Anna Freud
National Centre for
Children and Families

Guidance for offering DIT remotely during the COVID-19 Pandemic

We want to ensure that treatment and trainings can continue during the lock down and are providing some guidance to assist supervisors and practitioners with the necessary decisions around transferring DIT to remote ways of working.

1. Choosing a platform for DIT – this should be in keeping with your Trust information governance requirements and varies across different services. Some are using Google Hangouts, Anytime Anywhere, Zoom, Skype, telephone etc. Make sure you use a format that you feel comfortable with and that offers security and confidentiality to the patient. We cannot guarantee the same level of confidentiality as seeing our patients in an IAPT work setting, however, and none of the online platforms offer perfect solutions. Patients should be encouraged to use headphones to ensure greater confidentiality and if you can be overhead you should also use headphones when working remotely. However, the speaker We need to reassure our patients that we are providing a safe space for their sessions to take place. If you are using an online platform, there should be a password to protect the meeting and where possible, the meeting room can be locked and waiting room function enabled to ensure no one else enters the meeting unexpectedly.
2. Starting sessions with Outcome Measures – some services are set up to email sessional outcome measures to patients ahead of the appointment. It is still advisable to comment on the measures and how these compare to the previous week at the start of the session. If you don't have facilities to send this across, then email the blank questionnaire and go through the items verbally at the start of sessions.
3. Similarly, the Relationship Questionnaire can be emailed across to your patient and then discussed in the session during the Initial and Ending phases. If you are using a remote platform that allows for screen sharing, you can share the form with your patient this way and discuss the ratings with them; something similar can be done for the sessional outcome measures. With all questionnaires, we would still work with these from a psychodynamic perspective, regardless of working remotely or in person.
4. Sharing the goodbye letter – this can be emailed to the patient as a draft letter that is password protected; the password is then sent by separate email. You should be guided by your service as to whether you or your administrator has direct email contact with the patient and whether you need to use an NHS.net email account only for patient correspondence. We need to be particularly sensitive to the type of information we share in the goodbye letter, given that we don't know who may have access to the patient's emails and computer. You can make revisions to the goodbye letter and return it to the patient to read again and reflect on those changes. While using these different ways of sharing information with the patient it is important to keep any

discussion of these communications to the session time and not to be drawn into this in between sessions.

5. While it is always easier to work remotely with someone you have begun seeing in person, you may be offering DIT to someone you have only worked with remotely. Selection of suitable patients needs to take this into account. We would expect that most patients seen in primary mental health are able to manage remote ways of working, given that digital delivery has been part of the IAPT platform for some time. Notwithstanding this, we can't pretend that being seen remotely is equivalent to being seen in person. There will be some patients who cannot manage the remote setting, particularly where there are concerns around managing the boundaries and the limitations of the setting as well as those who are digitally disadvantage because they don't have the means to access remote work (e.g. no access to a pc, tablet or smart phone as well as no private space). It is difficult to proscribe who is and isn't suitable for remote DIT, given that this is an idiosyncratic decision that should be made on a case-by-case basis, and that takes into account the therapist's experience and competence alongside patient factors. We would encourage you to use supervision for this, and to arrange additional supervision if you feel you need more support at this time. Those patients with impulse control difficulties and high risk, body image disturbances, trauma with dissociative features, patients with psychotic, perverse, borderline or anti-social presentations are unlikely to manage remote therapy and may not be suited to this format.
6. Some patients may be disconnected from affect, particularly if they have a more deactivating attachment style. The techniques to identify, validate and mark affects will be important here.
7. You will also need to take account of the online disinhibition effect, where some patients may reveal too much of themselves too quickly. In these instances, pacing the remote sessions is an important part of the work and the therapist may need to find ways of slowing things down, to help the patient with processing and revealing aspects of themselves at a better pace. You can achieve this by asking the patient to stop and rewind, by reflecting on affects or different perspectives on what is being said particularly if there is a disconnect from painful or more disturbing affects. Highly aroused patients are likely to have poor mentalising capabilities and we would want to use some of our mentalising techniques to help them reflect on their current situation.
8. The BACP has developed a telephone and e-counselling competence framework: https://www.bacp.co.uk/media/8113/bacp-competences-for-telephone-ecounselling-apr20.pdf. Although these are more generic and not specifically psychodynamic, they form a useful addition to thinking about our remote DIT work.