British Journal of Psychotherapy **37,** 3 (2021) 362–379 doi: 10.1111/bjp.12654

REMOTE WORKING DURING THE PANDEMIC: A SECOND Q&A WITH GILLIAN ISAACS RUSSELL: Questions from the Editor and Editorial Board of the *BJP*

GILLIAN ISAACS RUSSELL

On the first anniversary of the beginning of the Covid-19 pandemic lockdown, Gillian Isaacs Russell, author of the influential Screen Relations: The Limits of Computer-Mediated Psychoanalysis and Psychotherapy, *returns to respond to a second set of questions from the* BJP. *In this interview by email, she considers the challenges and issues that came up for clinicians and patients during the last year of working remotely. Looking back at the year as a whole, she explores the impact of ongoing trauma on the therapeutic couple. She discusses the creative ways that clinicians have found to navigate the losses and differences between co-present and distance treatment, including holding an internal paradox of immersion in telepresence and the maintenance of a reflective distance, to be shared and explored with the patient. She examines the effects that differing hardware such as telephone or computer screen have on our intimate communication, how the intrusion of the personal environments of both clinician and patient may have affected the dynamics of the therapeutic couple, and the personal and global experience of loss and bereavement for both therapist and patient, particularly when it has to be processed remotely. Finally, the* BJP *asks her to give her thoughts on the future and whether the 'new normal' will include more hybrid forms of training and treatment.*

KEYWORDS: SCREEN RELATIONS, TECHNOLOGY, PANDEMIC, REMOTE THERAPY, COVID-19, PRESENCE, PSYCHOANALYSIS, PSYCHOTHERAPY

The world feels like a very different place than it did a year ago.[1] People talk about 2020 (and possibly longer, who knows?) peeling a layer off the surface of things, exposing vulnerabilities and more, leaving us raw. What at first might have felt temporary, has now been a year. What are your thoughts about how patients have adapted to working remotely over this time? And clinicians? What challenges or

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issues have come up during this time in relation to the therapeutic relationship, now that you can look back at the year as a whole?

As of March 2020, when the North American and UK lockdowns began and the significant impact of the Covid-19 virus became apparent, every psychotherapist became both a victim of the unfolding disaster and a disaster mental health responder. While we are accustomed to using the term 'disaster' to describe sudden and discreet occurrences, such as earthquakes or tsunamis, the term also applies to long-term processes which seriously disrupt the functioning of society, posing 'a significant, widespread threat to human life, health, property, or the environment …(International Federation of Red Cross and Red Crescent Societies, 2011)'. This dual role of victim and responder became our ongoing reality without any specific training or experience in disaster mental health and we were often unaware of the resulting tensions. The pandemic shrunk emotional distance between therapist and patient, because we too experienced pandemic stresses, losses, and traumas. One important feature of community response to disasters is that reactions change over time. Using the terms and concepts from Meyers and Zunin (2000), the path from warning and impact all the way to the reconstruction and meaning making is not linear (Meyers & Zunin, 2000 as cited in De Smet, Tegelberg, Theunissen & Vogel, 2021). Following impact there is a heroic response, a honeymoon period of community cohesion. During this phase that began in March 2020, we witnessed things like the community symphonies of pot-banging, singing, clapping, or 'wolf howls' celebrating medical first responders. The American Psychoanalytic Association (APsaA) quickly formed the Covid-19 Advisory Team to support our colleagues during the abrupt transition to telehealth, provide outreach to frontline workers, and respond to the public's questions about the implications of living in lockdown during a pandemic. With few exceptions, psychotherapy patients adapted to technologically mediated treatment with a positive spirit, a feeling that we were all in this together.

But the honeymoon phase inevitably gives way to disillusionment. As the lockdowns continued, every day brought an incremental increase in the traumas and stresses of living with pandemic grief and fear, exacerbated by uncertainty, both natural and also in some cases, a specific response to poor leadership. In the winter of 2021, an ambient sense of despair and fear from cumulative trauma was widely shared: 'I am having trouble with patients. I guess it may be, in part, my own feelings. I feel a loss: I want to be in the physical presence of the person'. 'I need a break desperately – but how can I take a break when my patients know I can't go anywhere? They will know I need a psychic break from *them*'. Clinicians have been challenged by their simultaneous immersion in the pandemic experience along with their patients.[2]

Vaccinations began their initially chaotic rollout, and by March 2021 many of us in the US had been vaccinated. It felt counterintuitive that, with light at the end of the tunnel, many colleagues felt increased exhaustion and despair, as did their patients. 'This is not what I signed up for when I trained: how do I know you are not all virtual avatars?' said a member of the APsaA Covid-19 peer groups. It was

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useful to learn from the disaster psychologists that the anniversary of the lockdown, shockingly longer than we had ever anticipated, triggered anniversary reactions. Hopefully, this was an inflection point from which we can collectively begin to work through the grief and make meaning of the experiences of our past year, while we strive to find a new normal that includes whatever opportunities for growth this disaster might bring.

