Exploring the views of child and adolescent psychotherapists on psychoanalytic remote work carried out during the COVID-19 pandemic: A reflexive thematic analysis study

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Abstract

The COVID-19 pandemic changed the way that child and adolescent psychoanalytic psychotherapists worked, almost overnight, by requiring the vast majority of therapy to be offered remotely, using telephone or video call. As the restrictions of the pandemic have been lifted, the interest in remote psychotherapy remains as an option that could widen access to treatment. There is a need to develop guidelines on best practice for on-going remote work.

Prior to the pandemic very little psychoanalytic remote work was offered to children and adolescents. The literature regarding adult patients suggests a relatively high prevalence of psychoanalytic remote work taking place in recent years. This work with adults has received a mixed reception, with questions arising on how a psychoanalytic setting and approach can be maintained remotely.

This research aimed to explore the views of a team of NHS child and adolescent psychotherapists working during the pandemic. Seven members of the psychotherapy team took part in a semi-structured interview, exploring their thoughts on the scope and limitations of remote work in child psychoanalytic psychotherapy. I used Reflexive Thematic Analysis (Braun and Clarke, 2006; 2022) to generate themes that represent the participants' views.

The findings of this study suggest that there are fundamental differences between in-person and remote child psychotherapy. Most significantly the absence of the patient and therapist being physically together appears to change the nature of communication and containment in the dyad. This study tentatively suggests that young patients with significant disturbance or impoverished capacities might struggle to make good use of remote work. Minimum requirements in the young person's physical and family environment are also described. Recommendations for further research into specific aspects of remote work are made.

Key words: COVID-19, remote work, child psychotherapy, psychoanalytic psychotherapy, reflexive thematic analysis, containment

Introduction

> "I think it's easy to develop a bit of a fantasy about what we're offering and perhaps smooth over the cracks. It's not the worst thing in the world but it's not the best…" (Participant 1)

Research context

The COVID-19 pandemic catapulted the world into a strange era of abrupt change and perpetual uncertainty. One of the countless interruptions to life in the United Kingdom (UK) was the requirement for the vast majority of psychotherapy to be offered remotely, on telephone or video call, without preparation or volition. With a new focus directed on psychoanalytic remote work (PRW) there is a need to explore the potential benefits and pitfalls of both continuing to offer and expanding its use. Research is required to develop guidelines for best practice, including looking at indications and contraindications for effective remote child psychotherapy.

Before the pandemic, PRW with children and adolescents was very rarely offered by child and adolescent psychoanalytic psychotherapists. Other forms of telemedicine (health appointments via telephone or video call) with adults had gained some popularity in recent years, in parallel with the increasing ubiquity of technology in everyday lives. However, even though the technology required to hold health appointments online has existed for some time there has been a limited uptake, for example in general practice (Atherton et al., 2018) where less than 1% of appointments were held on video call pre-COVID (NHS Digital 2022a; data for January 2020 in England). Professionals and patients perhaps intuitively favoured the experience of in-person contact.

Socio-political context

The UK National Health Service (NHS) Long term plan (NHS, 2019) set out goals for the way the health service will be improved over a ten year period. Amongst other aims, it focuses on both investing in digital health care provision and improving children's access to specialist mental health support to enable "100% of children and young people who need specialist care [to] access it." (NHS, 2019, p. 50). It states that "The NHS will offer a 'digital first' option for most [appointments], allowing for longer and richer face-to-face consultations with clinicians where patients want or need it." (NHS, 2019, p. 92). 'Digital first' appears to be presented as a way to boost cost and time efficiency.

In the wake of COVID there are increasing demands for child and adolescent mental health services to accommodate increasing numbers of referrals for children who have suffered as a consequence of the pandemic; between year ending April 2021 and April 2022 there was a 22% increase in under eighteen year olds who had contact with mental health services (NHS Digital, 2022b). Given that child and adolescent mental health services were already under-resourced (Education Policy Institute, 2020) and had no choice but to offer PRW during the pandemic, it seems even more likely that developing 'digital first' options will be prioritised in an effort to meet this new demand. In this context, looking at the value and efficacy of offering PRW in child and adolescent mental health services becomes increasingly important.

Within the NHS child psychotherapy provision, guidelines are required to map out when a digital option might be in a patient's best interest or conversely to present the argument that child psychotherapy should be prioritised as a treatment that works best in "longer and richer face-to-face" appointments (NHS, 2019, p. 92). The Association of Child Psychotherapists (ACP) have suggested that PRW must be carefully considered to ensure that

it provides safe and effective treatment, offered in the service of best clinical care rather than a drive to meet service needs (ACP, 2020).

Potential benefits of widening access through remote work

The Association of Child Psychotherapists has been focused on improving access to psychotherapy across the UK, especially in areas where there has historically been very little psychoanalytic resource in child and adolescent mental health services (ACP, 2018). One of the barriers to this is the large geographical area covered by some clinics outside of urban centres; patients travelling long distances to be seen in regional hubs restricts the potential for high frequency work. Accordingly, there is a lot of interest in using PRW to widen access to psychoanalytic psychotherapy and effectively remove geographical barriers. Udwin, Kufferath-Lin, Prout, Hoffman and Rice (2021) point out that PRW also increases the potential for very specialist work to be offered more widely, for example treatment with bilingual therapists or specialist provision for specific presentations offered by national centres.

However, whilst PRW removes some barriers to accessing psychotherapy, it appears to impose others. An Association of Child Psychotherapists' survey of PRW (completed by 376 members in May 2020) highlighted "… a strong consensus that children living in poverty or with dysfunctional families would struggle to access services delivered only online due to cramped living conditions, lack of private space and lack of equipment." (ACP, 2020, p. 5). With 31% of children in the UK living in poverty (Joseph Roundtree Foundation, 2022) this is a significant consideration.

Remote work in the pandemic

The Association of Child Psychotherapists' survey of members (2020) found that 89% of the 376 responders had offered PRW during the initial months of the pandemic. The survey gives an early snapshot of the type of PRW that was possible at the time, when the widespread emotional and societal impact of the pandemic was still at its peak. The findings are incorporated into the Association of Child Psychotherapists' Guidance on Working Remotely with Children, Young People and Families (ACP, 2021) which were initially published in rapid response to the pandemic in 2020 and revised in light of the survey findings and clinical experience in 2021.

The Association of Child Psychotherapists' guidance provided a timely, common-sense guide to practice, whilst also highlighting that further research is needed to consider the nature of PRW and who might benefit from it. There is a need to develop these guidelines in light of the profession's growing understanding of PRW. For example, the guideline's inclusion and exclusion criteria for PRW list "Child is too young; Child or young person is too ill" (ACP, 2021, p. ii) as two of multiple instances where PRW is not recommended. Unpacking how 'too young' or 'too ill' might be defined or assessed is the task of this and other research into best practice in on-going PRW.

Research rationale

PRW was a necessary adaptation to the restrictions of the pandemic. In considering its on-going value questions arise, not only about which patients could benefit, but also about how possible it is to work with a psychoanalytic approach remotely. There is a need to ensure that the vital therapeutic components of psychoanalytic work are protected in the way it is applied in PRW. As a novel field, there are many significant gaps in the literature on PRW.

Working within these gaps, in this qualitative research I will gather the views of child and adolescent psychoanalytic psychotherapists working in child and adolescent mental health services during the pandemic. I will consider the scope and limitations of PRW with children and adolescents, where psychotherapy was offered virtually, using audio or video call. I will use semi-structured interviews to guide the therapists to share their full range of thoughts on PRW, and then analyse the interview data using Reflexive Thematic Analysis (Braun and Clarke, 2006; 2022) to generate themes to address the research question.

Literature Review

This section presents the current literature on the scope and limitations of remote psychoanalytic psychotherapy. The first part looks at PRW pre-COVID with adults. This is an overview of the literature. A systematic review was not conducted because not all of the literature on PRW with adults would have been relevant to the research question's focus on work with children and adolescents. The second part provides a systematic review of literature on psychoanalytic remote work with children and adolescents, mainly consisting of evidence emerging from the pandemic.

Psychoanalytic remote work with adults

Overview

There is a significant volume of work describing PRW with adults. Corresponding with the huge growth in availability of technology in everyday lives, this research mainly spans the last twenty years. Over this period, publications have developed from speculative accounts of "experimental" treatments over the phone (Savege Scharff, 2010, p. 989), towards examinations of the nature of PRW in finer detail. It appears that PRW with adults has a mixed reception with many questions arising about its fidelity to a psychoanalytic approach.

Although this literature review is limited to publications in English, PRW appears to have been more widely used and written about in other parts of the world, due to the sparsity of analytic resource and greater geographical spread of populations. The psychoanalytic community in South America appears to be particularly advanced in their thinking on PRW (Carlino, 2011).

I have included an extended discussion of adult PRW literature as the 'nearest-neighbour' to PRW with children and adolescents, however there are fundamental differences that make findings from adult psychotherapy research only partially applicable to work with children. Considerations on transferability are included in a later section.

This is not an exhaustive review of the literature which would have been beyond the scope of this study. I found this literature by starting with the most frequently cited texts and using snowball searching to expand from these following a line of interest. Table 1 provides an overview of the literature used in the following section.

Table 1: Table of literature on PRW with adults; in chronological order of publication

Author surname	**Date of publication**	**Title**	**Nature of work**
Saul	1951	A note on the telephone as a technical aid	Journal article, documenting a single, brief, case study of an adult patient moving from in-person to telephone analysis.
Zalusky	1998	Telephone analysis: out of sight, but not out of mind	Journal article, documenting a single, detailed, case study of an adult patient moving from in-person to telephone analysis.
Richards	2001	Panel report: talking cure in the 21st century: telephone psychoanalysis	Record of panel discussion, briefly discussing three adult patients seen in telephone analysis.
Leffert	2003	Analysis and psychotherapy by telephone: twenty years of clinical experience	Journal article recounting work with several adult patients seen for PRW.
Carlino	2011	Distance psychoanalysis	Single author book offering theoretical exposition of PRW with adults.
Fishkin et al.	2011	Psychodynamic treatment, training, and supervision using internet-based technologies	Journal article giving an account of PRW offered to mental health professionals training in China.
Mirkin	2011	Telephone analysis: compromised treatment or an interesting opportunity?	Journal article, documenting two, detailed, case studies of adult patients moving from in-person to telephone analysis.

Bayles	2012	Is physical proximity essential to the psychoanalytic process? An exploration through the lens of Skype	Journal article written by a psychotherapist documenting their own training analysis, in which some work was done remotely.
Savege Scharff	2012	Clinical issues in analyses over the telephone and the internet	Journal article, describing current issues raised in PRW with adults.
Bell	2013	Psychotherapy via Skype: a therapist's experience	Journal article, documenting a single, brief, case study of an adult patient moving from in-person to PRW.
Caparrotta	2013	Digital technology is here to stay and the psychoanalytic community should grapple with it	Journal article, documenting a single, detailed, case study of an adult patient moving from in-person to PRW.
Savege Scharff	2013	Technology- assisted psychoanalysis.	Journal article, describing further issues raised in PRW with adults.
Lemma and Caparrotta	2014	Psychoanalysis in the technoculture Era	Edited book exploring wider issues of the psychology of the rise of technology in everyday lives.
Churcher	2015	The psychoanalytic setting, the body-schema, telecommunications, and telepresence	Conference paper on the implications of the work of José Bleger on PRW with adults.
Isaacs Russell	2015	Screen relations	Single author book reporting an in-depth ethnographic study of moving from offering in-person therapy to PRW with adults.
Merchant	2016	The Use of Skype in analysis and training: A research and literature review	Journal article reporting an informal literature review of current PRW practice and research.
Churcher	2017	Privacy, telecommunications, and the psychoanalytic setting	Chapter in Savege Scharff (2017) Psychoanalysis Online, volume 3. Explores issues in current PRW practice with adults.
Gutiérrez	2017	Silicon in 'pure gold'? Theoretical contributions and observations on teleanalysis by videoconference	Journal article offering theoretical exposition of PRW with adults.
Lemma	2017	The digital age on the couch	Single author book exploring PRW and wider issues surrounding digital culture.
Ehrlich	2019	Teleanalysis: Slippery slope or rich opportunity?	Journal article, describing theoretical issues raised in PRW with adults.

Wanlass	2019	Assessing the scope and practice of teleanalysis. Preliminary research findings	Chapter in Savege Scharff (2019) Psychoanalysis Online, volume 4. Reports the preliminary findings of a survey of psychotherapists views on PRW with adults.
Isaacs Russel	2020	Remote work during the pandemic; a Q&A with Gillian Isaacs Russell	Record of discussion on using PRW with adults at the start of the pandemic.
Savege Scharff	2020	In response to Kristin White "Practising as an analyst in Berlin in times of the coronavirus"	Published comment in response to White (2020).
White	2020	Practising as an analyst in Berlin in times of the coronavirus: The core components of psychoanalytic work and the problem of virtual reality	Journal article offering initial thoughts on moving to PRW with adult patients during the pandemic.

History of PRW

The first account of PRW with adults was published over seventy years ago when Saul (1951) describes telephone sessions with an analytic patient where the relationship was so intense that the patient was extremely inhibited in in-person work. Saul describes a change in the emotional quality of the work when meeting remotely which allowed the dyad to engage with the transference in a way that previously felt too distressing to manage whilst together in-person.

Since 1951 there had been very few published papers on PRW until around 2000 when a group of proponents began to write more widely. Work originally described 'teleanalysis'; psychoanalytic psychotherapy or analysis conducted over telephone. More recently there has been a greater focus on sessions using online video call.

Prevalence of remote work

Even in 1951, Saul writes that although nothing had been written about teleanalysis, many analysts had experimented with using the phone to support treatment. Now, there is a general acceptance that most therapists have used PRW at some point. This is typically in the interest of preserving the continuity of work in situations where it becomes impossible for the patient to attend in-person. With parallels to the present day, Saul suggests that PRW would allow for more patients to get treatment at a time when analytic and psychiatric resources are sparse.

Richards (2001) reports the results of a small survey completed by 120 members of the American Society for Psychoanalysis and Psychoanalytic Psychology; 83% of responders had used the telephone for treatment with adults in the previous two years, and of them 84% found telephone sessions "usually productive" (Richards, 2001, p. 389). However, just 3% of those surveyed said that they only saw their patients remotely.

Several writers have given accounts of why, despite its seemingly high prevalence, PRW is something that had been rarely discussed and at times appears to be something to be kept quiet. Again, with striking longevity, Saul (1951) describes resistance to change in general and how this might be especially true in the psychoanalytic community. Leffert describes feeling as though he "… was doing something forbidden…" by offering PRW (2003, p. 105). Zalusky (1998) describes feeling a sense of guilt for working outside of ordinary psychoanalytic norms. They grappled with feeling that they must be acting out by offering something they otherwise wouldn't. Caparrotta describes a feeling of "shame for betray[al]" (2013, p. 298) of tradition.

PRW has been used more extensively to facilitate training in locations where there is limited or no access to psychoanalysts. Fishkin et al. (2011) document the China American Psychoanalytic Alliance where video call has been used since 2005 to allow analysts from

America (and other English speaking countries) to offer analysis to mental health professionals in training in China where there is very limited availability of analysts. Fishkin et al. describe the assessment and process of analysis proceeding largely as it would in-person. Although they note the cross-cultural complexity of western analysts working with Chinese patients, little comment is given to any difference created by meeting only online.

Fidelity of psychoanalytic remote work

Since the first reports of PRW there have been questions about its fidelity to an analytic way of working. I will present a summary of the significant adult PRW literature as it addresses this debate, framed as key questions on the nature of PRW.

Is it possible to maintain a consistent analytic setting in PRW?

It is a widely held view that a critical element of the analytic setting is the mind of the analyst themselves and their ability to reflect on the material presented by the patient. Lemma helpfully reminds us that this "is portable" (2017, p. 84). On the other side of the analytic dyad, the patient requires conditions that allow them to participate in the session; where they can communicate with the analyst consciously and unconsciously including by free association. Both the psychological and physical environment are factors in this.

Much of the PRW literature describes the ways that analysts can maintain many of the setting boundaries applied in in-person work, for example having consistent times and agreed parameters for making payments. Leffert's (2003) case study account of several analytic patients moving to telephone analysis, suggests that the task of creating the setting in PRW is shared between patient and analyst in contrast to the carefully curated in-person setting that the analyst strives to keep consistent. They suggest that the way in which patients might manage

[or not] to co-create their setting becomes interesting material to be analysed, as it would be in-person, for example if a patient arrives late.

In the majority of PRW described it appears that the patient's greater control over the setting, particularly being in their own home, is regarded as having a facilitating effect which allows for good use of the therapy (Leffert, 2003; Mirkin, 2011; Savege Scharff, 2012; 2013; Caparrotta, 2013). Mirkin (2011) provides two detailed case studies in which one patient appeared to feel more able to take in the words of the analyst who they perceived as having a less critical voice at distance; in part due to being in greater control of the setting and feeling less need for defence "… away from [the analyst's] scrutinizing eye…" (2011, p. 652).

Leffert also provides the counterargument that some patients struggle to feel safe enough to allow for regression or working on their most vulnerable aspects whilst not in a setting managed by the analyst. Leffert gives "recognition that the office and waiting room constitute the physical container in which the analysis takes place." (2003, p. 120). Whilst the containment provided by the thinking mind of the analyst can be maintained remotely, this gives the suggestion that for some patients there is a physical need which is more difficult to achieve when the analyst does not provide the setting. Additionally, Lemma's (2017) theoretical exposition of PRW, suggests that the patient's experience of the availability of the mind of the analyst might itself be compromised by the loss of a fully embodied experience, which in turn degrades the patient's experience of containment. This will be expanded on in a later section.

In an informal literature review of current PRW practice and research, Merchant (2016) quotes Winnicott's (1956) discussion of a patient whose significant disturbance left them in need of the physical and emotional routine of the setting, rather than the words of an interpretation. Writing about work with patients who have experienced complex trauma in early

relationships, Isaacs Russell suggests it is “unreasonable to expect the patient to be able to provide a safe setting for themselves” (2020, p. 370) emphasising the need for the therapist to provide the safety that has been absent before.

In a rich theoretical examination of PRW, Gutiérrez (2017) expands on this, describing how in psychoanalytic work there is a need for some patients to re-experience primitive states of unintegration in order to work through issues arising from early life. Gutiérrez suggests that the need to compensate for not being physically with the analyst creates a significant “ego demand… [so that there is a need for]… forced ego integration” (2017, p. 98). Accordingly, forced ego integration blocks the potential for necessary regression. They also make the point that the same process might impinge on the analyst’s ability to remain in a state of evenly suspended attention (Freud, 1912).

What happens when the patient and therapist have a restricted view of each other?

Regardless of medium the dyad’s sensory impression of each other in PRW is compromised to varying degrees. Many authors point out the straightforward impact of not being able to see things like what the patient is wearing, how they hold themselves, how the tension in their body might change from moment to moment etc. Discussion in the literature of the impact of the loss of the fullest range of sensory information varies greatly.

Leffert (2003) described that when the patient’s voice is the only data available the analyst is able to tune into tone, speech rate, intake of breath, word choice, and pauses to a greater degree. They suggest that the voice alone can provide a rich source of emotional information.

It seems that some patients are acutely aware of not being seen by the analyst, to both positive and negative effect. Caparrotta’s (2013) single case study describes how in a video

call a patient felt the need to indicate in gesture that he was crying in case the therapist could not see his tears. However, the same patient seemed to feel freed up to speak more directly about issues that distressed him. Several papers make reference to patients feeling more able to talk about very sensitive issues, particularly topics that they find shameful or related to sexual themes (Richards, 2001; Leffert, 2003; Mirkin, 2011; Savege Scharff, 2012; 2013). Richards (2001) briefly describes work where the patient was able to talk about issues of both body shame and ethnicity more readily in PRW than in-person.

Recent literature accounts for this using Suler's (2005) online disinhibition effect. This describes how in an online encounter an individual might present themselves differently to in-person, particularly, in a disinhibited way. Although perhaps more widely applied to interactions on social media the concepts of increased anonymity and "solipsistic introjection" (2005, p. 186; the ease at which an online other is assigned with the subject's internal voice, influenced by transference/projection) would seem to apply to PRW settings. Using Suler's idea it is suggested that the patient presents different aspects of themselves in PRW based on interacting with a phantasy of the therapist that might differ from their reality in an exaggerated way, alongside feeling that less of themselves is on show when the therapist can't readily see the whole of them.

Although disinhibition that allows for fuller disclosure of shameful experiences is described as a positive aspect of PRW, Gutiérrez (2017) suggests that being able to 'say the unsayable' is merely a product of the patient relating to their phantasy of the therapist, rather than the real embodied person. This is echoed by White (2020) who, in a brief paper commenting on moving to PRW in the pandemic, describes the need for the patient to experience the discomfort of trying to address shame in-person, over time, in order to work through difficulties in a meaningful, transferrable way.

Opposing the idea that PRW is inherently disinhibiting, Bayles' (2012) autobiographical account of their own online psychoanalysis, suggests that the very up-close view of each other's faces, in face to face video call, made the experience of being embarrassed more intense and therefore activated more inhibition of what could be safely discussed.

What is the impact of the patient and therapist's bodies not being together?

Describing work that moved online for a fixed period, Mirkin's (2011) patient who had a history of childhood sexual abuse appeared to feel a greater sense of safety whilst working at distance; feeling that they no longer had to monitor the analyst to ensure their safety. The patient was able to reflect on this and move towards feeling able to voice anger at the analyst for the first time; in the knowledge that distance gave safety when in the transference the analyst had become an aggressor.

The more fundamental, implicit impact of the analyst and patient not being in bodily proximity is a much debated issue. Many proponents of PRW give vivid examples of somatic countertransference as evidence to support the idea that not being together does not preclude bodily connection or communication. In a demonstration of how intensely projections can be felt in PRW, Savege Scharff (2012) describes work with a patient who experienced childhood sexual abuse; in sessions on the phone the therapist experienced vivid bodily feelings in countertransference, which they understood as projections of the patient's experience of abuse. Talking about this allowed the patient to remember for the first time, details of the abuse that had been repressed until then.

In contrast, Isaacs Russel (2015; 2020) draws on extensive ethnographic research into her own and other's practice of PRW to suggest that a fundamental element is absent in the experience of both the therapist and patient when working at distance. Summarised as the

"potential to kick or kiss" (2015, p. 41) Isaacs Russel highlights that without the real, physical possibilities of the dyad being together, essential properties of relationships never come to light for exploration; the screen protects the analyst from the patient's phantasised attacks so that the patient doesn't have the opportunity to experience the analyst's survival. Similarly, the patient does not have to grapple with the reality that the analyst could 'kick or kiss' them but does not; the absence of this provides safety to the excessive extent that fears and phantasies do not surface and so cannot be analysed. Churcher (2015) gives the evocative example of a patient in an in-person session who imagined the analyst was about to hit him with a hammer and the subsequent analysis of the very primitive material that was aroused. They suggest that, as a consequence of working at distance with the implicit safety of the screen, an encounter of this sort would not happen and so the potential to analyse such infantile material is reduced.

Lemma (2017) suggests that the use of PRW needs to be carefully considered because of the centrality of working in awareness of the body. They helpfully redefine PRW as working with two bodies in separate spaces, rather than being without the body, whilst describing the profound loss of implicit bodily communications that occur without thought in in-person sessions. They advocate for effort to be made for the patient and therapist to establish an in-person relationship before moving to online sessions, to allow both members of the dyad to draw on the memory of being together physically to sustain the relationship at distance.

Findings from neurobiology

Findings from neuroscience have been used to evidence and explain the mechanisms involved in psychoanalytic therapy. Isaacs Russel (2015) gives an overview of the large amount of research from various fields of neurobiology that documents the complexity of the embodied experience in therapy. As a collective, this work supports the argument that embodied

experiences are vital for communication, including allowing a multitude of implicit communications which are only registered outside of awareness. Such evidence is important in understanding the nature of how the setting is changed in PRW.

Gallagher (2005) explores mechanisms that might account for some implicit communication in therapy. They describe the cross-modality of the sensory system, linking sensory inputs so that, for example, a bodily proprioceptive input alone can trigger a multisensory experience. This concept is used to both support and critique PRW. Savege Scharff (2013) and Merchant (2016) suggest that cross-modal neural functions compensate for the limited sensory input in video call by generating a fuller sensory response. By contrast, Bayles (2012) and Gutiérrez (2017) suggest that PRW (audio and audio visual) is critically limited by the absence of the body to a degree that would reduce the possibility of cross-modal perception.

Carlino (2011) gives a detailed examination of PRW linked to psychoanalytic theory and neuroscience. They suggest that the role of mirror neurons in communication is also of interest for PRW. Describing their function, Carlino explains that mirror neurons create a neural imitation response when seeing/hearing/sensing the action/emotion of another, meaning that parts of the brain associated with an action are activated without the person needing to experience it themselves. This happens without the need to consciously imagine as an automatic, implicit process. It is proposed that mirror neurons "… act in the complex process of identification and empathy" (Carlino, 2011, p. 47) and accordingly have a role in projective identification/countertransference (Isaacs Russel, 2015). Carlino suggests that mirror neurons are active in audio or video call mediated PRW, and so facilitate the same bodily responses that would be expected in in-person sessions.

