Out of Body: An Interpretative Phenomenological Analysis of how child and adolescent psychotherapists experienced the dissolve of the physical aspects of the psychoanalytic frame (body and setting) due to the COVID-19 pandemic.

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Abstract

Until the COVID-19 pandemic, CAPPTs had worked primarily in person with children – in 'body' and 'setting' - for as long as child psychotherapy had been practiced. CAPPTs found themselves catapulted into new and unknown territory, working 'remotely' from their own homes. This study looked at the experiences of CAPPTs in relation to the shifts in the physical aspects of the psychoanalytic frame.

Three CAPPTs were interviewed twice each, using semi-structured interviews: firstly, about their route into child psychotherapy and thoughts on the concept of the psychoanalytic frame, and secondly about working through Covid. An Interpretative Phenomenological Analysis was used to develop themes which aim to do justice to the experiences of the participants.

Findings suggest that the psychoanalytic frame for CAPPT has changed irrevocably, and that the impact of this, while not yet known, is felt in myriad ways. All participants expounded the importance of in-person work with children as optimal, however, all felt that the pandemic had allowed for new possibilities and a more flexible approach. All participants felt that participating in the research encouraged further reflection the impact of their experiences and the ongoing changes in shape and form on the structures surrounding their future.

Recommendations for further research are for investigation into how CAPPT trainees are making sense of the post-Covid frame, given the increasing offer of, and demand for, technology-based psychotherapy, as well as what is felt about the presence or absence of the body in their work. Furthermore, a larger scale study could valuably explore how CAPPTs are renegotiating and reclaiming the importance of the physical frame for the profession, in the light of the continued prevalence of and demand for remote work.

Key words: COVID-19 pandemic**,** psychoanalytic frame, setting, body, child psychotherapy, psychoanalytic psychotherapy, remote work, IPA, containment, holding environment, countertransference

Contents

Chapter 1 – Introduction

This study explores how child and adolescent psychotherapists (CAPPTs)[1] with differing levels of experience, make sense of the physical shifts in the psychoanalytic frame[2], including the changes in therapeutic setting and the body, during a time of great change and challenge. It hopes to add to the contemporary dialogue and provoke further thinking in the profession about how the pandemic has changed or developed the frame within which child psychotherapy is delivered, in a discipline which has arguably stayed static for the last century.

Methodology:

Qualitative methodology is concerned with language, the currency of thought and expression, and is therefore well-suited to the interpretative world of psychoanalytic psychotherapy, in which process and meaning of experience are explored.

This study uses an Interpretative Phenomenological Analysis approach to the data. Smith, Flowers, and Larkin point out that 'IPA is concerned with understanding personal lived experience and thus with exploring persons' relatedness to, or involvement in, a particular event or process (phenomenon)' (2009, p.40). I believe the particularity of context with which this study is concerned, lends itself to IPA's suitability in staying true to this aspect of analysis and interpretation.

[1] From here on in referred to as CAPPTs.

[2] I will use the terms 'frame' (referring to the 'psychoanalytic frame') – and 'setting' – interchangeably throughout this study.

NB - I will leave the quotes of others as they appear in print.

Rationale:

As a CAPPT whose training was interrupted by the pandemic, within six months of starting, I was impacted and influenced by the changes in practice which were implemented as a result of the restrictions imposed. This experience, which at times felt brutal, bewildering and lonely, is at the heart of where I find myself now as a newly qualified CAPPT, leading me to wonder how differently I might now work and think, if the pandemic had not happened when it did.

I am, therefore, a product of a very particular and unique time in the history of the discipline, and it is my consciousness of this that is at the root of this study, resulting in my curiosity and commitment to exploring other people's personal experiences of what changed during that time, and how it can be understood.

Thought will be given to the dissolve of the frame, with attention to the use of the word *dissolve*, and its associations with something moving into a different form and needing to be contained in a different way.

Bléger (1967) defined the analytic frame as a 'non-process', the constant which enables the process to take place. The solidity of the external [frame] permits the fluidity of the internal, providing limits or boundaries and allowing for there to be edges and a place where things end.

Traditionally, the many facets of the physical framework around CAPPTs include the use of the same therapeutic space/consulting room; the use of the same toy box, personalised for each patient (and depending on age); the regularity of session time; the adherence to and acknowledgement of impending breaks in the therapy. Other external aspects of the frame might also include the use of supervision and analysis to contain the work with patients, but

perhaps these fundamental resources have taken on more personal significance to child psychotherapists throughout the pandemic, as powerful tools for containing the therapist in the face of such change.

All these physical aspects provide a space within which therapy can take place, but for the purposes of this research, it is important to state that the frame is not confined to the room that the therapy is practiced within, existing in the minds of both the patient and the therapist – of 'self' in relation to the 'other'. It is the CAPPTs' 'internalised frame', therefore, which interests me - concerning the felt or perceived loss of the actual, physical aspects of the frame in their work with patients, and how CAPPTs of differing levels of experience have drawn on this internal resource, to adapt their work.

The thinking behind this study grew out of my own experience of the training being disrupted and the undeniable reverberations of the pandemic on my practice. Retrospectively I realise that putting the experiences of other CAPPTs under a lens was a way of trying to put my own experience into context. This consciousness of my own, parallel experience will be referred to reflexively throughout the study because I feel that the interrogation of my 'self' in relation to the research process is a necessary and hopefully enriching part of the iterative process of building this project.[3]

[3] The study creates a 'frame', of sorts, for my own reflective experience.

Chapter 2 - Literature review

This chapter provides a review of the literature related to this study's title:

Out of Body: An Interpretative Phenomenological Analysis of how child and adolescent psychotherapists experienced the dissolve of the physical aspects of the psychoanalytic frame (body and setting) due to the COVID-19 pandemic.

2.1 Strategy

In this section, I set out the strategies used to gather the literature around the broad scope of themes and concepts pertinent to this review. These include research literature and key texts related to the history and development of the concept of the frame in psychoanalysis more broadly, and then, more specifically, to the body and setting in child psychotherapy (Appendix A).

It is of note that most literature about remote working before the pandemic related to psychoanalytic work with adults. I have included an overview as it relates to the frame and the body, however, anything more extensive is beyond the scope of this review.

I then include an overview of literature relating to CAPPT born out of the pandemic, to show both the overlap with, and areas to be developed beyond, this study.

I undertook a narrative literature review, using APA PsychINFO and PEP Archive databases which specialise in psychological and psychoanalytic literature, including texts which related to child psychotherapy, mainly omitting literature pertaining to work with adults, except to

illustrate a historical or specific context (eg remote work pre-Covid) or where it is relevant to the development of CAPPT as a discipline. I used two concepts at a time, for example "the setting" and "child psychotherapy", combining them with the Boolean operator AND to yield the greatest results. I applied a range of limiters to narrow down relevance, limiting the search to those which were empirical studies, in English, written in the last 50 years. I also accrued papers and chapters in key texts (since 1900), along with suggestions from other CAPPTs or supervisors, as it took shape. This included, during the interview process, the noting down of literature participants mentioned in passing, some of which I went on to review. I also reviewed, more broadly, the Journal of Child Psychotherapy[4] archive for any publications missed through other searches.

2.2 The psychoanalytic frame – definition and origins

It was the psychoanalyst Marion Milner who first conjured the phrase 'psychoanalytic frame' (1952), providing an imaginative analogy between the idea of analytic boundaries and an artist's frame. The demarcation of outer and inner, using the idea of a solid frame within which a painting or creative process can be contained, can be seen as a helpful, visual metaphor for the psychoanalytic process which can only unfold within a particular set of boundaries. (p. 182)

These boundaries – the frame – will be discussed in relation to psychoanalysis more broadly, before thinking more specifically about the frame or 'setting' in child psychotherapy. In his highly influential paper, 'Psycho-analysis of the Psycho-Analytic Frame' (1967), the South American psychoanalyst José Bleger used the Spanish word *encuadre*, originally translated as 'psychoanalytic frame' but can be translated as setting, and the two are often used interchangeably in psychoanalytic arenas.

[4] Referred to as the JCP from here on.

Between 1904 and 1919, Freud wrote a series of papers on his experiences as a psychoanalyst. He offered recommendations for other practitioners of psychoanalysis, setting out a methodology which is still recognisable and practiced by psychoanalysts today (Quinodoz, p. 108, 2004). The rules Freud established consisted of a regular setting which didn't change: a couch for the patient with a chair for the analyst situated behind; consistent times and duration of sessions. Perhaps the most important reason behind these very particular parameters was to enable the psychoanalytic process[5] to play out. Freud felt that the situating of the patient facing away from the analyst enabled a symbolic blank canvas, whereby the patient could concentrate more easily on their internal world, rather than on the real person of the analyst.

Confidentiality was another key 'rule' of psychoanalysis - the patient's information, thoughts and phantasies must be kept within the parameters of the analytic situation, as well as contact between patient and analyst confined to these parameters, only. This was with a view to enabling the possibility of the patient's unrestricted freedom of expression and the analyst's 'evenly suspended attention' (Freud, p.111, 1913), within which the transference could play out. There is evidence that Freud himself reneged on his own rules, at times mentioning his patients' names in letters to friends, or even inviting patients for dinner, and it was only post-second world war, with the growing emphasis on the importance of the transference/countertransference relationship (Quinodoz, 2004, p. 114), that firmer boundaries were more universally implemented, in order for patient and analyst to more easily manage the intensity of feeling experienced between them.

[5] See p. 18 for Meltzer's ideas on this.

Quinodoz (2004) situates the implementation of stricter boundaries within a growing climate of theorisation of the setting, led by Bion's concept of 'containment' (1962) and Winnicott's idea of the 'holding environment' (1945) (discussed later on). He emphasises the importance of the development, over time, of the patient's transference to the setting's strict parameters: the rigorous regularity of the sessions; the presence or absence of sessions and the need to pay for missed sessions (sessions themselves representing a space in the therapist's mind, kept solely for that patient), leading to an internalisation of the setting as 'indispensable if the psychoanalytic process is to develop successfully' (2004, p.114).

Bleger (1967), asserts that the term 'psychoanalytical situation' should be applied to the 'totality of the phenomena included in the therapeutic relationship between the analyst and the patient' (p. 1 in Moguillansky & Levine (2023)). The phenomena he refers to includes the process that happens within the frame, which is thought about, analysed and interpreted – as well as the frame itself, which he deems to be a '*non*-process', distinguished from and within which, the analytic process can take place. He posits that the frame is a phenomenon which essentially goes unnoticed by the patient until something changes or becomes broken, at which point it makes itself visible.

Lemma (2016) cites the features of the frame as: 'consistency, reliability, neutrality, anonymity and abstinence'. Deviate from this and "you could easily find yourself having to contend with the analytic superego many practitioners internalise during training" (p. 95). Here she is alluding to the seeming rigidity and weight of tradition, perhaps felt in a persecutory way within the profession, yet is there for good reason as a way of safeguarding and strengthening the patient's trust in the analytic process and 'reveals an appreciation of the importance of stability and reliability for the patient's psychic development' (p. 100).

Parsons (2007) likens the analytic setting to the act of stepping into a theatre, where reality is suspended within time and space. He speaks about the features of the external frame but also alludes to his use of the internal analytic setting: a 'psychic arena' in which reality is defined by the language of, and dialogue with, the unconscious – a place protected from the disruptions or breaches of the external, physical frame. He cites Winnicott doubling the length of a patient's session without charging an extra fee, as a possible example of Winnicott 'pushing at the limits of the external psychoanalytic framework in an attempt to expand his internal sense of what a psychoanalytic process could encompass' (p. 1148).

2.3 Key concepts in relation to the psychoanalytic frame

2.3a Holding

The frame, which surrounds and supports the therapeutic relationship, can also be thought about or referred to as the 'holding environment', an expression born out of Winnicott's concept (1945). Winnicott felt that the frame symbolised the maternal psychological 'holding' which allows the baby to manage and come to terms with the reality of difficult early experiences. It was in his early paper, 'Primitive Emotional Development' (1945), that he first described the early developmental processes as he understood them.

He writes that the baby goes through three processes: of integration, personalization and realization, and that the baby begins life unintegrated, relying on both the external experience of the environment and the 'acute instinctual experiences which tend to gather the personality together from within' (p. 150).

Parry (2010) writes that Winnicott regarded the baby's journey, from total to partial independence, as crucial within the concept of 'holding', which includes not only the process of the baby being physically 'held' (either within the mother's body or, after birth, externally)

but also ‘held’ by the ‘total environmental provision’ (Winnicott, 1960, p. 43 as cited in Parry, 2010, p. 18). These dual vertices, with the mother’s ability to provide a continuous process of attentive adaptation to the baby’s needs (or period of ‘primary maternal preoccupation’ (1956)), allows for the experience of ‘going on being’ and the process of integration that the baby needs in order to adapt to the external world and know itself to be safely separate from its mother.

Parry posits that in Winnicott’s 1949 paper, ‘Mind and its relation to the Psyche-Soma’ he situates the mind in relation to the body, believing that the mind could not develop if the body had not also developed through the process of ‘holding’. This is then linked to Winnicott’s notion of personalization (1945), which he ‘defined as the “development of the feeling that one’s person is in one’s body. […] I suppose the word psyche here means the imaginative elaboration of somatic parts, feelings, and functions that is, of physical aliveness” (1949, p. 244). Parry writes that Winnicott meant ‘the development of a mind is one not governed by innate factors but […] influenced by environmental provision […] relocating the arena of psychic life from the internal world of the individual (which was a strong focus of the Kleinian contribution at the time) into the environment’ (p.19).

In clinical terms, it is therefore possible to understand the contribution of the dual aspects of both the body (the bodies of the therapeutic dyad as part of the setting), as well as the ‘environment’ (in the form of constant external aspects of the setting) to the ‘holding’ of the psychoanalytic process.

2.3b Containment

Another profoundly influential concept in the theoretical thinking around the frame, is that of Bion's idea of 'containment' (1962a). Bion compared a mother's capacity to accept her baby's intense projections - to bear and understand them, translating and returning them in digested and more manageable form - to that of the therapist's role of containing their patient.

Waddell observes that the emotional states of the baby are situated firmly in the body and the senses, but that their emotional state becomes 'educated and thereby achieves meaning' because of a mother's capacity to tolerate, make sense of and respond to her baby's communications 'in its own particular context' (2018, p. 18). She emphasises the meeting of physical needs as only one part of the process of containment, psychological and emotional openness being the key experience (what Bion (1962a) termed 'reverie'), within which the mother becomes the 'modulator of mental pain', thus enabling the infant to begin to develop a tolerance of their own emotions and, through this, a growing sense of 'self'.

Both Bion and Money-Kyrle (1956) were exponents of the idea of the therapist as 'container' for the patient's painful experiences, which through being understood and verbalised by the therapist could thus be 'contained'.

2.3c Transference and Countertransference

Countertransference has had a complex history, throwing up much discussion about its dangers and its uses. Freud and then Melanie Klein, saw it as the analyst's unconscious reactions to the patient caused by the analyst's psychopathologies. As such, countertransference needed to be dealt with by the analyst alone. Paula Heimann's seminal paper 'On counter-transference',

published in 1950, changed the landscape for thinking about it in a more positive light, as she believed that countertransference should be used as a tool for understanding the patient's experience, or the therapeutic relationship, defining it as 'an instrument of research into the patient's unconscious' (p. 82)

Racker also believed that what the analyst felt could originate from 'psychological happenings in the patient' (1953b, p. 129) and Little said it was a 'special kind of identification of the analyst with the patient' (1951, p. 33). Steiner describes how, if analysts can notice the 'pressures' which arise in themselves, but not act on them, they can begin to understand something of the patient's experience (2004, p. 38).

Moeller (1977) believed that the only way to really understand the transference of the patient was to think of countertransference as a 'specific non-neurotic reaction on the part of the analyst to the transference of the patient […] the necessary complement of transference' (p. 365) – what Money-Kyrle (1956) called 'normal countertransference'. This was countertransference at its most helpful and as an aid to understanding the patient's unconscious - yet the involvement of, and sifting through, the therapist's own internal world and unresolved conflicts have to be recognised and thought about as part of the work. It is precisely the containing nature of the frame, with its clear parameters - and what Bleger (1967) felt was its function as a depository for the psychotic parts of the personality - that enables the therapist to identify, translate and, importantly, 'work through' in the countertransference, before interpreting it for the patient (Pick, 1985).

Joseph's (1985) description of the 'total situation' (based on Klein, 1952), conjuring the therapeutic situation as something alive and active between them, further developed the possibility of the therapist's sensitivity to their own experience as a barometer for the patient's:

'experiences often beyond the use of words, which we can only capture through the feelings aroused in us, through our countertransference' (p. 62).

With regard to embodied or somatic countertransference, MacDougal (1979) believed that the body could express very early, pre-verbal experiences, both behaviourally and through somatic symptoms, whilst Field (1989), through much thorough interrogation and clinical research, believed that it was possible for the therapist to feel projected communications in his body, and therefore come to know something of the patient's experience that they could not express verbally.

In the light of the pandemic and the difficulties faced by clinicians working under uniquely pressured and previously unknown conditions - remotely and in-person wearing PPE - the difficulties, potential dangers and the blurring of, what Winnicott conceptualised as, the 'me/not me' boundaries,[6] took on a whole new meaning, in relation to what could be felt, or understood, to be the countertransference. This will be explored later in the study.

2.4 The frame or setting in CAPPT

2.4a Its roots

Freud's forays into work with children was primarily as a means of understanding what was already known from analysing adults. He wrote on childhood sexuality (1905) and in 1909 famously wrote his case study of Little Hans, conducted through the child's father, not directly with the boy himself. Both he and Melanie Klein analysed their own children, but it was Klein

[6] In 'Transitional Objects and Transitional Phenomena' (1958a), Winnicott develops ideas about the baby's growing awareness of the space between (her)self and object, whether blanket, teddy or parent, and the growing recognition of the object as 'not me'. The precursor to this stage of development, during which the baby might use its own thumb or the mother's breast interchangeably to self-soothe, highlights the confusion between what belongs to the self and what is part of the other.

who began to use play as a technique, as well as careful observation of 'all aspects of the child's behaviour as expressions of the unconscious mind' (Bott Spillius et al, 2011, p. 18).

In 1926, Klein began to set down her techniques on paper, based on her observation that there were 'certain differences between the mental life of young children and that of adults. These differences require us to use a technique adapted to the mind of the young child […] a certain analytical play-technique which fulfils this requirement.'

Bott Spillius et al (2011) note that Klein initially saw children in their own homes, using their personal toys, before she developed an understanding of how a child's difficulties could be exacerbated by being seen at home, due to its association with its family, and the complexity of unconscious meaning around this.

Klein grew to realise the impact and importance of the environment on an analysis and a more formalised approach came into being when she began seeing patients in a dedicated setting, introducing personalised sets of toys for each patient. This was the origin of the technique still used today, the box of toys 'representing continuity of the treatment and the uniqueness of the child's relationship with the analyst' (Klein, 1932, in Bott Spillius et al, 2011, p. 25).

Toys provided Klein with the access she needed to begin to understand early unconscious childhood processes, about which she wrote some of her greatest theories. Her technique also involved interpretation, which developed over time, but which transformed what she observed to be the effect on the young patients and the results of the analysis. Although Anna Freud actively worked to establish a positive relationship with a child in the introductory phase of an analysis, Klein felt that it was necessary to interpret the origin of a negative transference first, to relieve the child's anxiety. When interpreting the children's anxiety, she witnessed their relief through freer play and a more positive transference (1932).

Meltzer, heavily influenced by Klein's development of technique, wrote in 'The Psychoanalytical Process' (1967) that the 'evolution of the transference goes on without ever being visible to the analyst until the setting has been circumscribed and defined so that the anxieties are being contained within it' (p. 10). Here he was stressing the importance of the structure of the setting, both physical and conceptual, as the container within which the transference could unfold.

Isaacs-Elmhirst emphasises the importance of the meaning and security of the analytic hour, made up of Freud's 50-minutes (with 10 minutes to re-set between sessions). She says, 'with children a physical tidying-up time is essential and is a pertinent reminder that an emotional tidying-up time is needed between adult patients too. In my experience children quickly develop an inner awareness of the time provided […] especially for the most disturbed children, any variation of time available arouses intense feelings.' (p. 5)

Klein felt that from early infancy, unconscious phantasy played out in relation to internal objects and are situated and experienced through the child's bodily functions, such as hunger being felt to emanate from a hated object which wishes to cause the baby pain (Hinshelwood, 1989, p. 34). Thus, Klein and her exponents believed firmly that unconscious phantasy and emotional instinct are deeply rooted and expressed through the body, going back to the earliest stages of life.

2.4b Physical aspects of the setting for child and adolescent psychotherapy

Traditionally, the consulting room for seeing children is a neutral feeling space, in which the child's toys and the bodies of the therapeutic couple take centre stage. The simplicity of the setting is deemed important as a backdrop for the 'work' that goes on between therapist and

child: the work of bringing into consciousness what is unconscious, by exploring thoughts and phantasies.

Psychoanalytic psychotherapy with children is, however, a much more physical affair than psychoanalytic work with adults, and it is common for the therapist to move and find ways to engage with the child patient, without coming into physical contact. It can also be necessary to physically help a child to stay safe. The physical aspects of child psychotherapy, whether in the bodies of patient and therapist, or the constancy and function of the setting, are fundamental for the work of therapy to take place.

Anagnostaki, Zaharia and Matsouka (2017) refer to the way the setting is used as a depository for the patient's 'deficits in symbolisation', often manifesting in attempts to change the setting, or push at the boundaries. They cite Parsons (2000), who posits that the setting is a 'third' to the therapeutic dyad, providing a symbolic representation of the therapist's *in*-exclusivity to the patient – an object who is separate from them, thus becoming 'an external representation of the Oedipus complex' (Anagnostaki et al., 2017, p. 370).

Anagnostaki et al. suggest that there is not only one psychoanalytic framework within CAPPT work, but two – one in setting up negotiations with parents or carers and, in some cases, parent work running alongside the work with the child – the other with the child or adolescent themselves. Klein herself admitted that parents were a part of the setting but felt that the parents were too intimately part of the problem for the children and contact with her would 'touch too closely on their own complexes' (1932, p. 78). Nowadays, the issue of the 'closeness' of parents to the work is generally overcome in the form of parallel parent work, undertaken by another clinician.

In her famous paper, ‘Thinking about a Playroom’ (1998), Betty Joseph’s salient point emphasises that the environment in which the therapist practices is comfortable enough to ‘think and feel freely and thus be able to observe’, without anything external (or internal) obstructing the task of being with, and observant of, the patient (p. 360).

2.5 The body in psychoanalysis

> In the interpersonal, intrapsychic play of our lives, the mind has taken not just the lead role but all the supporting cast leaving the body as a kind of prompt when the lead actors lose their lines. (Orbach, 2003, p. 6)

In this quote, Orbach highlights what she feels is the absence of the body from the work of psychoanalysis, overshadowed by the privileging of the mind. Yet just as the baby’s first relationship is with its mother’s body, which is felt to be (and once was) an extension of its own, so, it could be argued, the work of psychoanalysis cannot exist without the dyad of ‘self’ with ‘other’ - two people together: in, and with, their bodies.

