Lockdown Learnings: No Longer the Mirrored Room

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During the COVID-19 lockdown in Aotearoa/New Zealand, a discussion panel was convened comprising of family therapy students and experienced family therapists to investigate the effects of the use of online digital mediums for family therapy. This article discusses the learnings from that panel. It seems that the use of a screen can change the power dynamic between therapist and client family, perhaps levelling the field slightly and resulting in implications for the therapeutic relationship. Suggestions for practice are given and the situation is likened to that of the ‘mirrored room’ proposed by Hare-Mustin (1994).

Keywords: COVID-19, family therapy, reflections, screen, mirror, team

Key Points

1. Practitioners should be aware of the difference that using a screen may make to the therapy situation. Specifically that power and agency are changed by the use of the screen. The screen seems to function almost as a partition.
2. It is important to ensure that practitioners have a discussion with client families regarding the set-up of therapy particularly with regard to risk prior to commencement.
3. When using the internet to meet with clients, practitioners need to ensure their own self-care needs are met adequately.
4. Ideas for changing interventions to work in online situations are provided.

Aotearoa/New Zealand’s 2020 COVID-19 lockdown experience was relatively short compared to many countries. For the majority of the country it was five weeks of strict lockdown (level four of the four-tier system) from 26 March to 27 April 2020, then level three until 14 May 2020. Our largest city, Auckland, went back into level three for three weeks in July/August as a large cluster emerged there whilst the rest of the country remained largely virus-free. Lockdown for Aotearoa/New Zealand meant only essential workers were allowed to leave home to work. Everyone else worked from home or didn’t work. Schools were closed, and we were allowed out of the house only for exercise, to get essential supplies, or for medical attention. Travel outside our local area was prohibited and only one person per household was allowed to shop. Social distancing was required when in public. The Prime Minister, Jacinda Ardern, and Dr Ashley Bloomfield (Director General of Health) appeared on media daily to reinvigorate the message to their ‘team of five million’ to keep the rules to stop people dying. Therapists were able to see clients in crisis face to face throughout, but most chose to use a platform such as Zoom to see families to keep up the distancing necessary.

During the lockdown period, I convened a discussion panel over Zoom for the benefit of students on the family therapy program I lead for the University of Otago.

Only one of our panel was from outside Aotearoa/New Zealand, from London. In late March in London most public mental health services had closed to face-to-face
work and clinicians moved to remote work almost overnight. The majority of psychological therapies delivered in the public sector, individual and family, have continued to be conducted remotely and are unlikely to change for some time.

All the panel were very experienced family therapists practicing in both the public and private sectors. We were interested in family therapists’ experience of using a platform such as Zoom with clients, and how this might change their family therapy practice. Hare-Mustin (1994, p. 3) said: ‘The therapy room is like a room lined with mirrors. It reflects back only what is voiced within it. When there is a one-way mirror and reflecting team, they too reflect back what has been provided.’

How might this new type of mirrored room shape the discourses that were prevalent? What muted ones might emerge? This article explores the themes we discovered, links them to practice examples, and gives some ideas for ‘best practice’ for ongoing work. Although I am the author of the article, the ideas have come from a collaboration of the group of people involved in the panel discussion.

Two Brief Practice Examples

Denise, John, and Pippa asked for a family therapy session over Zoom. Denise arranged the medium of communication before the therapist could, inviting her to a ‘Google hang out.’ The ‘hang-out’ invitation was accepted and the therapist turned up at the arranged time. Denise’s mother came alone into the room, approached the camera, and told the therapist that only John and Pippa were going to attend; she and Denise were going out for a walk as they needed a break. Before the therapist could answer she had gone, leaving the slightly bewildered John and Pippa behind to speak to the also slightly bewildered therapist.

Jason, Clara, and their three teenagers agreed to a Zoom meeting, to continue the family work they had been doing together with the therapist. The camera showed their lounge, with them all sitting in various odd chairs to try and fit in the camera frame. Clara’s mother was also present, and the teenagers were getting her a chair to squeeze in between them as the session began. The camera was quite a long way from the family so that they could all be in the frame, but it was still obvious that it was preferable for two of them to absent themselves from the picture, as they often moved in ways that took them out of frame. In the middle of the session Jason got up to ‘check on the dinner’ and was gone for several minutes.