Last year we asked you what happens to the core analytic principles of free association, evenly suspended attention and reverie when working by phone or online. What do you think has happened to these during this time? Also, with regard to the concepts of space and time, has the development of the transference slowed down or speeded up in any way as a result of the pandemic and different ways of working?

Some of your questions are very difficult to answer at this stage of the pandemic. We have all been in the midst of it, often in survival mode, and I think we will need some time after we re-emerge to assess exactly how we have been affected.

When we last corresponded, I described 'telepresence', the illusion of presence that occurs when communication via technology 'works'. 'At its core, presence is the feeling we get from attending perceptually to the present world (in both time and space) outside ourselves. Mediated presence is primarily the perceptual illusion of being in an external, sharable world. It is not an internal, imaginary 'thought experiment' (Waterworth & Waterworth, 2003).

Similar to perceptual illusions subsuming the nervous system to create an experience different from what is actually occurring in the physical world, such as watching a film based on illusions of apparent motion, telepresence is an illusion. It is an experiential 'illusion of non-mediation' (Lombard & Ditton, 2006) in which the technology being used disappears from experience and one simply feels oneself to be in a relational moment. Without telepresence, providing psychotherapeutic care over distance would be impossible, as would all the other moments of mediated intimate connection that we take for granted. But with it, as many have learned during the pandemic, a version of psychoanalytic care is possible.

But, as informatics researchers confirm, telepresence cannot be consistently maintained. We lose the illusion when we have to narrow our focus and concentrate, when technological glitches intrude, or when we become distracted and aware of our environment. The music of sessions is altered without notice by inevitable mediation artefacts which are unconsciously taken to be expressions of the other's subjectivity (Branham, 2017). Uncomfortable feelings or topics can be easily avoided by shifting attention away from screen or speaker.

We have found that the clinical value of telepresence for teletherapy and teleanalysis rests on clinicians balancing an internal paradox. We must cultivate being thoroughly immersed in the technologically mediated relational moment telepresence provides by fully committing to the illusion of non-mediation. At the same time, we must also maintain a paradoxical reflective distance from such immersion in the illusion by keeping in mind the inevitable differences between what physical co-presence affords and

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what telepresence affords. What is necessary is a kind of waltz between two fundamentally incompatible positions.

Curiosity about differences between physically co-present and technologically mediated experiences, including a willingness both to notice them and to discuss them with patients, is part of waltzing to the paradox of being immersed in the illusion of telepresence and maintaining a reflective distance. Those differences are indeed analysable. In fact, noticing and sharing differences between co-present and remote treatment as they happen simultaneously breaks and promotes telepresence, marking distance but by doing so promoting a closer shared experience. Consider the following paradigmatic example of a patient popping up on the screen at a loss for words for how to begin saying: 'I don't know what to say – I want to ask you how you are'. Rather than listening for further transference manifestations or responding from that perspective, the therapist chose to acknowledge that during lockdown there might be genuine concern for her health. Going further, the therapist noted the abruptness of appearing on a screen being so different from travelling to the session, walking into the room, exchanging greetings, sitting in the chair, and arranging bags on the floor, each having a look at the other whilst settling down. The patient expressed relief that these differences were now topics that could be thought about together.

In describing the differences between co-present and mediated experience, the therapist was breaking the illusion of non-mediation. But in doing so, and acknowledging the differences, she was also building a bridge back to their connection.

I feel it will be difficult truly to understand what has happened in the transference until we have actually returned to the co-present consulting room and had the opportunity to observe, compare, and contrast what occurs there with what has occurred during remote therapy. What appears to be an intensification of the transference when using technology may be a manifestation of the online disinhibition effect which leads some patients to become more emotionally forthcoming when treatments are moved onto screens or phones.

A colleague reported that a patient became much more casual in how she came to therapy, having clearly rolled out of bed, or lying down on her couch with her phone suspended above her. She had also become much more emotionally open than in the previous several years of therapy. Historically she had been painfully careful with what she shared. But the difficult and more emotional material emerged not because of increased trust or safety or because of insight developing. It emerged as a reaction to the attenuated risk and potential to 'kiss or kick' that the online context affords (Isaacs Russell, 2015, p. 39).

Others respond to the absence of social facilitation in teletherapy by becoming less forthcoming. One patient who used video conferencing all day at work refused to do video, insisting on the greater distance the telephone appeared to provide for him. While these changes in the relationship are obviously something to think about together, we also need to see that they are not necessarily due to our incisive (or awkward) interventions or the state of the relationship. They may also be the result of what the technological context affords (Isaacs Russell, 2015; Isaacs Russell & Essig, 2019).