Freud wrote: “the ego is first and foremost a bodily ego” (1923, p. 26). Many of his case studies of (mostly) women battling repressed unconscious phantasies, famously reported symptoms situated firmly in the body. One possibility about the seeming absence or, at least, repression of the body in psychoanalytic literature may, in part, be linked to the intimacy involved in coming into close contact with another person’s mind and inner world within the parameters of a dedicated setting, meaning that the proximity to the body and the potential to be put in touch with primitive urges and instincts: the fear of danger, threat or temptation, could be split off and avoided. On the other hand, perhaps the body can also be too much of an invariable to be noticed.

Bleger (1967) had the idea that we are working with two settings, referring to the separateness of the therapist and the patient, who bring their own individual settings, that of their own selves in their own bodies. Lemma (2014) thinks about this in relation to patients who struggle with a symbiotic transference, undifferentiating themselves from their therapist to the extent that any change in the therapist's appearance can be felt as catastrophic. She conceptualises an 'embodied setting', by which she means the bodily-ness and sensoriality of the analyst as a form of containment, and the analyst's somatic countertransference as part of her internal frame (p. 112).

The sensory qualities of the setting are also cited through Civitarese's idea of it functioning as a '"skin" still in adhesive contact, with the role of integration' (2008, p. 28). The significance here of the body of the therapist to the patient, as a containing part of the setting, is inescapable. This has derivations in Winnicott's thinking about the role of the skin in demarcating the "boundary between the me and the not-me […] for the establishment of the state of I AM, along with the achievement of psycho-somatic indwelling and cohesion" (1962, pp. 61-62).

2.5a The body in child psychotherapy

The body is an inescapable aspect of therapy with children, not least because children under a certain age can't, and don't, observe the same physical boundaries as adults. Their instincts, thoughts and feelings are naturally more 'in the body' and psychotherapy must respond to this. Work with different patient groups have been theorised and developed, calling for different techniques and approaches, particularly for children with autism, disabilities and severely traumatised or deprived children (Rhode, 2005; Alvarez, 1992 and 2012; Tustin, 1992;

Sinason, 2017; Horne, 2018), whose relationships with their own bodies and those of 'the other' can be complex and embedded, calling for sensitive and informed consideration.

Davies (1989) vividly illustrates how even the most 'neurotic' of children can present themselves in the most physical and sensorial of ways:

> In the early days of his treatment Matthew often climbed swiftly on to the edge of the sink, taking possession of it in his character of Baby Monkey. He drank avidly and frequently, in a state where there was no distinction between his body activity and the psychic pain he was expressing. (p. 130)

Davies's extract serves to show the ordinariness of how children make use of the setting in physical terms and, arguably, how the body/ies and setting become one, in the same way that the mother's body can be experienced as undifferentiated from the child's own. Meltzer, similarly, conceptualises the setting as a space which can represent something symbolic in relation to the child's sense of itself as inside, or outside of another / mother's body, describing a child who will:

> rush to the window and gesture in triumph toward the birds in the garden, though they are usually the objects of enraged fist-shaking when he feels that he is outside and the garden is experienced as the inside of the mother's body (1967, p. 19)

The inside/outside-ness of the body and the setting conjure thoughts about space, both temporal and physical, including transitional spaces and 'space between' (patient and analyst; waiting room and consulting room; time between sessions, to name but a few).

Lanyardo (2003) touches on the boundaries which may need to be set with regard to contact, not just with maintaining and looking after the setting so that the child doesn't feel persecuted

by damage done, but also in relation to the body of the therapist. She emphasises the humanity of the therapist, who may need to help children clean themselves up after a particularly messy session. The 'real person' of the therapist is distilled in Lanyardo's idea of the 'presence' of the therapist, which she delineates as being both the 'present relationship' - that relationship in that moment – and the bringing into the room of the individuality of the therapist, as their own person. (p. 5)

Presence and absence are fundamental to the work of psychotherapy, particularly in how therapists help children to understand and manage the difficulty of the endings of sessions; gaps between sessions and breaks over holidays. This work helps the development of a sense of continuity, in the form of the through-ness or 'thread' in the therapy, as the child begins to take in what the therapy in its 'present' form (and in its absence) represents. O'Shaugnessy, in her seminal paper The Absent Object (1964), writes about the infant's relationship with the mother's breast, which must be come to terms with as a sometimes depriving, yet, nevertheless sustaining object, even in its absence. (p. 208)

2.6 An overview of thoughts on the setting from pre-pandemic literature on remote psychoanalysis with adults

As early as 1951, Saul (1951) wrote of what he perceived as the advantages of work on the telephone, citing a patient who found the transference too overwhelming in person but was able to speak more easily and frequently on the telephone. He wrote:

> One wonders if the idea of using modern technology in the form of the telephone, as an adjunct to psychoanalytic technique, will be met with horrified resistance, or whether most analysts are already far ahead of this in their thinking and anticipate experimenting

> with televisual communication if and when this becomes practicable. (Saul, 1951, p. 287)

It seems that Saul's prediction was correct, that 'televisual communication' would become something to be experimented with and, eventually, a valid (if controversial) medium for psychoanalysis, in its own right. However, several analysts (Zalusky, 1998, Leffert, 2003 and Caparotta, 2013) have written about their feelings of guilt or shame at working outside of the traditional physical bounds of the frame. Sabbadini (2014) reflects on the impact of new technologies on the psychoanalytic community from the 1970s and the resulting complexity in relating to patients.

The speed of the sea change in technological advancements left many in the profession feeling deskilled (the 'digital immigrants', coined by Prensky, 2001), and confused about their professional identity. The use of remote psychoanalysis as a way of providing continuity and accessibility for patients, including those who could not access analytic work where they lived, meant that the prevalence of remote work offered by adult analysts grew out of a demand (Zalusky, 1998; Lindon, 2000; Leffert, 2003). It is notable that all declared that it was possible to work remotely, but that it was undeniably second best.

Sabbadini (2014) questions the growth of tele or video analysis as the patient's choice, rather than through necessity, calling it a 'questionable practice' because of the avoidance of the 'in-person analytic process' and a perpetuation of this resistance through the analyst's acceptance (p. 26). He, like others, advocates for a mixture of in-person and remote sessions, in order for patient and analyst to be put back in touch with each other's physicality and proximity.

As one of the major exponents of Skype/video-analysis, Scharff (2017) feels strongly that the setting up of the frame in tele-analysis is just as much a joint venture as it is in person - set up

flexibly to accommodate distance from the analyst, "but […] not bent or corrupted by doing so. It is simply adapted to current reality" (2017, p. 9). This bold statement leaves many questions about how this is achieved so 'simply', but it is also notable that Scharff created contracts with her patients that they would "return for a series of visits every few months […] to reconnect to the familiar and trusted holding environment of analysis in the office" (2017, pp. 9-10).

Churcher (2017), reflecting on Bleger's argument that the frame functions as a depository for the psychotic part of the personality - present in all of us, as a reverberation of "early symbiosis with the mother" (p. 37) - posits that, as humans, we establish a symbiotic relationship with *any* invariants, whether in our environment or in our bodies, taking them for granted until something breaks down (bringing to mind André Green's idea of the body being "silent in health" (Green, 1975, p.7)). Churcher warns that this is something to be curious about in relation to what gets deposited into the technology when working remotely.

Marzi and Fiorentini (2017) reflect on the increasing awareness needed by analysts to think about shifting perceptions of time and space. They posit that the development of technology, "require[s] us to confront and give meaning to the new ways in which our minds increasingly have to interact and our relationships have to take shape" (p. 65). They liken (along with Goldberg, 1998 and Gabbard, 2001) the march of indistinguishability between reality and cyberspace to "a space situated between external reality and the internal world, which begs the question whether this space belongs to the machine or to the mind" (Marzi and Fiorentini, 2017, p. 67). This brings to mind E. M. Forster's extraordinarily farsighted short story, 'The Machine Stops', which foresaw from as far back as 1903, a world in which we would connect via screens, without the possibility of touch, and the horrifying potential for our lives to be determined by the machine.

Marzi and Fiorentini talk of the inescapable “atmosphere” that a body produces around itself and resulting loss of this in remote work, without the “direct relationship with the reciprocal sensory channels conveying responses of anger, fear, excitement […] through projective identification” (p. 72). Lemma (2017), too, advises that, when offering remote sessions, careful consideration should be given to working with an awareness of the body, as two bodies working and experiencing themselves and each other - in and from separate spaces - rather than being ‘body-less’, or not being ‘in’ their bodies.

Saporta (2017) expounds the virtues of the bodily aspects of psychoanalytic work, emphasising the “ritualised bodily encounter with the physical space of treatment” (p. 86). He talks of the physical experience of approaching the therapy room or clinic, and the crossing of the therapeutic threshold. Lamenting a lack of theorising about the importance of physical space in psychoanalysis, Saporta suggests an inherited ‘Cartesian disembodied and decontextualised model of the mind. What transpires between heads is not shaped by body or physical context’ (2017. p. 88). In this context, Saporta (citing Bachelard, 1994) reflects on the attention that has been given to the mother’s body as protective, containing space in relation to the consulting room, but not the importance of the concept of ‘home’ or ‘house’ as “containing and cultivating a reflective, imaginative capacity to daydream” (p. 89).

The attention that Saporta gives to the resonances of physical space and the transferences one makes to physical spaces, are also explored in relation to the idea of cultural meaning attached to space, posing questions about the meaning and associations made, provoked and acted upon by CAPPTs and their child and adolescent patients, thrust into remote work during the pandemic.

2.7 Literature from CAPPTs written during the pandemic

When searching for literature about remote work with children before 2020, there was a noticeable gap. Only Widdershoven (2017) and Sehon (2015) had published articles about remote work with children, pre-pandemic. This gap highlights the starkness of the sudden shift to online work during Covid, forcing CAPPTs to work in a way which was unknown by the majority of professionals, particularly those working in the public and charity sectors. Of literature searched for and born out of the pandemic, I have chosen to focus on 10 papers from the Journal of Child Psychotherapy (JCP), December 2020 edition, which was dedicated to the work of CAPPTs during the pandemic.

Touching briefly on these two pieces of pre-pandemic literature, both were born out of clinical need due to difficulties in continuing the work, because of distance or circumstance. Sehon (2015) worked with two young children who couldn't have continued with therapy unless adaptations were made. It is notable that there was an extensive run-in to the shift to remote work, with a review of practicalities and much preparation. Sehon was generally positive that it was possible to work remotely with these children, utilising her internal frame and that adaptation was possible and progress was made. However, she states this was largely down to the already-established in-person work which had laid the foundations, as well as extensive preparation and prior notice. Widderhoven's (2017) work, with six sets of parents on the Greek islands, was fraught with difficulties in connection and in the families difficulties in creating safe spaces in their homes from which to meet. She concluded that the therapeutic work could only be successful with intermittent in-person work to shore it up.

In her editorial in the JCP edition (December 2020) entitled 'Child psychotherapy in the time of Covid: Voices from around the world on working through a pandemic', De Rementeria reflects on the collection as a 'snapshot of what has been possible during this time', whilst

recognising that it may be ‘a long time before we can really understand how we responded in the consulting room and why’ (2020, p. 269). Francis (2020), in her commentary on various papers under the title ‘The setting, technology and the body’, opens with the line: ‘It can be easy to forget how shocking it was in March 2020 not to be able to see our patients’ (p. 336). She describes the ‘salvaging operation’ of maintaining contact with them, providing a flavour of the sudden schism in the therapeutic dyad.

Garcia (2020) speaks of the attributes of the ‘normal’ psychoanalytic setting, emphasising the interplay between transference and countertransference, which “makes room for the fuller realisation for a fuller dialogue (a more ‘whole story’) of object relations *between* and *within* patients and their therapists” (p. 338). He posits that alongside the external conditions of consistency, frequency and physical setting, the “unspoken and unconscious forms of communication, such as eye contact and gaze (or lack of it) […] create the conditions for a ‘certain kind of thinking and learning to take place’” (p. 339). Garcia speaks of the importance of maintaining a capacity to ‘think through’ challenging situations in relation to loss of control of the setting online - fundamental to the success of maintaining a sense of linear connection to patients.

Kohon (2020) poignantly reflects on the confusion around his own countertransference when moving a long-term treatment with an adolescent boy to the telephone. He describes his difficulty differentiating his own feelings from his patient’s, aware of the overlap in circumstances due to the lockdown restrictions, and his own ensuing feelings of despair. Kohon notes how countertransference feelings and bodily states can consume CAPPTs and lead to feelings of shame at overwhelm, or an inability to contain something sufficiently for a patient – highlighting that existential preoccupations, triggered by the pandemic and coinciding with the change in setting, made this even more complex and difficult to manage. He cites the

structures and infrastructures around CAPPTs falling away and altering, unrecognisably - both in their clinical settings and in their personal lives: with disconnect from family, supervisors and other layers of containment.

Webster (2020) applies Freud's ideas on melancholia to the context of the pandemic, recognising her feelings of uncertainty at what had been lost, whilst knowing that something *had* been, and the ambiguity around this. Her language about remote work - 'unexpected things came into view'; 'children wandered off'; 'things occurred that we had not experienced before' - effectively conveys the confusion and chaos of the new (p. 291).

Shulman (2020), like Kohon, looks at the collective trauma of the therapeutic dyad, wondering about CAPPTs capacity to help their patients when experiencing similar concerns: 'a sense of uncertainty and helplessness in the face of an external super-force' can, she suggests, 'result in the loss of thinking and reverie' (p. 301).

Some papers think carefully about issues of presence and absence. Antonaides (2020) speaks about his initial denial of reality in the face of wanting to continue seeing patients in person, and his decision to keep seeing one particular boy, whilst others moved online. Feeling it was right intuitively and clinically, he found it difficult to judge what was ethically and socially correct, from inside the eye of the pandemic. He cites Lanyardo's 'the presence of the therapist' as a helpful clinical idea in relation to his work with this boy, who had suffered much trauma in early life, and for whom his insistence on continuing to provide a physical thread appeared to open up a space for improved communication in the therapy.

Paiva (2020) described how she became more present in her own body when working remotely with *only her* body in the room, finding more connection with her countertransference through the freedom she felt in being alone. This contrasted with her patient's experience of the video's camera as a self-critical eye. Zuppardi (2020) reflects in a different way on 'the gaze' in relation

to Tronick's (1998) research into infants and caregivers, highlighting the importance of 'synchronous exchange of bodily and facial cues in real-time' (p. 313). Zuppardi felt that it was possible to do important, emotionally connected remote work with some of their adolescent patients, but that the 'impossibility of eye contact' was a continuous loss.

Shillito (2020) feels that remote work with adolescents was ripe for their avoidance of the body, or absence of it. She cites an instance of assessing a patient online, before treating them in person later in the pandemic, only to realise the role that phantasy had played in her pre-conception of her patient as a much younger child, prior to meeting, which correlated with the patient's own denial of her body as a sexual one. Despite previous reservations, Schmidt Neven (2020) feels that remote work on video could facilitate powerful transference communications, transcending what she and others had previously assumed. She suggests that 'Attention is paid to what is seen, revealed and recognised during the tele-video sessions and how these elements contribute to creating a three-dimensional experience within a two-dimensional experience' (p. 388).

Wolpe (2020), on the other hand, gives thought to the fact that there is little to no literature on remote psychotherapy in child psychotherapy for good reason: "that our practice relies fundamentally on the physical setting and on the phenomenon of transference, we take it for granted that we should see the child patient in person, 'in the flesh'" (p. 349). They reflect on the wordless communications we rely on, the detailed observation skills CAPPTs are trained to use, and the physical contact that is sometimes needed to keep children safe. Wolpe suggests that, although their experience of remote work during the lockdowns was conflicted and compromised, what could be achieved was the creation of a 'holding setting', akin to Bick's (1968, 1986) idea of a skin which holds things together under duress.

2.8 Summary of Literature Review

1). The literature shows that the frame has been in development for over a century and its formalisation has grown out of, both the theorisation of the frame as a functioning concept which supports both psychoanalytic practitioners and patients alike, as well as the growth of psychoanalysis as a profession. This professional identity appears to be symbiotic with the frame itself.

2). It has been established that the term 'psychoanalytic frame' represents different aspects of a set of boundaries within which psychoanalysis can safely take place. The word 'frame' is born out of the need for a structured surround, to enable the necessary freedom of thought and expression to take place between analyst and patient. It could be argued that there are three aspects to the frame:

- The physical bounds – traditionally, in the same room, at the same time and on the same day/s; the financial contract between analyst and patient (if working privately); the understanding that the patient and analyst will not come into physical contact and that the relationship exists within that setting alone.

- The psychic bounds – the understanding between patient and analyst of what takes place between them within the physical parameters i.e. a phenomenon uniquely situated within the therapeutic relationship, as a backdrop upon which to explore how the relationship, in phantasy, allows internal and external relationships to unfold and take on meaning within the transference. This includes the function and use of the analyst's internal frame/setting and the impact of this on maintaining the frame when changes or disruptions occur.

- The relational bounds – the actual and symbolic reality of the therapeutic dyad as bodies physically together, and the impact on the potential of the psychic relationship. Through the changes to the frame, in the form of remote work coming into being (pre-Covid) as a modality of choice in adult analysis, the loss of the physical therapeutic dyad within a shared space is an ongoing area of scrutiny, in terms of the efficacy of the work undertaken and the impact on the quality of the therapeutic relationship possible.

3). This search has established that the body is of particular importance to the work of CAPPT, as children communicate more actively and unconsciously through their bodies, and in therapy this is no exception. The need for the therapist to maintain physical boundaries is a way of modelling the holding environment necessary for the work to safely take place. It is arguable, therefore, that the loss of this aspect of the work could be felt all the more profoundly by both therapist and patient.

4). It has been found that only two pieces of pre-pandemic literature readily exist on remote psychoanalytic psychotherapy with children. The reasons for this link to the presence and use of the body in CAPPT as a medium for communication, conscious and unconscious and, as such (and for young children in particular), in-person therapy has not been questioned. As is highlighted by the Covid literature, the difficulties in providing a safe and supportive setting within the children's homes and the need for parents to facilitate this as part of the (new) frame, sheds light on the dearth of exploration into remote work with young children through choice, prior to the pandemic.

5). It is important to recognise, from the rich and urgent outpouring of literature from CAPPTs during the pandemic, detailing the significant changes in form and practice, that this sudden dissolve of the frame caused CAPPTs to have an experience of something which could arguably be described as 'out of body', taking them outside of their bodies together with their

patients', as well as putting them in touch with their own, and the bodies of those around them, with new consciousness.

2.9 Justification for this study:

The results from this literature show the long history and breadth of thinking and theorising around the concept of the frame as fundamental to the practice of psychoanalysis, with both adults and children. This is shown to be linked to the physical and relational aspects of the therapeutic endeavour, which has resulted in fervent discourse around the efficacy and uses of remote psychoanalytic work, over the course of its short history.

The gap in the literature for remote psychoanalytic work with children is evidence of the complexity that this shift means for the profession as a whole, and which is further evidenced by the literature born out of the pandemic, not just in relation to the sudden shift 'from room to Zoom', but also in relation to the implications for contact with, and safety of, patients, in-person and from a distance, as well as the complex relational and health anxieties provoked.

This study is therefore justified on the grounds that it takes a unique stance in thinking about the physical aspects of the frame in relation to the sudden break in practice for CAPPTs everywhere. The hope is that it can add to the discourse around how the frame may have changed irrevocably - and what this means for the frame of the future.

Chapter 3 - Methodology

3.1 Aims:

This study aims to explore the impact of the Covid-19 Pandemic on Child and Adolescent Psychotherapists' (CAPPTs') experiences of the physical aspects of the psychoanalytic frame, as conceptualised and developed by theorists and practitioners over the last century.

This study is justified on the grounds of a need to understand the impact of the pandemic on the profession's thinking about, and use of, the frame and the need to understand the emotional and physical impact of the adaptations made to accommodate continued work with patients, and contextual implications on the body and environment. This study also hopes to foster a dialogue about ongoing 'form' within the profession. What has been learnt from the experience of the pandemic and what can, and can't, be developed.

3.2 Research title: the whys and the wherefores

- *Out of Body: An Interpretative Phenomenological Analysis of how CAPPTs experience the dissolve of the physical aspects of the psychoanalytic frame (body and setting), due to the COVID-19 pandemic.*

The interrogation of the wording of the title of this study, through the process of gaining ethical approval, was in itself a valuable part of the journey towards exploring with more clarity what it was that I was curious about and attempting to understand through this project. TREC feedback queried the use of the phrase 'psychoanalytic frame', suggesting that it might be too

vague a concept to include in the title, flagging up the possible disparity between participants' understanding of it potentially being detrimental to the findings. However, I felt that the interrogation of participants' understanding of the 'frame' would allow me to better understand their adaptations and management of the changes in the 'shape' of their work during the pandemic.

By situating their Covid experience alongside the context of their pre-Covid experience, I am attempting to honour something of what Smith et al. (2009, cited in Smith and Nizza, 2022) refer to when they describe IPA as a method 'designed to understand people's lived experience and how they make sense of it in the context of their personal and social worlds'.

It is also necessary to highlight the importance, not just of the obvious losses involved for the clinicians in the disappearance of the more familiar physical aspects of their work, but also (and perhaps because of this loss) the participants' understanding of their internalised sense of the frame, which they had to be in touch with, in order to provide containment for their patients.

Through this small study, I hope to explore both a development of the participants' understanding of their experiences *through* being interviewed for the study - as well as, on a more reflexive level - a development of my own understanding, not only of the concept of the frame, but also of my own parallel development, whilst training and researching under those circumstances.

My closeness to the subject matter and the impact that this could have on the data collection and analysis, as both researcher and as trainee CAPPT, was at the forefront of my mind throughout the process. My aim was not to 'negate' or merely 'accept' my impact on the

process, but to acknowledge and interrogate my closeness to, both the phenomenon explored, with my own first-hand experience which at times mirrored those of the participants' – as well as my more defining individual attributes, such as gender or ethnicity. Because of my own recent 'lived experience' of the chosen subject, it was particularly important that I kept notes about thoughts or countertransference feelings which arose during the interviews, in order for them to be explored in supervision, to minimise the impact on my analysis of the data.

I chose the word '*dissolve'* after much consideration, in an attempt to capture the essence of something more intangible, in contrast with the concrete reality of the physical aspects lost, i.e. bodies together, or the toy box. '*Dissolve*' aims to conjure both the confusion inherent in the universal changes imposed so suddenly, as well as the dissipation of the familiar, and the transformation from one form to another.

3.3 Why IPA?

Qualitative methodology is concerned with language, the currency of thought and expression, and is therefore well suited to the interpretative world of psychoanalytic psychotherapy, in which process and meaning of experience are explored.

