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Doing remote systemic psychotherapy during a pandemic: Learning from a Speedy Quality Improvement Project

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Abstract

This paper describes some findings from a rapid quality improvement project exploring clinician views about the delivery of remote systemic psychotherapy since the Covid-19 induced UK lockdown. Remote systemic psychotherapy is a practice response based on the need to remain physically distant from people and involves "meeting" via video link rather than in person. Written responses were gathered from early-adopter clinicians in one UK NHS trust, reflecting on their experiences of convening remote systemic psychotherapy sessions during March and April 2020. Overall, findings suggest that that remote systemic psychotherapy has been acceptable, effective and indeed welcomed by clinicians, within the pandemic context. Using a diffractive thematic analysis, four themes were constructed from clinician responses: practical and boundary issues need careful attention; the conversational flow of remote systemic psychotherapy sessions is different to that during in-person sessions; it is necessary to do things differently with words and bodies; the practice of creating meaningful dialogical communication when separated by screens is hard. Tentative practice recommendations are provided.

Introduction: Doing video consultations before Covid-19: what was known?

Before March 2020 and the UK lockdown in response to the Covid-19 pandemic, I occasionally used video technology to see families who couldn't attend an appointment in my office. These were mostly people in families that were separated by geography, or stuck at work, or who couldn't travel to the clinic for health reasons. I saw using video consultation as a better solution than not having any contact. It was an infrequent, ad hoc practice, rarely spoken of and perhaps not always made fully transparent to the institution. It was a practice that seemed broadly similar to how I usually worked but also somewhat different, although I was unclear how.

Physical distancing is playing a vital role in reducing the spread of the Covid-19 coronavirus across the globe. Alongside the ongoing restrictions we face in so many aspects of daily life, most non-emergency in-person healthcare interventions have been and / or remain suspended. Psychotherapeutic interventions that traditionally involve sitting together in a room and engaging in intense conversation have also, by and large, been suspended. In order to maintain a connection and service continuity, remote and virtual ways of working have been rapidly initiated. The delivery of remote systemic psychotherapy, that is seeing couples, families and groups using video link, has become part of daily practice. So, can we really do meaningful, effective systemic psychotherapeutic work when we cannot be in a room together? My aim for this project was to contribute to the practice-based research literature to explore what the delivery of remote systemic psychotherapy within the NHS involved. I was interested in the perspective of clinicians.

There is little published research regarding the process and outcomes of doing remote systemic psychotherapy, so in the section below I briefly describe the pre-Covid-19 published literature on doing video consultations in healthcare. I focus particularly on studies that have examined subtle interactional aspects of video consultations. Examining the detail of interaction is being increasingly taken up in relation to family therapy (Ong et al 2020a, 2020b) and I find it a helpful body of literature to orient me to the transactional processes of moment-to-moment interaction. I then draw the lens in to focus on pre-Covid-19 papers that describe remote family and systemic practice.

Video consultation by health and mental health clinicians has been shown to be an efficient, clinically and cost effective, accessible way of providing a service. It is described as beneficial for patients who cannot travel because of geography, mobility, or conditions which mean they needed to self-isolate (e.g. NHS 2019, Greenhalgh et al. 2016, Greenhalgh et al. 2020, Valentine et al. 2020). Following the evidence that remote health and consultations could work well, researchers across health and social sciences started to examine more subtle, processual similarities and differences between face-to-face and remote consultations, often using naturally occurring healthcare consultations.

This body of research broadly shows that the nature and quality of communication subtly changes when meeting by video link. For example, more informal "chat" and context setting seems necessary prior to the "actual" medical consultation (Pappas and Seale 2009; Pappas and Seale 2010, Stommel, Goor and Stommel 2019; Chatwin and McEvoy 2019). Similarly, rapport is established differently, with longer greetings and endings, including discussion of how the technology is working, and an acknowledgement of how disruptions to the connection could affect emotional attunement within the conversation (Weller 2017).

Seuren et al. (2020) found that in establishing the flow of the conversation, patients and clinicians sometimes wrangled for control to lead the conversation, and questions and instructions needed to be repeated and delivered in a more concrete way. These things seemed to happen before clinician and patient settled into a practice that enabled tasks to be accomplished – e.g. showing the clinician a part of the body or performing an exercise.