Reflections

These are just two examples of how the camera and associated screens seem to function as a partition between families and therapists, changing sites of power and control, perhaps a distinction that does not exist so obviously in the usual therapy space. The virtual ‘room’ is not a shared space; it is a window into your space, and into my space. Does this change the types of conversations we have or the way we have them? Does it influence the discourses open to us?

Neither space is co-habited by the family/therapist system together as it would be in a therapist’s office, or in a family’s home. Families can therefore take more control over the presentation of their space, including where the camera is aimed, and who is in the frame. There seems to be less inhibition about moving around, doing other
tasks, participation, changing the process, because families are in their own space and they are in charge of it. From the therapist’s perspective, as with home visiting, the ‘expert’ power dynamic is different because of this ownership of space.

The idea of ‘Tūrangawaewae,’ a Māori value, is useful here. Tūrangawaewae means ‘the place that I stand,’ and it is a powerful assertion of the value of whenua (‘my place’ or ‘land’) for whānau (families). When as a Pākeha I am welcomed onto a marae, it is made clear to me that I am manuhiri – visitor – and that the tangata whenua are the ‘people of the land’ for that marae. I am reminded of this distinction when I see people over Zoom: it is their land, not mine, they are the people there, and when I shut down my camera, they will be there and I will be here.

In turn, the land I am in, my home in lockdown, is mine and not theirs. They do not attend my space either – though there is an unusual reaching through that many of our team experienced. Families seemed more curious about therapists, more concerned that they were cared for and coping, than when the therapist was visited in a more official space. So the lens goes both ways – the camera turns back on itself. This reminds me of ‘the panoptic gaze’ – Foucault’s ideas about the way people act when they are watched and how the very act of being watched can be constitutive (Foucault, 1977). And in fact, on Zoom, the camera does show the therapist in the frame as well, so as well as watching the body language of the family system, the therapist is watching their own body language.

How many of us are bewitched by ourselves? Hypnotised and addicted to watching how we look when we respond to families, or how we look when at rest and listening? How are we informed by this gaze on ourselves? How are the family changed by being gazed upon? And how does the family feel about watching themselves? How does this immediate feedback impact on their ways of acting and interacting with each other?

In a world where we want families to be collaborators, holding their own power, the digital platform is an opportunity to work more on an equal footing, but equally, quite challenging to a therapist who has developed ways of managing families in their own space. For us at least, there was a transfer of power to the family, and the therapist having to work differently to ‘reach’ through the screen and manage such issues as dinner on the stove, the dog licking the camera or family members changing the rules of the session.

Of course, social constructionist frameworks would postulate that we should have already given up this expert role – so the family can manage it themselves – as with the first family example. Most agencies in Aotearoa/New Zealand find this stance too challenging, as they are tasked with ‘fixing’ diagnosable problems, and required to demonstrate both problem and solution – thereby inherently naming them as experts, families as lesser. Some agencies in lockdown attempted this – they put the power of the session into the hands of the family, asking them to prioritise their family and home needs over the need to do a ‘normal’ session. If children or other needs dictated, the session came second.

As for this change in location – how is it for the family? What is it like for the family to see the therapist in their home? Does it invite them into the therapist’s world? What about when children, pets, or other noises from the therapist’s home interrupt the therapy? How about when therapist uses virtual screens behind them? Does this change the experience again? We began to wonder about how families were experiencing this change in location and process. What did they think about their own power in this situation?
It seemed that families who had already met the therapist found it easier to adjust to Zoom sessions – although this was not always the case. Children with sensory or anxiety issues reported finding it more comfortable to stay in their own space for therapy, where change or surprises were less likely to occur. Other families reported that the gaze of faces from a mobile device was too intense, and opted for phone contact or just to wait to resume face to face. Still other families found that they liked the Zoom contact, and kept it up when ‘normal service’ resumed, as well as therapists noticing that they increased the ‘in-between’ contact, using emails, letters, and phone to do this.

There were many examples of family dynamics being shown in the ways that families attended Zoom sessions. For example, some families would attend on different devices, from different rooms in the house – defining the space between them. Some would attend from work and home to the same session or from separate homes. Some families found interesting ways of communicating their feelings – as the usual body language doesn’t convey well enough digitally. Shaking the device or using exaggerated gestures was a method employed to convey emotionality. And there were many examples of the COVID context influencing families, with many experiencing job insecurity, loneliness, and many over-burdened with caring for each other, children with schoolwork, and ensuring work was done too.

