
Imagination and Play in Teletherapy with Children



LYNN BORENSTEIN

The author describes how, during the COVID-19 pandemic, clinicians embraced telehealth for vulnerable children struggling with intense feelings, learning challenges, and isolation. She suggests that generating playful engagement, however difficult without the toys and comforts of the traditional office, remains crucial. She discusses the stresses of the telehealth experience and the importance of identifying and mobilizing a child's initiative and agency in this setting. She asserts that, when clinicians maintain empathy and share how they imagine children's experiences, a joining can occur that lessens the children's sense of isolation and emotional hurdles. She then concludes that, if a clinician's imaginative self becomes engaged with that of a child, spontaneity and forward movement are possible even when employing the medium of telehealth. **Key words:** clinician's empathy; imaginative play; sense of agency; telehealth.

Introduction

WITH THE ONSET OF THE COVID-19 pandemic, telehealth suddenly became the safe place to offer therapy to children, a space devoid of the requirements to mask, sanitize, and socially distance. For children previously seen in the therapist's office, telehealth offered to bridge physical distance and enable continuity of care. For new patients with access to the required technology, telehealth offered the possibility of receiving treatment during a perilous time.

Although new to many, telehealth has been used for mental health care for over twenty years, both in the United States and globally, typically for psychotherapy with those unable or unwilling to meet with a clinician in person. Veterans suffering from posttraumatic stress disorder (PTSD) have used telehealth services when they are alone, allowing them to access help (Chen 2019). Rural families without local services have been able to access care. Even when face-

to-face therapy is available, some individuals in rural areas prefer teletherapy with a distant clinician because they worry about confidentiality or encountering their therapist out of session (Nelson 2010). In both urban and rural areas, parents have found that the time and travel connected with the press of everyday concerns have made teletherapy a desirable choice. Telehealth allows patients access to experts when specialized diagnostic or treatment skills are required. For example, Wade and her colleagues (Wade et al. 2020) found telehealth to be effective in teaching problem solving and parenting skills to parents of neurologically impaired children.

For the practitioner, telehealth offers the opportunity to broaden practice geographically without the inconvenience and expense of travel. Indeed, clinicians sometimes use both in-person and teletherapy sessions with the same patient. Video sessions are facilitated by “residual trust and understanding when the patient has been seen face to face” (Russell 2018, 156).

Although embraced by many, telehealth is not without its critics. Hoffnung and colleagues (Hoffnung et al. 2020), in their study of forty thousand children served through telehealth, noted that many of them struggled with communicating and sustaining attention in this medium. Children using e-learning for school and then in telehealth were especially challenged. As Russell (2018) emphasized, “What is important here is the necessity to understand exactly what is taking place when we treat another human being via technology: what succeeds in getting through, what gets transformed into something different, and what is degraded or lost along the way” (154). Lemma (2017) noted that “body language, facial expression, and the pheromones [chemicals released during in-person interactions] fundamental to establishing human relationships [are] all missing in online psychotherapy” (91). Psychodynamic practitioners face the additional challenges of managing and monitoring transference and countertransference issues in the virtual world. Prezant (2021) and Sayers (2021) found that the rapid adjustment to telehealth proves particularly stressful for psychodynamic child therapists. Given the myriad stressful aspects of telehealth, no wonder zoom fatigue has been commonly reported and has become a focus of research (Shklarski, Abrams, and Bakst 2021; Burgoyne and Cohn 2020).

Whether in face-to-face therapy in our offices or via telehealth, play is an essential mode of communication in working with children. Given its centrality in the therapeutic relationship, how play is best adapted to the new environment proves of critical importance. My purpose here is to discuss the challenges of play as we transition from the traditional office to telehealth and also to elaborate

and illustrate—through case examples—the use of my clinician’s imagination to engage young patients therapeutically in the new medium. As background, I will discuss the stresses children have faced in the pandemic and the history and role of play in the therapeutic relationship.

