What was the experience of trainee child and adolescent psychotherapists working with their patients during the Covid-19 pandemic?

Nicola D. Levison

A thesis submitted for the degree of
Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

Tavistock & Portman NHS Foundation Trust
University of Essex

Submitted: September 2022

CONTENTS

LIST OF TABLES

LIST OF APPENDICES

ACKNOWLEDGMENTS

My gratitude goes to the participants of this study, who shared their experiences so freely and generously.

My thanks go to Judy Shuttleworth, my research supervisor, with whom I enjoyed many interesting conversations and who was supportive, patient and encouraging.

Thank you especially to Hen Otley, who shared her immense warmth, humour and no-nonsense editing skills.

Thank you also to Audrey, Tony and Frida, who were around in the background, doing nice things for me whilst I worked.

ABSTRACT

The purpose of this study has been to gain an understanding of the impact of the Covid-19 pandemic which brought challenges and great change to the work of child psychotherapists working for the NHS. CAMHS clinics closed in March 2020 as part of the UK government's attempts to control the spread of the virus, and therapists continued their clinical work using a technology-mediated setting, with both the child and therapist in their own homes. This study aimed to explore the impact of these changes on a group of trainee child and adolescent psychotherapists and their young patients. The experience of working in the context of a shared external threat, the move to a remote setting, and the implications for unconscious communication in the transference relationship are all explored. The research was conducted using a psychoanalytic framework of thinking and Interpretative Phenomenological Analysis was the methodology used for collecting and interpreting the interview data. Empirical evidence relating to the wider impact of Covid-19 on children and young people, as well as the past and current debate on the use of technology for therapy, is also explored. Semi-structured interviews were conducted with eight trainee child and adolescent psychotherapists, at various stages of their clinical training at the Tavistock Clinic. Reflexivity and the researcher's own place in the study are explored fully. **The key findings** of this study were that the early experience of the pandemic and national lockdown was shocking, traumatic, and difficult to think about; that the separation of therapist and patient resulted in an undermining of the containing function usually offered by an embodied psychoanalytic setting; and that participants showed creativity, tenacity and determination in the face of the personal losses brought on by a global health crisis.

Key words: child and adolescent psychotherapy; Covid-19, setting; containment; technology; transference and countertransference

CHAPTER 1: INTRODUCTION

The aim of this enquiry is to provide a picture of a unique and unprecedented experience – that of child psychotherapists and their patients, engaged in ongoing clinical work within the context of a global pandemic. My interest in this topic began in March 2020. I was six months into the second year of the child and adolescent psychotherapy training at the Tavistock Centre. As the country went into lockdown in response to the Covid-19 pandemic, in-person contact with patients, colleagues and fellow trainees was curtailed overnight. UK citizens were told to stay at home, permitted to leave home once a day for exercise only and told not to mix with people from other households. This had a profound and shocking impact, and I was left with many questions, along with a need to understand what this meant for my work and for my young patients. This is where my motivation for carrying out this research lies. I decided to design a study that would explore some of the questions that were bubbling up my mind and in the conversations I was having with friends and colleagues.

Context: Coronavirus 2019 (Covid-19)

During the final weeks of 2019 and into 2020, the world was becoming aware of a newly discovered virus, severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2), originating in China and spreading across the globe. In an attempt to limit the spread of Covid-19, the highly infectious and deadly disease caused by SARS-CoV-2, the UK government placed the country in its first national lockdown by the end of March 2020. NHS Child and Adolescent Mental Health Services, along with all other health and social care providers, were forced to adapt. For most clinicians, this meant finding ways of working remotely, away from the clinic space. Face to face clinic sessions now took place only with what were deemed 'high risk' cases and did so with significant changes to the norm: the use of PPE (protective personal equipment); social distancing measures; changes to clinic procedures in relation to risk assessments and use of the clinic space.

Lockdown measures were eased over the summer of 2020, with new restrictions and local lockdowns in some areas of the UK being introduced in the early autumn. A second, four-week national lockdown began in late October and restrictions continued into the end of 2020. In January 2021 a third national lockdown was announced, alongside a mass vaccination programme, including for NHS employees. For the first and third extended periods of lockdown, schools were closed to children, except for those who were deemed most vulnerable, and those of key workers. Children were taught remotely and were expected to observe new social distancing rules which meant they could only socialise outdoors with one person from one other household. During this period, NHS trusts had differing policies about returning to face-to-face or in-person work, so the experience of child psychotherapists and their patients varies from place to place. However, at various points in the year, all child psychotherapists and their young patients will have had to negotiate sudden, unexpected changes. Telephone and video technology was widely used for child psychotherapy for the first time. For some child psychotherapists and their patients, the use of technology remained in place throughout most of the pandemic; others have moved in and out of remote and clinical spaces as measures are tightened and eased.

This study explores the impact on the clinical work of trainee child psychotherapists working in CAMHS clinics during this time. By trainee child psychotherapist, I mean those engaged in a child and adolescent psychoanalytic psychotherapy training. I am curious about the impact of this existential, external threat on the clinical work of child psychotherapists. This is explored in relation to the quality and content of transference/countertransference communication. I explore with participants what they understand about the ways in which they and their patients have experienced changes to the therapeutic frame and how these are expressed unconsciously and explicitly. I explore how child psychotherapists understand the impact of moving in and out of remote work, the

significance of being together and being apart, and the use of technology for child and adolescent psychotherapy.

Rationale

I think this study would be of interest to the profession of child psychotherapy as well as those trying to understand the impact of the Covid-19 pandemic on young people and those who work with them. Whilst I plan to focus on the experience of child psychotherapists in relation to their patient work, one might assume that the findings would be relevant to other practitioners as well as people interested in child and adolescent mental health in general. Child psychotherapists work with unconscious material, yet it is reasonable to say that unconscious processes are not confined to the child psychotherapy consulting room.

The findings of this study will hopefully shed some light on what working remotely is really like, for the practitioner and the patient. It will provide a timely exploration of technology-mediated therapeutic communication, the differences between these and face-to-face work, and the impact on the therapeutic relationship of moving from one to the other. Its purpose is not to make a judgement about whether remote working is a good idea or not, but rather to provide a qualitative exploration of the experiences of those who, by necessity, are engaged in it.

The main research question is: **What was the experience of trainee child and adolescent psychotherapists working with their patients during the Covid-19 pandemic?**

To aid thinking about the background to this study and how the research question links to literature on the topic, I have chosen to collate a list of more detailed sub-questions, shown here.

- How are anxieties about an external, uncontainable threat revealed in a child psychotherapy session and what are the challenges in containing these?
- In what ways is the existence of an external threat felt to be present in the transference and countertransference?
- What is it like to work remotely as a child psychotherapist?
- How viable is unconscious communication in telephone and screen mediated child psychotherapy?
- What is the impact of working remotely on the nature of the psychoanalytic relationship?

Table 1: Research Sub-questions

A literature review is presented in Chapter 2. Chapter 3 outlines the research design, including the methodology, method, ethical considerations and an exploration of researcher reflexivity. The study's findings are given in Chapter 4. Finally, Chapter 5 presents a discussion of the findings and the main conclusions of the study.

CHAPTER 2: LITERATURE REVIEW

The aim of this literature review is to offer a comprehensive study and interpretation of the literature relating to a number of topics, which stem from the specific research questions identified in the Introduction. I intend to equip the reader with a context for the study and identify areas where further research is needed. I have identified the following topics:

- **The work of a psychoanalytic child psychotherapist**
- **The impact of Covid-19 on the mental health of children and adolescents**
- **Therapeutic work with children in the context of a shared, external threat**
- **The practice of remote working and the use of technology for psychotherapy**

Aims, Rationale and Method

I have used both narrative and systematic literature searches, depending on the nature of the topic. The aims, rationale and methods used for each topic are described below. See Appendix A for an illustration of searches and inclusion/exclusion criteria.

The work of a psychoanalytic child psychotherapist

To understand the impact of Covid-19 on the clinical work of child psychotherapists, it is necessary to spend some time considering the nature of both child psychotherapy and the therapist-patient relationship. I aim to clarify and explore what I mean when I use the terms unconscious communication, transference, setting, etc. To consider the impact of remote working, I aim to give space for an exploration of what happens between the therapist and child when they are together in the same space.

This exploration forms a narrative part of my literature review and here I make use of the reading lists for the workshops of the psychoanalytic child and adolescent psychotherapy clinical training at the Tavistock Clinic. Given the brevity of this section, it will not be a comprehensive overview, but aims to warm up readers' minds to some of the concepts that underly the work of the researcher and participants of the study, and which I will use to consider the material that is gathered.

The impact of Covid-19 on the mental health of children and adolescents

To provide a context for the study, I aim to give an overview of current evidence of the impact of Covid-19 on the mental health of children and young people. This includes the impact of enforced isolation, school closures and social distancing and allows for exploration of the unique circumstances within which children and young people were living during the pandemic. These are important to bear in mind when considering the experience of those children who were also patients in therapy during this time. Texts have been chosen from newspaper articles written since the beginning of the pandemic and for this I used the search engine Google. I have also used papers from a rapidly growing body of empirical research, found by systematically searching the database PsychINFO, selecting studies that included children or adolescents in their data samples. I searched for papers published up until September 2021, which was when I carried out the final interview.

Therapeutic work with children in the context of a shared, external threat

A global pandemic presents the unique context of a shared and existential threat. I aim to review what has been written about the experience of working therapeutically in similar contexts. This might include working during a time of war, living under the threat of terrorism, or in the aftermath of a natural disaster. I have carried out systematic searches on

PsychINFO and the PEP Archive to find relevant empirical papers and case studies. I chose to include only papers on psychoanalytic child psychotherapy or psychoanalytic/ psychodynamic psychotherapy with adults in this search.

The practice of remote working and the use of technology for therapy

For this part of the literature review I used the Tavistock and Portman Library catalogue and searched the database PsychINFO. A narrative search of the library catalogue found that there had been ongoing debate in the psychoanalytic field about using technology for remote therapies, and this had centred around a small group of writers. Not surprisingly, this discussion was re-ignited and expanded as the Covid-19 pandemic made remote working a reality for more than a small group of clinicians. I aim to summarise that debate and find out to what extent the nature and experience of online psychotherapy has been explored in the psychoanalytic literature. Whilst carrying out a systematic review of research into the topic, I chose to include studies which had used a range of methodologies. A preliminary search during the proposal stage of this project had already shown there to be very little written about remote working with children. I decided to include studies that looked at mental health professionals from a range of modalities, working with adults as well as children.

Outcomes of the literature review

The context of psychoanalytic child psychotherapy

Child psychotherapists complete a two-year pre-clinical observation course during which they carry out, in the home of the family, weekly observations of an infant from birth to two years. The purpose of this 'open-minded, naturalistic' (Reid, 1997) infant observation is that it provides a unique opportunity for encountering primitive emotional states in the child and family and for developing a particular sensitivity to infantile modes of communication, as

well as learning about one's own responses and feeling states in relation to projections from the family (Rustin, 1989). These are explored in a weekly small seminar group with a qualified and experienced child psychotherapist. The course also involves an observational approach to work discussion as the basis for clinical observation. The focus of this form of observation is theorised in terms of the impact of bodily and emotional communication within a developing clinical relationship. This contributes to the creation of a psychoanalytic attitude in prospective child and adolescent psychotherapists and prepares them for clinical work. A psychoanalytic attitude includes the recognition of an unconscious psychic reality and primitive anxieties, the ego's need for defences against intense anxieties and an assumption of the repetition of the past in the transference situation with the therapist (O'Shaughnessy, 1994).

'Working with' or 'gathering up' the transference is fundamental to the work of the child psychotherapist. Freud (1914) linked the idea of transference with what he called a 'compulsion to repeat': unconscious ideas relating to past experiences or relationships are repeatedly acted out and transferred onto the therapist. As such, 'the main instrument for curbing the patient's compulsion to repeat lies in the handling of the transference', (Freud, 1914, p.154). Klein (1952) believed that to unravel the transference it is 'essential to think in terms of total situations being transferred from the past to the present' (p.55) and these include aspects of relationships that have remained active since infancy – actual experiences as well as those that have been experienced internally in phantasy. External and internal experiences contribute to what are known as internal objects, which in a large part relate to internalised ideas about parental figures.

A framework of related concepts has evolved to explore the relationship between the psychotherapist and their patient and these draw on a body of work that likens it to that of the parent-infant dyad. The place of maternal functioning has been traced through Bion's development of projective identification and maternal reverie, an embodied experience whereby feelings are communicated at an unconscious level between mother and baby (Bion, 1962). As the infant projects into the mother his[1] overwhelming and unbearable feelings of anxiety and distress, she takes them in, feels their quality, and thinks about them, feeding them back to the baby in manageable, more palatable forms. In doing this, the mother provides a model for thinking about feelings. Maternal reverie provides the basis of containment: if it is experienced consistently, the infant learns to bear his own difficult feelings as well as the capacity to think about them. For many children who see a psychotherapist for treatment, there have been, for various reasons, difficulties or failures in maternal reverie and in the introjection or taking in of a good or containing object. Child psychotherapy offers an opportunity for an experience of containment and being held in mind, as well as to learn to mentalise feelings and experience.

Safeguarding the psychoanalytic setting is a key part of technique. Consistency in the normal setting of the therapy or clinic room establishes the necessary conditions for the unfolding of the patient's internal world and the transference relationship; these include holding the session in the same room, at the same time each week and minimising changes to the contents and appearance of the space. These allow the child to introject the receptivity, attentiveness and containing function of the therapist's mind and presence. In this way, the setting or frame

[1] A note about pronouns: where an infant or baby appears in the theory, I use 'he', to be distinct from 'she': the mother. The word 'mother' is used to be consistent with the original theory, but this could also mean father, or a caregiver who is in close contact with the infant. The therapist is referred to as 'she,' unless I am referring to a specific example from the data where the participant is male.

itself acts as a container and it includes the therapist's mind and body and her capacity to feel, contain and articulate the infantile transference experience.

Before considering the impact of the pandemic on the mental health of children and young people, I would like to highlight that in December 2020, the Association of Child Psychotherapists devoted an entire issue of the Journal of Child Psychotherapy (Vol 46, Issue 3), to the work done by child psychotherapists during the Covid-19 pandemic. Entitled 'Child psychotherapy in the time of Covid: Voices from around the world on working through a pandemic', the issue contains a number of shorter than usual papers, reflecting the immediacy of the topic. The aim of the issue was to give a snapshot of what had been possible over the preceding months since the first lockdown was imposed. Whilst individual papers are cited at relevant points in this review, the main themes of the issue are worth highlighting. Taking a central theme of 'the loss of, and consequent need to re-imagine, the psychoanalytic frame' (De Rementeria, 2020) most papers describe individual work with children and young people, although the issue starts with a helpful review of literature on digital psychotherapy (Monzo and Micotti, 2020). The issue is split into sections relating to the themes of the therapist, the setting, technology and the body, and groups. Common threads running through these papers relate to the interaction between internal and external phenomena, the challenges of responding to countertransference, and the third presence of the computer screen.

The impact of Covid-19 on the mental health of children and adolescents

The impact on children of the Covid-19 pandemic is an emerging, rapidly expanding, and significant research interest across the world. During 2020, concerns grew about the implications of enforced isolation, social distancing, and disruption of routine for children's mental health and well-being. In October 2020 the Guardian reported that advisers on the

Scientific Advisory Group for Emergencies (Sage) were warning the UK government of significant risks to people in the age group of 7 to 24, expressing concerns about the impact of school closures, poverty, exposure to domestic violence and youth unemployment (Hill, 2020). There have been many calls in the research community for rapid, collaborative action and the establishment of research priorities (Clemens, Deschamps and Fegert, 2020, Guessoum et al, 2020, Holmes, 2020, Hawke et al, 2021).

Brooks et al (2020) have documented the negative psychological impact of social isolation in a rapid review using studies from previous outbreaks of SARS, Ebola and Influenza. They found the impact of quarantine to be substantial and wide ranging, listing PTSD symptoms and experiences of confusion, anger, boredom and frustration. Most studies published in the early months of the pandemic focused on the adolescent population. Studies into the impact on young children are very few, possibly due to data being harder to collect and there being more ethical considerations. Guessoum et al (2020) suggest in a literature review that adolescent populations are particularly vulnerable, being more susceptible to Covid-19 related anxiety and finding it difficult to cope in confinement. They call for more research into the impact of lockdowns and excessive use of the internet on young people. In a quantitative study using depression and anxiety measures (*n = 3613)*, Duan et al (2020) report a sharp increase in time spent online on mobile phones, as well as increased fear of injury in children and social phobias in adolescents. Magson et al (2021) identify risk and protective factors for adolescent mental health, using data collected two months after government restrictions had been imposed in Australia (*n = 248*). Their results suggest that adolescents are more concerned about government restrictions than the virus itself and that these concerns are associated with increased anxiety and depression. They identify difficulties with online learning and increased conflict with parents as risk factors, and protective factors include adherence to stay-at-home orders and feeling connected with peers.

Loades et al (2020) carried out a rapid review of studies since 1946 exploring the impact of loneliness and social isolation on the mental health of children and young people. They found a clear association between loneliness and poor mental health, concluding that young people are more likely to experience high rates of depression and anxiety when a period of forced isolation ends. Ellis, Dumas and Forbes (2020) explore links between stress and loneliness in an adolescent population in Canada (*n = 1054*). They found that adolescents were especially worried about school and peer relationships during the pandemic and that loneliness was linked to increased stress, especially for adolescents who spent more time on social media. 48% of adolescents surveyed were using social media for over five hours a day, and 12% for over ten hours a day. Those with close connections to family and those who were physically active experienced lower levels of loneliness and stress.

Vulnerable groups and risk factors: Studies have found that certain groups have been at a greater risk of experiencing poor mental health during the Covid-19 pandemic. Negative mental health impacts are experienced more acutely by young people 'already isolated or on the margins, and more vulnerable to risk' (McClusky et al, 2021, p.57). Not surprisingly, those with pre-existing mental health and neurodevelopmental conditions are more vulnerable (Guessoum at al, 2020, Kwong et al, 2021, Rousseau and Miconi, 2020) as well as children living in poverty and where domestic violence is a concern. Asbury et al (2021) found evidence that children with special educational needs and their families are at greater risk of experiencing poor mental health than less vulnerable families during Covid-19. Rousseau and Miconi (2020) use case studies to explore the effect of the pandemic on vulnerable young people including looked after children and suggest that the pandemic can reactivate personal and transgenerational traumas. They also claim that confinement and isolation measures have a negative impact on caregivers' functioning.

In a study which uses online focus group interviews and a relatively small sample (*n = 45*) to explore the impact of school closures, exam cancellations and isolation on adolescents in Scotland, McCluskey et al (2021) found that young people with pre-existing health conditions, those needing extra support with learning, and members of some minority groups such as LGBT+ were most at risk. Hawke et al (2021) also found that transgender and gender diverse youth were more likely to be affected by mental health challenges during the pandemic, losing valuable support from peers and experiencing less support from family members. Using data from a longitudinal study (*n = 14,901*) Kwong et al (2021) identify a clinically relevant increase in anxiety and lower well-being amongst young adults aged between 18 and 24. Factors of social isolation, no access to a garden and financial worries were associated with higher levels of both anxiety and depression.

In the UK, commissioned reports have highlighted the extent to which young people have been affected by Covid-19. The Prince's Trust Tesco Youth Index (2021), a national survey which gauges young people's happiness and confidence, recorded their worst findings in their 12-year history in 2021 (Hill, 2021). More than half of those interviewed (*n = 2180*) said that current political and economic events had affected their mental health and half said they always or sometimes felt anxious, rising to 64% amongst those not in work, education or training (NEETs). The survey found that since the pandemic began, one in five young people had experienced suicidal thoughts, rising to 28% amongst NEETs and one fifth of young people reported they had experienced panic attacks. The Mental Health of Children and Young People in England 2020 report, a survey into child mental health using NHS digital data (*n = 3570*), found that 1 in 6 children were identified as having a probable mental disorder, an increase from 1 in 9 in 2017. Increases were more pronounced in primary age children, especially boys aged five to 10. Adolescent girls between the ages of 17 and 22 were also identified as a high-risk group (NHS Digital, 2020, Newlove-Delgado, 2021). These findings are consistent with

reports of greater pressures on the NHS. Between April and June 2021, nearly 200,000 young people were referred to Child and Adolescent Mental Health services in the UK - almost double that during the same period in 2019, according to a report by the Royal College of Psychiatrists (Hill, 2021).