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How has the intimacy of telephone working, i.e. with the analyst quite literally in the ear of the patient, affected the work? Perhaps you could comment on what your thoughts now are about the change in the spatial relationships of the work that we have seen – whether phone or video. And perhaps you could link that with the neuroscientific comments you made last year, which looked at what is 'registered' when working in the traditionally co-present way.

In the last pandemic year, along with organizing and facilitating international peer support groups with the APsaA Covid-19 Advisory Team for mental health professionals who identify as part of the psychoanalytic community, I have had the opportunity to teach a workshop with my colleague Todd Essig on average once per month. It is entitled 'The Long Haul of Teletherapy in a Pandemic: Making it Work' and we have presented to groups as different as the Austen Riggs Center in Massachusetts, Kyoto Psychoanalytic Center, the Center for Psychoanalytic Studies in Houston, and the British Psychotherapy Foundation (Remote Therapy Webinar, 2020). We had the privilege of listening to thousands of colleagues and were consistently impressed by their creativity, flexibility, and resilience in continuing to give therapeutic care during this distressing and challenging time.

We have heard how clinicians respond with ingenuity to both their own needs and those of their patients. One clinician said: 'My patient works on Zoom all day and is exhausted. She feels she needs the freedom to let her eyes wander and relax in order to be able to use our sessions. But after a while we tend to lose track of our sense of each other's embodiment. We have developed a rhythm of usually working audio-only on the phone, but also using Zoom from time to time visually to refresh our sense of the "physical us"'. Another clinician reported feeling frustrated by not being able non-verbally to convey understanding, care, and empathy. His creative response was to make gestures more intentionally performative and accentuated, so that intended meanings could be conveyed more easily within the constraints of the two-dimensional screen. Others describe discovering they need intentionally to put so much more into words, acknowledging and mourning the lost choreography of in-person work and shifting to a newly emerging focus on the poetry of sessions that teletherapy requires.

The perceived 'intimacy' of working on the telephone is very much a personal and treatment-specific experience. In my pre-pandemic research, some informants felt the phone was more intimate, literally a voice in the ear, just as you have put it in your question, and some felt that as it decreased most non-verbal aspects of the relationship, it was disabling. Recently a patient, who has pointedly preferred to use the phone during the pandemic said to me: 'Actually, it is incongruent and confusing to have your voice come out of my ear buds. Normally your voice is located in your special location from your chair next to the couch. It feels like a dismemberment to have your voice in my ears'. As I wrote in our last conversation, the telephone can allow you to more easily move your gaze around the room while you think, which is a more natural approximation to the way we move our eyes in conversation in a shared environment. Using the screen for communication does

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increase the information we receive from the other, but often makes us feel compelled in maintaining a constant gaze at the face, eyes locked on the other, without actually meeting the other's gaze because of the design limitations of the technology. This can increase Zoom fatigue and make working with one patient after another on the screen very taxing.

The hardware itself affects our perceptions of intimacy and distance, and therapists observe that their experiences can be confusing and counterintuitive. For example, they sometimes make the choice to use headsets because the potentially improved clarity, decreased echo, and noise-screening option provides more affective information. 'My patient chose to use a headset and asked me to do the same "because she felt closer to me"' an analyst told me. 'If I had a headset on and my analysand had a headset on I got a much better feel for how they were breathing, certain kinds of emotional tonalities … that I found was a better approximation of being in the room'. However, this analyst added, 'That is an issue in some sense. In a regular analysis, your mouth is not next to the ear of the person, but you are there in the room, so I do think there is something about keeping aware of the level of intimacy … which even has a sexual component to it' (Isaacs Russell, 2015, p. 116).

A patient told me, 'Using a headset does not feel like a step towards a deeper reality – it's more like a step away. There is something precarious about the feeling of a voice in your head, as if it weren't another person, but an internal conversation'. Scharff (2012) writes, 'When it enters the headset, the voice of the analysand is delivered inside the analyst's mind in a more total way than in the room where there is more space between them' (p. 81). She suggests that the voice broadcast direct to the ear fosters a sense of connection that supports containment. Another analyst has different views: 'A voice in the ear can be too close, a sort of perverse closeness, a *simulated* closeness'. Whether one's experience of the voice delivered direct to the mind is one of aural totality, perverse closeness, or, from the patient's point of view, unreality or containment, it is significant that the relationship of voice to ear is *different* to that in the co-present consulting room. The effect of that difference, on both the analyst and the analysand, needs to be taken into account. What does the increased closeness mean? What does it mean to *change* the experience from that of a voice in the room where there is more space between the participants to that of a voice down a wire delivered straight to your ear?

