

THE EXPERIENCE OF TIME BOUNDARIES IN REMOTE WORKING

SUE KEGERREIS

In this paper I consider the experiences around the time boundary of therapeutic sessions of both therapists and patients working remotely during the pandemic. I discuss the precision of electronic time and the different dynamics around the beginning of sessions. The business of arriving, whether early, on time or late, has different drivers and meanings in the online world. I consider how difficult it is to take up these dynamics adequately when faced with the real uncertainties of internet connections. Communications between therapist and patient around time boundaries have also presented new challenges, and the way sessions end is very different. The experience of time within sessions is altered, and sessions are no longer bracketed with the journey to and from the consulting room. The dynamics around power and vulnerability are different and the management of time boundaries bring these dynamics vividly to life. The paper closes with some practical considerations around remote working as this is likely to be a part of our practice even after the pandemic is finally over.

KEYWORDS: TIME BOUNDARIES, REMOTE WORKING, COVID 19 PANDEMIC, PSYCHOANALYTIC SETTING, LATENESS

INTRODUCTION

A significant number of interesting papers have already been written in the last two years about working remotely [e.g. clinical reflections by Isaacs Russell (2020), Sayers (2021), Murdin (2021), Essig & Isaacs Russell (2021) and research papers by McBeath, du Plock and Bager-Charleson (2020) and Boldrini *et al.* (2020)]. There will no doubt be many more as psychotherapists digest the enormous impact of the pandemic on our practice and subsequently navigate the complexities of returning to face-to-face work. As clinicians we have all had to manage an unprecedented upheaval in our professional (and of course personal) lives and been forced into working in ways we might have been dismissive of or anxious about in the past.

This paper is avowedly focusing on the experiences of those of us for whom this was an abrupt change for which we had little or no preparation. It should be noted, however, that those who worked remotely prior to the pandemic have written very usefully about their experiences. I suspect I am not alone in not having been familiar

with this literature before the pandemic, unaware that some psychoanalytic practitioners had already explored some of the key phenomena. It is important to acknowledge that some of the issues discussed here have been given serious attention before, and that in this sense this paper is not breaking any particularly new ground. Isaacs Russell's *Screen Relations* (2015), for example, explores these topics in depth and the ideas there are also referred to in Isaacs Russell and Essig (2019).

For those of us new to this way of working, we have learned that while much is lost in the move to remote working, certain essential elements of therapeutic work are retained, and we have all become more skilled in retrieving our professional and technical confidence over the months, restoring our ability to work in the transference and use our countertransference despite the constraints (Sayers, 2021; Kegerreis, 2020). We have even found that there are some advantages to online or telephone working. Patients who could not otherwise access therapy have found it possible to engage. The similarity between telephone work and work on the couch has been noted, given that in both, the therapist is not (directly) visible and is related to (almost) exclusively by voice. It has been acknowledged that some patients can be more spontaneous and less inhibited than they would be if present in person, and are able to experience unconscious and infantile transference dynamics more keenly as the therapist is not an embodied other.

This paper concentrates on one small element in these recent experiences, the change to our experience of time boundaries in working remotely. Brody (2009) reminds us of the key fact that 'Analytic pairs are experts in the art of loss but also in the art of attachment' (p. 95). The time boundaries of the analytic setting create opportunities to see most clearly how these dynamics of attachment and loss get re-enacted. In a previous paper I have written on the significance of time and time-keeping in psychotherapy (Kegerreis, 2013). In that paper I explored how our patients' management of the time of the sessions and their relationship with time-keeping are articulations and expressions of fundamental relational dynamics, and that work on their relationship with the timing within the therapy setting helps us explore and influence deep internal and interpersonal struggles. Of course, the move to remote working has thrown out of the window much of our treasured control over the setting. We have lost our rooms: our couches, our chairs, and all that went into our often carefully curated therapeutic environments. But we have also necessarily lost our previous relationship with the way in which sessions begin and end, and there have also been forced changes in how the time feels in the bulk of the session in between.

Our and our patients' relationship with time is not the same when they are having sessions remotely rather than coming to our consulting rooms, and in this paper I will explore some of the impact of these changes on the therapeutic work.