Therapeutic work with children in the context of a shared, external threat

One might reasonably suggest that the scale of upheaval and existential threat faced during the Covid-19 pandemic had not been experienced since the Second World War. Melanie Klein famously worked with her ten-year-old patient, Richard, in this context whilst evacuated to the small town of Pitlochry in Scotland (Klein, 1961). The presence of an external threat can be seen not only in the adaptations she was forced to make - using a girl guide hut as a makeshift consulting room, for example - but also in the ways in which the war is present in the material. Richard had been evacuated to Pitlochry to escape the bombings in London, and his parents sought help with his intense anxiety and incapacity to tolerate being around other children. In the clinical material we find his anxieties about the war's progress, fears about the safety of his parents and analyst, and a pre-occupation with bombs, air raids and Hitler, as well as Klein's country of origin. His drawings feature aircraft, bombs, tanks, and submarines. Despite the terrifying reality in which they were living, Klein focused on Richard's internal world, 'convinced that, however difficult the actual situation was, the analysis of the anxieties stirred up by his fears of war was the only means of helping him' (Klein, 1961, p19). Klein saw in Richard's pre-occupations a window to his own destructive impulses, persecutory anxieties, envy and greed. In her interpretations, bombs represented faeces, and leading war figures became enmeshed with objects in Richard's Oedipal phantasies, with Hitler as a proxy for his own father and destructive projections.

Very little has been written about child psychotherapy in the context of external, existential threat since Klein's Narrative of a Child Analysis was published in 1961. A search of the literature of child psychotherapy and psychoanalysis brought my attention to those working in New York in the aftermath of the 2001 attacks on the World Trade Centre. Aiello (2012a) presents the experiences of child psychoanalytic psychotherapists and the ways in which the events of 9/11 were enacted in the play narratives of children. She movingly describes the ways in which these were evocative of other, more personal stories, 'peopled with internal objects and unconscious phenomena' (Aiello, 2012a, p.34). She describes one boy's struggle to understand the attacks becoming fused with his own internal struggles in relation to the poor parenting he had received. Questions about why some men helped, whilst others did not, reflect his own deep yearning for a father's protection. Elsewhere, Aiello (2012b) describes a young child who had previously been traumatised by witnessing a family of little rabbits being run over. In his psychotherapy, he asked his therapist to become the Statue of Liberty and to cradle a family of rabbits safely in her hands: a linking of the symbolic and real tragedy of the rabbits with his own plight of witnessing the destruction of part of his home city. One might also wonder if this was an expression of the child's primal fears of annihilation, with the Statue of Liberty becoming a symbol of maternal protection and containment.

Saakvitne (2002), also working in New York after the 9/11 terrorist attacks but with adult patients, highlights the challenges in containing experiences that are shared with one's patients: 'the frame of our work shifts and we are forced to remain consciously aware of our own vulnerability' (p.444). This idea is developed by Boulanger (2013), interviewing adult psychotherapists working in New Orleans in the aftermath of Hurricane Katrina. She explores the countertransference dynamics that emerge when clinician and patient share the

same experience and related anxieties. She describes the 'disabling power of apocalyptic anxiety' (Boulanger, 2013, p.32) and questions whether the personal and private can be kept separate after a shared trauma, with breaks in the frame challenging the asymmetry of the treatment relationship, leading to what she calls 'fearful symmetry', borrowing the famous phrase from William Blake. Clinicians described providing a holding environment in the immediate aftermath, using the telephone, meeting their patients in improvised spaces, and feeling compelled to respond to personal questions and disclose whether they had been affected by Katrina. They reflected on the importance of 'enduring, persisting and holding' in the context of an 'uncharted territory' (Boulanger, 2013, p.31). Cohen et al (2014) examine the experiences of therapists working with traumatised children in Israel in the aftermath of the Second War between Israel and Hezbollah, and highlight the special dynamics involved in working in a situation where both children and therapists are affected by a 'common fate'. They describe therapists' concerns about their capacity to contain children's experiences as well as 'increased empathy and the forming of an emotionally intense caregiving relationship with the children' (p.77). Rather than the 'fearful symmetry' described by Boulanger in her context of work with adults, Cohen et al (2014) found that child therapists experienced a sense of parental responsibility in relation to safeguarding the well-being of children, with increased feelings of protectiveness, attempts to become the 'ideal parent' for their young patients and heightened concerns about doing no harm.

In a more recent paper published in the Journal of Child Psychotherapy, Prout et al (2019) explore therapeutic encounters in the Trump era, describing the tensions between attending to symbolism and the internal experience, alongside a harsh, political external reality. They argue that psychic deposits left by aggression and oppression in Trump's America are 'akin to pathological parental projective identifications' (p.193), producing echoes of previous

intergenerational traumas. Using clinical vignettes, Prout et al illustrate an intense pull for reassurance and various forms of disclosure which threaten to interrupt the asymmetry of the psychotherapeutic relationship. From a viewpoint rooted in the theory of American relational psychoanalysis, they argue that self-disclosure, when clinically indicated, can work as a therapeutic tool, and not necessarily compromise the transference relationship. In the context of a political landscape that frequently suggests persecution and annihilation, child therapists describe countertransference responses of 'a wish to save, to protect, or to be seen as good' (Prout et al, 2019, p.204).

Responding directly to the Covid-19 pandemic in the issue of the ACP journal devoted to the topic, Kohon (2020) asks what sort of parental figure child psychotherapists come to represent when living and working in the shared, uncertain reality of a health crisis. Using his own practice and the supervision of clinicians working with children and adolescents, he describes the complications of differentiating one's own anxieties and defensive reactions from those of one's patients. In the same issue, Shulman (2020) describes disclosing the reasons for cancelling sessions (self-isolating when family members had developed symptoms) and feeling pulled into placing herself in the role of a 'good therapist'. She refers to a 'loss of thinking and reverie' in relation to disclosure and other aspects of the pandemic, becoming 'sadly concrete and restricted' and finding it difficult to pick up on patients' reactions to the changing setting.

The practice of remote working and the use of technology for psychotherapy

On 30th March 2020, the ACP set out guidelines for how to work during the pandemic. Prior to this, there had been several communications with members. On 13th March, members were advised to 'plan for the possible eventuality that you are unable to provide face to face

therapy.' (ACP communication to members). Ten days later there were recommendations to think about putting in a 'holding arrangement' whilst new arrangements for therapy could be made, and leaving a 'door open' for online therapy for those patients for whom online working would initially appear to be difficult. The communication referred to 'the difficult business of managing daily life.' The ACP Guidelines for working remotely with children, young people and families (ACP, 2020) were issued just one week after the first national lockdown was announced. This document clearly anticipates some of the difficulties and challenges surrounding remote work with children and young people and sets out clear guidelines and advice in relation to the areas of setting, consent, technique, risk management and safeguarding, and supervision.

Whilst remote working was a new enterprise for CAMHS clinicians, several online services had been providing mental health support for young people for a number of years. The largest of these is Kooth, founded in 2001. Kooth provides mental health support and interventions to children and young people between the ages of 11 to 25 years at no cost to service users. A range of support includes personal journals, discussion boards, therapeutic text messaging and live text-based counselling. In their 2021 annual report, Kooth state that service user logins have risen from 682,000 in 2019, to 1.1 million in 2020 and 1.3 million in 2021 (Kooth 2021). A cohort study (Bernard et al, 2023) analysed and compared two cohorts (pre and post Covid) of Kooth users between the age of 14 and 25 who signed up and used the service more than three times. They found a significant increase in sign-ups between these two periods – from a mean of 19.72 per day to 24.28 new sign ups per day across the two cohorts. Another messaging service, Shout, which was launched in May 2019, reported that before Covid they were engaging in 750 conversations a day. This rose to 1,400 conversations per day in first months of 2021 (Shout, 2021).

Child psychotherapists working during the pandemic have had to adapt in various ways. The therapy room has been replaced by home working, and the need to communicate with young patients via phone or screen technology. This has allowed therapists to maintain contact, but the experience of two people being together in the same room is lost. There has been much more exploration of the nature and impact of technology-mediated therapy in the field of adult psychotherapy, where online or telephone work has developed over time and become more established, with clinicians aiming to provide therapy and continuity for patients facing the obstacles of geographical location, time limitations, travelling for work, physical disabilities, ill health, and natural disasters (Bee et al, 2008, Scharff and Hanly, 2010, 2104, Lemma, 2017, Perle and Nierenberg, 2013, Russell, 2015). In the context of the Covid-19 pandemic, that which Birksted-Breen (2020) has called a 'naturalistic experiment' (2020, p.433) remote working was not a choice, but a reality forced upon us and for which there was 'no time to prepare' (Scharff, 2020, p.585).

The scarcity of literature on online psychotherapy with children and adolescents has been recognised (Sehon, 2015, Monzo and Micotti, 2020), and reflects its experimental and emergent nature in response to the Covid-19 lockdowns. However, in 2013, Scharff commented, referring to private practice in the USA, 'teenagers are comfortable with teleanalysis, but I know of no instances where it was workable with a child, primarily because children need to play in the presence of therapists' (2013a, p.504). Much of the literature explored below is concerned with psychotherapy with adults, but I would argue that the questions and themes raised are also pertinent to this study.

The transference debate: Summarised by Gutierrez (2017) and Merchant (2016, 2020), the discussion about the use of technology for psychotherapy with adults has been dominated by Isaacs Russell and Scharff, who presented diverging viewpoints prior to the pandemic and

have both responded to it. Unsurprisingly, much of the debate has centred around possibilities for working with transference dynamics. The subject of psychoanalysis and technology was the subject of a series edited by Scharff (2013b, 2015, 2018, 2019) and she has provided a helpful overview of analytic thinking and experience of what she calls the experimental field of teleanalysis, arguing that transference dynamics can flourish on the telephone and be analysed as they would be in in-person sessions. Whilst many of Scharff's themes stem from her own clinical experience, her ideas are informed by others in the field, and by the outcomes of a panel held at the 46th Congress of the International Psychoanalytical Association in 2009, which aimed to explore the use of telephone and video technology as a means of widening the reach of psychoanalysis. The panel sought to answer questions about whether in a teleanalysis there can be effective affective attunement, possibilities for working with transference dynamics and for developing an image of the internal world of the patient. With arguments presented from panellists from the US, Australia, Argentina and the UK, findings were mixed in relation to maintaining the frame and affective attunement, and some panellists even argued that transference and countertransference occurred more vividly (Scharff and Hanly, 2010). Elsewhere, Scharff powerfully describes her own bodily countertransference experience in response to a projective identification with a patient struggling to work through his experience of childhood sexual abuse. She suggests that in the absence of a bodily presence, the analyst becomes more intent on listening and uses other observations: 'hesitations, tearfulness, catches of breath and changes in tone which reveal so much more than words alone' (2014b, p.57). She argues that in phone analysis, the nuances of a patient's voice can help to create an 'image of the body in the analyst's mind' (Scharff, 2012, p.990).

Isaacs Russell (2015) has described what she sees as the limits and losses of computer-mediated communication. Drawing on research in neuroscience and infant development, she argues that therapeutic processes are grounded in the body, that countertransference is by its nature an embodied communication, and that body-to-body processes are most important when a patient is at their most vulnerable. Questioning whether one can truly hold a patient in mind in a two-dimensional space, she suggests that a more diluted experience could act as a 'defence against strong countertransference feelings' (Isaacs Russell, 2015, p.27). She concludes that computer-mediated psychotherapy is not conducive to 'an optimally effective therapeutic process' because of the absence of a co-presence and the inability to 'kiss or kick', referring to love and hate in the transference. She describes a tendency for communication between patient and therapist to take an explicitly verbal mode, and a diminishing of the analytic tools of intuition and reverie. For Isaacs Russell, 'in screen relations the patient can never really truly test the analyst's capacity to survive' (2015, p.35). This view is criticised by Ehrlich (2019), who argues that patients can, in enactments of unconscious phantasy, kiss, kick or even kill in an online analytic setting, through words, tone of voice, and silences. Sabbadini (2014) has explored the nature of silences in relation to the transference dynamic when bodies are apart. Echoing Isaac Russell's suggestion that technology can end up being used defensively, he suggests that silences can feel more difficult to tolerate than when in the room together, are more likely to be experienced as threatening, and therefore more likely to be broken prematurely to prevent the emergence of persecutory anxieties.

Scharff (2014) has suggested that telephone analysis might be preferable for those patients with a history of trauma-related dissociation where shame and embarrassment can be provoked by being 'seen' by their analyst (Scharff, 2014, p.58) and Bakalar (2013) similarly suggests that for some, the medium of the telephone affords a safe space in which not only to

express rage and hate in the transference, but also to bear the shame associated with these. The debate continues into the Covid-19 era, with Martin et al (2020) finding that those experiencing shame and self-consciousness frequently prefer online contact. White (2020), responding to Scharff (2012) and describing her online work during the pandemic, shares her experience of a 'distancing effect' which allows patients to hide from their vulnerability behind the screen. Arguing that online psychotherapy undermines the key components of the therapeutic relationship which rely on physical presence, she also points out that when the journey to and from the psychoanalytic session is removed, something important is lost. Interruptions and ruptures in technology lead to a different kind of search for meaning which ultimately becomes a 'chase' (White, p.583). A similar view is shared by Trub and Magaldi (2017) whose respondents described having to attend more intensely to the patient, and not to themselves, thus working against reverie and experiences of countertransference. Responding to White, Scharff (2020) references Suler's (2004) 'online disinhibition effect' and argues that online work can 'enable patients to access negative transference that they had not been able to express in the analyst's office' (p.586). Revisiting her ideas during Covid-19 times, Scharff goes on to stress the importance of analyst and patient 'mourning together' the loss of the in-person connection and suggests that technology should be viewed by the analyst as a 'third element in the treatment relationship' which is projected into by the patient (p.587).

'Mediated' settings and the presence of a screen: Lemma and Caparrotta (2014, Caparrotta, 2013) lament what they have seen as an 'allergic reaction' shared by psychoanalytically trained practitioners when online interventions are discussed. They argue that communication technologies should be of great interest because the ways in which they facilitate and regulate intimacy 'strike at the heart of what we painstakingly try to understand

with our patients in our daily practices: how to manage being-with-self-and-others' (p.3). Exploring meanings associated with the screen in the digital age, Lemma (2017) draws on both her observations of the digital revolution and what she sees as its impact on the embodied mind, and her work with adolescents in both mediated and in-person settings. She highlights the tension between a world of technology where there is instant gratification and the emphasis in psychotherapy on deliberate, careful exploration over time. Lemma cautions against using online psychotherapy with some patients, including those who have never been seen in person by the clinician. Whilst stressing the importance of an embodied experience in the room and her concerns over the loss of it, she argues that there is not one way of viewing online phenomena: although they can lend themselves to perverse re-enactments or psychic retreats, digital connections can facilitate engagement, for example, in the area of gender and sexual identity formation. An example of this is presented by Paiva (2020) who describes how hiding from his therapist on video calls allowed a transgender adolescent to explore the ambivalence he felt about his body.

Much has been written in the media about children and adolescents' use of technology, social media and online spaces, and there is not scope in this study to explore this further. However, in the literature of online psychotherapy, Prensky's (2001) categorisation of 'digital natives' - a term used to describe the technological competency of young people who are at home in the virtual world - versus the more disadvantaged category of adult 'digital immigrants' is frequently referenced. As the digital revolution continues, one might question the ongoing relevance of these terms. Lemma (2017) argues that although psychotherapists are mostly concerned with internal worlds, they must also understand the external pressures that digital technology brings for adolescent patients. She describes the consequences of online activity on the development of a sexual identity, which adolescents seek to form and consolidate by

looking for a mirror beyond parental figures. In the pre-internet age, this would take the form of peers, music, TV, cinema or print pornography. In the 21st century, this is provided by what Lemma calls a 'black mirror': 'the cold, shiny screen of a monitor, tablet or phone' (p.47). The black mirror does not reflect back, but instead pushes intrusively into the body and mind of the viewer desires, images and sensations even when the young person has not asked for them. According to Lemma, this undermines the important psychic work of establishing an integrated sexual identity over time. Turkle (2012, 2015) writes about the internet creating an illusion of intimacy and connectedness, and more recently Zuppardi (2020) has highlighted that computers 'promote the cultivation of false selves in digital form' (p.312).

Sabbadini (2014) considers the implications of phone and video analysis for the analytic setting and attitude, pointing out that the therapist can see his/her own image in the corner of the screen, creating the effect of a small mirror 'which may acquire special significance in the context of the therapeutic setting' (p.27). He raises interesting questions about the experience of the computer as a 'third presence', which could have 'all sorts of connotations, including in the area of Oedipal phantasies, possibly stimulating curiosity, jealousy and persecutory anxieties' (p.28).

Screen-mediated psychoanalytic psychotherapy with children: Sehon, one of the first protagonists in the online psychotherapy debate to try the new setting with children, has thought about the digital screen as a transitional space that can offer scope for playfulness and growth (Sehon, 2018). She illustrates her point using clinical examples whereby online therapy was used as a temporary bridge to preserve continuity when a 'sturdy therapeutic alliance' (p.223) had already been established. For one patient, Violeta, the experience of

online therapy precipitated a period of growth after a household fire had exacerbated an already anxious state of mind. Taking some responsibility for the setting – adjusting the screen, keeping her play materials safe – contributed towards Violeta having a sense of power and control in her life and 'she became more capable of tolerating heightened aggressive and loving affects, feelings of helplessness and anxiety' (p.217). Acknowledging its fledgling status, Sehon calls for caution in the absence of empirical evidence of the effectiveness of teletherapy, suggesting that we should 'titrate the dose of technology carefully, ever vigilant to the evolving risks, benefits, side-effects, and varying process outcomes for a given patient at a particular time in the therapeutic relationship' (p.210). She stresses the necessity of a strong alliance between the clinician and parent so that a secure technological platform and private room can be provided, as well as the benefits of exploring with the child the meanings that the two different settings have.

A key difference between psychotherapy with adults and children is, of course, that 'whilst adults use talking to work out how they feel and make sense of experiences, children use play' (Slade, 1994, p.91). For child psychotherapists, play is seen as a source of information about the inner world of the child – an expression of inner conflicts and defences against unpleasure (Alvarez, 1992). Bomba, Alibert and Vett (2021) question whether the use of video for psychotherapy allows for the creation of a therapeutic playground. Sharing their experiences of video sessions with children in France and Italy, they wonder whether teleanalysis can become, at times, a dangerous method because of the way it can generate great excitement, unleashing infantile aggressions and perversions. They conclude that playing is possible online because it is the therapist's internal framework that allows for a playing or 'transitional area' and that there is scope for a co-creation of playfulness and creativity even across an interposed screen. They give an example of analyst and child drawing a series of pictures,

each one building on the last, 'reproducing the free association of words in analysis' (p.173). Bomba et al describe their experiences of teleanalysis as 'gruelling and tiring' (2021, p.175) and suggest that this is because it is the physical presence of the therapist that carries out a holding function and, in its absence, greater demands are placed on her to find ways of containing the patient. Also asserting the significance of the bodily dimension in child psychotherapy, Shulman and Saroff (2020) ask if playfulness is possible when 'the other exists only as a bodyless face' (p.339). Using material from their practice in Israel, they describe a struggle to compensate for the world of information and sensations usually received from body-to-body contact and attribute this struggle to how tiring they found online work. They also conclude that for children who have not yet experienced a robust therapeutic alliance, the possibility of work in a virtual space is extremely limited.

Empirical research studies

There have been repeated calls for more research into technology-mediated therapies for children and young people (Sehon, 2019, De Seton, 2018, Stoll, Muller and Trachsel, 2020, Danese and Smith, 2020, Rousseau and Miconi, 2020), which is still dominated by studies into work with adult patients. In the following exploration of empirical research, papers are considered in chronological order. The final study is the only one that considers the delivery of digital services to children and adolescents and was written in the response to the Covid-19 crisis. Its scope is limited and it does not include 1:1 therapies.

In a meta-analytic review, Bee et al (2008) explore whether psychotherapy mediated by communication technologies can provide a clinically effective alternative to in-person therapy where access to psychotherapy is limited in under-served communities and because of illness and disability. Using thirteen published small-scale studies, they conclude that

remote therapy has the potential to overcome barriers to conventional services and they identify the popularity of telephone-based interventions due to widespread availability and ease of use. Identifying some methodological shortcomings of the individual studies, they call for more rigorous and large-scale trials. Perle and Nierenberg (2013) also argue for the place of 'telehealth' as a means of reaching those in need including elderly and rural populations, and in relieving the 'mental health burden' in the US. They claim that their literature review finds substantial evidence for the safe and effective utilization of 'telehealth' with positive clinical impacts, although it is not clear what modalities underpin the terms 'psychological telehealth' or 'mental health interventions'. They also highlight a need for continued assessment and randomised control trials and a focus on long term outcomes to study lasting effects.