I undertook an Interpretative Phenomenological Analysis (IPA) study, using semi-structured interviews with a small sample of three CAPPTs. IPA is an experiential qualitative research methodology developed with psychologists in mind and is influenced by phenomenological philosophy (Smith, 1996). It is heavily influenced by phenomenologist Edmund Husserl (1900 [2001] p. 168) who was interested in the idea of going 'back to things themselves', rather than foreclosing with preconceptions or hypotheses. This enables the researcher to stay close to the original experience as perceived and felt by the subject, which feels entirely pertinent to the

particular and personal nature of the research title. It is IPA's interest in the individual's perception and the researcher's attempt to get close to the sense-making of the participants which, in my view, made IPA the most appropriate methodology for this study. The aim was to put each of the three participants' stories, situated in this unique context, centre stage.

IPA seeks to interrogate the lived experience of individuals by encouraging a dual interpretative (or hermeneutic) approach from the researcher: facilitating a forum for rich participant perspective whilst also decoding *how* the participant makes meaning out of their experience (Pietkiewicz & Smith, 2014). This layered approach to interpreting the data fits well with the psychoanalytic possibilities of the question posed. The hermeneutic idea IPA inherently promotes, of needing to understand the whole in order to see the parts and vice versa, chimes with the philosophical underpinnings behind the research question of how CAPPTs have made sense of the sudden dissolve of the traditional frame during the pandemic and the resulting impact on body, space and place.

IPA is appropriate to the concept of this project, because it is interested in how meaning is made and, on a meta level, I will be looking at the frame of meaning within which the participants set their experience. As a qualitative method it feels most apposite to this study, because of its idiographic focus on the particularity of singular experience.

Furthermore, IPA feels applicable to this study because it values me, as researcher, in bringing something active to the process. IPA's reflexive nature lends itself well to the use of the 'self' as part of the generation of data, and therefore my own inevitable experiences and reactions to changes in working practices during the creation of this study (as well as my own

countertransference experiences during the interview process), not only inform the gathering of data from the three participants but also form part of the discussion.

3.4 Study Design

Qualitative data was collected: three participants had two separate, semi-structured interviews. An IPA approach to interpreting the data was applied to six pieces of data in all.

3.4a Recruitment of participants

I chose to interview CAPPTs with differing levels of experience because I was curious about how their experience, or lack of it, may have impacted their experiences of change to the frame during the pandemic. In discussion with my supervisor, I recruited purposively, based on the inclusion and exclusion criteria below:

Inclusion criteria:

Participants needed to be CAPPTs with whom I did not have previous or current relationships as, ethically, it was important to me that they were distant enough for me to be comfortable inhabiting my researcher role. I also felt this was an important way of protecting them and their participant voices.

Because of this project's interest in and interrogation of the concept of the psychoanalytic frame (primarily its physical aspects), I decided to approach CAPPTs who had only trained at the Tavistock Clinic. This was one attempt at creating a sense of parity, in relation to the theoretical orientation of participants, in order to avoid skewing the data on what could be viewed as an already difficult concept to grapple with and define. Although this was a choice which invariably risked losing a more multi-faceted theoretical perspective, it also shone a light

on a particular experience of the shifts in the frame, matching the dilute nature of the very small sample necessary to suit the design of this study.

I chose two qualified CAPPTs with varying levels of experience and one trainee. One of the qualified participants had been qualified for just over 5 years at the time of interviewing, whilst the other had been qualified for 20 years or more. I recruited purposively in this way out of my own curiosity about how CAPPTs were impacted according to their levels of experience. In retrospect it was not possible to gain a definitive insight into this aspect of their experience, and a more extensive sample may have provided more possibility of generalisability in this area, but I maintain that it was an interesting lens through which to approach and understand participants' experiences.

By recruiting purposively, I spoke with trusted teachers, supervisors and colleagues about the aim of my study and acted on their recommendations for CAPPTs to approach. Knowing that I was looking for clinicians with varying levels of experience meant that people could recommend according to this criterion, as well as knowledge of their particular working circumstances during the pandemic and how this might make for rich interview material. Five CAPPTs were approached: three women and two men. Two out of the five quite vehemently rejected the invitation to revisit the pandemic in such an in-depth way, citing a need to forget or move on, whilst the three who agreed, agreed with openness and enthusiasm at the opportunity the project presented. The final three participants comprised two females and one male. Two participants were born in countries other than the UK, and all were perceived by me as 'white', although it is important to acknowledge that this may differ from how they themselves identified, as I did not ask the question.

With this in mind, I am aware that the parity gained through certain criteria (such as recruiting only those who trained at the Tavistock Clinic, to minimise confounding variables), does also highlight the inevitable dis-parities thrown up by recruiting purposively, particularly in the light of my decision to include a man, as an underrepresented group within child psychotherapy. These disparities could also be seen to reflect the paucity of representation of particular demographics within the discipline of child psychotherapy, most notably those coming from black, Asian or other minority ethnic groups, as well as those who identify as having disabilities, and my recruitment journey did not present what would have been a welcome opportunity to explore a more inclusive and diverse sample of participants.

It is of note that the pandemic served to highlight difference in very powerful ways, as well as, at times, a pull towards sameness, and this notion could provide a very powerful and important strand of further research within the profession, in the wake of the pandemic and how we make sense of our experiences and treatment of our patients and each other.

Exclusion criteria:

I excluded any CAPPTs I knew personally, through supervision or work. I anticipated the complexity of interviewing a fellow trainee when we were training together, as well as the potential for our paths to cross in the future. However, it felt important to interview a trainee, with a particular experience of working and training through the pandemic, adding to my own reflexive perspective of how I was experienced by them as researcher. I purposively chose a fourth-year trainee who had worked the longest under pre-Covid conditions.

3.4b Interview structure and schedule:

Interview 1:

A Zoom interview lasting 45-60 minutes, offering the opportunity to provide a summary of their journey into child psychotherapy; their understanding of the frame and its meaning for them, as well as to build a narrative about their experience of the internalisation of the frame.

Interview 2:

A face-to-face interview lasting 60-75 minutes, focused on participants' experiences of body and setting, working remotely and in-person. This included an opportunity to think about their experiences of countertransference in the context of Covid. (See Appendix C for schedules)

Although Interview 2 was designed, for parity, to be conducted in the same consulting room at the Tavistock for all face-to-face interviews, one of the participants requested that I interview her at home, due to her physical health at the time.

Undertaking the interviews in two different modalities, and consciously thinking about how that felt for me - in *parallel* to the participants' experiences - was pertinent to capturing something of the Covid experience of shifting parameters, providing a 'meta' level to the data. At the end of the interviews, participants were given a debrief (see Appendix E).

3.4c Ethical considerations:

TREC approval was gained (see Appendices for paperwork) and participants were made aware that they could withdraw at any time. Attempts have been made to preserve the anonymity of the participants through de-identification, however, because of the small sample size interviewees were made aware that full anonymity could not be guaranteed.

3.4d Data collection:

I recorded Interview 1 on Zoom and transcribed them myself, verbatim. Likewise, for Interview 2, in person, I recorded them on a Dictaphone and transcribed them myself. I found the transcription process a satisfying and enriching part of my initial familiarisation with the data. There was something surprisingly intimate about revisiting the experience of 'being with' each participant, in each of the two ways they were undertaken (remotely and in person) and I was transported back to the act of attending to the interviewees' responses and put in touch with Holloway and Jefferson's (2000) idea about IPA's emphasis on the relationship between researcher and interviewer, through their co-construction of the data.

3.4e Data analysis:

Smith, Flowers and Larkin (2009) expound the virtues of IPA's flexibility in relation to data analysis when they describe its iterative and inductive nature and the necessary "cycling and recycling" which the researcher must engage with when reading and re-reading the data (p. 105). It was this dynamic approach when interacting with the transcriptions which kept what mattered to each of the three participants alive throughout the analysis process.

In line with Smith, Flowers and Larkin's guidance (2009) for the analysis of data using IPA, I approached it in the following way:

1. Initial coding

Initial codes were written by hand on the transcript, as an 'immediate' response to the data. I approached the data in a free-associative way, in an attempt to stay with the 'here and now' of what I was reading. Holloway and Jefferson (2000) think about the parallel experience of knowing the researcher through their accounts, as *well* as the researched, 'as long as researchers are not seen as neutral vehicles for representing knowledge in an uncontaminated way' (p. 3). Psychoanalytic reflections were noted, including my own countertransference responses[7], highlighted as such, and forming an important part of the reflexive process.

2. Descriptive comments

These comments were about content and provided a way of further clarifying what I was reading, sometimes through re-wording, as a way of developing further layers of iteration.

3. Linguistic comments

These comments reflected participants' use of language or phrasing, eg pauses or hesitations; difficulty in articulating something clearly; laughter or repetitions. Tone of voice could also be illuminating, adding meaning or belying the words spoken.

4. Conceptual or interpretative comments

[7] My countertransference responses as a researcher analysing the data.

> These comments lay at a more interpretative level of experience for me as researcher, requiring a deeper level of reflection and a more intuitive approach to the meaning behind the data.

I repeated this process twice, the second time listening to the interviews back and repeating the above steps for each interview.

I made a table with three columns, putting the interview text into the middle column and typing up all my initial coding into the right-hand column. Into the left-hand blank column, I responded to the text by writing down what Smith and Nizza (2022) call 'objects of concern', interpreted as the things that matter to the participants, followed up with their 'experiential claims': the meaning of their 'objects of concern'.

Finding themes - for individual interviews:

The process of finding and collating emergent themes required different applications of technique, proposed by Smith et al (2009). From the many experiential themes and objects of concern, tentative groupings were made according to connections that stood out. There was much distillation within this process, as the groups were collated and gradually refined. Initially I tried the technique that Smith and Nizza (2022) suggest, of printing out and cutting up each statement which can then be placed on the floor for easy repositioning, as well as seen from above (adding an element of spatial perspective). However, I found this confusing, due to the sheer number of statements generated and, instead, turned to colour-coding the statements digitally in a Word document, as I began to see connections between them. As Smith and Nizza (2022, p. 43) caution, there is a risk of this method privileging statements which appear higher up in a list when looking for similarities. This warning enabled me to be aware of this within

myself, and to deliberately mix up the statements after an initial grouping, enabling me to see where changes could be made, or ideas adapted. There was a lengthy process of distillation and metamorphosis, until I was happy with the themes and subthemes for each interview.

Finding themes for each participant's pair of interviews:

Because I interviewed each of the three participants twice, I then undertook another layer of analysis by working through each of the groups of themes for the individual interviews and creating superordinate and subordinate themes for each participant, based on the cross-analysing of their two sets of data (1 and 2), thus creating a set of 'personal experiential themes' for each participant. (See Appendix C)

Journeying towards the Group Experiential Themes:

In trying to do justice to the individuality of each participant's experience, I wrote up the personal experiential themes for each one, as a way of sustaining their voices in my head and of expanding my understanding of the idiographic nature of IPA's task. This process created a further level of synthesis between the pairs of interviews, as well as a further dialogue between myself and each participant.

The superordinate themes and their subthemes were then reviewed across all the data sets and grouped together, depending on similarities or contrasts. There was a process of subsumption as subthemes became superordinate themes. The iterative process was continuous throughout writing up the findings, as meaning and emphasis shifted shape in a mirroring of the study's subject matter.

Chapter 4 – Findings

In this chapter I will introduce the participants, and then present combined findings from Interview 1 (contextual background) and 2 (navigating the pandemic), for all three. I will present themes and sub-themes which emerged from analysing both sets of data. Relevant quotations will illustrate and inform my explanations of the themes. See Appendix B for a table setting out the breakdown of the themes and subthemes, with each participants' contributions to each theme.

Table of themes:

Superordinate themes	Subordinate themes
1. Finding a way into Child Psychotherapy	1.1 Inside stories: relating to oneself and others 1.2 Continuous learning helps the frame evolve
2. Framing things up	2.1 Defining the frame: what is it and how is it used? 2.2 Making a frame of one's own
3. The shock of the new: defending against the unknown	3.1 Where are the 'parents'? 3.2 Fear and contagion in the work 3.3 Mutuality and intrusion: outside-in 3.4 Things got lost or got in the way
4. Body versus nobody	4.1 Making sense of presence and absence 4.2 Being 'in the body' at a distance 4.3 Body parts

5. Containing the new: no going back	5.1 Safety at a distance 5.2 Remembering the body 5.3 'Dissolve' of the frame? 5.4 What are we left with? Resistance and acceptance

Introduction to participants

Participant 1: Paul

Paul was a CAPPT trainee whose training had been interrupted by the pandemic, around half-way through. He was responsive to my enquiry about his possible involvement in the study and was interested in having a space to think about the impact of this time on his training, practice and thinking. As per the study design, I approached him purposively, as he had been suggested to me for his curiosity and openness. It felt important to hear and include a male, underrepresented as they are within the discipline of child psychotherapy.[8]

Participant 2: Sylvie

Sylvie was a CAPPT with over 30 years' experience. When we spoke first, she flagged up that prior to the pandemic she was already conducting some of her clinical work remotely, and wondered if this might skew my findings. In discussion with my supervisor, we concluded that, rather than being a reason to exclude this participant, this aspect of her data could potentially create food for thought in relation to the research question. The second interview was designed

[8] As is acknowledged in the Methodology, I was aware of other underrepresented groups in child psychotherapy, and how the limitations of my study, as well as the choices I had to make, have not allowed for representation of these groups in my small sample.

to be held at the Tavistock Clinic, to maintain a similar frame for all participants – however, this participant requested that we meet at her home, and due to her recent ill-health, I agreed.

Participant 3: Lira

Lira was a CAPPT with 5-10 years post-qualified experience. I sought a clinician with this level of experience to balance the experience of her two fellow participants. She was keen to participate, and we promptly arranged a date for Interview 1, on Zoom. Interview 2, to be held in person, was less straightforward to organise, meaning that there was a considerable gap between the two interviews.

Superordinate Theme 1: *Finding a way into Child Psychotherapy*

This study looks at the impact of the pandemic on the physical and psychic structures that surrounded the work of CAPPTs. Interview 1 set a personal scene for each of the participants to explain their reasons for entering the profession and their development of a frame, as a basis for exploring, in Interview 2, the adaptations needed during the pandemic, and their understanding of their experiences.

Theme 1 explored what was important to each of them, how they grew into their roles and developed an understanding of the frame.

Subordinate theme 1.1:

Inside stories: relating to oneself and others

Paul spoke about his desire to work with children and described how he had a

> *… definite feel of wanting to work with children. But I wasn't sure why. […] Analysis has helped me understand that a bit better.*

These opening thoughts presented a powerful sense of Paul's propensity to be curious about and understand himself. Having worked in a diverse inner-city primary school, he reflected on how quickly he had realised that having to manage large groups of children and

> *having to be very boundaried and structured, interested me less - I was more drawn to one-on-one. I found myself being given the more challenging ones to be with.*

Here Paul expressed something of a resistance to the imposition of rules and a natural leaning towards the underdog, drawn to the children who struggled.

> *I was quite an angry 3- or 4-year-old, there was quite a lot of messy parental separation, and I was extremely angry and quite uncontainable. There's something there […] about being drawn to an experience in yourself, and trying to have a different outcome, maybe.*

Reflecting on his identification with these more challenging children, he showed an awareness of a mirroring of his own, painful early experiences, and a wish to repair something in these children.

Sylvie reflected that her interest in the mind began to develop when she was still a child. Having studied Freud on dreams, in her early teens and Klein's ideas on play in her early twenties, she reflected on how books and stories fuelled her need to understand herself and others.

> *Martha Harris, who headed the child psychotherapy training, when she invited us to summer parties, had a stack of literature. She didn't have a stack of psychoanalytic*

> *books, she had novels – and she thought that's where you studied people.* […] *It's about understanding the infantile part of the personality, whether they're adults or children.*

Arriving in London from abroad, Sylvie described how she found her way to the training at the Tavistock:

> *I was with all the wonderful people who were alive – Martha Harris and Donald Meltzer and Herbert Rosenfeld and all those people who have gone.*

There was something of being told a story, in the way Sylvie remembered her training and, in listening, I experienced these real-life figures from her past as though they were fantasy characters - mythical protagonists in my own psychoanalytic narrative. I wondered about Sylvie's consciousness of time passing and of her stage of life, reflected in her comments that those figures had now passed on.

Born in Europe, Lira's reflections on entering the world of child psychotherapy were peppered with a sense of distance, both geographically and temporally.

> *It is quite different in my country – the course is 5 years, and you study different areas, um… current thoughts… And of all the courses, the psychoanalytic ones were the ones which interested me the most. The theory… the observation. It was then I learned about the Tavistock. There's very little public sector there… Very different… so when I graduated, I decided not to work privately. Then I worked for a few years with Roma children.*

In this extract, Lira gave the impression of having to overcome hurdles to do what she felt most drawn to. She presented the experience of hearing about the Tavistock as a turning point, somewhere she could move towards, away from what she felt to be the obstacles her own country imposed.

Her repetition of '*different*' seemed to highlight how it felt to live and study in another language and country. Oscillating between past and present tense may have represented a possible complication in her mind of living between two places, then and now. Her work with Roma children could also be viewed as representing Lina's curiosity about the 'other': a desire to understand and connect.

> *Roma people tend to live in camps outside the towns… I would try to bring the children back to school and do homework with them. I was mainly with the children and mothers, who lived very difficult lives… Very much on their own, very deprived. I spent time listening... Just sitting down and listening to what they were saying.*

I wondered about Lira being drawn to this community's separateness, finding a way to hold a space for them to communicate within. This resonated with the way she placed herself outside of something familiar, geographically and culturally, when coming to study at the Tavistock.

All participants spoke about the importance of looking beneath the surface, in order to understand. Paul described the challenge of his work with deprived children in a pupil referral unit and of needing to attach meaning to what he was witnessing and feeling. '*I've always had an interest in understanding behaviour. I remember wanting to really understand… and dig.'* Similarly, Sylvie explored the reasons for her attraction to teaching children with autism and an interest in play:

> *I was just trying to figure out how to relate to these children. I had an interest in understanding the inner world. I thought, there's a whole world to explore inside the mind. And I want to do that.*

Later, when asked to think about her understanding of the frame, she said,

> *I think that you don't really understand its meaning in a deep way, except through one's own analysis and one's own infantile dependency and feelings in relation to one's analyst.*

All the participants spoke of their experience of analysis as deeply fundamental to their understanding of themselves, the frame and the countertransference.

Subordinate theme 1.2:

Continuous learning helps the frame evolve

Sylvie cited supervision as an important aspect of the frame for therapists in the early stages of their career.

> *It's part of the frame when you're in training.* […] *I think we do internal supervision, rather than external supervision, after a certain degree of experience. I am somebody who supervises themselves every single day by writing up something about every single patient.*

Here, the spectre of an internalised supervisory frame came to the fore, giving a flavour of this participant's level of experience and a resulting self-sufficiency.

Lira conveyed a vivid sense of her learning being on a continuum. Six years post-qualified at the time of the interviews, she spoke with lively humility about the need to learn from experience.

> *I think you have to – find out… and experience it yourself? There's nothing like experience, especially with the countertransference. It's not something we can just have as a theory. It develops all the time.*

Paul expressed an awareness that the connections he felt to psychoanalytic theory were strongly linked to his training institution, and an integral part of what for him constituted the frame:

> *I suppose at the moment I feel very 'Tavi'. Kleinian. There's something about theory which can help establish the frame in your mind. If I think about which theory grounds me in the room it would be Klein, Bion, Meltzer. Having these people with you. On your shoulder…*

I was struck by an almost visceral sense of physical presence to Paul's experience of these theorists. Like the giants of theory who actually populated Sylvie's training and clinical life, Paul gave the impression of being accompanied by these figures in his work.

Superordinate Theme 2: *Framing things up*

Theme 2 gathers the participants' ideas about what the frame is to them, and how it developed. Lira and Sylvie trained and practiced pre-Covid, whilst Paul's training was significantly disrupted by it.

They were asked to approach their thoughts on the frame through a pre-Covid lens, as a way of allowing reflection in Interview 2 on the impact of the changes to the frame during the pandemic.

Subordinate theme 2.1:

Defining the frame: what is it and how is it used?

Paul's first reaction to being asked about the frame was a feeling of not knowing.

> *It's interesting that when I read your title and, even today, I had this pull to google psychoanalytic frame. What is it?* […] *It stirred up anxiety in me. A need to possess some kind of knowledge, so I was wondering […] what that was about. The psychoanalytic frame is very 'fluffy'… not very clear. In a way it does pull you into wanting something concrete to hold onto.*

His anxiety and almost guilty confession that he felt compelled to google what the frame '*is,*' spoke of a wish to be let into a secret, in order to 'know'. *'Fluffy'* conjured something ephemeral, neither shapely nor solid enough to '*hold onto*', and perhaps particularly in the context of his imminent leap into life after training, even more worrying to define.

> *I used to think of the frame as something like physical time… physical space. Now, I think of those things as something more like 'aids'… that they help you to establish a frame. I guess for me, the frame, nowadays, is about trying to create a shared mental space with a patient, and that feels hard to define. […] You kind of… know it when you have it. You're both in a frame… of mind, when mentally, psychically, you are, er… 'thinking'. That feels central to it.*

Paul's description of the 'fluffiness' of the frame could refer to a difficulty in having to define the frame through language at all. His halting speech illustrated how hard it felt to think and speak fluently about his ideas, signifying something of the intangibility of successfully creating a therapeutic space within which a patient can work and think with their therapist.

Lira's initial reflections on the frame highlighted different aspects, both physical and temporal. She spoke in detail about her own analysis and its pivotal part in developing her awareness of the impact of change in the analytic setting for patients.

> *I wasn't really aware of it – but actually through my analysis I really became aware of the impact on my psyche that small changes could have on me. […] Sometimes if I couldn't see a child, I would offer another day and another time. I thought it was completely fine. And then I observed how the child would react to change. For some it was really difficult. The whole session was feeling upset. It was really important to find*

> *out about that aspect of the frame. I can see how it changed my training and my professional work.*

Sylvie's conception of the frame found its roots in the legacy of her training at the Tavistock, influencing how she taught and supervised other clinicians.

> *Dr Meltzer was my teacher and he talked* [in 'The Psychoanalytical Process'] *about the function of a setting with some sameness in it, and then looking at how people make use of the changes to the setting that one makes.*
>
> *Changes to the setting are, the time frame, we try to keep that constant so we can see the relationship to 50 minutes and how it's experienced at different times, by different people, depending on their difficulties.*
>
> *The way the setting becomes overridden by psychotic states of mind, in which the sense of absence of the therapist might be overridden by just fleeing to the therapist in one's mind and continuing the dialogue with the therapist in one's mind, so that they haven't really had an ending to their session.*

Like Lira, Sylvie stressed the impact of changes to the setting on patients' states of mind and vividly highlighted the lengths patients can go to, to fill the gaps with their own phantasies. She made clear the importance of the physical aspects of the setting when working with young children and the symbolism involved.