Using a data set gathered in 2016, Shaw et al. (2020) found that latency (the technical lag or transmission delay between one participant saying something and the other hearing it) was common in their set of medical consultations using the platforms Skype or FaceTime, but that it was mostly swiftly addressed, often using explicit discussion to clarify who should take the next turn at talk. Their overall opinion was that these technical difficulties did not significantly disrupt the flow of the consultations.

So, drawing broadly from health care, it seems that with small adaptations, it is possible for a clinician and a patient to meet together via video link and for a meaningful healthcare consultation to occur. Can the same be said for systemic psychotherapeutic work, where the focus of the work is relational, where change lies in the spaces between people in relationship?

The use of digital communication for clinical work, supervision and teaching has gradually and pragmatically crept into the practice of all kinds of psychotherapists over the past couple of decades (see for example Edirippulige et al. 2013; Chipise, Wassenaar & Wilkinson 2019; Stoll et al. 2020).

While there are many good recent examples of research on remotely delivered psychoeducative or CBT-informed interventions to families (see for example Zhong et al. 2011; Boykin et al. 2019,;Shaw et al. 2020), and a wealth of hybrid psychoeducative / therapeutic couple interventions (see for example Roddy et al. 2018, Doss et al. 2020), there is far less research that has explored processes or outcomes when working psychotherapeutically in a synchronous (i.e. live) way with couples or families, for therapies in which the fundamental vehicle for change is the therapeutic relationship (Borsca and Pomini 2017).

In 2013 Livings conducted a content analysis of published research in family therapy journals about the practice of online family therapy. Finding ten published papers, she identified themes in relation to legal and ethical issues, particularly in relation to the issues of confidentiality and security; the benefits of online work to clients and therapists, and the use of technology as an adjunct to traditional therapy, for example using emails to scaffold traditional ways of working. She concluded that while online family therapy might be possible and while demand was set to increase, therapists needed to improve their knowledge of technology, they needed to learn how to practice in an ethically sound way, to learn how to incorporate multiple family members into conversation, to develop ways of making up for the lack of direct access to affect and to explore which specific theoretical models might transfer to the online practice domain. The majority of these recommendations remain pertinent today.

More recently, Wrape and McGinn (2018) produced a series of case studies illustrating the challenges of working remotely with couples and families. They highlight delivery challenges of managing privacy

and confidentiality when working with family sub-groups or with people whose screens and talk can be overheard by others; safety of family members during conversations involving high emotions; and the importance of building a meaningful therapeutic relationship with all family members involved in the work.

In the past three months, a number of thought-provoking first-person narrative accounts of working through a pandemic have been published, as have opinion pieces and practice notes on the practice of doing remote systemic psychotherapy (e.g. Fraenkel and Cho 2020; Rivett 2020). These practice-based reflections are resonant and helpful and they contribute to building an evidence base for the practice of synchronous (i.e. in real-time face-to-face communication) video-delivered systemic psychotherapy.

Project context: clinicians' experiences of remote systemic psychotherapy delivery

The onset of lockdown in the UK in March 2020 included instructions from the Government to work at home wherever possible. Therefore, I and my colleagues swiftly moved from our usual practices of working in person with families, either alone or as teams, to working via phone or video. At the start of the lockdown we had very little guidance about how to do this. Guidance was swiftly developed and continues to be honed as experience grows (AFT 2020; Helps et al. 2020). During early trust-wide discipline meetings and supervisory conversations, I became aware that clinicians were being highly creative in working out how to be and how to "do" systemic psychotherapy via phone and video. I wanted to capture their learning to ensure that many others could benefit from it.

Thus, this change, this natural experiment provided an opportunity to quickly learn from doing something different. Using quality improvement methodology, involving a Plan, Do, Study, Act (PDSA) cycle, I therefore sought to explore family therapy clinicians' initial experiences of doing remote systemic psychotherapy. The PDSA cycle is a way of making and evaluating improvements to practice, encompassing phases of action and of reflection (Cleghorn and Headrick 1996). It is commonly used within the NHS as a way of driving improvement of services. (NHS 2018). In view of the context, the project effectively began in the middle of the PDSA cycle: acting to do something different was the first step. Then we studied the impact of the actions so as to learn how to go forward.

The practice setting for the project is an inner-city NHS clinical service and training provider. Because of the specialist nature of the services we provide, families might live far away from our physical buildings, and for some families it can take a day to travel to the clinic, attend an appointment and then travel home again. Systemic psychotherapists all work within multi-disciplinary teams and each team specialises in working with families who present with specific concerns.