Stressed Children and Diminished Play in the Pandemic

With the COVID-19 pandemic, everyday reality changed dramatically in ways hazardous to child development. Children experienced—and tried to integrate—a seriousness brought by the pandemic that often surrounded them both at home and in e-learning at school. Families grew weary, worried, and impatient. Parents became more anxious and introduced new rules: wearing masks, avoiding group activities, and the like. Children were often exposed to talk of illness and death beyond their capacities to understand and integrate. Routines changed: many children no longer shopped with a parent, met playmates at the park, took the bus to school, or stopped at a grandparent’s house for a hug and a snack.

Even as children faced increased stress with the pandemic (Fergert et al. 2020), opportunities to play and connect with peers declined with mandates to maintain social distance (Loades et al. 2020). Free play in recess became restricted. For younger children in nursery school and day care, toys were frequently removed and cleaned and no longer spontaneously shared. For older children, sports teams and after school clubs were suspended. When parents worked from home or looked for work online, children were asked to be quiet, further dampening their play lives. A floating seriousness covered the family landscape. For vast numbers of children, the opportunities for active physical play diminished—and so did the sense of playfulness and the ability to play.

Changes in the family and social environment that constrict play have significant consequences. As Panksepp (2008) emphasizes, “Physical play should be part of the daily social diet of all children throughout grade school.... The playfulness intrinsic to childhood should especially help us promote the growth and maturation of the social brain” (55). Panksepp underscores the need for ample rough and tumble play.

Pandemic stressors added to the emotional burdens children already carried. The distress children experienced, coupled with the diminished opportunities to play, required those of us who are clinicians to find creative ways to foster

the therapeutic relationship in the virtual environment. Developing new ways to play was central to this task.

The Importance of Play and Playfulness in the Clinical Setting

The belief in the primacy of play in therapy with children has a long tradition in both theory and practice. Early psychoanalytic thinking established the centrality of play in the lives of children (S. Freud 1908; A. Freud 1965; Klein 1955). Sigmund Freud (1908) writes, "Might we not say every child at play behaves like a creative writer, in that he creates a world of his own, or rather rearranges the things of his world in a new way which pleases him? It would be wrong to think he does not take that world seriously; on the contrary, he takes his play very seriously and he expends large amounts of energy on it." (143). Klein (1955) pioneers the use of play to illuminate children's anxieties, defenses, and internal struggles both conscious and unconscious. Anna Freud, lifelong child advocate and founder of child psychoanalysis, underscores the importance of play, therapeutic alliance, child development, and work with parents and educators (Goldstein et al. 1973).

According to Winnicott (1971), psychotherapy with children "takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. . . . Where playing is not possible, the work done by the therapist is directed toward bringing the patient from a state of not being able to play into a state of being able to play" (38). He proposes that playing is "inherently exciting and precarious. The precariousness results from the interplay in the child's mind of that which is subjective and that which is objectively perceived" (50). Ruth (2006) expands on Winnicott's notion of precariousness in play, writing, "Precariousness also belongs to the creative, improvisational process that occurs between two play partners as they negotiate the shared creation of joint meaning and joint direction" (143).

Solnit (1987) coins the term "play state" to describe when children are available in play mode. He writes, "Play is pretend, another way of using the mind and body, in an indirect approach to seeking an adaptive, defensive, skill-acquiring and creative expression. . . . Play enlarges the child's sense of himself, his capacities and his effectiveness in altering the reality in which he lives. In that sense, play enables the child to explore safely how he can become active in

shaping his world and not feel helpless or dependent on it more than he prefers or can tolerate” (214–15).

According to Slade (1999), play is of “enormous value clinically and developmentally with children who cannot play coherently or meaningfully, who cannot use symbols of play and language to make sense of their emotional experiences, who cannot create narratives for their experiences” (89). When children have difficulty making meaning on any level, play offers the possibility of a psychologically organizing experience.

Yanof (2013) describes play as the cocreation of “new lived experience that can be reorganized and reintegrated into a different narrative. Rather than finding a definitive meaning in a particular piece of play, it is often the ability of the therapist to help the child to elaborate different meanings that is the most useful” (261). In considering the role of transference, she explains, “when children feel something about the therapist, they feel it in the present moment, and it seems very real to them and very big. Rarely do they understand that the strength of their feelings exists because the therapeutic relationship has triggered something from their past or from their current family lives. Because it is difficult for children to comprehend the paradoxical nature of transference, it makes sense to address what is happening between child and therapist in the present and to understand the moment” (270). Such “moments” often occur in play.

