I was asked to chair. The quality of the audio was not the best. Speakers were in two places in the UK, two places in the USA, and another in Sydney, with the discussion being led off by two Melbourne speakers in the hall of Queen’s College to an audience of seventy or so mental health professionals. This was the first teleconference experience for nearly all of the participants and the audience was very quiet and focussed very closely. Afterward, one of the audience observed how extraordinary the event was and how exhausted he was as he strained to get the most out of what each of the remote participants offerred. Super end-stuck, was my thought.

Occasionally, opportunities arose to teleconference, and sometimes I would provide secondary consultation by teleconference, but usually not video conferencing. At Victoria University, where I taught in the clinical Master’s program, my suggestions for technological

innovation usually did not result in application. However, I encouraged students to try to use the technology.

When Professor and Head of Clinical Services at the Cairnmillar Institute, I advocated the use of video teleconferencing as a means to enable expansion of services, while keeping remote clinicians in contact with the central clinic. Cost again was cited to put aside any such program, but Skype now existed. A technologically sophisticated client moved to rural Victoria and he insisted on being seen by Skype and we eventually presented on this work at a Rural and Remote mental health conference in Geelong (Grimwade & Holborn, 2013).

After seven years, I left the Cairnmillar Institute having recently started to use Zoom. I moved to work with an Aboriginal service in Alice Springs and took to using the medium for continuing clinical work with previous clients.

On return to Melbourne, a new mental health service, *Call to Mind,* had started and I was one of the first psychologists to regularly see rurally based people across Australia (*Call to Mind* used *Anywhere, Anytime* to videoconference, but then switched to *Coviu*). The psychology program with *Call to Mind*, did not succeed and so I took my online clients into my private practice. It was clear that the clinicians did not really know how to work online, and there were several clients I picked up who had begun with other psychologists or psychiatrists.

Now, in the time of the coronavirus, online skilfulness is much needed, but I am unsure if those teaching online counselling understand the medium and its subtleties. I have read research and, like most psychotherapy research, a positive effect is usually reported (Backhaus, Agha, Maglione, Repp, Ross, Zuest, Rice-Thorp, Lohr, & Thorp, 2012; Henry, Block, Ciesla, McGowan, & Vozenilek, 2017; Mohr, Burns, Schueller, Clarke, & Klinkman, 2013; Norwood, Moghaddam, Malins, & Sabin-Farrell, 2018; and Simpson & Reid, 2014). But much of the research focuses upon how technique needs to be adjusted to accommodate to the medium. There is little research that elucidates a couple of phenomena that are more evident online than in person: intensity and intimacy.

Many people starting out will report the effort involved to be much more intense or involving higher energy input. I think this is about having to concentrate on the words and emotions more closely, as other non-verbal signs are absent or limited. But this can be an advantage of being less distracted from the central themes; there is consumer research that highlights how much more business-like teleconferencing can be.

The intimacy has two qualities; being physically closer because of the screen enables closer examination of the face and the words used. Secondly, the lowered levels of distractions due to focus on the screen (end-stuckness, again) facilitates subtler communication with words and facial expression. A third factor has been reported in the literature: that the physical separation of bodies enables a heightened sense of safety (he can't touch me!) and a sense of heightened privacy and confidentiality as the client is so remote from the context of the therapist, what is said can be said with greater frankness.

Intensity and intimacy are resources to be used in videoconferenced psychotherapy that might be unfamiliar to many therapists and may erode surety in the process.

Key points to undertaking Tele Health therapy

The research literature (Backhaus, et al., 2012; Henry, et al., 2017; Mohr, et al., 2013; Norwood, et al., 2018; and Simpson & Reid, 2014) has highlighted that videoconferencing is viable and received well by consumers, but that therapeutic alliance can be felt to be inferior by consumers, but more inferior by therapists. Therapists seem to notice the lack of non-verbal information more than consumers (Simpson & Reid, 2014).