THE PRECISION OF ELECTRONIC TIME

When we are using clocks and watches, there is a certain fuzziness to time boundaries. It is clear that many, especially younger, patients are likely to be using their

phones rather than having a watch on their wrist as the previous generations would, so the change to electronic time has already been happening, but many of us still have analogue clocks in the consulting room and use watches for our own time-keeping. The experience of working on zoom or other screen-based platforms has brought electronic time right into the fabric of therapy in a way that cannot be fudged. The turn of the minute when recorded digitally is a very different event from the equivalent on a clock with hands. In what follows I will consider how this precision influences the beginning and the end of sessions, as well as the experience of time passing within the session.

THE START OF THE SESSION: THE PATIENT'S EXPERIENCE

Many therapists have made use of the 'waiting room' facility on zoom, others have not. In my own practice I have not done so, but colleagues have referred to it often. Having had my own experience in zoom waiting rooms for meetings and conferences, I can express the opinion from my own perspective is that this is a very different event from waiting in a physical room or lobby outside a therapy room. From the patient's perspective they are perhaps much more aware of being kept *out* rather than allowed *in*. With a physical space, they are brought into the therapist's orbit, and can make use of and fully experience the therapy setting's facilities. There might be a comfortable chair, some magazines, most likely a toilet they can use. There will be a history of waiting in that very room, memories of the first time they came, or that time a few weeks ago when they came earlier than usual and had to wait longer, or when they were in such a hurry being late that they almost knocked over the side table. There will be smells and sounds that are part of the therapist's world into which they have been brought. In more institutional settings there might be less comfortable experiences, although of course each patient will have his or her own connections and emotional reactions to the waiting area. There might be other patients coming and going, perhaps connected to other therapists or even to other services. There might be anxious rivalries, keeping an eye on who else their therapist might be working with, coming early to catch a glimpse or arriving late to make sure they do not have to face that possibility. There might be a wish not to be seen as 'one of them', or alternatively for some patients there is the comfort of not being the only one needing help. They get a sense of where the therapist is situated in the wider world, which can have a wealth of meaning, either reassuring or conveying, as one patient put it, a 'production line in a mental health factory'.

Online, by contrast, the patient is in their own space. They may be waiting for the therapist to start the session, to be sure, but they are not doing so having been 'let in' and they can be busy with all sorts of other elements of their lives until the session begins. They might be more anxious, as they can't hear reassuring movements and 'getting ready' noises, but they might also be able to distract themselves very easily from their anxieties. If they have been sent an online link they may be reasonably sure that the therapist is there and that they haven't got the wrong day

or time, as can sometimes happen in first sessions or less regular encounters in in-person encounters, but they also might be waiting more helplessly, with less readily available sense of agency on their part. They haven't quite made it 'in' yet and can feel very passive and vulnerable as a result. When we are linking with someone else electronically there is this somewhat bizarre juxtaposition of them feeling both very far away and being extremely close, just a click away, hovering just behind our screens in cyberspace. So for some patients waiting for the session to start is a far less powerful experience, less full of the anxieties around separation and attachment than waiting outside the therapy room, as they can feel that we are always 'right there' ready for them when the time comes. For others it is fraught with a sense that we are only precariously present and might not be there at all.

This has been about the start of the session, but a good deal happens, of course, before this. There has also been a great deal of learning needed about how to recreate the patient's responsibility to 'arrive' at the session. The sending of zoom links rests with the therapist, and there are different ways to do this, either having a repeated link or sending one out week by week (in once-weekly work). The former makes it more like an in-person arrangement in that the session is already 'there' waiting to be attended, while the latter places the onus each time on the therapist to renew the invitation and make it possible for the session to happen. At the beginning of the pandemic I sent out zoom links each time, which meant that the patient received evidence that I was keeping them in mind ahead of time, but also gave me – and them – more anxiety about this to ensure it happened. If this was left until later in the week than usual or, worse still, got forgotten until shortly before the session, then a wealth of emotionally important events had occurred before the session got started, with relatively little chance of this getting sufficient processing time.

Then there is the question of when the session actually starts. It can take time to click on a zoom link and get everything to work. The exact precision of electronic time, visible out of the corner of our eye at any time, means that we, or they, might be felt to be 'late' even if we become available during the designated minute. With analogue clocks we are unlikely to be timing things to the second, not least as our turn of the minute would not be likely to be at the same moment as our patient's. With electronic devices we have another set of issues to think about with regard to time-keeping. What do we count as being 'late'? What if there are technical difficulties and logging on is disrupted or delayed? What of this would we interpret and what would we just accept as the difficulties of the medium? A computer or internet link failing them is not quite the same as 'the bus came late' or 'there was terrible traffic'. While we can reasonably expect our patients to look after the connection with us to an extent, for example not allowing devices to run out of battery power just before a session, we all know how often the internet connection can become disrupted and issues beyond our patient's power can interfere. We can therefore either miss the opportunity to work on something significant if we do not take up the 'lateness' as an acting out, or be felt to be out of touch with the reality of internet communication if we do.