> *The provision of a constant setting, having the therapy box filled with toys that are unique to the child, is a very important part of our child psychotherapy work. I do see the value of having the child's box as being untouchable… Being preserved. Because it represents the setting as a unique space for that child: it's like a mother having a particular space in her mind, for a particular child in her family.*

Sylvie's description of the child's box echoes the uniqueness of each clinician's conceptualisation and development of a sense of the frame and the individual setting they try to establish for each patient.

Subordinate theme 2.2:

Making a frame of one's own

For all the participants there were certain things which seemed fundamental to their concept of the frame, even when thinking about flexibility.

> *There are various ways to help establish a psychic space. It doesn't have to be… for me, anyway… it doesn't have to be in a room, or even 50 minutes. You can use that frame walking around a garden. But I think there are certain things which have to be there, like confidentiality. I guess we'll think about that with Covid in Interview 2. But, otherwise, it's very flexible and malleable.*

> *Consistency and reliability are central. Making yourself available for a set period of time is really important, because you're saying, this is the space in which my mind is available to you.*

Paul mirrored Sylvie in his analogy of the mind as a space allocated solely to that particular patient for a pre-determined period of time, something he seemed to feel could be offered to a patient even outside of the therapy room.

Lira reflected on the dilemma of things coming in from outside and the difficulty in managing this when it occurred. Here, she stressed the importance of a clinician's flexibility of frame being linked to keeping the needs of the particular patient in mind.

> *It brings me back to bringing the toys in - something that doesn't belong to… to the frame that you have chosen for the patient, and to wonder, 'should we leave it out, should we let it in?'. Supervision helped me see that every time could be different… To think about the meaning behind it.*

Similarly, Sylvie's long career working in hospitals with in- and out-patients allowed her to develop a frame suitable to working clinically in a more applied way, adapting to what was needed.

> *At the end of my analysis, I was working with a very psychotic girl and my analyst encouraged that I should give more frequent sessions, because of how much time feels elongated when you're in a confused, terrible state. A very small dose was about as much as she could take in.*
>
> *When you work with an in-patient, they're going to get discharged and they might get ill-er, to get back into your house. You have to interpret what the re-emergence of something is. It might be linked with the phantasy that you get so worried you'll make them an in-patient again.*

Her phrase '*get back into your house*' in relation to the inpatient unit was striking, linking physical space to a feeling of home. In doing so, Sylvie seemed consciously aware of how her patients may have connected her with a place of safety, but I also found myself associating to an idea of the body as a house or container, to be 'got back into'.

Her adaptation of the frame in providing a more manageable structure for her patient, appeared linked to her own experience of internalising a frame through her analysis, where the shape of it was 'felt' and taken in.

> *I think you don't really understand its meaning in a deep way, except through one's own analysis and one's own infantile dependency in relation to one's own analyst. I think you realise how different the feeling between sessions can be, over time.*

Paul felt that working in the transference was crucial to establishing a frame and determining the therapeutic relationship, for both patient and therapist. He described wrestling with how to do this in a way which felt personal to him.

> *Trying to work in the transference as much as possible is part of it. Establishing that that is what this relationship is. Probably one of the most challenging things I've found in the whole training is how to work within the transference whilst also being authentic. Boundaries are super important. Sticking within the transference and not deviating from that.*

Superordinate theme 3: *The shock of the new: defending against the unknown*

With the implementation of the government restrictions in March 2020, and the abruptness of the first lockdown, CAPPTs found themselves catapulted into unknown territory. This theme aims to capture the sudden adjustments the participants had to make and the resulting challenges of the work.

Subordinate theme 3.1:

Where are the 'parents'?

Two of the participants expressed palpable loss at the familiar structures of the work they felt they knew, falling away. Paul and Lira reported feelings of loneliness and isolation, as well as of a lack of containment by the systems around them.

Paul explained his circumstances when the lockdown was imposed:

> *It was my second year and I was in a clinic which reacted quite anxiously to Covid, so there was a period when things were really chaotic and my service supervisor got Covid. The only CAPPTs left in the building were trainees. We had to discharge any patients who weren't high risk – all my patients, basically […] and that was stressful. I remember feeling overwhelmed all the time. Not very experienced.*

Paul's language here was peppered with words conjuring the uncertainty of the unknown. The disappearance of his supervisor so soon into the lockdown added to the feeling that the trainee children were '*left in the building*', unsupervised and inexperienced. There was also a threat that he could lose his own patient-children:

> *There was a month, I would say, when I was fighting on my own to keep patients, but that was seen as going against what the rest of the team was doing, as they were being very compliant.*

Here Paul appeared to take up the mantle of rebellious teenager, going against the crowd in the absence of grown-ups who would support him.

Lira conveyed feelings of physical isolation, as well as of the mental isolation she experienced in feeling alone with decision making.

> *I was working privately and there weren't many other people around. I was on my own, seeing an adolescent girl for long-term work, and I remember thinking, what am I going to do with her?* […] *My analysis stopped too, whilst my analyst was trying to work out what to do.*

The sudden disappearance of her 'parent' analyst mirrored that of clinicians everywhere needing time to '*work out what to do'* and how to keep seeing their patients.

Subordinate theme 3.2:

Fear and contagion in the work

All three participants evoked the presence and visceral nature of fear and contagion within their clinical work during Covid, and the need to make sense of this, in reality and phantasy.

Sylvie's experience was the most rooted in reality, due to being older and having been unwell before Covid. She conveyed awareness of the threat to herself, and the fear she felt it instilled in her patients in relation to her:

> *I had been ill and people knew I had been ill, and I'm old, so a more dangerous therapist. More in danger of getting Covid, and not doing as well as other people. But I remember people were quite anxious for me, partly because I was old and ill – but also, a bit of aggression was expressed, because one person came with a [pretends to cough], and I thought, if you have that, you should be at home testing.*

The words '*dangerous therapist*' seemed counter to the meaning, which she clarified by saying that *she* was '*more in danger'.* There was also a sense that, by being seen as vulnerable, she was actually felt to be somehow depleted, or deficient: '*not doing as well as other people'.* I was struck by her defensive aggression in response to her patient's perceived aggression (the cough), which may have transformed her into a more '*dangerous therapist',* in her own mind.

Paul's clinic made him work on a rota, one week in the clinic, one week at home. He described how this oscillation felt like an extreme response to the anxiety of infection.

> *I think there was this fear that if everyone got Covid at the same time, then the whole team would go down… They tried to keep people separate. I don't know… Everyone went through different stuff, but it felt quite extreme and quite isolated. Fragmented.*

Caught in the crossfire of the institution's fear of contagion and of the team falling apart, the sense of untouchability engendered by this half-life he had to endure, felt palpable.

Having to wear full PPE, consisting of mask, visor, apron and gloves, the disruptive, evasive nature of this could not be overstated by Paul:

> *It was so difficult to talk with younger ones about what the virus was, but I guess there's also something in there about the adults not being able to keep people safe and look after people.*
>
> *One boy - there's the whole Meltzer idea, isn't there, about being present or situated in a part of the maternal body and depending on where it is in the body can reflect the different kind of... I think he was a bit of a rectum boy, in the sense that he was very omnipotent. Doesn't need parents… But the way that got played out was this narrative around vaccines and he had an image of entering into people. I'd been vaccinated and he was inside me, around me. He'd be in the head, controlling me, and then he would go into my stomach and be like, I don't need you anymore.*

In this example, there was an experience for both Paul and his patient of extreme mutual projection, playing out between them. His awareness of the projected need in him to be protected against (and from), seemed to evoke strong feelings in his patient of needing to intrude upon and then discard his therapist.

Conversely, Lira felt that it was only in the aftermath of the pandemic that she was able to truly recognise the impact that the fear of contagion had instilled in her, in a way that, whilst living with it more directly, she wasn't able to allow herself to do.

> *I remember recently […] everyone around me was coughing. I thought, oh my god, if we were in Covid times I would freak out at this point.* [laughs…] *And then I thought, maybe I wouldn't… Maybe I was cutting off. 'The patients are fine, they're not going to give me anything'. It's now, when there's a bit more of an ordinary life that I allow myself to notice people coughing like that.*

There seemed to be a sense of lingering trauma here, as though it was only with an element of distance that Lira could feel the legacy of the virus and what she was left with.

Subordinate theme 3.3:

Mutuality and intrusion: outside-in

With a particular group of adolescent patients, Sylvie noticed that not being physically together and only being seen within the parameters of a screen, helped to move the focus away from the external and onto the internal.

> *The noise has gone. And the beauty of the depth that they could reach. I felt they grew, in a particular way, to appreciate the inner world. Covid almost moved us into our inner world. You had to have it to survive. I think the sense of therapy helping them navigate the internal world was a very good part of the experience.*

Through her metaphor of '*the noise*' having gone, Sylvie conjured a feeling of things being stripped back or filtered out. She described her understanding of how the eradication of the external provided access to an internal world and inner resource for these patients. When reflecting on the early days of the lockdown and the need to stay at home, she described how she, herself

> *felt more comfortable being in my own space at home… I think a meditative space allows a better space inside oneself to be present for the patient. I probably felt safer in my body, being alone in my room, meeting them. It's a strange thing to say, but, just as they probably felt safer in their bedrooms, I probably felt less intruded upon.*

When reflecting on work with a boy of 5, Paul described the oscillation between different mediums as he and his supervisor navigated how best to meet his needs and keep the contact going. The feeling of the outside coming in was very present, as were feelings of duality and confusion in the work.

> *Initially, the phone felt like holding, it didn't feel like we were doing much work together, other than, 'here's Paul, here's his voice, he's still alive, he's still listening to you'. Online felt like a shift: we could do more thinking together, but it felt more*

> *chaotic. He was in and out of the room quite a lot, so that was hard – taking me with him, so I once ended up in his mum's sock drawer… in her bedroom of course – which felt very uncomfortable.*

There was something mutual about Paul's description of both his and his patient's experience of him being, at first, a disembodied voice on the end of the phone, then later of becoming disembodied in a different way, physically transported via the child's ipad into the unchartered, illicit-feeling, 'inside' space of his mother's bedroom drawer.

Lira had a very concrete experience of intrusive safety measures and guidance in her clinic:

> *I just remember going with a lot of spray and disinfectant. I was seeing three different families and I just remember constantly disinfecting between one family and the other. And I remember thinking – something has changed, here.*

It was as though Lira's laughter indicated a sense of disbelief at what she was expected to do, in the name of safety – the cleaning out she had to do between patients and the bringing in of germs which somehow seemed inevitable. She seemed also to be communicating her awareness of it being a pivotal moment in terms of the frame – '*something has changed here*'.

Subordinate theme 3.4:

Things got lost or got in the way

All the participants described feelings of loss in their work. Feelings were often connected to a pervasive sense of obstruction in their relationships and interactions with patients – in its simplest form, the feeling that patients couldn't be 'reached' because of technical difficulties or because CAPPTs were having to wear multiple layers of protective clothing.

Lira remembered another aspect:

> *Something which changed was having to say, I'm in isolation – do you remember? I had to do that a few times - to tell the families, 'I'm in isolation', which – you wouldn't say before, you'd just say, I can't be there for the session. So again – how neutral you are – that changed.*

It was noticeable that she wanted to know whether I remembered what she was recalling during Covid. This reflected the universality of the Covid experience in a more generalised way, but also the particularity of our shared experience as CAPPTs. Her discomfort about disclosing personal information, spoke of a loss of neutrality to which the profession adheres.

Paul spoke of a case where things became too unsafe from a distance and of the deep anxiety this provoked in him, creating an obstacle to the work.

> *There was concern about domestic violence from dad towards mum, which had never really been got hold of, but at the clinic I could see him in a very contained, safe space. But then we moved online, and it was very unsettling. We lost something then.*
>
> *There was this constant threat of dad around the sessions. Very present. Scary, outside, this man's listening in and going to do something about it. In the end we had to stop.*

Here Paul reflected on the loss of a physical setting which could contain both parent and child, and the consequent risk. His staccato pattern of speech, using single words for emphasis, engendered in me something of the terror Paul felt on behalf of his patient.

Sylvie reflected on the complex ways in which patients can manipulate what is seen of themselves with online work. She spoke about her experience of very unwell patients with eating disorders and the ease with which they could hide their bodies in this context.

> *There's really a sense that you don't have your inspector eyes on them, when they're in a persecuted stage and when they're starving themselves, I find that their omnipotent selves can think, 'Oh she doesn't have a clue how thin I am, how I'm not eating, and so on…', and so the omnipotent self could feel they were very much in control of what the therapist understood of them. I think that the sense of feeling incapacitated and impotent can be very great with children who switch the screen off, play a game with all these contraptions on Zoom, which the therapist doesn't really know.*

Feelings of having been manipulated were very powerful in these examples of Sylvie's work with very troubled young people. The self-confessed '*inspector eyes*' were felt to be rendered blind by the patient who felt invisible beyond the screen. Feelings of loss of control and potency were also thought about, but here Sylvie moved into the third person, perhaps projecting a more universal experience rather than staying with something more painful and personal.

Superordinate theme 4: *Body versus nobody*

All participants spoke vividly about their experiences of their own bodies, and the absence of their patients' bodies during the pandemic. There were, at times, feelings of surprise or revelation when thinking about the body, as well as of anxiety about 'not knowing'.

Subordinate theme 4.1:

Making sense of presence and absence

Sylvie described how she believed that being physically together had an impact on the therapeutic process, particularly on the transference and, in turn, the countertransference.

> *I think you clearly have much stronger body countertransference when you're not working on Zoom. When somebody walks in the door, my body's affected differently before we've even begun the session. I feel a different level of pressure on my psyche, my physical psyche – my body… when I go to the door, compared to when I'm entering Zoom. Of the body…*

Lira recalled doing an online assessment for psychotherapy with a nine-year-old boy and then meeting him in person, months later.

> *I was really stuck because this boy who seemed completely ordinary on the screen, actually had some oddities about him. His parents had been very concerned about him and I hadn't picked up on a lot of things which, in person I could see were about the way he looked at people, the way he moved.* [Big sigh…] *But he didn't appear on screen…*

Lira's sigh appeared to communicate a painful recognition of the genuine challenge in seeing and feeling the needs of this boy, remotely.

Although Paul felt he didn't 'know' much about the bodily aspects of the work, his thoughtful exploration of the different aspects of the 'physical' in his work belied this.

> *When people talk in terms of 'embodied this' and 'embodied that', I end up thinking, I don't really know what that means. But I suppose it is a bodily thing. You feel it in your body first. It makes me think back to Bion and beta elements. That flood of information you have to digest and understand needs to be transformed, in some way. So, I suppose it is quite physical, because you feel it in your body first.*

Paul's use of psychoanalytic theory helped situate him at this moment of uncertainty. His repetition of the phrase '*you feel it in your body first'* felt like both a revelation and confirmation of something already unconsciously known.

His example of wearing full PPE with a young child conjured a visceral experience of preoccupation with his own body:

> *My memory is of being steamed up, sweaty. I mean, you're talking about the body, but you're totally thrown off, in your countertransference, because you're so caught up in*

> *your own stuff. Your own sweat and not being able to see… So I think it's harder to be present and to understand what's happening between you. It's a bit like doing a session with a headache, or something. You're impaired. (Interview 1)*

This was in conflict with his earlier conviction that it was important to be together in the room with '*little ones'*:

> *It made me think about different age groups, actually, because it's felt harder online with Under 5s, so I was wondering about how their modes and methods of communication <u>are</u> more bodily, than adolescents. It's less about using words to convey something.* […] *If you think about a baby, it's all in the body, isn't it. They communicate without words and all you're doing is using your countertransference to try to disentangle that. (Interview 1)*

Here Paul raised the importance of bodily communication and, in turn, the importance of countertransference in deciphering meaning.

Subordinate theme 4.2:

Being in the body, at a distance

This subtheme captures the adaptations that participants made to their physical settings and their awareness of their bodies when conducting remote sessions or in person.

Lira spoke of the lingering effects of the pandemic when she reflected that there are things she still does as a result of having to do things differently.

> *It's funny, I just remember opening the windows. Since Covid, I still do it. I remember the physical sensations: I remember breathing in the fresh air – feeling it as a comfort, feeling that there is the possibility of a session because there is something good to counterbalance the germs.*

> *It's interesting that I haven't stopped doing it. There was more of the outside coming in – all the full gear, not decided by me but by the clinic. And we shared our environments, mine and theirs. Everything became much less 'sealed'.*

She talks of allowing something '*good*' into the room, but there is also the presence of a sinister 'third', in the way that institutional decision-making was felt to take away her sense of control.

Sylvie described how she stands at the computer for Zoom sessions:

> *My computer is on a stack of books on a bookshelf. It feels very attentive. You know, maybe this is touching something which I have not consciously been thinking about very much, but I would much rather go to the theatre than sit watching television, and this is really capturing the truth isn't it, now… Perhaps standing I am more actively engaged in this little, tiny screen on the computer. More present… And so, therefore, that means that I feel a big absence, when it's not in the flesh, or I wouldn't be standing. I hadn't really thought of it that way.*

Sylvie seemed to be realising that being in front of a computer, like being in front of a television, demanded something more physical from her in the way she engaged with her surroundings and patients. The juxtaposition of the smallness of the screen and her emphasis on the size of the absence is striking here.

Paul reflected on how he managed his own body whilst oscillating between settings:

> *When I was doing the one-week-in, one-week-out, thing, I was still doing online work but sometimes in the clinic I would sit on the floor rather than on a chair. Because that's what I would do at home.*
>
> *How do you set it all up? I never really know how it's impacted on stuff. I don't really like sitting on chairs, so I sat on the floor with the laptop on my bed. I don't know how weird it was for my patients to know, probably on some level, that I was cross-legged on the floor. I never really admitted that to patients.*

It was notable that Paul attempted to recreate bodily parity in the two settings (home and clinic). It was also striking that there had been something of a denial about the impact of this on his patients or the phantasies they might have had about where he might be, or how he might be sitting.

Subordinate theme 4.3:

Body parts

Paul spoke of how broken up things could feel. One child wanted Paul to hide on Zoom, but couldn't manage him disappearing from the screen completely, requesting that he leave '*a body part in shot'*.

Sylvie described her mixed feelings when returning to in-person work with masks:

> *<u>Very</u> depriving… I didn't realise how much I use the face. Erm… and the patients use the face. Just seeing the eyes is not – the mouth informs the eyes… The whole face.* […] *They felt it like a wall – a psychological wall, until the face was visible. Almost like talking in the dark, even though there were the eyes.*

Here her disjointed delivery appeared to reflect the cut-off deprivation she experienced. There seemed to be nostalgia about the ordinary experience of in-person work – a recognition of a more '*whole*' therapeutic experience.

Lira noted a recurring theme in her young patients around mask use and a sense that facial features took on new and sometimes frightening resonance.

> *With my mask my eyes were more visible. More striking. The attack through the eyes. I remember a very distressed child. He didn't acknowledge the absence of the mask when*

> *I stopped wearing it, but then he talked about 'horrible mouths' and 'nasty teeth'. It seemed to be a real shock for him, to see me without.*

Paul also described how differently masks were understood and received by patients when working in person. He spoke about the difference between patients who had seen his face fully exposed before the pandemic, and those who had only ever known Paul with a mask on - and how, a bit like knowing someone hasn't completely disappeared when they are hiding, it made a difference to the way they responded to his mask.

> *There was a lot of build up to the mask coming off. He was excited about it, I think it represented something for him about us being closer – but then when I did take it off, it was too much, too intimate. He definitely exists by swinging between really wanting a relationship with me, and feeling overwhelmed. So, taking the mask off was like – 'will you be my daddy?', and then - 'woah, this is way too much, we're way too close!'. There was a lot of acting out around the mask: seeing my face and then attacking it.*

Superordinate theme 5: *Containing the new: no going back*

This final theme gathered together the participants' more retrospective thoughts about the impact of Covid - what they were left with and what the future of their practice, and the profession, might look and feel like.

Subordinate theme 5.1:

Safety at a distance?

All the participants reflected on the possibility of the transference during remote work and the effect of how remoteness could create new perspectives on the patient's object relationships. Paul gave an example of work with an adolescent boy he saw on Zoom.

> *We'd agreed to do the last three in person and then he didn't turn up to any of those.* [Haha!] *I think there is something in that, not necessarily about the virus but more*

> *about him not being able to admit that I was a significant person, which felt very painful. I think he liked working online because he could be in control of it, of whether he could not turn up and it would not be such a big deal.*
>
> *There's a book called The Body Keeps the Score? It's not very analytic, but I had a spare copy which I said I would give to him when I saw him 'in real life', and I wrote a little note to say good luck. I've still got the book, with my writing in it. He'll never know… what's he's left me with.*

This example of Paul's patient not managing to come back into the clinic to end his therapy after online work was made even more poignant by Paul's perhaps unconscious attempt to fill the gap of an embodied relationship, with a book about the body. Paul's laughter seemed to belie the pain of being cut off or 'ghosted' by his patient's inability to attend in person and the resulting absence of a physical goodbye. Paul seemed to feel, all too well, '*what he's left me with'*.

Lira had questions about whether the transference could really be felt in remote work, but gave an example of being felt, in the transference, to be someone else by a father she saw on Zoom:

> *The mother had just died. I thought that in that moment he was relating to me, almost as if I was a sort of friend or even girlfriend? Somebody who could distract him from the pain. So, I thought that he was using the sessions – this female therapist – as a way to escape the pain. I kept in touch with that feeling and then he was able to tell me about the funeral. But then when I was talking to my supervisor about it, she was wondering whether you can really feel the transference.*

It was noticeable how Lira's experience of feeling something quite strongly in the transference became more difficult to believe in the same way, because of her supervisor's role as a questioning third. I wondered about this affecting Lira's experience of the transference, making it feel lesser, because it wasn't 'in real life'. This contrasted with the parent who seemed able to express something in phantasy, *because* they were meeting remotely.

In relation to supervision of infant observations which needed to be moved online during the pandemic, she noted that observers wearing glasses - a symbolic double barrier to contact - could elicit fear in babies.

> *Babies who split off some of their aggression from their mothers - often it gets split into the observers' glasses at about 6 months. The glass around the eyes which must represent the mother with her barriers. The non-accessible mother who gets split off.*

Subordinate theme 5.2:

Remembering the body

Throughout the interviews, the participants found ways of being reacquainted with, or *remembering* / 'rethinking' the body, in the light of the pandemic. Paul was curious about '*embodiment*' in his work with patients and in connecting the physical body with the mind.

> *I think for me* [being embodied] *means being able to be fully receptive to a projection or a communication, in your body rather than psychically. Generally, it's harder online. It felt like online working dulled stuff down, made it harder to feel. Even bound to the practicalities of someone's internet connection wavering for a second, and you can't quite tell what they're telling you, or even what they're trying to give me an experience of. And if you lose that, you're working harder to get that back. That really ruptures something, between two people.*

Paul conveyed an experience of disconnect when working remotely, and a loss of understanding which, he felt, irrevocably damaged the therapeutic dyad.

> *It makes you feel more in touch with it when it does happen in the room. More aware of it, more interested – because you're comparing it to something. Whereas before you wouldn't have had anything to relate it to.*

His experience of Covid appeared to highlight the importance of the body, as though through new eyes.