Henry et al. (2017) noted that consumers and therapists did notice differences in pace, content, empathy building, and issues of privacy, but none of these differences led to dissatisfaction. Backhaus, et al. (2012) confirmed that differences of these sorts were perceived, but did not affect outcome, which was usually positive.

- What's missing?

Clearly, a video image of head and shoulders has reduced informational content than presentation in the consulting room. In face to face consultation, we have the opportunity to observe all sorts of subtlety in movement and bodily expression and can watch the client move into and out of the therapy room. Words used can be more easily contextualized within a full presence of the client.

But do these matter? Well, they do matter if the client cannot get online, or simply does not want to get online. Online can be excluding; but for many online allows for inclusion as a genuine option.

- What's possible?

Therapy is possible in a variety of modes and therapeutic orientations. This may be, primarily, a placebo effect: choosing to have therapy in the first place moves the client into a position of seeking whatever might be available in whatever form it is available.

What actually happens in online therapy sessions is constrained by the continuity and quality of the technology. Certain systems malfunction in predictable and unpredictable ways. But the design of the technology in its user interface, in particular, will constrain. Technology is discussed briefly, below, but having used a variety of media, the biggest negative effect is when the delivery system breaks down with lag (audio and/or video) or sudden disconnection. Some systems are more prone to interruptions of these sorts; in which case having a telephone as back-up is useful to continue the session or to guide the client through any re-connection process.

Having frequently used the back-up telephone option, clients often report that having the back-up is not so bad. That is, once contact has been made and the client has begun to explore the issues of greatest relevance, words are enough to sustain the session. With an image of how the client is for today, the therapist can continue, almost undeterred by the break. The client is usually not disturbed; it is the therapist who can be distracted or worried by such interruptions.

At the Aboriginal primary health care service at which I work (*First Peoples' Health and Wellbeing*), the lack of computers in the client community means that online means on telephone (we use *Skype for Business*, because of its privacy options). I have had to do quite complex first sessions with people I have never seen, yet the work can be analogous to that achieved in initial face to face sessions, because the client wants the session. However, I find such work to be more exhausting because of the greater attention needed for the words and their expression.

In short, then anything is possible, but do observe the constraints of a system and a circumstance.

- What's added?

Most people can recall the intimacy attained within a telephone call. Without other distractions, important, deep, emotional issues can be explored with rawness and honesty and the sense that the other is very close and listening with intensity. The telephone provides privacy and confidentiality that enables depth in expression and exploration of feelings and thoughts. This does happen with video conferencing, as well.

Further, technology malfunctions do not have to break such levels of communication, even if the therapist reverts to use of the telephone. As is often the case in any therapy, it is the constraints enacted by the therapist that are often the barrier to deep communication: Freudians use the term countertransference and it can be manifested as technological concern.

It is interesting that a lot of the research into therapeutic videoconferencing has concerned therapeutic alliance. I suspect part of this is because therapeutic alliance has had a lot of interest in face to face therapy over the past thirty years. I think that therapeutic alliance has been so systematized using research protocols, that the utility of the idea has faded. I think I make many TA errors, including too much laughter and not enough eye contact, and not enough repeating of what is said, yet am not sure I have ever worked as well as I do now.

I would ask the timid beginner to trust the fact that clients appreciate that you are available and that being available is much better than nothing or no-one listening.

- Technology choices

Frost (2020) in his recent presentation to an Australian Psychological Society webinar, described the key strengths and weaknesses of nine systems for video conferencing. There are four critical tests of the technology: end to end encryption, peer to peer connection, vendor non-accessibility, and the use of business associate agreements. End to end encryption is the means to ensure confidentiality: should the message be intercepted, it will be unintelligible. Such encryption has the added advantage that voice and image have to travel together and be unencrypted simultaneously. Distortions can still occur with *Zoom* and *Coviu*, but these are reduced by this design criterion.