THE START OF THE SESSION: THE THERAPIST'S EXPERIENCE

I have written above about the patient's experience of the waiting room. From the point of view of the therapist, waiting for them to 'arrive' online is also very different. If I am waiting for a patient in my consulting room I know I will hear footsteps on the pavement, the click of the gate and the sound of someone coming down the outside stairs. I will have fair warning that they are on their way and the absence of these sounds will mean that they are not about to arrive. I have the experience of hearing other people walking by and can become aware of the intensity of my own feelings about them arriving, or not arriving, as the time for the beginning of the session passes and I listen and wonder if this set of footsteps are theirs. In my consulting room I will be sitting in my chair in these moments, with nothing to do except think about my patient and consider the meaning of their lateness. I will be fully present in the waiting, remembering the session before and anticipating the session to come. These moments are part of our relationship, they mean a great deal and are both interesting and emotionally significant. Do I become angry, frustrated or hurt? Do I become beset with worry about their well-being, or concerned about the impact of what I said in the last session? If they are travelling a long way, I am necessarily involved in fantasies about their journey and what practical difficulties might have arisen unexpectedly, or, as is often the case with habitually late patients, what have they this time chosen, consciously or unconsciously, as a means to express their ambivalence towards or fear of having a full session.

On the other hand, when working in person, if they arrive early, I may be aware of the possibility that they saw or even met the previous patient. For some this will have been a powerful event, for both of them. The physical and literal awareness of the others we see is freighted with meaning, as we know, and is experienced very differently in in-person work. The time boundary is therefore given another layer of significance, providing, as it does, information about the place they occupy in our week and their sense of sitting down in the same chair/lying on the same couch as our other patients, breathing the same air, smelling the same smells. I have had patients with halitosis and body odour issues, leading to anxiety about ventilating the room sufficiently between patients, but this is just an extreme version of something universal, but challenging to each patient in a unique way, about seeing a therapist – you are not the only patient. This is not confined, of course, to the business of arriving early or not, but the moments before the session begins (and as you leave) are necessarily the most full of meaning in this regard. I had one patient who was very explicit about this, explaining her habitual minor lateness as being driven by her horror of bumping into and being seen by one of my other patients. We came to understand that she needed to protect us both from encountering her intense rage at always having felt second best to her older sister by preserving her fantasy that I was only working with her. Paradoxically she did this by taking elaborate precautions to avoid meeting someone who, as it happened that day as a result of my schedule, did not actually exist.

From my perspective, if I am about to see a patient who has arrived early and is sitting in the waiting area, I will be acutely aware of the intervening moments ticking by, the sense of the power and importance of the time boundary stopping me from ushering them in before the formal session time. I will be self-conscious of any noise I make in the room as I prepare it for them, plumping up the cushions or moving the chair back to where it belongs, knowing they can hear. Will they be feeling safe and contained by my adherence to the session start-time, or feel angry and hurt at what they might experience as my pettiness over a few moments? Of course, all this is open to interpretation if they are able to express their feelings, so becomes part of the work, sometimes very usefully so.

Online with zoom things are very different. The patient with us will not have to worry about someone else intruding into their space. The patient to come will not be in a position to encroach, or need to hold back in case of any overlap. For us as therapists, we are in our own space and unless we take deliberate precautions – which of course many of us might do – to recreate the therapy room experience, we are surrounded by all our electronic devices. Even if we are very professional about this, there will necessarily be electronic devices available as we are using them to contact our patients. However, it is a powerful fact of online work that the medium by which we conduct our therapeutic work is also most likely to be the one by which we play games, chat to our friends, answer emails and make online purchases. It takes a far greater act of self-discipline to wait for a patient in the single-minded way described above. Waiting is not the same when the distractions of all other aspects of our lives are just a click away. The moments before the session begins are not likely to be anything like as focused on the session to come and something intensely important is lost or avoided as a result.

