Sharing experiences and positive outcomes from working as a psychoanalytic psychotherapist during COVID-19

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Introduction

In this paper, I illustrate some of the benefits I observed as a psychoanalytic psychotherapist working with my patients under the restrictions imposed by COVID-19. That is not to say that the rapid transition to remote working was simple. Through various clinical examples, I illustrate how there was much anxiety evoked in both myself and my patients as we made these changes. As in any close analytic relationship, the changes were thought and worked through together. Ultimately, however, these clinical examples demonstrate how being present in a different way can add a depth and a quality to our work. These clinical examples also highlight that the physical presence of the therapist/observer is not necessarily paramount for therapeutic progress to occur. Indeed, throughout this paper I challenge the idea that it is absolutely essential for the therapist and patient to be physically present in the same room for transferences and counter-transferences to be felt (Oelsner, 2013). I also address the necessity of creating time and thoughtfulness to work on the transition to working remotely. The patient's internal world can be rocked by this transition, and there arises the question as to whether or not their "good internal object" can be sufficiently sturdy to withstand such disruption.

My Personal Context During COVID-19

Prior to the pandemic, I had little experience of working remotely. The bulk of my clinical workload involved seeing adults, parents, adolescents, and children, but almost exclusively in face-to face settings. I believed this was the most appropriate way to conduct therapy. My experience of working online was limited to running supervision for groups and individual therapists. The infant observation seminars that I hosted and ran for The Institute of Child and Adolescent Psychoanalytic Psychotherapy (ICAPP) were also run online, but all the observations undertaken by the students of the mother/baby couple were done in person.

From a technological perspective, I was anxious at the thought of moving fully online, as I felt my skills were very limited. The thought of systems "crashing" midsession or "bad connections" worried me greatly. Then there were the therapeutic concerns. When a patient's narrative comes too close to our own, a referral to another practitioner should be considered. Yet here we were, both therapists and patients, facing similar issues of fear,

dread, and anxiety over COVID-19. The referral to another therapist who might have a better capacity to think with *a third eye* (Ogden, 1994), was not possible, which brought about further questions for me in continuing ongoing therapies:

- Should I pause long-term therapy until we had a clearer picture of the constraints COVID-19 would place on us?
- Should I risk my patients' and my own physical health by continuing to have clinical appointments face-to-face? (Since my practice is in Sydney, this would have been possible.)
- What would happen to the quality of my work as psychotherapist if sessions where conducted online? Historically, online therapy had been scoffed at, with stories of not being able to feel the transferences, projections, and therefore not being a proper therapy at all.
- How would I maintain the all-important *frame* and provide a safe *containing space* (Bion, 1967) for my patients if I was unable to see no more than their upper bodies?
- How could I engage children in therapy if I moved online? For example, how would I encourage a young child to stay at the screen, in a different room from their parents, for the 50 minutes of a clinical session?
- Would the duration of sessions have to be shortened from the traditionally accepted 50-minute session? Would the session feel too intense for either or both therapist and patient?

Pulling all these thoughts and questions together, I turned to one of my favorite quotes for inspiration: "Imagination is more important than knowledge. Knowledge is limited. Imagination encircles the world" (Albert Einstein, as quoted in Viereck, 1929, p. 117). I had twenty years of knowledge gained through working as a psychotherapist in private practice with adults, children, parents, and families. What I had no knowledge of was how I could, or whether I should, move my practice online for the duration of the pandemic, however long that might be. Like everyone else in my profession, I had precious little time for thinking it through; I knew I had to make a fairly quick decision. Many of my patients are involved in long-term psychotherapy in which significant and important relationships have developed. Many of the important milestones achieved have been due to the consistency, reliability, and trust within the therapeutic relationship. To preserve these relationships as lockdown and restrictions kicked in, I took a leap of faith and made the decision to move my practice online.

