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

GILLIAN ISAACS RUSSELL

In this interview by email, Gillian Isaacs Russell, author of the influential Screen Relations: The Limits of Computer-Mediated Psychoanalysis and Psychotherapy*, responds to a set of questions from the* BJP*. The interview focuses on the impact of remote working during the coronavirus epidemic, starting with the question of whether an effective therapeutic process can occur without physical co-presence. Isaacs Russell shares her immediate thoughts about the virtually overnight changes to our practice that came with the epidemic, and the work of the American Psychoanalytic Association's Covid-19 Advisory Team, on which she sits. Her responses are informed by recent cross-disciplinary and neuropsychological research on the digital age. She considers what happens to free association, evenly suspended attention and reverie when working by phone or online; the loss of the consulting room as a containing physical space for both clinician and patient; the relationship between place and time; and whether (and how) we can maintain a focus on transference and countertransference in the presence of the threat of death. The interview ends with her thoughts on whether we should assume that the landscape of analytic therapy will be permanently altered by Covid-19, and with her hope that general awareness of the impact of trauma on our mental health has been raised.*

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

When you look back at 2015, when you published Screen Relations*, what were your priorities or concerns in exploring computer-mediated clinical work? How did you imagine the field developing?*

My interest in technological mediation began in 2008 when I moved from the UK to a remote part of the Black Hills of South Dakota. I was enthusiastic to use technology for treatment. I was hopeful that technology would solve the dilemma of distance and separation, allowing me to transcend space and time. If I were not

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dependent on a physical consulting room or co-present colleagues then the only instruments I needed were myself and my computer.

But back in 2008 I sleepwalked into the use of technology for treatment, expecting that what we would be doing on the screen was exactly what we do in the embodied consulting room. However, I was puzzled by my experiences using technology, as were my colleagues. We did not anticipate the fundamental clinical challenges posed by this type of work. So, as enthusiasm turned to disenchantment, I began to ask questions: *Can* a highly effective therapeutic process occur without physical co-presence? What happens when we reduce our therapeutic relationships to two dimensions bound by a screen?

To answer those questions I have done hundreds of ethnographic interviews with clinicians and patients about their experiences with technologically mediated treatment (Isaacs Russell, 2015). I have examined the technologies of mediated communication and how they affect our relationships and change how we practice. I've had the leisure to explore the emerging research in neuroscience, virtual reality, human–computer interaction, and communications theory that informs my thinking. I found that if one uses technology, it is crucial to recognize the differences between embodied communication in a shared environment and mediated communication.

In the intervening five years since *Screen Relations* was published, a raft of books have appeared by scholars of the digital age such as Sherry Turkle, David Sax, Nicholas Carr, and Michael Harris, arguing for an understanding of where technology can and can't take us. They make a case for embodied relating and for unmediated conversation, silence, solitude, empathy, contemplation, and attention. Psychiatrist researcher Alan Teo found that only face-to-face interaction forestalls clinical depression in adults over 50. Psychologist Jean Twenge observed that Post-Millennials' increased screen time and decreased face-to-face time with friends was leading to depression. At the same time, therapists seemed to be expanding their practices to a simulated form of relating, without co-present bodies or shared environments. There has been a paradoxical drive to *delete* the body from the therapeutic interaction in the name of such things as convenience, democratization, continuity, and cost-effectiveness. Online therapy providers like Talkspace and Betterhelp, promise 'Convenient, affordable, private online counseling. Anytime, anywhere'. They declare: 'There will be no couches, no tissues, no first-date-esque meetings'. US psychoanalytic institutes have offered 'full psychoanalytic training' online including personal analysis, initially to candidates in far flung parts of the world, but now also to candidates in the US. The proponents of technologically mediated treatment claimed that a very high percentage of patients feel satisfied with their experience; that we need to keep up with the demands of the future, avoid obsolescence and join the digital natives, meeting them where they feel comfortable. What was happening? Poised in what Sherry Turkle calls the 'robotic moment', we are willing to have relationships with computer programs, apps, robots, or on a screen, despite their limitations. We have been learning simply to accept simulated relationships, 'as if' relationships. We have been moving from regarding screen relations based treatment as better than nothing (for patients who have no other option,

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for example), to good enough (continuity when patient or therapist is travelling), to routine care and, in some cases, to better than anything.