Play and imagination are inseparable. Agnati and colleagues (Agnati et al. 2013) define imagination as “the act or power of forming mental images of what is not actually present or has never been actually experienced. . . . Imagination not only has the potential to enrich the meaning of an experience and deepening understanding, multiplying and expanding the perspectives, it also allows anticipating the outcome of action without actually performing it via a simulation. At its peak, imagination is the very mental faculty underlying visionary and creative thought” (2). As described by Brown (2010) our imaginations allow us to “create simulated realities that we can explore without giving up access to the real world. . . . Imagination remains a key to emotional resilience and creativity” (83–87). Schaefer (1993) points out that play enhances problem-solving skills and encourages creativity and flexibility because it provides opportunities to “experiment without fear of negative consequences” (7).

Children without imaginative, physical, and pretend play lose their ability to unwind, to recharge their psychological battery, to feel a sense of aliveness and purpose—all capacities sorely needed during the pandemic.

According to Hobson (2002), through imaginative play, pathways to inti-

macy and understanding are jointly created. It is in the realm and space of play, suspended from everyday reality, that a child finds the freedom to have flights of imagination and try on new ways of being. Imagination calls on memory without the constraints of reality. “You weren’t supposed to win!” “I wanted to be blue today.” “You are not the mom; you have to be the little sister” (76). Singer and Singer (1992) describe the importance of possibility in imagination, “what might be, being able to move in perception and thought away from the concrete given of what is, what could have been, what one can try for, what might happen, and ultimately to the purest realms of fantasy . . . a touchstone of that miracle of human experience, the imagination” (19).

Play serves a myriad of functions for children, helping them heal, engage with the therapist, and even develop neurologically. Erikson (1976) emphasizes that “‘to play it out’ is the most natural self-healing measure childhood affords” (475). A primary goal of play is engagement with the clinician. The Boston Change Process Study Group (BSPSG) (2018) notes that engagement and the sense of the therapist being a “charged other” propels psychological growth even as the content of play changes (550).

Marks-Tarlow (2012) points out, “Across all descriptive levels—neurological, psychological, sociological, and anthropological—investigations have identified a host of affective, cognitive, social, and motor capacities that accompany child’s play. . . . These include brain growth, self-regulation of behavior and emotions, the development of imagination and symbolic representation, the making of meaning, the development of language and narrative, meta-communication (i.e., communication about communication), creativity, divergent thinking, self-transformation, social competence, gender identification, community membership, and cultural awareness and creation” (354).

The efficacy of child treatment, of which play is an essential component, has been supported by extensive case studies in the *Psychoanalytic Study of the Child*, a review of research (Midgley, Hayes, and Cooper 2017), and research on positive neurological changes with treatment (Badenoch 2008; Cozolino 2016, 2017; Schaefer and Drewes 2014).

The Altered Physical and Psychological Environment

The traditional office with all it contains has been a place of safety and comfort for both our patients and ourselves, a place where imagination and play can

flourish. My now unused office is arranged to offer children freedom of movement and opportunities for self-discovery and agency. They can reach the hooks to hang up their coats even if they have to stretch on tiptoes. They can open a drawer full of Play-Doh cans or rearrange the dollhouse without help. Toys are available: a baby bottle, soft blankets, dolls, action figures, dollhouses with babies, moms, dads, grandparents, and siblings, and games of luck, chance, and skill. I often volunteer to save a child's artwork or special items in a secure and confidential location. For children I see after school, who need to shake off a long day of concentration and physical constraint, my office offers a space where they can be active. I can follow my patients with my eyes as they explore the space, chooses toys, and show me how they want to use them. In the course of a week, my office may serve as a stage for performance, an obstacle course, and a venue for playing hide and seek.