However, the connections between psychoanalytic practice and findings from neuroscience are tentative. There is much more to be understood in order to robustly use biological evidence to support any application to psychoanalytic work.

Role of the analyst's body

Churcher (2015; 2017) has written extensively about the work of José Bleger, an influential South American analyst. They describe Bleger's model as it theorises a position prior to Klein's paranoid schizoid position (1946) in earliest infancy. In this theory, the analytic setting, including the analyst themselves, becomes a depository for primitive, psychotic elements in a process akin to Bion's formulation of the infant's primitive projections into and containment by the mother (1962). Bleger's theory stresses the importance of the body and the embodied experience in analysis. Thinking about the implications of the absence of the analyst's body in a PRW setting, Churcher suggests that the technology used to communicate would become like a prosthetic extension of the body, and so becomes a depository for projections in place of the analyst, where presumably they would be inaccessible to the work of analysis. Churcher suggests his ideas are a "thought experiment" (2015, p. 2) which appear to stop short of making direct conclusions about the possibilities and limits of PRW.

Is it possible to work in the transference and experience countertransference in remote work?

The clinical examples documenting PRW give vivid examples of the analyst following communications from the patient to gather impressions of the transference as they would in-person. Bell gives a very simple, yet germane example of how their patient continued to communicate in PRW much as they had done previously; "the patient, who had reliably been

about 10 minutes late for the majority of our face-to-face sessions, was also 10 minutes late for his Skype session." (2013, p. 144).

As discussed earlier, Leffert (2003) and Savege Scharff (2012; 2013) suggest that in the presence of limited sensory information the analyst is better able to focus on listening to unconscious material, as though less distracted by the immediate reality of the patient. This is often described as being akin to using the couch. Leffert suggests that material brought to PRW sessions was largely the same as what the specific patient would bring to an in-person session and could be thought about in the same way.

Stimulated by their experience of PRW in the pandemic, White (2020) offers a different perspective. They suggest that negative transference in particular is masked or absent because PRW is less demanding of the patient's commitment. This impact on the negative transference suggests a vital aspect of analytic work is altered.

Zalusky (1998) and Mirkin (2011) both highlight an increase in maternal, gratifying material in the transference, perhaps being evoked by the sense that the patient is being offered something special in the continuation of work that would otherwise have ended. Zalusky described a long lasting telephone analysis. They suggest that the patient was able to continue working at the same depth as in the previous three years of in-person analysis. The distance the patient felt appeared to stimulate feelings in the transference related to being separated from their father in childhood, allowing for consideration of this previously unexplored area. However, they also suggest that PRW encouraged feelings of longing and hunger, implying that the work was not sustaining enough. They state that occasional in-person sessions were required as a reset; to prevent phantasies of both the patient and analyst moving too far from embodied reality.

Later writers have elaborated on the idea that both conscious fantasy and unconscious phantasy is distorted in PRW. Lemma (2017) suggests that some elements of the transference can come to the fore in an exaggerated way. They give the example of work with a patient where erotic transference played a much bigger role in PRW suggesting that this could flourish at a distance because the patient felt safe in the knowledge that the feelings could never be enacted. For this reason, it was also difficult to address the dynamic because it only emerged in the patient's acting out, outside of sessions.

Both Carlino (2011) and Gutiérrez (2017) echo the suggestion that phantasy can be readily distorted. Gutiérrez (2017) hypothesizes that without a full experience of the reality of the therapist in-person, the patient has to create a picture of them in their mind to allow for a relationship to be created and sustained. This fantasy of the analyst is intimately linked with phantasy. Accordingly, there is an increased opportunity for the transference relationship to be intensified and distorted.

Who is remote work suitable for?

Carlino (2011) suggests that PRW might be preferential for particular presentations, for example where anxiety prevents a person from leaving home; PRW might help improve symptoms to a degree that it becomes a bridge to in-person work. Lemma and Caparrotta (2014) suggest that PRW could act as a stepping stone for patients who would not otherwise seek help, for example those for whom an in-person session would feel too anxiety-provoking or too much of a commitment. In such cases, over time the meaning of choosing PRW could become material for the analysis. Addressing both practical and internal contraindications for PRW Savege Scharff suggests;

> Teleanalysis is not possible if the analysand lacks a capacity for maintaining the alliance and sharing responsibility for the management of the setting. It is not possible to do teleanalysis when the analyst or analysand has uncorrected deafness; when either of them speaks too softly or indistinctly, or is too silent to sustain the connection. It is unwise when the analysand has borderline features with suicidal actions… (Savege Scharff, 2012, p. 92)

Leffert states that of the many patients he moved to telephone work when he relocated his practice "… only two patients found it impossible." (2003, p. 106). They describe that in one case the remoteness stirred up a very painful negative paternal transference, where the analyst's physical distance echoed the emotional distance felt between the patient and his father. Leffert suggests that the patient's anger could not be contained in the PRW setting and this led to the patient ending the work.

Despite the apparent success of moving his practice online, Leffert is still cautious about the general application of PRW. They suggest "if the patient had significant ego deficits, problems with damaged or defective self or object representations, or a history of severe emotional trauma, telephone treatment would have seemed inadvisable." (Leffert, 2003, p. 126). This is echoed by Zalusky (1998) who regarded continuing analysis on the phone as preferential to a premature ending, but suggests many contraindications including the need to consider the patient's experience of intimacy, which might be lessened in PRW and therefore not available to be worked on.

Although Ehrlich (2019) writes passionately in support of PRW they cite the need for both the analyst and patient to be motivated to make the therapy meaningful in order to overcome the limitations inherent in PRW. It seems likely that those patients with particularly forceful resistance would struggle to sustain treatment adequately.

Managing and assessing risk

The vast majority of patients described in the reviewed literature could be described as experiencing significant distress and disrupted relationships, rather than psychotic illness or more serious psychiatric disturbance. The rare exceptions appear to be a very small number of analysts writing in South America who document effective PRW with psychotic patients (cited with minimal detail in Savege Scharff, 2013. I have been unable to find an English translation). From a legal perspective, writing about psychologists undertaking PRW, Harris and Younggren (2011) state:

> Until more research is conducted, it would be prudent to assume that patients who present high risk in more traditional contexts may not be good candidates for remote treatment. Clients who are highly dysfunctional, who have Axis II diagnoses, who have conditions that require team approaches or intensive care, who are at risk of self-harm, and who are likely to be noncompliant with the commitments necessary for treatment to be effective are probably not good candidates for remote treatment. (Harris and Younggren, 2011, p. 417)

At this point, such exclusion criteria seem to be devised instinctively out of necessary caution given the potential risk of harm to the patient. Whilst such safeguards are needed, it will be difficult to examine what happens if PRW were used with high-risk patients.

Evaluating the evidence base on PRW with adults

Nature of the evidence base

As a collective body of literature reviewed in this section, almost all of the evidence presented in support of PRW is in the form of single case studies. Although the evidence base is relatively small, when combined it represents many cases with broadly favourable outcomes. Much of the literature comes from a small cohort of proponents. There has not yet (to my knowledge)

been any systematic review of the efficacy of PRW. With this in mind, more robust, impartial, empirical studies are needed to substantiate the findings of the broadly case study based evidence in the literature, in order to more fully understand what happens in PRW with adults and its efficacy as a treatment.

Wanlass (2019) presents the preliminary findings of the first stage of a large scale research study supported by the International Psychoanalytic Association (IPA). In the first of a proposed three stage project, members of the IPA were asked about the prevalence of PRW in their practice and their thoughts on technique and efficacy. Wanlass highlights that the most significant limitation of the research is the small sample size: reporting that only 6% of the possible responders completed the online survey (341 responses). With this in mind the results are tentative. The author states that the findings are much more negative than expected; over 50% of responders suggest that PRW is not a good enough alternative to in-person work, describing loss of nonverbal cues and distortions of the transference as primary issues experienced.

Demographics of patients

It is worth noting that the vast majority of PRW literature describes patients engaged in private practice work, not suffering from acute psychiatric disturbance. Although not usually explicit in descriptions of patient work, it is also plausible to assume that most of the patients discussed were motivated to seek help and invested in their treatment having positive outcomes (at a conscious level at least). These factors perhaps make PRW appear more viable than it might be with patients in more deprived external or internal circumstances.

Impact of previous in-person relationship

The vast majority of publications describe work with patients who the therapist already had an established relationship with, developed through long term in-person work. In nearly all the cases described, the therapy moved online temporarily or until a planned ending because either the patient or therapist relocated. It is important to bear in mind the potential impact of the previous in-person relationship which perhaps allowed for rich work in the transference to continue. For example, in the way that Lemma (2017) suggests that existing bodily memories of the patient facilitate PRW.

Conclusions about psychoanalytic remote work with adults

In the twenty years of development in PRW with adults the literature has matured towards examining the nuances of this work. Ehrlich (2019) suggests that in considering PRW it's not a question of if it is or isn't possible, but how and for whom PRW is appropriate. They also point out that in comparing PRW to in-person analysis the arguments often become a straw man; where in-person work is idealised and the often disorderly, imperfect work of any analysis is overlooked. Savege Scharff (2020), perhaps PRW's most vocal advocate, writes that PRW is different from in-person work; it's not desirable for every patient or analyst, but it can be used to powerful effect if the loss of being physically together is acknowledged and the experience of being online is discussed to address its meaning. Much of the evidence base appears to arise from case study accounts from an affluent population in private practice. More robust research is required to continue to explore the impact of the therapist and patient being apart from each other, across a wider demographic of patients.

Transferability of adult findings to work with children: Nature of child psychotherapy

The internal frame of the psychoanalytic therapist and centrality of working with the unconscious through transference and countertransference is at the core of all psychoanalytic work irrespective of the age of the patient. However, how this broad model of therapy is applied in work with children and adolescents can be vastly different from work with adults. Most significantly, in children's work communication through play and action with the therapist is paramount, as compared to talk in adult work.

With this in mind, findings from adult PRW literature relating to accessing the unconscious, the significance of the body and working in the transference would seem to be of substantial relevance, though not directly transferable. Issues related to creating the setting for work with children and establishing the practical psychoanalytic frame has fewer correlates to adult work. For example, a distinctive area is the important consideration of how parents are required to support a child's work. (The term 'parent' will be used throughout to represent any adult with responsibility for the child, including foster carers, guardians etc.)

Describing the methods used in child psychotherapy, Boston lists "observing, understanding, and containing" (1977, p. 23) among the essential aims of the therapeutic relationship. In order to understand the child a great emphasis is placed on close observation taking into account "… the very nature of analytic work with children [is] dependent largely on action rather than words…" (Joseph, 1998, p. 359). In addition, observation of the therapist's response in countertransference perhaps provides the most vital data to enable understanding of the child's projections and therefore internal world (Heimann, 1950). It is essential that the setting for therapy, remote or in-person, provides the conditions to allow the therapist to achieve these aims.

Psychoanalytic remote work with children and adolescents

In the second part of this literature review, I conducted a systematic literature search to look for any publications describing PRW specific to children and adolescents.

Literature search method

To find all of the relevant research, the literature search was required to find published works that addressed the following three concepts:

Concept 1: Psychoanalytic psychotherapy

Concept 2: Remote therapy (i.e. on the telephone or video call)

Concept 3: Therapy with children or adolescents

Initially, I made a list of all possible synonyms for each concept (See table 2).

Table 2

Synonyms		
Concept 1	**Concept 2**	**Concept 3**
Psychoanal*	Remot*	Child*
Psychodynamic*	Distan*	Adolescen*
	Virtual*	Teen*
	Online	Young*
	Tele*	Youth*

After trialling some initial searches, I realised that the terms in concept 2 were too broad and so I refined the search terms as follows (See table 3).

Table 3

Synonyms		
Concept 1	**Concept 2**	**Concept 3**
Psychoanal*	"Remote therapy"	Child*
Psychodynamic*	"Distance therapy"	Adolescen*
	"Virtual therapy"	Teen*
	"Online therapy"	Young*
	Tele-therapy	Youth*
	"technology mediated therapy"	
	"Remote psychotherapy"	
	"Distance psychotherapy"	
	"Virtual psychotherapy"	
	"Online psychotherapy"	
	Tele-psychotherapy	
	"technology mediated psychotherapy"	

Notes on search method:

**Truncation used to search for all possible word endings*

"…" used to ensure that all text in quotation marks is searched for as a phrase

I searched individual concepts using all synonyms combined with the "OR" Boolean, then combined these searches using the "AND" Boolean, so that the final result showed all the literature where at least one synonym from each concept is discussed.

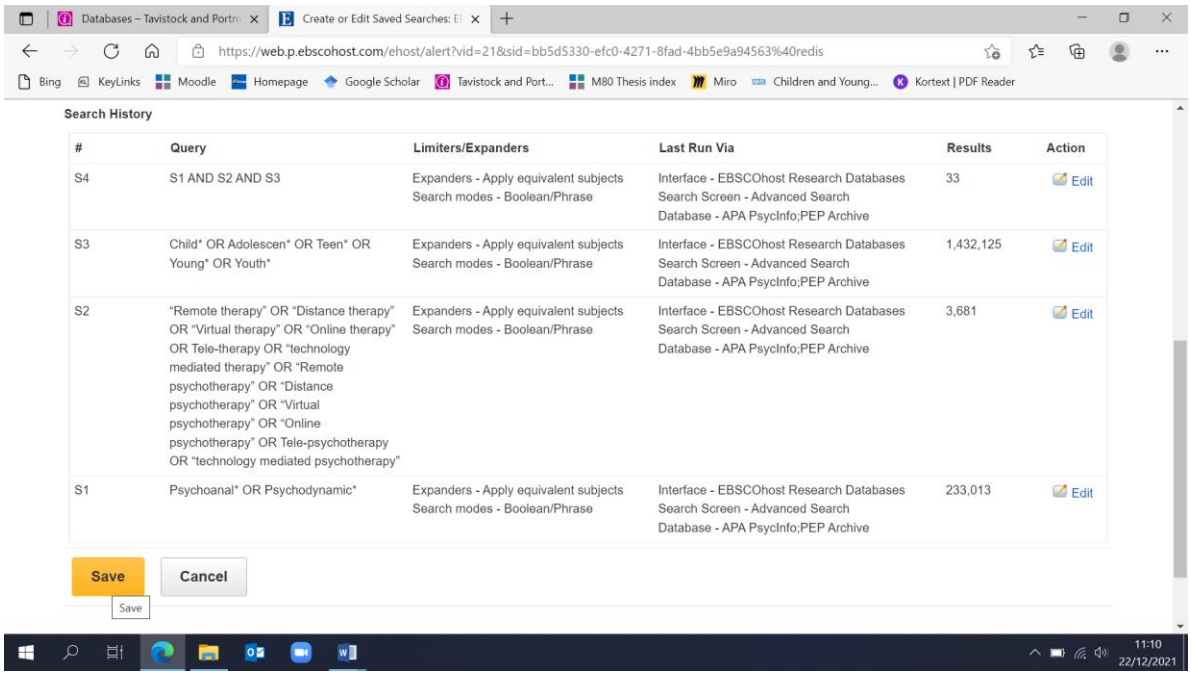
Databases

I used the database PsycINFO as the largest psychology/mental health related database to achieve the broadest coverage of the material, and PEP Archive as a leading psychoanalytic database.

Results

At the time of the initial search (December 2021), combining concepts 1, 2 and 3 as described yielded 33 results (See image 1) of which 27 appeared to be relevant (based on title and brief reading of the abstract. The 6 articles that were excluded because they did not relate to psychoanalytic work). The remaining 27 form the basis of the literature review.

Image 1



Additional hand searching

To get a greater insight into the scope of current research I conducted further snowball searches to look for other work by key authors and articles cited in the reference lists of prominent articles/in the publications they appear in.

Inclusion and exclusion criteria

Before the pandemic other disciplines had conducted some research on the applications of remote work. Findings from clinical psychology with children and play therapy have some relevance to the scope and limitations of PRW, particularly in terms of creating effective technical, at-home settings for sessions to take place. However, research into other modalities does not address the fundamental issue of working with the unconscious which is central to a psychoanalytic approach. For this reason, this literature is not reviewed in this study.

Of the 27 literature review results, 19 texts are explicitly referenced. Table 4 provides an overview of the literature used in the following section. The 8 omitted papers were either related to group psychotherapy or did not add anything additional to what had already been said.

This search was limited to English language publications, although I also found no reference to PRW with children documented in other countries.

Nature of literature

Although there is an expanding body of literature arising out of the pandemic, it is important to note that at the time of writing the majority of this conveys initial reactions and anecdotal accounts. Whilst this work is perhaps not of a rigorous standard, it gives an insight into the

emotional upheaval of life in general and work during the pandemic. Although the theoretical statements made are generally tentative, this literature offers valuable first impressions about adaptations to technique and implications for the psychoanalytic setting.

Table 4; Table of literature on PRW with children and adolescents; in chronological order of publication

Author surname	**Date of publication**	**Title**	**Nature of work**
Sehon	2015	Teleanalysis and teletherapy for children and adolescents?	Chapter in Savege Scharff (2015) Psychoanalysis Online, volume 2. Describes two case studies of children who's in-person psychotherapy partially moved to video call.
Widdershoven	2017	Clinical interventions via Skype with parents and their young children	Journal article describing parent-child psychotherapy with under-fives, conducted remotely.
De Rementeria	2020	Editorial	Introductory editorial in special edition of Journal of Child Psychotherapy.
Cohen	2020	Hanging on the telephone: reflections on conducting psychotherapy over the phone during the COVID pandemic	Brief journal article describing initial thoughts on offering PRW to adolescents in the pandemic.
Garcia	2020	'Sea of trapezoids': the analytic setting and virtual treatment during a pandemic	Brief journal article describing initial thoughts on offering PRW to children in the pandemic.
Hart	2020	Even though our bodies cannot be in the same place, focusing on body process is helpful in video mediated psychotherapy	Brief journal article exploring the nature of PRW with children
Holloway, Ramirez Hinrichsen, Oliver and Weddepohl	2020	Online child psychotherapy and the pandemic- vignettes from the Canadian association of psychoanalytic child therapists	Brief journal article reporting initial thoughts and vignettes from a group of psychotherapists working remotely with children.

Kohon	2020	Challenge of making use of countertransference responses during the COVID-19 pandemic- some preliminary thoughts	Brief journal article describing initial thoughts on offering PRW to children in the pandemic.
Hutchison	2020	Freudian glitch: mind the technology gap	Brief journal article describing initial thoughts on offering PRW to children in the pandemic.
Paiva	2020	Psychotherapy with no body in the room	Brief journal article describing initial thoughts on offering PRW to children in the pandemic.
Schmidt Neven	2020	The experience of working via tele video in Australia during the COVID-19 pandemic	Brief journal article describing initial thoughts on offering PRW to adolescents in the pandemic.
Shillito	2020	Reflections on working with adolescents during the COVID-19 pandemic	Brief journal article describing initial thoughts on offering PRW to adolescents in the pandemic.
Webster	2020	Fear of falling: impressions from working through a global pandemic and thoughts on burn-out	Brief journal article describing initial thoughts on offering PRW to children in the pandemic.
Wolpe	2020	Psychoanalysis with young children during the first wave of the COVID-19 pandemic: mapping the questions	Brief journal article describing initial thoughts on offering PRW to children in the pandemic.
Zuppardi	2020	'Only Connect': reflections on technology and transference	Brief journal article describing initial thoughts on offering PRW to adolescents in the pandemic.
Bomba, Alibert and Velt	2021	Playing and virtual reality: Teleanalysis with children and adolescents during the COVID-19 pandemic	Journal article describing theoretical considerations on offering PRW to children in the pandemic.
Sehon	2021	Technology as a Play Object in Teleanalysis with Young Children	Journal article, documenting a single, detailed, case study of a child patient moving from in-person to PRW.
Shulman	2021	The screen object	Journal article offering a theoretical exposition of PRW with children, including three accounts of PRW with young children in the pandemic.
Acquarone	2022	The only way: virtual experience becomes emotional reality	Journal article describing initial thoughts on remote psychoanalytic parent-infant psychotherapy in the pandemic.

Literature from before the pandemic

Before the pandemic compelled therapists to work remotely, very little had been written about PRW with children. Occasional mentions are given in literature on work with adults, all of which appear to suggest that PRW with children would not be feasible: “Teenagers are comfortable with teleanalysis, but I know of no instances where it was workable with a child, primarily because children need to play in the presence of the therapist.” (Savege Scharff, 2013, p. 504).

In the Journal of Child Psychotherapy special edition on PRW (2020), Sehon (2015) and Widdershoven (2017) are named as the only authors who describe PRW with children and adolescents.

Sehon presents very cautious “experimental” (2015, p. 222) use of PRW with two young patients already in established intensive psychotherapy. Both patients would have been unable to attend sessions without the switch to PRW. Sehon describes the work as a feasibility study to see if PRW is better than either no therapy or a long break. There was a substantial period of planning and preparation with the child and their parents, including ensuring that suitable materials and access to technology was available. Sehon suggests that both children adapted well, although one expressed a preference for in-person sessions. Sehon’s own view was that it was possible for the work to continue as it would have done in-person, using the same internal analytic tools available to the therapist. Sehon particularly notes moments of intense bodily countertransference. It seems very clear that the success of this PRW was built on the very solid foundation developed in the prior, extensive, in-person relationships with both children and their parents.

Widdershoven’s (2017) account of PRW is somewhat less encouraging. They describe parent-child work with six families. PRW was used because of the great distance between the

therapist and families' homes on the Greek islands. The therapist describes the need to initially meet the families in-person, feeling that too much sensory and bodily information is lost when meeting online. They suggest that the physical distance and a sense of tenuous connection might stimulate increased feelings related to loss and separation in the transference. In addition, the work seemed to be fraught with technical difficulties and complicated by families being in their own homes, in particular when a young child moved from room to room. Although the meaning of such events could be spoken about it seemed difficult for the therapist to feel they had enough information to fully understand what was happening. Widdershoven felt that supplementing the PRW with occasional in-person visits was vital. It seemed that although PRW made it possible for families who live in remote areas to access work that would not otherwise be available, substantial adaptation was required alongside some in-person work to facilitate effective therapy.

Literature emerging from the pandemic

In December 2020, the Journal of Child Psychotherapy published a whole edition titled "Child psychotherapy in the time of COVID: Voices from around the world on working through a pandemic." In the editorial, De Rementeria notes "All authors seem to share a central theme regarding the way the remote work brought the loss of, and consequent need to reimagine, the psychoanalytic frame" (2020, p. 269). Drawing heavily from this edition and subsequent publications found in the literature search, I will present a summary of ideas emerging in this newly forming field. Almost all of the papers surveyed briefly discuss aspects of PRW with many patients and make tentative theoretical links (the very few exceptions to this are noted in the text).

Pandemic conditions

Every author from this period, in some way, to varying degrees, recognises the enormous and varied emotional toll of the pandemic and the consequent impact on therapist's ability to work. The strain of working in such extraordinary times cannot be overstated and is intrinsic to the literature. In particular dealing with families whose lives had been irrevocably changed and disproportionally affected by the pandemic, whilst also managing one's own personal stresses brought about by the same global event. Kohon (2020) discusses the experience of both therapist and patient being subject to the same anxiety, claustrophobia and despair that the pandemic induced for many. They describe the challenge of working without many aspects of the ordinary frame and subsequent loss of containment for both members of the dyad.

It is also important to note that all of the PRW being described happened without any choice for either therapist or patient. Little advance warning or planning was possible; the change was abrupt and added to the great many losses and challenges experienced in the pandemic. These conditions are specific to the time and circumstances; they explicitly and implicitly colour the impressions of work in this time.

Change to the physical and bodily setting

Cohen (2020) suggests that something is lost from the experience when adolescent patients have therapy in their own home where they may be distracted by the activities of ordinary life and may be unable to benefit from the containing environment that the therapist aims to provide in-person. However, Cohen goes on to suggest that in the absence of the full sensory experience of being with the patient, the therapist using the telephone might be better able to tune into unconscious communications and "engage more deeply" (Cohen, 2020, p. 308). Similarly,

Paiva (2020) described feeling more aware of their own bodily feelings in countertransference when working remotely.

Zuppardi discusses the recognised importance of "synchronous exchange of bodily and facial cues in real time" (2020, p. 313) in communication between infants and caregivers, as documented by Tronick (1998). They suggest that this is also vital in the emotional exchange between patient and therapist. Remote mediums, even with the best video call facility, can only offer a slightly delayed, asynchronous, partial connection. Nevertheless, Zuppardi concludes that with many of his adolescent patients it was possible to create a feeling of closeness that perhaps mitigated this loss.