I decided against conducting face-to-face sessions using social distancing measures at this stage of the pandemic, primarily because I felt remote working was the safest physical option. I saw patients for their last in-person appointments in my room, where I explained that although we would continue to meet at the same date and time, from the following week sessions would be online. I offered a choice of phone or Zoom. Children and their parents were only offered Zoom. I was pleasantly surprised that all of my patients elected to continue with their therapy in this new paradigm. There was a collective anxiety around this change, but it felt like there was significant trust in me and within the patients' internal world to try to work through this. I was acutely aware of

schools having been closed and that both parents and children might find the continuity of the child's therapy very important. I asked parents to provide their child with a private space, some paper, pens and anything else the child wanted to bring to the session.

Theoretical Approach and Method

The majority of the work I do within my practice is based on psychoanalytic therapy. The psychoanalytic approach draws and builds on the theories of Freud, and enables patients to explore how their actions and behaviours are influenced by the unconscious mind. In this paper, I use cases studies to demonstrate benefits I observed while working remotely as a psychoanalytic psychotherapist during COVID-19. The use of case studies is a common approach, especially by those in the psychoanalytic and psychodynamic fields. It is an approach that provides empirical evidence "from the consulting room," which Rustin (2003) describes as a psychoanalytic equivalent to Pasteur's "laboratory". The names and identifying features of the individuals referenced in the case studies have been altered to provide anonymity.

Case Studies

Sue: A Nine Year-Old Emerging From a Psychic Retreat

Sue had been attending therapy for several years twice weekly, and I was anxious and unsure about what would happen when meeting via Zoom. I wondered whether she would attend, turn off the computer, or simply to walk out of the room after we had started the session. Her containing space of being with me in my room was going to be absent.

Sue was an emotionally neglected young girl who had been brought in for therapy by her distraught parents, who no longer knew what to do with her. At home, she would either remain silent for long periods of time or have screaming tantrums. I felt she was a child who had not really been "noticed" emotionally, had experienced many traumas, and had consequently developed a system of defences against needing anything from anybody. Her *psychic retreat* (Steiner, 1993) made it very hard to reach her. Many sessions over the years have been laden with silence, with both Sue and I struggling to find a narrative where we could reach each other.

Whatever my worries and doubts were about moving our sessions online, they had to be overridden by creating continuity of contact with this young girl. I moved to Zoom and tried to keep an open mind as to how Sue and I would manage this new space. In moving so swiftly to a remote setting, I was concerned as to how such a move might re-ignite traumas from her already chaotic life. I asked myself whether working remotely would leave her feeling once again "dropped and abandoned" by a positive figure in her interal world.The reality was that some astonishing developments led me to consider if perhaps Sue was able to open up more because the screen between us provided her with a protective, necessary "defensive" mechanism. It has made me rethink what could be considered as "containing" and what could also be considered "the safety of the frame".

Sue very quickly realised she was better at the technology than I was, and she took it upon herself to gradually teach me tricks one can do with the screen. She was interacting with me from “her space” (she had the screen set up in her bedroom). She started to speak more willingly, almost from the very beginning of working remotely. For example, she would initiate a verbal interaction with me that included asking me questions. Also, she showed me around her room, first at her mother’s house, and then in the second session at her fathers’s house. She seemed to delight in being able to do this. I was astonished at how previously I had not sufficiently understood how different and difficult it must be for a child to live in two completely different bedrooms. It is not a case of just moving between two households; it is about a child having to try to create two safe little “nests” in two bedrooms. How can your favourite things and the treasures that make you feel really at home be in two different houses? It is impossible to take everything you might need each time you move between the households. She would occasionally say in session that a favourite toy had been left behind at the “other house,” and a sad look would overtake her face, but I think sometimes the depth of her feeling had escaped me. I had thought that I held in mind how difficult it is for children transitioning between parental homes, but being part of the transitional process via Zoom offered me a much deeper perspective. Putting myself into Sue’s shoes became more literal, and I found myself feeling the shock of the different environments. I grasped in a new way how she had to make sense of different elements of her life. Indeed, I was the one who had to move from the containing space of my room into her world where there were two rooms. I was able to have a much deeper appreciation of how her world might have really felt and looked like for her.