Both my patients and I know the sounds from down the hall or from outside. We consider the locks on the bathroom door together. We use the old sink across the hall to clean paint brushes and wash off gluey hands. In the physical and psychological space of my office, I take our psychological temperatures during a session, noting how we feel and move and interact. Most importantly, the patient and I are a playful "we" in this space, my familiar office reinforcing the connection we create over time, albeit sometimes "precarious" (Winnicott 1971) and in need of repair. In the shared office setting, movement and ideas morph into creativity and a joint experience of growth, a pattern not easily replicated in telehealth.

With the arrival of the pandemic, this familiar and comforting environment abruptly disappeared from my life and the lives of my patients. I came to relate to my patients via telehealth and from a different physical space. From the child's perspective, the shift was huge and occurred at a time of heightened vulnerability. I had become two dimensional to my patient and without context. My office, with its opportunities for movement and exploration, had become an abstraction and there was no longer a comfortable place to flop down after a hard day of school. Along with what is now gone went what's new; in the new virtual world we cope with technological glitches, garbled voices, and parts of our bodies missing from the screen.

The shift to telehealth is not without novel opportunities. Children bring not only themselves to the screen but also their home environments, allowing me to enter their worlds in novel ways. They choose the settings for their sessions, whether such settings be bedrooms or forts the children have made of

blankets or on hammocks in a yard. I am a guest, sometimes welcome, at other times overstaying my invitation. Sometimes, I sneak glances under a patient's bed, check out the titles of books on a shelf or the food in the refrigerator as a child rummages for a snack. I note the orderliness or chaos that constitutes a child's bedroom or the tenor of the voices of parents working nearby.

As rich as this new access may be, it is also disconcerting, accustomed as we are to our offices and to moving with our patients. The imaginative play at the core of psychodynamic treatment and crucial to forward movement prove a challenge to generate in an environment devoid of toys, rituals, and shared physical space. No longer able to rely on our offices or its contents to build connections through shared meaning and play, we are challenged to innovate. What equips us to do so is a reliance on the fundamental therapeutic elements I summarize next.

Mobilizing Imaginative Play

Several therapeutic elements remain important in any space, whether a physical office or a virtual one. Our therapeutic stance needs to be one of careful attention to the patients' experience, that is, their empathic alertness. We need to take time to stop, look, and listen—and to imagine the child's experience, often feelings of isolation, fear, sadness, and frustration in the two-dimensional world. We need to be alert to the child's needs for physical movement and find ways to accommodate such needs. Most importantly, we need to do our best to encourage and participate in imaginative play, harnessing our own imaginative capabilities to do so.

Just as in traditional office practice, it is critical that we recognize and validate a child's fragile attempts to reach out for connection. Often hidden in a vulnerable, uncooperative child patient on telehealth we find the child's wish to engage with the therapist. Though sometimes disguised in provocation and negativity, the child's imaginative use of self is an invitation for engagement with the therapist. Some gestures may be difficult to recognize or misperceived as antagonistic in the teletherapy context, yet the potential for forward movement lies buried within the angst of these gestures. For example, when children turn their screens black, mute themselves, or float emojis, these communications can be received and appreciated by the clinician as an invitation to play, a faint signal that Tolpin (2002) describes as "restarting and reinvigorating an expectable

developmental process” (189). Over time, the therapist who welcomes antics on the screen by acknowledging the surly and often depleted child’s behavior fosters new ways of being together and moving forward. Again, as Tolpin puts forth, “Fragile tendrils of remaining healthy needs and expectations are not readily apparent on the surface, we have to be primed to look further” (189). The following case is illustrative.

Case 1

Eleven-year-old Jill was referred for therapy early in the pandemic when her parents noted that she had “lost her bounce.” She had become fretful, argumentative, and solitary. In teletherapy, Jill was initially quiet and polite. As I watched her sit at her desk and stare at me with a dull, annoyed expression, I tried to imagine what she had been like before the pandemic when she had friends, participated in choir, and joked at the family dinner table. That was before. Now I found her sense of defeat contagious, and I could find no easy way to connect. After several stilted sessions, Jill began a session with an accusatory question, “How come you always get to be the host?” Rather than viewing this as negative transference, I paused to imagine Jill’s day, the endless hours of e-learning and the accommodations she endured. I decided to embrace her spunk rather than respond to her negative feelings about my having taken the lead. “Maybe, you would like to be the host today?” I offered. She jumped at the offer.