Trust staff (many of whom hold both clinical and teaching roles) have used video-conferencing for a number of years in teaching and supervision work. This familiarity and indeed the superb technical support available undoubtedly helped the swift shift to using video technology to provide clinical services. The Trust worked quickly to devise clinical practice guidelines to ensure that video technology could be used in a way that was safe, confidential and adherent to local governance requirements.

Collecting responses from clinicians

I emailed a survey to clinicians who had most quickly moved to seeing families via video link. I asked clinicians to consider each session they had conducted, what if any technical challenges clinicians had noted, what they found was working well, what was tricky and what clinicians thought that they had done differently compared to their usual enroomed practice. Responses were received from twelve clinicians, including me on the basis of 21 clinical sessions.

Clinicians were both qualified systemic psychotherapists (n = 9) and clinicians completing their final training in systemic psychotherapy (n = 3). At the time of responding, clinicians had each completed between one and three remote systemic psychotherapy sessions via video link.

Survey responses were initially analysed by me using a Diffractive Thematic Analysis. An initial draft of the themes was shared with students on the systemic psychotherapy Masters programme at the Trust. A draft was also sent to respondent clinicians. Feedback from these conversations was used to thicken the description of the themes and strengthen the still tentative practice recommendations. Themes and practice recommendations were then rapidly circulated to all systemic clinicians in the Trust in order to inform ongoing clinical work.

Analysing the material

Diffractive Thematic Analysis (Helps 2019) extends the notion of Reflexive Thematic Analysis as described by Braun and Clarke (2006, 2014, 2019). Their widely used six-stage analytic approach involves: familiarisation with the material; generating first material codes; searching for themes; rreviewing themes; defining and naming the themes; and producing a report (Braun & Clarke 2006). They emphasise that these are not fixed stages and that the process of analysis is an iterative and recursive one. They particularly emphasise the importance of taking a reflexive stance to the material i.e. considering the assumptions and values that the researcher holds that will influence their engagement with the material, showing how the researcher is inseparable from the material (Braun and Clarke 2019).

Diffraction, like reflection, is an optical phenomenon (Barad 2007). However, whereas *reflection* and *reflexion* mirror incoming information and "displaces the same elsewhere" (Haraway 1997), diffraction introduces interference and difference, it involves a change in the direction of *stuff* (in this case participants' views about remote working) as it passes through other stuff (my views about remote working). Diffraction is therefore a relational concept, which maps where the effects of differences appear and foregrounds the role of the knower in producing knowledge (Barad 2007; Bozalek and Zembylas 2017).

For me, diffraction seems to convey a more accurate description of what I do when I "receive" material from another person (for example when I read the responses of my colleagues to a survey) than does reflection. I do not *reflect* the material that I receive so that it "bounces off" me but the material goes into me, is processed by me, is mixed up with my knowledge, experience, embodied and affective responses and is then pushed out again into the world.

In practical terms, Diffractive Thematic Analysis utilises the steps outlined by Braun and Clarke and remains open to the "interference" and intra-active entanglement of experiences along the journey to constructing findings. There is an attempt to map some of the interferences (in the context of this project, feedback from those who saw earlier drafts of the themes) and there is an acknowledgement that interference is a complex and not always cognitively overt process.

A note on being an insider-researcher

I am convenor of this project, I contributed to the material and I completed the analysis. While I take full responsibility for the way in which I have constructed the themes as described above, the work of constructing these belongs to multiple, layered conversations and experiences over the past few months with families, colleagues and students. My words come from within living moments of doing remote systemic psychotherapy, from within moments of supervising others who are doing the work and from within moments of exploring others' project responses. This entangled, multi-role position fits comfortably with a Diffractive Thematic Analysis, where difference and movement is encouraged. At the project outset I did not knowingly hold strong ideas about whether remote systemic psychotherapy was a good thing or indeed an effective thing, but I knew that I had found it helpful over many years. My highest context, as a leader, supervisor and clinician, was to find a way to support clinicians to continue to deliver a service. Through the doing of the project, and the subsequent rippling conversations around the themes identified, the practice of my colleagues, both those who contributed initial responses, and those who did not, has and continues to rhizomatically evolve.