In my recent conversations with clinicians, particularly around returning to co-present work, I have been fascinated to hear that some people are preferring the experience of working in person with masks to working remotely. This contradicts the prediction that some made earlier in the pandemic that working on screen would always be preferable to meeting in person with masks, because the mask hides so much of the face. 'I still felt I could see more of my patient's communications with a mask than I could with Zoom', said a colleague. The head of a training organization recently told me: 'A year ago we wouldn't have considered working in person with masks. However, our therapy groups particularly felt most impacted and impeded by working online and have opted to work in person in masks'. These observations are in line with pre-pandemic research (Aviezer, Trope & Todorov, 2012; Rutter,

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Stephenson & Dewey, 1981). For example, it has been found that during peak intensities of emotion, positive and negative affects were successfully discriminated from isolated body postures, but not isolated faces. The facial expression alone in periods of peak intensity is inherently ambiguous. It shows an overlap in the expression of positive and negative emotions and does not convey diagnostic information about a specific affect. In the study, it was the posture of the whole body that was crucial in conveying affect. This was true when participants were viewing images of a face without a body, a body without a face, a body with a congruent face, or a body on which a 'Photoshopped' face is displaying an incongruent emotion. In each case it was the posture of the body that communicated the accurate emotional information. These findings are counterintuitive and, in keeping with that, the viewers reported that their perceptions were dependent on the facial expressions, despite the fact that it was the body from which they actually gleaned the information. These results challenge the standard models of expression of emotions and highlight the crucial role of the whole body in expressing and perceiving emotion (Aviezer, Trope & Todorov, 2012).

When we consider the therapeutic relationship as a conduit of therapeutic action, it is important not to forget the non-verbal effects of the analyst's presence and the reciprocal perception of analyst and patient's non-verbal cues, which can operate relatively independently of both language and consciousness.

Now we would like to pick up and expand on the 'threat of death' in the original questions. Many therapists will have been working with patients who have suffered bereavements due to Covid-19 or whose jobs have put them in direct contact with death. Can you say something about the challenges of working remotely with such real, overwhelming loss (personal and global as it is), and how this might have implications for working in the transference? It seems real life events have encroached so heavily on our work.

The challenges with working with such a scale of profound loss in person, before the pandemic, are already enormous. We know this from the work of our colleagues who worked in disaster mental health during 9/11. Much work has been done in this very specialized area, but it is perhaps not something we generally expected to encounter in our ordinary practices. At the height of the pandemic, both here in the States and internationally, we heard heart-rending stories of frontline workers having to facilitate FaceTime meetings with terminally ill patients and their families who were unable to meet in person and having to break the news of patients' deaths to loved ones over the telephone. People were buried without family funerals. The very communal rituals we have specifically developed over centuries to enable people to mourn were not available to us. None of us were prepared to expect or think around these issues of lack of contact, lack of embodied or community support. At the time we had no choice but to use technology to the best of our abilities.

Early in the pandemic, when I was speaking (virtually) at an institute, a clinician told his story of initially meeting with a family for co-present therapy to work through the traumatic loss of a child. They moved the work online at the start of the lockdown. A short time into this phase of the treatment, one of the young and

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healthy parents was rushed to hospital struggling to breathe and died within 48 hours of admission. The other parent asked the therapist to help them break the news of the spouse's death to the children online. The therapist wondered specifically how to help traumatized patients via teletherapy and, for example, how long a session should last. In thinking about this, we all had to feel our way to the answers, just as he had to find his way to what felt helpful during the session, itself. Some of what became apparent is that acknowledging the shortcomings of the technology, the loss of being able to offer support and thoughtfulness in person, at least framed and clarified the relationship between therapist and patient. Rather than blindly ploughing forward with a session as if it were identical to the experience of sharing an environment, it was important to notice the frustration and helplessness, the differences, the loss in not being able to be together.

As I wrote earlier, we have been in the dual role of provider and victim in the pandemic. In addition, we have been on the frontlines of a concomitant 'mental health pandemic', and our patients were often aware of this. A central feature of the clinical context as the pandemic progressed was a significant rise in the need for mental health care. By July 2020, the CDC (US Center for Disease Control) was already reporting (Czeisler *et al.*, 2020) 'considerably elevated adverse mental health conditions associated with COVID-19' with '(y)ounger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation'. Just as we have needed to acknowledge the differences between co-present and technologically mediated relating, we have found that we have to move sensitively with our patients, exploring the way their own unique traumas and history are brought up by the pandemic, whilst at the same time recognizing that we all share the same uncertainty, fear and vulnerability embedded in the greater context of the pandemic.

On another note. Has a possible denigration of the work been hidden behind rational and often sensible eco-minded requests for continued remote working, and have Covid changes provided a sort of claustrum for perverse patients to take refuge in?