In a Swedish randomised control trial, Lindqvist et al (2020) examine the effectiveness of 'affect-focused psychodynamic internet-based therapy' in comparison with a control condition of basic support from a therapist via text messages and claim that the internet-based therapy was significantly more effective. However, the title of this study is quite misleading as the term 'therapy' consists of an 8-week programme of self-help modules which include texts, videos and follow up activities which participants submit to their therapist and receive feedback alongside a weekly thirty minute 'chat session.' They claim that this intervention reduced depression and anxiety as well as enhancing emotional regulation and that treatment gains appeared to be maintained at a six month follow up. This is a surprising outcome and perhaps illustrates the many ways that technology can be used to support young people, through what might be better termed 'psycho-education' as well as therapies rooted in more robust theory and practice.

Irvine et al (2020) carried out a systematic review of fifteen research projects, comparing telephone with face-to-face psychological therapies, and found little evidence of differences between them in terms of therapeutic alliance, disclosure, empathy and participation. However, studies used in this systematic review were mostly concerned with short-term counselling or CBT treatments, which do not rely on unconscious communication and the experience of and interpretation of transference dynamics over time. The study also highlights patient and practitioner reluctance and ambivalence towards therapy by phone. Practitioner ambivalence was also identified by Cipoletta and Mocellin (2018) in a survey of Italian psychologists exploring the possibilities and constraints of online counselling. They identified a lack of clarity and concerns about ethical issues and participant ambivalence towards working online, and called for more research into the ways in which therapists can receive and understand the projections of clients' inner states when working remotely. Ethical issues in online psychotherapy are the subject of Stoll et al's narrative review (2020). The ethical arguments 'for' online psychotherapy lie mostly in the realm of convenience, increased access and service flexibility. Conversely, arguments 'against' online psychotherapy are concerned with issues surrounding privacy and confidentiality, the need for special training and technological difficulties and failures.

Martin et al's (2020) rapid review for the Early Intervention Foundation was intended to support public sector services for children and young people across the UK. They describe a rapid mobilisation of the delivery of virtual and digital services in response to the Covid-19 crisis and looked at evidence for interventions in areas including education, health and obesity, substance misuse, and mental health and wellbeing. Of the six interventions identified to support mental health and well-being, they found robust or preliminary evidence of the efficacy of two programmes, both targeted at young people aged 18 and over. The first, named 'Overcoming Social Anxiety' involves a young person working through series of CBT

exercises which are personalised for the individual depending on their responses to an initial questionnaire. A randomised control trial found that, after completion of the programme, participants had significantly reduced social anxiety. The second intervention was a smartphone app designed to reduce PTSD symptoms, providing users with psycho-education about PTSD, a self-assessment tool and coping tools such as breathing techniques. The trial found that, after completion of the programme, participants had significantly reduced PTSD symptoms and enhanced psycho-social functioning. Reflecting overall, Martin et al highlight the challenges of engaging highly vulnerable individuals with complex needs as well as the fact that access to the internet and an available, quiet and safe place are all barriers to the delivery of virtual and digital services. They also found that the rapid adaptation from face to face to digital delivery creates the risk that the core components which make the intervention effective could be lost.

I found no empirical research into the experience of child and adolescent psychotherapists working remotely, or into the experience of child and adolescent psychotherapists working during the Covid-19 pandemic.

Conclusions

This literature review has highlighted that the work of child psychotherapists both in the context of a global health crisis and using technology-mediated settings are under-researched areas. This is not surprising given that both were unchartered territory before March 2020. The literature and research outlined above illustrates that an exploration of online therapy has tended towards a polarised 'what is and what is not possible' debate. However, the exploration of the experience of practising psychoanalytic psychotherapy with children and adolescents both using remote methods and during a pandemic is rapidly expanding, with individual

practitioners offering their observations and reflections in the psychoanalytic journals. These outcomes demonstrate and support the value of my research, which offers an exploration of the qualitative experience of shifting settings as experienced by both the child or young person (albeit through the eyes and experience of the practitioner) and the psychotherapist in the context of a shared external threat and significant impingements to social interactions and everyday life.

CHAPTER 3: RESEARCH DESIGN

Introduction Aims and Goals

This is a qualitative research study. The aim is to provide a picture of a unique and unprecedented experience – that of trainee child and adolescent psychotherapists engaged in clinical work in the context of the Covid-19 pandemic. By trainee child and adolescent psychotherapist, I mean those engaged in a psychoanalytic training and, as such, trainee members of the Association of Child Psychotherapists (ACP). I pay special attention to the nature of unconscious communication within the therapist-patient relationship. I am curious to learn about the impact of an external threat on the quality and content of transference communication. For this reason, by 'clinical work' I mean that which is described as 'psychoanalytic child psychotherapy': long term weekly or intensive work with a child or adolescent patient, which is supported by regular supervision. It is important to note that this study seeks to understand the patient's experience as well as that of the clinician: that is, the child or young person's experience of psychotherapy and the therapeutic relationship, as seen through the eyes of their psychotherapist and experienced by them in the transference.

Between March 2020 and the summer of 2021, when the data for this study was collected, all trainee child and adolescent psychotherapists in the UK were at some time engaged in remote work, using telephones or screens. This study explores clinical experience immediately prior to the first national lockdown, during the period of remote work, and the return to face to face or in-person psychotherapy. It aims to explore how these ways of working and the transitions between them were experienced by trainee psychotherapists and their patients.

In this chapter I present my research design for this Interpretive Phenomenological Analysis (IPA) study. I examine the suitability of this methodology in relation to the aims and goals outlined above.

I give an account of the method, including the recruitment of participants, the interviewing process, data collection and analysis, considering various issues relating to ethics and the limitations and scope of a small-scale study. I discuss how I have experienced my own place in the various stages of the research process and the role of reflexivity in the research endeavour.

Methodology

Interpretative Phenomenological Analysis

I chose to use Interpretative Phenomenological Analysis in this study, because its epistemological viewpoint is consistent with the aims and rationale for my research, that is: 'to elicit rich, detailed, and first-person accounts of experiences and phenomena' (Pietkiewicz and Smith, 2014, p.10). IPA is founded on the theoretical perspectives of phenomenology, hermeneutics, and idiography. A phenomenological approach looks at the ways in which people make sense of their own experiences. IPA has a double hermeneutic since meaning is made first by the participants, then there is a further level of interpretation on the part of the researcher through his/her own in-depth analysis of those meanings. IPA is idiographic in that it draws attention to the particular and individual as opposed to the general (Smith, Flowers and Larkin, 2009).

IPA offers a good way of answering my research question because I am interested in the lived experience of child psychotherapists and their patients within a particular phenomenon. I aimed to collect data that not only describes experience but explores what meaning has been made of it. Child psychotherapists are well-placed in this respect since their work is primarily about making meaning. My research holds a firmly idiographic stance: each participant's experience will be particular to him/her and each vignette, patient-therapist interaction, transference communication and countertransference experience is unique.

IPA is based on 'the close, line-by-line analysis of the experiential claims, concerns and understandings' of each participant (Smith et al, 2009, p.79), during which repeated levels of interpretation lead towards the establishment of a set of connected themes. Through my own analysis of the data, I hope to draw out meaningful themes and connections between them in a way that is coherent and resonates with readers (Elliot, Fischer and Rennie, 1999). A key part of IPA is the development of a dialogue between the researcher, their coded data or themes and their psychological knowledge.

The Role of the Unconscious

This study is underpinned by the two perspectives of phenomenology and psychoanalysis. IPA and psychoanalytic thinking are well placed to complement each other in that both seek to make meaning out of lived experience and ask questions about what can be known and understood. Like IPA, psychoanalytic thinking is idiographic in that it is concerned with the specific as opposed to the general, and both aim to explore what is possible rather than claiming to know absolute truths. Smith et al (2009, p.80) assert 'the truth claims of an IPA analysis are always tentative and analysis is subjective' and Midgley (2006) has highlighted similarities between the development of psychoanalytic thought and an emphasis in modern qualitative research on 'cautious, changing and evolving understandings' (p.215).

In this study, the role of the unconscious is present at several levels. Firstly, it appears explicitly in what is said by the psychoanalytically trained participants, as they make sense of their experiences using a psychoanalytic lens. Indeed, two key concepts in psychoanalysis – transference and countertransference – appear in one of the interview questions. Secondly, participants have already thought about their experiences in clinical supervision alongside qualified and experienced psychoanalytic psychotherapists in the workplace or at the Tavistock Centre. In this way, the

experience of supervision could be seen to add another interpretative level to IPA's double hermeneutic. Participants frame their own experiences consciously to me as they reflect on their experiences and comment on what they think might have been going on unconsciously for their patients. As the researcher, using IPA and a psychoanalytic viewpoint, I will be thinking about what is unconsciously communicated to me through the data.

Methods

Data Collection: Participants, Interviews and Setting

Participants in this study are trainee psychotherapists enrolled on the Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy at the Tavistock and Portman NHS Foundation Trust. I chose to interview trainees as opposed to qualified psychotherapists for the following reasons. Firstly, the trainee population is easily accessible to me. I hoped they would be easier to recruit. I had heard from peers that they were finding it hard to recruit child psychotherapists in their NHS trusts and we had wondered as a cohort if this reflected the current and particular pressures of working in CAMHS. Secondly, trainees make sense of their experiences in personal analysis and during weekly supervision of their training cases; my hope has partly been to draw on meanings they have already thought about within their trainee role. However, this meant that participants were at the beginning of their careers, and hence their developing understanding of the role of the child psychotherapist and its theoretical underpinnings. Qualified psychotherapists would have made sense of the phenomenon in different ways and with more previous experience to draw on. In this sense, not including qualified psychotherapists could be seen as a lost opportunity.

Initially I chose to interview trainees who were in their second or third year of training in the spring of 2020 and to exclude first and fourth year trainees. First year trainees had their clinical training interrupted by the lockdown just six months into their training and I wondered whether sufficient

experience had been gained for reflection on the impact of the lockdown and move to remote working. Fourth year trainees would be harder to recruit, having completed their training a year before the point of data collection. An opportunity missed by this decision is that fourth year trainees would have had the unique and unprecedented task of working towards endings with all patients during the pandemic and via remote methods. This experience itself would be worthy of an independent research study and I have chosen to focus on on-going work.

Inclusion and exclusion criteria are summarised here:

Inclusion criteria	Exclusion criteria
Child and adolescent psychotherapy trainees at the Tavistock Clinic and registered with the Association of Child Psychotherapists (ACP) Second, third and fourth year trainees enrolled in academic year of 2020/2021 Trainees with placements in the NHS	Child and psychotherapy trainees at other training institutions First year trainees enrolled in academic year of 2020/2021. Trainee psychotherapists with whom I had shared group clinical supervision

Table 2: Inclusion and Exclusion criteria

Participants were recruited through an email sent to all third and fourth year trainees enrolled in the academic year of 2020/21. An initial invitation to take part resulted in very few expressions of interest from fourth years and this prompted me to re-visit the inclusion criteria and make an amendment to include second year trainees, who had been in their first year during the first Covid-19 lockdown. The final group of participants included one second year trainee, five third year trainees and two fourth years at the point of data collection in the summer of 2021. The eight participants included two men and six women. Six of the eight interviewees work in generic

CAMHS clinics whilst two work in split posts, working in both a community CAMHS clinic and a specialist service. This is a rather skewed study in that all the participants are white, although not all of them were British and, for two participants, English is not their primary language. Whilst it would be interesting to hear the perspectives of a more diverse group, the narrow scope and time limitations of this study meant that I included the first eight respondents, who in this case formed a homogenous group.

Participants were sent an information sheet after expressing an interest in the study (see Appendix B). Data was collected in the form of semi-structured interviews conducted on video link via Zoom. Interviews lasted between one hour and one hour fifteen minutes. Participants were sent an interview schedule a few days ahead of the interview, to allow for some initial, preparatory thinking. I aimed to frame the questions in a way that allowed for the full and open expression of participants' individual lived experiences and the meanings they make of these. A question I asked frequently during the interviews was 'how did you make sense of that?' The schedule served as a guide throughout the interviews, which mostly took a more conversational and naturalistic structure. Interviews were recorded using the record function on Zoom and the audio recording was then transcribed ad verbatim.

Moving from a research question to an interview schedule

The research questions set out in the Introduction were helpful in sharpening my focus for data collection. They are repeated here to demonstrate how I moved from a set of more generalised research questions to those in the interview schedule below, which are designed to uncover individual experiences and interpretations in line with the method of IPA.

- How are anxieties about an external, uncontainable threat revealed in a child psychotherapy session and what are the challenges in containing these?
- In what ways is the existence of an external threat felt to be present in the transference and countertransference?
- What is it like to work remotely as a child psychotherapist?
- How viable is unconscious communication in telephone and screen mediated child psychotherapy?
- What is the impact of working remotely on the nature of the psychoanalytic relationship?

Moving from the general research questions to those for the interviews, it was important to think about what I might be bringing to the research process, and how my choice of words might influence the participants and the data collected. For example, the words 'external' and 'uncontainable' could be seen as loaded and might communicate something to the participants of my own experiences and views. However, it felt important to include the word 'threat' because I wanted participants to think about their patients' anxieties in relation to the unfolding health crisis. I also chose not to ask explicitly for opinions on the efficacy or viability of remote psychotherapy. This would be too leading and not in line with the phenomenological underpinning of IPA. The interview schedule is shown below:

Interview schedule

- Can you tell me about the context within which you have been working during the coronavirus pandemic?

- Thinking back to the beginning and height of the pandemic, do you think anxieties about the threat of coronavirus were present in your sessions –

perhaps in the content of children's play or in the way children related to you?

- Can you tell me what it was like to move to remote working? What do you think it was like for your patients? What impact did the move to remote working have on your relationships with patients?

- Can you tell me about your experience of transference and countertransference in your remote work with patients? How was it different from the experience in the room?

- Can you tell me about your experiences and your patients' experiences of using technology for child psychotherapy?

- What has been your experience of returning to face-to-face work with patients after the national lockdowns?

- What do you think has been the impact of a period of remote working on your ongoing relationships with your patients?

- What was it like for you to work remotely as a child psychotherapist? What were the challenges/difficulties?

- Are there any other areas that we haven't talked about that come to mind?

Table 3: Interview Schedule

Ethical Considerations

The Health Research Authority's decision tool questionnaire (HRA 2020) confirmed that this project would not be considered research by the NHS. Ethics was therefore reviewed locally by the Tavistock Research Ethics Committee (TREC, 2020).

For this study, some ethical considerations lie in the realm of protecting anonymity and confidentiality, and transparency in communicating this to participants. The anonymity of participants and therefore the anonymity and confidentiality of their patients have been protected by taking several measures. Firstly, once the audio file has been downloaded from Zoom, the video file was deleted. No real names of people or places were used on file names or in transcripts. On two occasions a participant used the first name of a patient in an interview, and this was omitted from the transcript. Once the audio file had been transcribed, it was deleted and only the anonymised transcript kept, on a password protected computer. Paper copies of the transcript and coding were kept in a locked cabinet. These measures were explained to participants on their information sheet (Appendix B) attached to the initial recruitment email, as well as in the participant consent form (Appendix C).

Issues of ethics contributed to the inclusion and exclusion criteria when recruiting interviewees. Given that I am a member of the population from which my sample has been selected, it is inevitable that some participants would be known to me. We might be in the same cohort or share the same seminar or workshop groups. As a trainee child and adolescent psychotherapist at the Tavistock, I was known to all but two of my participants. This could potentially create tension between the multiple roles of clinician, trainee, and researcher. By excluding trainees with whom I have shared a small clinical supervision group, I aimed to ensure that there are clearly defined roles throughout the interview process. This protects both participants and researcher from the impact of uncomfortable feelings, vulnerabilities or perceived judgement being transferred from one context to another. Where interviews were carried out with participants who are known to me, my aim has been to approach each interview as a single, new encounter. I was careful to put previous experience

of the trainee and their caseload aside, 'bracketing' previous conceptions and knowledge, and using only the experiences which were described to me during the research interview.

A third area in which ethical considerations lie is the domain of participant welfare. My decision to conduct research into a phenomenon which brings with it the context of serious existential threat comes with responsibility, and I aimed to approach the interview process with sensitivity and respect. During the interviews it emerged that participants' personal experiences of the pandemic was varied: some had experienced Covid-19 first-hand, either becoming ill themselves or looking after loved ones. Some participants spoke of the pain of being away from loved ones, worrying about family members overseas and feeling anxious about their own health. On two occasions when participants shared something about their own personal experience during the pandemic, they asked for it not to be included in the transcripts. Given both the difficult personal and global context, and the fact that I was asking them to reflect on their countertransference feelings which can be stirring and painful, I tried to create a respectful and non-judgemental atmosphere during the interviews in order to allow for subjects and feelings to be explored in what felt like a safe way. Pietkiewicz and Smith (2014) state that 'it is crucial that the interviewer monitors how the interview is affecting the participant' (p.10). Using my own countertransference, when I felt that a participant had been experiencing or remembering something difficult or painful, I suggested that we took a small break. At the end of each interview, outside of the recording, there was a moment for reflection on what the experience had been like.

It is interesting to me that in these moments of reflection, all participants said that it had felt good to have the opportunity to share, think about, and make sense of the experiences of the past year. Participants also expressed a sense of satisfaction in knowing that their experiences and reflections will be shared with others and contribute to the on-going discussion about the qualitative differences

between in-person and remote psychotherapy, as well as the clinical possibilities and limitations of the latter and the experience of Covid-19 as a whole. With hindsight, I would include these ending reflections in the transcripts and the data analysis, but in this case they happened once I had stopped recording.

Data Analysis

This study's data, that is the research interview transcripts, were analysed using IPA, following the step-by-step process set out by Smith, Flowers and Larkin (2009). This process is summarised here:

1. **Reading and re-reading:** immersion in the original data through close and repeated viewings and readings of interview transcripts.

2. **Initial noting:** Making exploratory notes, examining semantic content and language use. Making notes on content, use of language and possible interpretations.

3. **Developing emergent themes:** Revisiting notes to identify themes in the researcher's analysis**.**

4. **Searching for connection across themes:** Grouping themes together to produce a structure of themes and sub-themes.

5. **Moving to the next case:** Bracketing off the analysis of one case and beginning the process again.

6. **Looking for patterns across cases:** Carefully identifying generalities in the data.

The process of IPA and researcher reflexivity

It has been my aim to foster a reflexive relationship with the research, an intention which sets it as 'an internal, emotional task as well as an external, academic one' (Brown, 2006, p.187). When viewing the video recordings, I often felt very close to the data. I think this was because I could recognise something of my own experience in the material, and some of the participants I know

personally. Strong feelings were evoked during the interview process. It was easy to visualise participants' experiences as well as to be with the feelings that were expressed both explicitly and though the nuances of language and expression. This was both helpful and unhelpful at times. It made it easy to fully immerse myself, but I also felt somewhat bombarded, and it was difficult to make a space between myself and the data in order to take an analytical stance. I also found that when note-taking, if I re-read the transcripts on their own or with just the audio file playing, the experience of data analysis felt flat and two-dimensional. This was unsatisfying, as if an important element was missing. I talked about this in my research supervision group and a peer researcher suggested that I have the video playing at the note-taking stage so that I could see the faces of my participants. This made the stage of note-taking flow more easily, and it became a more lively and embodied experience.

Due to the timing of the interviews and availability of participants, it was not possible to fully analyse one interview before conducting the next. In fact, I conducted all eight interviews before beginning the process of analysis, although I did transcribe each one straight away. Pietkiewicz and Smith (2014), in their guide to using IPA, state 'the fundamental principle behind the idiographic approach is to explore every single case before producing any general statements' (p.8) and Smith and Osborn (2003) suggest that a researcher conducting more than three interviews might prefer to use themes from previous participants' accounts to guide subsequent analyses. Whilst it felt important to treat each interview and transcript as a new encounter, I have wondered how possible it is to approach each one without - to use Bion's phrase - memory or desire (1988). I found that I began to look for themes already identified once I had analysed the first four interviews, but I was careful not to make assumptions and, in my notes, tried to preserve the uniqueness of each participant's experience. This sharpened my focus towards depth as opposed to breadth.

Aware of the importance of triangulation in qualitative research, I took my initial themes to my research supervisor and to a fortnightly peer supervision group, where we discussed them and thought about the ways in which they overlapped and linked together. The process of triangulation - getting a third position between and in relation to the data and myself - represents an effort to bring a fresh perspective to the research process and helped to keep my conceptions and perceptions under scrutiny.

My interest in both the experiences of trainee child psychotherapists *and* their patients perhaps sets up a dilemma in the process of analysis and further discussion. Data collected about the two groups cannot be treated in the same way, since they have been gathered using different methods. I speak directly to trainees and hear first-hand what they saw, heard, felt. I hear about ways in which they have made sense of these. I do not hear from the patients themselves, but I am clear about my interest in their experience of the same (yet different, as experienced from another perspective) phenomenon. For patients as subjects, I rely on what I hear from their therapists. The experiences of patients are therefore seen through the perspective of the clinician, as experienced through him/her using his/her skills of observation, description, and interpretation, then communicated to me as the researcher. As such, my aim is not to provide further interpretations of clinical material but to think about the ways in which clinicians make meaning of the interactions and experiences they have had with their young patients. My own interpretation of the findings adds to those of participants' in the double hermeneutic. There are drawbacks and challenges as well as strengths brought about by the double hermeneutic and the method of IPA. One might ask how generalisable it is to rely on participants own interpretations of their work using a sample of eight people. How subjective are these and how much do they depend on meanings made alongside supervisors and in personal analysis? The nature of IPA makes the outcomes of the study tentative, subjective and without claims of finding absolute truths. As a study conducted at a point in time with unique and transitory circumstances, it would be impossible to replicate.