Findings: Clinician's reflections on doing remote systemic psychotherapy

I created four themes from the clinician responses regarding their early experiences of remote systemic psychotherapy, summarised as follows: i) practical and boundary issues need careful attention; ii) The conversational flow of remote systemic psychotherapy sessions is different to that during in-person sessions; iii) it is necessary to do things differently with words and bodies; iv) the practice of creating meaningful dialogical communication when separated by screens is hard. Below I give a description of these themes, drawing heavily from the words of the clinician participants.

i) Practical and boundary issues need careful attention

This theme refers to the need to attend to boundaries, both practical and psychological, in a different way when working remotely.

Between two and seven screen-devices were used in each session, shared between clinicians and family members. In line with the need for social distancing, clinicians always joined the conversation using separate devices, but this varied for family members. If families shared the same device there were often challenges regarding whether the microphone picked up everyone's voice. This was particularly the case when families were using their phones rather than a laptop or tablet device. One clinician commented:

"We encouraged family members to sit equidistant to the mic and camera to avoid inequitable access." Who was holding the device, and different family members' distance from the device / microphone,

were sometimes hypothesised to involve issues of power and control, i.e. who got to hold the device and orient it to whomever was speaking.

There was some reflection about overlapping talk, both regarding family talk and clinicians, with one clinician describing the conversation as “stilted” as a result of slight lag. Overall, the technical aspects of conversational flow were generally seen as adequate. One clinician commented:

“To my surprise I did not feel that this was disrupted very much at all. Everyone's internet connection was working well, and there was no freezing or delay with the speech. The sound and video quality was good and this enabled the communication to flow quite naturally. I had to ask the family to speak up a couple of times which worked fine.”

Managing boundaries was noted as a challenging but ultimately engaging issue. For example, one clinician noted:

“One call family was on iPhone and child decided it would be fun to take the phone and show me her house, much to mother's embarrassment - but all okay and good natured. So, something tricky about boundaries, work/ therapy into personal spaces.”

And another commented:

“There is something about being invited in families’ homes which I find humbling. And also, inviting them in our homes.”

And another noted that:

“I had flowers in my background which the young person had commented on informing that they preferred seeing them as opposed to a beige wall. This made me think about the message I am giving if I choose to present a blank wall in my background.”

Both clinicians and families therefore revealed things about themselves and their environments that would not usually have come into the therapeutic space. Managing these boundary issues as well as the conversational boundary issues of who speaks when are important.

Echoing the published research from medical consultations, clinicians noted that the initial set-up of remote working took some time, often before the video session as well as at the start of it. Clinicians noted that they needed to more clearly outline the structure of the session, the way in which session recordings would be made, how people might signify that they wanted to say something and the clarity of roles when there were multiple therapists.

Overall, clinicians were very positive about their early experiences of delivering systemic psychotherapy in a remote format. One clinician commented:

“The quality of the family therapy session and supervision was maintained. Family expressed their

gratitude that therapy could continue and found the reflecting team particularly powerful, perhaps because they were seeing our faces clearly for the first time."

Overall, while there were minor technical issues and boundaries needed to be negotiated in a slightly different way, this was not seen as problematic or detrimental to the work.

ii) The conversational flow of remote systemic psychotherapy sessions is different to that during in-person sessions

Clinicians often commented that working remotely via video changed aspects of the flow of the session but equally noted that this was not necessarily problematic. The Trust initially provided the basic version of the video consultation platform which limits sessions to 40 minutes before the session must be restarted. This restriction was frustrating to some clinicians, but others incorporated the time limit into their session structure, using the end of the first 40 minute block to punctuate the therapeutic session, to reconvene and to move into a reflecting conversation space in a second, shorter, block.

Clinicians noted that families who were already engaged and familiar with a team and screen set-up seemed to adapt particularly well to this remote model. Meeting new families for the first time was experienced as more complex, but not impossible.

Clinicians also reported that the following worked as well as usual: asking risky / tricky questions, giving bad / unwanted news, hearing from all members of the family, setting teenagers up on their own screens, having teenagers who had been reluctant to attend sessions join in as the session was "happening" in their kitchens.

One clinician commented on how they had been able to continue as usual with their creative practice, for example:

"I was able show previous relational patterns that we drew out previously and brought the paper to the screen to show this."