This is a very interesting question which needs to be enlarged to encompass both patient and clinician. In the USA, the CDC has advised that two fully vaccinated people can safely be in a room together without masks. This is in line with all the epidemiological and virological research. In spite of this, I have observed a reluctance and fear amongst many clinicians to consider going back to the consulting room for co-present sessions with their vaccinated patients. Some of this has to do with concrete considerations of people's individual work environments (some people work in shared office spaces, for example, with shared waiting rooms and more public toilet facilities), or family situations where some family members may not yet have been vaccinated. Some clinicians have given up their rented offices during the pandemic in the US where home consulting rooms are not the norm and face a complicated process of deciding when to rent a new consulting room, with all the accompanying ambivalence about taking on increased overheads. I have heard a

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tremendous anxiety about liability, whether to require patients to sign waivers, release, or consent forms when they come back, whether they should install air purification units in their consulting rooms or sanitise surfaces between patients (even if only seeing fully vaccinated patients), whether they should continue to wear a mask and require their patients to do so. The guidelines for going back to co-present work posted by APsaA, itself, echo these anxieties, to the point where a clinician said: 'It sounds like APsaA really doesn't want us to go back to the office!' (https://apsa.org/sites/default/files/In_Person_Work.pdf).

The assessment process about re-emergence has taken on an odd and concerning moral tone. A fully vaccinated patient who is also a clinician and has begun to see her fully vaccinated therapist in person worried about her own process of coming back to the consulting room with her patients. When the therapist wondered how she squared her worries with the fact that she had returned to her own therapist's consulting room, she replied: 'I thought it was a secret between us. I wanted to keep it hidden from the therapeutic community in order to protect you'. She spoke of the fear of mob rule, cancel culture and her being excluded by colleagues, if they found out she or her therapist were not fitting in with the precautions, over and above the recommendations of the CDC, that her colleague group was taking.

The chronic trauma we have all experienced during the last pandemic year, exacerbated by poor leadership and conflicting and confusing information, certainly has led to a state of extreme vigilance, uncertainty and mistrust. The terror has activated our own individual and unique previous trauma and transgenerational trauma. The APsaA Covid-19 Advisory Team describes this interpersonal and community stress response to the pandemic as 'PTSE', pandemic trauma and stress experience. People may experience such things as chronic mental preoccupation, an absence of thought, weariness, worry, confusion about the passage of time, a loss of focus, and increased mental mistakes (https://apsa.org/PTSE). This has been intensified by social unrest and violence, including the murder of George Floyd shortly after we last corresponded (and the Chauvin verdict as I write), environmental catastrophes such as the wildfires in Australia and the US west (some very near my own home), and US mass shootings, one of which recently took place in my relatively small university town of Boulder, Colorado.

Having lived for a year in lockdown whilst treating patients remotely, chronic stress and fear has been somewhat tempered by the illusion of safety and control in isolation. Many of us settled into lockdown as a predictable and convenient way to manage anxiety and now find the prospect of changing this state frightening. Re-emergence is going to carry with it complicated feelings we may not anticipate. Recently, I was invited to an outdoor social gathering with neighbours, all fully vaccinated, all previously quite isolated, all over 65. It was the first such gathering most of us had attended and the host joked that we should come and 'practice socializing'. One of the guests said, her eyes filling with tears, 'I have to tell you, I was so frightened before I came here today …'

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Various layers of meaning inform our reluctance to resume co-present treatment. A supervisee said to me: 'I know it is going to take a lot of energy and hard thinking in order to go back'. Using technology can feel easier, more convenient, less emotionally challenging. 'At Any Time, From Anywhere. Video Chat Sessions. Skip the Office Visit', advertises an online therapy app. As one therapist said to me in my pre-pandemic research: 'Sometimes I am filled with profound countertransference reactions, like terror or grief. It's easier online: [the patients] can hurt you less – and they're probably saying the same thing!' (Isaacs Russell, 2015, p. 27).

Clinicians have described to me a reluctance to be in the room with patients who have intense transferences and evoke similarly intense countertransferences, which have felt diluted by a year of technology and working from separate environments. 'I have a deeply judgemental attractive male patient', a female therapist said, 'And I dread being in the same room with him where he can see my whole body again. I will feel in the cross hairs. Especially as I have gained weight during lockdown'.

Patients express anxiety about finding their familiar therapist again: will they have changed over the separation, will their consulting rooms have changed (and in some cases the change of environment is quite real, as therapists have had to move their offices during lockdown)? I cannot help but be reminded of the Robertsons' heartbreaking film on attachment and separation, 'John, Nine Days in a Residential Nursery', where the 17-month-old child lost the sense of a good connection to his mother and upon reunion 'looked at his mother in a way she had never seen before' (http://www.robertsonfilms.info).

When discussing coming to the consulting room for the first time, a new patient who had started therapy online during the pandemic told her therapist: 'It's been a comfortable distance meeting this way, I feel anxiety coming in person'.

A supervisee described to me starting to see patients in person: 'I had forgotten how being bodies in the same room felt. When I saw my first patient in person, I felt a physical sense of relaxing and ease: I didn't have to be vigilant, my sensory array worked. Working online felt like a cheap imitation of life … But my second in person patient has an eating disorder. I felt much more unsettled. She was anxious that I was going to see her whole body and I was anxious that she was going to see mine'.