In 2015 I was concerned that clinicians considering the use of technology for treatment look at the cross-disciplinary research 'without memory or desire' to make the very best informed decisions about its use, as well as communicate that understanding to their patients.

We know that our clinical practice changed virtually overnight, in a sudden, unplanned way, with the global Covid-19 emergency. What were your immediate thoughts about the changes?

Little did I imagine that by March of 2020, we would all be forced by Covid-19 abruptly to adopt technologically mediated treatment as the safest way to practise. We have had immediately to move treatment, supervision, and classes online. Our decision had nothing to do with personal preference or political agendas. We have scrambled to familiarize ourselves with technologically mediated treatment to maintain connection, because it is 'better than nothing'. With no transition period and no choice, the move to distance treatment and training has found many of us unprepared and vulnerable. My immediate thoughts were how to help – how to use what I knew about technologically mediated treatment to ease this transition for my colleagues. I was very grateful to be asked to join the American Psychoanalytic Association's urgently organized Covid-19 Advisory Team.

Can you tell us about the APSaA Advisory Team's work?

The Team provides emergency response to the pandemic in all areas of our work, from addressing the sudden transition to technologically mediated treatment and its impact on patient and therapist, to outreach to frontline healthcare workers, to answering questions from the public about the psychological implication of living in lockdown and in the shadow of disease and death. We have organized international peer consultation groups for any mental health practitioner who identifies as being part of the psychoanalytic community. These weekly groups, one of which I facilitate, provide a safe (virtual) place for clinicians to share and support each other as we navigate through the uncharted waters of the pandemic. On the first day of registration for the initial groups, over 1000 clinicians applied for just 245 openings. We are in the process of launching another set of groups this week [early May 2020 – Editor].

What are the overarching concerns expressed by clinicians whom you and your colleagues are advising?

Unsurprisingly, themes of loss, fear and grief have emerged. Depending on where they are located, many colleagues are navigating the loss of family and friends to the virus, as well as their patients' losses. They are dealing with the loss of routine, environment, life as we have known it. We are all threatened with helplessness, loss, with death.

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A primary, concerning theme is how *exhausting* working online can be. There has even been a term coined for it: 'Zoom fatigue'. They wonder why a day online is so tiring – it seems counterintuitive: after all you don't have to travel, it's convenient, many people don't even get out of their workout clothes or pyjamas.

We speak of what it feels like to be impacted by the concrete limitations of technology: the dropped connections, the pixilated screens, the echo or the broken sound.

Our devices bring our work into our homes, into our personal space, dissolving boundaries of space and time. Research shows that, as a result of the lockdowns, US workers are working an average of three hours more per day! In France, Spain and the UK the workday has stretched an additional two hours (Davis and Green, 2020): '… There's no escape. With nothing much to do and nowhere to go, people feel like they have no legitimate excuse for being unavailable'. Our personal time is online. In the initial adrenalin rush of the lockdown people had Zoom family reunions, Zoom cocktails, Zoom dinner parties. Our work time is online. I find myself working seven days a week, clinically and with additional APSaA Covid-19 support group meetings. There is little space for silence, solitude and recalibration.

When we use technology, whether a computer or a phone, the loss of many subtle non-verbal cues means that we have to work so much harder to perceive the whole communication. When working face-to-face on screen, the view of the face without the whole body is closer than with in-person connection and distracting. It is two-dimensional. Even when patients use the couch where the face is not fully visible, in co-present environments we have a sense of the posture of the full body and the non-verbal messages it sends. We see the patient's face at the beginning and end of the session. Online, we sometimes feel alone in the *absence* of another.