Sylvie reflected on the loss of detail in the 'online face' of a patient, equalling loss of nuance and meaning.

> *They won't be able to see the intricacies of the face online and, you know, we've learned about the function of the interpretation relieving the anxiety of being persecutory, but the non-verbal communication, on both parts, is a huge part of therapeutic progress or lack of progress. Not the clever interpretation.*

For Sylvie too, Covid seemed to have brought into focus a generalised lack of attention to the body and the face, as communicator or receiver of the unconscious.

Lira noticed feeling more conscious of health and a sense that this had lingered:

> *Attendance keeps being disrupted. The pandemic changed me because I had to think about what it would be like for patients to see me ill. It also changed for families. They tend to cancel more easily. During Covid there was always a good reason to cancel. It's as if it's still there – people are acknowledging that how the body feels, matters.*

Subordinate theme 5.3:

'Dissolve' of the frame?

Participants reflected on the post-Covid frame in many and varied ways. Lira spoke about the need for the presence of parents to facilitate work with younger children, online:

> *You're not on your own with the child. I remember this mum, she was chasing these twins around the room, with the ipad. In a way it worked, to understand a few of the issues that were going on for them. But thinking about the setting: the ipad became the frame. More porous…*

Lira's use of the word '*porous'* gave an impression of a more permeable frame, vulnerable to intrusion in a new way.

Paul's reflections on the frame and its applications seemed linked to an idea of his developing experience:

> *You've got to be comfortable in yourself because it takes time to have that structure within yourself, solid enough to be able to play around with it. Earlier in the training I couldn't have said, 'you're struggling to be in the room, let's walk around the garden but we'll stay in this shared thinking space'. I could do that now.*

Moving towards qualification at the time of the interviews, Paul seemed aware that his confidence as a CAPPT was growing out of a more solid sense of an internalised frame, which he felt enabled him to hold boundaries outside of the traditional setting of the consulting room.

> '*My view has shifted – it's less rigid. Less - this is what psychotherapy looks like'.*

Paul's mind also went to his wider analytic experience and the possibilities there, inspired by historical exponents of a more flexible approach:

> *I don't know how important the couch is, really. Like obviously it can be helpful, but I kind of wish we were free to stand up and walk around a bit more. I think maybe we are freer than we think. There's pressure not to, but perhaps it's internal. I was reading that Winnicott used to do extended sessions, like 2 hours, and he described a patient walking around the room and looking out of the window or crouching down. He was still working psychoanalytically, in my mind.*

Whilst Sylvie's experience working in hospital settings meant that she was used to working in an applied way, not to mention her previous work with adolescents on Zoom, she reflected on the shift in the boundaries of the frame relating to the loss of choice in the setting.

> *You're in the child's home, and that frame of being the non-intrusive person is broken. You're almost like a visitor, rather than a therapist – the boundary gets a bit shaky*

> *when it's their bedroom – and usually it is because there's no other private space in the house. That's very strange, isn't it? Someone coming into your bedroom? I wouldn't want my therapist coming into the bedroom.*

Subordinate theme 5.4:

What are we left with? Resistance and acceptance

When asked to think about his overall experience of the pandemic, Paul felt that, from a training and teaching perspective, his experience could be viewed as less '*valid*' and that he had lost out by being taught online whilst, from a clinical perspective, he felt more able to work flexibly.

> *I'm someone who is always trying to think about how you can adapt and not stagnate. Thinking about how we can push things forward a bit or do things differently. I think that's been an advantage.*

Here, Paul conveyed something of an urge to move forwards in his clinical practice, full of momentum for future work. There were, however, feelings of ambivalence, as he reflected on what it means to be physically together:

> *If you're in the room, you're having a shared experience of each other. I think that is possible online, but it can be trickier, because the experiences you are having are different, or more different, than the ones we are having in the room together.*
>
> *I suppose fundamentally it's about being understood, isn't it. Containment, and the feeling that someone understands you. Part of being understood is that the other person is 'in' something with you. Being physically in the room can help with that.*

Lira was put in touch with a need to '*mourn the loss of the certainties'* around the physical frame of the work. Later she reflected:

> *I still prefer, and I think it is the best way to interact with the patient, in the room. But I saw that it was not impossible to gain some understanding online, especially with work with parents, in support of therapy. I didn't want to do it. I guess, as a psychotherapist, that's the only thing you can do – to try to keep the thinking process open. Keep adapting, not denying it.*

There were several aspects of the Covid experience which Sylvie felt were beneficial, particularly because she felt that it provided access to therapy for those who would have missed out, as well as connecting those in the profession in a new way.

> *I think for child psychotherapy specifically it's been fantastic. Because - I think Gill Scharff, who started this tele-analysis 20 years ago – it's more possible to experience the richness of analytic work with all the Zoom conferences which are international, or to do analysis online. So it's opened more doors than it's shut. One can get out of one's own little straitjacket, as well… I think knowledge is going to be greater, richer – less culturally bound.*

Chapter 5 - Discussion

Finding a way into Child Psychotherapy

The data captured what drew each of the participants to train as CAPPTs, and the particular circumstances surrounding them. All of them spoke of a pull towards wanting to understand either themselves or others at a very deep level. An early foray into trying to understand the unconscious world of dreams was cited by Sylvie, and Paul made insightful links about memories of being an angry child due to parental difficulties, sparking reflections on work with troubled children posing potential opportunities for reparation to take place. Lira cited work with people on the margins of society and her experience of providing a space for deprived mothers to talk without judgement, which seemed pivotal in connecting her to her own internal resources and in developing a sense of a shared space.

Two of the therapists interviewed were not born in the UK and a strong sense was conveyed of them both reaching a destination (their training school, the Tavistock), which had been pursued and perhaps idealised in their minds from afar, whether consciously or unconsciously: 'I accidentally walked by the Tavistock and thought, this is a good place to train, but I had studied Freud when I was 14, so…' (Sylvie). I was interested in her use of the word 'accidentally' in relation to her now-conscious connection to Freud, particularly in relation to Freud's belief that there is no such thing as an accident (1901b). The other participant also travelled from within the UK to pursue their training, giving a sense that all had made their own, particular and very personal 'pilgrimage' to do the child psychotherapy training.

I became aware of a particular prevalence of the word 'different' and noted the differing contexts in which it was used. Lina felt she had to fight her way out of the bureaucracy of her

own country's systems around psychological trainings and the work market, very different to that of the UK's – as well as feeling drawn to difference (as seen in her work with Roma families), and her own feelings of difference when coming to train, work and settle in this country. Paul's experience was in relation to feeling on the outside of what he could sometimes experience as a rather 'exclusive' and, perhaps, excluding world of psychoanalysis and the CAPPT training.

The findings identify that, for all three participants, the layers of supervision and personal analysis which began in training and continued onwards to varying degrees, were pivotal to their thinking about the physical frame. Fundamental to this, aside from the obvious physical and mental containment these embodied relationships and spaces provided, was the aspect of continuous learning and introjection throughout their careers, which not only provided theoretical foundations but also facilitated the development of a sense of the frame itself and with it a sense of their own identity and practice. This aligns with Meltzer's view that supervision is 'meant to be a feeding situation – and not force-feeding, but a feeding situation in which what you have to offer is laid before the […] supervisee for him to select what suits him' (2005, p. 455). Throughout the interviews, two of the participants expressed a need to be in touch with nurturing, parental figures who could 'hold' them in the light of such a new and unknown situation which, even in the remembering, felt complex and unreal.

By contrast Sylvie, whilst emphasising the necessity of supervision as '*part of the frame when you're in training'*, spoke of the need for CAPPTs to self-supervise as they develop, something Casement (1985, p. 31) believes is linked to the therapist's experience of being a patient in analysis. All three participants drew on key psychoanalytic theorists as if they were fellow companions on their continuous journeys of learning, grounding them at times of uncertainty. The use of theory appeared very connected to their identification with the Tavistock, as their

training institution, and the frame of reference around a Kleinian and post-Kleinian school of thought.

Framing things up

In this theme, all three participants attempted to articulate what the frame meant to them and to their practice, culminating in a sense of them having developed individual frames of reference and approach. Paul's experience of being a trainee was very present in his data when the concept of the frame was introduced and there was a striking feeling of him expecting to be caught out, as though I, as researcher (despite being a fellow trainee), was somehow in the know about something he wasn't – or that perhaps he was being tested, at risk of being exposed as 'not knowing'. His admission that he '*had a pull to google the [….] frame*' and that it was '*fluffy'*, seemed to illustrate a worry about defining the frame, as well as something of the experience of being a not-yet-fully-formed CAPPT, and a hunger to be taught and to 'know'. This felt particularly linked to the tension of being in a profession where the need to learn through clinical experience and through 'doing', in order to understand what can be otherwise-abstract theory, is crucial - bringing to mind Bion's theory of 'K' (1962), in which 'knowledge' is learned by experiencing through feeling, rather than through an assumed form of academic knowledge.

It was striking, therefore, that Paul's thoughts about the frame, despite his self-doubt, actually appeared quite 'formed' and naturally grounded in experience. He suggested that the 'physical' allowed for the development of something 'internal', akin to a '*shared mental space*' with the patient: '*you kind of... know it when you have it'.* Linked to this, Lira's reflections on the impact of changes to the frame in her own analysis, which allowed her to understand her child patients' reactions and distress when things changed ('*the whole session was feeling upset'*), tally strongly with Bleger's (1967) idea that 'the frame […] acts as support, as mainstay, but, so far,

we have been able to perceive it only when it changes or breaks' - the view that it is only through breakage that the setting becomes visible (Bleger, 1967, in Moguillansky et al., 2023, pp. 3-4).

This 'visibility' of the frame in relation to the dissolve of the physical aspects of the frame during the pandemic, belies the *in*-visibility of those very aspects of the physical frame which dissolved and became unavailable when CAPPTs couldn't work in person in their usual rooms, meaning that what *wasn't* there became visible. Sylvie emphasised the importance of noticing the patient's relationship to changes in the frame, which provides vital communications to the therapist and a means of understanding their unconscious processes. Just as Bleger (1967) talks of the frame as a depository for psychotic parts of the personality, so Sylvie spoke of it as a medium into which the patient can project their anxieties about, and difficulties with, inconsistencies or variables within it. It was noticeable that Sylvie, as the most senior CAPPT with a decades-long clinical and supervisory career, spoke about the frame in the most theoretical terms with, at times, a didactic quality.

Sylvie's example of the patient who described continuing a dialogue with her in their mind after the session had finished, to manage the pain of it ending, highlights the difficulty even ordinarily of patients managing gaps and transitions - let alone during the pandemic, when the physical transitional spaces of waiting rooms didn't exist and travel to and from clinics couldn't happen (Saporta, 2017). These inside/outside aspects of the frame link with Sylvie's metaphor of the child's box, '*unique to the child',* representing '*a mother having a particular space in her mind, for a particular child'* and the painful absence of 'the box' as a private, internalised space for children during the pandemic.

I find myself wondering where, in phantasy, the space in the therapist's mind may also have gone, symbolically, for those children who were separated in time and space. As Webster (2020) describes: 'the children had lost their place' (p. 291).

All three participants felt strongly that some aspects of the frame were non-negotiable, naming consistency, reliability and confidentiality as fundamental. It was, however, clear that once these important parameters had been named and thought about, elements of flexibility could be brought into the data. Paul's idea that '*it doesn't* have *to be a room* […] *you can use that frame walking round a garden*' refers to the metaphor, similar to Sylvie's, of the mind as a space made available to the patient for a particular length of time, here being illustrated as something almost portable (Lemma et al., 2008) and, in Paul's words, '*malleable*'. Despite Interview 1 explicitly focusing on the participants' *pre*-Covid experience, it was notable and could be hypothesised that Paul's '*malleable*' frame may have developed out of his training being interrupted and, inevitably, heavily influenced by Covid, perhaps making it difficult for him to keep in mind his *pre*-Covid preconceptions of what the frame should, or could, be.

The data shows that the frame, as container for the work of the transference to emerge between the therapeutic dyad, is established as what Parsons (2007) calls 'a psychic arena in which reality is defined by such concepts as symbolism, transference, and unconscious meaning' (p. 1444). This was strongly linked to the importance of the experience of personal, in-person analysis in shaping and forming the therapist's understanding of the frame, ignited by an awareness of what Sylvie called '*one's own infantile dependency* [on] *one's analyst*'.

Both Lira and Sylvie's data showed more cautious approaches to flexing the physical boundaries of their work, emphasising the need to assess what is best for the patient on an individual basis. Overall, Lira was most traditionally orientated towards staying within the boundaries of the work but admitted that there were times when things happened which

couldn't be predicted, particularly with younger patients bringing things in from outside. Here she cited the helpfulness of supervision as another aspect of the frame for thinking about the unconscious meaning for that patient, in that particular moment. Similarly, Sylvie, when remembering her less-experienced self, cited external influences on her clinical decision making, in the form of her own analyst, who had encouraged her to see a patient little and often, to reduce the gaps between sessions that they were too unwell to manage. The complex 'in-patient/out-patient' nature of her hospital setting necessitated a more adaptable, less formal approach to her work which, at times, led her to use analogies relating to the physical spaces of body and home – eg patients who wanted to '*get back into your house'* - resonant of the prominent body/mind dichotomy in work within hospitals. This chimes with Kirchkheli's (2021) description of a patient who, during the pandemic, felt severed from her, as though torn from the mother's body. She writes: 'She is right. It is not the broken frame that we need to repair. For her the room represented my body that she would enter and feel safe. She wants to get back into my body' (p. 406).

The shock of the new: defending against the unknown

This theme set the scene for the suddenness of the first lockdown and the aspects of the work which felt new and frightening for the participants. Both Paul and Lira's experiences of shock and loss tallied with that of many of the CAPPTs whose literature was published in 2020. Webster (2020) reported that 'the clinic fell silent, the children's boxes were stowed away' and writes poignantly that something 'live' had got lost: in the absence of the presence of her patients, 'something had died' (p. 293). Paul conveyed strongly that the 'parental' figures he had relied on so much in the first half of his training had disappeared quite suddenly, leaving him feeling alone and childlike, without instruction or guidance.

Lira described the period before the ACP[9] issued their guidance for CAPPTs (2020) (which was incrementally reformed and updated over the course of the pandemic), as a place of limbo and paranoia, whilst clinics and NHS trusts followed government guidance and implemented it as best they could. She identified feelings of alarm and suspicion about working on Zoom, preferring to use the telephone for contact with patients until further guidance came out. Even then she spoke vividly about her preference for the telephone over Zoom as a more intimate medium, and of finding herself closing her eyes to shut out her home environment and concentrate on the auditory quality of the patient's voice. There seemed to be something reminiscent of the mother/baby-in-utero dyad, for Lira – in her attempts to stay present as the maternal container for her patients (de Setton, 2017, p. 187).

Leader (2021) posits that the classical understanding of the word contagion is the concealment of a wish to touch, either with sexual or aggressive intention to damage the 'other'. He says:

> the underlying wish is repressed, so we are not consciously aware of it, and instead we suffer from painful symptoms where we worry about picking up and spreading infection. […] The new rules of social distancing and hygiene are good news here, because they replace an internal prohibition with an external one. (p. 3)

It is not surprising that the fear of contagion was so powerfully present in the data of all participants in Interview 2. When the interviews took place in summer 2022, the pandemic restrictions were starting to lift, and I and the participants all met without masks. This was something about which I gave the participants a choice, and it was noticeable that all felt the need to meet mask-less. There was, I felt, an illicit excitement about this, which mirrored the

[9] Association of Child Psychotherapists

trepidation and novelty of tentatively meeting with a patient without masks for the first time in 18 months - in favour of a more 'whole-person' experience. Music (2020) says:

> I have been watching my own and others' reactions on the streets. Fear, anxiety and distrust are powerfully present. It feels strange to shirk proximity, move away from strangers and avoid close contact. I particularly feel for children now, as they, as potential 'spreaders', are eliciting fear and disgust reactions in many which could have a psychic effect. […] children particularly tend to interpret the world through adult eyes, and as Winnicott said, gain their sense of self that way. Who wants to be viewed as a social leper, a dangerous potential pathogen inducer to be avoided?

There was something of what Music touches on here in the way Sylvie recalled feeling when she was with patients in person - fearing what others might pass on to her, but also being the potentially vulnerable, feared object: *'the dangerous therapist […] not doing as well as other people'*, who 'the other' could be responsible for infecting or killing off. Paul, too, found himself on the receiving end of what he felt to be the overly-persecuting, institutional anxiety of his clinic. In the room, he experienced the fear of a child who defended himself from the threat of infection by 'becoming' the infection or, perhaps, the vaccine - omnipotently 'entering' Paul and controlling him from the inside. What feels striking about such vivid in-person examples is the consciousness with which participants were having to attend to their 'individual and collective fears' (Perini, 2018), and to their awareness of the body.

Lira's experience seemed more distanced as she only retrospectively noticed being concerned about people coughing, questioning a need to defend against feelings of being in danger - '*maybe I was cutting off*'. She also poignantly described feelings of anger and humiliation at having to wear the '*full gear*', a repeated refrain throughout the interview, particularly in relation to what

had recently come to light, prior to Interview 2, about 'party-gate'[10] and a residual feeling of having been duped: '*it was stressed how important it was not to create new cases and there was a lot of emphasis about protecting* […] *those around you. I was just so distressed when all this about the parties came out. I felt like we were treated like fools'.* This aligns with Leader's thoughts from the pandemic (2021): 'Remember that we are infantilised now on a daily basis. We are told what to do and what not to do to maintain our safety and that of others in a way that we have probably no experienced since our childhood'. Leader maintains that these feelings of lost potency bring out 'our earliest relations to knowledge: what do the grown-ups know that we don't?' (p. 2).

The data shows that the participants found themselves having had parallel or at least similar experiences to their patients, to varying degrees. The confusion and uncertainty of change at a global, as well as personal level could, at times, feel unifying whilst also highlighting stark differences, in health, environment and quality of life, between therapist and patient. As De Rementeria (2020) describes, 'while we are all in the same storm, we are not in the same boat' (p. 270). There were, however, times when participants felt as confused and at sea as patients, through loss of control of the setting or worry about their own and their patients' safety, as well as moments of mutual recognition at shared feelings or states of mind.

Sylvie's example, describing Zoom sessions with a number of adolescent patients, found her observing a phenomenon where, for them, being at home and being seen by their therapist within the parameters of a screen, took the focus off their bodies and a preoccupation with the 'external' - moving their view inwards to '*appreciate the inner world*'. Her observations seemed to align with her own experience of feeling safer in her own body, at home, and a consequent move towards her own internal world. Sylvie's experience is supported by Kirchkheli's (2021)

[10] A phrase the tabloid newspapers coined in relation to the parties held during the 'lockdowns' by the Conservative government at 10 Downing St, which only later came to light.

descriptions from remote work during the pandemic, of turning her 'attention inwardly towards the interior of my own body restor[ing] psychic aliveness and facilitat[ing] the process of analytic holding' (p. 404).

Paul vividly described his remote encounters with an Under 5's patient – firstly on the telephone, through which he had to provide a sustaining thread with his voice, conjuring what felt like a lifeline or umbilical cord for a child who needed convincing that his therapist wasn't speaking from beyond the dead ('*here's Paul, here's his voice, he's still alive*'). Later, on Zoom, Paul found himself manhandled through the iPad and deposited rather illicitly in the child's mother's underwear drawer. In both examples, patient and therapist experienced each other as disembodied – voices from, where? – and then, when they could see each other, they were cut up and cut off, in and out, discarded. Paul reported feeling intensely out of control of the physical frame, humiliatingly positioned as the intruder into the internal world of the mother's drawer. Bachelard (1994) writes that wardrobes' and drawers' 'inner space[s] are also intimate space, space that is not just open to anybody' (p. 99). This chimes with the dilemma that CAPPTs and patients had to wrestle with daily during the pandemic, in a wider sense, of losing the privacy of their homes through technological intrusion.

There was a pervasive thread of things lost - whether through loss of control, the losing of patients, of confidence or presence of mind - this aspect of participant experience was pervasive and appeared throughout the data, sometimes subsumed by other themes. Tallying with Kohon (2020), Webster (2020) and Shulman (2020), Lira mourned the loss of something she felt was an important part of the frame – perhaps not only physically, but ultimately impacting the whole and in ongoing ways: that of the loss of analytic neutrality. She missed the containment she had felt from patients not knowing personal things about her, ie her family circumstances, or why she was not there for a session, feeling that this was an important part of the frame within which the patient

could also feel safe enough to bring the transference into their work together. She felt that the 'track and trace' rules leading to CAPPTs having to share when they were isolating, as well as being seen to work from home, damaged her sense of anonymity, leading her to feel that her own sense of frame and professional identity had been broken. This poses the issue of analytic safety, not just for the patient but also for the CAPPT's potential feelings of diminution, loss of potency and, ultimately, of feeling less effective as a container for the patient. And, I would argue, this loss of neutrality and the resulting dilution or compromise of work in the transference which leaves room for phantasy, links fundamentally to the loss of, or confusion around, professional identity.

Keeping children safe from a distance could at times feel like a grave responsibility, not just from a health perspective but also in relation to safeguarding and physical risk. The safe familiarity and containment of the physical setting became a longed-for aspect of the work for Paul when he became aware of a patient's difficulties around confidentiality and a fear of being overheard. His description, not only of the danger he felt his patient was in, but also of his own lack of agency in being able to keep his patient safe, was a painful reminder of the pressures the pandemic put on both families and professionals in different ways.

Sylvie's reflections on the ways that patients with eating disorders could take control of the setting on Zoom, conveyed a sense of detached observation and interest in their uses of technology. I wondered whether her previous work on Zoom meant that she could experience it from a less persecuting, more distant standpoint than the other participants, who were dealing with it for the first time. She cites the potential for the therapist '*feeling incapacitated and impotent'*, but it is notably commented on in the third person, as though talking about how others might feel. Nevertheless, her use of language (her '*inspector* eyes') and her description of her patients' omnipotent control of what she could see of their bodies, put me in touch during the Zoom interview with a powerful feeling of fragmentation, and of her – and me – being nothing more

than ‘heads in boxes’, reminiscent of the body/mind split so often prevalent in work with eating-disordered patients.

Body versus nobody

As proposed in this study’s literature review, the presence of the body in the work of CAPPTs in particular, is so integral that it can at times be rendered invisible: the invariable which, as Green (1975) proposes, only makes its presence known through absence or ill-health. In the light of the pandemic, this aspect of the frame loomed large, as participants reflected on the question of the body taking centre stage, whether in its presence or its absence.

All participants spoke adamantly of the need for therapy to be in person, for the best work to happen. All felt that it was possible to experience the countertransference remotely, but none of them could give an example of feeling something in their body more powerfully through remote work, than in person. Sylvie’s position felt most multi-perspectival, partly because she had been practicing for over 30 years, but also because she had had the unusual experience and arguable advantage of having experience of remote work for two decades, prior to the pandemic. Whilst she was an undoubted exponent of the uses of remote work for adolescent therapy, she underlined the need to be physically together for ‘*a different level of pressure on my psyche’*.