In the last year we have dealt with the possibility of an invisible and potentially lethal intruder inside us or another, an intruder we could not control or defend against. This viral intruder could cause us to harm others or them to harm us. Fully vaccinated therapists have expressed to me intense worry and anxiety about returning to in person work with fully vaccinated patients, something that the CDC has stated is safe and permissible. They have particularly cited fears of themselves or the patients unknowingly harbouring the virus and passing it on, despite the evidence that the potential for this sort of transmission is vanishingly small. Continuing to think about the virus in this way gives us a way of not thinking about other things. The fear of going back to co-present work when fully vaccinated and with fully vaccinated patients is a way of focusing and concretizing fears that we have always had to manage and analyse before the pandemic. How do our feelings of love and hate impact our patients and how do theirs impact us?

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When I wrote *Screen Relations*, I discussed one of Winnicott's final papers 'The use of an object', where he wrote of the need for opposition in the apprehension of the reality of the object: 'The object, if it is to be used, must necessarily be real in the sense of being part of shared reality' (Winnicott, 1969). The development of the capacity to use an object is part of the maturation of the individual in a good-enough facilitating environment. He states that the subject experiences the reality of the object, when the object is perceived as outside of the subject's omnipotent control, that the subject creates the object in the sense of finding externality itself.

In other words, to develop the patient must be enabled to perceive the analyst as someone who is a separate person, not just a receptacle of projected fantasies and expectations from the patient's internal world. This development happens through the subject's experience of destroying the object and the object surviving the destruction. The analyst keeps on living, keeps on thinking, does not retaliate or withdraw in the face of the patient's intense feelings/fantasies. Winnicott says that without the experience of maximum destructiveness ('object not protected') the subject never places the analyst outside, and therefore, can never do more than experience a kind of self-analysis, using the analyst as a projection of a part of the self (1969, p. 714).

With the analyst's continued survival despite the impact of the patient's love and hate, the patient discovers the limits of his/her omnipotence – and the analyst can be experienced as whole, separate, and available for interaction in a shared reality/environment. The companion piece to this development is that the patient also feels separate and whole, with a discrete inside and outside, situated in a shared reality (Winnicott, 1969).

In 'screen relations', however, the patient can never fully test the analyst's capacity to survive. The extent to which the patient can 'imagine' the destruction of the analyst (by zealous love or hate) is bound by the barrier of the screen. There is never the potential to 'kiss or kick', as a patient said, grounded in embodied reality in the consulting room. Whatever moments of functional equivalence the screen offers are inevitably rooted in the awareness of simulation, which automatically confines potentiality. Therefore, the use of the object is foreclosed by the limitations of the medium.

Likewise, remote treatment protects us from the full impact of the love and hate of our patients and our own fantasies of our impulses and reactions, which we recognize and restrain in a shared environment. We can move away from the stresses of being co-present bodies, with all the anxieties of empathic embodied responses.

If we continue to survive and refrain from retaliating or withdrawing, it costs us something. As Winnicott (1949) wrote in 'Hate in the countertransference', 'A mother has to be able to tolerate hating her baby without doing anything about it'. He emphasizes the importance of recognizing the anxiety and hate (and, also, desire and love) experienced by a therapist in order to avoid a therapy 'that is adapted to the needs of the therapist rather than the patient' (*ibid*.).

Freud writes, 'For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*' (1912, p. 107). He is talking about the reality of lived

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experience and the immediacy of the moment in the consulting room. We make ourselves available to our patients to work through their internal damage and discord in vivo. As a patient movingly wrote to me recently: ‘Trauma happens in person. Healing happens in person’.

Re-emerging from lockdown to work co-presently, embodied in three dimensions, in the shared consulting room exposes us to our own and our patients’ fantasies and potentials without the protective veil of technology. The prospect of that may for some clinicians and patients feel a relief, but for others a dangerous situation.

The analytic principles of neutrality, abstinence and anonymity have been challenged during this pandemic as therapists have been forced to adapt and reveal some aspects of their reality (inadvertently). How does this change the dynamic of the analytic encounter, particularly when returning to see each other again?

We have had to learn to be curious about how the common experience of our having access to patient private spaces and theirs to ours both reveals and hides. One colleague told me ‘… most of the time I am in their bedrooms – they sit me on their beds and talk to me from there. Sometimes leaning back against the headboard; other times they are stretched out in comfortable clothes like talking to their best friend. They show me their cats, their dogs, and sometimes I get to meet their new baby or their children who drift into the conversation. I get to see a part of who they are in ways never even thought of before the pandemic’. While this provides information we would not otherwise possess, it also hides defences and makes it more difficult to access information about the private (internal) spaces patients do not want us to see. As Lakoff (1995) presciently said about the Internet, ‘It will be different information, not more information’. The visual clues that seem to speed up and deepen understanding and add to the clinician’s concrete knowledge of the patient in powerful external ways, may also make it harder to find and focus on the unconscious and implicit aspects of the analytic work.