This demonstrates a loss of *presence*, that core neuropsychological phenomenon stemming from an organism's capacity to locate itself in an external world according to the action it can do in it. Presence is not the same thing as emotional engagement, absorption or the degree of technological immersion. For humans these actions specifically include the person's capacity – even potential capacity – to interact with another person in a shared external environment, the potential to 'kiss or kick'. The sense of presence enables the nervous system to recognize that one is in an environment that is outside one's self and not just a product of one's inner world (i.e. being awake, not dreaming).

We understand well that shared physical presence is critical, even with the constraints of social distancing. A colleague of mine, the mother of a small child, powered through several weeks of work on lockdown, sharing childcare with her partner who was also working from home. She was containing her child, her partner, her 'on screen' patients, and of course her own fears. Finally, following a Colorado spring blizzard, when the sun came out and the snow had begun to melt, her family took a walk outside. They paused outside the house of friends, who ventured out onto their porch to wave. And only then could my colleague cry, when she was in the physical presence of friends, so near and yet so far. When she could recognize what she had lost on the screen and what she was so close to, hovering on the pavement and waving, with all the palpable potentiality that shared proximity implied.

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Taking that thought further. What happens to the core analytic principles of free association, evenly suspended attention and reverie when working by phone or online?

When communication via technology 'works', it is because we have an *illusion* of this sense of presence: 'telepresence'. But the illusion cannot be consistently maintained. We lose this illusion when we have to narrow our focus and concentrate. This is what one of the therapists I interviewed in my book described as being 'glued to the screen'. That is one of the reasons why working with technology is so tiring. It is more difficult to dwell in those moments of evenly suspended attention, reverie, where your attention can 'move in and out'. The ability to move away inside in your thought process and reconnect underlies a mutual ongoing sense of reliable presence that enables reverie. This is not always possible with the effort or anxiety of concentration that accompanies work with technology.

The nature of the technology encourages a kind of distraction called 'continuous partial attention', a state when we are hyper-vigilant, anticipating potential connection, always on anywhere: when we are so accessible we are inaccessible in the here and now. Both analysts and patients have reported to me wondering about email, actually checking it surreptitiously, leaving various programme windows open and phones left on desks, set on silent, but available for a glance as texts come.

It has been found that the mere presence of a mobile or smartphone on a nearby table – even if turned off and face down – can lessen the quality of a co-present conversation, lowering levels of affinity, trust and empathy between the participants, especially if they already have a close relationship (Misra *et al.*, 2014).

There are practical measures one can take to deal with distraction. Todd Essig and I devised a set of guidelines we give to patients when beginning to work remotely1 (see also Isaacs Russell & Essig, 2019, pp. 250–1). We suggest that one turns off or 'puts to sleep' all devices other than the one you are using to make the call, including watches, laptops and other phones. If using a smartphone or a computer, do your best to quit all programs other than the one you are using and turn off all notifications. It is best to leave your hands free by using headphones. If you are using audio-only on the phone be sure to put it screen-side down. If using a computer for audio-only, turn off your monitor or completely darken the screen.

Phone and Zoom/Skype are different. What do you see as the chief characteristics of each, and how do they impact on the individual session?

We rarely spend long periods of time with our eyes locked in a mutual gaze (although to compound this unusual aspect of working online, the nature of most technology means that we don't make actual eye contact). We are accustomed to controlling our personal space and the distance we create around us in relation to others. Think of getting into a crowded lift (when people used to get into crowded lifts) and how we naturally look down or away from the other passengers. A study at Stanford University showed that when people stare at large virtual faces they

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flinch physically. Staring at a large head creates the illusion of someone very 'up close and personal' and activates our fight or flight response (Bailenson, 2020). So while using a screen gives you more information about the other person's facial expressions and position, it is not the natural view we have when we are in person and sharing an environment.