I turned off my camera and lowered my screen so I could not see her, ostensibly “leaving” the meeting. Then Jill pretended to call me as if the meeting were hers. I answered by turning my camera and lifting my screen so I could see her again. As I joined her meeting, I saw Jill sitting tall in front of an image of a rising sun, a background that she had chosen. Now wearing fancy virtual sunglasses and a goofy hat, she no longer looked passive and bored. “That hat is awesome,” I said. “You are partly hidden under the rim of your hat, but I bet you can see everything.” Jill grinned and gave me a thumbs up. Emerging from our joint stupor, we had found a way to engage in imaginative play. I followed her lead, and she wowed me with her creativity. We felt revitalized.

Though cloaked in negativity, Jill’s brave question was an invitation to play. Importantly, I did not direct her toward this play gesture. Rather, I provided the conditions of safety and empathic alertness that allowed it to emerge. She had spontaneously felt an oomph of initiative, a reemergence of the capacity to play which had been buried for months. I responded by suggesting a way to proceed. As she enjoyed our new flexibility, sharing became less fraught with anxiety.

With Jill as host, we played with the experience of teletherapy, using functions of Zoom as shared toys. Jill's ability to draw on the screen and use filters became the "toys" we engaged with together. As host, she was psychologically empowered and experienced an enhanced capacity for self-expression (Bennett and Eberts 2014), moving around her room, bringing her stuffed animals to the screen, teaching me what brought her comfort and what annoyed her.

From a psychological perspective, a spark of initiative in Jill was encouraged by her sense of safety and my alert and empathic stance, and she was able to harness aspects of the virtual office in imaginative play. Together, we were able to build a virtual space in which we both felt safe to explore. We owned the experience together—but only because she had first asked to own the space herself and I could empathize with her need and find a way to follow her. Building on the foundation of our joint play, we were subsequently able to approach the topic of her loneliness and her feeling out of step with me in our first attempts at teletherapy.

All children begin to own their therapy in unique ways, and under pandemic conditions on telehealth, trust and a sense of safety can be slow to develop. Without our office, toys, and familiar boundaries, we must build with our patients what can be possible in terms of imaginative play, attending closely to both verbal and nonverbal messages. The teletherapy setting challenges us to be especially resourceful. When possible, we honor the child's urge to be physically active in play, often at the beginning of the session. With empathic alertness, the therapist needs to be ready to engage imaginatively and with an openness to play whenever a patient offers even a disguised invitation. As illustrated in the next case, this listening and following is a bumpy process, sometimes literally as well as figuratively.

Case 2

When nine-year-old Ryan said, "I want to show you something" and carried his iPad through the house, I recognized his need to move physically and his willingness to treat me as a trusted companion. Even though I sat in my comfortable chair, I felt jostled as he climbed "me" upstairs to see a picture he had in his bedroom. Even as I glimpsed the ceiling, then carpet, then floor on this roller coaster ride, I recognized the playfulness in our exchange and pushed it forward. I said "Ryan, I'm spinning because you are turning your iPad upside down! Are we there yet?" I moan. He laughed raucously, "Shh! Yeah, we are almost there." Ryan and I were playing, we were together on an imaginary trip.

As the driver, the tour guide, he had a bounce in his step and was leading the way with his own agency.

My spontaneous trip through Ryan's house brings to mind Lyon-Ruth's (2006) description of the therapeutic voyage, "The meaning of this voyage is being co-created between interacting partners rather than a meaning that is pre-existing within the child and unilaterally introduced into the play" (157). In teletherapy, as in my office, my goal is to create with my child patients what Panksepp (2008) aptly termed a "play sanctuary." In teletherapy, through a computer screen, we do our best to coconstruct a psychologically safe sanctuary where we engage in virtual play.