Acquarone (2022) provides initial thoughts on PRW with parents and infants linked to psychoanalytic theory. They point out that PRW provides a more intense face to face interaction because of the direct, often 'in your face' positioning of the camera in video calls. They suggest that having such a clear, up close view of the face might allow both therapist and patient to better read the other's emotions.

Facilitating effects

Literature on work with adolescents seems to echo the debate in PRW with adults, where it is often reported that patients are sometimes more able to discuss sexual themes or experiences of shame, although the ability to work through these themes might be limited. Webster notes briefly that some adolescents "felt more able to explore traumatic, abusive events, which they may have struggled to discuss in the room." (2020, p. 292). No further discussion of what facilitated this is given, although Cohen speculates that adolescent patients were at times more able to allow their internal world to be seen when "a potentially judgemental gaze is removed" (2020, p. 310).

Similarly, Paiva (2020) suggests that PRW allowed a greater freedom to explore bodily shame or issues related to 'being seen' when working with adolescents. They describe work with a transgender adolescent who appeared to be able to confront the hated aspects of their body in the online work; aided by their body not being seen by the therapist. Extending this idea in descriptions of parent-infant psychotherapy, Acquarone suggests that PRW uniquely provides a space where the patient is "free to act 'as if'" (2022, p. 98); to take risks in what they say and do, trying something out before it becomes an emotional reality.

Shillito (2020) presents the mixed finding that whilst some adolescents were perhaps freer to explore deeper, emotional issues, the artificial separation of mind and body in PRW created distortions in understanding and at times colluded with issues related to the difficult task of integration in adolescent development. They also point to the fact that although the body is not present, PRW might actually feel more intimate when the therapist is "right in [your] ear" (Shillito, 2020, p. 332). Shillito also describes "holding back" (2020, p. 333) from addressing things that might be too stirring for a patient, feeling that the lack of full view of them meant they couldn't gauge their reaction well enough and that the patient could be "left sitting alone" (2020, p. 333) with their feelings.

Impact of the technology mediated setting

In PRW access to technology is a prerequisite for the therapy session. Shillito (2020) highlights the inequality and additional difficulties faced by families living in deprived circumstances, where there is more likely to be a lack of access to a suitable device, internet/phone connection and private space in the home to allow for PRW.

In a developed examination of how the psychoanalytic setting is altered in PRW well-grounded in theory, Shulman (2021) makes the point that the experience of having therapy via

a screen is disorientating, due to the a-synchronous image, the inability to give eye contact, seeing an image of yourself on screen and the lack of control over what can be seen. Although, in a similarly, in-depth theoretical consideration of offering PRW to children in the pandemic, Bomba, Alibert and Velt (2021) describe the new possibility provided by the patient seeing their own image alongside the therapist. Making a link to the mirror function of the maternal gaze (Winnicott, 1971), they note the potential for re-working the internal image of the self in the transference, afforded by the new opportunity to see the self and the therapist in the same moment.

Holloway, Ramirez Hinrichsen, Oliver and Weddepohl (2020) suggest that screen-mediated therapy might encourage some patients to withdraw into a comfortable virtual world, for example patients with autism spectrum conditions retreating to other activities on the computer whilst in a therapy session. The authors suggest this can have a regulating effect. However, it also seems this could come at the cost of exclusion of the therapist and collusion with a tendency to withdraw, in a way that is hard to address at a distance.

Zuppardi (2020) speaks to his fear that in telephone PRW with adolescents the therapy can both be reduced to an indistinct activity on the phone and that contact with voice only could encourage a patient to present only one aspect of the self, a curated self, rather than the whole of themselves, therefore working against the therapeutic goal of integration. They also highlight ways in which their patients interacted with technology to communicate in the transference, for example turning off the screen as an expression of ambivalence.

Impact of technology-mediated access to the unconscious

Holloway, Ramirez Hinrichsen, Oliver and Weddepohl describe how the device screen can be experienced in different ways that seem to become a symbol through which the transference is

expressed. For example, suggesting that the screen could be “an open door… [a] teasing sort of chain-link fence… a frightening window, leading to excessive exposure…” (2020, p. 416). Schmidt Neven (2020) suggests that the patient’s freedom to determine the view the therapist has gives important information about their state of mind. They give the example of an adolescent choosing the have a session from inside their unkempt bed as an indication of the level of their withdrawal from ordinary social life.

Bomba, Alibert and Velt (2021) describe how the therapist-on-screen can be moved and played with as expressions of unconscious phantasy in a way that is not possible with the reality of the therapist in their adult body. For example, actually putting the therapist-on-screen in the rubbish bin. In this way the content of phantasy, perhaps especially omnipotence or sadism, is on view to be worked with in a different way. They suggest that this might at times allow the reality of the session to become too close to phantasy, for example allowing a denial of separateness or validation of omnipotence.

Developing their view since their 2015 account of ‘experimental PRW’, Sehon (2021) describes very successful PRW with a seven year-old girl, making the suggestion that the patient was able to use the PRW technology as another toy in the playroom; although communications were different from in-person they still allowed for psychoanalytic work. Sehon gives the visceral example of the child covering the whole of the camera with her mouth in a paradoxically, embodied demonstration of the wish to eat up the therapist. Sehon credits the success of this work to a well-established relationship with the child, who had been in intensive psychotherapy, in-person for three years and the devotion of her well-resourced parents.

Hart (2020) suggests convincingly that as with in-person child psychotherapy, communications mediated through technology in PRW offer rich insight into the transference.

They give several clinical examples with young children where the child seems to convey vivid experiences through projective identification, where the therapist can have intense countertransference sensations. It is perhaps significant that Hart states that they have been working remotely for several years, and so developed their views on PRW outside of the anxiety infused experiences of the pandemic.

Hutchison (2020) describes making use of glitches in technology as an avenue for communication; both making meaning from the ways the dyad might unconsciously act out through technology, for example by failing to charge the battery of a device adequately for the session, and looking at how a patient might project into independent technology issues, for example feeling abandoned when the screen freezes. Hutchison advocates for speaking about these communications to ascribe meaning.

Shulman (2021) describes the huge potential for things to be misunderstood or misattributed in PRW, so that the meaning of something can be lost when it is attributed to a mere function or mishap with the technology, rather than an important meaning in transference. They also make the suggestion that at times the therapist is too distracted by technology to really notice moments when something related to the technical setting has importance and/or have a feeling that they need to compensate for the deficits of meeting remotely which might mask a communication.

Work with young or very disturbed children

It appears that within the emerging literature on PRW with children, work with young children is significantly underrepresented. It is perhaps the case that many child and adolescent psychoanalytic psychotherapists opted to continue with parent work rather than PRW with the

child during the pandemic. Schmidt Neven (2020) describes ruling out work with under twelves in part because of the lack of privacy in having sessions from home mediated by parents.

Garcia (2020) describes work with a latency-aged child who had been very physically active in in-person work; communicating with bodily actions and requiring the physical intervention of the therapist. After moving online, Garcia's narrative of the work suggests that although communications could be understood at times, there were many distractions and possibilities for acting out that were beyond the reach and earshot of the therapist. This gave the impression that although the therapy had been maintained, it was compromised.

Also describing work with young children, Wolpe (2020) suggests that whilst some children with greater ego strength or maturity were able to play in an adapted setting, for example directing the therapist to use toys on screen, other more disturbed patients communicated in ways that were harder to work with, for example turning off the screen and not responding. Wolpe makes the tentative suggestion that in order to manage without physical containment there is a requirement for "the mobilisation of ego forces to strengthen defences, at the expense of more in-depth analytical work." (2020, p. 352). This seems to accord strongly to ideas put forward by Gutiérrez (2017) relating to forced ego integration in adult PRW.

In their detailed account of PRW, Shulman (2021) describes work with three young patients, aged four to five years, in intensive psychoanalytic psychotherapy. They were all looked-after children who had experienced extreme interruptions to ordinary development. Shulman suggests this PRW was very limited because where there is a need to address primitive deficits from a developmental perspective and in the transference the body is essential. This mirrors the care of infants where physical presence is a correlate of psychological holding. Shulman indicates that this is relevant for all psychoanalytic work because of its focus on the infantile transference.

In addition to the presence of the therapist's body, Shulman (2021), referring to Bleger (in Churcher (2015; 2017), describes how the actual playroom provides a physical container essential to the setting. They highlight the need for the real barrier of the room to delineate the inside and outside of the therapy space, with its correlates to the mother's body in phantasy, and to provide containment for inchoate, psychotic projections. They suggest that physical space becomes a "depository of the psychotic parts of the self" (2021, p. 286). In the absence of the physical therapy setting, PRW does not provide the same therapeutic capacities for work at primitive levels. Shulman's paper seems particularly relevant to work in child and adolescent mental health services where the majority of children referred for psychotherapy have experienced profoundly adverse early life circumstances, chronic deprivation or abuse, leading to complex deficits and relational trauma. Bomba, Alibert and Velt (2021) echo Shulman, in the suggestion that in PRW unconscious containment provided by the bodily presence of the therapist has to be replaced with a psychic containment, for example the therapist being more active in helping a child to play when dysregulated in a way that was different from their usual in-person technique.

Implicit tasks of therapy

Thinking about the implicit, perhaps embodied tasks of psychotherapy has been a consideration in work with both adults and children. This is brought into sharper focus when the range of therapeutic communication is compromised in PRW.

Stern et al. describe "moments of meeting" (1998, p. 903) in the therapeutic process when the dyad shares a moment of attuned, authentic implicit connection, leading to emotional and relational growth. Schore (2021) presents a similar account of the vital role of implicit communication. Evidenced by recent neuroscience findings on multiple neural mechanisms,

they suggest that as part of the unconscious-unconscious communication in therapy there is an implicit body-body dialogue, where layers of implicit information are communicated, outside of awareness, by facial and non-verbal expressions.

Emanuel (2021) highlights the need to work in the knowledge of and engage with body states in psychotherapy with traumatised children. They suggest that in order to benefit from therapy the patient must be emotionally regulated; neither hypo or hyper aroused at a physiological level. To achieve this the therapist must tune into the body state of the patient, in part by registering their own countertransference, and at times encouraging physical action in the body, for example regulating breathing together.

Taking into account the importance of implicit communication, body states and the therapist's ability to access their bodily countertransference appears not to directly preclude the possibility of effective PRW. Implicit communication is likely to still be available through audio/video call. However, it seems highly likely that alongside the sense that explicit communication can be compromised by the restricted view offered by PRW, the same would apply to implicit communication. Considering PRW with adults, Bayles (2012) refers to this as "dampened" nonverbal, implicit communication (2012, p. 569).

Introduction to empirical study

Gaps in the literature

The literature on PRW with children and adolescents is a newly emerging field, arising directly from experiences in the pandemic. As it evolves, every aspect of PRW with children needs to be closely examined in robust empirical research to ensure its efficacy and to further understand how it differs from in-person child psychotherapy. In particular, there is a need for greater consideration of the conditions required for PRW to be successful and the joint role of the

therapist and parent in establishing this for a child. This includes exploring how the setting can provide adequate provision for the child's enacted communications. Further examination of the role of embodied experience in child psychotherapy and the impact that being remote might have on the transference is also required.

Addressing gaps in the literature, in this study I aim to explore the questions arising about this novel way of working. To do this I will examine the views of child and adolescent psychoanalytic psychotherapists in child and adolescent mental health services offering PRW in the pandemic.

I will use a qualitative approach, with semi-structured interviews, to enable participants to discuss any thoughts arising about PRW with few constraints. This will allow me to gather a rich, first hand, account of remote work taking place at this time. I will use Reflexive Thematic Analysis (Braun and Clarke, 2006; 2022), informed by a background framework of psychoanalytic theory, to analyse participants' thoughts. I aim to explore the nature of the PRW taking place in a particular team, to begin to describe its scope and limitations.

Methodology

I aimed to explore the scope and limitations of PRW by interviewing the child and adolescent psychoanalytic psychotherapists in an NHS trust to ask about their experience of remote psychoanalytic psychotherapy with children and adolescents during the pandemic. I used Reflexive Thematic Analysis (RTA, Braun and Clarke, 2006; 2022) to analyse the data.

Research question

The overarching research question of this study was 'What are the views of child and adolescent psychotherapists, conducting PRW in the pandemic, on the scope and limitations of PRW with children and adolescents?' In the interviews I invited participants to explore what was lost or gained by working remotely, using a background knowledge of psychoanalytic literature as a guide to aid discussion. I aimed to consider what the therapists understood of what happened in PRW; what was possible and what felt out of reach across the distance of not being physically together. This allowed for exploration of the nature of being a remote therapeutic dyad and how this impacts on psychoanalytic processes.

Although research on PRW with adults has suggested that a focus on comparison between in-person and PRW fails to recognise PRW as a distinct activity (Ehrlich, 2019), in this study I asked participants to reflect on the difference between their ordinary in-person therapy sessions, as compared to their new experiences of PRW during the pandemic. This provided a framework for participants to access their thoughts on PRW at a time when their practice in this area was still very new, under the oppressive background of the pandemic.

Research design

RTA was initially described by Braun and Clarke in 2006 and then refined in further methodological publications (notably Clarke and Braun, 2017; Braun and Clarke 2020; 2022). It is a branch of qualitative data analysis with purposely flexible, non-defined ontological underpinnings which allows the researcher to create their own version of the method as appropriate for the research.

I chose to use RTA because acknowledging the impact of researcher reflexivity has been a primary consideration, in order to take into account the multiple perspectives on PRW I hold, as a PRW researcher, clinician and analysand. RTA's focus on reflexivity aims to provide a platform in which subjectivity can add richness and depth, rather than be confounding (Braun and Clarke, 2022).

I have approached the research question and analysis from a deductive "orientation" (Braun and Clarke, 2022, p. 9). Taking this "top down" approach (Terry and Hayfield, 2021, p. 9) has allowed me to develop the data analysis within a psychoanalytic epistemology.

I have used psychoanalytic theory as a background framework of reference to understand what was being discussed by participants. The participants also explicitly referenced psychoanalytic theoretical constructs as they described aspects of PRW.

As a central tenet of psychoanalytic thought, the influence of the dynamic unconscious has been taken into account throughout. I have worked in the acknowledgment that the participants and I communicated at a conscious level, with further unconscious processes occurring outside of awareness. This includes the assumption that the participants are "defended subject[s]" (Hollway and Jefferson, 2013, p. 4) whose conscious ideas are filtered and repressed by unconscious defence against anxiety. Hollway and Jefferson's work (2013) expands upon the Kleinian concepts of defence against anxiety by unconsciously splitting off

and locating unwanted emotions in the other (notably Klein, 1946). In this research, this might have manifest particularly as an unconscious disavowal (Zepf, 2013) of the fears evoked in working during the pandemic.

With this in mind, I have tried to adopt a researcher stance that somewhat mitigated for this by following the flow of conversation and paying close attention to the emotional response of the participants, conveyed by non-verbal communication (Holmes, 2017) and experienced in countertransference (Heimann, 1950) to try to notice when a topic might for example be cut short or sanitised by participants' words. In this way, I have somewhat emulated the approaches put forward in Holmes' (2019) Reverie Research Method and Hollway and Jefferson's (2013) Free Association Narrative Interviews.

Moments when these unconscious processes seemed to be most striking in the interviews were noted in the field notes I wrote at the time of the interviews. These notes then informed the codes I used to denote latent meanings in the data (also see process of data analysis section later in this chapter). The most vivid example of this was the participants struggle to articulate what they felt the contribution of their physical body is to a psychotherapy session. Each of the participants came to this important idea at some point in their interview but appeared to stop short of offering a full explanation. I often noted the jarring quality to this in my field notes and was able to add in a latent level code to describe this countertransference data, which later fed into aspects of theme 1 and 2.

Similarly, all of the clinical work described by participants follows these principles in the way it privileges unconscious communication.

The process of creating the themes described in the research results was an active exercise of making meaning from the data. This was informed by what the participants said and my own reflexive interpretation (Braun and Clarke, 2022).

The findings of this research capture a moment in time, are situated in a particular child and adolescent mental health service team as we emerged from the peak of COVID restrictions and arise from the relationship that I and the participants had with the research. I make no attempt to generalise the findings to a wider setting. However, in the triangulation (Elliott, Fischer and Rennie, 1999) of my results and evidence from the literature I hope to address the research question and make suggestions for further research.

Ethical review

Ethical governance was provided by the Tavistock Research Ethics Committee (TREC). Permission to conduct the research in the NHS trust was granted in December 2020. TREC approval was granted in January 2021 (see appendix 1 for TREC application form and letter of approval). The nature of the study did not require any enhanced ethical considerations.

Participant sample and recruitment

The participants were all members of the child psychotherapy team in the NHS trust where I am a trainee child and adolescent psychoanalytic psychotherapist. I have an individual, established relationship with all participants. The team comprises of therapists from three separate child and adolescent mental health service clinics that are part of the same NHS trust. At the time of the interviews there were ten members in the team; eight qualified, Association of Child Psychotherapists registered child and adolescent psychoanalytic psychotherapists, one other trainee and myself. I recruited therapists to the research by sending out an email, via the team's lead therapist (see appendix 2). Following the procedure outlined in the ethics application, I asked the team lead to exclude any members of the team who might find talking

about working through the COVID-19 pandemic particularly distressing. Seven members of the team responded to the email and agreed to take part in an individual research interview.

Interview procedure

After expressing their interest in the project, I sent each participant an 'information for participants document' (see appendix 3). This included material about the nature of the project; what taking part would involve; supervisory and ethical governance; consent and withdrawal. Participants each gave signed informed consent (see appendix 4). Shortly before the interviews I sent an additional 'preparing your thoughts document' which outlined the topics to be covered to aid any preparation the participant might make, although preparation was not explicitly required (see appendix 5).

Each interview was carried out remotely, using an online video call platform. The participants and I did the interviews from either our usual child and adolescent mental health service clinics or home working spaces. Interviews lasted between 50-90 minutes. The length was determined by how much time each participant had available. Each interview was recorded using the video record function on the video call platform.

I asked each participant a series of questions following a semi-structured schedule developed in consideration of how participants might address the research question (see appendix 6). The questions were intended to prompt participants to talk about their experiences of PRW, encouraging them to discuss rich case examples which we could unpick together in our conversation to examine the research question. The interviews followed the flow of topics brought by each participant, using selected questions and prompts from the schedule rather than following it exhaustively.

At the start of the interview I reiterated consent and practical arrangements with participants, and gave a short introduction to the research. In this I recapped the scope of work I wanted participants to discuss (any applied psychoanalytic work, with any child and adolescent patients/groups of patients using any remote medium). I gave a special emphasis to the request that participants try not to let the impact and difficulties of the pandemic itself dominate their thoughts, so that we might look beyond the pandemic to the nature of PRW itself. I suggested this with an acknowledgment that it could only ever be partially achieved because of the inseparable link between the pandemic and the need for PRW, and the emotional character of therapy during COVID.

Following each interview, I provided participants with verbal and written debrief information primarily to express my thanks for their participation (see appendix 7). I also provided the details of the NHS trust employees well-being service and the offer of an additional debrief session with me, in the event that any participant had been distressed by taking part. None of the participants requested an additional conversation with me for this reason. During the debrief participants were reminded of their right to withdraw their data until an agreed date.

Demographic data

At the start of each interview I asked four preliminary professional-demographic questions to orientate myself to the role of each therapist. I asked about participants' previous experience of PRW; how long they had been working as a child and adolescent psychoanalytic psychotherapist; a broad summary of the nature of their caseload; and the approximate number of child or adolescent patients worked with remotely in this period.

The majority of participants work in NHS-Tier three generic child and adolescent mental health services, where they mainly see children from 6-18 years of age with acute, chronic and/or highly complex difficulties that impact on their daily lives. Excluding the 1 trainee participant, participants had worked as child and adolescent psychoanalytic psychotherapists for an average of 8 years (range 1-20 years post qualification). None of the participants had any prior experience of clinical PRW before COVID. On average each participant had seen approximately 10 children or young people for PRW during the pandemic (range 7-15 cases).

In keeping with the research design, the personal-demographic details of the team have not been recorded (gender, age, ethnicity etc.). The research is situated in the nature and task of the team as a whole and does not make any attempt to be representative of any particular population. It will suffice to say that participants were fluent in English and all working as Association of Child Psychotherapists registered child and adolescent psychoanalytic psychotherapists in generic NHS child and adolescent mental health services.

Confidentiality and data storage

Ensuring the confidentiality of the participants and patients discussed was a primary concern. During the interview I asked participants not to use patient's real names or any overly identifying information. I ensured that any lapses in this were redacted in the interview transcripts along with any information that could identify the participants themselves or the NHS trust. The raw data from the project (interview recordings and transcripts) will be stored on servers within the NHS trust until completion of the project, when it will be securely deleted.

Process of data analysis

To analyse the interview data, I conducted a RTA following the steps below, informed heavily by Braun and Clarke (2006; 2022)

1. **Annotated data collection:**
    a. I made field notes during all the interviews relating to anything that seemed striking, my countertransference responses and reflections on the participants' relationship to me or the research topic.
    b. After all interviews, I collated these field notes into a list of ideas that had appeared important in relation to the topic of PRW and the RTA method.
2. **Familiarisation with data**
    a. I began familiarising myself with the data by transcribing the interviews. Initially I used speech to text software, followed by reading through each rough transcript whilst watching the videos of the interviews. At this point I corrected any transcription errors and added in iterations, hesitations and gestures. I also de-identified the participants and redacted any patient identifying material to ensure confidentiality.
    b. I further familiarised myself by re-watching the video of each interview without pauses before starting the next phase of analysis.
3. **Data coding**
    a. I went through each interview writing initial codes for every salient segment of the data. Each code provided a label for the data which summarised or described either the manifest content of the data section (what the participant said) or a derived latent content (meaning that I could infer or generate from the moment referring to field notes and countertransference data).

b. Some sections of the data were assigned multiple codes in order to capture multiple meanings.
c. Each coded section of data varied in length from a short phrase to a paragraph. I typically chose to leave some of the surrounding text with the key point in each coded section so that the context of the participants words was not lost. (See appendix 8 for an example of coding.)
d. After coding the first interview I tentatively started to group the coded data segments to test how well the depth and style of coding would lend itself to further analysis at the theme generating stage. After satisfying myself that the method of coding was appropriate for this stage, I set aside these groups and continued to code each of the transcribed interviews in order of date.

Additional considerations made in coding process

At the coding stage I chose to remove all reference to any work described other than individual child psychotherapy with children of all ages. This was a pragmatic decision to narrow the focus of enquiry to individual work only and make best use of what was available in the data. In practice, the vast majority of work discussed was included because there were very few mentions of group, joint or parent work. I also excluded PRW discussed that was carried out in other settings, for example where the patient joined a video call from their school. Again, this was rarely discussed and appeared to represent a different sub-category of PRW.

I also removed any areas of superfluous data that did not relate to answering the research question. This was typically parts of the transcript where participants described in-depth background of a patient or work with the patient when in-person work resumed.

I included the few references to private practice work that were discussed by some of the participants. Although this work is outside of the context of the NHS team, the participants' multiple roles remains part of their overall view of PRW.

4. **Generating prototype themes**

    a. I combined all of the coded transcripts into an entire data set deliberately shuffling them so that in the next step of analysis I read each segment at random to avoid any one participants' voice being dominant in my mind at any time.

    b. I then grouped the coded segments into around 50 clusters which collated codes with similar meaning. The actual number of clusters varied a little through the analysis as I began to consider how different codes might go together and the links between them.

    c. From there, I arranged the clusters into a concept map to begin to look further at links and relationships in the data.

    d. By refining and reflecting on connections and relationships between ideas emerging in the concept map, I generated a number of subthemes organised within 4 initial themes (see figure 1 in appendix 9) with the aim of "capturing patterns in the data" (Braun and Clarke, 2020, p. 6) to address the research question. At this point there were a number of aspects of the data that hadn't yet been resolved in the analysis.

    e. With further consideration and discussion with the project supervisor, over time I further refined the initial themes into 1 overarching theme and 3 multifaceted prototype themes, 1 of which has 4 subthemes. A table of themes will be presented in the analysis section.

5. **Confirming prototype themes**

    a. In order to get a sense of whether the prototype themes represented the data set as a whole, I re-watched the interview videos to look at how well the themes seemed to accord to the original voices of the participants.

    b. Whilst re-watching the interviews I gathered data extracts from the original transcripts that seemed to exemplify facets of each theme. These will be used to illustrate the results in the next section. In places extracts have been edited to remove extraneous utterances or to condense a longer section where there was unnecessary detail (this is indicated by …). Grammatical errors and missing words are left in original form.

    c. The exact form of each final theme continued to change over the whole thesis writing period as I continued to digest and rework the analysis.

Results

Using RTA, I generated one overarching theme and three themes to capture the participants' views on the scope and limitations of PRW with children and adolescents during the pandemic. Theme 2 is further divided into four subthemes.