Sometimes the telephone or audio-only, while one loses some visual cues, allows one to more freely move one's eyes, as in a shared environment meeting, and can be a bit easier.

But both technologies change our perception of the other. Over 65% of our communication is non-verbal, and much of that is lost when we are mediating our communication through technology.

This brings us to the consulting room. What are your thoughts about the loss of the consulting room as a containing physical space for the clinician – and for the patient? What are the psychic (and practical) implications for the patient, who is likely to be speaking to their therapist from their own personal space?

It is hard to provide containment in a session when both patient and therapist are dealing with pain that is grounded in a shared reality. Faced with uncertainty and the unknown in a way we have never been before, we are unable to do anything but attempt to maintain and preserve an interior analytic space, a space in which to think. This is not easy when we don't feel safe ourselves.

There is an additional lack of consistency and security when we and our patients must communicate from two different environments. In my original research interviews, patients reported doing therapy from everywhere: bedrooms, living rooms, work offices, home offices, cars in work car parks, stretched out on lounge chairs next to a swimming pool. An astonishing number of patients worked in bed under bedclothes. This is perhaps even more pronounced in the time of lockdown when patients have no alternative but to work from home. Finding privacy becomes much more challenging when people live in small living spaces with housemates or family always home.

All analysts I spoke to when doing my original research commented on the difficulty of patients keeping spaces consistent and free from intrusion. This is not surprising because it is traditionally the analyst's responsibility to do so and indeed part of the therapeutic process. It is now something we cannot choose to provide. In the larger sense, it is not only patients' historic traumas of lack of safety that comes into our work, but the very real shared experience of danger from an invisible intruder, uncontrolled and menacing, and perhaps literally existing in the other. During the pandemic, therapists, too, must work from various places other than their consulting rooms (unless their consulting rooms are at home), including home offices, living rooms, and kitchens, often with partners, children and assorted pets nearby. A colleague tells me, 'My patients now know I have a parrot who can whistle the theme from Star Wars'.

I have written before: 'A bed is not a couch and a car is not a consulting room'. But now we have little choice. The necessity for the patient to engage in the task of

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maintaining secure boundaries and providing for his/her own environmental needs represents a serious shift from the shared environment to the computer-mediated setting. The very introduction of technology abrogates analytic responsibility for the setting. It is unreasonable to expect the patient to be able to provide a safe setting for themselves, if they have never had that basic experience of safety and cannot even imagine it. So many pats come into therapy having experienced early impingement. Ideally, this provision needs to be a fact, not just a concept discussed cognitively or interpreted: it needs to be experienced.

Moving on from the changes in the setting. How can we think about the relationship between place and time, as if the disruption of place has resulted in changing perceptions of time?

Our perceptions of time and place are dependent on each other and have a relationship with moving in space.

In my pre-pandemic research, patients reported to me that the journey to and away from the consulting room is an important aid to remembering the session. Turning off the computer is not a journey. A patient said to me: '[Leaving a Skype session] with a click of a mouse is like having a Caesarean instead of a natural birth'. Analysts also reported unusual difficulties in remembering both the times and actual content of sessions when using technology for treatment. For example, people who never took notes in co-present sessions found themselves 'discreetly' taking extensive notes in technologically mediated sessions. A colleague recently said to me: 'I've found myself, quite without intending to, making notes in my phone sessions – I'm not working in Zoom – and feeling guilty about it. I've also found it very difficult to remember the content of phone sessions. When I look at my notes it's as though I'm seeing something for the first time. It's unnerving and disturbing'. The embodied experience of acting and moving in space is connected to learning, mental processing, and memory. Movement and the three-dimensional qualities of physical co-presence may make a greater and more lasting impact on our memories. Researchers have found that the experience of more complex movement, such as handwriting as opposed to typing, not only improves cognitive abilities, but also affects memory (Bounds, 2010). The richer our embodied experience of acting and moving in space, the more profoundly it affects our perceptions, consciousness, and memory.