In general clinicians felt that the therapeutic relationship could be maintained. However, engaging with teenagers was a very mixed bag. Three clinicians noted that it seemed easier to connect with teenagers, particularly when they were on their own screens, and four clinicians noted that it was hard to engage teenagers, whether on their own screen or sharing those screens with their parents, due to the lack of visual cues and non-verbal feedback that might usually be noted and commented on.

One clinician noted:

"It was difficult to ascertain whether the young person not wanting to talk was because of the context of a video call, my presence or something else"

Another commented that a teenager had struggled to stay seated on a sofa with his parents while sharing a device between them:

"I feel like I lost the therapeutic alliance I built with this young person in our face-to-face session. I also lost his voice in the session."

Two clinicians noted the way they were able to position themselves in more of an observer role than had been possible when physically in the room with families. Clinicians also noted that they left longer gaps after asking a question to see who might respond, and that they used people's names more frequently to signify who the therapist wanted to answer to the question.

One clinician subsequently noted that using written ways of communicating as of behind the screen worked well:

"Communicating between therapists using WhatsApp to share hypotheses / ideas as one might if sitting behind a screen. There was unanimous view that work could and would carry on in this way."

One clinician commented:

"The lead therapist allowed every family member a voice in the room, including the youngest member of the family who was more engaged than during the in-person sessions that took place in the months before. The conversation flowed, family took turns in speaking and the lead therapist skilfully placed interruptions when monologues went on too long and punctuated important moments."

Overall, the flow of communication was seen to be affected by the mode of delivery but accommodations were made in a straightforward way.

iii) it is necessary to do things differently with words and bodies

Most clinicians reflected on the challenge of understanding the affective communications of the family when not enroomed. One clinician described how they had started to use more "verbal commentary" in order to clarify what their and others' facial expressions might mean. Clinicians noted that reading the room was much harder, for example:

"It wasn't always easy to see the non-verbal cues (e.g. eye rolls, raised eyebrows etc.) made by family members one to another."

Another noted how they had

"Struggled to read how my questions landed when taking a risk due to being only able to see the face due to how they were seated and position of the device."

And another commented:

"Whereas I for instance gesticulate quite a lot in in-person sessions, this may be less useful in a video session. However, describing to the family when we look down – perhaps we are taking notes, when we show our "thinking face" – our faces are more the window and reflection of our thoughts perhaps".

Other clinicians described using bigger gestures, exaggerated smiles or frowns or looks of puzzlement so as to more effectively communicate their feelings and their embodied responses.

The lack of access to the embodied, felt, in-the-room communication was not necessarily seen as a problem, for example one clinician noted

“I believe I am more succinct and clear in my questions, perhaps due to lack of body language”.

There was a worry expressed about what might have happened if emotions had become very high, with comments that practice needed to be slightly different:

“discussion about risk and safety – trying to gauge how worried to be, needed to ask lots more detailed questions”.

There were notably no reports that strong emotions had not been managed safely. Overall clinicians seemed to express concerns about building or maintaining a meaningful therapeutic relationship, that included dialogical conversation.

In sum, while there was a general acknowledgement that words and bodies were used slightly differently in the remote context, clinicians seemed to feel that this was not necessarily problematic and that it might even create benefits for their practice.

iv) The practice of creating meaningful dialogical communication when separated by screens is hard

Clinicians frequently commented on how hard it was to engage in dialogue involving all parties, in that the conversation seemed to involve sequential monologues rather than active dialogue.

For example clinicians noted that family members sitting together often talked to each other and it was hard to hear or hard to intervene. One clinician commented that

“mother and son talked over each other a lot but this is normal for them.”

Another commented that:

“Co-ordinating reflecting team comments sounded more like three separate reflections, we will work on this.”

Regarding families talking together, clinicians remarked that it was difficult to follow the conversation between family members who shared one screen, for example:

“I found it tricky when the family members who were in the room together (mother and two teenagers) shared comments among themselves that were inaudible and not directed to me. This happened a couple of times, mainly between brother and sister- who would sometimes speak to each other. In the room of course this would be less likely to happen, or if it did you could incorporate what they might have shared into the dialogue however I sometimes felt unsure/ left out of what they were saying and

had to encourage them to remain focused with the session."

Thus, there was a general view that the video platform constrained the kind of messy, partial, overlapping, conversation that is so common in systemic sessions and that something might have been lost as a result of this.