Similarly, Paul was adamant when thinking about the body’s role in the work that it is fundamental because ‘*you feel it in your body first*’. My experience of Paul’s thinking about the body which, like his first tentative thoughts about the frame, seemed rooted in slightly diffident self-doubt (‘*embodied this and embodied that, I end up thinking I don’t really know what that means*’), became one of excitement at his growing awareness of the body’s role in his work, as though the interview itself was a catalyst for solidifying something of what Bollas (1987) refers to as the ‘unthought known’ (p. 277). His most vivid encounters of working uncomfortably and distractedly in full PPE (mask, visor, gloves, apron) with young children, bring to mind

Winnicott's (1967) idea of the baby's need to see itself reflected back in its mother's face and, in response to this, Fonagy et al., (2003)'s discussion of a child's experience of the mother's failure to mirror, through a preoccupation with herself.

Both Paul and Lira voiced doubts about the success and efficacy of their work with younger children, particularly under 5s, who invariably needed the support of parents to facilitate the child's separate setting. Lira recalled two experiences of not really 'seeing' her young patients on Zoom and then experiencing them as something different when meeting them in person. Paul had thoughts about younger children's modes of communication emanating more from their bodies than from their words. His example of the need in ordinary life to interpret a baby's needs through one's countertransference feelings (often based in the body) because of the absence of speech, illustrated the potential difficulty in remote work of interpreting meaning, conscious or unconscious, due to the absence of the togetherness.

Participants shared the lengths they went to, to situate themselves in their bodies more comfortably, when working remotely. This awareness of a need to be present for themselves as well as their patients, whilst physically absent from one another, is a striking reminder of the complex lengths CAPPTs had to go to, to embody their work at a distance. Paul's pull to replicate his position sitting on the floor, during his disorientating period of weekly oscillation between home and the clinic, fulfilled a need to feel comfortable in his body, in both places. One could wonder about his discomfort in conducting therapy via this modality and a rather concrete need to be grounded by the earth beneath him, whilst entering a virtual space devoid of physical reality. This chimes with Hart's (2020) ideas about focusing on 'body process' during remote work, and Paiva's (2020) experience of being in her body whilst alone in her room, and her '*need to increase my access to parts of myself* […] *the stuff that boundaries are made of, so that I could be present for myself'* (p. 359).

Sylvie's realisation that her wish to stand up during Zoom sessions was based on a desire to feel more '*attentive* […] *more present*', felt like a poignant revelation to her. Strikingly, this was something she started to do during the pandemic – different to her remote work prior to Covid – and I wondered about her need to feel more physically connected to those patients whom she was used to seeing in person, but who had had to move to the *'Covid Zoom'*, as she called it. Kirchkheli (2021), when reflecting on her experience of cultivating what she calls 'visceral attention' during Covid, explains that 'It is through concentrating on our bodies that we free our mind to attend to the primary process and widen the scope of our receptivity. In other words, the mind surrenders to the body and it is a mindful body that listens' (p. 409).

Working in person with masks threw up rich data for all participants, highlighting the powerful responses provoked in the patients, and the difficult feelings evoked in the therapists. Participants recognised their pre-pandemic reliance on the face but, interestingly, only retrospectively: like Bleger's invariable frame (1967), the face as a medium for communication, both conscious and unconscious, only seemed visible in its absence. All described the work wearing masks in terms of fragmentation, obstruction and persecution: '*it felt like a wall… a psychological wall… almost like talking in the dark…'* (Sylvie); '*the attack through the eyes* […] *it seemed to be a real shock for him to see me without it'* (Lira); '*too intimate* […] *this is way too much* […] *seeing my face and then attacking it'* (Paul).

Sylvie hypothesised about the patient's experience of losing the whole face of the therapist, – '[…] *the face of the therapist is a receptor, like the baby with the mother – they're redoing 'How do you feel about me? How do you feel when I am aggressive?*', making me wonder about the less 'whole' experience of being with a part-object (Klein, 1936) and how that might have affected the already-established therapeutic dyad - not to mention the potential for a mask to be experienced as, what Bion conceived as an 'attack on linking' (1959).

Containing the new: no going back

The data showed how participants developed ways of managing being at a distance on Zoom, and of managing the transference relationships which developed. Lira's experience of working with a bereaved father who had recently lost his wife allowed her to wonder who she had become to him in phantasy. His avoidance of the reality of such an overwhelming loss meant that, in the transference, Lira felt he was relating to her more like a friend, or even a girlfriend. Her awareness of the role the screen played in distancing this father from his painful reality, not to mention the part that Covid played in keeping families so brutally apart during that time, felt key to her understanding of her countertransference feelings of discomfort and her capacity to 'hold' and bring reality sensitively into the picture, for the work to progress. Lira concluded that one of the most positive and productive uses of remote work was for work with parents, because of its accessibility and the natural distance needed to work 'through' the parents, in order to help the child.

Paul's descriptions of remote work with two adolescent patients who couldn't manage to return to the clinic to meet in person, showed the complexity of how pre-existing therapeutic relationships could change or rupture. One boy, who had expressed an interest in coming in for his last three sessions to say goodbye to Paul, could not manage the shift back into in-person work and Paul felt that this was largely to do with a difficulty in admitting how important Paul was to him. I also find myself wondering about the significance and meaning of the clinic or the therapy room itself, and how the lost holding environment might have felt too difficult to be reminded of. Even with the promise of Paul's 'IRL'[11] gift of *The Body Keeps the Score*[12],

[11] Contemporary slang for 'in real life'
[12] By Bessel van der Kolk (see references)

this boy left Paul feeling empty-handed, perhaps giving him a sense of what remote work had felt like to him.

The interviews highlighted how Covid had allowed participants to think about the role of the body in their work, when previously it had felt dormant. All agreed it was more difficult to feel things in the body online, though not impossible. Paul used phrases like '*dulled down'* and '*harder to feel',* commenting on the loss of a more innate understanding caused by technological rupture, and the ensuing physical disconnect he felt as a result. He noted that since being back with patients in the room, he was more aware and in touch with the bodily aspects of the work – '*more interested* […] *because you're comparing it to something'.*

Sylvie's reflections on the importance of non-verbal communication for both therapist and patient being a *'huge part of therapeutic progress or lack of progress',* is supported by Saporta (2017), Marzi and Fiorentini (2017) and Cohen (2020). Her reflections on how the detail of faces can get lost online, are at once counter to others' experiences of how the face can become magnified or more obviously present online (Garcia, 2020), as well as, perhaps, in alignment with the frozen-face quality which comes with technical glitches (Hutchison, 2020).

Lira's awareness of the body seemed steeped in the reverberations of the health aspects of the pandemic. She felt that both her and her patients continued to be affected by health anxiety more generally. Her preoccupation felt linked to safety and self-preservation - a sense that the pandemic restrictions, whilst being difficult in other ways, had allowed her space to protect herself by taking time off, if needed. Conversely, she linked this to patients' attendance dropping since Covid for similar reasons, leading to the beginnings of a looser frame.

The data showed that the physical frame, which the participants had worked so hard to uphold during the pandemic, has been affected in multiple ways. Words and phrases used in the findings to describe this phenomenon included:

'*porous*'

'*permeable*'

'*malleable*'

'*less rigid'*

'*you're not on your own with the child*'

'*the ipad became the frame'*

'*you're in the child's hom*e'

'*the frame of being the non-intrusive person is broken*'

'*the boundary gets a bit shaky when it's their bedroom*'

There was a dislocated and confused quality to the participants' shared experiences of the changed frame, giving a sense that the space provided could more easily be intruded upon, broken up or misshapen. There was also a sense that something had shifted internally, particularly for Paul and Lira, for whom the sudden changes in the work left an indelible mark on their practice. Paul, however, seemed most profoundly affected by the increased flexibility that he felt had grown out of the pandemic – keen not to '*stagnate*', he spoke of wanting to *'push things forward a bit, or do things differently'.* There seemed to be a tension between his openness to an expandable frame which could be extended to taking patients outside of the therapy room (as supported by Sloan Donachy (2020), who met with her adolescent patient for walks in the run-up to the therapy ending, and agreed she would definitely work like that again) – and a sense that the expandability didn't extend to a desire to continue working remotely

after the pandemic had ended. Lira reflected on how vehemently against working online she had been, initially - '*I didn't want to do it'.* Her change of stance was interestingly worded: not so much, 'I saw that it was possible', but '*I saw that it was not impossible to gain some understanding online',* she used a double negative to emphasise her unsure feelings. She mourned the loss of the '*certainty*' of the physical frame and Paul mirrored this, but also acknowledged that his flexibility might come from '*defensiveness about needing – you hold onto the certainty of things, so that might be Covid-related, as well - being forced to work in a different way'.* This thought chimes with Lemma's idea of 'Skype slippage', where the boundaries fall away and the setting becomes 'increasingly loose' (2017, p. 105).

Sylvie, as the most senior and experienced participant, felt that the legacy of the pandemic was a positive one for the CAPPT profession itself – based on the fact that it has opened up learning, geographically, crossing previously unchartered boundaries and improving accessibility, not only for patients' treatment, but also in allowing CAPPTs to link up remotely and learn from each other in ways not previously considered. She cited the ACP conference and other international conferences being held online, as well as trainings being delivered remotely or in a hybrid mix of in-person and online. Here, she highlighted the changed physical frame of the profession more broadly, as teaching and supervisory relationships become increasingly remote. What are the implications for this on CAPPTs experiences of being with; being taught; learning to observe dynamics, both inter- and intra-relational, institutional and group, on their future work?

Chapter 6 – Conclusion

A reflexive note on the interviews

During Interview 1, on Zoom with each participant, I became aware of wearing two hats, that of researcher and of fellow CAPPT, with my own journey and reasons for entering the profession and, as can feel the case when providing a therapeutic space for a patient, a sense of privilege at being entrusted with what were undeniably personal accounts. Zoom was chosen deliberately, providing a chance to engage reflexively with the experience of meeting and conducting the interviews remotely, prior to meeting the participants in person for Interview 2.

With Paul, I was aware of another layer of relating to him, not just as researcher and CAPPT but also as fellow trainee. Meeting me on Zoom from his workplace, I wondered whether this choice of setting provided Paul with a confidence with which to approach the interview, presenting him on his own turf and on his own terms, rather than in the training setting of the Tavistock. Lira's interview was conducted from her home, and I was aware of the parallels with the work of CAPPTs during the pandemic: of being privy to something private and personal in relation to the unknown other, but also of the way one's mind, at times, went to noting their environments and the assumptions that could be made about their external worlds. Likewise, Sylvie was interviewed from home, an experience which felt, from my perspective, too close for comfort, as though I was intruding on her personal space. At times my experience felt blurred, as though we were in a supervisor/supervisee dyad (reminiscent of the online supervision I and others had to adapt to during the pandemic), or possibly a teacher/student dyad, and I was aware of struggling to embody my role as researcher, consciously having to pull myself into a researcher frame of mind.

There was a moment when Sylvie's head and shoulders shot out of sight and stayed out of sight for what was probably only 10 seconds, but felt longer, as I grappled with what might have happened, left with a view of her bookshelves behind. When she reappeared, I realised she had sneezed, but the disconnect and what felt like the sudden decapitation felt quite shocking under the circumstances. It was only later in Interview 2, that I learned that Sylvie chose to stand when conducting remote sessions, giving more meaning to her sudden disappearance from the screen as she bent down to sneeze, out of sight of the camera.

I noted how surprised I was by all participants' capacity to reflect and 'make contact' with me via Zoom, becoming aware of my own preconceptions of, and anxiety about, whether I would be able to facilitate a contained-enough 'remote' space for participants, with good-enough connections for rich data to be gathered.

Interview 2 was held in person and I had hoped to be in the same room at the Tavistock, to create parity with the frame, however, because of the difficulty with organising suitable times to meet with each of them, that wasn't possible. Sylvie, however, could not get to the Tavistock and asked if I would visit her home, which I did. It was interesting to note that, on meeting all three participants, they each looked and felt different to be in the presence of, and retrospectively I have realised that there could have been interesting data gathered if I had added a question enquiring about their own experiences of meeting me in two different modalities. Body language, gesture, facial expressions, posture, eye contact, physical characteristics such as height and body type, were all things I noticed in person – things I was not nearly as aware of in the online interviews. I was also able to note my own countertransference feelings much more easily from the material I gathered in person, and noted listening back to the interviews that I was much more interactive during the in-person interviews than in the online ones, where I held back much more, conscious of not wanting to

cut across the other person, or for my voice to get lost in the ether. Transitions, too, felt easier, with more informal hellos and short de-briefs at the end of each.

All participants commented in the in-person interview that they had benefited from reflecting on the shifts in the physical frame and the body in their work, and that it had provoked a consciousness and curiosity which they would use in future work.

Brief summary of findings

The study identifies that CAPPTs were profoundly affected in myriad ways by working through the pandemic, not least in relation to the 'dissolve' of the physical aspects of the frame. CAPPTs experienced the changes brought by the pandemic as disruptive, both physically and psychologically. It took much resilience to manage the transition from in-person work to working remotely, and support was needed. The one participant who had previously worked online noted differences in the work before and after, both personally, as someone who was classed as 'vulnerable' and needed to protect herself, as well as professionally, as she got to grips with a different flavour of remote working – something she differentiated as the 'Covid Zoom'. The two participants who had never worked remotely before were not only affected by the loss of the physical aspects of the work, but also the loss of the physical presence of supervision and support from colleagues, epitomised by the concept of 'container contained' (Bion, 1962a). All participants felt that the body came to the fore during Covid in ways in which it had previously been taken for granted, leading them to anticipate a potential shift of focus in their practice to incorporate and think more consciously about the body as integral to the work.

Scope and limitations

The data from the three CAPPTs interviewed for this study supports and contributes to existing psychoanalytic and research findings, through its unique contribution to thinking about the dissolve of the physical attributes of the frame, during the pandemic. Despite there having been a flurry of literature born out of the pandemic - more from CAPPTs than previously existed, on remote work in particular – I noted a gap in the research literature since then on collective experiences of CAPPTs in relation to the pandemic more widely, rather than individual case studies or papers on individual experience. Wheatley's recent study (2024) provides a comprehensive analysis of the views of CAPPTs, specifically on remote work during the pandemic, but this does not cover in-person work, nor look closely at the changes in setting and body in the work – something she flags as an area for further research.

This study's sample size of three is small, due to the study's purposive design of two interviews per participant and the breadth of data generated through six interviews. I had originally hoped to have a fourth participant of 20 years+ experience who *hadn't* worked on Zoom prior to the pandemic, however, my supervisor and I decided that the added interest of having a very experienced participant who was fully versed in remote work, would add an unexpected and potentially refreshing perspective to the study. My preconception, prior to setting up the interviews, was that more experienced CAPPTs might struggle more with remote work, because of more entrenched and potentially purist views that remote work wouldn't be possible. One of the limitations of this study is the difficulty in judging whether this might be the case, as could be assessed through further research with a larger sample. This study is also limited, due to its very small sample size, in its capacity to explore the experiences of a more diverse sample of CAPPTs, something which a much larger scale study could valuably address for the profession.

Ideas for further research

Further research could be undertaken into how CAPPT trainees make sense of the post-Covid frame, given the increasing offer of, and demand for, technology-based psychotherapy. It could also be interesting to investigate how post-Covid CAPPT trainees feel about the presence or absence of the body in their work, particularly with the advent of AI and its inevitable and potentially very provocative impact on the future of the profession. I also feel that a larger scale enquiry into how CAPPTs are renegotiating and reclaiming the importance of the physical frame for the profession, in the light of the continued prevalence of and demand for remote psychotherapy.

Due to the word count and limitations of this study, I had to discard an area of data relating to eye contact and the gaze in remote work, but this could be a very interesting standalone study, with regard to the impact of this on the quality of the therapeutic relationship.

Final thoughts

As stated previously, this study was born out my own particular set of experiences when training, learning and practicing during the pandemic. At the time of choosing a title, I had various areas of interest, but all felt overshadowed by a nagging curiosity about the experience I was still reeling from, of the sudden shift from solely in-person work to online therapy, and therapy wearing masks.

I have many vivid memories of my work during the pandemic, some which parallel those of the participants: eg Zooming with a child who took me with him on his iPad under his bedcovers, or being thrown off a fourth storey balcony by a 3-year-old I was trying to do Watch

Me Play![13] with on the parent's phone, as well as poignant in-person work with small children wearing masks, or struggling not to come close. I had a long period of being apart from an intensive patient whose family couldn't maintain and facilitate a safe-enough remote setting for her, and the rupture created by my sudden and prolonged, 5-month absence, shaped the rest of the in-person therapy over the following three years.

I have strong memories of the intrusive, judgemental language around the pandemic, some of which comes into play in this data and is mentioned as a theme in some of the literature, often with remembered anxiety, like Webster (2020) who noted the sometimes-militaristic tone, of words like 'redeployed' or 'mobilised'. Leader comments on the 'stock phrases' which came into use: 'unprecedented times', 'second wave', 'outbreak', 'lockdowns' and 'social distancing'. He notes:

> The way that we are bombarded with these repetitive, empty expressions is telling in itself. The minting of a new vocabulary is a basic human response to crisis and trauma. The first thing to do is to name, but what the pandemic shows so clearly is how there is a difference between naming and knowing. […] The new language might suggest some mastery of our situation, but it adds nothing to what we know or can really make sense of (2021, p. 1).

Other areas of language which came to light were the way in which remote work was talked about and thought about – below, with some thoughts about what each might conjure:

[13] Watch me Play! is an intervention which can be undertaken with young children and their carers to promote therapeutic observation. See https://watchmeplay.info

- ‘Remote’ work - working ‘remotely immediately sounds lesser, distant or even vague.
- ‘Online’ - feels very abstract and doesn’t really conjure what exactly is being undertaken.
- ‘Zoom’ - elicits a sense of being rushed or of something immediate, perhaps, belying the often-long delays in being connected and the battle with disconnect.
- ‘In person’ - feels ordinary enough, until you question whether one is not ‘in person’, or in one’s body, when seeing someone on video or speaking on the phone.
- IRL – (in real life) – has a flavour of sarcasm, as though one can’t believe what one is seeing.

I have memories of constant ambivalence – ambivalence about remote working and ambivalence about having to leave the house and go into the clinic, stuck between two strange stools of decision-making, about what was in the patient’s best interests. It was lonely, fearful and - like some of the participants – I felt isolated, scared of holding responsibility in way which felt like I was alone, dealing with difficult things from afar. I was still in a team, but the team wasn’t with me, and I missed the important transitional interactions with colleagues who were present and available. Home felt more important than ever, but at the same time strangely foreign, in its new multi-purpose guise of clinic, office, and consulting room (for patients and for myself, as a trainee having my own analysis, now on the telephone, in the same room as I had just ‘seen’ a patient).

Freud’s essay ‘The Uncanny’ (1919h) translates as *unheimlich*, meaning homely or familiar, the opposite (as Freud points out) of the meaning of the word *heimlich*, which means ‘concealed, secret, kept from sight, or dangerous’ and this somehow tallies with the anxious

dread I felt almost continuously during that time – what Freud called 'a "special core" of feeling which no doubt lies somewhere in the unconscious' (Quinodoz et al., p. 166). It is this "special core" of feeling which I feel is left over from the pandemic, and, I would suggest, what the participants in this study have also been left with – that is, to not really know the shape, or edges or firm boundaries of the work of CAPPTs anymore. There is the sense of a phantom limb, or the space where a figure has been cut out, and I think there is a question for the profession of how to re-establish a robust-enough frame, not excluding remote working in the right circumstances, to feel safe and comfortable-enough again in oneself and for one's patients.

One of the reasons for undertaking this study was to encourage the changes and the losses to be talked about, particularly given the distance that is often wanted, or needed, from thinking about the collective trauma of the pandemic. This need for distance was illustrated by some CAPPTs actively not wanting to think or talk about the pandemic when they were approached to be involved in the study, as well as what I have experienced as a difficulty within the profession in acknowledging the enormity of the shift in a wider sense - with patients; in supervision; attending seminars - to a world in which we now, almost unquestioningly, have the option to connect online without having had a space to mourn what is lost of the fundamentally embodied nature of the discipline.

I wonder whether the difficulty in looking back at what is lost, aside from a defence against thinking about something which is painful to remember, may also be linked to a lingering confusion over what we have been left with, and a reticence about how to make sense of a new frame of working, in the shadow of traditional and formative models of child psychotherapy.

But, I would argue, this study suggests that the shape and feel of the frame has changed irrevocably and with it the profession's sense of identity, previously founded on clarity of boundaries, setting and embodied relationship between self and other. I wonder whether others feel, like I do, that the rug has been pulled from under their feet, and that the push/pull of patients' shifting expectations (and, perhaps more painfully, ours as CAPPTs) in the wake of the pandemic - of how and when they can attend, and what shape the therapy might take - may mirror Lemma's 'slippage' (2017) in relation to our internal frames, in holding fast to the value and power of physical presence and embodied space.

We can revel in a renewed flexibility of the boundaries, utilising our internalised settings to practice anywhere, but does this belie an omnipotence which fails to recognise our vulnerabilities? Perhaps it takes an interrogation of what feels lost (including, perhaps, something of our own professional identity, rooted as it is in embodied presence and physical boundaries), to acknowledge what is important for psychoanalytic psychotherapy and, at the heart of it, for the therapeutic endeavour to be effective and transformative. I hope that this study begins a conversation about how we can reframe and reclaim the physical frame, within an inevitably changed and changing world.

Sinason (1988) writes:

> The pioneers clearly had the freedom as well as the responsibility of finding out which play material worked for them and why. We are now in the position of automatically receiving toys that represent the symbolic tasks of cutting, sticking, building, repairing without thinking about it. The danger of this is that we can forget the theory behind the choice of toys and feel constrained by our inheritance into not questioning current needs. Ferenczi (1929) aptly commented `I really do not know whether I envy our

> younger colleagues the ease with which they enter into possession of that which earlier generations won by bitter struggles. Sometimes I feel that to receive a tradition, however valuable, ready- made, is not so good as achieving something for oneself'. (p. 350)

I suspect that, in relation to the prevalence of online work which is now offered as an option in many CAMHS settings, there is much that we can learn as a profession from the thinking that has gone into theorising remote work by adult exponents over the last 50 years – particularly with adolescents, for whom the medium may be most appropriate (and closest to remote work with adults, as communication is primarily verbal). Perhaps we need to 'find out what play material works for us' and remind ourselves of 'the theory behind the toys', reacquainting ourselves with the physical aspects of the work as a way of reconnecting with the past and taking ownership of our present and future reality.

It does, however, feel important to remember that CAPPTs use of remote work has been born out of a particularly shocking and affecting set of circumstances in the shape of a global pandemic – primarily out of necessity, rather than choice – and, as such, may carry with it residual layers of trauma, not only of the clinicians' sudden losses and adaptations, but also of what their patients have endured, and how we have to find a way to robustly contain their changed worlds, as a result of the pandemic.