This section provides a description of each theme, illustrated by extracts from the interviews. Each theme is organised under subheadings which describe a distinct "facet" of the theme or subtheme (Braun and Clarke, 2022, p. 80). Table 5 lists all themes, subthemes and facets within them.

In-keeping with a RTA approach, I aim "to tell [the] *whole* analytic story" (Braun and Clarke, 2022, p. 118; original italics) by creating a narrative with the data to address the research question. The extracts have been chosen to best illustrate the point. Effort has been made to ensure a broadly even spread of inclusion of extracts from each of the participants. Some participants are included fewer times than others because their interviews were shorter and/or they gave fewer clear, succinct examples.

Table 5: Overview of themes

Overarching theme **The task of therapy was changed by the pandemic**		
Theme	*Subtheme*	*Facet within theme or subtheme*
Theme 1 **The therapist's [and patient's] experience was unpleasant and strained**		Psychoanalytic remote work feels exhausting
		The loss of the in-person setting was disorientating
		Offering sustained focus in psychoanalytic remote work is more difficult that in-person
Theme 2 **Working with the unconscious was altered**	*Subtheme 2.1* Remote mediums allowed for adapted communication between therapist and patient	Interacting with technology provided new forms of communication
		The depth of psychoanalytic remote work ranged along a continuum
		Some patients were enabled by the remoteness
		The ability to make good use of psychoanalytic remote work was influenced by internal capacity
	Subtheme 2.2 Psychoanalytic work relies on an embodied experience	'child psychotherapy isn't just about talking'
		The physical body of the therapist contains and/or acts as a depository for unconscious projection
		Without an embodied presence, the therapist's identity was distorted in the mind of the patient
	Subtheme 2.3 The therapist struggled to fully understand the internal world of the patient	The patient could not be known as a whole person
		Distracting external elements could not be excluded and impeded the therapist's understanding
		The transference can be distorted

	Subtheme 2.4 The capacity to work with a psychoanalytic approach is diminished	The patient's internal world was observable but not fully available for working through
		Capacity for containment is critically compromised
		The therapist's capacity to make interpretations was reduced
		Setting is too unsafe to allow aggressive and erotic transference
		Therapeutic potential was slowed down and diminished
Theme 3 **Facilitating and obstructing factors**		Psychoanalytic remote work provided greater flexibility and access to treatment
		Parents were required to facilitate psychoanalytic remote work to a much greater extent than in-person work
		There are minimum practical requirements
		There was a shift to shared control of the setting
		Having therapy in your own home could feel more uncomfortable
		Transitions were lost or changed

Overarching theme: The task of therapy was changed by the pandemic

This overarching theme encompasses participants' thoughts on working during the pandemic. I have used the term overarching in recognition of the profound scale of the impact of COVID and its intrinsic link to all of the other themes. All of the results should be considered as arising from this theme in some way, as the need for PRW arose from the pandemic.

All of the therapists were acutely aware of the emotional impact the pandemic had on them, their patients and in wider society. They discussed many manifestations of loss, grief and longing to return to 'normal life.' These emotional experiences became a significant focus to be considered in therapy.

> "… there's just this general sense of just sort of waiting for normality to come back in." (Participant 1)

Uncertainty over restrictions and anxiety about who might get ill or die was palpable.

> "… this pandemic that was hugely anxiety provoking for everybody… many of them were desperately worried about how the pandemic was proceeding…" (Participant 6)

> "… they became *very* anxious before the lockdown…" (Participant 4)

> "... I'm so exhausted and absolutely shattered because, I don't know, you know we're in the business of exploring not knowing, but we keep on getting 300 million 'not knowings', thrown from the outside world." (Participant 3)

They described seeing parents and children struggle without their usual routines and social networks, including access to support from child and adolescent mental health services.

> "… they were just trying to cope with the day to day, survival, and literally it was survival in many of these families, just managing the children, just managing…" (Participant 6)

All of the therapists described disorientation and feeling that they could not guide patients through such unknown territory. This especially applied to the experience of being forced to work remotely without any prior experience and in the absence of preparation.

> "…I couldn't give her any reassurance basically to calm her when those moments happening and that also felt bad for me because I don't know what's happening, how am I supposed to communicate to her." (Participant 2)

The disruption to clinical work was compounded by the level of distress experienced across every aspect of life. Against this backdrop it is important to emphasise that the emotional character of this time coloured the therapist's appraisal of PRW.

Theme 1: The therapist's [and patient's] experience was unpleasant and strained

This theme describes the therapists' emotional response to PRW. It provides an exploration of 'what was PRW like' as compared to themes 2 and 3 which will go on to examine the question 'why was PRW like this?'

Psychoanalytic remote work feels exhausting

All of the therapists described PRW as gruelling and exhausting. This seemed to go beyond the ordinary demands of in-person psychotherapy and cannot be entirely accounted for by the emotional strain of the pandemic. This suggests that the nature of the work was negatively changed. This experience appeared to be shared by many of the patients discussed, although this is a tentative suggestion because I did not speak to patients directly.

All of the therapists described being exhausted by a constant attempt to fill in or work around the gaps in information created by having a restricted, partial view of the patient.

> "I feel like I've been unplugged, you know, [laughing], just kind of absolutely drained … because it takes so much concentration I think to sort of hold in mind a 3 dimensional person when you're looking at a 2 dimensional screen… that is exhausting…" (Participant 1)

The therapists strained to make up for missing sensory data; feeling far away and reaching for more information. There was a need to concentrate harder to discern slight bodily communications and an awareness of how much the scope for full psychoanalytic observation was diminished.

> "I think one is straining constantly to pick up any minute cues from the voice, and constantly missing the visual cues that would fill in and help one get a picture of what's going on." (Participant 6)

> "… I don't know, you kind of pay much more attention to little sighs, or, you know, the tone of an answer or something like that, I think definitely trying to really get all the information you can get…." (Participant 7)

<u>The loss of the in-person setting was disorientating</u>

The sense of an unpleasant, strained experience centred on the loss of the in-person therapeutic frame.

> "I have had different experiences, but… I find it very, very difficult." (Participant 7)

It is difficult to unpick how much of this arises from the nature of PRW and how much is due to the sudden, unwanted changes brought by the pandemic.

> "… we've all done it because we've had to, and it's better than nothing. We don't know what the impact is..." (Participant 3)

> "… and I think moving everything remote, especially the first lockdown it was a bit kind of loose, we didn't know what to do, what to expect, maybe things are much more settled now… so it's a bit like kind of being a first time mum… You're trying to figure out if the baby's ok, if you can do it and you and baby can get together."
> (Participant 2)

Some of the therapists spoke about their experience improving over time as they adapted both their attitudes and technique. However, an underlying negativity remained, indicating that elements of PRW intrinsically put strain on the therapeutic dyad and its work in a way that was difficult to define.

> "… I think because we have to I think it's easy to develop a bit of a fantasy about what we're offering and perhaps smooth over the cracks. It's not the worst thing in the world but it's not the best..." (Participant 1)

It seemed that both patient and therapist often had an awareness of the incongruous quality of their relationship; simultaneously feeling a tenuous, far away connection whilst having an up-close intensity on screen.

> "I also think it just, she just, there's a build-up of frustration. I think there was something about not having access to me, it feeling quite sort of flat and limited, but also intense at the same time." (Participant 5)

<u>Offering sustained focus in psychoanalytic remote work is more difficult that in-person</u>

All of the therapists grappled with many conflicting thoughts and feelings outside of the ordinary complexity of the work. They described feeling that it was difficult to give their full attention in the same way as they would naturally, sitting together in-person. This therapist describes the difficulty of taking in the experience of a PRW session;

> "… it's not even countertransference, I don't think it's countertransference, I think it's just my own attitude to it. Ummm, that it's actually really hard to even kind of hold on to what happened during online sessions." (Participant 4)

There was a pervasive sense that offering PRW felt depriving and neglectful.

> "… it's less than what I can offer, it feels like, it's not the full what we could have… So settling with the best kind of possible option but it is not the real thing to offer…" (Participant 2)

> "At some point I felt like, am I really doing this child any favours [shaking head emphatically]" (Participant 2)

It seemed that some therapists were more likely to act out by loosening boundaries that were unaffected by being remote, for example the duration of the session. This seemed to stem from feeling that 'it didn't matter anyway' as the work was so compromised.

> "… I think there were a few sessions that literally, we had a 10 minute session because I was like well okay, you know, which is, I mean I suppose I also really acted out because I just, I found it quite intolerable..." (Participant 4)

> "… I actually quite enjoy seeing her [in-person], … she's quite interesting, you know, whereas if I need to speak to her online, I feel quite stressed about it, I dislike it, I really dislike it, and it's, it's, it's a chore… my attitude is quite different..." (Participant 4)

The therapists described that their negative attitudes towards PRW, alongside its difficulty, led to the work feeling less successful.

Theme 2: Working with the unconscious was altered

This theme brings together the therapist's thoughts on the ability to work with the unconscious in PRW. It is divided into four subthemes which address distinct aspects of psychoanalytic work.

Subtheme 2.1 Remote mediums allowed for adapted communication between therapist and patient

Interacting with technology provided new forms of communication

All of the therapists gave vivid examples of how patients found ways to communicate that evoked strong feelings in countertransference. This often involved interactions with the technology facilitating the PRW session; either using its various functions (for example using text boxes to type things that were too difficult to say aloud, or an online drawing tool instead of real paper) or in technology facilitated acting out.

> "… a young patient used to walk out [of in-person sessions] … walk out and slam the door. And in the online ones, he just used to close the top of the laptop. So he found a way to tell me, you know, do exactly the same thing." (Participant 7)

Finding ways to communicate through technology was particularly important for younger patients who would ordinarily express themselves in play and actions with less focus on conversation. In the next example the therapist describes a range of intense feelings experienced in countertransference as the patient uses the camera as a mirror to apply make-up.

> "… [the patient] psyched herself up to sort of put her face on, really, to go out and kind of be in the world… she also squeezes her skin, which is not so pleasant [laughing]… I feel like I'm sort of, I'm given the revolting bits in a way, and then I'm, I'm sort of given this transformation into, you know, kind of how she thinks she should look when she kind of steps outside the front door…" (Participant 5)

Here, PRW gave the therapist the opportunity to see 'through the mirror', to have a direct experience of the patient's feelings about themselves and in transference, through the countertransference evoked.

Some examples highlighted how the PRW platform enabled the patient to show aspects of themselves that might be more inhibited in in-person work.

> "… I find the countertransference more, much more intense now than when we were working in-person, and I think partly, it's that he's got a lot more control, you know, he can come very, very close to the camera, errr, and he can control the camera, i.e. he can control me in the room in a way that he probably couldn't before… he can come behind the camera and kind of peer down [hand gesture, looming in] … if I were in the room would he come so close? And I think he's quite a tentative boy, I don't think he would actually." (Participant 1)

The therapist goes on to describe how they could talk about the child's interaction with the technology to introduce meaning whilst helpfully keeping the conversation in displacement.

> "… it gives me an opportunity to talk about the transference in a way that sometimes feels a bit more comfortable for him, so I can talk about how he relates to the *camera*… Errm, and we talk about what he lets me see… so I guess it sort of introduces some new sort of ways of talking about transference in a way you wouldn't ordinarily use." (Participant 1)

For this patient interaction with the PRW medium provided the means to show aspects of the transference and for the therapist to explore that with him, perhaps more readily than in in-person sessions.

<u>The depth of psychoanalytic remote work ranged along a continuum</u>

When online work had been established, the depth of work varied from a shallower 'check-in' to work that could maintain a deeper, transference led approach.

From

> "So, although we kept contact we weren't going increasingly in depth, which I would hope we would be doing face to face, on the contrary, we were just sort of keeping contact, holding, checking in." (Participant 6)

To

> "…I think there are those that have chosen to do it… my experience is that they have been able to, to speak about things that are really troubling to them…. I'm thinking of another adolescent who I didn't work [with] before, in-person before, only assessment on zoom, and has been very, very responsive. And, you know, being able to say a lot, actually." (Participant 7)

Although this variety in depth of work also exists in in-person work, the propensity to remain at surface level seemed exaggerated in PRW. This was also closely related to the impact of the pandemic, when the priority of some therapeutic work switched to day to day management in times of exceptional stress.

> "So sometimes it felt like it was just a quick catch up of the week and just to see how she was doing. And then she would hand the phone over to her mum, so it sort of became a little bit more like parent work really, errm, and that was okay because I think the family needed quite a lot containing really during the first lockdown." (Participant 5)

Many of the therapists described ways in which they adapted their technique to address the shallow feeling of PRW. This included a frustrated tolerance of sessions which were reduced to 'questions and answers,' as well as more active narration of the limitations of being remote in an effort to engage the patient to work to overcome them. Although at times their greater activity perhaps took the therapists outside of their usual role.

> "… [in-person] she's quite chatty and she's quite engaged and you know she does give you a lot and in various ways. Online, it was very different; so became much more of a question and answer, rather than a spontaneous sort of sense of just things coming up… it felt like there was nothing to say, you know, it was difficult to fill a 50 minute session… and she, and she became much more remote. I don't mean like literally. Well, actually I do mean, you know, I don't mean physically but emotionally felt much more remote." (Participant 4)

Here, it seemed that the quality of sessions changed in part because of a difficulty to move into a state of mind where the patient was able to free associate or play in a free associative way.

<u>Some patients were enabled by the remoteness</u>

The possibility that therapy might be less intense in PRW enabled some patients to manage sessions better or use PRW as a stepping stone to being more able to use in-person sessions. The next extract provides an interesting parallel between PRW and times during in-person sessions when the therapist might deliberately restrict the depth of work to allow for therapy to be tolerated.

> "I think, had she been in the room with the full force of her counter-, or her transference, [she] wouldn't be able to bear it [shakes head emphatically]... She'd be the sort of patient where I'd feel compelled to water it down a little bit to make it tolerable in order for her to feel safe in the work, and so maybe that distance that we've been talking about that's sort of inherent in remote work suits her better, it makes it feel safer, and easier to engage with… I think the fact that it feels in the transference less intense I think allows you to speak to it a little more in a way that the patient then feels is tolerable." (Participant 1)

In this example there is an idea that PRW is preferable to in-person work which might have felt too intense.

Work was often described with patients where issues related to the body or shame could be more readily discussed.

> "… I think she was a young person who struggled a bit with being looked at. And she had a physical condition that made it more difficult, she felt more self-conscious. And I think she held a lot of shame physically, but also in terms of just to her general history. So I think to not see me-, although she knew me really well, I'd been working for with her for I think it was two or three years in-person. But it just sort of, sort of lifted something off, you know, just potentially gave her a different kind of space to say things." (Participant 7)

> "I think, one might argue that the phone, and the remote work has helped him… he can't stand his self-image, he hates his body so we-, hates… how he looks." (Participant 3)

The therapists suggested that these issues might feel safer to discuss in the absence of being together in close proximity. The capacity to work through feelings of shame in PRW will be explored in a later section.

<u>The ability to make good use of psychoanalytic remote work was influenced by internal capacity</u>

Some of the therapists described aspects of a patient's presentation that might be indicative or contraindicative of an ability to manage PRW.

> "… I think, you know, it's very dependent on the, on the patient. I think you can work at it, you can struggle with it, you can try as much as you can. But I think there is something about the patient..." (Participant 7)

At a conscious level, a strong motivation to have therapy was an indicator that a patient might have a greater tolerance for working to overcome the difficulties of PRW and benefit in a similar way to in-person treatment.

> "… it's *tough* I think, but for her I think she really wanted to do the work, it's someone that really wants to understand what is going on, even though it's really hard and painful at the same time." (Participant 2)

With younger children the motivation of the parent was also important. In addition, there were obvious practical and safety related limitations in work with young children, where the presence of an adult in real life is required to ensure safety. Considering developmental capacity, there was a view that PRW was not possible at all with this group.

> "… it's impossible with under-fives, particularly the children that I work with that are mostly, somewhat developmentally delayed. Errr, certainly their language is delayed so they need to be with me so that their bodies can express what they're trying to communicate, in the room." (Participant 6)

However, before the pandemic, across our team there was very little direct work with under-fives, therefore most members of the team were not well placed to consider PRW with very young children.

Some of the therapists used various different theoretical concepts to account for the internal attributes that seemed to enable a patient to benefit from PRW. Here, emotional regulation is discussed.

> "… a little boy we've got in our clinic who is, umm, who's, who really wants the appointments, he's quite bright and in our initial appointment he's like you know 'I've got things I want to say' and then he looked at the screen and then *immediately* got really emotional and kind of had to dash off and the carer had to sit, to take care of him… I think if you were in a room with him you'd be able to contain him and sort of engage with him very well, but having to do it [remotely], I think he just can't quite hold himself together enough and I suppose that's it, he does have to hold *himself* together a bit more because the therapist remotely can only offer so much containment I think, to a child that's feeling really, really unsettled." (Participant 1)

This therapist also described the requirement for established ego maturity and resilience in order to manage in PRW;

> "… I think where there's been a more resilient ego… I think the fact that they can hold something in mind and in a more stable way means I think they can tolerate the sort of distance that's involved in sort of remote working [to and fro pointing hand gesture]. So for me that's felt like the sort of deciding factor… You know, I don't like the word regulate, but those children who sort of more easily feel fragmented or feel like they fall apart, I guess, ummm, where they still need that kind of auxiliary ego, you know, I think where they're still at that level of emotional development an online platform just doesn't feel suitable." (Participant 1)

Here, less propensity for fragmentation and an established internal structure are given as indicators for the capacity to work well remotely. The therapist suggests that this allows for an impression of the therapist to be held in mind and for the patient to tolerate waiting across the distance created by being remote.

Additionally, it was suggested that patients who had a more established, three-dimensional internal space could mitigate the two dimensional flatness experienced.

> "… I also feel like, … that she doesn't-, can she sort of-, am I a person to her really or am I, head and shoulders to, just to sort of you know, just a sort of someone that will receive something from her, but, but that is not really sort of terribly three dimensional…" (Participant 5)

Some of the therapists had thoughts on how these capacities might contraindicate PRW in particular patient groups, for example in the case of neurodevelopmental differences.

> "… think that sort of physical presence, particularly with younger children and potentially with, with, with young, younger children with ASD [Autism spectrum disorder], I think, you know, you do become that sort of flattened two dimensional thing [in PRW]." (Participant 7)

In this example, there is a suggestion that children with ASD might not be able to benefit from PRW.

Subtheme 2.2 Psychoanalytic work relies on an embodied experience

‘child psychotherapy isn’t just about talking’

Although PRW allowed for talk between therapist and patient, the capacity for close observation of the self and other was compromised even when visual information was available. All of the therapists described the absence of being together in-person as a profound loss to the psychoanalytic process. There was a feeling that the therapist just wasn’t there with the patient;

> “You know, that was quite an odd experience for him just to be sitting in a room with a camera.” (Participant 7)

Straightforwardly, the therapists spoke about the absence of the full range of sensory information leaving them feeling that they had a partial picture of the young patient. This appeared to be the case even in the most ideal remote set-ups; video call with clear, consistent connection, and would be further exacerbated in audio only work.

> “… so much of how she communicates is with her body and I guess really also your field of vision is just kind of shoulders up, you know, I would lose her tapping her foot, you know, I wouldn’t be able to see that, or her hands around her knees, you know, so maybe she’d also feel that I’m not *hearing her* as much, you know.” (Participant 1)

In therapy with children, being able to clearly see what the patient is doing is vital to work which would ordinarily involve communication through play and actions, using toys or art materials. In many cases this was very difficult to replicate in PRW. Even when a toy box was used the limitations of not being together physically was keenly felt as a block to communication.

> "sometimes she refused to come to the phone, sometimes it was a very quick phone call. I think she, she did struggle with talking to me on the phone… she's a young person who finds it really hard to talk about things directly. Ummm, there's quite a lot of acting out." (Participant 5)

> "[In-person] he's constantly, errm, aggressive, and throwing his body and using his body, and there is no body on, on, on remote platform for child work, they cannot use their body… to express and use of my body too, the proximity and distance to my body to work something through [is lost]." (Participant 3)

There was a sense that some level of communication cannot be expressed unless the therapist's and patient's bodies are in proximity.

> "… I suppose it's not just so much what I-, it's what I can't see, but it's not so much what I can't see, it's what I can't feel…" (Participant 4)

The partial experience of being together, but not embodied, was felt to be something that compromised the therapist's ability to respond in real time. This seemed to be something operating at a level outside of awareness which might be described as body to body communication.

> "I think maybe it's that there's something to be said for not just that you're observing closely, but that you are responding, sort of moment by moment to the patient, there's that kind of attuned experience that you can offer in-person…" (Participant 1)

The lack of embodied, in-synch experience compromised the therapist's ability to draw on a full range of feelings in countertransference and to trust this enough to act on it (discussed in greater depth in subtheme 2.4).

> "… because you don't have the person in front of you to get a sense of yourself too, you, you've got to almost actively kind of think what you feel like." (Participant 7)

This therapist described feeling unable to reference countertransference in their own body to understand the patient.

Additionally, many of the therapists were mindful of their patient being aware of not getting a full picture of them. Again, this was exacerbated in telephone contact, and perhaps more of a concern when there were specific barriers to connection in the dyad.

> "I felt [the patient in face to face sessions] was observing me incredibly intently. And, and in my mind, I linked to partly her childhood, her hyper vigilance and her the quite horrendous domestic violence that she had suffered… So I think, I think it was both ways she couldn't read me so to speak, when she only heard my voice, and I couldn't read her well either." (Participant 6)

In this example the patient's past experience of trauma impacted on their ability to manage contact without seeing the therapist.

<u>The physical body of the therapist contains and/or acts as a depository for unconscious projection</u>

In the absence of being present with their body, all of the therapists felt their capacity to contain the young patient was critically diminished. This was true in an ordinary, uncomplicated way in vivid moments like the one described below.

> "… the sadness and the tears and it's a different experience seeing someone on the screen, all that you see their head and their kind of sobbing [tears running down face gesture] and crying… I wish that we were in the same room, I had no presence, … I'm just an image on the screen and… [shaking head emphatically] I felt like my voice wasn't enough to hold it… she was really falling apart…" (Participant 2)

The unconscious correlate of this seemed fundamental to what is altered or lost in PRW, leading to a feeling that it was not containing enough. It was striking that the implicit, embodied experience of containment was very difficult to articulate; what was understood to be happening/not happening in PRW was hard to say, often resulting in a standalone statement like "it was more containing for her to be seen [in-person]" (Participant 4). When it was

possible to begin to unpick this, the therapists noted the need for their physical presence in both work with younger children and where addressing primitive, infantile issues was especially important.

> "I feel she needs something quite primitive. I think she needs something quite holding. You know, the sort of warmth of a presence in the room. You know like the few times that she *would* let herself go, she would be like a very little child, it really did feel like you were watching a toddler, you know kind of big eyes, watching, following her play, you know, even though she's a teenager. She needs something *quite* gentle and, errm, I almost don't feel emotionally that she's kind of mature enough to be able to sustain something remotely..." (Participant 1)

Many of the therapists suggested that their physical body acts as a vessel to receive and contain unconscious projections. More than just the mind of the therapist, the body is required for the patient to feel that projections have landed and been contained. This therapist described this vividly as they considered their patient's feelings of aggression.

> "the body is a container that you can express your aggression or your project your aggressions because the body is there to contain it, you can become aware of it, you can try it out, whereas without the body, there is, errr, suddenly it's not safe anymore to go to that level… it feels like the aggression is in cyberspace as opposed to being, the projections being contained in the physical, you know, [pause, touching body, trying to find words] person to person." (Participant 3)

It was suggested that even with patients where there is a limited internal capacity to be contained, the physical body is still vitally important as a place to deposit unconscious projections, perhaps in a more evacuative way. The following extract describes a brief period of PRW with a patient who seemed to feel that they could not make a physical impact on the therapist, who in turn, felt as though they were behind the shield of the screen which lessened the intensity of the projections received. Ultimately the patient could not tolerate what seemed to be a dilution of the therapeutic relationship he had previously experienced in-person.

> "… to me, actually, interestingly with him, it didn't feel too awful… In a way it was a bit, you know in a way, maybe because the projections were less [smiling] and for me was a bit more relaxing with him because he's like, he's just like a little time bomb you know... but he just did a few… and then he said 'No, [it's] just not working for me.' … I think it's, it's the projections are much less intense…" (Participant 4)

The importance of physical containment seemed to vary in line with the internal capacity of the patient (see subtheme 2.1). It seemed that patients operating at a more primitive level, with an impoverished internal world or lack of internalised capacity for containment had greater need for the physical presence of the therapist.

Without an embodied presence, the therapist's identity was distorted in the mind of the patient

The absence of being together in-person allowed patients to feel that the therapist had become someone else to them, in a way that was beyond the ordinary shadows of internal objects being cast in the transference. The therapist, not physically present and in the home of the patient, more readily became a peer or romantic partner in the patient's eyes.