In her early life, Sue had received little maternal reverie. Her mother had explained to me that at the birth of her daughter she had felt none of the brightness or pleasure that she had felt with her first daughter. She had in fact felt quite depressed. During a parent session with the mother, I observed no “glittering” in the mother’s eyes as she spoke about her daughter, no hint of the preoccupation or loving gaze that is essential for healthy development (“No place apparent to receive the transmittance of a need, to be watched to be seen, the light of the maternal gaze” [Golinelli, 2005, p. 245]). No wonder Sue had trouble being so close with another in the therapy room. We had spent a lot of time together in the therapy room in which there were quiet times, withdrawn times, times of hostility, where I would receive her projections without returning them to her. She was communicating much to me, not with words, but with non-verbal communication (“If his lips are silent, he communicates with his fingertips; betrayal oozes out of him at every pore” [Freud, 1905, p. 77]).

Sue, with the screen between us, was able to maintain eye contact with me more comfortably, especially when she was talking. In my room, I would be lucky to get little sideways glimpses of her eyes, and maybe a few words if she did not feel too intruded upon. Having these experiences leads me to think that the screen offers this girl a positive defensive mechanism. She seems able to leave her “retreat” within the safety of her bedroom, regardless of which parental home she happens to be in, and communicate something different to me. Something very intriguing, which she has been doing of late,

is to close her eyes and type a message to me on her screen. She tells me what the message is supposed to say, then closes her eyes, then types. The messages are impossible to decipher, so I try to use my imagination. Is she telling me that being in my room is too close for comfort or “too hot to handle,” but at a safe distance she can talk, and tell me her secrets? During lockdown, Sue’s parents began to fear she had become addicted to the computer screen. What if we thought about this in a different way, about her “needing this screen” as a modern-day security blanket in order to manage her world? This would also help to explain how this particular child benefitted from a therapy that was not so physically intimate.

During this time of her therapy, I had wondered how she might be changing in the world beyond the therapy room, as this is sometimes hard to gauge in child work. Was this child, who was able to relate more openly with me within this new way of working, also able to do so in the broader world? While I had regular meetings with her parents, I wondered what else there might be that was evolving in her daily life which I might not know about. Again, via our sessions over Zoom, I could see for myself those changes which may not have been apparent in person.

For example, Sue had two cats in one of the homes she resided in. Historically, she had largely ignored them, or occasionally mentioned them disparagingly in session. However, they started to appear in the corner of the screen while we were having our sessions together. I commented to Sue one day that I could see the cats, and she proceeded to talk about them quite lovingly. She left the screen, went to the kitchen, and returned with a little bag of cat treats, which she gave to each of the cats. She then gently picked one up and put him on her lap, while explaining to me how the cats were, what they liked to do, and how they liked to be looked after. She was so empathetic; it was very moving to share. “I would like to be a cat,” Sue said to me one day after she had settled them down close to her and returned to the screen. “You need to be looked after and feel safe like your cats feel,” I replied. She agreed and continued to attend to her cat, so very gently and empathetically. I said, “He’s looking up at you for some understanding. He’s communicating with you. He really trusts you”. “He’s purring… sometimes he scratches me,” Sue replied. I said, “Perhaps that’s when he gets frightened. He’s rather like you”. She smiled. “In his whole life, he will never have spoken with you, and yet you will really understand him,” I continued. Sue started singing to herself, as she started to make a drawing. I said, “You’re like the cat purring, now you feel safer you can create a picture. You watch over the cat, and I watch over you”. The parallels between Sue’s care of her cats and the care I was trying to show to her were palpable. This very caring part of Sue had previously been frightened away with all the hostility with which she had constantly lived. However, through this interaction with her cats, as transitional objects, she was showing me that she had been able to introject a “good therapist,” who cared about her, who she was, and what she liked. The emergence of her thinking mind would likely not have been seen in such a clear way if she had not been feeling safer and more spontaneously present in her own home, protected by the computer screen. Having sessions from home has allowed her to build a firmer sense of self.