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Appendices

Appendix A - Literature Review results relating to the psychoanalytic frame for CAPPT

Search 1

Search number	Search terms	Number of papers found
S1	Psychoanal* OR psychothera* AND the setting OR the psychoanalytic frame	76,874
S2	Child and adolescent OR child*	1,432,329
S3	S1 AND S2	147

Search 2

Search number	Search terms	Number of papers found
S1	Psychoanal* OR psychothera* AND the body	7,907
S2	Child and adolescent OR child*	1,432,329
S3	S1 AND S2	231

Search 3

Search number	Search terms	Number of papers found
S1	Psychoanal* OR psychothera*	233,048
S2	“remote therapy” OR “remote psychotherapy” OR “tele-therapy” OR “telephone therapy” OR “video therapy” OR “video psychotherapy” OR “virtual psychotherapy”	3,845
S3	Child and adolescent OR child*	1,432, 329
S4	S1 AND S2 AND S3	36

Appendix B - List of superordinate and subordinate themes across all three participants' interviews (Interviews 1 and 2 combined)

Superordinate & subordinate themes	Paul	Sylvie	Lira
	Page/line Interview 1 = 1/1 Interview 2 = 1:1	Page/line Interview 1 = 1/1 Interview 2 = 1:1	Page/line Interview 1 = 1/1 Interview 2 = 1:1
1. Finding a way into child psychotherapy			
1.1. Inside stories: relating to oneself and others	1/2, 2/35, 3/72, 4/83 5/114, 7/154, 8/163, 8/183, 9/215	1/1, 2/12, 2/23, 2/26, 2:36, 2:39, 6:178	1/10, 4/96, 5/125, 5/130, 6/170, 6/189, 7/214
1.2 Continuous learning helps the frame evolve	7/158, 8/168, 10/234, 13/308, 14/331	1/9, 2/15, 5/149, 2:15, 2:38, 4:94, 8:235	3/74, 3/89, 9/269
2. Framing things up			
A. Defining the frame: what is it and how is it used?	9/198, 9/209, 12/287, 12/298, 9/215, 10/223, 10/237, 10/240, 11/256, 13/308	4/112, 5/126, 5/136, 5/149, 6/159, 9/264	2:46, 3/74, 5/153, 9/269
B. Flexibility of frame: a frame of one's own	12/287, 9:1, 19:10, 19:11, 22:7, 23:24	2/39, 2/41, 4/48, 5/123, 8/231, 5:162	1/20, 7/192

3. The shock of the new: defending against the unknown A. Where are the 'parents'? B. Fear and contagion C. Mutuality and intrusion: outside-in D. Things got lost or got in the way	13/308, 1:1-4, 1:15, 1:18, 2:2, 2:9, 2:22, 10:21 2:19, 4:24, 5:18, 7:1-15, 8:9, 10:4, 12:5, 15:18 4:11, 4:18, 5:21, 9:21, 12:16 10:1, 5:21, 14:10, 11:16, 14:10, 18:6	8/235 13/379, 2:38, 2:58, 3:71, 5:153, 13:383 7/190, 7/197, 8/242, 1:8, 1:18, 1:27, 3:74, 5:153, 6:191 3:79, 5:153, 11:322, 11:335, 11:342, 12:345	5/151, 1:6, 2:45, 3:82, 4:75 1:6, 1:20, 5:151, 6:173, 13:403, 13:412 2:48, 6:163, 6:166, 6:180, 7:198, 9:247, 11:331 1:6, 1:27, 2:59, 3:65, 15:476, 4:112, 13:411
4. Body versus nobody 4.1 Making sense of presence and absence 4.2 Being in the body, at a distance 4.3 Body parts	18/441, 24/501, 20/464, 21/474, 4:24, 8:27 5:21, 11:16, 11:18, 17:19 4:24, 7:1, 8:1	5/138, 6/181, 9/276, 10/292, 10/307, 11/339, 5:165 5:166, 6:171, 6:184 3:79, 3:86, 4:100	2:19, 2:56, 4:89, 10:257, 10:264, 13:411 7:198, 12:375 9:215, 10:264, 12:292, 14:414

5. Containing the new: no going back	15:5, 16:1	1:21, 1:32	4:112, 5:146, 9:215
5.1 Safety at a distance?	17/404, 25/514, 25/520, 4:26, 5:18, 11:15, 21:7	5:165, 6:172, 6:184, 10:307	16:498
5.2 Remembering the body	10:4, 14:2, 14:10, 16:1, 17:19	7:211, 5:162	2:59, 4:106, 4:120, 6:180, 13:393, 13:411, 16:498
5.3 ‘Dissolve’ of the frame?			
5.4 What are we left with? Resistance and acceptance	18:8, 19:1, 19:11-13, 22:18, 23:23	1:21, 5:156, 5:162, 6:251, 12:356,	9:286, 10-11:315-325 14:427, 20:606, 20:629

Appendix C - Participant's Personal Themes

Paul's personal experiential themes

Theme 1: Child psychotherapy feels personal	1.1 Searching beneath the surface 1.2 Internal push and pull 1.3 There's a need for parents
Theme 2: Belonging	2.1 How to belong? 2.2 What belongs to whom?
Theme 3: Developing a frame	3.1 Wanting to know 3.2 A Covid baby 3.3 Flexibility is key
Theme 4: Presence and absence	4.1 Temperature and distance 4.2 Permeability and intrusion 4.3 The body in the work

Sylvie's personal experiential themes

Theme 1: Childhood curiosity	1.1 Rooted in stories and words 1.2 Interested in inner worlds 1.3 Settling in
Theme 2: Dual aspects	2.1 Teaching and learning 2.2 Covid work is familiar yet different 2.3 Outside in
Theme 3: Covid as intruder	3.1 Feeling vulnerable 3.2 Covid provokes aggression
Theme 4: Framing things differently	4.1 Grounded in theory 4.2 Thinking about loss 4.3 Bodily contact

Lira's personal experiential themes

Theme 1: Journeying	1.1 Getting there 1.2 Feeling different 1.3 Finding the words
Theme 2: Shaping the work	2.1 Minding the gap 2.2 Clarity and rules matter 2.3 It's a balancing act
Theme 3: The work can feel dangerous	3.1 Threat to the body 3.2 Something feels difficult 3.3 The lines got blurred
Theme 4: Is this it?	4.1 All in it together 4.2 Memory and loss 4.3 Having to accept

Appendix D – Interview Schedule

Semi-structured interview schedule

Title: Out of Body: An Interpretative Phenomenological Analysis of how child and adolescent psychotherapists experience the dissolve of the physical aspects of the psychoanalytic frame (body and setting) due to the COVID-19 pandemic.

Interview 1

Welcome

- There are two parts to the interview process: Interview 1 (which will take place via Zoom) will aim to frame Interview 2 (which will take place in person). Both will be semi-structured.
- Interview 1 will last between 45 and 60 minutes and will focus on the clinician's training and profession, pre-Covid.
- Interview 2 will last between 60 and 75 minutes and will focus on work during the pandemic. There will be an opportunity to reflect in more detail about specific clinical work (past or present) which may feel relevant/helpful to the wider context.

Who are you? Why Child Psychotherapy?:

Key question: Thinking about the long view, I'd like to take you back to a state of mind which is pre-Covid. Can you tell me where and how you trained, and what drew you to child psychotherapy?

Prompts:

- Did you have a prior profession? My thinking being: if you train in something you internalise a way of doing things.
- Give me a sense of your reasons for pursuing a career in child psychotherapy. What drew you to becoming a child and adolescent psychotherapist?

The psychoanalytic frame:

Key question: What does the idea of the psychoanalytic frame mean to you, both personally and conceptually?

Prompts:

- How would you define the pillars of the frame for yourself?
- How did the frame come to be established for you (eg supervision, analysis, influences during training, or theoretically)? What has helped you internalise the frame that you use in your work?
- What do you perceive it to be constituted as? How do you feel it? How do you value it?

Countertransference:

Arguably, the frame helps child and adolescent psychotherapists make sense of countertransference experiences. The following questions relate to this aspect of their work.

Key question: How do you conceptualise the countertransference?

Prompts:

- How much do you understand this as relating to the physical aspects of the work?
- How has your understanding of 'self and other' been influenced by being part of a physical couple in a room?

Key question: What does the body and the experience of 'being together' mean to you in your work?

Prompts:

- I'm thinking again about my wish to return to a pre-Covid state of mind and wondering about how drawn we are, as therapists, to working 'with people' (as bodies together in the room).

Interview 2

- Remind them that they are welcome to talk freely about the topic: their personal thinking, reflections and experiences of the dissolve of the physical frame in their clinical work. Explain that they can discuss specific cases (past and present) that may feel relevant.

Context of working during Covid:

Key question: What were the circumstances you found yourself in at the first lockdown in March 2020?

- Elicit the chronology and shape of their experience of Covid.
- Was there any face-to-face working? Did everything move online?
- Specifics: memories; feelings.

Working in person:

NB: *If a participant has not gone back to working in person, there will be a separate question relating to how this has been experienced and the impact of this on them and their work.*

Key question: I've understood that you spent some of the time in the clinic - what did it feel like initially, to work, or return to work in-person during the context of the pandemic?

- What was the extent of your use of PPE?
- How did you feel about working person – was this something you wanted to do?
  Did it feel important to be in the same room as patients or did you feel resistance?

Threat to self and other:

Key question: Have you ever felt that there was a physical threat to you when working with patients during Covid? Can you give me a clinical example, either in-person or online (see prompt no.2).

- I am wondering about examples of bodily or somatic countertransference.
- Is there still the feeling of a risk of contagion online? There's been a lot of talk about threat to the body, even in phantasy - I am wondering about the place of phantasy in relation to physiological feelings.
- What are your feelings about the dis-embodiment of working online – does it foster a sense of safety and therefore connection, or does the distance and the virtual create something more impenetrable and paranoic?
- When the physical aspects of being 'with' are taken away, what is your experience of using your 'self' (still working within your own body) and your mind, to contain the 'other'?
- How do self and other relate in this context?

Shifting parameters – the frame and the future:

Key question (1): Thinking about the frame which we spoke about in our first meeting, how has that translated in the covid experience - are there things which have come to the fore or become less important?

Prompts:

- Examples of patients from differing age groups, which might illustrate the particular challenges of the dissolve of the frame?
- Does anything stand out for you as exemplifying the shift in the physical frame in the work?
- Can you give an example of how you might have relied more heavily on your internalised frame as a result?
- How has working during the pandemic effected the way you use and relate to your physical environment - internalised frame now - what has changed? The way you work from home and the way you work in the clinic.

Key question (2): Thinking about the longer-term view, and bearing in mind our initial conversation (in Interview 1) about your sense of the analytic frame, can you tell me what you believe the experience of the pandemic means for your work as a child psychotherapist going forwards, paying attention to what you feel has been lost and what might have been gained?

Prompts:

- I am wondering about your particular circumstances, eg the stage of your career and experience: do you believe there is any advantage, or disadvantage, to where you find yourself personally, in relation to what the pandemic has highlighted regarding the physical and environmental aspects of the work?
- What do you keep and take from this experience? What has gone and what won't return?
- There is a phantasy that the pandemic will be over at some point, but what comes next?

End

- Thank them for taking part.
- Anything not covered that they would like to mention?
- Any questions or if they want any further information to contact me.
- Signpost them to research supervisor if they need support following the interview discussion. Give debrief to them.

Appendix E – Public Facing Documents

Recruitment email

The Tavistock and Portman NHS
NHS Foundation Trust

Dear Prospective Participant,

My name is Rhianwen Guthrie and I am currently a third year doctoral student on the Child and Adolescent Psychoanalytic Psychotherapy training at the Tavistock and Portman NHS Trust. I am also on placement at South Camden CAMHS and Robson House Primary Pupil Referral Unit.
I am purposively contacting Child and Adolescent Psychotherapists at different stages of their careers (trainee; 5-10 years post-qualification and 20 years-plus qualified, who have trained at the Tavistock) with the hope of recruiting for my qualitative research project. The title of this project is:

'Out of Body: An Interpretative Phenomenological Analysis of how child and adolescent psychotherapists experience the dissolve of the physical aspects of the psychoanalytic frame (body and setting), due to the COVID-19 pandemic.'

The project is in an enquiry into the experiences of Child and Adolescent Psychotherapists working both online and in person throughout the pandemic, with a particular focus on the shift in the physical aspects of the 'frame' and the impact of this on the therapy they provided for patients and on themselves and their own countertransference responses.

My study will aim to explore the therapists' conceptual and theoretical understanding of this, from a psychoanalytic perspective and any other perspectives that the participant feels is relevant.

I aim to interview three Child and Adolescent Psychotherapists, twice each: once via a video platform and once in-person, onsite at the Tavistock and Portman Clinic. All participants will be expected to have trained through the Tavistock and to have worked through the pandemic. The first interview will last between 45-60 minutes (online) and the second will take place in person at the Tavistock and Portman Clinic and will last between 60-75 minutes, at a time that is convenient to you.

If you are interested in taking part in this study, please find the attached Participant Information Sheet which contains more background information. If you decide you would like to take part, please contact me on this email address stating your interest in participating in the project.

Best wishes,

Rhianwen Guthrie

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

Project Title

Out of Body: An Interpretative Phenomenological Analysis of how child and adolescent psychotherapists experience the dissolve of the physical aspects of the psychoanalytic frame (body and setting), due to the COVID-19 pandemic.

Who is conducting this research?

My name is Rhianwen Guthrie and I am a Child and Adolescent Psychotherapist in Doctoral Training, studying at the Tavistock and Portman NHS Foundation Trust. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex. I have designed the study and will conduct the interviews and data analysis.

What is the purpose of this study?

In this study I will explore Child and Adolescent Psychotherapists' experiences of working through the pandemic, focusing on the shift in the physical aspects of their clinical work (the environment and the body) and the psychoanalytic frame. My study will purposively explore the experiences of three child psychotherapists at different stages of their careers: one trainee; one post-qualification 5-10 years and one with 20 years+ of qualified experience. My hope is to capture the impact of this particular aspect of the experience on the work of child psychotherapists, at different stages of their practice and careers.

What will taking part in the study involve?

You will be invited to take part in two differently-focused interviews, that will last no longer than 45-75 minutes each. All interviews will be audio recorded. During the first interview, which will be a video interview (and will also be video recorded, using Zoom), I will ask you to think about how you have conceptualised an idea of the 'psychoanalytic frame' and the development, in particular, of your own internalised frame.

The second interview will take place in person at the Tavistock Clinic and will tackle the practical aspects of the shift in your clinical work, the impact of working from home and/or working with restrictions in place (distancing and PPE), and the impact of the shift in the 'frame', both personally and professionally.

This will provide a chance for you to talk freely about this clinical work, with prompts from myself.

Who can take part in the study?

All participants will be expected to have trained at the Tavistock and Portman Trust on the Child and Adolescent Psychoanalytic Psychotherapy course (now known as M80). All will be expected to have continued working clinically during the pandemic, either via video or telephone working or in person (or both).

I will not be interviewing any trainee in the same year group as me, or who I work with clinically or interact with in training seminars, supervisions or workshops. In the same way, I will not be interviewing any qualified child

psychotherapists with whom I have a pre-existing relationship, in the form of supervisor, seminar leader, or who I might have come across in a clinical setting.

Do I have to take part?

There is no obligation to take part in this study and it is your choice to be involved. If you do agree to take part, you can then withdraw your data without giving a reason, up to 21 days after the interview. If you do decide to withdraw from the research, all data collected from you will be permanently destroyed and will not be used in the data analysis. There is a 21-day limit, as after this point I will have begun to analyse and process the data collected.

How will I use the recorded data?

The recorded interviews will be transcribed and analysed by myself and will form the data for the doctoral thesis that I am completing as part of my studies. It may also be used in future academic presentations and publications. All audio and video recordings from the interviews will be destroyed following completion of the project and no later than five years after the interviews take place.
During the transcription process I will de-identify participants, anonymising any identifying details to maintain the confidentiality of those involved, or spoken about, in the study. As such, any identifying details will have been anonymised in the final doctoral thesis or any future publication of the work.
I will strive to make the information as anonymous as possible, however, it is important to state that because of the smallness of the sample size, it may not be possible for this to be complete, and this is something which should be born in mind when deciding to take part.

What will happen to the recorded data?

The sponsor for this study is the Tavistock and Portman NHS Foundation Trust, based in London. I will be using information from you to undertake this study and will act as data controller. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 3-5 years after the study has finished. The interviews will be audio recorded and transcribed by myself.

Your legal rights to access, change or move your information are limited, as I need to manage your information in specific ways for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will only use your name and the contact details you provide to contact you about the research study. I am the only person who will have access to information that identifies you. Even if I am assisted in the analysis of this information by senior colleagues, you will not be identifiable and they will not have access to your name or contact details.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Data from the study will be retained, in a secure location, for up to 5 years. Electronic data will be password protected and any physical copies will be stored in a lockable filing cabinet.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:
https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/
https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

Are there any benefits to taking part?

You may benefit from the opportunity to think about, and make sense of, your experience of clinical work during the pandemic. This could be helpful on a personal as well as professional level. It will be an opportunity to reflect on these experiences with someone who is genuinely interested and curious about them. The study is also an opportunity to contribute to psychoanalytic thinking in this area and it is hoped the results of the study will capture, and contribute to, a greater understanding of a very particular, and perhaps pivotal, moment in the history of child psychotherapy.

Are there any risks to taking part?

There are no direct risks to taking part in this study. However, I am aware that the context, and experiences evoked in this project might, for both personal and professional reasons, stir up strong feelings. As such, anyone taking part in the study will be sent a debrief email in which they will be provided with details of how to access a confidential service which they could use to reflect on the experience of the interview.

What approval has been gained to protect you, and information about you, in the research study?

This research study has received formal approval from the sponsor of the research, the Tavistock and Portman Trust Ethics Committee (TREC). These processes ensure I conduct the study within legal and ethical standards. If you have any concerns or queries regarding my conduct, you may contact Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Additional accountability is provided by the study sponsor for this project, Mr Brian Rock, Director of Postgraduate Studies, Tavistock and Portman NHS Healthcare University Foundation Trust, 120 Belsize Lane, London NW3 5BA, (BRock@Tavi-Port.ac.uk).

Contact Details

Please do not hesitate to contact me, the Researcher, if you have questions about the project or would like to discuss anything further.

Rhianwen Guthrie
Email: RGuthrie@tavi-port.nhs.uk
Telephone:
Address:

Alternatively, any concerns or further questions can be directed to my Research Supervisor, the Principal Investigator for this study:

Dr Laura Balfour
Email: laura.balfour@nhs.net

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

Thank you for taking the time to read this information and considering taking part in this study.
If you are willing to take part in the research, please complete the consent form provided.

The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

Project Title: Out of Body: An Interpretative Phenomenological Analysis of how child and adolescent psychotherapists experience the dissolve of the physical aspects of the psychoanalytic frame (body and setting), due to the COVID-19 pandemic.

Name of Researcher: Rhianwen Guthrie

I confirm that I have read and understood the Participant Information Sheet and been given time to study its contents and ask questions. I can confirm any questions asked have been answered satisfactorily.	
I understand that participation in this study is voluntary, and that I am free to withdraw at any time, or to withdraw any unprocessed data previously supplied. I understand that I can withdraw my data up to 21 days after the interview has taken place.	
I understand that the interviews will be recorded and transcribed by the researcher as described in the Participant Information Sheet.	
I understand that information I give in the interviews will be kept confidential by the researcher unless I, or anyone else, is deemed to be at risk.	
I understand that direct quotes from the interviews may be used in this research study but will be anonymised and held securely by the researcher.	
I understand that the results of this research will be published as part of a Doctoral Thesis and may form part of future publications or academic presentations.	
I understand that all data collected from the interview will be destroyed no longer than 5 years after the study has finished.	
I understand the interviews may involve the risk of emotional upset or discomfort, and that I can stop the interview at any point and will be offered a chance to debrief after the interview has concluded.	

I confirm that I, _____,(Participant Name) have understood all of the above and what is required of me, and give my consent to participate in this study.	

Contact Details:

Researcher: Rhianwen Guthrie Email: RGuthrie@tavi-port.nhs.uk

Signature: _____

Date: _____

Supervisor and Principal Investigator: Dr Laura Balfour
Email: laura.balfour@nhs.net

Participant's Name (Printed):_____

Participant's Signature:_____ Date:_____

Thank you for agreeing to take part in this study.

I am very grateful for your contribution.

Debrief form

NHS
The Tavistock and Portman
NHS Foundation Trust

Dear Participant,

Thank you for taking part in my research project.

I'd like to remind you that all information collected during your interview will be stored securely and that 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. All audio/video recordings will be destroyed after completion of the project. I will hold on to your contact details so that I can let you know when the research is published, in case you'd like to read it.

If you have any further questions, my contact details and those of my research supervisor are:

Rhianwen Guthrie - RGuthrie@tavi-port.nhs.uk

Laura Balfour - laura.balfour@nhs.net

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

Best wishes,

Rhianwen Guthrie

Appendix F– TREC form

The Tavistock and Portman NHS
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC)
APPLICATION FOR ETHICAL REVIEW OF STUDENT RESEARCH PROJECTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

FOR ALL APPLICANTS

If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters. You need only complete sections of the TREC form which are NOT covered in your existing approval

Is your project considered as 'research' according to the HRA tool? (http://www.hra-decisiontools.org.uk/research/index.html)	Yes
Will your project involve participants who are under 18 or who are classed as vulnerable? (see section 7)	No
Will your project include data collection outside of the UK?	No

SECTION A: PROJECT DETAILS

Project title	Out of Body: An Interpretative Phenomenological Analysis of how child and adolescent psychotherapists experience the dissolve of the physical aspects of the psychoanalytic frame (body and setting) due to the COVID-19 pandemic.		
Proposed project start date	February/March 2022	**Anticipated project end date**	September 2023
Principle Investigator (normally your Research Supervisor): Laura Balfour			
Please note: TREC approval will only be given for the length of the project as stated above up to a maximum of 6 years. Projects exceeding these timeframes will need additional ethical approval			
Has NHS or other approval been sought for this research including through submission via Research Application System (IRAS) or to the Health Research Authority (HRA)?	**YES (NRES approval)** **N/A** **NO (HRA approval)** **X** **Other** ☐ **NO** **X**		
If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters.			