> "It made me feel like I was just another, at some level, another computer friend who was coming around for a playdate. And I'm not… [in-person] he used the therapy sessions to bring his most aggressive [clears throat]. His most aggressive side, and was incredibly rageful, domineering… whereas suddenly on Zoom because I'm in his bedroom, and I'm suddenly this quasi computer friend… there's been none of that rage and aggression, it's all softened." (Participant 3)

Here, the impact of the loss of the therapist's role seemed to limit what could be worked on in the therapeutic relationship. The propensity for slippage of the role of the therapist accords strongly with the distortions in the transference addressed in subtheme 2.3.

Subtheme 2.3 The therapist struggled to fully understand the internal world of the patient

The patient could not be known as a whole person

Most of the therapists described a disconcerting sense that they could not see the whole picture or make sense of the patient as they might expect over time in in-person therapy. This led to a feeling of needing to work harder to compensate. There was a sense that even when work appeared to be going well, something might still be missing.

> "… I think it's, it's harder to get an impression of what the… kind of what the core, core issues, you know… when I first met [the patient]… she's somebody that talks a lot actually, has gone straight into it as if it's you know, kind of second nature to talk about herself. But I think it was, it was really difficult to sort of get an idea [of her]…" (Participant 5)

> "I'm, errr, conscious that she might be trying to give me a message or trying to tell me things in the appointment, and I, you know, I don't feel I have enough information to be able to tell that apart from what might be really going on for her." (Participant 1)

Whilst in either of these cases the apprehension described might be an important communication in its own right, it appeared that the possibility for part of the young patient to be obscured was exaggerated and difficult to work with in PRW.

Distracting external elements could not be excluded and impeded the therapist's understanding

The therapists described how PRW from the young person's home gave an unprecedented view into their real, external world. There was a recognition of the value of having a deeper understanding of the patient's reality.

> "… I was right in *her bedroom,* where she experienced all these intense feelings, maybe that also plays a part; you're on your bed doing this therapy… she could show me all of, almost her external immediate world, here and there, which helped me to think of her internal world I suppose, her internal world, much better, so it definitely kind of brought something there…" (Participant 2)

However, entering into the patient's home opened up an array of complexities to be negotiated in the work. Many of the therapists were conscious of how exposing and intrusive it might feel to 'invite the therapist into your home.' This was exaggerated when the patient was living in deprived circumstances that could be felt to be shameful.

Being surrounded by so many external distractions meant that the patient could be less focused and the therapist struggled to understand if there was any significance to the things allowed to be seen on screen.

> "you know she's just quite thoughtful young person, and, and, and on the phone, it was more difficult and then suddenly she would like play with a cat and she's like, 'oh that's my cat.' [laughs]" (Participant 4)

> "… you know she's kind of coming straight after a lesson and she's in her bedroom, you know, how much of that do I attribute to the part of the day that I'm catching her at, or the fact that were doing it by video and how much do I attribute to her relationship to the idea of this appointments and the transference with me, you know it's harder to discern." (Participant 1)

The loss of the tightly controlled in-person psychoanalytic frame left the therapists struggling to attribute meaning in a way that they might otherwise do with greater certainty. This was particularly relevant where there were technical problems. The therapists were often unsure if the problem was a genuine issue with the technology or acting out by the patient, but felt they could only explore this in a tentative way.

<u>The transference can be distorted</u>

The altered PRW setting seemed to distort what could be known of the transference in the dyad. Some aspects were readily obscured and remained hidden, whilst others seemed exaggerated.

> "…the transference runs amok, I think is what I want to say [laughs], the transference runs amok, very deeply, very quickly." (Participant 3)

This therapist described the impression they got of a new adolescent patient, suggesting that some aspects of the young person could be known about more easily than in in-person work, although this was at the expense of a more rounded picture.

> "… it's somehow distorts it, speeds it up. Yeah, because I was very quickly able to gather that up from him. And then when I wonder if I'd seen him in-person, what I would have been able to, as quickly, think about that internal little fragile boy. I don't think I would, I think I would have been, actually the other aspect of him [would mask that]" (Participant 3)

The distortion of the transference links strongly with the therapist's ideas about the loss of an embodied experience (see subtheme 2.2). In the example above, working in the absence of the patient's body allowed a younger, internal part of the adolescent to come to the fore.

Many of the therapists suggested that the nature of PRW seemed to magnify some aspects of the transference or the self. This was because they could either be more readily observed or the nature of PRW fostered some qualities of relationships more than others. Aspects of the negative transference appeared to be particularly amplified. Collusion with a tendency towards omnipotence was perhaps the most striking example of this; the patient not being with the physical therapist and having far greater control over the therapy platform allowed omnipotence to be acted out in greatly exaggerated form.

> "… and I think it's, you know, it does invite other things, too, for example like for them to be able to move you around, whereas physically, you know, you have more of a presence, so you sort of, you know, have more of a command of this physical space." (Participant 7)

PRW also allowed for the tendency towards withdrawal to feel more concrete and intractable. This corresponded to the therapists feeling that a physical presence was required to reach

withdrawn patients and that very close observation was needed to gauge their near imperceptible responses.

> "… I think in a room… I suppose I can also see when I say something what the actual reaction is, and, and also if she, even if she, we can tolerate silence, *I can* tolerate silence a bit more, ummm, but also she doesn't withdraw completely so she does come back to me." (Participant 4)

> "… just feeling a bit more absent sometimes and, you know, having to maybe work a bit harder to retrieve somebody. And it can be more difficult with certain patients definitely, definitely." (Participant 7)

A kind of withdrawal was also noticed in patients who might outwardly appear engaged, but could use the remoteness to avoid psychological intimacy.

> "I think she felt very, she seemed very practised at talking in this way. Ummm, I wonder whether I'd see a little bit more of her vulnerability if I met her in-person. Errm, and interestingly enough, she's, she's not keen to come for face to face… so I don't know whether there's something quite defensive that goes on remotely maybe." (Participant 5)

Resistance to therapy or to meaningful engagement appeared to be both easier to act out and harder for the therapist to get hold of. This was especially true when patients blamed technical issues for their non-attendance or late arrival; as real technical problems were also rife, the therapists felt that they had to give the patient the benefit of the doubt before attempting to interpret.

> "… so it is much easier to pass off resistance as a technical, remote issue rather than resistance to engaging." (Participant 6)

Unsurprisingly many of the therapists were concerned about the propensity for a tendency for intrusion being exacerbated, both by the patient intruding upon the therapist/their home and the feeling that the therapist was being intrusive or voyeuristic themselves. In this extract describing therapy with a girl who had experienced sexual abuse who used the camera as a

mirror to apply make-up, the therapist spoke about worries that the video call allowed for unintentional collusion with witnessing or taking part in an abusive, voyeuristic, relationship.

> "…I think I feel like I'm a bit a bit intrusive at that point, actually, I sort of feel like she's doing something a bit, private, maybe, but yet I'm kind of, there really close, sort of watching it happen." (Participant 5)

In another example, this therapist describes how working remotely allowed their patient to dress in an overly exposing way.

> "she's often in her bath-, in her bathrobe, which, you know, [pushing back from the screen, grimace], which, I, also there's just something about that that just feels a bit, I mean, it's a three o'clock session by the way, three o'clock in the afternoon, it's not nine o'clock, even nine o'clock, but you know when she's in the bathrobe..." (Participant 4)

In some cases, separation issues also appeared more visible and perhaps harder to address because the patient had no choice but to have therapy in close proximity to the parent, outside of the controlled boundaries set by the therapist.

> "… he has got difficulty with separation but I think it's much more difficult… he's in a room with mum close by, you know, boundaries is different, more difficult to negotiate, I think because you are in his house." (Participant 7)

Subtheme 2.4 The capacity to work with a psychoanalytic approach is diminished

<u>The patient's internal world was observable but not fully available for working through</u>

Thinking especially about elements of the patient that seemed to be more vividly brought to PRW sessions, the therapists described being able to see and understand things that might helpfully be brought to the patient's attention, but having a limited capacity to do this.

In a concrete way, the ease at which the patient could disengage, at the touch of a button, seemed to give some patients a way to avoid things that felt too much. Technology colluded with a sense that painful moments cannot be tolerated and sped up the potential for acting out

so that there was no chance for the therapist to interject or try to introduce a space for thinking before action.

> "in a way she has to kind of persevere a little bit in the room [in-person], I mean it's so tempting for her to just, you know, kind of cut the, cut the video. During the online session she could, she could leave straight away… she'd just leave…" (Participant 5)

There was a conflict between the value of the patient's difficulties being more visible and the increased struggle to address them. In the following extract the therapist described being disarmed by losing contact with the patient; both losing their identity as a therapist in phantasy and literally after the video call device had been placed 'in the corner' while the patient moved away from the screen. The opportunity to work through the very vivid issues presented was diminished.

> "… she wanted to be an adult, you know, that young person, to be a child was, was incredibly painful for her… and I think their technology did make that she could probably act on it slightly more in that sense, but it became sort of so obvious that then it became you could speak about it, you know, it was just so sort of readily available and between the two of you… I mean, it was problematic too, don't get me wrong, because there was something also about, you know, how do you kind of come out of the corner and be the speaking therapist somebody that she could hear and take something in from?" (Participant 7)

The same therapist also highlighted the need for an embodied presence to allow for difficulties to be worked through *within* the relationship.

> "… another young person said that, although they could say more, they felt as though they'd been slightly robbed of the experience of doing it in-person and the intensity and the sort of the way of relating to somebody when you're speaking about something that could be shameful, shaming, you know, they weren't having to negotiate that, they were, they were doing it online and not-, they didn't have to sort of think of either being seen or physically be in the room with somebody… Yeah, dealing maybe with those, you know, those very particular feelings or sitting one or two metres away from somebody, having said something and then sort of waiting for a response…" (Participant 7)

This example highlights the conflict between PRW promoting a greater freedom to discuss experiences of shame in particular, alongside a perhaps diminished capacity to explore the feelings this generated within the dyad.

Capacity for containment is critically compromised

As described in subtheme 2.2, the altered capacity for containment in PRW was profound. This therapist vividly states the quandary of feeling that the connection was too tenuous and they were not present enough to safely do work at a psychoanalytic level.

> "what's the worry? [contemplating] I'm not sure, ummm, I suppose that I'd be leaving them alone to deal with something that would feel a bit much. That it wouldn't, that you know, actually it's not contained enough, you know if you're going to go there you do it in a, you don't just get a child deeply in touch with their unconscious stuff… I guess it can feel, a little bit cruel, or clumsy or inappropriate." (Participant 1)

Taking into account the partial view of the young patient and loss of bodily presence, there was a pervasive sense amongst all of the therapists that a virtual connection often didn't feel robust or safe enough to allow the therapist to provide containment.

The therapist's capacity to make interpretations was reduced

Many of the therapists described feeling that the normal delicacy and nuance that in-person work in the countertransference allows for was often lost in PRW.

> "I guess it feels a little bit like you're working in broad strokes sometimes rather than being able to just in that very gentle way [rubbing fingers fine grain gesture], ummm, be alongside [weaving gesture] sort of every moment of what's happening in the room or you know in the session." (Participant 1)

> "I think in the room [in-person], I have more of a sense what might be going on for that person… I think I trust my own countertransference, I suppose feelings, more." (Participant 4)

Without the certainty of knowing one's own feelings in countertransference and with the sense that the capacity for containment was compromised, the therapists described feeling restricted in how secure they felt about their understanding of something to be addressed and speaking about this with the patient.

> "I can feel less confident about what I'm seeing and maybe I can take up transference less confidently because there's so many other things coming into play" (Participant 1)

The dual task of both containing whilst challenging feelings is perhaps already difficult in any psychoanalytic psychotherapy, this seemed to be exacerbated by the limitations of PRW. This was also added to by the feeling that the connection was not robust enough to withstand a rupture and allow for repair.

> "… I think in-person, I feel like I know her and I can, and if I, if I get something wrong, I noticed it, and then I can say 'okay sorry maybe that was a bit too much'… I can sort of repair things I feel in-person, whereas online; she just goes…" (Participant 4)

There was a sense that in order to feel able to name something with a patient, the therapist needed to be able to see, with full sensory, countertransferential information, where and how their words had landed. Without this the therapists were inhibited, reluctant to suggest something without the ability to see its impact as well as not having enough information to know 'where to go next.'

> "… I think there is something about losing a bit of intimacy, doing this online, in terms of being a bit challenging, so I think I'm a bit more hesitant really to make int-, sort of those sorts of interpretations, at the minute with this young person. Ummm, but I feel like I'd be able to hold it a little bit, a little bit better, or a bit more compassionately, or

> it would come across a little bit differently if I, if I bought something in from the transference… [in an in-person session] I felt I could do it, because I was almost there to catch her if it didn't work…" (Participant 5)

Some of the therapists described feeling less able to take risks about what might be put into words in the absence of being present to provide something more active or embodied in response.

Setting is too unsafe to allow aggressive and erotic transference

There was a strong feeling that aggressive and erotic transference were especially difficult to work with.

> "I think it's particularly those who struggle with sort of uncomfortable, aggressive feelings that, that are, you know, it's, it's quite tough to know how to contain them in a way, you know, it's not easy and you have to challenge it a little bit as well as containing it and I think, I personally think that's almost impossible online." (Participant 4)

Some therapists suggested that the patient was less likely to allow any sort of communication, conscious or unconscious, of these feelings. These are also aspects of the work that would be more challenging in-person, but appear even less accessible in PRW.

> "… once we were back to clinic… I saw the angry child again, very angry."
> (Participant 2)

> "… and on the telephone I'd already got this maternal countertransference to this cute little boy, right… [In-person] I'm very frightened… presentation is very big and strong, and his thinking is very disturbed [pause] and violent. And none of that, that's an important thing, none of that came across on the phone, the violence… the projections are greater in-person..." (Participant 3)

This appeared to correspond with the loss of an embodied experience. In this example the therapist spoke about the protection offered by meeting over the phone which also obscured

their ability to work on aggressive aspects of the patient. Discussing the same patient, the therapist suggests that aspects of erotic transference are similarly too dangerous in PRW.

> "… we're in, I'm in his bedroom, is *way* too dangerous to have sexual fantasies when you're in your own bedroom with a therapist. God Almighty, that's like major taboo, isn't it, so you know that's just too dangerous... you're in their space, it's not contained, neither in its separate space nor with the use of our bodies…" (Participant 3)

There was a question of the efficacy of the work with some patients because these important aspects of the self could not be addressed in PRW.

Therapeutic potential was slowed down and diminished

Taking into account all of the facets of PRW described, there was a consistent sense that working remotely limited the type, depth and quality of the work. As well as limits on working with specific aspects of a patient's presentation, the therapeutic potential for integration was diminished when only part of the patient was received and only part of the therapist's response was registered.

> "… and thinking of the idea of int-, you know, integrating their thoughts and make them as a whole, help them to see as a whole person, how to achieve that when you only see half of each other really [laughs] on a very simple way…" (Participant 2)

Theme 3: Facilitating and obstructing factors

In the following theme factors that allowed for optimal PRW are examined. The altered nature of the setting and the impact on the work is also considered.

Psychoanalytic remote work provided greater flexibility and access to treatment

The flexibility of PRW enabled some patients to get better access to therapy during the pandemic. Some have benefitted from the reduced time commitment in PRW, where travel times are reduced or removed. This was particularly relevant for families who travel long distances to the clinic. The wider benefits of this included young people missing less school to attend therapy.

> "Some young people have said that they would not be able to come to these sessions if it wasn't remote at the moment, either practically speaking, or for other reasons, but that has enabled them to have some input, you know, that they might not have had… because you know, either being in school or, or job or something like that…" (Participant 7)

This therapist also highlighted the need to integrate the potential to change the plan if necessary, in planning for treatments offered remotely.

> "If you feel that clinically it's not working correctly, there is a sort of a stagnation and it has to do with the actual being online or something I think that as a clinician, you know… be firm and to say clinically, you know, my opinion is that it isn't working." (Participant 7)

Parents were required to facilitate psychoanalytic remote work to a much greater extent than in-person work

All of the therapists vividly described that in work with all young people PRW has demanded far greater contact with parents than would ordinarily be the case in most in-person treatment. For young children parents were required to facilitate sessions entirely, and for adolescents the parent's cooperation to allow for a private space was critical.

> "… from an outside, it might look like remote sessions should be easier [shaking head] to manage for families, and it is definitely, for the cases I had, it is *not* the case. It was definitely more effort… you kind of need to work in a partnership, real partnership, you are relying on them to set up the time, to give the space, to keep the box safe and you're

> communicating if that doesn't go well or does go well or what needs to happen…" (Participant 2)

> "[the carer] found the whole experience of trying to set it up and get on the camera-… the [carer] got incredibly stressed out…" (Participant 3)

The child's experience of their parent and therapist visibly working together to support the therapy was described as a positive aspect of PRW. However, this was offset by the challenges faced in this process. Many of the therapists acknowledged that, particularly in work with younger children, it was a complicated, difficult task for parents to establish a good enough setting for meaningful therapy.

> "to sort of rely on mum and dad to help *me* to keep the boundaries of the therapeutic setting. And I think that was a real challenge to me, I think that was really different because it just felt as though, you know, a lot of it began to slide…" (Participant 7)

It was particularly difficult for parents to recreate aspects of the usual in-person setting without the awareness of why some things are important, for example a toy box only to be used in the session. Additionally, the safety of PRW sessions was something that the therapists had to take into greater consideration in negotiation with parents.

> "… you got the five year-old with a pair of scissors and you can't be there, you know, there are those kind of issues that need, errm, really thinking through…" (Participant 3)

The difficulty creating the setting was compounded in work with families who were already struggling with high levels of distress or dysfunction.

> "… four year old was in such a chaotic home where mother forgot the times, errr, could not get the video working when it was needed… I think one is so reliant on the family constellation and commitment to the therapy. And if it's a lone mother struggling with

> chaos at home and other kids and, I think it's very difficult, very, very difficult." (Participant 6)

In some cases, where parental capacity or attitude towards therapy was compromised already, they may have been able to bring the young child or allow the adolescent to attend in-person, but the requirement to be more active in setting up or facilitating PRW was unachievable.

> "… if you've got somebody who's sceptical, or suspicious, who is likely to sabotage, you're going to have that anyway. But having that on line, on Zoom remotely makes it very, very difficult for both clinician and child to get enough out of it." (Participant 3)

In families where parental mental ill health was a factor in the child's difficulties, the therapists often described a greater likelihood that a parent's dysfunction might limit the success of establishing PRW or be a more prominent factor in the dynamic with the therapist because of the much increased contact. The impact of the pandemic is also of significance here, as parents were under greater strain and parental mental ill health issues were often exacerbated.

> "Well I think what was amplified was pre-existing parental mental health issues. I think that is what was amplified… and so any pre-existing issues were amplified along with that." (Participant 6)

This therapist described a family where it seemed that the parents own ambivalence, separation issues and envy of the child's therapy was detrimental to setting up remote sessions.

> "… each week [the carer] would go and tell the child "oh go and tell [therapist] what your [family member] did to you" or something like that, like very unhelpful. And they're in the living room, not leaving the child alone, and each time I think the child resisted more and more… the mother's needs are greater than the child's needs… it was, errm, difficult for the mother and I think sometimes rivalry as well… So I think maybe the remote work was another again, layer on top of everything..." (Participant 2)

Although these difficulties would also impact in-person therapy, it might be hoped that a parent could manage to bring the child for therapy and, in the most ideal set up, have their feelings contained by parallel parent work.

Additionally, some therapists described how it could be challenging for parents to be more exposed to the content of therapy sessions and brought into painful contact with the extent of the child's difficulties.

> "… and parents can hear it from downstairs and got quite anxious and sort of came into the session and needed to check and see what was going on. And I think that was a bit inhibiting [for the patient]… I think parents felt very awkward about hearing things..." (Participant 5)

In this example it seemed that the parents struggled to trust that the remote-therapist was present enough to keep the child safe alongside perhaps feeling over exposed to the child's difficulties.

<u>There are minimum practical requirements</u>

In order for PRW to be possible all of the therapists described minimum requirements for access to technology and a good enough, private physical space. Clearly, doing therapy online is only possible if the patient has the capacity to get online; this includes access to a suitable device and stable internet connection. The quality of connection also had an impact. When the connection was poor or unstable, glitches in the call appeared to be felt as painful or as a loss of psychological connection by some patients.

> "… when it goes quiet, sometimes the silence can feel like a *real* parting, you know, like you're really, like that togetherness is completely lost in the moment, that connection, or if there's an interference, you know, it can feel *very* abrupt, you know, it can, errm, so I think I probably work a lot harder in sessions and so he's got also, in some ways a more distant therapist and in some ways a more active therapist…" (Participant 1)

These moments perhaps had the effect of breaking the façade and exposing the reality that patient and therapist were not 'really together.' Although this could be spoken about it altered

the quality of the work. Access to a private space to have the session was also a key consideration.

> "… you know she often gets interrupted, sometimes I see that she's whispering because she doesn't feel that it's private enough, errm, and [shaking head]." (Participant 1)

> "I think the issue of confidentiality can be particularly in-, with young people who have, you know, a lot of family members, large families in a small space, and they just can't find a space to have it in the home." (Participant 7)

Without their own space, patients were more likely to be inhibited and unable to use the therapy as they would in-person.

In PRW with patients where English is an additional language, without the full ability to take in gesture and extra verbal communication the dyad's struggle to communicate was exacerbated.

> "body language was important… [PRW] really didn't work… there were no, errr, physical cues, visual cues that I could try and use to help me understand what [patient] was trying to say so, it, it really fell apart." (Participant 6)

Although having a sufficient level of spoken English is important for in-person therapy (without a translator) this was perhaps exaggerated in PRW where visual information is obscured.

<u>There was a shift to shared control of the setting</u>

Most of the therapists described being limited to guiding the patient or family to allow them to set up the physical and psychological setting, in contrast to having full oversight of this in the clinic. For some patients having greater control felt safer and enabled them to enter into the therapeutic relationship more readily.

> "the telephone … was a stepping stone, allowed him to test the water… I think the phone was actually a very helpful thing because he could, ummm, in terms of temperature and distance, he had some… this child needed the control to be able to trust enough to come at all." (Participant 3)

Some of the therapists also highlighted that their young patients typically had greater familiarity with technology; at times this seemed to have an enabling function as another aspect of feeling in control. However, where the patient or family struggled to create a consistent setting this contributed to therapy breaking down or feeling unsafe and lacking in the containment required to be in touch with distress.

<u>Having therapy in your own home could feel more uncomfortable</u>

Talking about intimate or exposing things in the patient's own home had a different resonance to coming into a clinic and could feel too difficult. This had an impact on what could be safely thought about in sessions.

> "I often think about the fact that you know she's having a session and talking about things that feel incredibly painful or evocative and then the screen switches off and she's in her bedroom still [grimace] and supposed to spend the next 3 hours on the same screen doing her lessons, and how bizarre that must feel." (Participant 1)

Without the distinction between ordinary life and therapy there seemed to be a feeling that the confines of the session could be broken. This exacerbated the propensity for issues to be hidden, distorted and more difficult to address. This links with acknowledging the significance of having therapy in a distinct, neutral setting.

> "it's not just how they relate to the therapist… but also how they relate to the room itself, the physicality, you know the physical space, the container, you know, in which the therapies happening… now, because the room is their bedroom, or the room is their living room, and it doesn't have the same, it's not *charged* with the same significance

> during a session as it would do if it were a separate space that they use *only* for this purpose." (Participant 1)
>
> "Yeah, and I think there is a value in going to a neutral place. That you go and you leave and you know I think there is even kind of-, ... Because you leave something there, I mean, I, you know, and I, and I was gonna say in a concrete way, I mean in a way it's not concrete but he kind of even feels concrete that you do leave something in the room that you can also then leave." (Participant 4)

This issue was further complicated for young people whose home is not ordinarily a safe enough space.

Transitions were lost or changed

Without ordinary transitions to and from sessions all of the therapists noted that beginnings and endings could feel abrupt. They described the therapeutic value of the journey to and from in-person sessions; the preparation time in the young person's mind; and on arrival at the clinic, the opportunity for non-verbal communication to be gathered from the moment of meeting in the waiting room.

> "… it is the, the *suddenness* of the start of the session, and the end of the session, which I think is so unsatisfactory… it starts just like that [clicks fingers]. It's just like that, and I'm back in my kitchen… Yeah. And I think that transition is not helpful, psychologically, one needs a bit of time." (Participant 6)

Some therapists described adaptations to mitigate this, for example encouraging patients to create their own routines to establish a transition before and after sessions, or relaxing the pace/depth of the session as it comes to a close to prepare the patient to finish. Without real transitions this therapist discusses how the session time was compromised.