Before our most recent break, Sue had started to return to the therapy room, as restrictions in Sydney eased. Sue, her parents, and I decided that she would have one of her sessions from home and one in the therapy room. This was mainly due to the worry that lockdown might happen again and a sense that we were reducing the chances of another big change, but also because working remotely seemed to be advantageous for Sue. When children are to have a break from therapy, I make a chart with them showing how many sessions are left before the break. Sue and I made this chart together in the therapy room. I waited for her to decide whether she would ask to take the chart home with her as the next session would be via Zoom. Normally, all Sue's "work" and drawings stay in my room, but we were in new times and exploring new possibilities. Sue announced she would take home the chart and mark off the next date when we met for our next session. So the chart went backwards and forwards between home and the therapy room until the break. The psychic growth in Sue, and the feeling and action of being "dropped," had transformed into something creative, and more importantly into an understanding that relationships could be ongoing.

The screen, the object Sue returns to for safety when she is most anxious, has actually become a tool in helping her to gently "peep out" from behind her distress and take part in a healthier world. We will be thinking long and hard before we relinquish these remote sessions. Clearly, we have achieved a deeper connection than we had in the room despite the limitations of a screen. It certainly has not been my experience, as some therapists have said, that you cannot play with children on Zoom. Far from it! In fact, in my work with Sue, the screen has enabled a deeper form of play to emerge.

Jim: The Importance of the Father for His Anorexic Daughter

When the pandemic hit, Jim had been attending psychotherapy sessions several times a week for six years. He had always come to session in person, and previously I had resisted his growing request to have online sessions. Without his physical presence in the room, I had thought we would lose much of what is important to psychotherapy, including the feelings of transference and countertransference, which are such a crucial gauge to the unconscious lives of our patients. He would often travel overseas and interstate, and quite justifiably would ask to speak via Skype or WhatsApp. It is almost to my shame that I held a quite hard-line approach to what I saw as his avoidance of the intimacy of the room. However, as with Sue, in March 2020 COVID-19 forced us to move onto an online platform.

In order to achieve privacy from his family, Jim would often drive to a spot a short distance from his home, where he said he had a "nice view" from his car. Here he would be able to think about the work he wanted to do in his therapy. What evolved was a whole new space for his therapy. He was no longer rushing from business meetings across the city to arrive for session time. In fact, he had plenty more time: time to think about the upcoming session, time to park his car, and often time for a thoughtful walk before entering the "new setting". The new physical frame of the car provided the containing

function of the therapy room that had preceded it. We made an agreement that all sessions would be held this way so that we both knew what the setting would be. My setting of the same therapy room would also remain constant.

Parallels Between Jim's Therapy and His Family Relationships

As our therapeutic work continued to develop, Jim's relationships with his family were also changing. Now forced to work from home, he was spending much more time with his family. There was more time for him to think, time to process, and time for him to appreciate "being with" his family in painful situations. For the previous three years, his daughter had been held in the grips of anorexia nervosa, for which she has been hospitalised several times. When not in the hospital, she was in outpatient treatment with a psychiatrist and a dietician. She has also been plagued with obsessive-compulsive disorder (OCD) involving a "very critical" inner voice, keeping her mind in a cult-like grip. It was hard for anyone to reach and mend her armour-plated soul. During long periods of his therapy, Jim had been trying to work out what he could do to "save" his daughter, who has been near death on several occasions. Like many anorectic girls, she was high-functioning academically while remaining "a little girl" emotionally; as Magagna and Pepper-Goldsmith (2009) note, "They do not seem to view their emotions with compassionate comprehension providing reflective understanding" (p. 62). She was extremely sensitive to many triggers within her family and her social environment and would react with extreme hostility (albeit sometimes inwardly) if her belief system was challenged. Her family felt they were "treading on eggshells" for fear of further exacerbating her anorectic starving of herself.