There are inevitable potential tensions and dilemmas present in carrying out a research project of this type. I have striven to realise the ontological and epistemological intentions of my chosen methodology, which asks: what has been the lived experience by individuals of the phenomenon, and what sense have they made of that experience? The research question both defines and limits what can be found. It places the research enquiry within a particular population group and a specific time frame. The study design and the method of analysis affect the nature of the data and the analysis of it. It is qualitative, descriptive, exploratory, and idiographic. My intention is to ask how a phenomenon was experienced, not make judgments or state opinions about practice.

Place of Self, Countertransference and Reflexivity

As stated above, this is a study with an interest in the unconscious at its centre. Maintaining transparency about this intention, and the psychoanalytic underpinnings of interpretations made by both the participants and me as the researcher, will contribute to its validity. Again, I acknowledge that as the researcher, I am in the same group as the participants in the study; I too am in the position of a trainee child and adolescent psychotherapist and worked with my patients during the Covid-19 pandemic. This brings a peculiar dilemma in relation to my place in the study. Questions arise: should I make attempts at 'bracketing', the process of putting aside my own experiences and what I think I already know about the phenomenon, or are my own experiences relevant? How possible is it to bracket my own experiences? Can they bring something to the research rather than be seen as a potential hindrance? After all, the fact that I have my own lived experience of the phenomenon under scrutiny is what brought my interest to the topic in the first place. My own experiences preceded the research and it feels right to state what they are in order to keep them out of the data analysis, but there is a fine line between how much to include and how much to bracket. For the sake of transparency and 'owning one's perspective' (Elliot et al, p.221), I have decided to give space to my own, unique experiences of the phenomenon and my attempts to understand them. This

brings my own experiences into focus and adds another narrative layer, separate from the data analysis. This short reflective piece, in which I reflect on my experiences of working in the pandemic with four of my training cases, can be found in Appendix D. Reflecting on this further, I have questioned how bracketing my own lived experience and preconceived ideas can actually be achieved and whether this might be to some extent both elusive and illusory. My own experiences during Covd-19 were characterised by loss, frustration, powerlessness and isolation, and my experience of clinical work was mostly negative and something I did not enjoy. I remember feeling the painful absence of a sense of agency in relation to my role and my place in the wider CAMHS team. There was a long delay in setting up appropriate technology for online work within my trust and for weeks I was without a laptop, using WhatsApp on a work iPhone to communicate with the young people and families on my caseload. 'Bracketing' this is experience is not straightforward and I wonder whether my own lived experience has been part of the research process in ways that I did not realise when I was immersed in it. I have puzzled over this: was my interest and drive to carry out this research fuelled by a desire to repair both a professional and personal, internal rupture? What were my countertransference responses to the data and to what extent were these influenced by my lived experience? Did I have an unconscious desire to hear that others had struggled as much as I had, or was I hoping to find the opposite? Did interviewing my peers stir up uncomfortable feelings of rivalry and comparison? Although I was genuinely moved when I heard about the positive experiences of what had been possible by other trainee psychotherapists, I do think it was also painful to hear that others had achieved more and been able to make connections in a way that I perhaps had not. If I am truly honest, I do think some envy as well as admiration was evoked. Whilst there was a conscious desire to protect the research from these, I feel it is important to remain true to a psychoanalytic stance and acknowledge that unconscious drives and anxieties are present and cannot always be known about in the moment.

Etherington (2004) states that thinking about the place of the self is a key part of any qualitative research study and this must 'inform decisions, actions and interpretations at all stages' (p.36). The nature of a phenomenological enquiry lies in approaching another person's experience by means of reflecting on our own perceptions of the world (Smith et al, 2009). Throughout the research process, I have reflected on my role as researcher and the ways in which I am an instrument in the research process. The outcomes of the study are inevitably a result of what I have brought to it: my own underlying assumptions, biases, and unconscious motivations. I have asked myself how I am connected to the research theoretically, experientially, and emotionally, and what effect these will have on my approach and the data. It is certainly motivated by my own experiences. Working as a trainee child and adolescent psychotherapist during the pandemic was generally a negative and very challenging experience that was at times traumatic and very frustrating.

Finlay (2003a) describes reflexivity as the 'project of examining how the researcher and inter-subjective elements impact on and transform research' (p.4) and unlike reflection which takes place after the event, reflexivity involves 'immediate, continuing, dynamic and subjective self-awareness' (Finlay, 2003b, p. 108). I have considered my own place in the different stages of the research endeavour. What have I consciously and unconsciously brought to the interview process – in the way I approached participants, framed the questions, or conducted the interviews? What were the reasons for choosing to ask supplementary questions or moving on to another topic and were these decisions dependent on the participants and their responses? Was I at any time directing the interview towards an outcome that was already unconsciously determined, in line with my own experience? Again, was I, in an attempt at some kind of internal reparation, searching for experiences that were different from my own? Countertransference responses to the interview and data were strong and I have wondered to what extent a bias has emerged in the data analysis towards seeing the experience of working during a pandemic as difficult, negative and characterised by loss.

Keeping a reflexive journal throughout the research process was a helpful way of keeping my mind focused on these issues. Making a note of countertransference responses allowed me to bring into consciousness what was going on inside of myself as well as between me and both the participants and the data. I was also able to speak to this in my own personal analysis.

Furthermore, my own countertransference responses to the participants and the material they brought contributed to a dilemma I had when choosing examples and vignettes to include when writing up the findings. Strong feelings had been expressed in the interviews and I had been affected by these. I was grateful to my participants for evoking their unique and often painful experiences so freely. There were moments when they had clearly felt vulnerable and anxious. I found it very hard to collate and summarise their experiences in my own words and found that I had chosen far too many quotes to illustrate the themes. Again and again, I came to an impasse as I felt a responsibility to the participants to present the data in their own words. I realised that I needed to put distance between myself and the data before I could write up the findings. I took a few weeks away from the project to write my qualifying clinical paper, and, when I returned, found that the distance had helped. With some time apart, my relationship with the data and the participants had changed and I felt much more robust in being able to summarise, compare, encapsulate and omit parts of the data transcripts as well as choose direct quotes that would best illustrate the themes, show both individual experiences and common threads, and hopefully achieve my aim of 'resonating with readers' (Elliot at al, 1999, p.7).

I have reflected on this idea of taking time away from an experience and returning to it with a fresher perspective and renewed clarity. I have wondered if it in some way links to an aspect of the study that could be seen as a strength, but also a limitation. My participants were talking about their lived experience in the here and now, or at least in very recent times. In some ways this makes the data

'live,' and captures an emotional experience that inevitably would become less potent over time. But in such a short time frame, how possible is it to understand our experiences and responses and those of our young patients? This brings to mind a comment made by the Editor-in-Chief of the Journal of Child Psychotherapy in its December 2020 issue, which was dedicated to working in Covid-19 times:

> '*It will be a very long time before we understand the scale or detail of how the pandemic has affected our world. We might expect that it will be longer still before we can really understand how we responded in the consulting room and why.*' (De Rementeria, 2020, p.269)

CHAPTER 4: FINDINGS

The outcomes from the analysis of interview transcripts are laid out in this chapter. There are three main themes, each with four sub-themes, which are explored in turn. Where themes are inter-connected, I have pointed out the links. The clinical experiences of participants are summarised and collected around each theme, as well as explored through more detailed examples, often from participants' intensive cases, some of which span across different themes. All participants are given pseudonyms.

The themes are outlined here:

Main theme	Subordinate themes
1. Experiences of rupture and loss	a. A sudden change / no time to think
	b. Lost connections – '*and you'd be left without anything'*
	c. Loss of a sensory experience – '*it felt different; there was just something lacking.'*
	d. Mourning lost cases
2. Experiencing a shifting frame	a. Relying on parents
	b. The patient's use of the setting
	c. How private is a home
	d. Safety / risk
3. What kind of object am I in the child's mind	a. Early experiences repeated
	b. Being experienced as a cruel object – 'a mean twin'
	c. Holding on to the good whilst being apart
	d. The capacity to survive: 'a beautiful reunion'

Table 4: Themes and subordinate themes

1. Experiences of rupture and loss

a. A sudden change / no time to think

This theme touches on the language of shock and totality found in the data as participants describe their responses to the closure of clinics during the first lockdown. Their words, as well as the way they were spoken, reflect the abrupt and unprecedented nature of the phenomenon.

When coding on a linguistic level, I was struck by the number of pauses, hesitations, and repeated words I found in the data when participants speak about their experiences at the beginning of the pandemic and the first lockdown. Six out of eight participants comment that it is hard to recall the timings and detail.

> *'Um… it's hard to remember when things happened…looking back from, like, March time, everything was so heightened, I don't know… anxiety was so high in the clinic… and just everywhere… you know, people trying to keep a distance, constantly washing our hands so they were so sore… um… everyone feeling nervous and it was very hard to be in a therapeutic state of mind…'* (Rebecca)

The language reflects an experience that was difficult to grasp, put into words, or think about in a coherent way. The words '*sudden', 'abrupt', 'shock', 'uncertain', 'difficult'* and *'rupture*' are used repeatedly, as well as words denoting a feeling of totality: '*everything', 'everyone', 'completely', 'massive'*. A sense of something being suddenly imposed from above, with little choice or sense of control and no time to prepare, is present.

> *'There was such little time to think…I mean a lot of thinking was done, but very quickly… I… we usually think in much more reflective and long-term ways. These are organisations that would probably value themselves on stopping and pausing and thinking but we didn't have that luxury in this situation so a lot of panicky kind of scraped together plans were made. And I think that's really hard.'* (Bridget)

Participants describe feeling deskilled, anxious and in shock. There is some variation in experiences described, ranging from one participant who was able to see all her patients in person to talk about the upcoming move to remote therapy, to another who became ill with the virus herself, finding upon her return from sick leave that everything had changed, and she did not meet with her patients again for several months. Michael was left to make plans without his service supervisor, who was on sick leave with Covid-19 in March 2020, leaving him '*not really knowing how to carry on… so I just had to muddle through.'*

b. Lost connections – '*and you'd be left without anything'*

This theme speaks of the frustrations present when relying upon technology, and the difficulties in staying connected with patients during remote working. These are exemplified using striking existential and figurative language.

All participants describe the exasperation and distress they felt when technology failed in some way. Difficulties in establishing and maintaining links during remote sessions are described with raised eyebrows and heightened voices, and strong feelings of frustration and anger are communicated. There are many examples of the internet 'going down', the sound not working, platforms 'dropping out', cameras failing, cameras and speakers out of sync, laptops running out of charge. The words '*falling', 'dropping', 'losing', 'crashing*' are found repeatedly, as well as '*fragile', 'desperate'* and '*tentative*'.

> '*It felt like purgatory at times. You'd think, 'am I going mad?!' I think I am going mad! I'm fully prepared to have this session and it's just crashed… and I'm thinking of these eight-year-olds on their own in a room… it was more like that in the beginning… absolute despair.'* (Kelly)

The language used, of being 'lost' and 'found again' has an existential flavour, as if the survival of something vital is at stake. Very strong countertransference feelings are described. Natalia laughs with disbelief when remembering her experience of trying to hold on to a phone connection with a young adolescent girl, even calling the clinic administrators to ask for help, telling them to '*leave everything else… this is a matter of life and death*!' She goes on to say '*I can't even convey how wonderful it was when we managed to speak but it just felt like we really fought to be together.'*

The quality of technology and internet connections made meaningful work feel at times impossible. The pain of this is apparent in the tone of voice and facial expressions captured on the video recordings. Participants worried about the impact on their young patients of repeatedly dropping out, disappearing, and freezing. Sometimes if felt as though the distance created between therapist and child was too big to make anything work, and three participants felt that all that could be managed was a superficial checking in before the connection was lost, leading to feelings of powerlessness and desperation and being 'not good enough.'

This theme links strongly with later themes about who the therapist became in the child's mind; sudden ruptures and frozen screens stirring up the patient's past experiences of failures in containment as well as fantasies about the therapist.

c. Loss of a sensory experience – '*it felt different; there was just something lacking.'*

This theme is about what was felt to be absent and how this relates to sensory aspects of communication. As such, the experience seemed difficult to put into words. Whilst some senses were lost, others took on new meanings.

There is a sense of something being lost by not being in the same physical space. The words and phrases '*live*', '*alive*', '*lively*,' '*aliveness*', '*hot*' and '*muted*' as well as '*not the same*' *not good enough*, '*something missing'*, appear repeatedly, and it was noticeable from the linguistic features how difficult it seemed for participants to make sense of an altered sensory experience, as if they were still grappling with this, months after moving to remote work. The language used was tentative with many pauses and phrases such as '*somehow, something*,' '*I don't know*…'. Voices often had a puzzling tone, with sentences turning upwards at the end, as if asking a question rather than making a statement.

Three times in the data this theme, of loss of a full sensory experience of another person's presence, is linked to a desire to be a '*good therapist'*, wanting to do a '*good job'*, and worries about being '*not good enough'*. Bridget even wonders whether she was experienced as a real person at times. She reflects that her female adolescent patient was able to hide behind the phone, denying her feelings of anger, but communicating them by banging about in the background and then saying that nothing was happening. This caused Bridget to cast doubt over what she could only hear and imagine; she concludes '*I began to not even trust the senses I did have at my disposal.'*

For Kelly, the loss of two bodies in the room removes the messy, tactile nature of work with her intensive latency patient:

> *'I lost all of the sensory input that I would have in the room. He made all sorts of little noises in the clinic room that I couldn't hear on the video. He was a terrible farter as well. And so the atmosphere in the clinic room was really putrid. And that's all lost. In the clinic room he would keep some sort of, I always thought of it as an umbilical cord link, just a tiny part of his body in contact with my body physically, you know it might be a toe. And of course, you can't do that on video.'*
> (Kelly)

And for Rebecca, the loss of sensory information precipitated the discovery of creative new ways of communicating on the phone with a nine-year-old girl who seemed to easily drift off in the absence of a shared play space. They found a way of playing with voices and sound. After the girl sang down the phone, Rebecca began to sing back to her, and they would tap out different rhythms for each other to copy and build on. She reflects:

> *'I think we were kind of saying, okay, we can't see each other, we can't play together, we can't share the same toys or be in the same room. But we have our voices. That was a way of keeping connected.'* (Rebecca)

d. Mourning lost cases

This theme speaks of endings experienced during the pandemic and the way they were experienced both at the time and as participants made sense of them over time.

Feelings of sadness are expressed in relation to cases that ended prematurely during the early months of the pandemic. Some were lost because the separation of remote working proved too difficult, and others because of family breakdown brought about by the stress of repeated lockdowns and social isolation. Here participants' accounts seem to trail off mid-sentence, or end with a pause, as if there is something more to say but the words cannot be found.

Describing a case with an older adolescent whose foster placement broke down because of tensions around sticking to lockdown rules, Rebecca expressed a deep sense of loss. Her voice is flat and hollow as she describes his move to temporary accommodation and involvement in petty crime.

> '*I never got to see him again. And I just carry that with me because I feel like that is such a loss as he was doing so well. And he was really engaged and I felt very caring towards him. And it's very… it's really hard to have that taken away. And if the pandemic hadn't happened, he probably would have stayed with the family. We could have done some work together. It just feels like a massive loss and I don't know what's happened to him...'* (Rebecca)

For Susan and an adolescent patient, the case broke down at the point when the clinic sessions resumed. The girl lived with her grandparents after a breakdown of the relationship with her mother, but there had been hopes that this could be repaired. Because her grandparents were physically vulnerable and shielding, links between the patient and her mother became more distant and cut off. When it was possible to resume face to face working, her mother disengaged and said she couldn't manage to bring the girl back to the clinic. Susan understood the ending in terms of the situation worsening for the family during the pandemic, the patient's loss of faith that things could change, and the transference of feelings of disappointment onto the therapist:

> *'I think I had become the disappointing mother who wasn't there, you know, I would only be there for fifty minutes, once a week, on the phone. And in the end the case broke down, the girl herself didn't want to come in anymore. And I could understand why, nothing in her family had changed for the better, in fact it had got worse.*' (Susan)

The ways in which participants have understood ruptures in the work is further explored within the third, broader theme of the therapist as an object in the patient's mind.

2. <u>Experiencing a shifting frame</u>

a. Relying on parents

Within this theme are participants' concerns and frustrations in relation to passing aspects of the therapeutic frame to the responsibility of a child's parents. Implications for keeping a case going are touched upon.

Participants describe the need for considerable groundwork alongside parents in setting up a space at home: getting together suitable toys and resources, establishing whether there was an adequate WIFI signal as well as a reliable and available device, deciding where to place it, making sure the device was fully charged and set up on time. This creation of a new setting was described by Kelly as a '*massive piece of work at the beginning – I remember it as a really intense period*.' Elsewhere it is described as '*challenging*' and '*exhausting*'. All participants speak of the frustration of needing to call parents mid-session to ask them to come and attend to connection issues or manage boundaries and behaviour, causing repeated disruptions and creating complicated dynamics.

> *'And it was hard - really frustrating. Mum tried her best and she did try to facilitate it. She had to put the laptop out of his reach, because he would turn it on and off and I would have to call her to come out. It was really tricky. In the end she put it on a high cupboard so he couldn't fiddle with it, but then I could only see so much of the room, and sometimes I couldn't see him at all….'* (Rebecca)

> *'I could tell he was looking at something but he said he wasn't. He would turn off his camera and sometimes his sound. I ended up finding it really difficult because I'd then have to start calling Mum in to check because I didn't know if he was looking at inappropriate things on the computer and I found it really, really complicated. That sense of he's a boy who can be very dangerous. And how do you keep someone safe when you're not in the same room as them? I felt like I heavily relied on Mum for this. At times, it helped in building us as a unit. And at times, she felt that she was having to enforce my rules. And it was causing issues between the two of them.'* (Bridget)

For Sophia, the therapist-parent alliance helped a piece of work to survive the move to remote working. An adolescent patient was refusing to meet via phone or video, but Sophia kept in regular contact with his mother. They developed a good working relationship which then enabled them to help the boy re-engage with his therapy. And for Susan and a weekly under-five case, a piece of parent-child psychotherapy grew out of the fostering of a therapist-parent alliance, although she reflected that she may have been pulled into this new way of working by the mother's own needs and loneliness during the national lockdowns and wondered if the boy had consequently lost out.

A common concern found in the data is for those families for whom this alliance proved to be too difficult. Wealth inequalities and parents' own vulnerabilities were brought into painful awareness for therapists. They spoke of the most vulnerable families not being able to cope with the kind of organisation required to keep a piece of remote work going, and some not having access to computers at all.

> '*It feels so humiliating when someone has to tell you, well, actually, I don't have a phone, or I don't have the internet at home*.' (Sophia)

b. The patient's use of the setting

This theme outlines some of the ways in which children used aspects of the technology to communicate, control and create as well as their therapists' countertransference responses to these.

Participants speak about the ways in which children and adolescents used the technology and how challenging this became at times. They tell of patients not answering calls or joining video sessions, turning devices off mid-session, muting their therapist or themselves, playing video

games or watching YouTube during sessions, disappearing from view, placing their device in a way that meant they were out of the frame. This caused a lot of anxiety in participants as they were left to imagine what was going on. There are also many examples of children moving around with their device – walking or running around the room, especially spinning around and giving the therapist the experience of being '*jolted and thrown around*,' taking the device/therapist around the home into different rooms, including to the bathroom. A young under-five intensive patient even delighted in placing his therapist Jack ('in' the iPad) in his mother's sock drawer. Participants describe children repeating these behaviours many times during and across sessions. They tried to make sense of these experiences in relation to patients' past experiences and previous themes in therapy as well as the experience of a sudden separation, describing what they thought of as omnipotent defences against feelings of vulnerability and dependency, and the projection of feelings of rejection and fragmentation into the therapist.

Rebecca describes the responses of her under-five intensive patient, a traumatised boy living in kinship care. He became confused by seeing her on a screen and after some time she discovered that he thought she lived in the iPad. He would deliberately knock it over so that they could no longer see each other, eliciting a response from her that would necessitate her ringing his carer to come back into the room to set it up gain, repeating a sequence of failures and attempted repair that she recognised as a re-enactment of his early experiences of being cared for.