Peer to peer connection ensures that the message is not intercepted in intelligible form; this is a corollary of encryption and of the privacy that comes with the barring of vendor access. When using *Skype*, for instance, encryption does not occur and every now and then messages appear of another user with contact has been made, is online. That is, other users known to you know when you are online and could know that your client is online, as well. This is undesirable.

Finally, it is better if there is a contract with the technology supplier that sets out conditions of use and the obligations of supplier and user. Such an agreement ensures certainty and security. This is the final criterion of the Health Insurance Portability and Accountability Act (HIPAA) compliance principles adopted in the USA. *Zoom* does not enter into such agreements unless you buy the system that allows for group meetings. *Zoom* is free for one to one consultations. *Coviu* has such agreements and has fees.

Frost (2020) discussed other media: *VSee, Cisco Webex, Face Time, Google Hangouts, WhatsApp*, and *Duo*. Some of the systems have problems with vendor access, and sometimes systems are confined to being Apple only applications. He did not consider

Anywhere, Anytime, as a system designed for health applications, which both *Coviu* and *VSee* are and have virtual waiting rooms. *Coviu* was developed in Australia by *CSIRO*, but is now a separate company. In his own business, Frost uses *Zoom* for group meetings and *Coviu*, for client consultation.

This part of the discussion by Frost (2020) was thoughtful, thorough, and informative. But there was not enough on skilful practice.

- Technology additions

Frost (2020) discussed technological enhancements using webcam with microphone. This can make a difference to quality of image sent, but may not make such a difference to the quality of message received as the client's computer and camera may not be of the same quality. Webcam can be bought for about $200.

The most interesting quality upgrades could be produced by cleansing the camera (the camera is usually located at the point where a laptop if opened and he demonstrated what a good clean could do for image enhancement!). The other enhancement was having a light on the face of the user.

- Further tips

Frost (2020) provided a few tips about where to sit and how much of one is needed to be sent and how close to the screen one should be. Head and shoulders is enough; close up can be threatening. With couples you should encourage them to sit further back so that interaction between them might be noticed, but let the client sit as close as they feel comfortable. This will often be closer than needs be as they will be concerned that you should hear them and that they want to be sure of hearing you!

Frost (20200 also highlighted that many consumers report that videoconferencing can be felt to be rather business-like, initially, and there is less small talk that would otherwise happen to warm the client to the process. Having done many hours of this work, I think small talk does occur, so I expect that the business orientation is a quality more of the therapist than the client. For me, small talk is part of the business as it will reveal current concerns and preparedness to examine important issues.

There is something unfamiliar to the ending of videoconferencing and videoconferencing programs of treatment. Terminating a session can be more difficult. I am not sure why this should be, but think it has to do with the lack of the process of ushering the client out of the consultation room. Between the consultation and the return to usual life in face to face work, there are passages of time and journeys to be undertaken, which can involve reflection by the client. Online therapy ends and the client is back in their usual world. There is no time for reflection and confrontation with partners, children, or the demands of work can be immediate. I think I do spend a little time trying to encourage some departing reflections and trying to prepare the client for the immediacy of what might come next. I think this is necessary.

Similarly, terminations from videoconferencing treatment programs can be rather odd. When we finish, we want to finish and not have to consult with that person again, unless they return with a new problem or a new view of the old problem. I think the remoteness of the client from the therapist is a significant issue here. Because of remoteness, it is likely that a wider brief is taken with client problems than would be taken in the city. Advocacy with local agencies or with Centrelink can be part of the work with remote clients that is never considered in work with local clients in face to face therapy. The role of advocate needs to

be terminated, as well as the role of therapist. The role of “being someone to talk to” needs also to be terminated; of course, this is part of doing therapy, but it can become the sole reason for contact for a lonely, isolated person. It is hard to move out of this position, comfortably.

I have written some notes about therapy with children online and upon the changes in presentation of clients in recent weeks. These are attached.

Much of this will be further researched by more rigorous means than a lifetime of experience, but this is where I have arrived. Trust the client to use the system as best they can. Be prepared to find the task exhausting as you begin. Be open to a level of intensity and intimacy not always achieved in face to face consultation.