Likewise, clinicians have sometimes had to struggle with maintaining their privacy and neutrality. Those who have had children at home during lockdown have had a particularly difficult time, sometimes sharing the space with a partner who also needs to work. While some clinicians are lucky enough to continue to work from their consulting rooms (either because they have home consulting rooms or because they have been able to use their office consulting rooms as a space from which to practise remotely), others have had to use home offices, bedrooms, kitchens and sitting rooms. Several colleagues have used a photograph of their consulting room as a Zoom background, which they felt provided some continuity and privacy. It seems to me that the only way to manage intrusions and inadvertent revelations is to do what we have always done: be curious about them, explore them, analyse them.

At the same time that we have visual access to our patients’ private spaces, and they to our home office backgrounds, or other location if not working from our usual space, they no longer have physical access to our consulting rooms. Whatever facilitating or holding function there was from being in a space provided by their analyst was lost (Winnicott, 1965). The holding environment is now almost

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exclusively constructed by how we hold our patients in mind and how we are able implicitly and explicitly to convey such holding. The more our curiosity can be made to include pandemic-specific experiences, both the ones we share and the ones unique to our patients' life-circumstances, the better we can hold them in mind.

Looking ahead. Have there been some advantages for our profession in having to find ways of working differently? Might a more flexible approach to in person or online/phone therapy be the result of recent changes in practice and would that be acceptable? Many of us may have occasionally resorted to online sessions in the past where a patient had to be abroad for some time but can we now envision that happening where a therapist needs to be away from their usual consulting room, or where either party is temporarily unable to travel to a session for any reason or indeed where a patient might prefer online therapy because of time constraints.

The option to use technology for treatment has always been useful for unusual situations such as the ones you name above. Indeed, without technology to continue treatment, we would have been in a very different and dangerous situation at the beginning of lockdown. It has enabled us to maintain all sorts of essential connections in the last year, including continuing psychotherapeutic treatment. The very fact that clinicians have valiantly demonstrated their devotion to their patients through this time, showing flexibility, creativity and curiosity, must have had a positive effect on their relationships with their patients.

However, an emergency situation, an unusual or temporary circumstance, is very different from an ongoing choice to use technologically mediated communication. When one makes this decision with one's patient, one needs to be very sure about the reasons for the choice, because there is no getting away from the fact that technologically mediated treatment, and indeed all relating via technology, *is not functionally equivalent to co-present relating*. While we have moments of 'telepresence' where we have the illusion that we are not using technology, the limits of technological mediation impact the therapeutic process, and indeed the communication process in any relationship.

It can be a slippery slope from offering technologically mediated treatment when someone is temporarily unable to travel, to someone preferring online therapy for convenience. That thinking includes both the therapist and the patient. We need to make very sure that the use of technology is not enabling an avoidance of the kind of things that deepen the therapeutic process, and sometimes make it uncomfortable and painful, such as separation. The constant availability that technological connection affords can get us into all kinds of difficulty. Consider the inability for people to take breaks, not only therapists, but all working people who during the lockdown have worked two to three hours more per day (Davis & Green, 2020). The rhythm of time off, whether it be weekends, holidays, or even breaks because of illness or unusual life circumstances, allows us to think in the moment with our patients about separation and loss and the challenge of maintaining an internal thread of connection and continuity. Technological mediation potentially allows us to avoid those vital experiences.

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Again, the therapeutic process is not easy for clinician or patient, and it is vital to recognize and work through all manner of resistances and defences that can be employed by meeting in separate environments and on a screen or phone. A therapist recently told me, 'I feel that many of the new patients I have taken on remotely during the pandemic are people who might have found it frightening to work in person … People with sexual trauma … people who habitually hold themselves and can't depend on another …' Technology changes everything because it is specifically designed to provide illusory experiences, such as being co-present in the same environment with someone when actually sitting all alone. Part of its design, such as the Comfort Noise we discussed in our last correspondence, includes obstacles to becoming aware that the mediated experience is in fact a simulation with limits that can easily be encountered (Alter, 2017; Branham, 2017; Lanier, 2014; Rushkoff, 2019). This intentional design combines with our own strong drive to connect, causing us to persist with a communication, ignoring or blind to disruptions and differences caused by technology (Olson & Olson, 2000). Understanding that the meanings and consequences of telepresence experiences are different from similar experiences that happen in person is no small task. Technology profoundly changes the clinical meaning and consequences of what one directly experiences in treatment.

How might trainings need to think of adapting to a world in which technologically mediated therapy is an element, however much we might cavil against it, of the 'new normal'. Might it be important for trainees to experience part of their training therapy or analysis remotely, even if they begin their training at a time when teaching and therapy/analysis can be in person? What about the situation currently where trainees are seeing their patients remotely? How can that best be managed?