Adapting face-to-face practice for working remotely

It also seemed really important to change specific interventions to match the new setting. For example, instead of doing a ‘sculpt’ with a family, the family could be invited to share onscreen photos that demonstrated their family structure. In response to future questioning, the family could look together for photo examples of ways they would like their family to be – *unique outcomes* were easier to come by, as cameras often capture behaviours that are otherwise subjugated.

Some therapists experimented with tasks that could take place in the family home, for example, indoor scavenger hunts, where the family members work together and then join together for a reflection. This again put the family in the position of leading as the therapist could only observe a part of the experience.

Lockdown exacerbated difficulties for those with eating disorders and also led to an increase in referrals. Different ways of supporting families were rapidly developed including groups for families and friends, support for parents and partners as well as family and couple therapy. Often the whole process of engagement happened online as new referrals during lockdown necessitated this.

So far I have been describing individual therapists’ experiences with families over Zoom. Two of our group belong to a team accustomed to using a reflecting team process in viva. They decided that they would not have a ‘team’ approach over Zoom, but change to a co-therapy team, without a reflection. They hypothesised that the ‘gaze’ of a team would be too intense via a camera on a mobile phone, and also that they could not show all the team’s faces this way, so to decrease this power, they removed the reflecting team. Their experience was that this was a loss to the process. The reflecting team is experienced as a valuable and important part of the therapy offered and the same outcomes could not be achieved with a different process.
Addressing practicalities and setting boundaries

There was a lot of talk in our group about managing risk from a distance. And what about emotional safety? Again, the actions that a therapist can take because a family is at their premises are lessened by the distance imposed by the internet. However, the responsibility of the clinician to help manage this remains. Some therapists found that instead of allowing a higher level of expressed emotion in the session, they were working with clients on managing the emotion and keeping life ‘calm’ as our Prime Minister Jacinda had encouraged! ‘New Zealand, be calm, be kind, stay at home’ (Wade, 2020).

How did this feed into family homeostasis? Were there times when issues were dismissed because of their potential to inflate emotions? How were we to deal with this safely through a screen?

To counter these issues our panel had some suggestions as follows.

- Ensure that the therapist is aware of the physical addresses that all participants are at and has current contact details for all.
- With clients for whom there is identified risk, have a conversation at the beginning of the session about where to go for support after the session should they need to – this might be a safe physical address to go to – and discuss how they might get there during lockdown conditions, or identify a connection that could be accessed digitally.
- One model of intervention developed in situations with a high risk of conflict is where work is undertaken with the parental sub-system whilst the client is in individual therapy, and then everyone is brought together for a session with the option of separating during the session if things become too heated.

Setting a secure base and rules for the work with the family formed a major part of the initial engagement. Ideas included the use of rituals to mark the space and time of the session, for example, changing the lounge room to the therapy room physically for the session, and then changing it back by moving furniture purposefully. In this discussion the family and therapist could decide when someone might leave the screen, who was allowed in the room, whether to record the session or not, what to do if technology broke down – all topics that could lead to interesting family discussions exploring relationships, power, and agency.

Another identified risk was that of mental health services being unable to reach those who needed it most. A major barrier in areas of poverty and deprivation has been the availability of devices, a sufficient data package, a reliable internet connection, and privacy to make the call. Often these are the families who are struggling most in the pandemic, the people who are already facing barriers to accessing services leading to further discrimination. In the UK COVID-19 and the Black Lives Matter movement has brought into sharp focus the stark inequalities within society impacting on both physical and mental health particularly for those from Black, Asian, and minority ethnic backgrounds.

Therapist self-care in the Zoom age

There was a focus on the importance of therapists looking after themselves. Everyone had noticed that the constant communication through a screen was exhausting, especially those needing to attend many meetings with colleagues as well as families. The
increased energy and attention needed to read body language was tiring and diverted attention from other themes. There were also our own families to manage, with children needing schooling, teenagers needing consoling, and partners needing space as well as the worry of family members separated by closed borders or enforced quarantine. There were many demands. The opportunity to get away from these demands of course was limited. In Aotearoa/New Zealand we were allowed outside our homes for exercise, but only locally. That meant that some people walked around a city block, others had access to the beach. Some might see nobody on their walk, others would meet a small army of others out for air. Having been on screen for much of the day, many people did not want to access screens for relaxation, potentially creating tensions with their families and friends. There was more of a focus on creative tasks to help with this – some of our panel wrote songs and comedy scripts, publishing them on YouTube, others made cakes and cider, others constructed things, knitted, and cleaned. Some went to bed with the cat. There were many ways to self-care but everyone found it important to consider themselves.