References

Backhaus, A., Agha, Z., Maglione, M., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N., Lohr, J., & Thorp, S. (2012). Videoconferencing psychotherapy: a systematic review. *Psychological Services, 9*(2), 111-131.

Clough, B., Ruddell, S., White, A., & Casey, L. (2018). Your therapist is calling. *InPsych, 40* (5),

Frost, A. (2020). *Webinar: Adjusting your practice for COVID-19 Telehealth*. APS Institute, 26 March.

Grimwade, J. (1985). Setting up a system for tele-tutorials. *International Council of Distance Education conference*, Latrobe University, Bundoora.

Grimwade, J. (2020). Self in the time of corona (discussion paper).

Grimwade, J. (2020). Tele Health and kids; challenges not obstacles. Part 1: Starting to think about online child therapy (discussion paper).

Grimwade, J. (2020). Tele Health and kids; challenges not obstacles. Part 2: Puppets, toys, and the play space when online (discussion paper).

Grimwade, J. (2020). Tele Health and kids; challenges not obstacles. Part 3: Therapy cards and drawing games (discussion paper).

Grimwade, J. & Holborn, T. (2013). Some barriers to rural practice for urban Mental Health practitioners can be overcome. *5th Rural and Remote Mental Health Symposium*, October, Geelong.

Henry, B., Block, D., Ciesla, J., McGowan, B., & Vozenilek, J. (2017). Clinician behaviors in telehealth care delivery: a systematic review. *Advances in Health Science Education: Theory and Practice, 22,* 869-888.

Mohr, D. C., Burns, M. N., Schueller, S. M., Clarke, G., & Klinkman, M. (2013). Behavioral intervention technologies: evidence review and recommendations for future research in mental health. *General Hospital Psychiatry, 35*(4), 332-338.

Norwood, C., Moghaddam, N., Malins, S., & Sabin-Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: a systematic review and non-inferiority meta-analysis. *Clinical Psychology & Psychotherapy, 25*(6), 797-808.

Simpson, S. & Reid, C. (2014). Therapeutic alliance in videoconferencing psychotherapy: a review. *Australian Journal of Rural Health, 22*(6), 280-299.

Self in the time of corona

Jo Grimwade

As a clinical psychologist and family therapist, many people have come with viral worries. They want to know how to keep themselves and their families safe. Of course, I am not an authority on such matters, but they do want to be able to talk things through. Mostly, I listen, as is my usual practice.

People of many ages talk with me during my week. The virus is a lens onto their world. Last night, a bookshop manager was speaking about her interstate trip to set up a new store and how the movements were curtailed by the anticipation of closure of state borders. She had taken her mother with her for company and for her mother's chance for a change of scenery. This worked well for a relationship that has been fractious, at times.

This successful woman's concerns were revealed for the first time, or perhaps in the clearest way, to be about stability in her life and in her family's life which stretches from Europe to South America due to the multi-national marriage that brought her into life.

Another person was talking about her anger and her drinking and ended with a realization that maybe the problem of the virus was it exposed her to fears of abandonment. An older man, bereaved in the not too distant past, opened up for the first time about his loneliness and how self-isolation meant loss of all remaining connections. An ADHD young man talked of being restrained by staff as a teenager within a corrective facility.

Current events prompt new versions of longstanding problems. Interestingly, the virus has provided a new lens for seeing a central problem obscured by the familiarity of usual routines and contacts. Suddenly, we can see things from new angles and find new ways to understand the personal distress and how self is experienced.

Everybody who has mental health concerns seems to have heightened fears, worries, and distress. I am working online with video, over the telephone, and, for some who have to go through a sanitizing routine, in the usual consultation room. Some of this work is in my role with First Peoples' Health and Wellbeing. Trauma stories abound; again, these are amplified as lost contacts and the cause of the losses, are approached from a new angle.