The next two cases illustrate the use of therapist memory and imagination to help young patients transition to a virtual play space after losing the sanctuary of the therapist's office.

Case 3

John, age ten, experienced both e-learning and telehealth as intensely uncomfortable; he had nowhere to hide on the screen and felt utterly self-conscious. During free time at home, he retreated to his bedroom to play video games, emerging only for meals. Although he had been animated and cheerful in my office, his quick smile and spontaneity had disappeared online, and his negativity permeated our sessions: "This is boring," he said, "I have nothing to talk about. I'm fine." I sensed John's wilting spirit and worried that I was asking him too many questions, like a distant relative visiting from another state. The rituals of beginning a session that had evolved in the physical environment of my office were no longer available to us.

This particular day, another session with John began with a long painful silence. As I listened to the quiet, I remembered how our therapy sessions had usually begun in my office, and I was filled with longing and frustration. I spontaneously began to share what I was remembering with John.

Me: John, you know this feels so different, doesn't it, from when I could hear your car from my office window? Your dad always seemed to slam on the brakes at the last minute. I sometimes thought he might whack into the side of the building with your car.

John grinned broadly, so I went on.

Me: I could hear you guys get out of the car, two door slams and then a pause,

another slam a few minutes later. I guessed you had forgotten your phone.

John: Not fair, sometimes it was my dad forgetting stuff.

Me: I correct. Yep, your dad would forget where he put his phone, and you both searched the car. Then, a few minutes later I would hear the candy jar open and close very softly.

John: No way can you hear that!

He was right. It was his bulging candy-filled pockets that tipped me off. I noticed that he had shifted to the present tense, becoming more engaged. I followed his lead, staying in present tense.

Me: Then you guys come up the stairs. I don't know how you do it, but you are able to sneak up on me all the time. I'll look down for two seconds to do something on my desk, and the next thing I look up and you are sitting in the blue chair. It always feels like a boo-yikes moment!

John: Sometimes you jump!

Me: I know. Ridiculous, right?

I hesitated.

Me: John, this is a "what if" kind of idea, ok?

There was a pause in the conversation.

Me: I wonder if it feels weird that I call you on telehealth . . . cuz you never get to walk into my office anymore. I just pop up on your screen. It feels off to me. I am wondering, what if we changed this and you call me?

John did not hesitate. He jumped up from his chair.

John: Yeah!

Me: Should I call you first, so you have my number?

John: No, I know your number.

Before I could reply John slammed down the phone. He called back immediately.

Me: Hello?

John: Oops, wrong number!

He started to laugh and banged down the phone. He called back again, still laughing. I smiled.

Me: That was a tiny bit evil!

Our playful exchange felt like a teletherapy version of John sneaking up to my office and surprising me. We were both infused with energy as we restored and advanced our psychological connection.

In this session, as I shared my memories and playfully imagined, John joined me, feeling our connection. We expanded the play to try out a new version of how to begin a session. By being first scaffolded in his play, his ability to reframe our connection in the present was enhanced, and he regained a sense of agency. He could decide when and how to begin and how he wanted to engage or disengage. Using our imaginations in play enabled us to reengage comfortably. Then we could jointly shift to the reality of our impasse and talk about possible solutions. How clinicians can use memory and imagination finds further illustration in the next case.

Case 4

Eight-year-old Sarah was having a miserable time with e-learning. Bored, frustrated, and angry, she muted her computer during class, took frequent bathroom breaks, and got further and further behind in assignments. She made lame excuses and belligerent demands of both her teachers and parents. While I understood her fears, I struggled to understand her total shutdown. Tension at school and home escalated. Her parents—both working from home—were defeated and exhausted.

Sarah: I want my mom to homeschool me. We could have a Pod with my friend Emily. My laptop never works. I really do have stomach aches. Why don't you just tell my mom I can't do e-learning?

Reasoning and strategies got us nowhere, though I could remember our doing well together before the pandemic. Then she was engaged in accelerated classes at school and had friendships and hobbies. Now—and for several weeks—she was defensive, angry, and unreachable.