Michael makes sense of the ways in which his vision-impaired patient used technology in the context of his early experiences and disability, feeling that he was being given an experience of the boy's sensory impairment and frustration. The boy repeatedly and deliberately

disconnected the WIFI router, busied himself outside of the camera frame, banged things in the background so that he could not be heard, and made accusations that Michael had not been listening or paying attention. Michael suspected that this had been his experience at school and with his parents and described in the countertransference '*getting very much into the role of being blamed, powerless and got at.'* He describes feeling how hard this had been for his patient, and through the technology he was able to communicate this to the therapist, who could help him to see that some of his experience was being understood.

> *'And I think that reassured him and enabled him to be more vulnerable and bring the experience more from his point of view rather than putting it into me.'* (Michael)

In the following extract, Jack describes how a game of hide and seek in video sessions evolved over time and how this supported his young under five intensive patient, an adopted child with a diagnosis of Foetal Alcohol Syndrome, in allowing himself to be helped:

> *'Obviously, I couldn't look for him, but I could guess where he was. Initially this instilled in him a sense that I was interested in finding him, that it was important to me to find him. I think that allowed him to start to internalise something good about me. And from there the game kind of developed... he would move the camera instead, which allowed him to hide without hiding and he got a lot of enjoyment out of that. And that developed into the idea of seeing things from different perspectives: I could see the wall and he could see the whole room, so we were different, which linked up with his idea that when he gets very dysregulated, everyone else is overwhelmed and unable to care for him. It helped him to see that children and adults are different and that adults might have capacities to look after him that he doesn't have. And I think that allowed him to be more the child in the relationship. This was very important for him because he was getting into all sorts of omnipotent states in his relationship with his Mum – not letting her be the adult. From there it developed a little bit further, even… A big thing for him was around dealing with not knowing. He really needed to know everything. We started to develop the idea of me hiding on screen. I was allowed to hide, but with one part of my body still showing, so he could find me straight away. But we started to develop the idea*

that if I hid completely, he would have to allow me to help him to find me by asking questions. This really developed the idea that when you are struggling with something, you might need help from someone else, and that when you allow people to help you, you can get through something that might be a bit worrying, because I think when I disappeared completely, it stirred up a lot of anxiety for him. Again, the technology really helped with that, because I would not have been able to completely disappear in the room.' (Jack)

Kelly was surprised when her latency intensive patient chose to use the chat function for whole sessions, barely speaking at all. Together they constructed a creation story which Kelly came to understand as a version of his very traumatic birth; he had been born not breathing and needed life support. This quiet 'to and fro' of messaging whilst sitting together slowed down communication and allowed the child an opportunity to communicate his experience of 'just surviving.'

'He was a child who broke links between us regularly, you know, he would type random letter strings and it would be quite violent at times, just running his hands across the keyboard. But I guess there was the part of him that did want to connect and the part of me that just had to work really hard to find a meaning. He would do these random letters strings, and I started to just talk with him about how hard it is to communicate. I mean, I didn't put it in that kind of way. But you know, that kind of idea - how hard it was for him to get his message across to me, when I was in my room, and he was in his room, how hard, how disappointing. And, you know, it was like, it was quite beautiful in a way because he, he did have a sense of humour. And at certain times, I could see little patterns appear in what he was doing. And if I commented on the pattern, I could see a bit of a lighter mood become possible. And then slowly, and over time, he started to type a story. He might type something about in the beginning, there was a big bang. And it was like, his idea of the primal scene of the original conception, his conception. And so I start thinking about his story on two levels. And it was deeply moving, because I mean, basically, the story, the way it unfolded was… he'd say, 'and it rained for thousands and thousands of years.' And at that point, it just felt between us so deeply sad, and I just thought about a baby crying. You know, and I put it into words, and it seems to feel right. And then he types the next thing. And it's just really moving. He talks about cells that get poisoned by oxygen. Um and, you know, the very thing that's supposed to keep us alive, and as I'm falling into despair, he kind of, towards the end, and it's nearly right at the end of the session, he says, 'but one cell evolved to use the oxygen' and I could have cried. And the

> *session ended practically at that point and the beam on his face when he could see that we'd created something together! It was really something.'* (Kelly)

Participants' reflections on play tend to focus on the ways in which children played with or manipulated the technology. Bridget reflects that it felt like watching rather than '*playing with'*, and that some of her younger patients felt it was '*all on them'*, which could be inhibiting.

c. How private is a home

In this theme participants reflect on the strange and often painful experience of conducting clinical work from their own homes. Issues of trust and confidentiality are explored in relation participants' their own homes and lives, and those of their patients.

Participants are keen to describe and explore the unique experience of being in contact with their patients whilst situated in their own homes. Their voices rise and eyes widen in lively disbelief and painful recognition of the impact of this on their personal lives, some experiencing their own personal losses whilst striving to carry on working. The words '*lonely*', '*alone in the work*,' '*removed*' and '*isolated*' as well as '*bizarre', 'strange'*, '*weird*', '*intrusive*', and '*bombarded*' feature in the transcripts. All participants welcome a chance to detail the ways in which they adapted their own home environment and negotiated the use of a space shared with partners, their own children and flatmates. For some this created tension and put strain on personal relationships, and there were worries about maintaining a private, confidential space in shared homes. Most participants were forced to work in their own bedrooms, transforming part of the room into a neutral space, removing pictures and setting up a workspace against a blank wall. Bridget describes the discomfort of working in a small bedroom in a one-bedroom flat, feeling unable to open windows which would let in the busy sounds of the street. Michael speaks about the complexities of working from his bedroom at

home, with no physical separation between work and personal life, and not knowing what to 'do' with difficult material and projections when a session ended. Sophia speaks about the pain and repulsion she felt after a young girl disclosed sexual abuse to her as they each sat in their bedrooms. Without a journey home or colleagues close by, she felt the need to cry and take a long walk outside, alone.

Concerns about privacy and confidentiality recur in the data. Participants speak of the discomfort of feeling watched and intruded upon. They describe how this shaped their therapeutic responses as well as helped them to understand the child's own experiences. Jack describes a powerful sense of not knowing who was listening in on sessions when the boy he was seeing was in a home where there was suspected coercive control by the boy's father. Jack said he felt '*very on edge, not free'*, noticed that he became reluctant to ask questions and felt a pull towards changing the direction of the session when the boy spoke about his parents. Jack's patient let him know that his father was listening, and the sessions moved to a private space in school - a relief for them both. Jack reflects that the '*incredibly intrusive*' experience gave him a taste of what home life was like for his patient.

Michael speaks of intense transference experiences expressed in face-to-face sessions as his latency patient found it difficult to communicate verbally and used bodily contact instead. In order to communicate something that felt 'abusive' and 'creepy' the child '*would terrorise me and chase me and try and molest me and hurt me, edge up to me in the room and try and look up my trouser leg, saying he could see my genitals…*' Online, the boy tried to take photos and videos of Michael, giving him a similar feeling of being trapped and abused. Michael describes the '*creepiness*' as the '*same but also different. It wasn't as potent and it wasn't as exhausting.*'

Natalia found that she changed the style of transference interpretations, knowing that a young boy's mother, who had her own mental health difficulties, was listening in:

> '*Instead of saying that he really wanted to be with me, and it felt unbearable that he couldn't come close to me, I would say he really worried about the people who mattered to him. I was speaking about 'people' and wanting to be on 'people's' minds. But I think this was difficult because he was little, and he actually did respond quite well to direct interpretations, and this was just confusing and hypothetical for him. You know, who are these people?'* (Natalia)

d. Safety /risk

This theme deals with feelings stirred up in participants in relation to keeping patients' safe whilst being apart. The relationship between distance/closeness and violence and sexuality are explored.

Every participant experienced children using the physical space in ways which were felt to be unsafe: climbing on tables and window ledges, scaling up bookshelves and jumping on beds and chairs and doing back flips. This seemed to stir up great anxiety and caused them to reflect on how possible it is to keep a child safe in a remote home setting. Frequent disruptions are described, as parents were contacted to intervene.

> *'I felt huge danger in that first session. I mean, he started climbing up onto the window ledge and I had this real fear that he was just going to fall out the window and die. And I do think he was a boy who felt very uncontained. You know, with this flat image on a screen.'* (Kelly)

Rebecca describes her under five intensive patient finding it helpful to walk around with the phone and show her what it's like for him when he wakes in the night and thinks something scary has come into his room. Natalia and Bridget both speak of cases whereby the separation and distance were felt to be helpful with children who had previously been violent in the clinic.

Because the child could no longer physically hurt their therapist, they were no longer frightened of hurting their therapist or being hurt by their therapist; taking the heat out made space for something more thoughtful and hopeful. Bridget thought that for a ten-year-old girl who was moving into residential care and facing a painful ending, the distance provided by Zoom enabled talking and relating as opposed to '*acting out the chaos'*. The girl, who had been very violent in the room and often left sessions part way through, managed to use the chat function to write messages about how she was going to miss Bridget and how sad it was to say goodbye.

> *'She couldn't actually hurt me. So she could stay with the feelings a bit more, because she knew that I was safe, I think. And the thought of what she was capable of in the room had terrified her.'* (Bridget)

In work with adolescents, issues of safety, risk, closeness and distance lay more in the realm of sexuality. Bridget and Natalia both spoke of their suspicions or fantasies that patients were viewing pornographic material whilst on the phone, of hearing the clicking noises of a computer and of feeling '*kept in the dark*'. Adolescents often chose the phone over Zoom when given a choice, and Michael tries to make sense of this for his female patients:

> *'I think it's about sexuality. I think there are connotations for them at that age. I mean, I'm not up to date on social media and whatnot. But sexting, and you know, taking dick pics or whatever goes on. Yeah, I think the connotations of a computer screen are a bit kind of… what's the word? You know, they stir stuff up in a way that that I think makes it harder for them. It adds a level of ambiguity to the relationship. You're doing something you might do with a boyfriend or at least that you hear people do with their boyfriends… or the screen connotes something (sigh) not arousing, but kind of inflaming of something that is already there, maybe. I think a lot of males take advantage of females at that age and beyond. I think being exposed on a screen… yes, having your appearance scrutinised like that… Someone can look at you in a way that you don't quite get a sense of in person.'* (Michael)

Sophia and Natalia describe their experiences with adolescents and the expression of sexuality in remote sessions, both feeling that something was 'freed up' by the distance between them.

> *'He felt almost like a big latency boy. It was very difficult to explore sexuality and fantasies and difficult feelings towards me. And I felt so sleepy in his sessions. I think in the video, that danger of going into those dynamics was lifted, and he felt a bit less scared about thoughts about me being a woman, and him being a boy and the fantasies he might have. And when we came back to the room things had changed. We could think more about these dynamics. I didn't feel so sleepy. I think in the room there was something we couldn't think about together and I needed to be put to sleep. And I think it was this side of himself in relation to me – the sexualised transference.'* (Sophia)

Natalia describes work with a twenty-year-old woman who found it very difficult to talk about sexuality and bodies in the room and had linked this to taboos in her religion. There had been a lot of unbearable silences as the patient felt judged and persecuted when Natalia looked at her. Natalia reflects that on the phone the patient began to talk much more and began to think about boys and dating:

> '*There's something about this third dimension that impinged on her in a way and sort of helped her to come out of the dyadic relationship. Sometimes there would be a long pause and she would get worried if I'm there or not and she would have to speak. This gradually developed her capacity to express herself more and say what was on her mind.'* (Natalia)

Sophia describes a '*horrible, awful*' countertransference response when moving to work online with her under-five intensive patient, a little girl who Sophia suspected had been sexually abused. As the child was getting used to the new setting, she would ask Sophia what she wanted to see. Remembering this in the interview, Sophia's face became distorted with discomfort and disgust.

'I didn't know at this point if she had been abused online. I felt like I was grooming her online. It felt like – what is the word? A breach. I really questioned myself because I thought 'am I doing something with this new platform that makes her feel that I am interested in sexuality and whatsoever? Something about this video platform made me feel like I was a groomer… And then later I was literally talking about sexual abuse in my own bedroom. And she was in her bedroom too. I mean, it must have been awful for her.' (Sophia)

3. What kind of object am I in the child's mind

a. Early experiences repeated

This theme contains participants' reflections on the ways in which early experiences of deprivation and neglect are re-enacted in a new setting. These provoke powerful countertransference responses.

'I think there's something about the pandemic for children who have had repeated disruptions in their experiences, exclusions from school, foster care, adoptions breaking down, there's something that has really ignited some of those early experiences and confirmed for them that things aren't consistent, things can just fall out from underneath their feet. And I worry that it's going to have a hugely lasting impact, because it's just reaffirmed all of their fears that the world isn't a consistent and helpful space.' (Bridget)

All participants spoke about feeling that aspects of their patients' early experiences were being repeated in the newly imposed context. Past experiences of neglect, separation, rupture and rejection came up in therapists' minds, prompting strong countertransference responses. Kelly and Rebecca both describe experiences where, seemingly in response to a rupture in technology, a child suddenly appeared much younger on the screen, seeking comfort from tactile sources. Rebecca's patient needed to eat during video sessions. He made his way through a bowl of biscuits and, when they were finished, struggled to engage with WhatsApp video. Once, after an agonising pause when the boy's mother's phone had run out of battery, he returned, seated on the floor, '*drinking a carton of milk from a straw, gazing into the screen,*

looking tiny and helpless. It felt unbearable.' Kelly's patient, an eight-year-old adopted girl, at the clinic had been working on feeling that she was an unwanted baby and finding her place in her adoptive home. Online, with a poor internet connection, there were many ruptures with the screen freezing. Kelly describes the impact on her play: '*she stopped playing completely, and she would just turn up in her dressing gown with a little blanket and she would just cuddle up on the sofa.'* Susan spoke of feeling like a '*useless object, bringing nothing'*, when working with an adolescent girl whose experience of video sessions was painfully reminiscent of her early experiences of neglect in an orphanage and foster placement.

> '*She had been wrapped in a chair in front of the TV and prop fed with a bottle with no interaction. And in the transference, you know, a baby just sitting there and an adult who brings you something that in the end gives you nothing, there's no reward in it. And for her to be in front of the laptop and see me in the laptop, I think it was very disturbing for her and she became more and more cut off.'* (Susan)

Susan spoke about her experience of having Covid-19 at the same time as one of her patients, a child who '*did have a fear that he could kill me off anyway*.' Soon afterwards she had some time off work to attend a funeral, and this created great anxiety in the little boy, who asked his father if she was dead. His family had had Covid-19 at the same time and there was an idea in everyone's mind that they had passed it on to Susan. She reflects that it was something that felt too difficult to talk about in his video sessions: '*I knew that because of his early life he had a very huge fear of what he can do to his objects*.'

Jack spoke about a dream told to him by his under-five intensive case – the boy described earlier in the hide and seek extract. In the dream, the boy was in the driving seat of a car, which was flying at great speed towards a train. Jack was in the back seat of the car, busy on a tablet.

Jack hadn't been able to help the boy steer the car away from the train; all he could do was ask him to stop. The train ended up crashing into the car.

> *'I think there's something about 'what can you really do on a tablet, Jack?' Can you really keep me safe? Yeah you've got your words, but if I jump out of the window, you can't do anything… you're a bit useless. So it felt like the technology was emphasising some of those early anxieties about his parents not being able to keep him safe. Some of my countertransference responses with him are the strongest I've ever had in terms of just feeling completely overwhelmed and useless.'* (Jack)

b. Being experienced as a cruel object – a 'mean twin'

In this theme, patient responses to a changing setting are explored, exemplified by two young children's fantasies of a distorted and frightening therapist/object.

Strong countertransference responses of feeling '*depriving', 'abandoning', 'cruel'* and *'like a bad object'* are described by all participants. A patient of Bridget's became anxious and preoccupied with there being enough soap for the clinic toilets when hearing about shortages in the shops, causing her to wonder if he was experiencing her as impoverished or withholding. For Rebecca, packing away toy boxes and removing fabric toys and dolls clothes at the beginning of the pandemic felt horrible and cruel: '*it felt like we were deliberately damaging something we had set up together*.' Three participants spoke of difficulties in taking breaks during the pandemic, especially at Easter 2020 which was shortly after the announcement of the first lockdown, worrying it would feel cruel and rejecting to patients.

For two patients, described by Kelly and Sophie, fantasies of what their therapist had become were explicitly expressed. Kelly's patient, the young girl in the dressing gown mentioned

above, began to see her therapist as a cruel and frightening figure as she experienced Kelly's face freezing repeatedly on the screen, making it grotesque and unrecognisable.

> *'So we had a period of time where we turned the video off, but would use the audio. But of course, that is not a containing situation at all. And I think she began to really suffer, actually, in the video work because I became a very, not only cruel, but very, very unreliable object. Torture, really. I think there was something about the different distances between us. On the screen, my face loomed very close to her. So she would scrutinise me. And she could look in a way at me that she couldn't or didn't do in the room. So as she looks, she can really notice in quite a concrete way, my hair. And she's just starting to think about Cruella de Vil, having grey hair and black hair. And that is who I became, quite concretely in her mind.'* (Kelly)

Sophia describes the confusion that her under-five intensive patient felt during video calls. The child experienced Sophia as 'not real' and a bad version of herself.

> *'From the beginning, she needed to be reassured that it was really me and not somebody else - not my mean twin, which is what she used to say sometimes. If I froze on the screen, it was as if I was becoming a monster. She was so frightened. It was very hard. The disclosure of sexual abuse was coming to the surface and she was very worried about me and very worried about herself. I really felt this paranoia of her feeling that I just wasn't me. She would say 'move your hand because I don't know if it's really you there.' It was very challenging. The fact that we weren't physically together made it very difficult.'* (Sophia)

c. Holding on to the good whilst being apart

Within this theme are anxieties about becoming a distant, useless object and some of the ways in which participants defended against these.

The words 'consistent/inconsistent' and 'reliable/unreliable' appear many times across the interviews, as if participants felt worried that something good had been lost. Participants

describe their fears that the altered frame and precarious context would lead to their patients feeling abandoned and left alone.

> *'Being online, we can become this sort of person who can't do anything. It was so hard at times. Sometimes with my under five intensive boy, I would just end up saying 'I see you, you see me' and he would say it back to me.'* (Sarah)
>
> *'The experience of remote working for me, has just been about loss'* (Susan)
>
> '*It was very painful. Sometimes it was just this thing that felt like nothing'.* (Natalia)

This led to strong feelings of wanting to protect and persist, to '*keep going,*' and participants describe feeling pulled into different ways of behaving. Bridget describes feeling pulled more into speaking about reality rather than staying with the child's fantasy, for example, when she had to take time off work because she had Covid. Rebecca speaks about tension at the end of sessions as a latency girl repeatedly manipulated the calls to '*steal extra minutes*', reflecting that in a clinic session she was able to hold the boundaries around the beginning and ending of sessions, but '*to just cut off the call would have been cruel.*' Kelly and Susan speak about their anxiety when witnessing their young patients' panic as the battery on their devices ran down. In what are described as '*unbearable moments*' they had felt an urge to immediately take away the anxiety and panic for the child, stepping in quickly with suggestions and phone calls to parents.

> '*Usually, we sit with anxiety and try to think about it and contain it, but how was that possible when the link might just disappear from under our feet?'* (Kelly)

Bridget reflects on her experience of being pulled into a different sort of role from the one she holds in the clinic setting and wonders how helpful this had been with an adolescent boy.

> '*A lot more accommodating and chasing went on that might not happen in normal times. I was pulled into a role of somebody chasing after him, trying to look after him, but maybe nagging him as well. And I don't know how helpful that was as, you know, he opted out of the motivation he needed to find in himself.'* (Bridget)

d. The capacity to survive: a 'beautiful reunion'

This theme touches on the common feeling of relief at having got through an experience which was felt to be coming to an end. Descriptions of coming back together are given with energy and passion. The complexities of keeping going beyond this and through 'hybrid' working bring more complex and difficult responses.

A more elevated tone was noticeable when participants spoke about returning to face-to-face sessions. Relief, triumph, even joy was expressed, and four out of eight participants became tearful when speaking about it. Transcripts contain smiles, gasps and sighs and repeated use of the words '*survive*,' '*fragile*,' '*robust*.' This seems to go with an idea that something, as a result of a struggle, had become stronger and deeper. Bridget used the word '*powerful*' several times in relation to '*sticking with it when everything else was crumbling*.'