Discussion of findings: What have we learnt about doing remote systemic psychotherapy thus far?

In this paper I have described a rapid quality improvement project designed to learn from the early experiences of clinicians who moved their systemic psychotherapy practice online. Four main themes were created from survey responses received from 12 clinicians based on 21 clinical sessions. Diffractive Thematic Analysis highlighted: practical and boundary issues need careful attention; the conversational flow of remote systemic psychotherapy sessions is different to that during in-person sessions; it is necessary to do things differently with words and bodies; the practice of creating meaningful dialogical communication when separated by screens is hard.

Overall, systemic clinicians' experiences broadly fit with that already described in published health, mental health and psychotherapeutic research. The current findings contribute to the development of practice-based evidence about doing remote systemic psychotherapy.

Contrary to previous research (Livings 2013; Wrape and McGinn 2018), clinicians did not raise concerns about the ethics of working online or issues of consent and confidentiality. Perhaps this was because in the context of the Covid-19 pandemic, the choice about *how* to work was largely removed, leaving a binary choice to meet remotely or not meet at all. Perhaps the time that clinicians took to discuss video consultations prior to actually starting the sessions was vital to ensuring that everyone, clinicians and family members, felt safe to converse in this way. It is also possible that clinicians and families alike were experiencing a great deal of unsafe uncertainty (Mason 1993) whilst knowing that everyone was trying to do their best in unprecedented and unchartered circumstances.

Further, although it has been identified in the broader healthcare literature (e.g. Shaw et al. 2020), latency or lag was not identified a particularly significant issue during the sessions. This may be a function of swift developments in technology and perhaps the specific functionality of the video consultation platform that we were using. This finding is very encouraging given the clinical importance placed on noticing, understanding and using hesitation, lapse, pause and silence within therapeutic conversation (Rober 2002; Helps 2019).

Overlaps in talk both between family members and between team members were reported. It is possible that overlaps were heard as a result of lag and latency but not recognised as such. Overlapping talk did not generally appear to happen any more than when enroomed, but its management was addressed differently in the remote environment. Whereas eye contact and hand gestures might commonly have been used in the face-to-face setting to encourage a person to start or stop talking, the challenge of overtalking was solved by clinicians using explicit verbal invitations regarding who might talk next.

The number of participants in an in-person conversation has been reported to effect the way in which the conversation unfolds in a variety of ways, one of which being how schisming (Egbert 1997) can occur when there are four or more participants. Schisming refers to how with four or more people, multiple conversations start to happen which run alongside and criss-cross each other. Schisming seems a helpful focus of future inquiry in video-conducted multi-actor conversations.

Given the importance that systemic psychotherapists place on being in and doing dialogue, (Seikkula 2011) the complexity of doing exploratory and deep listening and talking in the remote context is a concern. While sequential monologue or even additive dialogue seems possible, video link platforms do not facilitate the kind of overlapping, messy, conversation that is so familiar within groups of connected and connecting people. This particular challenge might again have to do with technical aspects of how sound is processed by video consultation systems or by lag, which means that it is harder to manage the ordinary to and fro of a conversation or to interrupt, question and build on others' comments, but given the minimal technical difficulties reported this seems unlikely. It might also have to do to with the way in which intimacy is differently navigated when communicating from different spaces. It might also relate to how in the context of this project, all actors were in the very early stages of communicating via video link.

The primary vehicle for change in systemic psychotherapy is the psychotherapeutic relationship. That relationship is based on exploratory (as opposed to additive) dialogue and on the experience of dialogue, of co-presence, of being heard and felt. Participating in generative, truly co-creative and meaning-making dialogue can be done remotely, but it takes commitment, practice and innovation (Boe et al. 2017). Part of that experience relates to how our brains and bodies attune to each other as we act together (Dikker et al. 2017). Exploring if and how it is possible to do in-depth interpersonal and intra-personal, dialogical work, particularly when there is no pre-established therapeutic relationship, will be vital in coming months.

Many video conferencing platforms provide the opportunity to see oneself on screen at the same time as seeing everyone else whose cameras are switched on during the call. None of the clinicians made any comment about the affordances or constraints of being able to see themselves as they conducted sessions. This might be because systemic practitioners are so used to recording their work and reviewing themselves on video so as to improve their practice. While the remote consultation reduces what we can see, feel and experience of the families with whom we work, this added window into what others see of us warrants further exploration. This would seem to have great utility in terms of self- and relational reflexivity, (Burnham 2005) and to learning something new about our practice.