It is vital that trainees are offered education in understanding the differences between co-present and technologically mediated treatment, which may include personal experience of it in their own therapies or analyses and the treatments they offer. This should always be accompanied by extensive reading and teaching on the subject, so that they can become aware both clinically and theoretically about their experiences and the research behind them. One of the clinicians who translated my book into Chinese had the opportunity to have a shuttle analysis where they spent a chunk of time in their analyst's country seeing them in person, whilst seeing their patients remotely, and some of their time in their own country seeing their patients in person and their analyst remotely. This was necessary because there were no analysts available locally for them to see. The experience was challenging, sometimes frustrating, but very enlightening as it allowed them to compare and understand distance and co-present treatment from the perspective of both the analyst and patient.

Trainings must be very cautious about the financial temptation to enlarge their training cohorts by offering exclusively distance training, with the assumption that remote classes, supervision, and personal therapies are identical to co-present ones, and that the quality of the training experience for the trainees will be equivalent to co-present ones.

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Last year, you said to us: 'While we are grateful for the capacity to maintain a thread of continuity through technology in the time of pandemic emergency, we also recognize that we are wired to relate in embodied co-presence … True presence, as unpredictable, spontaneous and messy as it is, is irreplaceable'. Would you still say the same?

Absolutely. I listen to clinicians describing their gradual returns to co-present work: 'My first session back was terrifying. I felt like a beginning trainee all over again. I was nervous, more conscious of my body, unable to hide my fidgeting as I could do on the screen. It was a huge physical and emotional adjustment to be in the room. But the next time we met I felt more energized and happier than I had been for a year'.

Having said that, yesterday a colleague said to me: 'I can't imagine going back to the consulting room. There's been so much loss for so long, we've had to divorce ourselves from the experience to bear it'. We have experienced a collective trauma, and our task is to feel it and make meaning of it together. That will be painful and hard work. It will necessitate our finding trust again, and safety in the presence of the other.

A prime concern with technologically mediated treatment is that the elimination of co-present bodies largely confines the psychoanalytic process to 'states of mind' rather than 'states of being'. It is when one can dwell in a 'state of being' that one can take part in the psychoanalytic process of communicating with oneself and the other. Without a true sense of presence, we miss the opportunity to experience a space of internal and external reality, as well as that intermediate space which can be used for joint play and the creation of symbols. Simulation may take the potentially symbolic into the realms of the inauthentic because it is not counterweighted by the experience of body-to-body communication, with all the palpable risk and potentiality that it implies.

Asking a patient to provide their own safe space is also foreclosing an area of potential healing and growth. Balint (1950) spoke of 'creating a proper atmosphere *for* the patient *by* the analyst'. The provision of a safe space for the patient, in addition to providing a 'good-enough' environment enabling the patient to heal psychic damage and foster psychic change, is akin to Turkle's (2009, 2011) concept of 'sacred space'. This is the place where people can feel most fully themselves. It is the protected place where both analyst and patient have the freedom to be just as they need to be in order to find joint analytic understanding. The security of the external space makes possible a similarly secure internal space (Parsons, 2014). Significantly, Turkle describes it as a place where people can hold themselves apart from simulation.

There are times when mediated communication can go some way to include a mutual experience of 'states of being'. Our evidence from the last year, in addition to the research I have done before the pandemic, tells us that there are times when unconscious to unconscious communication can take place, despite the limitations of the medium. Maintaining the illusion of presence could give real moments of

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deep understanding because our desire to connect is so strong and we instinctively make the most of what material we have. Knowing a patient very well before using mediation can provide a sort of bridge of familiarity on which to travel for some time. It might enable one to be more sensitive to communications because one recognizes previous patterns. However, the current state of technology, coupled with the fact that we have evolved to relate as bodies together, militates against it. Although needing further study, the information we have about communication, the limits of technology, and the way we are neurologically wired points to the fact that we need to experience presence to 'keep it real'. Technologically mediating our relationships does change them. It is not the same as co-present relating.

While making psychoanalytic treatment available via mediation to those who have no other option is certainly possible (and a godsend during the pandemic), both clinician and patient need consistently to be aware, to keep noticing as part of the fabric of the session, the inherent differences between mediated and co-present embodied relationships. We need to be cautious that we don't model to our patients that our bodies are just incidental. At some point, they deserve the experience, many for the first time, of the 'primacy of safety' (Modell, 1988). At some point, they need to test the analyst's capacity to bear the impact of their love and their hate in the flesh and not protected by the barrier of a screen. The truth of these experiences needs to be lived, not simply described and not simulated.

NOTES

1. The Editorial Board and I worked with Gillian Isaacs Russell on this interview between March and early May 2021 – Ed.
2. Quotes are from respondents to the APsaA Covid-19 Advisory Team's initiative and from conversations with colleagues. All quotes, both in this paragraph and throughout the interview, are disguised and anonymous.

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