I recalled Sarah when we first met, two years ago after she was first referred for therapy by her day care teachers who had exhausted their ideas about how to engage her. She had been enrolled in after-school day care but was determined

to escape, heading for the exit doors, and ending up in the parking lot or walking home. At the time, I had no idea why she detested compliance, but it was clear there was no “we” joining together in play and learning; rather, it was the teacher and Sarah in a battle of wills, both losing. Over time and through shared play, Sarah and I had become a “we” and worked hard together to find meaning in day care, a connection to the teachers, and a feeling of having a voice to be heard, but in a reasonable way. Resparking her sense of agency had been crucial in enabling her to engage more productively at school.

My imagining the Sarah that I had known prior to the pandemic allowed me to wonder about her subsequent regression at school and shutdown in our virtual meetings. Then, Sarah had felt invisible, enraged that life was not going her way. She would fly off the handle if she was not the snack helper or if her friend refused to sit with her at rug time. Perhaps her problems now stemmed not from endless e-learning or fear of the future but rather her sense of diminished agency with the changes. I decided to share with Sarah how I imagined she had felt when she first came to my office.

Me: You know Sarah, I was thinking about the time you first came to my old office. You told me I needed to get rid of my chairs and get bean bag chairs instead. And you told me I should buy a new dollhouse. Remember that? You weren't so sure I had the right stuff to help you. Maybe you were feeling worried or disappointed. You were not in a good place. And you didn't even know me at all. I probably was nothing like you thought I might be. Do you remember that too?

Sarah: Yeah. I miss your office. We can't really play hide-and-seek anymore. And I could dance in your office.

Me: I miss us there too.

Sarah: Will you tell my parents that I can't do e-learning and she has to homeschool me? Where are all my pictures now (from sessions in my office)?

Me: I have them right here in my private drawer. Do you want to see them? I remember the picture you drew of the little girl; she was so tiny in the rain. It was raining so hard, and she didn't even have an umbrella to help her stay dry. It made me so sad. I remember looking at the tiny girl and wanting to take out a pretty light purple marker and draw a fancy umbrella for her to hold.

She nodded.

Sarah: I would have gotten so mad! And you can't draw either! I remember drawing a lot of rain.

Me: I know. That little girl in the picture was soaked. For sure she needed

help. So, what if some of these old feelings of being alone and unhappy are peeking around the corner? (We sometimes played the “What if?” game together.)

Sarah’s body relaxed. She made eye contact. Once we had found connection through imagining her earlier self and the picture she had created, Sarah could begin to acknowledge her currently messy situation at school.

I believe that our earlier work had offered her a bit of protection and scaffolding. She had brashly and impulsively walked where she wanted to and stepped in a lot of puddles along the way. In therapy she had turned to me for a bit of shelter and safety as she learned to move forward and conform to expectations for her behavior at school. As Geist (2016) writes, “The depth and curative potential of any treatment is contingent on a sensibility in which patient and therapist allow themselves to be a presence in each other’s experiential world. . . . It is only through reestablishing connectedness developmentally or therapeutically, that hope is preserved. The protective part of connectedness is particularly important as it affects the modification of defensive structures” (370–73).

When Sarah’s hard-won progress eroded under the stress of the pandemic and virtual therapy, I offered shared memory to reestablish connection and forward movement. As we reimagined six-year-old Sarah, we felt that we knew the map of how to feel frustration and move forward anyway. Together we could feel sad about not being in our old office, playing and hanging out. Although we did not want to “grow up” and find solutions to all the new messes, our imaginative joining was emboldening. Allowing myself to imagine playing with the six-year-old Sarah and inviting her to join me enabled Sarah to give voice to her complaints. A shift in her behavior at day care affirmed the value of the therapy; she began to talk with her teacher about what she needed—which was more advanced reading and occasional time out from the video screen—putting into words what she had previously expressed in defiant actions.

Discussion and Personal Reflection

As the cases have illustrated, even in the virtual environment of telehealth, the imaginative potential of therapist and child can be harnessed in a “we” of creative play. Through playful engagement, the child can transition from feelings of isolation, anger, sadness, and hopelessness to feeling a renewed sense of agency.