All communication is a complex social interaction but is particularly intense in the therapeutic relationship (Iedema et al. 2019). As experts in close observation of patterns of communication, systemic psychotherapists know that the frame of the conversation will affect how all people present (Goffman 1956). The potential for editing the online self, for presenting *this* rather than *that* aspect, affords different possibilities and constraints to that in real-life (Bullingham and Vasconcelos 2013). Given our current context of remote delivery of psychotherapy, the performance of the front-stage self might differ due to circumstance rather than active choice, as we all interact from our kitchens, bedrooms and domestic environments and we might have to work harder, to use additional signifiers (for me it has involved ensuring that I dress formally for work, that I wear earrings and have books and

plants around me) to perform an authentic sense of self. As a discipline we are increasingly embracing the embodied turn (Nevile 2015) and now have to find ways of turning embodied responses that might not make it through the screen into language, so that they can be worked with. Finding ways to "do" embodied work when distanced by a screen is therefore a huge challenge.

Limitations of the project and future directions

This is a small-scale project using material that I gathered quickly from a small number of clinicians working in one UK trust. Whether these experiences resonate with clinicians in other services or countries remains to be seen. The clinicians who responded had quickly switched to seeing families via video link and so were perhaps more positive about this way of working than clinicians who took some weeks to starting working in this way. Given my hierarchical position in relation to the clinicians and students it is possible that responders sought to provide positive responses that they thought I might like and so did not describe their challenges in great details.

There are solid concerns across the field of psychotherapy that video consultation will not be as "good" or effective as enroomed psychotherapeutic work (Russell 2018). Continuing to learn from feedback from clinicians and families in this natural experiment of remote working is required, as is gathering material about what actually happens as well as what clinicians think is happening within their remote practice. Just because we can do remote systemic psychotherapy does not mean that we should always do it. The clinical reasons for doing it and the ethics of when and how to do it need ongoing consideration.

While some evidence exists (see for example Wade et al. 2020; Dross et al. 2020; Datta et al. 2020), we do not yet clearly know which people facing which presenting problems will be best suited to maintaining this way of working. Likewise, it is not yet clear how families find remote service delivery. Early practice-based experience suggests that families find remote systemic psychotherapy acceptable, accessible and engaging, but it may be that some people are disadvantaged by remote consultation. More generally, there is a need for an exploration of how age, material resources, culture, language and other issues of social difference intersect at a micro as well as a macro level within remote psychotherapeutic conversations. It must not be assumed that all families have a safe-enough space, good-enough technology or sufficient WIFI to participate in remote systemic psychotherapy. This needs careful assessment at the start of any work.

What the project has provided is material on which we can build future cycles of exploration, to help us learn how the change to mostly working remotely is affecting the delivery of services and ultimately whether this impacts the quality of the service provided.

Findings from this project suggest that there are many similarities between what we do when working in-person and when working via video link. We need to hold on to the similarities and continue to explore the subtle communicational and interactional differences that might have an impact on the effectiveness of the work and on the therapeutic relationship. We particularly need to work out how to do dialogue in which living, lively and attentive communication can occur between enscreened people (Seikkula 1993, Rober 2005).

I long to be sitting in my clinic room with a family, to engage with bodies and movements and feelings and words in ways that I feel competent and confident to do. The rare times that I have done this in recent months have been rich, intense, and also bizarre given how we have covered ourselves with personal protective equipment and sat in echoey rooms usually designed for lecturing 80 people. Is it better to work with families while wearing a face covering and sitting at a two-metre distance in a cavernous space or to work remotely with a family while we each sit more comfortably in our home environments? Is it better to sit in a room divided by a physical screen of plastic or to sit in separate rooms connected through the internet? And what difference will the ongoing presence of Covid-19 make to how we and the families we support feel safe-enough to do?

What is abundantly clear is that adopting remote ways of working involves relational bravery on the part of all participants. It involves navigating unchartered waters. Perhaps over the past four months sailing these waters has shifted from feeling unsafely uncertain to, at least for some, a place of safer uncertainty (Mason, 1993). Still there is much to learn. Ongoing PDSA cycles alongside diffractive considerations of experience provide a useful framework in which to gather practice based evidence and to share and grow our learnings.

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