> *'I genuinely believe that it felt more stable and stronger. We just felt like we'd been through this horribleness together. When my under five intensive patient saw me, he just ran! He knows we don't hug, and it's not like being with Mummy or Auntie, but he kind of buried himself into me. I think he couldn't believe that we had survived, and he wanted to see his toys. And he was relieved to see that they were all there. It really felt that what we had had before was preserved and become somewhat stronger.' (Natalia)*

> *'Immense relief. I mean, he was bouncing when he saw me in the clinic the first time, literally bouncing on the spot. But we were coming back gradually. So he came back for one session and then had two online. Because we had, you know, the clinic rules where, you know, time in the clinic had to be limited. So that became a complicated thing about him feeling well, you know, not quite as safe and secure as perhaps in the initial relief he had hoped... You know, he'd hoped*

> *he would be 'back back' and there was this thing where he's back and he's not back.'* (Kelly)

Kelly's comment of being 'back but not back' was described by other participants as a new phase was negotiated, particularly with intensive patients, of having a hybrid experience as NHS Trusts tried to reduce the amount of patient contact and enable social distancing measures to be followed. Most participants felt that swapping back and forth between remote and in-person sessions was not helpful, confusing to patients and detrimental to the work. Remote sessions were more likely to be cancelled or missed, as if they didn't matter as much in the patient/family's mind and this led to a blurring of boundaries. Several participants describe adolescent patients asking at short notice for a clinic session to be replaced by a video session; Zoom became an option in the patient's mind and this allowed patients to slip through the cracks and stay in bed if they wanted to.

> *'What does it matter if they don't click on the link? It's not the same as not turning up to the clinic.'* (Bridget)

Participants use the phrases '*going back and forth'* and '*toing and froing*' in relation to moving in and out of remote working as the nation went into repeated lockdowns. Again, there is a consensus that this was disruptive and unhelpful and made it very difficult to keep a meaningful link going.

All participants noticed that on returning to face-to-face sessions, a fear about infection and risk of illness and death became much more alive in the work. Natalia interprets a child's play as a communication of the anxiety he had felt during a break when his mother had been very ill with Covid, and Bridget noticed a young boy expressing a fear that those who help can also carry something that might cause damage.

'*He started to play with something he hadn't played with before, with a little toy truck, which he tied with a string, and started driving around the room along the floor. And he was connecting it to other things. And everything was about sticking together and connecting. And then all of a sudden there was this thing - a puppet - which was placed in a swing and catapulted out of the room. And I think this had been his fear – a sudden and real breaking down of the relationship.'* (Natalia)

'He repeatedly played out scenes of devastation and disaster. The people who are there to help are coming to save you, but you can still get hurt in the process, you know, something about people who are helpful can also be harmful. And I had wondered is that, you know, does that feel very linked to Covid? Did he think I could give him Covid? But I think it also links to his early experiences of being harmed by the people who were there to help him.' (Bridget)

General reflections on the experience of working clinically during the Covid-19 pandemic were mixed and often contradictory within one interview. Remote sessions felt restricted in scope and possibility – a '*superficial checking in*', '*containing maintenance'*, *'holding process*' or '*holding space*' whilst waiting to return to the 'real' work. And they were described as very tiring by all but one. Yet participants reflect that some patients were able to use the space for something that felt more like child psychotherapy, with some unexpected and positive outcomes. I present a final comment from Kelly:

'It's really just about the challenges that are beyond the technical ones, but are about how do two people relate? And the other person being somebody who is there because they're, you know, they've got significant issues relating in the first place? How does that not get forgotten?' (Kelly)

CHAPTER 5: DISCUSSION AND CONCLUSIONS

The aim of this study has been to:

provide a picture of a unique and unprecedented experience – that of trainee child and adolescent psychotherapists and their young patients during the Covid-19 pandemic. The aim has been to learn about the influence of both the external threat posed by the pandemic, and the move towards separation and remote working with a new technology-mediated setting. The aim has been to explore these in relation to participants' experience of the nature and quality of transference communications and the therapist-child relationship.

The findings of the study are that:

the onset of this experience was sudden and shocking, which made it difficult to think about. Technology-mediated therapy was experienced with a sense of loss in relation to keeping a connection going and what was possible on a bodily level. Cases were lost and this experience was still being worked through. The relinquishment of the physical setting brought complex consequences, with parents becoming custodians of the therapy space and children using the new setting to communicate in ways that could be both challenging and creative. These caused anxiety about safety and privacy as well as adaptation in technique. Participants made sense of these experiences through a psychoanalytic, object-relations lens. They felt themselves to be experienced at times as cruel, bad, or unreliable. Connections were made between these and patients' early infantile experiences. Holding on to being 'good enough' became important and the experience was characterised by fantasies of life, death, survival and endurance.

The findings of this study demonstrate that the most striking aspect of the Covid-19 pandemic for its participants and their child and adolescent patients was the experience of something being lost or missing. What does the material tell us about what was lost for the practitioner, the patient, and the practice of child psychotherapy during that time? In different ways, they all point to a deprivation of the experience of being in the physical presence of an other, a consequential loss of containment, and a fundamental breach in the psychoanalytic setting or frame. What light does this research shed on what we mean by the containment offered by a psychoanalytic setting? These thoughts are explored below.

Sudden breach experienced as traumatic and unthinkable

Participants' reduced fluency when speaking about the beginning of the pandemic suggest they are revisiting an experience which not only caused anxiety, shock and confusion at the time, but remains difficult to think about. In March 2020, predictability was lost overnight. Everything that participants were being trained to set up and think so carefully about had to be re-thought and re-negotiated without warning, whilst also tolerating losses relating to the sudden and legally enforced physical separation from their own analysts, training school, supervisors, fellow trainees, colleagues and family members *and* in the context of daily updates in the media about the spread of the virus and its growing death toll.

That participants found it hard to remember the detail and the sequence of changes and events suggests that the early days of the pandemic were traumatic and have been difficult to process. From a psychoanalytic perspective, a traumatic experience is understood to feel as though it is happening internally as well as externally and can lead to a fundamental disruption in functioning: 'primitive fears, impulses and anxieties are all given fresh life' (Garland, 1998, p.11) and trust in the goodness of one's objects and therefore the predictability of the world is

lost. The trauma provides confirmation of the most persecutory unconscious phantasies, stirring up infantile anxieties including a fear of total annihilation (Klein, 1946, Segal, 1973). Developments in neuroscience show us that when memories of a traumatic experience are reactivated, regions of the brain go 'offline.' The frontal lobe shuts down, including the part of the brain necessary to put feelings into words and the region that creates a sense of location in time (van der Kolk, 2014). At this point, the emotional part of the brain dominates. Feelings take over, and words fail us.

An unplanned break to allow for the establishment of a new remote setting, or, as Shulman puts it, a 'hole in time' (2020, p.299), represents a significant rupture in the psychoanalytic frame within which breaks are usually carefully planned and meanings explored. A break in psychotherapy is thought about both as an opportunity for previous real and phantasised experiences of endings and separations to be worked through, and as a rehearsal for a final ending that can be experienced in the presence of a containing other. The findings show how urgent and vital it felt for participants to avoid a prolonged break in their work. They expressed genuine concern for the impact on patients, but perhaps in their language of totality we find their own unconscious fears about a sudden and catastrophic rupture. Endings arouse physical and emotional states experienced from the beginning of life, bringing into being infantile and child-like states of mind associated with early endings (Salzberger-Wittenberg, 2013): the 'catastrophic change' of being born (Bion, 1962), the realisation of one's position in the Oedipal situation and exclusion from the parental couple (Klein, 1945), weaning, and other separations. For Shulman, aspects of the pandemic: 'recurring isolation periods, a sense of dread of passing on infection or being infected, the threat of serious illness or even death – all accumulate to create an overwhelming load of beta-elements - very difficult to process' (Bion, 1957, Shulman, 2020, p.300). Beta- elements are un-mentalised bodily states that are

evacuated if they cannot be turned into something that can be thought about. Participants tell us that early in the pandemic there was little time or space for thinking, and we know that primitive anxieties evoked by trauma generate paranoid schizoid defences of splitting and projective identification (Klein, 1946). This might go some way to explain why, as has been found elsewhere, clinicians quickly become unreflective about moving to online work and show reluctance towards exploring with patients the role of technology (Isaacs Russell, 2015, Trub and Magaldi, 2017, Scharff, 2020). The findings of this study suggest that, in the early experience of the pandemic, the capacity to think through experience was under threat and usual sources of containment and holding were compromised. This is supported by the fact that all participants spoke of their relief and even enjoyment in having the opportunity to look back and think about the experience several months later.

Loss of a physical presence and the containing function

In his theory of container-contained (1962), Bion makes a significant adaptation to Klein's concept of projective identification, which she defines as a primitive defence against persecutory anxiety, characteristic of paranoid schizoid functioning in early infancy but also employed at times throughout the lifespan. In the Kleinian (1946) definition, unconscious phantasies and anxieties in the newborn infant emanate from the earliest bodily experiences associated with instinctual drives to be held and fed. Feelings of hunger give rise to phantasies about part objects, namely a depriving bad breast. These anxieties are experienced as attacking and are expelled outwards. Bion (1962) saw projective identification as an essential communication between a baby and his caregiver, and necessary for development. Feelings are projected from the body of the baby to the mother's body. If the mother is receptive and has the capacity to understand feelings and mentalise, she is able to pass back a feeling to the infant of having been understood and thought about, which then ameliorates his anxiety and

distress. From this, a capacity in the infant to learn from experience grows. The knowledge that builds from this learning is rooted in feelings in the body – knowledge that is 'akin to the Biblical sense of 'knowing', being in touch with the core and essence of something or somebody. This is a form of knowledge imbued with emotional depth' (Rustin, 1989, p.8).

These are important concepts to return to because the same processes of projective identification, reverie and containment are central to the relationship between therapist and child. If, as theory and experience tell us, these processes, which are rooted in the infantile experience, involve the bodily communication of feelings, then co-presence is paramount. The outcomes of this study point to an undermining of the capacity for containment when therapist and child are physically removed, become reliant on verbal modes of communication and are at the mercy of 21st century technology.

More recent research into infant development has produced findings that support the idea of the innate object-seeking capacities of the newborn child, who is considered to be 'primed' to relate to people and faces as well as make use of a caregiver's capacities (Music, 2011). Babies prefer the sound of the human voice over other sounds and can feel comforted by 'rhythmic rocking and the sound of the mother's heart and the familiar smell of her body as it is held against him' (Shuttleworth, 1989, p.24). Studies on the intersubjective communication between parent and infant have shown the importance of a synchronous exchange of bodily and facial cues from birth (Tronick, 1998), and according to Beebe, 'interactions in the non-verbal and implicit modes are rapid, subtle, co-constructed, and generally out of awareness. And yet they profoundly affect moment-to-moment communication and the affective environment' (p.49). Stern (1977) examined communication and attunement between mothers and babies using video analysis, looking for

mis-cues, which he called ‘missteps in the dance’ (p.133). He found that mothers and their babies are extremely sensitive to each other. Infants give subtle cues, such as turning their head away when they find the intensity of an interaction too much to bear, and an attuned mother will take a step back, allowing her baby a moment of respite. Field (1981) found that a baby’s heart-beat increases a few seconds before he turns away, and returns to normal when he feels able to return to the interaction. According to Stern, ‘all mental acts are accompanied by input from the body, including, importantly, internal sensations’ (Stern, 1998, p.xvii).

The ‘something missing’ in online work that participants found hard to articulate, points to this bodily dimension. Perhaps it felt hard to put into words precisely because the intersubjective aspects of relating are unconscious and non-verbal. When describing technological ruptures, participants’ words evoke the fragility and total helplessness of the newborn infant, his catastrophic terror of endlessly falling or liquefying (Bick, 1968, 1986), and need for a containing object. Dropping, crashing, falling all signify a feeling of not being held, like the baby Esther Bick’s describes, who, having been held securely in the mother’s womb, after birth finds himself ‘in the position of an astronaut who has been shot out into outer space without a spacesuit’ (1986, p.66). The introjection of a feeling of being held together by the containing object helps to form a psychic skin, which is felt to keep parts of the self together. With this in mind, participants’ descriptions of children climbing precariously on bookcases and window ledges, jumping on beds, leaping about, perhaps takes on new meaning. If the fundamental containing function provided by being in the presence of the therapist’s body and mind is undermined, then what does happen between therapist and patient in remote, online psychotherapy? Elsewhere, repeated technological ruptures have been described as akin to Stern’s missteps in the dance, but this assumes that the mother(therapist) has the opportunity to repair, as she learns about her baby(patient) and what he can tolerate. A ‘good enough’

(Winnicott, 1971) mother has the capacity to help the child to recover and keep going, and we have seen that participants often felt flooded by feelings and thoughts of being not good enough. A closer look at the way patients used the setting may shed light on how the loss of a bodily presence was experienced by patients and what this means about the capacity to be thought about and understood.

Participants interpret individual communications in relation to the patient's own history and ways of relating and this is not the place to add more interpretation to the clinical material. However, a striking finding of this study is the perverse and alarming ways in which children used the new setting and they are worth exploring here because they happened for every participant without exception. One wonders what it was like for children and young people to lose contact with their therapists overnight, to suddenly be expected to take responsibility for the continuing link between them, and then to make an alarming discovery of the powerful position in which the technology put them. What meaning, if any, can be found in the repeated switching off, muting, turning away and breaking of technological links? What lies behind the seeming compulsion towards motility - spinning, twirling, jumping, walking or running around the home, taking the object/therapist/device with them? What generalisations can be suggested about the anxieties or defences being expressed and deployed?

Some have proposed that technology offers a different channel for the free expression of negative transference, an outcome of the online disinhibition effect (Suler, 2004, Monzo and Micotti, 2020, Scharff, 2020). Bomba et al (2021) describe enactments of the infantile perversions of cruelty, sadism, voyeurism and exhibitionism, in response to an environment that does not guarantee an experience of affective continuity and the 'excitement and anguish of the time' (p.160). In the findings we see attempts to manipulate and ridicule the therapist,

reducing him/her to a state of impotence. We find efforts to humiliate parents and therapist by entering the parental bedroom and bathroom. That these behaviours are repeated again and again feels compulsive and brings to mind Freud's key idea (1917) of an experience being unconsciously repeated until it can be thought about and worked through in the transference. In normal circumstances, perverse excitements would be contained by the setting and the feeling that there is an adult in the room who is both surviving and trying to make sense of things. One might wonder about the possibility of a true experience of being understood if the therapist is rendered impotent or killed off, creating an experience of repeating with little or no scope for working through. Furthermore, descriptions of continuous of spinning, jumping and running summon Bick and her concept of 'second skin' defences whereby an individual attempts to hold themselves together using sensations of muscularity in the face of what is experienced as existential anxiety (1986). It seemed at times that participants experienced a bombardment of beta-elements with a concurrent cutting off from the capacity to think, feel, turn feelings into thoughts and communicate them. One might wonder about the extent to which therapists themselves felt contained, being at the mercy of all of this without the holding environment and boundaries provided by a workplace, colleagues, in-person supervision and personal analysis.

At times the data does suggest that something more positive and creative can be brought about by the mediated setting. For some therapist/child pairs, online working brought the possibility of doing things differently, and this led to unexpected new developments. Perhaps, like Sehon (2018) and Bomba et al (2021), we see the therapist and child playing together, creating meaning in a transitional space. A game of hide and seek played out in the intermediate space between two screens allowed a unique testing out of the therapist as a containing, consistent object, which participant Jack acknowledged would not have been possible in the therapy

room. Furthermore, the chat function on Zoom provided a means of communicating that kept Bridget's patient safe from her own violent persecutory attacks, allowing an expression of loss to be communicated. One might hypothesise that it enabled the child to get in touch momentarily with a more developmental, depressive position. The time lag whilst child and therapist type in the chat text box will inevitably slow down communication and this was found to be helpful by Kelly and her latency patient. After repeated experiences of attacked and broken links, a tentative link was preserved and built upon and Kelly could patiently demonstrate her capacity to think with the boy. Together they were able to co-create and understand an experience relating to a primitive phantasy of how the boy himself came into being. It is important to acknowledge and recognise that at times remote working did facilitate something helpful, creative, and even playful. It is striking that strong feelings were evoked in the passionate re-telling of these experiences in the research interviews.

What light does this shed on what we think of as the psychoanalytic setting?

Klein (1955) evolved a play technique for the psychoanalytic treatment of children, describing a physical setting suitable for analytic work – a simple, private room, with a box of toys and drawing materials for the child to use which are packed way and returned to each time, and some shared toys which are kept in the room and do not change between sessions. It is widely recognised that the analytic setting is both physical (in the sense of the playroom) and human. This 'human' aspect can be explored along three planes: the therapist's mind (sometimes called the internal or mental setting); the body of the therapist as a feature of the setting; and the co-presence of the bodies of the psychotherapist and child in unconscious communication.

Much has been written about the internal setting of the therapist's mind (Alvarez and Reid, 1998, Blake, 2008, Joseph, 1998, Lemma, 2017, Isaacs Russell, 2015). For Joseph (1998) it

is the most crucial element in the psychoanalytic setting: just as the playroom must be consistent and sturdy enough to withstand attacks by the child, the therapist must be equipped to take a great deal of whatever the child brings. Lemma has likened the internal setting to an anchor, as it 'orientates the therapist to the patient's communications and allows her to monitor her own internal processes' (Lemma, 2017, p.84). The physical setting provided for the patient has been created by the therapist's mind and this is an important point in relation to this study. That the therapist is the custodian of the physical setting contributes to the containment provided by it: she maintains it, takes care of it, is responsible for it, and protects it from intrusions. The therapist's body, as well as her mind, contributes to a psychoanalytic setting or frame. As Lemma (2017) puts it: 'the therapist's physical appearance and the way she inhabits her body and physical space in the room – the way she sits in the chair, breathes, moves in the room, speaks, dresses and so on – constitute core sensory features of the setting that contribute to the containment provided by the therapist' (p.85).

Countertransference is a somatic communication and as such, requires true co-presence: that which Isaacs Russell (2020) calls 'unpredictable, spontaneous and messy' (p.373). According to Joseph, part of transference is how the patient 'conveys aspects of their inner world built up since infancy, experiences often beyond the use of words, which we can often only capture through the feelings aroused in us, through our countertransference' (Joseph, 1983, p.448). With echoes of Stern's 'dance' (1977), Garcia (2020) describes a 'duet between transference and countertransference phenomena', which includes 'underlying psychic meaning, bodily sensations, underlying phantasies, and a myriad of experiences in relation to space, time and contact' (p.339): a description evocative of what happens naturally, in infancy, in the physical presence of a mother or primary caregiver. Alvarez and Reid (1998), writing about their work with autistic children, describe observing how minute changes in their own responses might

trigger changes in the patient, and suggest that these can be used to 'reclaim' the child back into the world of human feeling and communication. For this, the therapist must have a 'mind for two, hope for two, imagination for two' (p.7). In Alvarez' work (1992, 2012) we find a call for active engagement rather than explanatory interpretations. Drawing on years of work with autistic, borderline and very traumatised children - those who may have never felt themselves to be of interest to anyone - Alvarez describes their need to be drawn towards the experience of human relationships in the presence of a lively, attentive partner. This hugely sensitive work involves fleeting steps and the gradual emergence of 'proto-positive feelings' in the presence of an object (2012, p.68).

The literature strongly points towards a limiting of what is possible in the therapeutic encounter when the experience of being together is removed. Isaacs Russell (2015) suggests that states of being are lost and replaced by states of mind. A similar view was expressed by Symington (2011) in response to a survey of British psychoanalysts on the use of telephone and Skype (Fornari-Spoto, 2011). He insisted that that for clinicians whose theoretical foundations rest upon instincts, a physical presence in the consulting room is essential.

The ideas outlined above relating to the bodily dimension in a psychoanalytic setting can be found implicitly in the cautious approach that participants took to setting up online work. Whilst feeling the pressure to get things started quickly, they also anticipate the limitations and potential losses associated with this new, unknown medium. All participants speak about the importance of having already formed a relationship with a patient in person before beginning a remote phase, a pre-requisite that was also described as desirable or necessary in the literature. When describing positive developments in online therapy, participants stress that benefits were there because the work had been established for some time, often more than a year, implying

that an important dimension was already in place. None of the participants started a long-term piece of work online: one might wonder what this says about underlying assumptions about limitations and potential risks. Participants shared concerns about how the youngest patients might manage remote therapy. Children under five were offered much shorter sessions (ten or fifteen minutes) in the first instance, building up the session time in increments - like a titration or gradual weaning. Although not stated, there is a suggestion that longer session times would be difficult to tolerate, as if a young child cannot be held without the physical presence, or that the experience would be unbearable in some way. It might be that we also see a need for the therapist to defend against a feeling of providing something on the one hand whilst depriving the child of something fundamental on the other.

What is lost to the child when, after a significant stretch of time meeting regularly in the same space with a living, feeling person, a sudden and sustained separation is enforced? Gone is any sense of what might be evoked of the therapist's smell, clothing, skin, body temperature, muscularity, solidity, softness, all of which contribute to how the child perceives her receptivity and robustness. Subtle changes in the way the therapist sits, leans forward, uses her hands - gestures that happen intersubjectively, without thought, and in response to unconscious communication - are lost. Not only are losses experienced in relation to the nature of the object, but patients also lose out on their experience of being rooted in their own bodies, and this is what children who are referred to mental health services so often need help with. With so much lost, the therapist becomes a flattened facsimile of her former self: a two-dimensional surface, a version of the 'still face' (Tronick et al, 1978). The baby in Tronick's experiment recovers as the mother resumes her usual warm smile and cooing, but in a screen interaction, that which is lost cannot be regained, although therapists work very hard to reassure as best they can.