In 1980 I was a new graduate working in teleconferencing research for Telecom Australia. I have been teleconferencing across all possible media ever since. One of the things I concluded about teleconferencing was that a certain sort of intimacy could be generated by the medium. The lack of a full picture of the other draws attention to the face and to the words. Deeper listening can occur; closer examination of emotional expression is possible.

All those who are suffering mental health problems are encouraged to continue rather than consider the contact to be second class or a poor imitation. There is something else that can be revealed as the self looks through the prism of coronavirus.

Tele Health and kids; challenges not obstacles

Part 1: Starting to think about online child therapy

Jo Grimwade

The parents were at their tether's end: ten-year-old Warwick ("Wocker the shocker") had pulled a stunt at his next new school. This was the Christian one with calm and compassionate values and a real wish to help disadvantaged students. He had had a bad week, but walking out of class while swearing at a kindly, elderly teacher, was just not sustainable.

The mother had heard of an online video conferencing Tele Health service and this was the day of our first meeting. Dad was out and about but hoped to arrive before the end of the meeting. Mum sat and talked as Warwick sat beside her and seemed engaged by the novelty of the technology. He told me about the things he liked to do and what school was like. He was positive about school and liked to read, but he was distractible and when his mother tried to get him to talk about "the bus" that day, he became angry. I suggested that he might be better doing a drawing for me of the family: which he agreed to do.

Mother and I chatted about his developmental history and the troubles he had had at kindergarten and his three previous schools. Sitting on the floor and remaining still was a challenge he had never mastered, and he had kicked a few kids in his time. Sometimes this was because they had accidentally bumped him, but other times because he did not like the kid or wanted to create trouble so that he could leave the room. There were a number of times when he would be in an altercation and suddenly he would become sort of wild and fight dangerously, which would scare the kids and the staff.

Dad walked in about this time and Warwick cleared off. He would do this; dad thought he was afraid of him, but at other times when they kicked the footy or went to the park he was fine. Father admitted to a bit of a temper when kids did violent things ("I saw too much of that as a kid, myself; but I do know that my response can be a little too strong"). He hated seeing Wocker disrespect his mother by refusing to do things.

I explained that I thought this was ADHD and asked about hyper focus. Father laughed; "you're right, it's amazing, if I walk in front of him while he is playing he does not even seem to notice. Eventually, he will stop when I stand squarely in front of the screen and he will be angry with me. But I am amazed at his concentration, when at most other times he is all over the place. Then, he seems to lose interest in the game; it's like I've broken a spell or something".

We discussed the mechanism of ADHD and how stimulant makes for better focus and suggested they try him on Red Bull. They were reticent, but were willing to try as I had been able to put together the picture unlike anybody else had. Next time, dad was there, and Warwick had had a bad day; "look at this!" He opened a can of Red Bull which Warwick drank willingly. He went out of the room and disrupted his sister and then came back and taunted the dog. After another ten minutes of flitting around and the parents talking with me about several incidents in the past fortnight, father called him over and we discussed the family drawing he had done in the previous session. He was calm and thoughtful. Father beamed: "I didn't really believe you, but how good is this … twenty minutes and he is settled and at his best!". Next task was the diagnosis by a child psychiatrist. I have had word that he is doing well, but I only ever saw him twice.

Video provides a chance to see the child and his behaviour and interaction with others. Video creates a space for close exchange between psychologist, parents, and the child.

Words are more easily focussed upon when the range of stimulation is narrowed by watching a screen. Drawings can be done and displayed and discussed.

Diagnosing ADHD online like this is useful when other means are not possible. One or two sessions can be managed under such circumstances, but can ongoing work be done?

Longer term work is aided by the narrowing of focus by the screen exchange. There is an intimacy created when the link seems fragile. Words are important. Expressions are more visible due to the closeness of the camera.

But what of play-based therapy? I think it is very useful to ask a child what it is that they like to do. Concentrate on what they like. Avoid speaking of what they dislike, initially. See them at their best. In finding out what they like, discuss the toys they like to play with or the ones they used to play with. Ask the child to find five toys they like best. As they go off, you find five toys that you think they may like. Puppets are especially useful as they can speak to the child in different voices.