COMMUNICATION AROUND THE TIME BOUNDARY AND TECHNICAL ISSUES

There are many more issues around lateness in the online environment that we have had to contend with. In my in-person work, I would wait through a whole session and write afterwards acknowledging that the patient had not made it to the session and letting them know I would look forward to seeing them next time (here I am alluding to once-weekly patients – this would be different in more intensive work). On zoom, especially earlier on in the pandemic when I was less adept at and familiar with the technology, I would text or email soon after the session time to let them know I was there and to query if they were having trouble connecting. I would worry that I had not sent the link properly or that their equipment was failing them. Sometimes, indeed, it turned out that their internet was causing trouble, and we had to quickly instate a telephone session in order to connect. However, it would often transpire, especially with adolescents or with children where parents were in charge of managing access to the session, that the therapy had been forgotten or my patient had ‘lost track of time’ or overslept. By checking in with them in my own anxiety about the technology, had I by contacting them foreclosed on letting them express

their hostility or anxiety? Had I avoided fully exploring their ambivalence? Had I expressed more of my own need for them to attend than I would have done in the in-person scenario, affecting the relational dynamic and how it was perceived, and maybe protecting both of us from knowing the full impact of them not managing to come? Or had I helpfully expressed the fact that the session was important and that the real world, the real electronic world at least, might well have got in the way and disrupted our connection?

In one situation recently with a young male patient the internet was erratic as the session began, so we had to move our session to the telephone, having had to abort the zoom connection. This worked well, but was full of potential meanings and emotional experiences, both about the change of medium and the process by which we had negotiated the change as two real people in a real relationship. As with so much during this massively disrupted period, there was not enough time to explore all this. The patient had just started to tell me about a disastrous family dinner which had led to an episode of self-harm, and to spend a lot of time and attention on the change of medium would have been difficult at best and hurtful and inappropriate at worst. Yet it mattered, and we both knew it mattered. There was a moment later in the session when it was possible to reflect on it having been different, but it was not possible to work it all through effectively. I think all of us have had many experiences like this over the last year or so, particularly early on – having to focus more on the immediate material of the session and less on the way in which the relationship between us, both in reality and in the transference, has been experienced. The knowledge that so much has necessarily remained unexplored has created an attenuated, thin feeling to the work at times.

THE END OF THE SESSION

The ending of a session is always a powerful event. As Brody (2009) puts it, ‘What is being “staged” in the analytic hour, in our playground of what Modell (1989) terms a *symbolic actualisation*, is the fort/da game – backwards. There/gone, there/gone, there/gone. Session after session. We are in the playground of intimate connection and loss’ (p. 89). This is going to be true however we end the sessions, but the manner of our disconnecting with patients and theirs with us will affect how these profound dynamics are played out and experienced. The drama enacted and re-enacted as the analytic dyad separates is different when we work online in a number of important ways.

To state the obvious, the precision of electronic time operates just as forcefully around the boundary at the end of the session. When we work in person in our rooms we have a bit of flexibility in judging just when and how to end a session. We know that ending and leaving the session will take some time and that we can use words and gestures, body language and our own movements as we get up, walk to the door etc. in order to bridge the gap between the session’s end and the patient’s actual exit. We can wait for that moment in the conversation where the end does not feel too brutal, while still managing the boundary. If we are faced with a

digital clock, we and our clients will – or at least could – know if we are even seconds late, or seconds early in ending the session. Some patients in the consulting room will pack up their things slowly, gathering the trappings of their ordinary life as a way of preparing themselves for returning to it. One young woman usually uses the toilet after the end of the session, prolonging her presence in the therapeutic territory for a bit longer and leaving me on tenterhooks as to whether she will leave before the next patient arrives. Another almost always has a moment of hesitation and return towards me from the door as she checks whether she has left her phone on the side table. All these details have significance, but also they allow the sessions to end in a way which is itself indicative of specific dynamics around connection and disconnection, which are emotionally meaningful. The way the session ends is an event in itself.

Online it is just a click on the leave button. We can think about the way they click – do we click first or do they? Is there an embarrassed awkward fumbling or is it a confident, abrupt finish. Whichever way it goes, the disconnection is sudden and total. We return to our lives and they to theirs, quite possibly immediately immersed in whatever is going to happen next. There is an even greater contrast, to my mind, in the way sessions end than is the case with the beginning.

This can, of course, be taken up with the patient and there is a lot to be gained by exploring with them their experience of these somewhat brutal endings, with all the idiosyncratic meanings this may have for each one. The pandemic stirred up so much anxiety about abrupt and final separations as a result of the (reality-based rather than paranoid) terror of sudden illness and death, the patient's feelings about parting and reunion were brought into sharp focus by the manner of finishing an online session.