I've thought about this in neuroscientific terms. New research suggests that we think not just with our brains, but with our bodies. What goes on in the brain depends on what's going on in the body as a whole, and how that body is situated in its environment. We don't just have 'states of mind', the brain is now regarded as part of a broader system that critically involves perception and action as well: that is, 'states of being'. As Damasio says: 'We are embodied, not just embrained' (Damasio, 2005, p. 118).

The three scientists who won the 2014 Nobel Prize in Physiology and Medicine have done research connecting navigation, knowing how to find one's way in physical space, with the way memories are created and stored. The same neural systems

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that support physical travel also support the mental travel of memory (past, present, and the capacity to imagine the future). This may go some way to explain the uncharacteristic lapses of memory analysts have both about the times of sessions and the content within them, and that patients have in remembering and processing mediated sessions. If you're not moving in space you are not actually confirming these things in memory.

So the unchanging stasis of lockdown (what one person described to me as a 'soup of experience'), without much movement in space or change in routine or environment, affects our memories and our perception of past, present and future.

In the guidelines Todd Essig and I wrote for patients, we suggest: 'Try to leave yourself an additional 15-minutes both before and after the session for a walk, either by going outside and doing something like going around the block (if you are comfortable doing so) or, if staying inside, wandering around your place. If there is no way to take a walk it makes sense to do some simple stretching. It is not a good idea to leave another remote meeting or call or an activity requiring focused attention (either work or play) and then immediately calling in to start the session. You will need some time to get ready for the work we are about to do. Similarly, after the session is over, take 15 minutes to do the same thing before diving into the next activity. This will give time for the session to resonate before jumping back into whatever you have next'. This suggestion to move in space can be helpful for clinicians too. In addition to the obvious physical benefits, there are the additional benefits of internalizing the session and marking the passage of time.

Covid-19 presents us all with the threat of death, whether near or far. You've mentioned this yourself at a couple of points in our discussion. How do you think clinicians can maintain (if this can be maintained) a focus on transference and countertransference? How do they change (or how does the way we work with them change) in a global crisis?

I am reminded of Margaret Little's story of a meeting of the British Psychoanalytical Society that took place during World War II. There were bombs dropping every few minutes and people ducking as each crash came. In the middle of the discussion, Winnicott stood up and said 'I should like to point out that there is an air raid going on', and sat down. Evidently, no one paid any notice, and the meeting continued (Little, 1985). *There is an air raid going on*. We are all living in the greater context of the pandemic. And somehow this must be acknowledged both personally and with our patients who share this greater context with us. The countertransference/transference is taking place within that context and while we keep an eye on the dynamic, we can't forget and bear witness to the realities of the world situation that we all share.

This need to acknowledge reality is also necessary when we use technology. There is a new aspect to our communication being introduced. Technology can be intrusive both in its distortions and its additions, and research shows that we tend to ignore them. We persist with the call, despite visual or voice distortions, rather than

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acknowledge that something unusual and intrusive is happening. In fact, fieldwork in the area of human–computer interaction shows that participants are often *unaware of the difficulty* they are having with the communication device. Micro-analysis of transcripts of mediated interaction show that distortions can contribute to serious shifts in meaning, with neither participant being aware of the miscommunication (Olson & Olson, 2000).

Breakdowns of communication causing ongoing anxiety/anticipation of disruption, or traumatic rupture in the safety of the environment, have tremendous implications for those treating patients via technological mediation. The time and distance it takes for a signal to travel, zigzagging through myriad nodes, and the signal processing that occurs along the way as analogue is converted to digital, affect the quality of communication in sometimes subtle but significant ways. Throughout the audio/video transmission process not only are distortions introduced, but as errors are detected, enhancements are made that sharpen signals, heighten colours, suppress noise, and augment missing data. Removing intrusive noise creates a silence that is experienced perceptually as a disconnection, so Comfort Noise, a low but audible synthetic background noise, is generated and inserted to be unconsciously reassuring. The result is that what is communicated at the source is very different from what is ultimately received.