Drawings can be done at any time to help explain situations or events. Drawings of dreams can be useful. The child then puts the completed picture up to the camera to show what has been done. Parents can be asked to scan pictures and have them sent for the next session.

Parent-child work is very possible using such techniques, but even in talking exchanges with younger children. The closeness of the camera allows for detection of subtle messaging not easily recognized from usual social distances.

The next things I would like to have is interactive drawing on iPads or tablets: child does a few lines, therapist does a few lines and picture is created together. Of course, the squiggle game could be done with interactive technology.

These are just the beginning of exploring the strengths and limitations of the technology, but be ready to be surprised by how the intimacy of the medium creates therapeutic opportunities.

Tele Health and kids; challenges not obstacles

Part 2: Puppets, toys, and the play space when online

Jo Grimwade

When selecting toys for online therapy with children, puppets can be very useful. Having a child help you choose the type of puppet can provide a means to understanding the child's interests and fears. Having a small assembly of finger puppets can provide the child with choice; put one on each finger and ask which one makes sense; have a range of people, animals, and birds among the array. But also have a small range of hand puppets.

Hand puppets can "talk" to each other; left hand to right hand and to the therapist in different voices with different views about things. A conversation with one puppet with the other can argue a point: a conversation of puppet with the child or with the child's favourite toy (Teddy bear, doll, robot ...) can generate much material.

The aim is to bring out central concerns through play. The central concerns can be made available through the therapist's toys which the child has used in the past; but if the child is at home the child can introduce the therapist to his or her favourite toys. The toy can be introduced to a puppet, as well, and the toys reaction to the puppet (joy, fear ...) can be identified.

This is not so different to what happens in therapy, but there is a closeness possible, indeed is necessary, with online work. Puppets can kiss or hug or fight the child's toys. Facial expressions are more obvious.

Not all children use soft toys and puppets as preferred therapy items. Small cars or soldiers or cowboys can be used, but the solitariness of such play is not so easy to interpret. Also, such toy play has a three-dimensional aspect to it that may not easily be captured on video because of the positioning of the camera and the lack of space in front of the computer screen if the computer is on a normal desk with a keyboard in the way. Better to have such play enabled by putting the computer on a table with plenty of play space in front.

Games using building materials (Lego, Meccano, Jenga) have similar problems of dimensionality and will occur without the mutuality of searching for obscure pieces and putting things together, together. These are not suggested as very amenable to online play therapy work.

Mutuality is also a problem for many card games and board games. With board games it would be possible, if this is the preferred mode of the child, to have parallel games in motion where each player moves pieces according to the other player’s moves. However, these games are often not all that appropriate in face to face therapy as the rules and the technology of the game become a focus that precludes focus on the underlying issues.

In the next part of this series, therapy cards and drawing games will be discussed.

Tele Health and kids; challenges not obstacles

Part 3: Therapy cards and drawing games

Jo Grimwade

An array of card packs have been produced to aid Cognitive-Behavioural Therapy and have been taken up by therapists of various therapeutic orientations. The images of emotions and of things to do provide a path for exploration and learning about human interaction. I do not use any such items online or face to face. For me the images are often romanticized or idealized in a way that gets in the way of the child expressing what they really feel, rather than what a card tells them how to look like when they have a particular feeling. These images are static; authentic emotion is dynamic. These images suggest that there are right and wrong emotions or forms of expression.

If cards are to be used, then duplicate packs would need to be had on both sides of the screen. There will need to be sufficient space in front of the screen to manipulate and display the cards. The child may need to be helped by a parent with such materials meaning that confidentiality would be lost. In face to face work, such card use is supported by the therapist interacting with the child as the cards are manipulated. This process of direct support is an important part of play therapy and not being able to provide such direct support may compromise the medium's effectiveness.