To explore this sense of loss or deprivation for the child patient further, we might look to the two examples of children in the data who expressed vivid fantasies about what had happened to their therapists when encountering them on a screen. In both, we find a split: the mean twin vs the good twin, and Walt Disney's Cruella with her hair of half-white, half-black. In Kleinian theory, splitting – the separating and projecting out of loving and hating feelings, or what are perceived as good and bad experiences - is a defence against persecutory anxiety used by the very young (Klein, 1946). As part of healthy development, the re-introjection of good and bad objects enables the baby to hold onto sufficient good experiences and thus begin a process of integration. Psychoanalytic psychotherapists recognise the rigid splitting of an idealised 'good' and an omnipotently denied 'bad' as a defence used when a child or young person feels persecuted by anxieties relating to internal or external objects. If the containing function of the good object is diminished in this new setting, then what sort of object does the therapist become? Participants asked themselves the same question as they tried to find meaning in patients' projections. It seems that there is something akin to Bion's bizarre object (1957) in the therapist's face on a flat, opaque screen, which talks and can hear but is not, and cannot be felt to be, a real, living, feeling person. It should not be surprising that the effect of this can be extremely disturbing, especially for children who have a tendency to be unsure about what is real and what is not, as is often the case with the youngest children who are referred for treatment.

The caseloads of child psychotherapists in the NHS tend towards children who have experienced failures in maternal containment and complex developmental trauma. Those who are looked after in the care of their local authority have often experienced significant deprivation as well as repeated ruptures and separations. These are children who we know can

experience the ‘double’ and ‘triple’ deprivation described by Henry (1974) and Emanuel (2002), whereby crippling defences prevent the child from making use of sources of support, and thinking in the professional network can become inhibited. These children already, before Covid, found it difficult to relate, and have had limited experiences of containment. Children who use mental health services are already vulnerable, and we know from the empirical evidence that vulnerable children are even more so during a pandemic (Guessoum et al, 2020, Kwong et al, 2020, McCluskey et al, 2020, Rouseeau and Miconi, 2020). With relationships outside of the home significantly curtailed by school closures and enforced isolation, all children and young people were contending with the challenges of separation from significant others: friends, teachers and grandparents. In this context the screen has taken on new meanings, being used for schoolwork (although experiences of this were mixed from school to school and crucially depend on a reliable device and internet connection) alongside increasing amounts of time spent online and using social media. One wonders whether the screen itself has become a contaminated medium, loaded with anxieties and meanings. The sleepy, hungry, wide-eyed children described in the findings conjure up the hypnotising effect and mindlessness of endlessly repeated TV shows, computer games and TikTok videos: a bland diet of experiences on repeat, which are often devoid of meaning. For some participants, WhatsApp video was the only tool available initially, and messaging in group chats has been linked to increased possibilities for aggression, ostracism and bullying amongst young people (Meter and Bauman, 2015). It is little wonder that when contact with the therapist, who in normal circumstances offers an opportunity to discover different ways of relating and understanding oneself, enters the realm of screens, anxieties prevail.

Most participants chose to speak at more length and in more detail about their under-five and latency cases than about their adolescent patients. However, it is striking that when describing

the cases that broke down or were in danger of breaking down during the period of online work, all examples given were of adolescents. One can only wonder about the reasons for this: perhaps the younger cases were more likely to prevail because of the role of parents in maintaining the home setting and getting the child ready. The social restrictions of lockdown were certainly in conflict with what is widely recognised as a hallmark of adolescence: the emergence of a personal identity whilst moving away from the childhood relationship with parents and towards independence and separateness (Jarvis, 1999, Waddell, 1998). As new relationships with peers are made, new identifications and relationships are internalised, and a personal identity grows out of them (Copley, 1993). Research into the impact of Covid-19 lockdowns on the developmental trajectory of adolescents would be an interesting topic for further research. The findings also identified that adolescents often choose the phone over a screen - or Lemma's black mirror' (2017) - for contact with their psychotherapist. Moreover, perverse manipulations of technology and the setting tended to be quieter, less overt, and furtive, suggesting a sexual transference. Therapists' experiences of exploring adolescent sexuality online were mixed and it would be interesting to explore this further with a wider sample.

Participants in this study describe finding online work particularly tiring, and clinicians writing in the psychoanalytic journals have also commented on this (Bomba et al, 2020, Shulman and Saroff, 2020, Webster, 2020). 'Zoom burn-out' or 'Zoom fatigue' has been a popular topic discussed in the media during the Covid-19 pandemic, as many people moved to an online workplace (Sklar, 2020, Busby, 2021). A search of the phrase 'Zoom fatigue' on Google brings up over 300,000 results. What sense can we make of the fatigue or burn-out described in relation to the findings of this study? Shklarski, Abrams and Bakst (2021) found it to be one of the biggest challenges for psychotherapists as they 'attend to faces without full body

representations' (p.60) and Freudenberger (1974), who coined the phrase 'burn-out', wrote that the phenomenon 'has within it the dynamics of mourning' (p.165). Perhaps the ways in which experiences of reunion were described can shed some light on what was so draining about the time spent apart. Even remembering the return to the clinic brought a rush of powerful emotions for participants, as they recalled the immense relief, for them and their young patients, of coming back together and being in the same room once again. Links had survived, in spite of significant losses in the capacity to contain in a remote setting where the bodily dimension was removed and a deep sense of absence prevailed.

CONCLUSIONS

When I embarked on this project, I did so with Melanie Klein and her young patient, Richard, in mind. Just as aspects of the war in Europe were present in their clinical material, I was curious to find the extent to which fears about contamination and infection might feature in the work of present-day psychotherapists, and what they made of these. I found out that it was not anxieties about Coronavirus that preoccupied children and young people, but anxieties about separation from their therapist.

For child and adolescent psychotherapists, the restrictions associated with Covid-19 brought a massive breach of the setting, mandated from above and with no warning. This was shocking, traumatic and difficult to think about. All that we know about the psychoanalytic setting – the physical setting of the playroom, the experience of being two bodies together engaged in the somatic communication of transference and countertransference, the containing function of the therapist's presence of body and mind, was under threat. Technology and home working

offered the only alternative. Setting up this new mediated setting was a huge task and was fraught with anxiety and frustration.

For children and adolescents, the pandemic brought many, far-reaching challenges, not least in the area of mental health. For those in therapy, a sudden and enforced separation from their psychotherapist was accompanied by a new expectation that they, with the help of their parents, take responsibility for maintaining aspects of the setting. The findings show that this caused great anxiety as well as excitement. Patients responded in ways that felt difficult to understand in the moment, such was the bombardment of projections, communicated through perverse manipulation of the technology and an alarming use of the physical space of the child's home.

This study has asked important questions about what becomes of the contact between the child and the therapist when they are apart. It concludes that the loss of a physical presence represents a significant undermining of the capacity for reverie and containment. The 'something missing' feeling experienced by participants was difficult to articulate, and I suggest that this is because it is something that exists on an unconscious, non-verbal, bodily level. An exploration of what is meant by containment in the psychoanalytic literature and related findings in infant developmental psychology and research reminds us of this.

I have found in the results of this study many moving examples of the ways in which participants and their patients found their way together in the most extraordinary of circumstances. In the face of great adversity, separation and losses in their own lives as well as a significant impingement on their experience of clinical training, participants showed remarkable creativity, tenacity and determination. The clinical material they shared is moving and often painful to read. Participants describe the experience of working with their patients

during the Covid-19 pandemic using the language of survival. Despite fundamental losses in the containing function of the therapeutic setting, they endured, and did indeed survive, an unprecedented phenomenon together.

Considering implications for future clinical practice, if child psychotherapists find themselves in a position of having to adapt and change at such speed in the future, this study might in some way help the profession to slow down and not be in such a rush to find a way of replacing what we have, and perhaps to stay longer in the ACP's position of a 'holding arrangement' for the sake of professionals as well as children and families. Responding so quickly to an unavoidable and potentially traumatic event might in other circumstances bring an interpretation of a manic defence, and perhaps this study shows how much we need to mourn what has been lost.

Importantly, this study also shows what is possible in extreme circumstances of separation and loss and this might support future clinicians in working out what can be achieved in their own practice. It has shown what was lost but also what was possible if remote working whilst physically separated is all we have. However, future implications are limited in the sense that the phenomenon studied was unique, transitory, not likely to be repeated (hopefully) and is based on the experiences of a small, homogenous, and specialised group. Despite this, I hope that the findings are interesting and relevant to a wider group of mental health professionals and policy makers.

The debate about the possibilities and limitations of online therapy will no doubt continue, and the naturalistic experiment of Covid-19 may well offer an opportunity for further thoughts on the psychoanalytic situation. By looking at the issues and challenges provided by it, we are perhaps prompted to revisit what we believe to be important.

REFERENCES

Aiello, T. (2012a) What the children said: children's narrative constructions of the events of 9/11 in psychotherapy. *Journal of Infant, Child and Adolescent Psychotherapy*, 11(1), pp. 32-38.

Aiello, T. (2012b) Out of destruction, a terrible beauty is born. *Journal of Infant, Child and Adolescent Psychotherapy*, 11(2), pp. 60-169.

Alvarez, A. (1992) *Live company: psychoanalytic psychotherapy with autistic, borderline, deprived and abused children*. London: Routledge.

Alvarez, A. (2012) *The thinking heart: three levels of psychoanalytic therapy with disturbed children*. Hove: Routledge.

Alvarez, A. and Reid, S. (eds.) (1999) *Autism and personality*. Town: Routledge.

Asbury, K., Fox, L., Deniz, E., Code, A., Toseeb, E. (2021) How is Covid-19 affecting the mental health of children with special educational needs and disabilities and their families? *Journal of Autism and Developmental Disorders*, 51, pp. 1772-1780.

Bakalar, N. (2013) Transition from in-person psychotherapy to telephone psychoanalysis. In Scharff, J. S. (ed.) *Psychoanalysis online: mental health, teletherapy, and training*. London: Karnac. pp. 103-118.

Bee, P. E., Lovell, K. Gilbody, S., Richards, D., Gask, L., Roach, P. (2008) Psychotherapy mediated by remote communication technologies: a meta-analytic review. *BMC Psychiatry*, 60(8), https://doi.org/10.1186/1471-244X-8-60. [Accessed 21st March 2020].

Beebe, B. (2004) Faces in relation: a case study. *Psychoanalytic dialogues*, 14, pp.1-51.

Bernard, A. *et al.* (2023) 'Patterns of engagement in a digital mental health service during COVID-19: a cohort study for children and young people', *Frontiers in Psychiatry*, pp. 1–12. doi:10.3389/fpsyt.2023.1143272.

Bick, E. (1968) The experience of the skin in early object-relations. *International Journal of Psychoanalysis*, 49, pp. 484-486.

Bick, E. (1986) Further considerations on the function of the skin in early object relations: findings from infant observation integrated into child and adult analysis. *British Journal of Psychotherapy*, 2(4), pp. 292-299.

Birksted-Breen, D. (2020) Writing in the time of Covid-19. *International Journal of Psychoanalysis*, 101(3), pp. 433-435.

Bion, W. (1957). Differentiation of the psychotic from the non-psychotic. *International Journal of Psychoanalysis*, 38, pp. 206-27

Bion, W. (1962) *Learning from experience*. London: Karnac.

Bion. W. (1967) *Second thoughts*. London: Karnac.

Bion, W. (1988). Notes on memory and desire. In E. B. Spillius (Ed.), *Melanie Klein today: Developments in theory and practice, Vol. 2. Mainly practice* Taylor & Frances: London. pp. 17–21.

Bomba, M., Alibert, M., Vett, J. (2021) Playing and virtual reality: teleanalysis with children and adolescents during the COVID-19 pandemic. *The International Journal of Psychoanalysis*, 102(1), pp. 159-177.

Boulanger, G. (2013) Fearful symmetry: shared trauma in New Orleans after hurricane Katrina. *Psychoanalytic dialogues*, 23, pp. 31-44.

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet,* 395(10227), pp. 912-920.

Brown, J. (2006) Reflexivity in the Research Process: Psychoanalytic Observations. *International Journal of Social Research Methodology*, 9(3), pp. 181-197.

Busby, M. (2021) How to avoid 'Zoom fatigue' during the Covid pandemic, The Guardian, 27th February 2021. https://www.theguardian.com/technology/2021/feb/27/how-to-avoid-zoom-fatigue-during-covid-pandemic [Accessed 12th August 2022].

Caparrotta, L. (2013) Digital technology is here to stay and the psychoanalytic community should grapple with it. *Psychoanalytic psychotherapy*, 27(4), pp. 296-305.

Cipoletta, S., Mocellin, D. (2018) Online counselling: an exploratory survey of Italian psychologists' attitudes towards new ways of interaction. *Psychotherapy research,* 8(6), pp. 909-924.

Clemens, V., Deschamps, P., Fegert, J.M. (2020) Potential effects of "social" distancing measures and school lockdown on child and adolescent mental health. *European Child & Adolescent Psychiatry,* 29(6), pp. 739-742.

Cohen, E., Roer-Strier, D., Menachem, M., Fingher-Amitai, S., Israeli, N. (2015) "Common-fate": therapists' benefits and perils in conducting child therapy following the shared traumatic reality of war. *Journal of Clinical Social Work*, 43, pp.77-88.

Copley, B. (1993) *The world of adolescence: literature, society and psychoanalytic psychotherapy*. London: Free Association Books.

Danese, A. and Smith, P. (2020) Debate: recognising and responding to the mental health needs of young people in the era of COVID-19. *Child and Adolescent Mental Health,* 25(3), pp. 169-170.

De Rementeria, A. (2020) Editorial, *Journal of Child Psychotherapy*, 46(3), pp. 269-272.

Duan, L., Shao, X., Wang, Y., Huang, Y., Miao, J., Yang, X., Zhu, G. (2020) An investigation of mental health status of children and adolescents in China during the outbreak of COVID-19. *Journal of Affective Disorders, 275*, pp. 112-118.

Ehrlich, L. T. (2019) Teleanalysis: slippery slope or rich opportunity? *Journal of American Psychoanalytic Association*, 67(2), pp. 921-939.

Elliot, R., Fischer, C., and Rennie, D. (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, pp. 215-229.

Ellis, W.E., Dumas, T.M., & Forbes, L.M. (2020) Physically isolated but socially connected: psychological adjustment and stress among adolescents during the initial COVID-19 crisis. *Canadian Journal of Behavioural Science, 52(3), pp. 177-187.*

Emanuel, L. (2002) Deprivation x 3: the contribution of organisational dynamics to the 'triple deprivation' of looked after children', *Journal of Child Psychotherapy*, 28(2), pp. 163-179.

Etherington, K. (2004) *Becoming a reflexive researcher: using ourselves in research*. Jessica Kingsley: London.

*F*inlay, L. (2003a) The reflexive journey: mapping multiple routes. In Finlay, O., Gough, B. (eds.) *Reflexivity: a practical guide for researchers in health and social sciences*. London: Blackwell, pp. 3-20.

Finlay, L. (2003b) Through the looking glass intersubjectivity and hermeneutic reflection. *In Finlay, O.,Gough, B. (eds.) Reflexivity: a practical guide for researchers in health and social sciences. London: Blackwell*, *pp. 105-119*.

Fornari-Spoto, G. (2011) *Bulletin of the British Psychoanalytical Society*, 47(7): –11.

Freud, S. (1914) Remembering, repeating and working through. In *The standard edition of the complete psychological works of Sigmund Freud. Vol. 12.* London: Vintage Press, 2001, pp.147-156.

Freudenberger, H.J. (1974) Staff burn-out. *Journal of Social Issues*, 30(1), pp.159-165.

Garcia, M. (2020) Sea of trapezoids: the analytic setting and virtual treatment during a pandemic. *Journal of Child Psychotherapy*, Vol 46(3) pp. 38-347.

Garland, C. (1998) *Understanding trauma. A psychoanalytic approach*. London: Duckworth.

Guessoum, S.B., Lacjal, J., Radjack, R., Carretier, E., Minassian, S., Benoit, L., Moro, M.R. (2020) Adolescent psychiatric disorders during the COVID-19 pandemic and lockdown. *Psychiatry Research, 291.* https://doi.org/10.1016/j.psychres.2020.113264 [Accessed 30th November 2020].

Gutierrez, L. (2017) Silicon in 'pure gold'? Theoretical contributions and observations on teleanalysis by videoconference. *The international journal of psychoanalysis*, 98(4), pp. 1097-1120.

Hawke, L. D., Hayes, E., Darney, K., Henderson, J. (2021) Mental health among transgender and gender diverse youth: An exploration of effects during the COVID-19 pandemic. *Psychology of Sexual Orientation and Gender Diversity.* Advance online publication. http://dx.doi.org/10.1037/sgd0000467. [Accessed 16th June 2021.]

Health Research Authority (2020) *Is my study research?* [online] Available at: http://www.hra-decisiontools.org.uk/research/result7.html [Accessed 20th April 2020.]

Henry, G. (1974) 'Doubly deprived', *Journal of Child Psychotherapy*, 3(4), pp. 15-28.

Hill, A. (2020) 'Scarred for life': Sage experts warn of impact of Covid policies on the young', *The Guardian*, 20th October 2020. https://www.theguardian.com/uk-news/2020/oct/20/sage-experts-warn-of-impact-of-covid-policies-on-young-generation-z-harm-pandemic-coronavirus [Accessed 12th December 2020].

Hill, A. (2021) Children's NHS mental health referrals double in pandemic, *The Guardian*, 23rd September 2021. https://www.theguardian.com/society/2021/sep/23/childrens-nhs-mental-health-referrals-double-in-pandemic [Accessed 13th May 2022].

Holmes, E.A. (2020) Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *The Lancet Psychiatry, 7, pp. 547-560.*

Irvine, A., Drew, P., Bower, P., Brooks, H., Gellatly, J., Armitage, C.J., Michael Barkham, M., McMillan, D., Bee, P. (2020) Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies. *Journal of affective disorders*, 265, pp.120-131.

Isaacs Russell, G. (2015) *Screen relations: the limits of computer mediated psychoanalysis and psychotherapy*. London: Karnac.

Isaacs Russell, G. (2020) Remote working during the pandemic: A Q&A with Gillian Isaacs Russell. *British Journal of Psychotherapy*, 36(3), pp. 364-374.

Jarvis, C. (1999) Adolescence: a personal identity in a topsy-turvy world, in Hindle, D. and Vacagio Smith, M. (eds.) *Personality development: a psychoanalytic perspective*. London: Routledge.

Joseph (1983) Transference: the total situation. *International Journal of Psychoanalysis*, 66, pp. 447-454.

Joseph, B (1998) Thinking about a playroom. *Journal of Child Psychotherapy*, 24(3), pp. 359–366.

Klein (1945) The Oedipus complex in light of early anxieties, in *Love, guilt and reparation and other works 1921 – 1946.* New York: The Free Press, 1975.

Klein, M. (1946) Notes on some schizoid mechanisms, in *Envy and gratitude and other works 1946 – 1963*. London: Virago, 1998.

Klein, M (1952/1975) The origins of transference, in *Envy and gratitude and other works 1946 – 1963*. London: Virago, 1998.

Klein, M. (1955) The psychoanalytic play technique: its history and significance, in *Envy and gratitude and other works 1946 – 1963*. London: Virago, 1998.

Klein, M. (1961) *Narrative of a child analysis.* London: Hogarth Press.

Kohon, S. (2020) Challenges to making use of countertransference responses during the Covid-19 pandemic. *Journal of Child Psychotherapy*, 46(3), pp. 283-288.

Kooth (2021) *Kooth Annual Report, 2021.*

Kwong, S.F., Pearson, R.M., Adams, M.J. Northstone, K., Tilling, K., Smith, D., Fawns-Ritchie, C., Bould, H., Warne, N., Zammit, S., Gunnell, D.J., Moran, P.A., Micali, N., Reichenberg, A., Hickman, M., Rai, D., Haworth, S., Campbell, A., Altschul, D., Flaig, R., McIntosh, A.M., Lawlor, D.A., Porteous, D. and Timpsn, N. J. (2021) Mental health before and during the Covid-19 pandemic in two longitudinal UK population cohorts. *The British Journal of Psychiatry*, 218, pp. 334-343.

Lemma, A. (2017) *The digital age on the couch: psychoanalytic practice and new media*. Oxford: Routledge.

Lemma, A., Caparrotta, L. (2014) *Psychoanalysis in the technoculture era*. Hove: Routledge.