> "… very suddenly they come in, they don't have a sort of journey to orientate themselves… and they don't have that journey back to kind of reacclimatize to being

> outside of the session. Ummm, sometimes I wonder if I hold back on allowing the sessions to develop more depth because I'm so aware of the context, and you know that's how I'll very soon be sending them back into their real life..." (Participant 1)
>
> "I don't know, just sort of there was a sense that she showed up, but that was all that, that she was going to give. And I was left to, to kind of do the work…" (Participant 4)

In parallel, PRW appeared to magnify a tendency for the patient to go 'through the motions' of doing therapy, where it becomes just another activity on the phone or computer. In this way its distinct purpose and value was diluted or lost.

Discussion

Overarching theme: The task of therapy was changed by the pandemic

This overarching theme is critical to understanding the rest of the results of this research. Whilst the research question seeks to examine the nature of PRW, this aim must be looked at together with the acknowledgement that the work being discussed by the therapists was intrinsically coloured by the emotional experience of the pandemic. For this reason, the conclusions drawn are limited to describing the scope and limitations of PRW with children and adolescents against the backdrop of working in frightening, uncertain times.

Theme 1: The therapist's [and patient's] experience was unpleasant and strained

This theme gives a description of the therapist's feelings about PRW and its efficacy. This theme stands apart from the content of the other themes, to vividly demonstrate the pervasive emotional experience conveyed by the therapists in their descriptions of what doing PRW in the pandemic was like. Aspects of both the overarching theme and themes 2 and 3 combined perhaps offer an account of why PRW could feel unpleasant and strained.

The way that the impact of the pandemic influenced the quality of the work itself and the therapist's view of PRW cannot be overstated. It will be important in future research to explore how the 'unpleasantness' might be less prominent when PRW is offered by mutual decision and with careful planning, without the heavy toll of the pandemic in the background.

Nevertheless, it seems likely that the strained feelings evoked in PRW are also closely tied to the nature of the setting, examined in depth in themes 2 and 3. The therapists appear to describe the difficulty of creating a setting that allows for the essential tasks of "observing, understanding, and containing" (Boston, 1977, p. 23) in PRW; capacities that would ordinarily

rely on being in close visual and physical proximity. In the absence of being together in-person working towards these aims of child psychotherapy felt like a strain and could be exhausting.

Theme 2: Working with the unconscious was altered

2.1 Remote mediums allowed for adapted communication between therapist and patient

All of the therapists described how their patient's communication was mediated by the technology of PRW. For some this allowed for rich dialogue in sessions. This included both older children being able to speak or type to the therapist and times when younger patients could communicate with technology-mediated actions. This echoes findings emerging in the literature, for example Zuppardi (2020) and Bomba, Alibert and Velt (2021) who describe how interactions with the PRW medium can communicate unconscious dynamics in a similar way to action and play in in-person sessions.

However, the therapists were aware of the limits of this adapted communication. They describe how the restricted view of the camera in a video call or hearing the voice alone meant that much of the child's communications could be lost. In psychotherapy with children this appears to be a critical issue as so much of the work relies on the therapists understanding of enactments rather than talk (Joseph, 1998). Garcia (2020) described the changes in the way physical actions could be used by their latency aged patient in PRW, suggesting that vital communication was missed because it was not seen or heard fully. They also highlight the loss of the therapist's physical actions in play or response to the young patient which are similarly requirements in therapy with children.

Amongst this group of therapists little PRW was attempted with very young children. This was largely due to the ordinary caseload of the clinics, however it was also suggested by

some therapists that work with this group would be fundamentally limited without being physically together.

2.2 Psychoanalytic work relies on an embodied experience

Not being in the same room limited the therapist's sensory impression, both explicitly in terms of what they were aware they could see or hear, and implicitly; in an intangible sense that they couldn't feel the full presence of the patient. In this context it was harder for them to observe and understand unconscious communications, making insight more tentative. This seemed to compound the sense that PRW can feel like straining towards something out of reach.

This finding opposes the robust claim, described by multiple adult PRW authors, including Leffert (2003) and Savege Scharff (2012; 2013), and more tentatively in work with adolescents by Cohen (2020), that in the absence of a full view the therapist is better able to tune into unconscious material. It is perhaps the case that in work with younger or more disturbed patients this is not observed because the therapist relies so much more on enacted communication which was easily obscured in PRW.

The sense that PRW did not provide enough containment for work with many patients was pervasive amongst the therapists. It was difficult for participants to articulate what contributed to this, however it seemed, at least in part, to arise from the loss of being together physically to allow for projections to be received in the body as well as the mind of the therapist. They described feeling that without the presence of their body the patient's projections were left "in cyberspace" (Participant 3) and therefore uncontained. Echoing this, Shulman describes the therapist's body and room being a real "depository of the psychotic part of the personality" (2021, p. 285). The critically reduced capacity for containment in turn limited the possibilities of the therapy. This was perhaps most significant in work with most

disturbed patients addressing infantile aspects of the self, for example the very dysregulated adolescent boy described by Participant 4 who felt that PRW was not enough for him and so insisted on being seen in-person.

Some of the therapists suggested that in order to sustain virtual contact, to mitigate the loss of not being physically together, the patient needed to have reached a level of cognitive, developmental or internal maturity. This study tentatively suggested the ability to hold a stable internal impression of the therapist in mind and engage in a three dimensional relationship over a two dimensional medium are significant. The dimensionality of the patient's internal world (Meltzer, 1975) would seem critical to this point. Additionally, having the internal capacity to regulate one's self in the absence of the therapist appeared vital, particularly considering the need to be able to address distressing aspects of the patient's experience. This seems to correspond to the patient's internalised capacity for containment and echoes Wolpe (2020) who described the child's need to rely on their own ego resources to mitigate the inherent lack of containment in PRW.

Changes to the physical setting in PRW perhaps diluted the contact between the dyad. This appears to be evidenced by the patients described who seemed to benefit from being remote. Some of the therapists suggested that being remote was experienced as less intense in terms of the "temperature and distance" (Meltzer, 1976, p. 374) experienced in sessions. Patients were discussed who were better able to tolerate the relationship with the therapist at distance. This seems to accord with Holloway, Ramirez Hinrichsen, Oliver and Weddepohl's (2020) suggestion that some children could regulate their contact with the remote-therapist by withdrawing to other activities on the device. They highlight this particularly in young patients with autism spectrum conditions.

In this study, a number of patients were discussed who seemed to feel freed-up to discuss issues relating to shame or their body. This mirrors a widespread agreement in adult PRW literature which is also emerging in writing about PRW with young patients (Cohen, 2020; Paiva, 2020; Webster, 2020). It is suggested that speaking about such concerns is easier when the patient is not seen directly by the therapist. There is an argument that where a young person would benefit from merely speaking more openly, PRW might be indicated in preference to in-person work. However, some of the therapists also noted the way that working through shame in the therapeutic dyad seemed to be changed; perhaps being "robbed of the experience of doing it in-person" (Participant 7). In adult PRW literature, Gutiérrez (2017) and White (2020) describe the same sense that working through shame in proximity of another is a necessary, though painful, part of the therapeutic process.

2.3 The therapist struggled to fully understand the internal world of the patient

In acknowledgment of the partial and altered nature of communication and containment in PRW, the therapists suggested that getting a full understanding of the young patient was difficult. Although this is only ever partial, what could be known of their internal world appeared to be distorted.

Many of the therapists described how PRW allowed some elements of the transference to come to the fore more easily, whilst others were inhibited. For example, it was strongly suggested that a tendency towards omnipotence might be easily enacted by the patient's greater ability to control the therapist-on-screen. Conversely, showing aggression was perhaps inhibited by the patient being in their own home in the absence of the physical body of the therapist. The potential for transference to be distorted is well documented in much of the literature on PRW with adults, notably Gutiérrez (2017) and Lemma (2017) who both suggest

that the physical presence of the therapist and patient is necessary to ground the dyad in reality. In emerging literature with adolescents Zuppardi (2020) describes the propensity for some curated elements of the self to be displayed at the expense of a rounded view. This links to Shillito's (2020) suggestion that supporting integration can be more difficult in PRW when aspects of the self can be presented or excluded in isolation.

Whilst there was an acknowledgment of the value of having a greater insight into the young patient's external world, the therapists also felt preoccupied by the difficulty of untangling aspects of the material that was meaningful from technological or outside distractions. This accords to Shulman's (2021) suggestion that there are many ways that the content of a PRW session might be misunderstood, and the therapist can struggle to unpick the meaning of events.

2.4 The capacity to work with a psychoanalytic approach is diminished

In the work described in this study, a difficulty working through in the transference appeared to be created by the combined change to the physical setting, the loss of an embodied experience and the partial impression of the internal world. In this light it seemed that PRW with the young patients described often felt limited. Some explicit tasks of therapy appeared to be compromised, for example many of the therapists described being unsure about making interpretations, raising difficult topics or challenging the patient without being able to see in the fullest sense how their words landed. Similarly, Shillito (2020) described being concerned that they could not see their patient's reactions and felt they might be leaving them to deal with too much on their own.

Theme 3: Facilitating and obstructing factors

It is clear that PRW can provide a more flexible option for some children and families. The therapists in this study particularly highlighted the benefit for some adolescents who were able to attend therapy with minimal disruption to their school attendance.

All of the therapists highlighted the critical requirement for the patient to have adequate and robust access to technology, in a private good enough physical space. The therapists also described the significant demand on parents to facilitate PRW; for younger children co-creating the setting to enable the child to engage in the work through play; for an adolescent the requirement to give space and privacy without intrusion. Being so heavily involved in the process afforded a greater likelihood that the parent's own capacity and feelings about the therapy could have a negative impact on the work. Some of the therapists discussed how this was particularly relevant in families where parental mental ill health was a factor. In cases in the literature where PRW with children has been successful a common feature is the dedication of well-functioning, well-resourced parents (particularly Sehon, 2015; 2021; Hart, 2020). It is perhaps not surprising that much of the work described by the therapists in this study appeared to be limited by the patient's home situations and capacity of the parent, as it reflects the high prevalence of family dysfunction and deprivation in those who are seen in child and adolescent mental health services (NHS Digital, 2018), further exacerbated by the pandemic.

The therapists noted the many changes to the work resulting from the shift to co-creation of the setting. The loss of transitions and the distinct space for therapy outside of the home changed the way the patients described interacted with the therapist, in seemingly both positive and negative ways which needed to be considered in making sense of the patient's experience. For some the value of the therapy seemed to be diminished in the way that Cohen

(2020) and Zuppardi (2020) suggest that PRW can become indistinct from any of the other tasks of life happening on a device.

Reflexive Commentary and Evaluation of Research

In this section I will give an account of some of the significant research design and reflexivity considerations I have made, and evaluate the strengths and weaknesses of the project.

Strengths

This study has presented a comprehensive literature review which highlights questions arising about the nature of PRW. In the interviews, participants provided rich first-hand accounts of work in the pandemic, which they could compare to many collective years of qualified practice in child and adolescent psychotherapy.

I used a RTA approach (Braun and Clarke, 2022) as the qualitative research methodology that seemed to best fit with the research question and the ontological underpinnings I brought to the study. RTA was particularly fitting because it forefronts considerations of reflexivity as compared to other qualitative methods of thematic analysis, for example Interpretative Phenomenological Analysis (IPA; Smith, Flowers and Larkin, 2009) where reflexivity plays a smaller role.

Considering the multifaceted researcher role

Comparison to my experience as a clinician

A foremost reflexivity consideration has been working in acknowledgement of the multiple positions I have in relation to the topic, particularly being a trainee child and adolescent psychoanalytic psychotherapist working remotely in the pandemic. This role provided a helpful additional source of reference, when for example I could bring to mind a moment from my own practice to further understand a point made by one of the participants. However, at times I

wondered if I was drawing too much from my own thoughts. For example, as I worked through the process of reporting the analysis, the first illustration that came to mind for a facet of a theme was sometimes a moment from my own practice. This accords with the nature of RTA which aims to weave together ideas and create an analysis that goes beyond the words of the participants (Braun and Clarke, 2020), but it led me to question whether the predominant source of data was my own work or the participants'. Considering this in research supervision led me to Ogden's concept of the analytic third (Ogden, 2004) which describes how ideas that emerge in a psychoanalytic session do not appear in the mind of either the analysand or analyst independently, but are a product of their unique, joint endeavour at conscious and unconscious levels. In this research, through the process of spending a substantial amount of time immersed in the data, it is likely that these ideas combined with and enhanced my thinking about an encounter with my own patients.

Nevertheless, it was important to keep returning to the verbatim words of the participants to ensure I was able to find a clear example from the interviews to evidence each aspect of the themes. I was greatly helped by the supervision process to keep returning to the developing themes, over time, and to examine my reflections on them in order to better understand what the participants themselves had said. This mirrors the process of clinical supervision described in Vassilopoulou and Layiou-Lignos (2019) who apply Ogden's concepts to capture how clinical work develops through the process of supervision.

Comparison to my experience in therapy

As I read about adult PRW my mind was often drawn to thinking about my experience as an analysand. Like the vast majority of in-person work, my well-established in-person training psychoanalysis abruptly switched to telephone sessions at the start of the first COVID

lockdown. In my experience, I felt that my therapy largely continued at the same depth of connection in the transference. However, there was something intangible missing.

Throughout the project I attempted to use the phenomenological principle of bracketing this personal experience in order to keep it separate from the data collected from participants (Husserl, 1927; In: Smith, Flowers and Larkin, 2009). For example, by re-focusing on what was said by participants when my mind wandered to my experiences to actively move away from my own thoughts. I recognise that my attempt to do this could only be partially achieved as my own experiences of PRW influenced my thoughts during the RTA.

Participants' existing relationship with researcher

During the interviews I was aware of the way that the participants' existing relationships with me influenced their responses, both consciously and unconsciously. For most of my colleagues I am a junior member of the team, by experience and age, who they do not work with directly. I was very grateful for participants' generous offer of time to take part, and at the same time I was aware of feeling the impact of an undercurrent of envy of my protected position as a trainee with the luxury of time to engage in academic tasks. There also seemed to be an unsaid assumption made by nearly all the participants that I would take a 'pro-PRW' stance; so that they were almost apologetic about saying things that were more negative.

Difficulty of considering researcher intersectionality

I have been fleetingly aware of the difficulty of turning my mind to the consideration of ways that my personal intersectionality might impact the study. This perhaps reflects the challenge of considering intersectionality in general, and specifically how the broad, theory/technique led topic of the work might not lend itself to think in depth about issues of diversity.

Nature of the research

Double and triple hermeneutics

I've been aware of the double hermeneutic in this research (Smith, 2003); the participants and I trying to make sense of PRW and then in turn, my effort through RTA to make sense of this. In this light the results are only one, partial way of understanding the topic's many facets, many of which will not have come to light in this study.

I have also considered a triple hermeneutic in recognition of the research dyad's unconscious response to the tasks (Alvesson and Skoldberg, 2009). It is understood that the dialog of the interviews are partial representations of the research dyad's thoughts and feelings, with limited access to the unconscious. The distressing nature of PRW in the pandemic makes this especially relevant, as it would seem to make it more likely that the participants and I would struggle to explore the topic to its fullest without the need for defence against psychic pain (Hollway and Jefferson, 2013). Using concepts taken from Holmes' (2019) Reverie Research Method and Hollway and Jefferson's (2013) Free Association Narrative Interviews, in the analysis of the data I have attempted to take into account what 'wasn't said' when omissions and hesitations seemed striking, or times when I might have been blind to something in the data.

Trends amplified by COVID

I have been interested to notice the ways that feelings arising from considering PRW in the pandemic have influenced the research process. For example, I wondered about a tendency for the narrative told by me or participants to pull towards polarised views; that PRW affords 'too much…' or 'too little…' across many facets of the work. There also appeared to be an idea in the participants' minds that there could be a right or wrong answer to questions. This perhaps

represented some part of them feeling that they ‘should know’ things as senior clinicians talking to a trainee, however I think that this also highlights a wish for certainty in response to the uncertainty of the pandemic. I wondered if this has also been a factor in my desire to organise the themes in very clear, unambiguous ways, whilst simultaneously worrying that I was closing down thinking about connections prematurely; I was aware that I might have ‘cleaned up’ the themes, moving away from something much messier in reality.

I noticed my own wish to distance the project from COVID as a central component of the work. Consciously this has been in the service of spot-lighting the nature of PRW itself. I’ve been less aware of my possible desire to move away from the pandemic as a topic because of the anxiety it provokes, as a “defended researcher” liable to unconsciously avoid anxiety in the same way as the defended subject (Hollway and Jefferson, 2013, p. 154).

Mirrors between the research process and topic

In almost all of the interviews we found ourselves reflecting on ways that the PRW experience was replicated in the research interviews, in particular navigating technical glitches and the asynchrony of responses. This gave an experiential window into being a remote dyad. Navigating the silences was a good example of this; participants reported feeling that silence was often too uncomfortable in PRW sessions; then in the interviews I noticed (particularly whilst watching the recordings) that I tended to speed onto the next question rather than wait in silence. At times I felt that a topic might have developed more had there been a more comfortable pause for thought.

Evaluating the research methodology

Application of the methodology

I set out to use a psychoanalytically informed approach by referencing existing theoretical concepts as a background framework, at all stages of the research; in interviews, coding and theme generation. This was important in recognition of the topic of the research and the vocabulary/concepts that the participants would naturally use. However, I am mindful that hanging the research findings onto existing constructs has the potential to distort or lead the findings rather than allow them to develop in a more inductive way (Terry and Hayfield, 2021).

Whilst coding, I was aware of feeling that by isolating very specific segments of data there was a danger of disembodying fragments of case material (Braun and Clarke, 2006) and losing the complexity and nuance that another approach, for example a case study, would provide. I was preoccupied by the difficulty of case backgrounds and presentations being separated from the content of a data segment, for example a patient's history of significant trauma being separated from the therapists account of PRW. However, as I got further into the analysis it became clear that the conclusions drawn transcend individual clinical presentations to explore overarching factors involved in PRW.

Applying a psychoanalytic lens to qualitative data analysis

The primary application of psychoanalytic principles in this research has been the use of theoretical concepts in understanding the data that participants brought to the interviews. For example, where a participant used the term 'containment' (Bion, 1962; 1967) I have used my own clinical understanding of the concept to allow me to think about the point being made by the participant.

In grappling with processing how participants where using clinical concepts, alongside the thoughts about my own clinical work that these evoked, I tried to take a stance of negative capability in the data analysis, as developed by Bion (1970). Bion uses the term, taken from writing by the poet Keats, as part of a wider description of an ideal state of mind for the analyst, in which they avoid coming to simplistic, premature conclusions. I was mindful of attempting to actively take full account of everything that participants said and follow my own thoughts as they came in response, even when new ideas were contradictory, confusing or created uncertainty. I tried to prevent avenues of thinking being closed off if they didn't match with my expected map of the terrain.

I found myself being aware that it was challenging when participants described a view that opposed either my own thoughts or went against the predominant voice of the participants. It was important to recognise this discomfort, rather than act on it by moderating any part of the data, so that all the views expressed were taken into account appropriately in the analysis as far as possible. It was important for me to use the containing function of the research seminar group to enable me to continue grabbling with the data (Rustin, 2008).

I also aimed to use a psychoanalytic approach in the way I conducted the interviews, particularly by being aware of my countertransference in response to what participants said (Holmes, 2019) and in listening out for the un-said content that was unconsciously defended against (Hollway and Jefferson, 2013). As a trainee psychoanalytic psychotherapist, this state of being with another is familiar, however in the new role of 'interviewer' my own anxiety about the task made it difficult to follow the moment by moment feelings in the room as the therapist might do with a patient (Pick, 1985). I think that this led to sometimes not asking a follow up question to get to the heart of what was being said. In this way, some of the material that flows through to generating themes was perhaps underdeveloped (Connelly and Peltzer, 2016).

It is also perhaps the case, that like PRW where unconscious communication and its interpretation has been described as "dampened" (Bayles, 2012, p. 569) by the nature of being remote, my experience of researcher countertransference and how I could use this data to enrich the research was perhaps also muted by conducting the interviews remotely.

I have also been aware that in the final iteration of the themes, it could be argued that the themes are closer to "domain summaries" (Terry and Hayfield, 2021, p. 50) where the theme presents a topic related to the research question, but is underdeveloped as a complex, multifaceted theme that should have a richer meaning. Braun and Clarke (2020; 2022) suggest that this is a common issue in RTA. On reflection, I wonder if this result is also in part due to the novel topic of the research being conducted in the context of the pandemic: it was perhaps difficult to move beyond topic summary type themes when the topic was so broad and emotive.

Areas not addressed in this study

I have been aware of the many areas of PRW that this study did not address. In this research, it has been difficult to isolate and comment on the impact that a therapist and patient's previous, in-person relationship might have on the quality of subsequent PRW. Although the therapists in the study referred to work with both existing and new patients, in the analysis it was difficult to give due weight to the difference between the two groups and factors that interacted. It seems very likely that having previously been in in-person treatment before the pandemic was both an enabling and inhibiting factor; providing the physical memory described by Lemma (2017) and an understanding of what the work of therapy itself is, whilst also being something that was missed and longed to return to in the very particular situation COVID created. Further research is needed to explore how meeting in-person before starting PRW might impact on the work.

Additionally, this research addressed the broad scope and limitations of PRW with all children and adolescents. Further research is needed to explore PRW with particular populations at greater depth, for example with specific presentations or neurodevelopmental differences.

This study has also not considered the possibilities of offering PRW from a setting outside of the home in a third space, for example where the child has remote sessions from their school. This option has the potential to mitigate some of the pragmatic issues of PRW from home, including for children living in deprived circumstances. However, the difficulties suggested with working at a deep, unconscious level would likely be as problematic, and other issues related to the shared space and privacy might arise.

Further research recommendations

The research and literature on PRW with children and adolescents is a growing field, arising from the need to work remotely in the pandemic. Research is now required to explore the nature of PRW offered outside the conditions created by COVID. This should include robust empirical research into its efficacy and a full exploration of indications and contraindications for offering PRW. This research particularly highlights a need to closely examine the impact of the therapeutic dyad not being together in the same physical space. This study has suggested that this has a profound impact on the capacity for containment and working through in the transference; a claim that needs to be replicated in further research.

Conclusion

This research aimed to explore the views of a team of child and adolescent psychoanalytic psychotherapists working remotely due to the COVID-19 pandemic in order to evaluate the potential scope and limitations of PRW. It is important to situate these findings in the context of an evolving view of PRW. This study was small in scale and aimed to reflect the work of one team of child and adolescent psychoanalytic psychotherapists at a particular moment in time. As such the conclusions drawn are tentative. Using RTA to explore this topic provided one specific lens that has highlighted questions that could be explored in future research. However, there is significant triangulation between the findings of this study, research findings from work with adults and the emerging literature on PRW with children. This seems to imply a consensus on some of the key issues raised, discussed below. The themes I generated from the participants' words have highlighted more limitation than opportunity in PRW with young patients and at times present a starkly negative assessment.

Implications for clinical practice

Possibilities of psychoanalytic remote work with children and adolescents

This research has highlighted the complexity of PRW with children and adolescents. Much like the distinction between once-weekly and intensive psychoanalytic psychotherapy, in comparing PRW with in-person sessions the two things have more similarity than difference. However, what sets them apart appears to create fundamental changes in the nature of the work. This needs to be taken into careful account when considering if PRW is suitable for the patient and for the goal of therapy. It seems that there is a need for case by case consideration of the offer of PRW, much like any assessment for the suitability of child psychotherapy where a whole range of factors are taken into account.

This study and emerging findings from the literature suggest that young children and patients with the greatest level of need require the physical presence of the therapist to allow for fully embodied communication and containment. With this in mind it may suggest a limited potential application of PRW for psychotherapy in child and adolescent mental health services. This is perhaps especially true taking into consideration that the majority of patients referred for psychotherapy in child and adolescent mental health services are likely to have experienced environmental deficits or trauma, or have neurodevelopmental differences. These factors might lead to impoverished internal capacities and the need for their therapy to address primitive issues in their internal world. In these circumstances PRW may not provide an adequate setting for effective work.

Findings from Wolpe (2020) and others describing PRW with adults (Gutiérrez, 2017) indicate that PRW requires the patient to use their own ego-strength to compensate for limits on the containment provided by the therapist. As a result, the therapy might not penetrate deeper, more infantile concerns.

These factors combined perhaps suggest that PRW lends itself to work at shallower depth with less disturbed patients, although far more research is needed to fully explore this. This corresponds to the Association of Child Psychotherapists' guidance which recommends PRW might be appropriate for "Brief treatment of some adolescents and others with less complex presentations" (2021, p. i). This is echoed in this study, where some productive work with adolescents was described.

The requirement that parents create the setting for PRW also limits the potential for wide spread application. This study has highlighted the need for parents to have sufficient internal and environmental capacities in order to establish a good enough setting for therapy. Considering the high prevalence of family dysfunction and socio-economic deprivation

affecting a large majority of children who are seen in child and adolescent mental health services (NHS Digital, 2018), it seems that PRW might not be appropriate for a large proportion of patients seen in child and adolescent mental health services.