Drawings are dynamic, immediate, and generative, but not all children like to draw, especially as they approach teenage hood and drawing skill (or the lack of it) becomes a disincentive to expression using this mode. However, viewing drawings as they happen, and when complete, is difficult online. Holding a drawing up to the screen necessarily hides the child's facial expressions and such expressions are often key to understanding the meaning of a drawing when it is being discussed.

It is suggested that as the picture emerges, the therapist does not try to imagine what is being drawn; it will be upside down in any case. However, comments like "that looks interesting!" and "now you're using red" will enable the child to understand that you have their attention and will not need to check if you are paying attention. When finished, and before being shown on the screen, ask the child to tell you what it is about and who are the people and what are the things in the picture. Then ask to see the picture and look carefully naming the parts that the child had previously pointed out ("I can see the …, and the …"). Then talk with the child about the picture again with the child reviewing their art. This would be the time to produce an interpretation.

Obviously, this procedure would slow down the process of finding meaning, but the meaning is on the paper and in the child's face: these need to be understood, together. Scanning pictures and sending by email allows for the therapist to review post-session, but needs to be done in a way that confidential material is not open to parental observation. This would be tricky in situations of possible abuse or neglect. In such cases, ask the child to place the picture so that a screenshot can be made.

Interactive drawing games will be difficult, but two seem possible. The Squiggle game can be introduced, and the child can be asked if the game can be played next time and could the child make ten potential Squiggles and then send them for the next session. The therapist produces ten Squiggles and sends them. Neither player should look at the Squiggles before the session. Then, in turn, a Squiggle is chosen, and drawing completed.

DW Winnicott invented the Squiggle game in the 1950s. It is not known if the Australian television puppet, Mr Squiggle, arose from Winnicott's work. But the drawer is presented with a non-descript set of a few randomly scribbled lines, by the squiggler. The drawer's task is to turn the lines into a picture of something. Whether the child or the therapist is the squiggler, it is for the child to interpret the picture. The child is encouraged to say what the picture is about and even tell a story about the picture. In face to face therapy, the squiggle and the drawing follow, and this could happen in online work, so long as the squiggles can be easily copied from one side of the screen to the other. In any case, it is better to use simple squiggles, rather than complex ones, as then the drawer is freer to make what they see.

Another interactive online drawing game was developed by Raven in the 1930s, who was very interested in developing tests of children's psychological abilities. His Raven's Progressive Matrices were developed to test for non-verbal intelligence among Australian Aboriginal children. The drawing test has the rather confusing or formidable name of Raven's Continuous Projection. But, really, it is just a story drawing game and does not have to be conducted with psychometric rigour.

Tell the child that this is a drawing game in which a story is told by doing pictures of events during the telling. The aim is to continue to draw and make the story without letting the pencil or pen off the page. This can be varied such that each new image must be connected with what had been done before (this is the "continuous" part).

The story begins as in all nursery rhymes: "once upon a time, there was a …". The child fills in the missing word ("boy", "dog", "mother" …) and starts to draw. The therapist then asks: "what was this … doing?" and the child thinks about this and draws more, adding words as appropriate. The drawing is the "projection" and will reveal the child's concerns. The method can be slow, but can occur over many sessions; stop when the child wants to change games. Ask that the drawing be scanned and sent between sessions.

However, for true interactivity when drawing online, we need someone clever to invent interactive iPad drawing. This may already be possible. There are programs for online interaction using electronic blackboards between several sites. There are many drawing programs for iPads. Anyone who has seen David Hockney's interactive, electronic art will appreciate the possibility. We just need someone to apply the available software to iPads and to enable communication between the tablets while video connection is retained through computer screen.

Interactive drawing is not greatly used in children's therapy. This is partly because the big hands of the therapist would intrude on the small hands of the child and we do not encourage touch between therapist and child. But, with extra lines suddenly appearing on a screen, a new sort of therapeutic exchange would be possible. Even without such direct interactivity, having Squiggle games or Raven's projection appear in front of us would enable live commentary.

Does any play therapist have a software engineer as a partner?