And of course, the most important question: What is the effect on outcomes for families when using a digital medium? Does the ability of the therapist to read the room or individual body language have an effect on the outcome of the therapy? Did the change from a reflecting team process to a co-therapy team affect outcomes for families as well as therapists? We wondered whether the screen acted like a one-way mirror – that in being a little more divorced from the family, it was more tempting to see them as it were from the outside. What did this do to our connection, to our need to consider our influence on them?

Do I sit more in an ‘expert,’ first-order position – because of concern about risk, the need for structure in order to facilitate talking and listening and because I am less clear as to the responses of the family without all the different sensations experienced when in the same room? How do I interpret cues when I cannot see their whole body? How do they see me and interpret my reactions? How is communication changed when the internet connection is poor and picking up on subtleties of tone is so difficult?

Equally, we might wonder whether the family was allowed more influence over themselves by us as therapists? Perhaps the ‘partition’ created by the screen allowed us to take less responsibility, thereby creating space for more agency on the families’ part. Can the family have these conversations without the therapist? Can they make changes that they have determined alone? Does the therapist need to be taken care of too? These are new discourses that can be allowed into the room.

**Conclusion**

As a group we began this panel discussion with many questions. How would the experience of Zoom or ‘telehealth’ change the way that therapy occurred? How would it change the experience of the family, the therapist, and the therapeutic system? Does the changed format alter the conversations that we have with families? How are we informed as therapists by the gaze on ourselves, and how are the families changed by being gazed upon? In the service of risk avoidance have we diluted our interventions too much? And of course, what is the effect on outcomes for families of this new mode of therapy? As is critical for family therapy, questions are
interventions in themselves. Perhaps we don’t have answers for all of them, just more questions that arise.

Digital therapy has changed the experience in many ways, but the old issues of power and agency are still foremost. How do families want to be considered in therapy, how much do they want to be in charge of conversations, how much do we want to be in charge?

A newer issue, care of ourselves, has become more critical – the space the therapist inhabits seems to be as important as the space of the family. Families were wont to be very aware of the self of the therapist, to have concern for them, and to expect that they were being cared for too. And this was a new message from both clients and government – that being compassionate to ourselves is an integral part of remaining available as caring professionals.

And instead of a mirrored room reflecting back at us and the family, perhaps it is a window that we are looking through – albeit sometimes a dirty one – through which we may consider one another on more of an equal footing.

Perhaps we might answer that question posed at the beginning – Does the virtual room change the types of conversations we have or the way we have them? – with a simple ‘Yes, it does.’ And thank goodness it does.

**Postscript from London**

When I participated in the June 2020 panel discussion for the Families and Systems Therapies program, University of Otago, I could not have imagined what London life would be like eight months later – so different a position from the lives of my family, friends, and colleagues in Aotearoa/New Zealand. Now in November 2020, we have just finished a second short lockdown though like most of the country we remain under restrictions. Details of the proposed vaccine roll-out changes almost hourly. Working remotely is now our ‘new normal.’

As therapists we have gained in confidence and become more familiar with the technology, different ways have evolved in adapting interventions commonly used in the face to face. Remote family therapy clinics have evolved, ranging from two clinicians working together – one leading, one reflecting – to training clinics with reflecting teams where the team turns off their cameras during the session and on again when they reflect, recreating ‘the mirrored room.’

As time has passed the level of burn out and Zoom fatigue after many hours in front of the screen has become a major issue for many of us. How as a clinician do I remain curious, empathetic, and alert to the wider context when I have spent much of the day on a computer looking at a computer screen. How do I organise my working day to take into account my own needs in order to meet the needs of my clients?

When there is the opportunity to go back to face-to-face working what learning points will we take with us? Will many more therapy services continue online and will that be the choice for many families? When we start to evaluate outcomes and client feedback as we surely will, what will we find? What of the trainees whose experience has been largely online? How will they transfer their existing skills?

Telehealth is surely here to stay in many parts of the world and training and practice will need to evolve to reflect this.
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Notes
1 The panel convened was made up of Bruce McNatty, Terry Ebeling, Rewa Murphy, Liz Dodge, and myself. Kate Ross-McAlpine, Megan Weir, and Tessa Grafton formed the student group.
2 Cases mentioned here are an example of the kinds of ways that families presented; they are not real families.

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