Considering clinical risk

Considering working remotely with young people presenting with increased clinical risk has been outside the scope of this study. In all the cases the therapists discussed where the risk was significant in-person work was resumed. It seemed that the sense of having a partial view of the patient was heightened by the presence of risk, whilst it was simultaneously more vital to be able to fully observe the patient in order to have an accurate picture of their state of mind.

There is a broad consensus in the literature (for example, Savege Scharff, 2012) and amongst the therapists in this study that PRW is not advisable where there is increased risk of the patient deliberately harming themselves to cause significant injury or with suicidal intentions. This might also apply to patients where the level of disturbance is extremely high and interfering with normal functioning to a very significant degree.

Implications for technique

The therapists in this study described various ways that they adapted their technique in order to intuitively react to the ways PRW differs from in-person therapy. This sometimes took the form of practical steps like suggesting that an adolescent creates an artificial transition before/after the session. Other measures included increasing how much the therapist spoke in sessions, both asking more questions to compensate for the somewhat partial view and narrating the experience of meeting in a virtual way. Future research might seek to capture further insight into technique that best facilitates PRW. Beyond the pandemic, with the benefit

of practice and application of knowledge from new research, it might be the case that some of the strain of PRW can be mitigated.

Widening access to psychotherapy

During the pandemic PRW was "better than nothing" (Participant 3) for the majority of patients, even taking into account the many instances where therapy was diminished to 'checking-in.' Being able to keep some contact over such a turbulent time was vital for many. Looking beyond the pandemic, the possibilities of using PRW to widen access to psychotherapy changes the boundaries of when 'better than nothing' might apply. This is important in the context of a drive to improve access to specialist mental health treatment for children and adolescents (NHS Long term plan, 2019) and in recognition of the varied availability of child psychotherapy in child and adolescent mental health services across the UK.

The Association of Child Psychotherapists' survey of member's use of PRW (2020) suggested that it could bridge gaps to allow for continuity of work in specific circumstances, for example when a looked-after-child is relocated or when a young adult goes to university. In these cases, for some patients, the benefit of work being enabled to continue might outweigh any limitations inherent in PRW.

Looking beyond offering continuity when in-person work is interrupted, the 'better than nothing' argument might also apply in cases where in-person therapy is unavailable, for example when the distance to local child and adolescent mental health services prohibits attending regularly or where other factors limit travel, for example work with patients in secure settings.

It is also worth considering times when a young person, particularly an adolescent, has a preference for working remotely. Whilst it would be important to explore their conscious and unconscious motivations, offering PRW might foster good engagement.

In situations where PRW appears to be the most or only viable option, ideally it would only be offered where it appears the patient has the necessary internal and external prerequisites to make good use of it. However, in some cases applying flexibility to any suitability criteria might also be in the patient's best interest if PRW is the only option available. In this case assuming a minimum safety requirement is met and the barriers to access are not insurmountable, less than ideal PRW could be better than no treatment. Widdershoven's (2017) work with families on the Greek Islands demonstrates this well; although the treatment was difficult and ultimately deemed to be not as good as it would have been in-person, the families would not have been able to access the therapy at all without PRW. However, there are other circumstances where it seems likely that fundamental difficulties would arise in PRW which would render it not only ineffective but unethical to recommend as a treatment. For example, where the level of internal deficit is too great to allow for sustained, meaningful virtual contact.

Compounding inequality

It is important to consider that attempting to widen access to services using PRW would exclude families living in deprived circumstances including in digital poverty. Taking into account the need for robust access to technology and private space, those living in poverty are likely to be unable to benefit from improved access to psychotherapy through PRW for several reasons. This is suggested in the Association of Child Psychotherapists guidance for PRW, alongside emerging literature from the pandemic, including Shillito (2020) who highlights the impact of living in poverty on the ability to engage in PRW.

This issue is exacerbated further when the comorbidities of poor mental health and poverty are taken into account; families in deprived circumstances are more likely to experience difficulties with parental mental ill health or dysfunction and might therefore be excluded from benefiting from PRW on multiple levels.

Under-represented groups

There is a question of whether PRW might help or hinder underrepresented groups to get better access to child and adolescent mental health services. For example, children from minority ethnic backgrounds who are less likely to be seen at child and adolescent mental health services despite a high level of need for mental health support (Edbrooke-Childs et al., 2016). More thought is needed to consider whether the nature of PRW might encourage or discourage increased engagement with services in some communities. For example, it might be the case that if PRW can be used as a less intense, stepping stone to services (Lemma and Caparrotta, 2014) it might benefit young people in communities that are traditionally fearful of getting external help. Conversely, where difference from the majority is a source of pain, exposing your family's 'different' culture by showing the therapist inside your home in PRW might feel too threatening.

Other forms of remote work in child and adolescent mental health services

This research has primarily considered individual psychoanalytic child psychotherapy. It is important to recognise that the portfolio of child and adolescent psychoanalytic psychotherapists in child and adolescent mental health services is far wider than this. It is reasonable to assume that many of the facilitating and obstructing factors described in theme 3

could be applied to the wider work that psychotherapists and other clinicians undertake in child and adolescent mental health services.

It might be the case that remote work has a wider application in work less concerned with working in the transference and is therefore more likely to widen access to this kind of treatment. For example, in parent work offered remotely the greater flexibility might help with engagement, particularly in cases where a parent attending in-person is difficult due to work commitments or lack of childcare.

Final thoughts

Ehrlich (2019) suggested that in much of the comparison between in-person therapy and PRW there is a tendency for in-person work to become idealised when the deficits of PRW are highlighted. Whilst it is vital to consider the limitations of PRW, it is also important to keep in mind the possibility that all psychotherapy can be gruelling and fruitless. Shulman termed psychotherapy in the pandemic "the (almost) impossible profession" (2020, p. 296); however, in the original reference Freud (1937) suggests that any work with the unconscious taking place within the analytic dyad is limited.

In 1984, Miller wrote about the place of once-weekly psychotherapy in a profession which at the time prioritised intensive work; something that is now hard to imagine in modern day child and adolescent mental health services. It seems likely that in another forty years time, PRW will be as common-place as once weekly therapy is now. In order to ensure that this expansion is in the best interest of our patients and the profession, thoughtful consideration is needed to ensure that PRW is regarded as different from in-person psychotherapy, offered on its own merits in acknowledgment of its inherent limitations. As with all treatment, grappling

with the nature of PRW and its potential is ultimately required on a case by case basis, taking into account on-going research and evolving guidelines.

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Appendix

Table of Appendices

Appendix 1

The Tavistock and Portman NHS
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

SECTION A: PROJECT DETAILS

Project title	An exploration of the views of child and adolescent psychoanalytic psychotherapists conducting remote work during the COVID-19 outbreak; what is gained and what is lost in psychoanalytic remote work?		
Proposed project start date	December 2020	**Anticipated project end date**	September 2022

SECTION B: APPLICANT DETAILS

Name of Researcher	Liz Wheatley
Email address	[email address]
Contact telephone number	[contact number]

SECTION C: CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES** ☐ **NO** ☒ If **YES**, please detail below:

Is there any further possibility for conflict of interest? YES ☐ NO ☒ If **YES**, please detail below:

FOR ALL APPLICANTS

'Is your research being commissioned by and or carried out on behalf of a body external to the trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES ☐ NO ☒ NA ☐**
If **YES**, please supply details below:	
Has external* ethics approval been sought for this research? **(i.e. submission via Integrated Research Application System (IRAS) to the Health Research Authority (HRA) or other external research ethics committee)** *Please note that 'external' is defined as an organisation/body which is external to the Tavistock and Portman Trust Research Ethics Committee (TREC) If **YES**, please supply details of the ethical approval bodies below **AND** include any letters of approval from the ethical approval bodies:	**YES ☐ NO ☒**
If your research is being undertaken externally to the Trust, please provide details of the sponsor of your research?	
Do you have local approval (this includes R&D approval)?	**YES ☐ NO ☐ NA ☒**

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION

I confirm that:

- The information contained in this application is, to the best of my knowledge, correct and up to date.
- I have attempted to identify all risks related to the research.
- I acknowledge my obligations and commitment to upholding our University's Code of Practice for ethical research and observing the rights of the participants.
- I am aware that cases of proven misconduct, in line with our University's policies, may result in formal disciplinary proceedings and/or the cancellation of the proposed research.

Applicant (print name)	Liz Wheatley
Signed	[signed]
Date	15.11.2020

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor	Dr Jenifer Wakelyn
Qualification for which research is being undertaken	Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy (D.Ch.Psych.Psych.)

Supervisor –

- Does the student have the necessary skills to carry out the research?
  YES v☐ NO ☐
- Is the participant information sheet, consent form and any other documentation appropriate?
  YES v☐ NO ☐
- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?
  YESv ☐ NO ☐
- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?
  YESv ☐ NO ☐

Signed	Jenifer Wakelyn
Date	25/11/20

COURSE LEAD/RESEARCH LEAD • Does the proposed research as detailed herein have your support to proceed? **YES** ☒ **NO** ☐	
Signed	[signed]
Date	14.12.20

SECTION E: DETAILS OF THE PROPOSED RESEARCH

1. Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)
This research will ask participants to reflect on their experience of delivering psychoanalytic treatment remotely, via video or audio call, in response to the restrictions on meeting patients in person due to the COVID-19 outbreak. All participants will be child and adolescent psychoanalytic psychotherapists (CAPPTs) or CAPPTs in training, employed in [host] NHS trust. I am also a member of this psychotherapy team so all participants are already known to me as colleagues (I am employed by Tavistock and Portman NHS Foundation Trust, in a training post in [host] NHS Trust). Participants will be asked to take part in a semi-structured interview, lasting between 60-90 minutes. Interviews will take place over video call using MSTeams video software. Questions will ask participants to consider the work they have undertaken remotely by reflecting on what work has been possible and any limitations of remote work that they have encountered.
2. Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)
This work is a qualitative exploration of the views of clinicians, intended to add to the current research interest in understanding more about the application of remote working to child and adolescent psychoanalytic psychotherapy. The findings of this research will contribute to an understanding of the value and potential of remote working. Furthering this understanding will be vital to inform clinical decisions of what treatment can be offered remotely, to which patient groups, and conversely which treatments should be prioritised for face to face delivery. This is particularly significant at the current time when the on-going COVID-19 outbreak continues to limit the face to face appointment capacity in many CAMHS. It is perhaps even more significant when it also seems likely that in the future when the COVID-19 restrictions are no longer applicable, clinics may seek to continue to offer remote working as part of the standard clinical offer in CAMHS. There has been very little previous research into remote work with children or adolescents.
3. Provide an outline of the methodology for the proposed research, including proposed method of data collection, *tasks* **assigned to participants of the research and the proposed method and duration of data analysis. If the proposed research makes use of**

pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)

Participants will be asked to take part in an individual semi-structured interview with the researcher. This will be conducted remotely using MSTeams video call software. The interview will be between 60-90 minutes in length. Participants can take part from their CAMHS clinic or from another private space where they might have delivered remote treatment from whilst 'working from home.' Interviews will take place within the working day at an agreed mutually convenient time.

The interviews will be video recorded using the record function on MSTeams and audio transcribed following the interview. Original video recordings and interview transcripts will be stored securely for the duration of the research period, and then destroyed (No later than September 2022).

All participants will be de-identified in interview transcripts and all research outcome documents. No demographic information will be recorded.

As a stimulus for thinking, prior to the interview a prompt sheet will guide participants to think about specific patients who they have seen as part of their psychoanalytic psychotherapy caseload during the period of remote working in response to the COVID-19 outbreak. Participants will be asked to avoid using identifying details or names of patients to preserve patient confidentiality. Where necessary the interview transcript will be redacted to disguise any information that clinicians have unintentionally disclosed.

The researcher will read questions from the attached interview schedule, and ask related spontaneous follow up questions to encourage participants to further expand on their responses.

Following the transcription of interview data the researcher will conduct a Reflexive Thematic Analysis to analyse the data, as described by Braun and Clarke (2020)*. Each transcript will be read closely, several times and assigned codes which label elements of what participants have said. The codes are collated and grouped to generate a list of themes which will describe the views of clinicians reflecting on remote psychoanalytic work. The method provides an abstracted and amalgamated analysis of the participant's words so that the whole of the data set is considered in exploring the research question. In subsequent writing about the work direct quotes from participants will be used to illustrate conclusions drawn.

*Reference; Virginia Braun & Victoria Clarke (2020): One size fits all? What counts as quality practice in (reflexive) thematic analysis?, Qualitative Research in Psychology, DOI: 10.1080/14780887.2020.1769238

SECTION F: PARTICIPANT DETAILS

4. Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why this criteria is in place. (Do not exceed 500 words)

All members of the child psychotherapy team in [host] NHS trust will be invited to take part in this research, via email. This includes the nine qualified and trainee CAPPT clinicians in the trust who work across the three CAMHS teams in [host] NHS Trust. Clinicians will be asked to reply by email if they would like to take part in the research or if they wish to ask any questions about the research before agreeing to take part.

Before the interview, clinicians who have expressed an interest in taking part would be given the participant information sheet and asked to give their informed consent.

The only inclusion criteria is that participants must be or have been a CAPPT or CAPPT in training offering treatment to children or adolescents in [host] NHS trust at any point from April 2020 to present day.

Clinicians would be excluded from the research if reflecting on the COVID-19 outbreak was likely to cause significant emotional distress for personal reasons. The researcher will ask the team's Lead Child and Adolescent psychotherapist to circulate the research invitation to team members, excluding any clinicians who they understand in their supervisory capacity might be adversely affected by taking part.

5. Will the participants be from any of the following groups?*(Tick as appropriate)*

☒ Students or staff of the Trust or the University.

☒ Adults (over the age of 18 years with mental capacity to give consent to participate in the research).

☐ Children or legal minors (anyone under the age of 16 years)[1]

☐ Adults who are unconscious, severely ill or have a terminal illness.

☐ Adults who may lose mental capacity to consent during the course of the research.

☐ Adults in emergency situations.

☐ Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).

☐ Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).

☐ Prisoners, where ethical approval may be required from the **National Offender Management Service (NOMS).**

☐ Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).

☐ Healthy volunteers (in high risk intervention studies).

☐ Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).

☐ Other vulnerable groups (see Question 6).

☐ Adults who are in custody, custodial care, or for whom a court has assumed responsibility.

☐ Participants who are members of the Armed Forces.

[1]If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.

[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)

[3] Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.

6. Will the study involve participants who are vulnerable? YES ☐ NO ☒

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from the participant's personal characteristics (e.g. mental or physical impairment) or from their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness). Where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable.

Adults lacking mental capacity to consent to participate in research and children are automatically presumed to be vulnerable. Studies involving adults (over the age of 16) who lack mental capacity to consent in research must be submitted to a REC approved for that purpose. Please consult Health Research Authority (HRA) for guidance: https://www.hra.nhs.uk/

6.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?

If **YES**, the research activity proposed will require a DBS check. *(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance)*

7. Do you propose to make any form of payment or incentive available to participants of the research? YES ☐ NO ☒

If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.

8. What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)

All participants have sufficient communication skills to work in English speaking clinics

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

9. Does the proposed research involve any of the following? *(Tick as appropriate)*

☐ use of a questionnaire, self-completion survey or data-collection instrument (attach copy)

☒ use of emails or the internet as a means of data collection

☐ use of written or computerised tests

☒ interviews (attach interview questions)

☐ diaries (attach diary record form)

☐ participant observation

☐ participant observation (in a non-public place) without their knowledge / covert research

☒ audio-recording interviewees or events

☒ video-recording interviewees or events

☐ access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes

☐ administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process

☐ performance of any acts which might diminish the self-esteem of participants or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction

☐ investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)

☐ procedures that involve the deception of participants

☐ administration of any substance or agent

☐ use of non-treatment of placebo control conditions

☐ participation in a clinical trial

☐ research undertaken at an off-campus location (risk assessment attached)

☐ research overseas (copy of VCG overseas travel approval attached)

10. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life? YES ☒ NO ☐
If **YES**, please describe below including details of precautionary measures.

It is possible that reflecting on the challenging task of continuing working through the COVID-10 outbreak might be emotionally distressing to some participants.

To reduce the risk of any participant becoming significantly distressed any CAPPT in the psychotherapy team who has been significantly personally affected by COVID-19 (for example by bereavement or illness) will be excluded from recruitment to the research. The invitation to take part in the research will be distributed by the psychotherapy team Lead CAPPT who would be aware of any such circumstances in their supervisory capacity.

It is envisaged that members of the team who feel particularly unsettled by the idea of discussing remote work during the COVID-19 outbreak will not offer to take part.

In the unlikely event that participants become distressed during the interview the interviewer will attempt to manage conversation with sensitivity by acknowledging the strong feelings involved; encouraging participants to continue at their own pace and only talking about things that they are comfortable to discuss; moving the interview on to another question; offering a short break in the interview; or offering to end the interview.

After the interviews participants can request an additional time to debrief with the researcher at a later date and will be encouraged to talk about any thoughts they are left with in their regular clinical supervision. All participants will be given a letter of thanks, which includes information on how to self-refer to the [host] NHS Trust emotional support services for employees.

11. Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.

The researcher has considerable experience of as a CAPPT in training working in a mental health setting. Although it is unlikely that any participant would experience significant distress during the interview, should any participant appear to become distressed the researcher will take a sensitive

approach to the conversation and where necessary move on in the interview to another topic or pause for a short break in the interview.

Participants can request additional time to debrief with the researcher at a later date and will be encouraged to talk about any thoughts they are left with in their regular clinical supervision with a senior CAPPT. All participants will be given a letter of thanks, which includes information on how to self-refer to the [host] NHS Trust emotional support services for employees.

12. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)

NOTE: Where the proposed research involves students of our University, they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

Participants will have the opportunity to reflect on a time in their career which has brought significant changes and challenges. It is hoped that the additional time to consider work over the COVID-19 period with a thoughtful, engaged listener would be a positive experience for participants.

Participants might also be pleased to have the opportunity to share their knowledge and point of view in research aimed to add to the professional knowledge base for psychoanalytic child psychotherapy.

13. Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)

In the unlikely event that a participant becomes distressed the researcher will attempt to give a sensitive response; by moving the interview on to the next question; encouraging the participant to continue at their own pace and only talking about things that they are comfortable to discuss; suggesting a short break in the interview. The researcher will bring interviews to an end if requested to by the participant or if it seems that continuing with the interview would cause undue distress.

After the interviews participants can request an additional time to debrief with the researcher at a later date and encouraged to talk about any thoughts they are left with in their regular clinical supervision. All participants will be given a letter of thanks, which includes information on how to self-refer to the [host] NHS Trust emotional support services for employees.

Participants will be able to withdraw sections of the interview or the whole transcript, by email request, up to two weeks after the interview date.

14. Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)

At the end of the interview participants will be thanked for their participation in this research. All participants will receive a thank you letter. This will remind them to direct any questions they might have after the interview to the researcher and of their right to withdraw any material they wish to have removed from the transcript, up to two weeks after the interview.

After the interviews participants can request an additional time to debrief with the researcher at a later date and encouraged to talk about any thoughts they are left with in their regular clinical supervision. All participants will be given a letter of thanks, which includes information on how to self-refer to the [host] NHS Trust emotional support services for employees.

Participants will also be provided with the correspondence details for the research supervisor and academic quality contact should they have any concerns about the conduct of the interview.

FOR RESEARCH UNDERTAKEN AWAY FROM THE TRUST OR OUTSIDE THE UK

15. Does any part of your research take place in premises outside the Trust?

☐ **YES,** and I have included evidence of permissions from the managers or others legally responsible for the premises. This permission also clearly states the extent to which the participating institution will indemnify the researchers against the consequences of any untoward event

16. Does the proposed research involve travel outside of the UK?

☐ **YES,** I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

☐ **YES,** I am a non-UK national and I have sought travel advice/guidance from the Foreign Office (or equivalent body) of my country of origin

☐ **YES,** I have completed the overseas travel approval process and enclosed a copy of the document with this application

For details on university study abroad policies, please contact academicquality@tavi-port.nhs.uk

IF YES:

17. Is the research covered by the Trust's insurance and indemnity provision?

☐ **YES** ☐ **NO**

18. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place.

NOTE:

For students conducting research where the Trust is the sponsor, the Dean of the Department of Education and Training (DET) has overall responsibility for risk assessment regarding their health and safety. If you are proposing to undertake research outside the UK, please ensure that permission from the Dean has been granted before the research commences (please attach written confirmation)

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

18. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. YES ☒ NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

19. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.
YES ☒ NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

20. The following is a participant information sheet checklist covering the various points that should be included in this document.

☒ Clear identification of the Trust as the sponsor for the research, the project title, the Researcher or Principal Investigator and other researchers along with relevant contact details.

☒ Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.

☒ A statement confirming that the research has received formal approval from TREC.

☒ If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.

☐ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.

☒ Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.

☒ Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.

☒ A statement that the data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.

☒ Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

21. The following is a consent form checklist covering the various points that should be included in this document.

☒ Trust letterhead or logo.

☒ Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.

☒ Confirmation that the project is research.

☒ Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.

☒ Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.

☒ If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.

☒ The proposed method of publication or dissemination of the research findings.

☐ Details of any external contractors or partner institutions involved in the research.

☐ Details of any funding bodies or research councils supporting the research.

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

SECTION H: CONFIDENTIALITY AND ANONYMITY

22. Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.

☐ Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?

☐ The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).

☒ The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).

☐ Participants have the option of being identified in a publication that will arise from the research.

☒ Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)

☐ The proposed research will make use of personal sensitive data.

☐ Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

23. Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.

YES ☒ **NO** ☐

If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

24. Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES ☒ NO ☐
If **NO**, please indicate what alternative arrangements are in place below:

25. In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.

☐ 1-2 years ☒ 3-5 years ☐ 6-10 years ☐ 10> years

NOTE: Research Councils UK (RCUK) guidance currently states that data should normally be preserved and accessible for 10 years, but for projects of clinical or major social, environmental or heritage importance, for 20 years or longer.
(http://www.rcuk.ac.uk/documents/reviews/grc/grcpoldraft.pdf)

26. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.

☒ Research data, codes and all identifying information to be kept in separate locked filing cabinets.

☒ Access to computer files to be available to research team by password only.

☐ Access to computer files to be available to individuals outside the research team by password only (See **23.1**).

☐ Research data will be encrypted and transferred electronically within the European Economic Area (EEA).

☐ Research data will be encrypted and transferred electronically outside of the European Economic Area (EEA). (See **28**).

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

☐ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.

☐ Use of personal data in the form of audio or video recordings.

☒ Primary data gathered on encrypted mobile devices (i.e. laptops). **NOTE:** This should be transferred to secure UEL servers at the first opportunity.

☒ All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.

☒ All hardcopy data will undergo secure disposal.

NOTE: For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.

27. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.

N/A

28. Please provide details on the regions and territories where research data will be electronically transferred that are external to the European Economic Area (EEA).

N/A

29. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs? YES ☐ NO ☒

If **YES** please provide details:

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

30. How will the results of the research be reported and disseminated? *(Select all that apply)*

☒ Peer reviewed journal

☒ Non-peer reviewed journal

☒ Peer reviewed books

☒ Publication in media, social media or website (including Podcasts and online videos)

☒ Conference presentation

☒ Internal report

☐ Promotional report and materials

☒ Reports compiled for or on behalf of external organisations☒ Dissertation/Thesis

☒ Other publication

☐ Written feedback to research participants

☒ Presentation to participants or relevant community groups

☐ Other (Please specify below)

SECTION K: OTHER ETHICAL ISSUES

31. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?

No

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

32. Please check that the following documents are attached to your application.

☐ Letters of approval from any external ethical approval bodies (where relevant)

☒ Recruitment advertisement

☒ Participant information sheets (including easy-read where relevant)

☒ Consent forms (including easy-read where relevant)

☐ Assent form for children (where relevant)

☒ Evidence of any external approvals needed-

☐ Questionnaire ☒ Interview Schedule or topic guide ☐ Risk Assessment (where applicable) ☐ Overseas travel approval (where applicable)
34. Where it is not possible to attach the above materials, please provide an explanation below.

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement

Directorate of Education & Training

Tavistock Centre

120 Belsize Lane

London

NW3 5BA

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

Elisabeth Wheatley

By Email

19 January 2021

Dear Liz,

Re: Trust Research Ethics Application

Title: An exploration of the views of child and adolescent psychoanalytic psychotherapists conducting remote work during the COVID-19 outbreak; what is gained and what is lost in psychoanalytic remote work?

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Paru Jeram

Secretary to the Trust Research Degrees Subcommittee

T: 020 938 2699

E: academicquality@tavi-Port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix 2

The Tavistock and Portman
NHS Foundation Trust

Dear psychotherapy team,

I am writing to you to ask you to participate in my doctoral research project.

As you know I am currently in my third year of study for a Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy, at Tavistock and Portman NHS Foundation Trust. The doctoral research project is part of this qualification.

My research project is called

An exploration of the views of child and adolescent psychoanalytic psychotherapists conducting remote work during the COVID-19 outbreak; what is gained and what is lost in psychoanalytic remote work?