BEFORE AND AFTER THE SESSIONS

In addition, Sayers (2021) has written about the significance of the loss of the journey to and from the sessions. The buffer that this can create is often felt to be very valuable by patients, giving them time to shed their daily busyness on the way, preparing their mind for therapy, and time to digest what has happened in the session on the way home and to help them reacclimatise to whatever waits for them at the other end. Isaacs Russell (2020) reported that patients told her 'the journey to and away from the consulting room is an important aid in remembering the session. Turning off the computer is not a journey'. Apart from all other considerations, having to travel to and from sessions makes therapy, quite simply as well as metaphorically, a bigger event. Online therapy may be much more accessible to clients who live too far away to come in person, and this is one of the serious and valuable advantages emerging from the pandemic, but equally it becomes potentially less significant, more disposable, precisely because it takes less effort to attend. We become less a major and important part of our patient's week, occupying a noticeable chunk of their diary, and more a small interruption in their busy schedules, sandwiched perhaps between a work meeting, getting the washing into the washing machine,

dealing with the children or an online game with a friend. This has been brought into sharp focus as we negotiate returning to face-to-face work. It is borne in on patients that they will, if they come in person, need to create considerably more space for the therapy than they have done before, and it throws up powerful conflicts about how much they value it or wish to minimise its place in their lives. Those who came in person before may be more likely to be relieved to return and to restore the far more textured experience of being in the therapy room, but those who started online are given a complex task of working out what this new experience means to them, having to encounter a new vulnerability and to decide whether they can commit in a more significant way to the work.

Connected to this is the shift in the power dynamics working online or on the telephone. As I explored in more depth in my previous paper (Kegerreis, 2013), the time boundaries of the therapy sessions bring into focus the power relationships in the work, and acting out around the time boundaries is often very usefully understood as bringing to light problems with power, as well as the fundamental issues of dependency, vulnerability, capacity for closeness, management of anxiety and the patient's relationship with the finiteness of life and with reality itself. The power we have when patients are in our consulting rooms is very different from that which we have in remote work. One of the reasons given by patients for being able to use online or telephone sessions more readily than in-person ones is that 'I can leave at any time, just by clicking a button'. This makes it easier to talk about embarrassing, shaming or otherwise difficult things, which is an advantage, but it also makes it very much easier for our patients to leave if they want to. To state the obvious, it takes a lot less effort and determination to leave a zoom session with a click than to leave a room in someone else's house or in a clinic. This place might be quite far from home, we might need to take time to gather our belongings, all the while experiencing the response of the person you are leaving and having to carry through the somewhat drastic step of leaving a session. I have very rarely had a patient leave a session before the end – it did happen once or twice when I was a school counselor and on occasion with one particularly volatile patient in private work – but I have had a child patient who would often leave a zoom session when angry with me, particularly when I would not give him power over the session by making him host or if I resisted answering his questions about my personal life. If we had been meeting in person he could not have done that, partly because I would probably have been able to navigate his longing for control and his curiosity more effectively, but also because he was far from home and had parents coming to pick him up after the 50 minutes!

Even if a patient has no intention of leaving before the end of the session, the fact that they could do so at any moment is something all of us know, and it affects the connection between us and the dynamics of control in the work. We are powerless to stop them, beyond our capacity to allay their anxieties or address their frustrations, and they know this. In our rooms they are in our space and we have an authority over the setting which becomes woven into the fabric of the relationship. Leaving us takes a lot more determination, the temperature would really need to be

high for it to feel warranted. We are *there* in our concrete reality, full, three-dimensional beings with whom they have a history and a complex relationship. Online we have no such authority, and the insubstantiality of the connection means that we can be more readily reduced to something far less nuanced and can therefore more easily dismissed.