Jim, who was based at home throughout the period of lockdown, began to notice changes in his daughter, as though she was returning psychically, firstly to him, and then ever-so-gently creeping, as though on tippy-toes, back into both her family and her social circle. During his sessions, Jim talked about how his daughter was changing. She had begun to ask him questions and tell him her worries. He was concerned that he did not always have the answers and then realised that perhaps listening and "being present for her" were what she needed. He began to notice that one cannot have a relationship with someone who is not emotionally present, but through being more available, one can begin to build a bridge with the other. Realising this, Jim recounted how he and his daughter laughed and cried together, and in one session Jim recounted how his daughter had complimented him on the smell of his cooking, a comment indicating a significant shift in their relationship. It was apparent that the remote sessions that I was having with Jim and the benefit he accrued from having more time to think and reflect on his feelings, coupled with the new intimacy he was able to have with his daughter as she would be at home when he was ready to return from our sessions, created a more available father with whom his daughter could engage.

Infant Observation During COVID-19

Background

Developed by Ester Bick at the Tavistock Clinic, psychoanalytic infant observation provides a deep learning experience for therapists, counsellors, and other professionals such as social workers and nurses, allowing them to develop an understanding of an infant and its relationship with its mother or carer during the early stages of life. As Bick (2011) said,

I think infant obersvation is important for many reasons, but perhaps mostly it helps the students to conceive vividly the infantile experience of their child patients, so that when, for example, they start the treatment of a two-and-a-half years' old child they would get the feel of the baby that he was and from which he is not so far removed. (p.98)

Traditionally, this method of study involved weekly visits to the home of the mother and baby, for an hour at a time, where the student would observe and note the development in minute detail. Following the meeting, the student would write up their visits, utilising all the transferences and counter-transferences that were felt. Following the observations, weekly seminars would be held for the students in order to discuss further thinking and processing of what they had observed. Bick recognised the value for students of not trying to alter the family situation. She felt that infant observation, over any other training method, is valuable in helping students to become receptive observers, and that through this exercise there is no obligation to do anything beyond observing. Indeed, the observer must refrain from defensive comments, questions, or interpretations. Martha Harris (1987), who for many years headed the training for child psychotherapists at the Tavistock Clinic, said of infant observation,

The observation experience helps (the observer) to endure "living in the question" (as Keats puts it) with his patients, to struggle till he can discern the implications of his first-hand, detailed impressions rather than to flee to premature application of theory. It helps him to see the infant both in the child and in the adult, and in his work to stay with that infant and aid him in his arrested or distorted development… observation helps to slow down undue therapeutic zeal, and helps us to learn to feel and to respect the drive towards development in every patient as in every baby. (p. 267)

Infant Observation Today

The principles remain the same today, but as with any healthy child and/or organisation there have been some developments. I run infant observation courses for ICAPP, with weekly seminars conducted online, thus enabling students from other parts of Australia and overseas to have access to an experience that might not have been previously possible. So, as a group, we were comfortable and confident working online prior to COVID-19, and I had a sense of awe that the group, however physically distanced they were, bonded and were supportive of each other, and rapidly it felt they had begun to know something of one another. Of course, the expectation was that the observations of the baby and the family would be conducted in the home. The course started just before COVID-19 arrived, with some of the students having secured a baby to observe and some still looking for a suitable family. Ironically, one student who had specifically asked if they could do a remote observation was told firmly that would not be appropriate!