Lindqvist, J. M., Mechler, J., Carlbring, P., Lilliengren, P., Falkenström, F., Andersson, G., Johansson, R., Edbrooke-Childs, J., Dahl, H., Lindert Bergsten, K., Midgley, N., Sandell, R., Thorén, A., Topooco, N., Randi Ulberg, R., Philips, B. (2020) Affect-focused psychodynamic internet-based therapy for adolescent depression: randomized controlled trial, *Journal of Medical Internet Research*, Vol. 22 (3) http://www.jmir.org/2020/3/e18047 [Accessed 10th March 2021]

Loades M.E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M.N., Borwick, C., Crawley, E. (2020) Rapid systematic review: The impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child & Adolescent Psychiatry,* https://doi.org/10.1016/ j.jaac.2020.05.009. [Accessed 1st June 2021]

Magson, N.R., Freeman, J.Y.A., Rapee, R.M., Richardson, C.E., Oar, E.L., Fardouly, J. (2021) Risk and protective factors for prospective changes in adolescent mental health during the COVID-19 pandemic. *Journal of Youth and Adolescence, 50(1), pp. 44-57.*

Martin, J., McBride, T., Masterman, T. Pote, I., Mokhtar, N., Oprea, E., Sorgenfrei, M. (2020) Covid-19 and early intervention: evidence, challenges and risks relating to virtual and digital delivery, *Early Intervention Foundation*, 2020.

McCluskey, G., Fry, D., Hamilton, S., King, A., Laurie, M., McAra, L., Stewart, T.M. (2021) School closures, exam cancellations and isolation: the impact of Covid-19 on young people's mental health. *Emotional and Behavioural Difficulties*, 26(1), pp. 46-59.

Merchant, J. (2016) The use of skype in analysis and training: a research and literature review'. *Journal of Analytical Psychology*, 61(3), pp. 309-328.

Merchant, J. (2021) Working online due to the COVID-19 pandemic: a research and literature review. *Journal of Analytical Psychology*, 66(3), pp. 484-505.

Meter, D. J., Bauman, S. (2015) When sharing is a bad idea: the effects of online social network engagement and sharing passwords with friends on cyberbullying involvement. *Cyberpsychology, Behaviour and Social Networking*, 18, pp. 437-442.

Midgley, N. (2006) Psychoanalysis and qualitative psychology: complementary or contradictory paradigms? In *Qualitative Research in Psychology* 2006(3), pp. 213-231.

Moodle, The Tavistock and Portman NHS Foundation Trust (2020), *Tavistock Research Ethics* (2020) [online] Available at:
https://moodle.tavistockandportman.ac.uk/course/view.php?id=908
[Accessed 20th April 2020]

Music, G. (2011) *Nurturing natures: attachment and children's emotional, sociocultural and brain development.* Hove: Psychology Press.

Newlove-Delgado, T (2021) Child mental health in England before and after the COVID-19 lockdown. *The Lancet Psychiatry,* https://doi.org/10.1016/ S2215-0366(20)30570-8 *[Accessed online 9th March 2021]*

NHS Digital (2020) *Mental health of children and young people in England, 2020: wave 1 follow up from the 2017 survey. UK: Health and Social Care Information Centre.* https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up *[Accessed 22nd October 2020].*

Paiva, N. D. (2020) Psychotherapy with no body in the room. *Journal of Child Psychotherapy*, 46(3), pp. 55-361.

Perle, J. G., Nierenberg, B. (2013) How psychological telehealth can alleviate society's mental health burden: a literature review. *Journal of technology in human services*, 31(1), pp. 22-41.

Pietkiewicz, I., and Smith, J. (2014) A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne – Psychological Journal* 20(1), pp. 7-14

Monzo, M.P., Micotti, S. (2020) Making the best of a bad job: a literature review on digital psychoanalytic psychotherapy with children, adolescents and families at the time of the Covid-19 pandemic', *Journal of Child Psychotherapy*. 46(3), pp. 273-280.

Prensky, M. (2001) Digital natives, digital immigrants: a new way to look at ourselves and our kids. *On the Horizo*n, 9(5), pp. 1-6.

Prince's Trust Tesco Youth Index (2021) *https://www.princes-trust.org.uk/about-the-trust/news-views/tesco-youth-index-2021* [Accessed: 3rd March 2021]

Prout, T.A., Faber, L.J., Racine, E., Sperling, R., Hillman, R.F. (2019) Clinical encounters with children in the Trump era. *Journal of Child Psychotherapy*, 45(2), pp. 191-208.

Reid, S. (1997) Introduction: psychoanalytic infant observation. In Reid, S. (ed.) *Developments in Infant Observation*. London: Routledge, pp.1-18.

Roesler, C. (2017) Tele-analysis: the use of media technology in psychotherapy and its impact on the therapeutic relationship. *Journal of analytical psychology,* 62(3), pp. 372- 394.

Rousseau, C., Miconi, D. (2020) Protecting youth mental health during the COVID-19 pandemic: a challenging engagement and learning process. *Journal of the American Academy of Child & Adolescent Psychiatry*, 59(11), pp. 1203-1207.

Rustin, M. J. (1989) Encountering primitive anxieties. In Miller, L., Rustin, M.E., Ruston, M.J., Shuttleworth, J. (Eds.) *Closely observed infants*. London: Duckworth, pp. 7-21.

Saakvitne, K. (2002) Shared trauma: the therapist's increased vulnerability. *Psychoanalytic dialogues*, 12, pp. 443 – 449.

Sabbadini, A. (2014) New technologies and the psychoanalytic setting. In Lemma, A., Caparrotta, L. (eds.) *Psychoanalysis in the Technoculture Era*. Hove: Routledge. pp. 23-32.

Salzberger-Wittenberg, I. (2013) *Experiencing endings and beginnings*. London: Karnac.

Scharff, J.S., Hanly, C. (2010) Telephone analysis. *International Journal of Psychoanalysis*, 91(4), pp. 989-992.

Scharff, J.S. (2012) Clinical issues in analyses over the phone and the internet. *International Journal of Psychoanalysis*, 93, pp. 81-95.

Scharff, J.S. (2013a) Telephone-assisted psychoanalysis. *Journal of the American Psychoanalytic Association*, 61(3), pp. 491-509.

Scharff, J.S. (2013b) *Psychoanalysis online: mental health, teletherapy and training*. London: Karnac.

Scharff, J.S. (2014) Clinical issues in analyses over the phone and the internet. In Lemma, A., Caparrotta, L. (eds.) *Psychoanalysis in the Technoculture Era*. Hove: Routledge. pp. 47-61.

Scharff, J.S. (eds.) (2015) *Psychoanalysis online 2: the impact of technology on development, training and therapy*. London: Routledge.

Scharff, J.S. (eds.) (2018) *Psychoanalysis online 3: the teleanalytic setting*. London: Routledge.

Scharff, J.S. (eds.) (2019) *Psychoanalysis online 4: teleanalytic practice, teaching and clinical research*. London: Routledge.

Scharff, J.S. (2020) In response to Kristin White "Practising as analyst in Berlin in times of the coronavirus". *International Journal of Psychoanalysis*, 101(3), pp. 585-588.

Sehon, C. (2015) Teleanalysis and teletherapy for children and adolescents. In Scharff, J. S. (eds.) *Psychoanalysis online 2: impact of technology on development, training and therapy*. London: Routledge. pp. 209-232.

Segal, H. (1973) *An introduction to the work of Melanie Klein*. London: Hogarth Press.

Shklarski, L., Abrams, A., Bakst, E. (2021) Navigating changes in the physical and psychological spaces of psychotherapists during Covid-19: when home becomes the office. *Practice Innovations,* 6(1) pp. 55-66.

Shout (2021) *Shout Annual Report, 2021.*

Shulman, Y. (2020) The (almost) impossible profession: face-to-face child psychotherapy during the Covid-19 outbreak. *Journal of Child Psychotherapy*, 46(3), pp. 296-304.

Shulman, Y. and Saroff, A. (2020) Imagination for two: child psychotherapy during coronavirus outbreak; building a space for play when space collapses. *Journal of Infant, Child and Adolescent Psychotherapy*, 19(4), pp. 339-345.

Sklar, J. (2020) Zoom fatigue is taxing the brain and here is why it happens. *The National Geographic,* https://www.nationalgeographic.com/science/article/coronavirus-zoom-fatigue-is-taxing-the-brain-here-is-why-that-happens. [Accessed 10th August 2022].

Slade, A. (1994) Making meaning and make believe: their role in the clinical process. In Slade, A. and Wolf, D. P. (eds.) *Children at play: clinical and developmental approaches to meaning and representations*. New York: Oxford University Press. pp. 81-107.

Smith, J., Flowers, P., and Larkin, M. (2009) *Interpretative phenomenological analysis. theory, method and research.* London, Sage Publications.

Smith, J.A., and Osborn, M. (2003) Interpretative Phenomenological Analysis. In Smith, A.S. (ed.) *Qualitative Psychology: A Practical Guide to Methods,* London: Sage, pp. 53-80.

Stern, D. (1977) *The first relationship: infant and mother*. Cambridge: Harvard University Press.

Stern. D. (1998) *The interpersonal world of the infant: a view from psychoanalysis and developmental psychology*. London: Karnac.

Stoll, J., Muller, J.A., Trachsel, M. (2020) Ethical issues in online psychotherapy: A narrative review. *Frontiers in Psychiatry,* 10:993. doi: 10.3389/fpsyt.2019.00993. [Accessed 5th July 2021].

Suler, J. (2004) The online disinhibition effect. *Cybertechnology & behaviour*, 7(3) pp. 321-326.

Symington, N. (2011) Analysis and supervision by telephone and skype: letter' *Bulletin of the British Psychoanalytical Society*, 47(9), p.46.

Tronick, E. (1998) Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, 19(3), pp. 290-299.

Tronick E.Z., Als H., Adamson L., Wise S., Brazelton T.B., (1978) The infant's response to entrapment between contradictory messages in face-to-face interaction. *Journal of the American Academy of Child & Adolescent Psychiatry,* 17(1), pp. 1-13.

Trub, L., Magaldi, D. (2017) Left to our own devices. *Psychoanalytic perspectives*, 14(2), pp. 219-236.

Turkle, S. (2012) *Alone together: why we expect more from technology and less from one another*. New York: Basic books.

Turkle, S. (2015) *Reclaiming conversation; the power of talk in a digital age*. New York: Penguin.

Van der Kolk, B. (2014) *The body keeps the score: mind, brain and body in the transformation of trauma*. London: Penguin.

Waddell, M. (1998) *Inside lives: psychoanalysis and the growth of the personality*. London: Karnac.

Webster, C. (2020) Fear of falling: impressions from working through a global pandemic and thoughts on burn-out. *Journal of Child Psychotherapy*, 46(3), pp. 289-295.

White, K. (2020) Practising as an analyst in Berlin in times of the coronavirus: the core components of psychoanalytic work and the problem of virtual reality. *International Journal of Psychoanalysis*, 101(3), pp. 580-584.

Winnicott, D.W. (1971) *Playing and reality*. New York: Penguin.

Zuppardi, S. (2020) Only connect: reflections on technology and transference. *Journal of Child Psychotherapy*, 46(3), pp. 312 – 320.

Appendix A: Systematic literature searches

Covid-19 and the health of children

Database searched: PscyhInfo

"mental health" OR well-being OR emotional OR CAMHS
AND
Covid OR COVID-19 OR coronavirus OR lockdown
AND
child* OR "young people" OR adol*

Inclusion criteria: children and young people as population, empirical studies, not opinion pieces, quantitative and qualitative methodologies.

n = 24

Working in the context of a shared, external threat

Databases searched: PsychInfo and PEP Archive

War OR terrori* OR "political threat" OR famine OR flood OR earthquake OR hurricane
AND
"child psychotherapy" OR "child analysis" OR "child psychoanalysis"

Inclusion criteria: children or adults as population, those underpinned by psychoanalytic thinking.

n = 8

The practice of remote working and the use of technology for therapy

Databases searched: PsychInfo

Telephone OR phone OR video OR skype OR zoom OR technolog* OR remote OR teletherapy OR teleanalysis
AND
psychoanaly* OR therap* OR counselling OR CAMHS
AND
"young people" OR children OR adolescen* OR covid-19 OR patient OR client

Inclusion criteria: adults as well as children as population (due to scarcity of papers about children and young people). Range of methodologies and modalities included.

n = 22

Appendix B: Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Participant Information Sheet

Research Project Title: What was the experience of trainee child and adolescent psychotherapists working with their patients during the COVID-19 pandemic?

What is this project about?
This project looks into the experience of trainee child and adolescent psychotherapists engaged in clinical work during the COVID-19 pandemic of 2020/21. It pays particular attention to the nature of unconscious communication within the therapist-patient relationship. It will explore the impact of an external threat and a move to remote working on the clinical work of a child and adolescent psychotherapist.

What will participating in this project involve?
Participants are asked to take part in a semi-structured interview, which will last for up to 90 minutes. Interviews will take place remotely, using zoom. During the interview, you will be asked to reflect on your clinical work with child psychotherapy patients during the pandemic. This will involve thinking about your patients' experiences as well as your own. You will be asked to consider the ways in which the existential threat posed by the pandemic, as well as a change in the therapeutic frame (move to remote working and the return to face to face work) are felt to be present in transference and countertransference communication. You will be sent the interview topics beforehand to allow for some reflection prior to the interview.

What are the possible benefits of taking part in this project?
You may benefit from the opportunity to think about and make sense of your experience of patient work during the pandemic. This could be helpful on a personal as well as professional level. You may gain some personal satisfaction from knowing that your involvement in this project could contribute to the body of knowledge and understanding in the field of child and adolescent psychotherapy.

What will happen to the data collected?
Each interview will be recorded and transcribed. Any information from the interviews about you, your work setting or your patients will be anonymised so that they cannot be identified in the study's write-up. Electronic data will be stored on a password protected computer and paper copies will be kept in a locked cabinet. All audio/video recordings will be destroyed after completion of the project.

What will happen to the results of the project?
The results of this study will be used in my Professional Doctorate thesis. It may also be used in future academic publications and presentations.

Disclaimer
You are not obliged to take part in this study and are free to withdraw from the project for up to three weeks after the interview. Accepting the offer to participate or choosing to decline will have no impact on your assessments or learning experience at the Tavistock and Portman NHS Foundation Trust or the University of Essex.

This research has been formally approved by the Tavistock and Portman Trust Research Ethics Committee.

If you have any concerns about the conduct of the researcher or any other aspect of this research project, please contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Contact details:
Nicola Levison
Child and Adolescent Psychotherapist in Training
Tavistock and Portman NHS Foundation Trust and University of Essex
nicolalevison@yahoo.co.uk
07771920086

Appendix C: Participant Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project: **What was the experience of trainee child and adolescent psychotherapists working with their patients during the COVID-19 pandemic?**

Researcher: **Nicola Levison**

Participant Consent Form

Participant's name and signature:	
I confirm that I have read the participant information sheet, which provides details of the nature of the research and how I will be asked to participate. I have had the opportunity to consider this information and ask any questions that I might have.	
I understand that I am being asked to take part in a semi-structured interview with the researcher and that my interview will be recorded, transcribed and analysed for the purposes of the study.	
I understand that my agreement to participate is voluntary and that I am free to withdraw it without giving a reason, up to three weeks after my interview.	
I understand that any identifiable information linked to my participation in the research will be anonymized and held securely by the researcher.	
I understand the results of this research may be published in the form of a thesis, journal article, academic publications or presentations with no personally identifying details included within the write-up.	

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Appendix D: Reflective account of researcher's own experiences

My experience of the first national Covid-19 lockdown and the impact on my working life is a painful thing to revisit. I remember the look of disbelief on my colleagues' faces as we were told to go home and not return the next day. Managers and the IT department of the trust quickly mobilised, and plans were made to find ways of meeting patients electronically. Laptops were ordered and meetings went online. The first few weeks after the announcement in March were dominated by the seemingly impossible task of securing the right equipment for myself, so that I could begin to think about how I would carry on with clinical work. I had no work laptop and no work phone. I kept in contact with patients and their families using my personal phone, dialling after changing the setting to "No caller ID" – a phrase which began to feel unnervingly apt as the weeks went by. The phone calls I made during this time felt like a perfunctory 'check in' to keep a link going. The children felt it was odd, and so did I. Their voices sounded small and younger than their chronological age. Phone calls with adolescents were full of persecutory silences. Sometimes I felt as though I was pestering them. Eventually a work phone arrived, and I could at least begin video calls using WhatsApp. A work laptop took much longer, and by the time it arrived, the WhatsApp sessions were in full swing and since I was hearing about the repeated failures of the preferred platform used by the trust, I stuck with WhatsApp. At least it was reliable. I have chosen to write a paragraph about each of three weekly patients with whom I worked during this time, outlining briefly their responses to the new way of working and the impact on me in the countertransference. Pseudonyms are used.

Hector, age 16

Hector, an academic and talented boy, who for the past two years had been troubled by crippling anxiety, had been working towards his GCSEs when the lockdown was announced, and exams cancelled. We had been meeting weekly for over a year. Prone to feeling incredibly 'awkward', he felt he could only manage 25 minutes on the phone, so I called him twice a week for two 25-minute phone sessions. Looking back, I think I was too eager to agree to this and the new arrangement meant that we could rarely get a good in-depth conversation going, which contributed to the 'checking in' feeling. Hector and I spent months talking about the ways in which he was managing the feelings of loss about missing his girlfriend, his friends and the school day, which he felt he relied on for structure and routine. He filled his time learning long sequences of *pi* and challenging himself to solve increasingly complex Rubik's cubes which he ordered on the internet. As we were approaching a loosening of Covid restrictions, Hector told me mysteriously that he had something to tell me that he couldn't say on the phone. I worried about a potential safeguarding risk, and arranged to see him in the clinic. It turned out that he wanted to say that he missed his sessions and wanted to come back. Later we saw this as a key moment in his therapy; in a way he had 'been a bit sneaky' as he put it: causing alarm in me so that we could see each other face-to-face again. But he had also expressed a need to be together and to be understood. Hector was a boy who was persecuted by harsh 'superego' thoughts of needing to always do the right thing and he worked hard to avoid disapproval in others. That he was able to break out of this, and risk something different happening between

us, brought shifts in the transference when we eventually did return to weekly sessions in the clinic.

Lucy, aged 8

Lucy had been attending weekly sessions for three months before lockdown. She was a very anxious little girl who worried terribly about her mother who had had physical and mental health problems since childhood. Lucy and her mother struggled greatly in maintaining the setting at home and at times this felt too painful to bear. At first, she was excited to have the WhatsApp sessions, peering into the screen and asking what I wanted her to do. Her Mum had set up the session in her bedroom and as she sat on her bed, legs crossed, looking down at the screen I was struck by how vulnerable and deprived she was. Thoughts of online child sexual exploitation and grooming entered my mind, and I was repulsed by the imbalance of power in this potentially unsafe and un-monitored setting. She thought I would be interested in her TikTok dances and would do little else. Lucy quickly became 'bored' of the online sessions. She couldn't manage the contact and I felt that I couldn't make meaningful contact with her. Our sessions were often disrupted by her little brother screaming and her mother trying to calm him, often shouting herself. One day I noticed that the door of her bedroom was missing. She told me that her brother had pulled the door off its hinges in the night (he was four years old). Sadly, the work with Lucy came to an end as she disengaged, and her mum was unable to keep the link going. However, after a conversation with Lucy's mum I shared my concerns with the family support worker in Lucy's school and her mum was given more support in the home. Lucy and her brother began attending school again, as vulnerable children.

River, aged 5

River's mother had suffered from severe depression in pregnancy and during his early months. She had been unable to keep him safe and he had been removed into care twice before he started school. When we met a year before, things were going much better at home. In the clinic room River liked me to play with the farm animals, putting fences around them and telling him what I was doing. He would interject with suggestions about which animals could go together to make pairings and families. Sometimes he just curled up on the couch and slept. River's mum was very thoughtful about setting up the WhatsApp sessions and as long as he kept the phone stationary on his chalkboard, we managed to connect – he would play and I would comment from time to time. River spent a lot of the session time poking swords and guns into the frame of the screen with exaggerated jerky movements. It was hard to make sense of these without any other cues and because he would often disappear in the middle of a session to get a drink or go to the toilet, and then forget about me. One day he put the phone on the window ledge of his bedroom and together we watched six fire engines carry out a drill in the carpark opposite his flat, an experience which fascinated him, and he still talked about months later. River asked repeatedly when he could return to the clinic and when he did, was overjoyed. For the next few months, he spent the sessions wrapped in a blanket 'like a burrito' and asked me to tell the story of 'us' – how we worked together in the clinic, then were on the phone, then again in the clinic. That this work seemed to be relatively unaffected by the period of separation between us, I attribute to the skilled parent work that his mum was making use of, and what I came to see as River's innate resilience.