EXPERIENCE OF TIME DURING THE SESSION

We have explored the beginning and ending of the session so far, but, as is evident in the last section, the experience of being online or on the telephone affects the way the session feels all the way through, and there are changes in the way in which the passage of time during the session is experienced. It is far harder, I think, for patients to become fully immersed in the session, to let themselves relax into a state of mind very different from their day-to-day adult alertness. This is partly because the technology, with all the distractions it can readily offer, as mentioned above, itself diminishes our capacity to be 'present'. Misra *et al.* (2016) reports that in face-to-face meetings, just having a phone or tablet present on a table nearby, even if turned off, can reduce our levels of connectedness. This effect is magnified by our communicating using the technology itself, with so many ways in which our devices remind us what else is coming in. Our patients are surrounded by possibilities of checking this or responding to that, wondering what is happening on social media or worrying about what that WhatsApp/Facebook/Twitter alert might indicate. If they are in their homes they might be unable to relax into the session fully because family members might intrude at any time, and, even if they are thought to be safely out of earshot, it is undoubtedly harder to speak openly about people who are close by – far closer to you than your therapist with whom you want to confide.

The precariousness of the medium also affects the quality of time as perceived by patients in the session. If at any point one might be cut off by an internet disruption or a battery running out one cannot relax. One patient referred to the (in-person) session as being a 'moment out of time' for him, set aside safely by virtue of physically being somewhere different away from his ordinary life. This is very difficult to recreate online or on the telephone. I think that in remote work we are simply unable, however hard we try, to be as exclusively focused on our clients, or they on us. The sense of the minutes ticking by seems more acute, as the timer in the corner of our screen is constantly reminding us of this with inexorable accuracy. If seeing a patient in my consulting room I might glance at the clock only occasionally, and usually only towards the end of the session to check how much time is left. On zoom the timer is constantly available in the corner of my eye, and much harder to ignore. When in our physical presence our patients are being invited to shed something of their adult selves, to put some of that self-conscious monitoring and control on standby, and to allow the experience of the moment be the most important thing. Alongside this we endeavour to encourage the emergence of their less consciously regulated communications and to tune into that experience in the moment as much as we can. When meeting online or on the telephone this is far, far more difficult,

and the adult, cognitive, concrete elements of both our personalities are necessarily kept vigilant.

There is much to say about the different experience and management of silence when working online. This is linked to the different feelings generated by the passage of time if not present in person. If in the same room there are so many other ways of showing you are present, there is much less sense of just 'waiting'. There is so much more scope for being in a thoughtful and connected silence rather than the awkward, anxious and more distant silence that prevails if working remotely. A detailed exploration of this is beyond the scope of this paper but has been and will be written about in more depth elsewhere.

EXPERIENCE OF TIME IN THE PANDEMIC

Many writers from within our profession and beyond it have written about the effect of the pandemic on our perception and experience of time more generally, and this has relevance for the experiences within therapy. In lockdown we have been caught in a pretty-much unchanging environment with all the markers which usually shape our day/week/month/year taken away. Brown (2021) describes this eloquently as living 'during the pandemic, in an anxious present, within lonely walls'. This leaves us in what has been eloquently described as the 'soup of experience' (quoted by Isaacs Russell, 2021, p. 371). The rhythm of leaving home and returning has disappeared, the alternation of school terms and school holidays ceased for some while, and for those of us attached to universities the difference between term and vacations has been blurred by online teaching. We have missed annual events, birthday celebrations, holidays away from home, family gatherings and all the other markers of a year passing. Having been unable to plan ahead over such a long period has left us living in a 'never-ending present'. The experience has made us acutely aware of how in normal times we would be heavily invested in and aware of a past and future calendar marked out in chunks, demarcated with big events, imbued with a sense of 'only so much time before this' or 'oh yes, it happened after that'. We spent a lot of energy, not always helpfully, preparing for and predicting our immediate or more distant future plans, carving out our year ahead of time and parcelling it up into distinct phases. Without any of this over such a long time it has all become what a colleague called a 'big mush'. It has become hard to remember when anything happened, was it this year or last year? Now that the pandemic and related lockdowns have been in place for 18 months¹ many of us find it difficult to locate our experiences over this period with any kind of clarity.

We have lost, also, as has been widely commented on, some of the clarity between working and not working, within the day and within the year. As Isaacs Russell points out 'With nothing much to do and nowhere to go people feel like they have no legitimate excuse for being unavailable' (2021, p. 367). This is true in general terms, but has a particular relevance to therapy. It is noticeably harder to work out whether and when to allow a patient to change a session time if they feel they need to. I have found that the lockdown has created in my patients, and in me,

a sense that as I am 'there all the time' they can much more easily ask for a different time if it is inconvenient. In addition, there is a shift in the impact and meaning of taking our conventional holidays from patients, as they know with near certainty that we were not going anywhere. Why couldn't we go on seeing them in through the summer holidays, given that at that time nobody was allowed to travel? Taking time out is much more vividly seen as a turning away, a deliberate exclusion rather than, even if this were to some extent a bit of a fiction, an episode in which we are physically absent doing other things altogether elsewhere.