Moving Observations Online During COVID-19

When COVID-19 stopped the students from being able to visit their infants, as a group, we had to seriously consider conducting the observations online. After consulting with the head of our institute, we concluded as the observations had become an important part of the family's weekly routine, we needed to offer them an alternate way of staying connected. For the mother to have an observer who is primarily and only interested in her and her baby is very precious indeed. We worried that the families might be very disturbed during lockdown if the observers "pulled the rug out from underneath them".

There was precious little time. Health warnings and rules were passed down from governments for everyone's safety, and our approach had to be ironed out in one seminar session. A letter from ICAPP was forwarded to the families explaining that the family and observer's physical health was a major priority. They were asked if they would like to stop the observers' visits or continue in a virtual way. I was holding anxiety for myself, for my students, and they, in turn, for the families. One student who had not secured a baby to observe wondered whether she should leave the group and return when the pandemic was over. However, she decided to remain as an important member of our group. She would, with or without her own observation, be part of something "ground breaking". Psychotherapy, and how it was defined, was being challenged, and history was pushing us forward. All families we were working with were contacted, and each and every one decided to proceed with their observations, using various technological methods (primarily iPhone video connection or WhatsApp). Some parents were concerned about sessions being recorded, and assurances were given that this would not happen. One mother asked that the phone screen be turned off while she breastfed her baby, which was understandable in such an intimate situation.

After having approached their first online observation with considerable anxiety, the students waited for the first online seminar with a great deal of feeling and discussion. The students commented that they thought their first online sessions had gone surprisingly well, with several of the mothers going to quite great lengths for the babies to be able to see the observers on the screen and for the observer to have a good view of the baby. One mother noticed that observer's physical view was obviously limited by the use of an iPhone. The observers talked of having to be slightly more "active" when viewing remotely compared to when they were there in person. Naturally, a physical presence is different from an online presence. Students made a more pronounced "hello" to the baby, particularly when the parents were encouraging the baby to look at the screen.

Interestingly, the students commented that as well as some frustrations with the limitations of being on camera, there were also greater intimacies. One student observed that the camera was placed closer to the baby than the position that she would have physically sat in, allowing her to see intricacies of the baby's movements and facial expressions that she could not usually see. Another student was "left alone" in the bassinet where the baby was sleeping. The student recorded how she could imagine far more closely the feelings of being this little baby, and the baby's limited view from it's

cradle. Online observations also provided a parallel of sorts into the sensory and auditory experience of the baby. The observers were not always able to see what was happening beyond what the camera shows, which mirrored the babies' experience of not having enough control to turn their heads. Indeed, one student reported a "bombardment of shrieking noises" that they could hear but could not determine what was making the noise or where it was coming from. How similar would the student's experience be to that of the baby? Finally, some students noticed ways in which the mothers were communicating differently with them. For example, one mother took to calling the observer "Auntie" (perhaps pulling her further into the family, during these difficult times).

On a first observation via Zoom, one mother put the iPad into the 10 month-old's cot and announced that the observer could watch her baby waking up. Again, the proximity of this is far closer than sitting outside of the cot; the observer was literally in bed with the baby. In her observation notes, this observer wrote,

…the baby didn't initially make eye contact, but appeared to be looking at the device. Then our eyes met and he looked frozen, as though trying to make sense of what he saw. I spoke softly and slowly to him, saying "hello". I normally would wait for Timmy to take the lead, but I realised I wanted Timmy to realise I wasn't fixed, but someone he could feel was very present for him. A little smile hovered then broke into a bigger smile with vocalisations and his whole face was lit up. It was strange to be so close to his face and I could see his new broken-through top and bottom teeth beautifully.

This observer reported that the baby would often relate to her on the iPad as a base to return to, in the same way he did when the observer was present in the room. The observer as a response to this asked the mother if Timmy was experienced in interacting over an iPad, and the mother said as a family they regularly spoke with family overseas. I think it can be easy to forget that we are fundamentally living in a digital age, and that what has seemed like giant steps for those of us who are "techno-dinosaurs," may not have been such a great shift for the younger generation. Necessity is, after all, the mother of invention. Many extended families are now separated by oceans and continents and yet still have regular face to face conversations with grandchildren and other relatives.