Although daunting, the telehealth version of therapy nevertheless contains the potential for rekindling affect, the sharing of ideas, and the conversion of a passive experience into one of spontaneity and play. And it is through the connection of imaginative play that forward movement becomes possible.

Working in telehealth continually presents thorny challenges for the clinician. In the case examples I have offered, the treatment benefitted from spontaneous imaginative play that was initially evoked by a profound sense of disconnection between me and my young patient: John, who desperately missed being with me and the rituals of engagement in my office; Jill, who had lost her sense of vigor and required encouragement to find her psychological well-being and creativity; and Sarah, who lost her newly acquired problem-solving capacities but reengaged through our remembering her previous mastering of messes. My sense of the “Zoom fatigue” of my patients—the frustration and mounting sense of defeat they experienced struggling for connection through their screens—is part of what propelled me to use imagination and play as a bridge.

I, too, struggled with Zoom fatigue, initially blaming technical glitches for my dismay. The adaptive demand of transitioning to the new technology was considerable. I missed the relative absence of bodily cues, being able to follow a child’s gaze, and the essential connectedness that face-to-face human contact offers. I missed the abundance of toys in my office and the office itself with its rhythms and rituals of use. I especially missed the physicality of hellos and good-byes, the beginnings and windups of sessions.

My patients came to learn that cleaning up the office space was a necessary and helpful ritual, bringing closure to a session. Over the years, I have found this to be a tender time as we transitioned together from the therapy space to everyday existence. As we put toys back on shelves, vacuumed the floor, and looked around together, our ritual affirmed that moving from chaos to repair was possible. In contrast, teletherapy endings feel more abrupt, even though we may choose the same words for good-byes and try to establish ending rituals. As Kashyap, Chandur, and Reddy (2020) summarized in regard to treating adults, “At the scheduled time, they (patients) had been greeted at the door, invited into the therapy space . . . wind down with small talk and shown out by the therapist. Now (using telehealth) in a single click, we start and end the session. The abruptness of transition between reflective space and ‘real life’ (both entering and leaving) was experienced as jarring”(3). Zoom fatigue may be understood, at least in part, as a serious alert to review and rethink our clinical work in a session. The challenge of shifting from office rituals to saying telehealth hellos

and good-byes is but one example requiring thought and creativity.

In efforts to deal with my Zoom fatigue, I sought articles (Sayers 2021; Russell 2015) and consulted with tech-savvy colleagues. Even with a career of doing and teaching child therapy, presenting workshops, and writing articles, I struggled with whether I was a good enough therapist to adjust to the telehealth format. Ultimately, it was my experience working with young children during the pandemic, as I have described here, that convinced me that telehealth could be effective. It requires vigilant self-reflection, consultation with colleagues, and confidence that our training in intense listening and observing of patient process is relevant and transferable to the new medium.

Telehealth challenges will continue to require our thoughtful attention and creativity. If we appreciate that our Zoom fatigue is a call to attention, we can adapt. Whether beginning our career or adapting to teletherapy after years in practice, active engagement in the learning process is essential and ongoing. And a focus on finding ways to join our patients in imaginative play—even in this medium—is essential.

Optimal use of the therapist's imagination is built on the foundation of empathy, and it entails active engagement with the child patient's "what-ifs?" Opportunities for imaginative engagement occur when the child patient feels safe to explore in both physical and psychological space. We clinicians need to attend closely, to stop, look, and listen, staying open to the gestures our patients use to indicate stirrings toward agency even when disguised in what may be perceived as negative behavior.

Yesterday seven-year-old Tom carried me to his kitchen on his iPad and left me in the refrigerator with the door barely ajar. Staring at the milk cartons, I felt isolated and anxious, momentarily forgetting that I was actually sitting in my own cozy chair. I reminded myself that the child who shows me his room, walks me through his house, and puts me in his refrigerator is owning his therapy, using playfulness to define himself and claiming his place in the teletherapy experience. Can we use our imaginations to engage such sparks of initiative? Is it workable? On behalf of the children we serve, we need to try.

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