SO WHAT HAVE WE LEARNED?

There are many things keenly looked forward to in returning to face-to-face work, and at the time of writing I and colleagues are mostly bringing our practice back into the therapy room, but the likeliest scenario in the future is that many practitioners and services will be operating a hybrid model, with some online or telephone work being on offer either for some clients or for clients some of the time. This means that we need to give careful attention to the experiences around time boundaries in order to define for ourselves what will be best practice going forward and to learn from our mistakes during the trial and error period we were thrust into with little or no preparation.

I will start with the practical arrangements which are most helpful – nothing very subtle but in my own case overlooked or not sufficiently considered in the original rush to continue our work with patients after the lockdown.

1. It is useful to settle on a *clear and consistent* system for your client to access you on zoom or telephone. Be absolutely clear who initiates the contact if working on the telephone and do not change this. With zoom, a single repeated link is much more helpful than sending a new one weekly. However, for some clients the weekly sending of the link has been meaningful and containing, serving as a reminder. It will be a matter of clinical judgement whether this is helpful or whether it is foreclosing on some dynamics and putting too much responsibility on the therapist for the sustaining of the work. There is a strong need to think about why we may make one decision with one client and not with another – is this acting with sensitivity to a client's needs or being driven by an enactment of a counter-transference dynamic?

2. *Waiting rooms are useful* (I wish I had incorporated them). They restore the idea of 'letting the patient in'. Otherwise the patient can be 'in' the room before you come in, so creating an experience more like them sitting in the consulting room waiting for you to arrive.

3. *Agree on a protocol for non-attendance* and try to stick to it. Like with all elements of the setting, if we have a policy which we have thought through and established, we can deviate from it, but then we have at least a chance to work out why we are doing so and whether this is helpful or collusive. If we don't have a system then we have far less of a chance of establishing what dynamics have created a particular scenario.

3. *Always keep yourself as the host.* My experience with a young patient letting him be host (he held the work hostage by refusing to communicate if I did not!) was highly instructive on how much of a problem this can be. I learned a lot about him and could use these experiences in the work for sure, but the loss of control was actually quite scary. He could rename me, mute me, disable chat, and claim all power over how the session proceeded. He could lodge a complaint against me. He could also borrow my face and make use of it in fake videos (though in fact he could do this anyway using publicly available images). Paul Terry has made the comment (private communication) that ‘the consulting room itself is like a set of toys with which to play and communicate, and similarly the zoom screen is a new set of toys with which to communicate unconsciously’. So the power play with zoom is a new version of the power dynamics which are always at work in any therapy, but maybe particularly with an 11-year-old whose main defences were omnipotence and denial of need or vulnerability.

4. Consider giving a more explicit *warning of the end* of the session than one might in person. The ending is so abrupt otherwise that more care is needed to manage the transition.

5. When setting up the work it is worth talking in some detail with a client about *how they are going to manage beginnings and endings*. Alongside the necessary work on privacy and confidentiality, it will be useful to think with them about how to give themselves a margin of time to be ready and to decompress afterwards.

6. As always, *attend to the enactments* which ambush us, and to the *power and vulnerability dynamics* around the time boundary as enacted by our clients. We need to reclaim our confidence in the unconscious meaning of the relationship with technology, for ourselves and our clients. We need also to reclaim the idea that we can consider the unconscious meaning of everything that happens, and resist the temptation to ignore enactments or surprise events because they are ones which couldn’t happen in ‘real’ life. Brody (2009) puts strongly the importance of reflecting fully on endings – ‘When “the end,” this co-created moment occurs in the absence of awareness, there can be avoidance and nonreflective enactment. But when it occurs within a context of shared understanding, the analytic pair is free to intensify, play with, and confront the limitations and inevitabilities of life that are revived again and again as we approach and reach the end’.

If we can now espouse remote working consciously and deliberately, rather than having it thrust on us and taken up reluctantly, we can more robustly claim this new therapeutic space, without compromising our psychodynamic principles.