Discussion and Conclusion

The three very different examples from my work as a therapist and teacher during COVID-19 illustrate important aspects of this rapid transition from being together in the room to working remotely. My observations, of having to work remotely with both patients and with groups, reveal some important advantages to families of being flung together during the time of COVID-19.

Working remotely with nine year-old Sue provided her with the "protection" of the screen, which she needed in order to have the courage to emerge from her psychic retreat. Her progress has been maintained as she alternates working remotely with working in the therapy room. These experiences have allowed me to think differently about what constitutes play in the analytic playroom, both in person and virtually. In other words,

working remotely has forced me, as a psychoanalytic psychotherapist, to “play” with the very idea of what constitutes child-play in my work, and what leads me to understand the unconscious world of my child patients.

Spiegal suggests that child therapists should stay in the metaphor as much as possible. He particularly notes that, “interpretation to adolescents is almost never to be recommended” (Spiegal 1989, p. 155). Playing delivers meaningful communication. It provides a space where a child’s mind might unfold and part with its secrets. Working remotely with play, Sue was provided with some of the ordinary tools, resources, and content she would have in her bedroom. This poses very interesting questions for my work: Sue brought these items to the screen to share, and on some pre-conscious or unconscious level, to communicate the emotions inside of herself. She did not, as I had feared, move away from the screen to hide. How would it be if sometimes the therapist and young child left the consulting room and went for a little walk in a nearby park? What other forms or play or exploration are possible within the therapeutic frame? COVID-19 has allowed me, and many other psychotherapists, to consider new possibilities, providing some exciting and perhaps new parameters for our ever-evolving psychodynamic work.

The benefits of working remotely were also illustrated in the improved relationship Jim developed both with himself in therapy and with his anorectic daughter. However, the health of Jim’s daughter has regressed since he has returned both to the therapy room and to his place of work. She has been readmitted to hospital, as her weight has become dangerously low. Realising how much his absence affects his daughter, Jim is attempting to work remotely rather than travel so much away from home. Sometimes something practical has to be experienced by patients in psychotherapy in order for the work to progress at an interpersonal and intrapsychic level. One aspect of Jim’s case that has contributed to my psychotherapeutic knowledge is that some “quiet space” around the actual session has proved to be of real value. The session is extended both before and after the actual 50 minutes session time. The additional time and quiet moved Jim’s unconscious thoughts toward a kind of “wakeful dreaming”. The experience for Jim reinforces the idea that psychotherapy cannot be rushed into the therapeutic hour and then put away. It illustrates that if time and thought can be placed around the actual sessions, therapy may actually advance in a deeper and more meaningful way. The remoteness of the sessions accidentally—as is the case for many scientific progressions — provided time and space previously unavailable.

The continuation of the infant observations remotely during COVID-19 provided a platform that, remarkably, added new insights, closer proximity to the baby at times, and a whole new lens to be continually explored in the future. When future trainings revert to the physical attendance of the observer, the option to work remotely will provide protection against potential missed sessions due to ill health or relocation of the observed family during the process. For me, the most powerful insight is the “view from the cradle” that gave the observer a real understanding of the baby’s perspective, also requiring the observer to use his/her imagination as to the source of other sounds from the room.

Uninvited, COVID-19 made me make changes in the way I work, breaking my belief in many of the tenents that have shaped my practice and those of colleagues all around the world. In spite of the raised levels of anxiety around COVID-19 and removal of the intimacy and security provided by my practitioner's room, my patients and I have found new ways of working that have deepened our experiences. This makes me pose the questions: What other ways of working are we rigidly holding onto which perhaps also need to be challenged, and looked at through a wider lens? Do we too easily accept the norms of our work, without challenging them and searching for a different and more appropriate ways of providing therapy?

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