SECTION B: APPLICANT DETAILS

Name of Researcher	Rhianwen Guthrie
Programme of Study and Target Award	M80 Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy
Email address	rhianwenbailey@ntlworld.com
Contact telephone number	07968829716

SECTION C: CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES** ☐ **NO X** If **YES**, please detail below:
Is there any further possibility for conflict of interest? YES ☐ **NO X**

Are you proposing to conduct this work in a location where you work or have a placement? **YES ☐ NO X I will be interviewing trainee and other child psychotherapists but they will be not be people I work with clinically. Please see Recruitment section.** If **YES**, please detail below outline how you will avoid issues arising around colleagues being involved in this project:

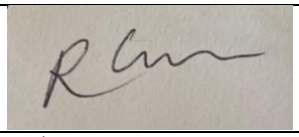
Is your project being commissioned by and/or carried out on behalf of a body external to the Trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES ☐ NO X**
If **YES**, please add details here:	
Will you be required to get further ethical approval after receiving TREC approval? If **YES**, please supply details of the ethical approval bodies below AND include any letters of approval from the ethical approval bodies (letters received after receiving TREC approval should be submitted to complete your record):	**YES ☐ NO X**
If your project is being undertaken with one or more clinical services or organisations external to the Trust, please provide details of these:	
If you still need to agree these arrangements or if you can only approach organisations after you have ethical approval, please identify the types of organisations (eg. schools or clinical services) you wish to approach:	
Do you have approval from the organisations detailed above? (this includes R&D approval where relevant) Please attach approval letters to this application. Any approval letters received after TREC approval has been granted MUST be submitted to be appended to your record	**YES ☐ NO ☐ NA X**

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION

I confirm that:

- The information contained in this application is, to the best of my knowledge, correct and up to date.
- I have attempted to identify all risks related to the research.
- I acknowledge my obligations and commitment to upholding ethical principles and to keep my supervisor updated with the progress of my research
- I am aware that for cases of proven misconduct, it may result in formal disciplinary proceedings and/or the cancellation of the proposed research.
- I understand that if my project design, methodology or method of data collection changes I must seek an amendment to my ethical approvals as failure to do so, may result in a report of academic and/or research misconduct.

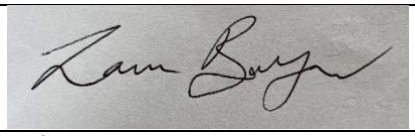
Applicant (print name)	RHIANWEN GUTHRIE
Signed	
Date	11th April 2022

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor/Principal Investigator	LAURA BALFOUR

Supervisor –

- Does the student have the necessary skills to carry out the research?
  YES ☒ **NO** ☐
- Is the participant information sheet, consent form and any other documentation appropriate?
  YES ☒ **NO** ☐
- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?
  YES ☒ **NO** ☐
- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?
  YES ☒ **NO** ☐

Signed	
Date	11th April 2022

COURSE LEAD/RESEARCH LEAD

Does the proposed research as detailed herein have your support to proceed? YES ☒ NO ☐

Signed	 DIGITAL SIGNATURE
Date	11th April 2022

SECTION E: DETAILS OF THE PROPOSED RESEARCH

1. **Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)**

The aim of this proposed research is to explore Child and Adolescent Psychotherapists' (both qualified and in training) experiences of working through the pandemic, focusing on the shift in the physical aspects of their clinical work (the body and the environment) in relation to the psychoanalytic frame.

The arrival of the Coronavirus pandemic and the imposition of restrictions surrounding it, particularly lockdowns, meant that Child Psychotherapists (CPTs) had to suddenly, and for the first time, work 'remotely' from home. The intention of this project is to explore the impact of this shift in the environment and the body, relating not just to video/telephone working, but also to their return to work in person, using social distancing and/or PPE.

Thought will be given to the dissolve of the analytic 'frame' - defined as the physical environment; the conception of time; psychoanalytic theory and the use of other minds through supervision and personal analysis – with attention to the use of the word *dissolve*, and its associations with something moving into a different form and needing to be contained in a different way.

Bléger (1967) defined the analytic frame as a 'non-process', the constants within which enable the process to take place. The solidity of the external [frame] permits the fluidity of the internal, providing limits or boundaries and allowing for there to be edges and a place where things end.

Traditionally, the many facets of the physical framework around psychoanalytic child psychotherapy include the use of the same therapeutic space/consulting room; the use of the same toy box, personalised for each patient (depending on the age of the child); the regularity of session time; the adherence to and acknowledgement of impending breaks in the therapy. Other external aspects of the frame would also include the use of supervision and analysis to contain the work with patients, but perhaps these fundamental resources have taken on more personal significance to child psychotherapists throughout the pandemic, as powerful tools for containing the therapist in the face of the shock of the new.

All these physical aspects hold something in, but for the purposes of this research, it is important to state that the frame is not confined to the room that the therapy is practised within, existing in the minds of both the patient and the therapist – of 'self' in relation to the 'other'. It is the child psychotherapist's 'internalised frame', therefore, which interests me - concerning the felt/perceived loss of the reality of the physical aspects of the frame in their work with patients, and how psychotherapists of differing levels of experience have drawn on this internal resource, to adapt their work during the pandemic.

This study is justified on the grounds of a need to understand the impact of the pandemic on the profession - not only as a way of capturing something of the sudden and seismic shift in the working practices of child psychotherapists, and of understanding the emotional and physical impact of the adaptations made to accommodate continued work with their patients, and the contextual implications on the body and the physical aspects of the work – but also, as a way of fostering a dialogue about ongoing form within the profession; what has been learnt from the experience of the pandemic and what can, and can't, be developed?

I plan to collect qualitative data using two separate semi-structured interviews with a small sample of three CPTs. I will use an interpretative phenomenological analysis (IPA) approach

to interpreting the data, as I will be exploring participants' experiences in the context of the Coronavirus pandemic, relating to the dissolve of the physical aspects of the 'frame' and its particular focus on 'self and other'. The research will be separated into two parts, generating six pieces of data in all from the participants.

2. Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)

Having begun the training for psychoanalytic child psychotherapy only six months before the Covid-19 pandemic took hold, and Britain was first 'locked down', I have lived through a very particular moment in time, not only in relation to social history but, more particularly, in relation to the profession I have chosen to enter.

I therefore intend to approach this study as a means of recording a unique moment in the history of psychoanalytic child psychotherapy; a way to discover whether an analysis of the experiences of CPTs could contribute to further thought within the profession about what is understood of the frame in relation to the physical parameters within which the work takes place - either '*remotely'* or in '*real life*', and what can be learnt from the adaptations made, and potentially gained or enhanced, with remote working used as a medium of choice, for instance, rather than through necessity.

I want to know how participants in the research understand the psychoanalytic frame pre-Covid, how they developed it and what their understanding of it is now. I will investigate how the 'dissolve' of this has challenged, or enhanced, their own internalised frame - depending on how experienced each practitioner is.

It is with this in mind that I will be interviewing one trainee CPT; one CPT who is 5-10 years post-qualification and one CPT with 20 years-plus experience. It is my hope that approaching this subject from the unique perspective of differing levels of experience will contribute to, and provoke, an ongoing dialogue about the psychoanalytic frame as it evolves and adapts within the profession.

Whilst it is important to state that the discrepancy in the experience of the participants does create a difference between them, it is also important to highlight that this difference is deliberate and explicit, as my interest lies in how clinicians with more, or less, experience of working in person in the traditional way, have shifted and adapted to the experience of working at a distance from their patient and/or away from the therapy room and how their internalised frames have aided them and/or developed as a result.

It is possible that, as the three clinicians will have trained during very different epochs and political eras, account will need to be taken, in each case, of changes in understanding and definitions within the discipline over time eg in relation to the frame or of changing perceptions of physicality.

Significantly, this project will provide thinking about, and give attention to, the connection between body and mind in the context of a global preoccupation with matters of the body, and links to 'self and other' as the essence of the therapeutic relationship, whilst aiming to

highlight the particularity of the relationship in the hostile shadow of Covid. Therapists have continued to work 'in' their bodies, but the body has taken on a different focus. It will be important to explore the impact of the preoccupation with the bodily on the psyche during the pandemic, especially in relation to working with children who are less affected themselves by the dangerous, physical aspects of the virus, but could be considered more of a threat to the therapist. Are we safely disembodied online? Or does the gaping chasm of the ether numb the terror? And what about in person? What kind of bodies are we in the room together? How can we manage guilt and anxiety about spreading?

Previous research has been undertaken during the pandemic, however this study will be unique, particularly within the discipline of Child and Adolescent Psychoanalytic Psychotherapy, looking at the 'always' aspect of the frame, as well as through the topical lens the pandemic provides, and with a focus on the body and physicality in therapy, its presence and its absence.

One such example is from the Association of Child Psychotherapists, which produced a large survey during the pandemic in 2020, based on responses from 376 child and adolescent psychotherapists, leading to a comprehensive report on technology-assisted therapy which recorded, amongst other things, the benefits and long-term usefulness of it as a suitably-enduring medium with which to support certain patients and their families, as well as the more negative impact of the use of it on the child psychotherapists themselves, both on their mental health and their work-life balance. In contrast, a survey carried out by Békés et al (2020) and published in a paper called 'Stretching the Analytic Frame: Analytic Therapists' Experiences with Remote Therapy During Covid-19' in the Journal of the American Psychoanalytic Association, concluded that analysts transferring their work during the pandemic to videoconferencing platforms reported remaining "as strong, emotionally connected and authentic in their online therapy sessions as they were in person".

3. Provide an outline of the methodology for the proposed research, including proposed method of data collection, *tasks* assigned to participants of the research and the proposed method and duration of data analysis. If the proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)

Methodology:

I plan to undertake an Interpretative Phenomenological Analysis (IPA) study, using semi-structured interviews with a small sample of three child psychotherapists (CPTs). I will use an IPA approach to interpreting the data, as I will be exploring participants' experiences in a particular context and with a particular focus on 'self and other' and its associated meanings. The research will be separated into two parts, generating six pieces of data in all from participants.

IPA feels appropriate to the concept of this project, because as a methodology it is interested in how meaning is made and, on a meta level, I will be looking at the frame of meaning within which the participants set their experience. It feels most apposite to the research question, because of its idiographic focus on the particularity of singular experience. This study will be an enquiry into a particular aspect of the lived experiences of CPTs, in relation to the physical shift in their working practices due to the Covid-19 pandemic.

IPA seeks to interrogate the lived experience of individuals by encouraging a dual interpretative (or hermeneutic) approach from the researcher: facilitating a forum for rich

participant perspective whilst also decoding *how* the participant makes meaning out of their experience (Pietkiewicz & Smith, 2014). This layered approach to interpreting the data fits well with the psychoanalytic possibilities of the question posed in this study. The hermeneutic idea, which IPA inherently promotes, of needing to understand the whole in order to see the parts and vice versa, chimes with the philosophical underpinnings behind the research question, of how CPTs have made sense of the sudden dissolve of the traditional boundaries during the pandemic and the resulting impact on body, space and place.

Furthermore, IPA lends itself well to this project because, as a qualitative method, it values me as researcher, in bringing something active to the process. IPA's reflexive nature lends itself well to the use of the 'self' as part of the generation of data, therefore I intend to keep a diary throughout the research journey, documenting my own experiences and reactions to changes in working practices, not only to inform the gathering of data from other participants, but also to be used as data itself.

Method:

1) Three participants will be recruited, each with different levels of experience. All participants will be child psychotherapists who trained at the Tavistock. For details of inclusion criteria, see Section 4. As part of recruitment, I will give them Participant Information and they will need to provide informed consent (appendices a and b).

2)

Interview 1:
Participants will be required to take part in a semi-structured video interview, offering the opportunity for them to provide a summary of their understanding of the psychoanalytic frame and its personal meaning for them, as well as to build a narrative about their experience of the internalisation of the frame. This interview will last for 45-60 minutes.

Interview 2:
A face-to-face, semi-structured interview lasting 60-75 minutes, focusing on participants' clinical work during the pandemic, regarding their experiences of the body (of 'self' and 'other'; theirs and that of their patients) and the environment, both working remotely and in-person. This will include an opportunity to think about their experiences of countertransference in the context of Covid.

There will be discussion of contextualising information, including the practical and personal parameters of each practitioner, relating to the pandemic. I anticipate that this will cover the circumstances around them having to work from home, or with Covid restrictions in their workplace (and possible use of PPE), as well as the guidance and support they have experienced during the pandemic and continue to have from their work setting (NHS or private practice).

Interview 2 will be conducted at the Tavistock Clinic and it will be necessary for the same consulting room to be used for all three face-to-face interviews, to ensure parity of experience across certain aspects pertaining to the physical frame.

At the end of the interviews, participants will be given a debrief, providing information about who to contact if they wish to access support in the wake of the experience of participating in the project.

3) After the interviews I am going to transcribe them.
4) Interview data, as well as my own diary data, will be analysed and interpreted using a process of coding informed by IPA methodology, after all the interviews have taken place.
5) Findings will then be written up.
6) All data will be kept confidentially and only the researcher will have access to it.

Undertaking the interviews in two different modalities/formats, and what that feels like for me (as well as for the participants), will be pertinent to the experience and provide a meta level to the data, as I will be keeping a diary of reflexive field notes (and bracketing) about my own experience.

SECTION F: PARTICIPANT DETAILS

4. Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why these criteria are in place. (Do not exceed 500 words)

Recruitment

Because of the approach I am taking in looking at differing levels of experience of the therapists involved, as well as the smallness of the sample size (three people, interviewed twice each), I am going to recruit purposively, based on the inclusion and exclusion criteria.

Inclusion criteria:

Participants will need to be CPTs with whom I do not have previous or current relationships as, ethically, it will be important that they are distant enough from me for me to be comfortable in inhabiting my role as researcher, and to protect them and hear their voices.

All participants will need to have been trained at the Tavistock Clinic. This is because of the project's interest in, and interrogation of, the concept of the 'frame' and the importance of consistency in the trainings of the interviewees.

I will approach two trained child psychotherapists and one 'in training' and there will be an expectation that all three can access the Tavistock Clinic for the second part of the interview process.

I will be choosing three members of the profession and interviewing them in significant detail. There is the important question of anonymity in the light of choosing purposively and I am aware that there will need to be transparency about this in the Participant Information (Appendix A). As a result, I am taking the

decision to de-identify participants, making the data they provide as anonymous as possible, with recognition that this may not be complete.

Exclusion criteria:

I will need to exclude any child psychotherapists I know personally. With regards to the trainee participant this will be the most ethically complex, as I can anticipate the potentially tricky nature of interviewing a fellow trainee when we are currently training together, as well as the potential for our paths to cross in the future. Nonetheless, interviewing a trainee who has a very live experience of working and training through the pandemic, does feel important.

I will not interview a trainee from my year group, nor one from the year group below me, as they did not have much, if any, experience of working and training prior to the pandemic.

I will therefore choose a 4th Year trainee (one year ahead of me), who will have had 1.5 years-worth of working pre-Covid, before the changes in modality, and with whom I will not be sharing seminars or workshops in the future (because they will have qualified).

This places a time pressure on my project but is important and means I will need to prioritise interviewing them first.

5. Please state the location(s) of the proposed research including the location of any interviews. Please provide a Risk Assessment if required. Consideration should be given to lone working, visiting private residences, conducting research outside working hours or any other non-standard arrangements.

If any data collection is to be done online, please identify the platforms to be used.

Video (Zoom) or phone call for the first part of the interview will need to be undertaken in places where the participants are free to speak without the risk of being overheard. This will need to be made explicit.

The same consulting room in the Tavistock will be used for all three participants, in an attempt to provide the same frame for all.

6. Will the participants be from any of the following groups?*(Tick as appropriate)*

X☐ Students or Staff of the Trust or Partner delivering your programme.
☐ Adults (over the age of 18 years with mental capacity to give consent to participate in the research).
☐ Children or legal minors (anyone under the age of 16 years)[1]
☐ Adults who are unconscious, severely ill or have a terminal illness.
☐ Adults who may lose mental capacity to consent during the course of the research.
☐ Adults in emergency situations.
☐ Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).
☐ Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).
☐ Prisoners, where ethical approval may be required from the National Offender Management Service (NOMS).
☐ Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).
☐ Healthy volunteers (in high risk intervention studies).
☐ Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).
☐ Other vulnerable groups (see Question 6).
☐ Adults who are in custody, custodial care, or for whom a court has assumed responsibility.
☐ Participants who are members of the Armed Forces.

[1]If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.
[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)
[3] Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.

7. Will the study involve participants who are vulnerable? YES ☐ NO X

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from:

- the participant's personal characteristics (e.g. mental or physical impairment)
- their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness).
- where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable
- children are automatically presumed to be vulnerable.

7.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?

If YES, a Disclosure and Barring Service (DBS) check **within the last three years** is required.
Please provide details of the "clear disclosure":

Date of disclosure:
Type of disclosure:
Organisation that requested disclosure:
DBS certificate number:

*(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance). Please **do not** include a copy of your DBS certificate with your application*

8. Do you propose to make any form of payment or incentive available to participants of the research? YES ☐ NO X

If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.

9. What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)

N/A

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

10. Does the proposed research involve any of the following? *(Tick as appropriate)*

☐ use of a questionnaire, self-completion survey or data-collection instrument (attach copy)
☐ use of emails or the internet as a means of data collection
☐ use of written or computerised tests
X interviews (attach interview questions)
☐ diaries (attach diary record form)
☐ participant observation
☐ participant observation (in a non-public place) without their knowledge / covert research
X audio-recording interviewees or events
☐ video-recording interviewees or events
☐ access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes
☐ administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process
☐ performance of any acts which might diminish the self-esteem of participants or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction
☐ Themes around extremism or radicalisation
☐ investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)
☐ procedures that involve the deception of participants
☐ administration of any substance or agent
☐ use of non-treatment of placebo control conditions
☐ participation in a clinical trial
☐ research undertaken at an off-campus location (risk assessment attached)
☐ research overseas (please ensure Section G is complete)

11. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life?

YES ☐ NO X

If **YES**, please describe below including details of precautionary measures.

12. Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.

It is not anticipated that interviews will cause discomfort or distress, although I recognise that speaking about one's own experience can be unpredictable. As a child psychotherapist I am familiar with working with sensitive material and feel confident that I can handle it with care. In the unlikely

event that participants feel distressed by their involvement in the project, I will provide the de-brief which will direct them to further support.

13. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)
NOTE: Where the proposed research involves students , they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

This project will provide an opportunity for participants to reflect on a moment in time in the history of Child and Adolescent Psychoanalytic Psychotherapy, and to contribute to a wider understanding of how the pandemic has altered, or shifted, our perspective on the psychoanalytic frame as we have come to know it. It will also provide each participant with an opportunity to have their experiences listened to and discussed from a unique perspective, providing something of a reflective space.

14. Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)

Though not anticipated, participants will have a debrief as well as contact details of my research supervisor.

15. Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants.

A verbal debrief will be given to participants at the end of the interview, including contact details of my research supervisor and the offer of external support should it be needed (see Appendix C)

16. Please provide the names and nature of any external support or counselling organisations that will be suggested to participants if participation in the research has potential to raise specific issues for participants.

N/A

17. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)

N/A

FOR RESEARCH UNDERTAKEN OUTSIDE THE UK

18. Does the proposed research involve travel outside of the UK? ☐
YES NO X

If YES, please confirm:

☐ I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

☐ I have completed ta RISK Assessment covering all aspects of the project including consideration of the location of the data collection and risks to participants.

All overseas project data collection will need approval from the Deputy Director of Education and Training or their nominee. Normally this will be done based on the information provided in this form. All projects approved through the TREC process will be indemnified by the Trust against claims made by third parties.

If you have any queries regarding research outside the UK, please contact academicquality@tavi-port.nhs.uk:

Students are required to arrange their own travel and medical insurance to cover project work outside of the UK. Please indicate what insurance cover you have or will have in place.

N/A

19. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place. Please also clarify how the requirements will be met:

N/A

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

20. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.

YES X NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

Participants will be able to withdraw up to 21 days after interviews, prior to analysis of the data.

21. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.

YES X NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

22. The following is a participant information sheet checklist covering the various points that should be included in this document.

X Clear identification of the Trust as the sponsor for the research, the project title, the Researcher and Principal Investigator (your Research Supervisor) and other researchers along with relevant contact details.
X Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.
X A statement confirming that the research has received formal approval from TREC or other ethics body.
X If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.
☐ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.
X Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.
X Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.
X A statement that the data generated in the course of the research will be retained in accordance with the Trusts 's Data Protection and handling Policies.:
https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/
X Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)
X Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

23. The following is a consent form checklist covering the various points that should be included in this document.

X Trust letterhead or logo.
X Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.
X Confirmation that the research project is part of a degree
X Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.
X Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.
X If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.
X The proposed method of publication or dissemination of the research findings.
☐ Details of any external contractors or partner institutions involved in the research.
☐ Details of any funding bodies or research councils supporting the research.
X Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

SECTION H: CONFIDENTIALITY AND ANONYMITY

24. Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.

☐ Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?
☐ The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).
X The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).
☐ Participants have the option of being identified in a publication that will arise from the research.
☐ Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)
X The proposed research will make use of personal sensitive data.
☐ Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

25. Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.

YES ☒ **NO** ☐

If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

26. Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES X NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

27. In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.

☐ 1-2 years ☒ 3-5 years ☐ 6-10 years ☐ 10> years

NOTE: In line with Research Councils UK (RCUK) guidance, doctoral project data should normally be stored for 10 years and Masters level data for up to 2 years

28. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.

☒ Research data, codes and all identifying information to be kept in separate locked filing cabinets.
☒ Research data will only be stored in the University of Essex OneDrive system and no other cloud storage location.
☒ Access to computer files to be available to research team by password only.
☐ Access to computer files to be available to individuals outside the research team by password only (See **23.1**).
X Research data will be encrypted and transferred electronically within the UK.
☐ Research data will be encrypted and transferred electronically outside of the UK.

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

Essex students also have access the 'Box' service for file transfer:
https://www.essex.ac.uk/student/it-services/box

☐ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.
☒ Collection and storage of personal sensitive data (e.g. racial or ethnic origin, political or religious beliefs or physical or mental health or condition).
☒ Use of personal data in the form of audio or video recordings.
☒ Primary data gathered on encrypted mobile devices (i.e. laptops).

NOTE: This should be transferred to secure University of Essex OneDrive at the first opportunity.

X All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.

X All hardcopy data will undergo secure disposal.

NOTE: For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.

29. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.

N/A

30. Please provide details on the regions and territories where research data will be electronically transferred that are external to the UK:

N/A

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

30. How will the results of the research be reported and disseminated? *(Select all that apply)*

☒ Peer reviewed journal
☐ Non-peer reviewed journal
☐ Peer reviewed books
☐ Publication in media, social media or website (including Podcasts and online videos)
☒ Conference presentation
☐ Internal report
☐ Promotional report and materials
☐ Reports compiled for or on behalf of external organisations
X Dissertation/Thesis
☐ Other publication
☐ Written feedback to research participants
☐ Presentation to participants or relevant community groups
☐ Other (Please specify below)

SECTION K: OTHER ETHICAL ISSUES

31. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?

No

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

32. Please check that the following documents are attached to your application.

☐ Letters of approval from any external ethical approval bodies (where relevant)
X Recruitment advertisement
X Participant information sheets (including easy-read where relevant)
X Consent forms (including easy-read where relevant)
☐ Assent form for children (where relevant)
☐ Letters of approval from locations for data collection
☐ Questionnaire
X Interview Schedule or topic guide
☐ Risk Assessment (where applicable)
☐ Overseas travel approval (where applicable)

34. Where it is not possible to attach the above materials, please provide an explanation below.