CONCLUDING REMARKS

Time boundaries are an essential element of the setting. Historically they have been something that the therapist sets and rigorously maintains, as part of what they offer the patient in order to provide a containing environment. Alongside the physical environment, concretely representing the provision for their needs in the form of a comfortable chair or couch, a toilet, tissues and a quiet space, the regularity and

reliability of the time boundary has been long felt to be of profound significance in creating the conditions for the therapeutic relationship to develop. It provides a medium for negotiating profound issues in the patient's relationship to us, to others, to his own life and to reality. Much of this has remained true during the pandemic, but nonetheless our experience of the time boundaries has been disrupted. One could argue that of all the elements of the practical setting, the time boundaries have been least affected. However, as I have tried to elucidate in this paper, the experiences around them have still been changed significantly. There are new challenges to overcome in relation to the experience of beginning and ending sessions, new issues that have arisen regarding lateness and absence, and a different experience of time passing in the session.

For most of us, we are resuming work in person now or in the near future. We will have another set of challenges as we return to the idea of sessions including a journey before and after. They will have a beginning led up to by a wait, announced beforehand by noises indicating one another's presence, and an ending spread out over significant moments of gathering possessions and leaving. For me that will be a great relief.

But if we continue with some remote work, we have learned a lot over the last two years about how to make this effective. We can embrace it with more clarity and understanding of the issues and be in a position to make much better and more deliberate choices about how we manage the boundaries of the sessions.

NOTE

1. At the time of initial writing (October 2021).

REFERENCES

- Boldrini, T., Lomoriello, A., Del Corno, F., Lingiardi, V. & Salcuni, S. (2020) Psychotherapy during COVID-19: How the clinical practice of Italian psychotherapists changed during the pandemic. *Frontiers in Psychology* 21 October.
- Brody, S. (2009) On the edge: Exploring the end of the analytic hour. *Psychoanalytic Dialogues* **19**(1): 87–97.
- Brown, S. (2021) Time during lockdown, a personal reflection. *Psychodynamic Practice* **27**(2): 176–91.
- Essig, T. & Isaacs Russell, G. (2021) A report from the field: Providing psychoanalytic care during the pandemic. *Psychoanalytic Perspectives* **18**(2): 155–77.
- Isaacs Russell, G. (2015) *Screen Relations: The Limits of Computer-Mediated Psychoanalysis and Psychotherapy*. London: Routledge.
- Isaacs Russell, G. (2020) Remote working during the pandemic: Q and A with Gillian Isaacs Russell. *British Journal of Psychotherapy* **27**(2): 364–74.
- Isaacs Russell, G. & Essig, T. (2019) Bodies and screen relations: Moving treatment from wishful thinking to informed decision-making. In: Govrin, A. & Mills, J. (eds), *Innovations in Psychoanalysis: Originality, Development, Progress*, pp. 228–249. London: Routledge.

- Kegerreis, S. (2013) When I can come on time I will be ready to finish. *British Journal of Psychotherapy* **29**(4): 449–65.
- Kegerreis, S. (2020) Some thoughts on working psychodynamically in the pandemic: The loss of the good object. *Psychodynamic Counselling* **26**(4): 364–8
- McBeath, A., du Plock, S. & Bager-Charleson, S. (2020) The challenges and experiences of psychotherapists working remotely during the coronavirus* pandemic. *Counselling and Psychotherapy Research* **20**(2).
- Misra, S., Cheng, L., Genevie, J. & Yuan, M. (2016) The iPhone Effect: The Quality of In-Person Social Interactions in the Presence of Mobile Devices. *Environment and Behavior* **48**(2): 275–98. doi:[10.1177/0013916514539755](https://doi.org/10.1177/0013916514539755)
- Murdin, L. (2021) Is anyone there? Use of the telephone and use of the couch. *British Journal of Psychotherapy* **27**(2): 234–43.
- Sayers, J. (2021) Online psychotherapy: Transference and countertransference issues. *British Journal of Psychotherapy* **27**(2): 223–33.
-

SUE KEGERREIS is Professor at the Department of Psychosocial and Psychoanalytic Studies at the University of Essex. As a psychotherapist (both child/adolescent and adult) she has practised in health, education and community settings as well as in private practice. She established the MSc Psychodynamic Counselling with Children and Adolescents at Birkbeck and the MA Psychodynamic Counselling at the University of Essex. She has also taught on numerous other psychotherapy and counselling trainings. She has published widely in professional journals, is Managing Editor of *Psychodynamic Practice* and her book *Psychodynamic Counselling with Children and Adolescents* was published in 2010. Address for correspondence: [skeger@essex.ac.uk]