I am looking for qualified and trainee child and adolescent psychoanalytic psychotherapists from our team to take part in an interview which will explore your experience of remote work. The interviews will be with me, on MSTeams at a time to suit you and will last about 90 minutes.

During the interview I will ask you questions about your experience of delivering or supervising applied psychoanalytic remote work using any platform (audio or video call) with all patient groups (child, adolescent, parent and family group service users).

If you are interested in taking part I will provide you with an information sheet with further details about the project and how I will use your data.

I hope that taking part will be an interesting opportunity to reflect on the work we've all been undertaking in recent months.

If you would like to know more about taking part in my research please do email me; [email address]

Many thanks,

Liz Wheatley

Child and Adolescent Psychotherapist in Doctoral Training

Appendix 3

The Tavistock and Portman
NHS Foundation Trust

Information Sheet for Participants

An exploration of the views of child and adolescent psychoanalytic psychotherapists conducting remote work during the COVID-19 outbreak; what is gained and what is lost in psychoanalytic remote work?

Thank you for considering taking part in my research project. This information sheet is intended to inform you of the key facts about this project to enable you to decide if you are willing to take part.

What is the project about?

This research will be a qualitative exploration of psychoanalytic remote working in response to the COVID-19 outbreak. During this time the vast majority of contact with services users changed from face to face appointments to remote work. I am going to ask the child and adolescent psychotherapists in our NHS trust about their experiences of applied psychoanalytic work during this time. The findings of this research project and others like it will contribute to our profession's understanding of the scope of psychoanalytic remote work and inform future practice.

Who is doing the research?

I am conducting this research as part of a Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy.

The research is being supervised by Dr Jenifer Wakelyn [email address]

Ethical approval has been given by the Tavistock and Portman Trust Research Ethics Committee (TREC). If have any concerns about any aspect of this research project you can contact Simon Carrington, Head of Academic Governance and Quality Assurance academicquality@tavi-port.nhs.uk

What will taking part involve?

If you agree to take part I will ask you to do an interview conducted over MSTeams. It will last approximately 90 minutes and can be arranged at a time in the working day to suit you. I will use the record function on MSTeams to audio and video record the interview.

During the interview I will ask you questions about your experience of delivering or supervising applied psychoanalytic remote work using any platform (audio or video call) with all patient groups (child, adolescent, parent and family group service users).

I will ask you to sign a consent form to confirm your agreement to take part. Before the interview I will send you a brief prompt sheet to stimulate your thoughts before the interview.

What happens to the data from the interviews?

After the interviews I will make a written transcript of what was said. Using the research method Reflexive Thematic Analysis (2020) I will use all of the transcripts to establish themes which illustrate

combined the experiences of remote working in our team. I hope to be able to make some tentative conclusions about what has been possible and how psychoanalytic technique translates in remote working.

The research will comply with the university's Data Protection Policy. Confidentiality of data is subject to legal limitations, including being subject to subpoena.

To protect your confidentiality all of the transcripts and subsequent writing about the project will not include any names or information that could identify you. My dissertation and any subsequent publications might include information that could identify the NHS trust and will include direct quotes from the interviews. I will ensure that these cannot be traced to any individual clinician, however if you were to read any subsequent publications you might recognise your own words.

No information will be discussed or shared with any other member [host] NHS Trust, unless I am concerned about somebody's safety.

If you decide that you would like some or all of your interview data removed from the study you can withdraw at any time until an agreed date, outlined in the consent form.

For the duration of the project I will ensure that the data and all related material is stored securely. Once the study is complete the original interview recordings will be permanently deleted.

If you would like to know more about the research please do email me at [email address]

Thank you for your interest in my Research.

Liz Wheatley
Child and Adolescent Psychotherapist in Doctoral Training

References

Virginia Braun & Victoria Clarke (2020): One size fits all? What counts as quality practice in (reflexive) thematic analysis?, Qualitative Research in Psychology, DOI:10.1080/14780887.2020.1769238

Appendix 4

The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

An exploration of the views of child and adolescent psychoanalytic psychotherapists conducting remote work during the COVID-19 outbreak; what is gained and what is lost in psychoanalytic remote work?

Thank you for agreeing to take part in my research project which is part of a Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy.

By signing this consent form you are agreeing to take part in a video recorded interview with me exploring your thoughts on psychoanalytic remote work in your role in [host] NHS Child and Adolescent Mental Health Service (CAMHS). The findings from this research will be written up in a dissertation and may be published.

The decision to take part is entirely your own personal choice. You can withdraw your consent at any time before or during the interview without needing to give a reason. After the interview if you wish to withdraw some or all of your data you can do so up to two weeks after the date of the interview (after this time I may have already started to use the data).

As the researcher I will ensure:

- The research complies with the university's Data Protection Policy. Confidentiality of data is subject to legal limitations, including being subject to subpoena.
- All of the transcripts and subsequent writing about the project will not include any identifying information or names to protect your confidentiality.
- My dissertation and any subsequent publications might include information that could identify the NHS trust and might include direct quotes from the interviews. I will ensure that these cannot be traced to any individual clinician, however if you were to read any subsequent publications you might recognise your own words.
- For the duration of the project the data and all related material is stored securely.
- Once the study is complete the original interview recordings will be permanently deleted.
- No information will be discussed or shared with any other member [host] Trust, unless I am concerned about somebody's safety.

The research is being supervised by Dr Jenifer Wakelyn [email address]

Ethical approval has been given by the Tavistock and Portman Trust Research Ethics Committee (TREC). If have any concerns about any aspect of this research project you can contact Simon Carrington, Head of Academic Governance and Quality Assurance academicquality@tavi-port.nhs.uk

The researcher is Liz Wheatley [email address]
Child and Adolescent Psychotherapist in Doctoral Training

Consent

I have read and understood this consent form and accompanying participant information sheet. I confirm that I agree to participate in the research and understand that I am free to withdraw at any time without needing to provide a reason why.

Print Name:

Signature:

Date:

Appendix 5

The Tavistock and Portman
NHS Foundation Trust

Preparing your thoughts before the interview

An exploration of the views of child and adolescent psychoanalytic psychotherapists conducting remote work during the COVID-19 outbreak; what is gained and what is lost in psychoanalytic remote work?

Thank you for agreeing to take part in my research.

During the interview I will ask you about your experience of delivering or supervising applied psychoanalytic remote work. This could be work using any platform (audio or video call) with all patient groups (child, adolescent, parent and family group service users).

Before the interview you might find it helpful to think about your psychoanalytic caseload and any work you have supervised. I am interested in any work where use of transference and countertransference would ordinarily be a significant part of the work (this might therefore exclude generic assessments or case holding).

I would like to hear about applied psychoanalytic remote working that you felt went well, and work that has been more difficult or ultimately broke down.

I will ask you to talk about remote work with a particular patient. Before the interview it might be helpful to consider which of your patients comes most to mind when you think about remote work, and to think back through your experience of working with them remotely; in particular stand out moments or vivid impressions from this work. I will ask questions about how you understand this patient's transference in sessions and your experience of countertransference in remote work. I will also ask about any patients who you have only seen remotely to think about how you have developed an impression of them.

It is important to acknowledge that remote work became necessary because of the impact of the COVID-19 pandemic. This context is perhaps inseparable from our thoughts about remote working. However this research is primarily concerned with the scope and limitations of psychoanalytic remote working as a treatment option.

Please try not to use the real names of any service users and their families. However if you do accidentally mention a name or something that might identify a particular person, I will disguise this in the interview transcript.

If you have any questions please do email me at [email address]

Liz Wheatley

Child and Adolescent Psychotherapist in Doctoral Training

Appendix 6

Proposed Interview Schedule

-Thanks and recap of consent information

-Reminder to try to avoid patient's names or identifying details

-Recap guidance to orientate participants from prompt sheet;

Please consider all the applied psychoanalytic work you have done yourself or supervised during this period, this could include individual therapy with any age child or adolescent, parent or family work, assessments or group work, using any type of remote work medium.

At points I would like you to think particularly about one particular patient who you have worked with remotely and to try to give as many examples as possible from that patient. As you speak other examples, from different patients which give a contrasting or similar experience might also come to mind; I would like to hear about these too.

Have you got a patient in mind?

Four preliminary questions;

Can you give me a rough estimate of how many patients you've worked with remotely over this period?

Can you give a rough impression of the make- up and range of your case load (in terms of age and presentation)

Prior to COVID-19, did you have any experience of psychoanalytic remote working?

(Researcher prompts; media used before? with adults or children? teaching or supervision?)

How many years have you worked at as a CAPPT?

The interview is divided into 3 sections;

1. *Thinking about existing patients who moved online*
2. *Thinking about patients you have only seen remotely*
3. *Some final questions about all remote work*

So I can keep a track of the time we spend discussing each question, it would be helpful at this point to check if you have started any work with new patients who you hadn't previously met face to face?

First section- please only consider patients who you had previously worked with face to face and then moved to remote working;

Thinking about working with one of your patients, can you describe **how remote sessions were different** seeing them in person?

Have there been any aspects of sessions or the patients way of relating that have remained **consistent** in both remote work and in-person sessions?

Thinking about your patient, can you tell me about any moments from remote working that stand out as times when you've felt **vivid feelings in the countertransference**?

… How do you think this was impact by being remote from the patient in that moment?

… Did being remote from the patient at that moment effect how you responded? What might have been different if you were in the room with the patient?

Have you had any other experiences of countertransference, **with other patients** that have stayed in your mind? Prompt to consider different age groups/presentations

Thinking about your patient, can you think of any moments or period of time when you felt you have further **understood something about the patient's transference**?

… How do you think this moment was impact by being remote from the patient in that moment?

… Did being remote from the patient at that moment effect how you responded? What might have been different if you were in the room with the patient?

Have you had any other experiences of insight into transference, **with other patients** that have stayed in your mind? Prompt to consider different age groups/presentations

Second section- in this section please only consider patients who you have only worked with remotely;

Have you started any work with **patients who you have not met face to face?** [Or only met in an introductory meeting before starting remote work]

Thinking about this new patient, can you tell me about how getting to know them remotely differed from starting work in person?

Are there any **areas of difference in remote work with patients you've only met on line** versus patients you've previously seen in person?

Thinking about your new patient, can you tell me about any moments from remote working that stand out as times when you've felt **vivid feelings in the countertransference**?

… How do you think this was impact by being remote from the patient in that moment?

… Did being remote from the patient at that moment effect how you responded? What might have been different if you were in the room with the patient?

Have you had any other experiences of countertransference, **with other new patients** that have stayed in your mind? Prompt to consider different age groups/presentations

Thinking about your patient, can you think of any moments or period of time when you felt you have further **understood something about the patient's transference**?

… How do you think this moment was impact by being remote from the patient in that moment?

… Did being remote from the patient at that moment effect how you responded? What might have been different if you were in the room with the patient?

Have you had any other experiences of insight into transference, **with other new patients** that have stayed in your mind? Prompt to consider different age groups/presentations

Third section- please consider all of the patients you've worked with remotely;

Based on your work in this period, did you work with **any patients who seemed to particularly make use of remote** psychotherapy?

… What were the factors that made it possible for them to work well remotely?

Researcher prompts:

- Age/developmental stage
- Presentation (chronicity; functioning; level of risk)
- Child's engagement
- Parental engagement
- Technology availability, physical space, access to materials (toys)

… Have you had similar experiences with other patients who were able to make use of remote work?

Based on your work in this period, did you work with **any patients who could not make use of remote** psychotherapy?

… What were the factors that seemed to lead to this?

… Have you had similar experiences with other patients who were not able to make use of remote work?

*Supplementary question; Thinking about any patient, can you tell me about any other ways in which you have **adapted your technique** for remote working?*

Has this been similar or different in your work with other patients?

Given the **choice would you continue** to see patients remotely in the future?

… What would determine the decision to see a patient remotely? (Inclusion/exclusion criteria for remote work)

-That's the end of the questions I have today, before we finish is there anything else you'd like to say about remote working that we haven't already discussed?

-Thanks and debrief information

Appendix 7

The Tavistock and Portman
NHS Foundation Trust

Dear [name],

Thank you for taking part in my doctoral research project. I am very grateful for your time and thoughts.

I do hope that reflecting on the remote work that you've been involved in during recent months has been an interesting experience.

I appreciate that talking about our work, particularly in the context of the COVID-19 outbreak, can be distressing. After the interview, if you would like to talk about any thoughts that you have been left with we can arrange a time to have a debrief. I would also encourage you to discuss any thoughts arising from interview in your clinical supervision. If you feel upset or in need of further emotional support you can get support from [host] NHS Trust services, including [name of trust's wellbeing service];

[information and contact details for NHS trust's wellbeing service]

You can withdraw a part or all of your interview data at any time up to two weeks after the interview. Please contact me if you would like to discuss this.

The research is being supervised by Dr Jenifer Wakelyn [email address]

Ethical approval has been given by the Tavistock and Portman Trust Research Ethics Committee (TREC). If have any concerns about any aspect of this research project you can contact Simon Carrington, Head of Academic Governance and Quality Assurance academicquality@tavi-port.nhs.uk

Please do get in touch if you'd like to discuss my research or your interview again,

Many thanks,

Liz Wheatley
Child and Adolescent Psychotherapist in Doctoral Training
[email address]

Appendix 8

	Participant 2 **Data section**	**Code**
2.01	it's been different in many ways because I get to see the patient's home environment [laughs lightly] I don't see that… in, in the clinic. Ummm, it gave me a better idea about the interaction between the ummm carer, ummm, this person has got a step mother so their relationship and also her relationship with dad because they usually set it up, I say hello and goodbye with [them]. And in the clinic that's very limited really and as were doing the session in the bedroom… it really gave me an idea, what it is like, the life like at home for her.	Unprecedented insight into external world of child
2.02	it gave me a better idea about the interaction between the ummm carer, ummm, this person has got a step mother so their relationship and also her relationship with dad because they usually set it up, I say hello and goodbye with [them]. And in the clinic that's very limited really	Requirement for cooperation with and facilitation by parents/carer
2.03	it gave me a better idea about the interaction between the ummm carer, ummm, this person has got a step mother so their relationship and also her relationship with dad because they usually set it up, I say hello and goodbye with [them]. And in the clinic that's very limited really	Therapist has more direct dealings with parent/carer than they might otherwise-impact on relationship with patient?
2.04	I think it made her feel relaxed about the situation because it's her own environment, I think that's one of the reasons that it worked well; it was kind of the safe place for her, I think, being at home and doing the sessions from home and the sessions have been supported *so well* by the step mother.	Being in own home environment provides sense of safety for the work
2.05	I think, being at home and doing the sessions from home and the sessions have been supported *so well* by the step mother. And We kind of discussed what to get for her in the box and she did it, she gave, ummm, the patient a choice, 3 choices what she can add it in, we discussed and they were really kind of helpful things and the box has been, ummm, safely, it doesn't, it didn't happen with my other cases you know they got damaged and so on.	RT possible/works well with right support from parent/carer
2.06	So it really, I think really showed the child that adults were thinking for her, I was talking to mother, mother was thinking of her, things were kept safe for her.	Increased contact with parent/carer provides opportunity for child to experience a benign/good parental couple with therapist
2.07	Ummm, so that's been different. Ummm, and I do ask myself what was it that in the clinic that I haven't seen it yet and was safer to do it [in] online sessions.	Patient presents very differently in RT
2.08	I think also it's important to mention the timing, I mean I only saw her 3 times in the clinic, we meant to meet 4 times for an assessment, then everything moved to online. We had a gap, almost 2 months, because everything was on hold, so I think that time, really, was crucial	Impact of pandemic; uncertainty about everything

2.09	We had a gap, almost 2 months, because everything was on hold, so I think that time, really, was crucial and I did send a letter saying I'm thinking of you, we're going to resume the work and so on, but possibly it kind of maybe triggered something in the situation, maybe she felt like she was already losing her spot, before having it, if it makes sense…	Impact of pandemic; gap in treatment intensified experience
2.10	it was very early days, meeting someone 3 times and initial meeting, and then moving to remote work, and it's *tough* I think, but for her I think she really wanted to do the work, it's someone that really wants to understand what is going on, even though it's really hard and painful at the same time. So I'm thinking all that kind of play a part.	Patients desire for therapy meant contributed to success of RT
2.11	it was very early days, meeting someone 3 times and initial meeting, and then moving to remote work, and it's *tough* I think, but for her I think she really wanted to do the work,	"it's tough"
2.12	So it's not easy having [history of extreme neglect] background and going to somewhere and just opening up and just telling all that… so I think the safety was key for her, in general, not just for the therapy purposes, because that's what she lacked a long time in her life, on kind of early part of her life, yeah… I think this case [RT] made it safer…	RT space/being at home gave a greater feeling of safety than in the room
2.13	I think this case [RT] made it safer because during the assessment period she has space in the room, so it was bouncing the balls, bashing it and you know towards me and I got it all from her, basically, like kind of you know she was that function of muscular skin thing, you know I'm gonna do these skills and she's into football and all that and I was kind of receiving end the whole of it. And in the bedroom… no way that she can have a space, to bounce the ball and all of it, so all she could do actually, just do something maybe in a smaller scale, kind of sitting down and all that, which led to other possibilities,	Physical boundary of the setting changed [according to child's home circumstances]
2.14	I think this case [RT] made it safer because during the assessment period she has space in the room, so it was bouncing the balls, bashing it and you know towards me and I got it all from her, basically, like kind of you know she was that function of muscular skin thing, you know I'm gonna do these skills and she's into football and all that and I was kind of receiving end the whole of it. And in the bedroom… no way that she can have a space, to bounce the ball and all of it, so all she could do actually, just do something maybe in a smaller scale, kind of sitting down and all that, which led to other possibilities,	Anger can't be brought in RT? [Therefore sessions feel safer, can't access all areas needed?]
2.15	And in the bedroom… no way that she can have a space, to bounce the ball and all of it, so all she could do actually, just do something maybe in a smaller scale, kind of sitting down and all that, which led to other possibilities, so I think at some point she was talking about a school project during home learning, which maybe she wouldn't necessarily remember and tell me, end of the day, if she was coming to the clinic. They had to write a self, ummm, biography about themselves, self-portrait or something. And that was an opening door for us and she brought so much material about her past…	RT setting encouraged conversation linked to home life/activities [material for therapy]

2.16	and in one of the sessions I observe her actually, turning into a foetus shape, on her bed, and didn't wanna talk and there is, I dunno, I'm thinking if she was in the clinic, would she have that kind of comfort, your own bed, and you kind of, you can't really, you don't have a bed there, you don't have that cosiness, it's still a clinic room isn't it… And it really come out and I think for the first time I saw lots of sadness, the anger was gone and a lot of sadness came out.	Safety/Comfort of home environment means child can communicate differently to in clinic setting
2.17	And it really come out and I think for the first time I saw lots of sadness, the anger was gone and a lot of sadness came out… I felt *absolutely rubbish* and I felt that *I made her* so sad [touches chest], basically, yeah, and have I done her any good? By making her absolutely, I don't know, despair and all hopelessness and all of it and I had weeks and weeks seeing her crying on the screen,	Strong feelings communicated
2.18	And it really come out and I think for the first time I saw lots of sadness, the anger was gone and a lot of sadness came out… I felt *absolutely rubbish* and I felt that *I made her* so sad [touches chest], basically, yeah, and have I done her any good? By making her absolutely, I don't know, despair and all hopelessness and all of it and I had weeks and weeks seeing her crying on the screen, which is very different than the girl trying to hit me with the ball basically…	Strong feelings in countertransference
2.19	And it really come out and I think for the first time I saw lots of sadness, the anger was gone and a lot of sadness came out… I felt *absolutely rubbish* and I felt that *I made her* so sad [touches chest], basically, yeah, and have I done her any good? By making her absolutely, I don't know, despair and all hopelessness and all of it and I had weeks and weeks seeing her crying on the screen, which is very different than the girl trying to hit me with the ball basically… [LW nodding], week by week [laughs]. Ummm, so I think it made it harder for me, in that sense, the remote working…	Harder to understand what's being communicated remotely
2.20	I don't know, despair and all hopelessness and all of it and I had weeks and weeks seeing her crying on the screen,	Harder to get hold of things- harder to settle and move on?
2.21	so I think it made it harder for me, in that sense, the remote working, because when you finish a session you see the child picking themselves up, in the clinic, kind of maybe changing the body a bit, kind of going to the corridor, and when you say bye maybe that already kind of like put themselves together, but the remote sessions [shaking head] she often had her hood down and crying, kind of really kind of getting smaller in the screen and I can't really see, we talk with mum at the end, just say yesterday so and so felt a bit sad, but I didn't see it further, I think that was hard for me, I didn't see if she perked up 5 minutes or a few minutes after when the session finished.	Difficulty of loss of transition from therapy back to life (for child and therapist)
2.22	but the remote sessions [shaking head] she often had her hood down and crying, kind of really kind of getting smaller in the screen and I can't really see…	Loss of sensory information needed for communication

Appendix 9

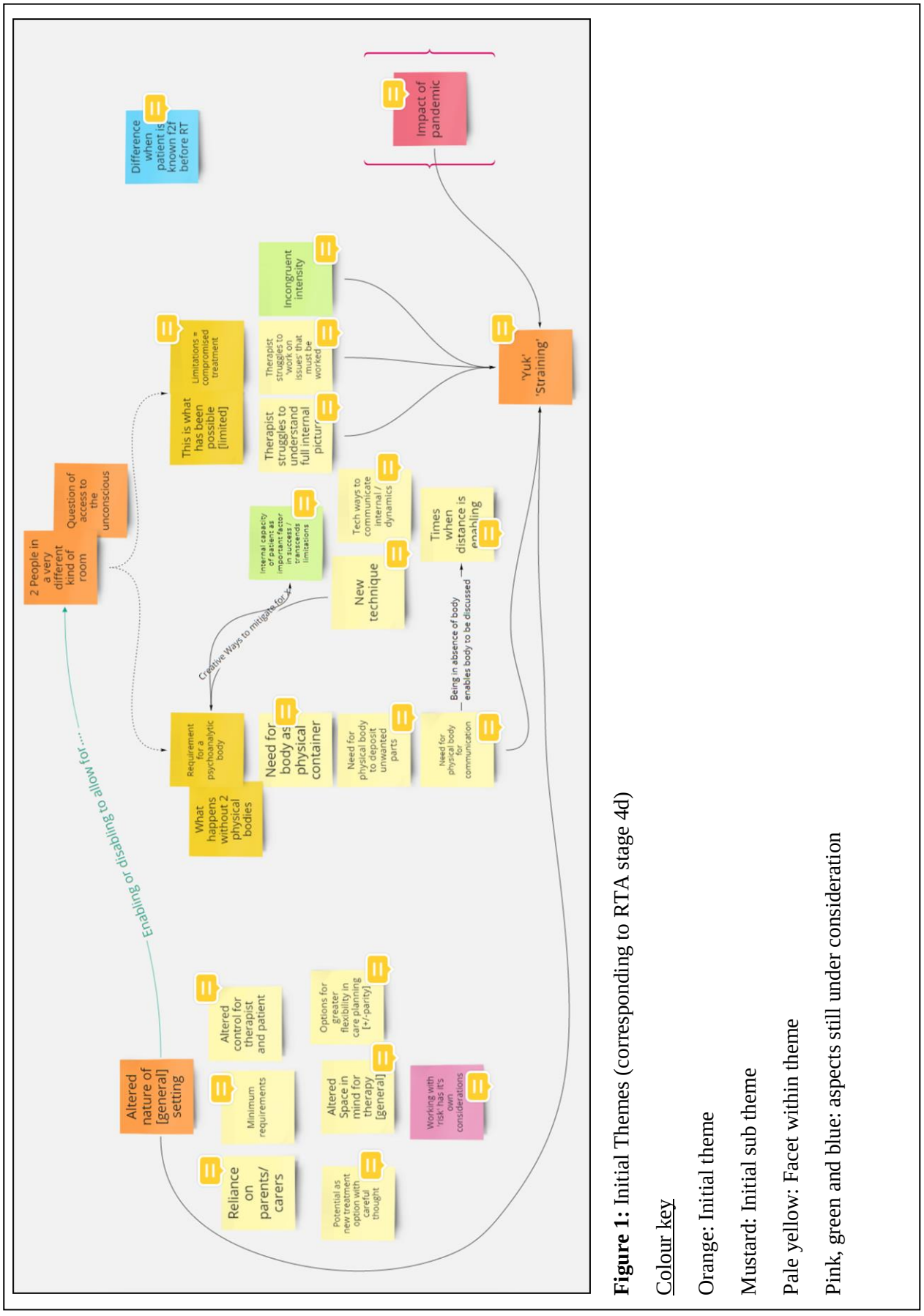

Figure 1: Initial Themes (corresponding to RTA stage 4d)

Colour key

Orange: Initial theme

Mustard: Initial sub theme

Pale yellow: Facet within theme

Pink, green and blue: aspects still under consideration