Just as we must acknowledge the greater context of the pandemic in which we all reside, we also need to acknowledge the technology that is mediating our relationship and the loss of the fullness of non-verbal embodied communication. I find that talking about this with my patients is very fruitful. When the call drops, when we miss parts of sentences, when the picture is fuzzy and unclear, it is helpful to point it out. Not only does this clarify the communication, it distinguishes the situation from what we shared in the consulting room to what we are sharing whilst depending on technology now. There is a loss and a difference which cannot be ignored.

We're coming to a close. How do you see the future of our work, as and when we can transition back to work in person? What are your thoughts and concerns? Should we assume that the landscape of analytic therapy will be permanently altered by Covid-19, with more people expecting the option of working online? To what extent can this be acceptable practice?

One of the traumatic aspects of the pandemic, right now in the beginning of May when I speak with you, is that we cannot clearly see the future. In fact, we are existing *in* the trauma right now, without any advantage of hindsight or perspective. And when we are in a trauma it is very difficult to think or project into the future. We are collectively grieving. There are so many losses, loss of connection, loss of safety, loss of a future about which we are now uncertain. This is what David Kessler calls 'anticipatory grief'. I do not think it is easy to make assumptions or guesses about what the future holds. When I spoke with a colleague of mine in Beijing, where they are anticipating a return to the consulting room, she describes the need to find trust all over again: trust in the journey, trust in the environment, and

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trust in each other. This includes concrete trust – Will the subway be safe? Will the consulting room be sanitary? Can we trust each other to be healthy? – and a more internal trust of the analytic process and relationship in a shared environment, rather than from the perceived safety of separate spaces and two screens. I do not observe many therapists or patients revelling in the enforced separation of lockdown at the moment – although there are some who find remote work easier (both emotionally and physically). I think that our entire future landscape will be inevitably altered, including our experience and expectations of analytic therapy. However, I am hoping that our experience of remote practice will motivate us to familiarize ourselves with the changes and losses inherent in technology use. That includes understanding the limits of technologically mediated relating, and therefore what is acceptable in practice. These limitations and the research behind them is what I have been thinking, writing and talking about for some years before Covid-19. In general, both in my own practice and from the many colleagues with whom I speak in my role in the Covid-19 Advisory Team, what I hear about is loss and frustration and a longing for embodied co-presence. I hear a deepening awareness of the shortcomings of all kinds of intimate relating through technology and an appreciation of the experience of shared presence. It is one thing to be able to choose, in an informed way, if and when one uses technology for treatment. Having no choice is quite another.

Lastly, leaving the illness itself to one side (if one can), do you see any advantages in what has happened?

The pandemic has brought issues of mental health front and centre in the media, where two pandemics are written of – the virus and the concomitant distress brought on by trauma and loss. There has been an acknowledgement of the emotional needs of a population dealing with a frightening, painful reality. In particular, we have seen the struggles of first responders, and frontline health care workers, and perhaps better appreciated the gruelling demands of these jobs – even in non-pandemic times. One would hope that general awareness of the impact of trauma on our mental health has been raised and that it might be easier to discuss these issues in the future.

For some, the shelter in place order has created a time for reflection and reassessment of their pace of life and priorities. Families have been able to make more time and space for each other, deepening relationships. While working from home has proved stressful and challenging, it has also increased time for togetherness. My colleagues have spoken of appreciating being granted the time they might have spent commuting, for example, to do other rewarding activities.

To follow on from my thoughts in the previous question, I would hope that the value of co-present relating has been rediscovered and reasserted. 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. This is a gift to be treasured and preserved, not lightly thrown away for the convenience of our devices. *True* presence, as unpredictable, spontaneous and messy as it is, is irreplaceable.

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NOTE

1. https://apsa.org/sites/default/files/Guide3-24.pdf

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