

Psychotherapy and COVID-19: reflections on the pandemic

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Foreword

Psychotherapy as we know it today is a profession that many people turn to in times of existential and psychological crises. Others seek therapy in order to gain deeper insight into their experiences or to enhance their wellbeing. Psychotherapy exists in a state of tension between science and art, and between theoretical ideas which can be applied to a range of life's/societal situations and those that form the bedrock of clinical practice.

When I was asked to write a foreword for this eBook, I spent time thinking about what I would focus on. I wondered what the many prolific contributors to the different psychotherapy traditions would have said about the way psychotherapy has evolved, but more importantly how we as modern-day psychotherapists have responded to questions raised by the COVID-19 crisis. As I was seeking a perspective from those who have given us such rich ideas which have informed our practise. I remembered what I always say to trainee psychotherapists and psychologists whose learning I facilitate: that we need a psychotherapy profession that befits the times we inhabit. That we need to have psychotherapy perspectives which offer adequate responses to the big questions and challenges that are emerging in our multicultural contemporary societies today. That we should value a vision of being part of a profession that is outward looking, which offers hope in times of crisis and for whatever the future holds.

With these bold words in mind, I reflected on the year 2020 and how the COVID-19 crisis resulted in significant challenges for the psychotherapy profession in relation to the way practitioners practise. Most poignantly, for many it was not possible to conduct psychotherapy face to face because of the social distancing guidelines. Interlinked challenges in society regarding mental health included loss, grief, trauma, anxiety, anger, the psychological impact of distancing, and the known, as well as not yet known, mental health impacts of contracting the virus. Given these and many other challenges, there are many questions about what responses psychotherapy can offer and how therapists are engaging in contemporary practice in these times.

This eBook, therefore, is a timely compilation of submissions by UKCP members who responded to the UKCP COVID-19 article competition. The chapters are a microcosm of the innovative practice, thoughtful critical questions and reflections raised for readers to consider.

The chapters are informative and will be of interest to those curious about lifting the veil of perspectives within the field of psychotherapy, or indeed those inquisitive about therapists' experiences, thoughts and expert opinions during the COVID-19 crisis. They focus on a range of subjects including trauma-informed approaches to psychotherapy, as well as the complexities and challenges of facilitating group psychotherapy online. Others offer some reflective perspectives which highlight the experiences of working with a diverse range of clients, including children and young people, their families, and homeless people.

Given the multicultural nature of our society, psychotherapy is increasingly responding to matters of social justice. Thus other authors in this eBook have rightly focused on sharing practice in relation to working with clients who have a history of migration, or indeed raising critical questions in relation to the disproportionate effect of COVID-19 on those from black, Asian and minority ethnic communities in the UK. Reflective chapters on therapists' experiences of the lockdown, assessment of risk, as well as challenges and successes of shifting to work online, invite the reader to appreciate the significance of psychotherapy and technology meeting. Equally, the challenges on which many of the authors reflect also raise questions about what is lost and missed from psychotherapy as it was practised before the pandemic.

Whatever position one reaches after reading this publication, one thing is clear; our COVID-19 experiences provoke questions about the potential of psychotherapy to affect social and political issues. Furthermore, the evolving nature of psychotherapy practice, and an appreciation of the reparative qualities of diverse therapeutic encounters, are brought to the fore.

While at the time of writing we do not know how the COVID-19 narrative will end, the critical questions raised by the authors and the agility of psychotherapy practice are evidenced by examples of practice throughout this eBook. Lastly, the embrace of diversity of theoretical thoughts and modalities demonstrated here offers hope for a psychotherapy for today and tomorrow in a troubled world.

Professor Divine Charura
31 January 2021



Technology and online therapy

Towards blended psychotherapy: a COVID-19 legacy

Rodney Hill and Jen Ayling

Introduction

Over the COVID-19 pandemic, psychotherapy has changed forever. Therapists have dramatically upskilled in our technological literacy and competency. In February 2020, most therapists had never heard of Zoom. After a few months of lockdown, many of us were confidently using it (some even enjoying it) – not only in one-to-one therapy, but to facilitate supervision, continuing professional development and conferences.

The upskilling of our community offers an opportunity for a much-needed paradigm shift as to how and (more importantly) *why* technology is utilised in therapy. In this article, we imagine a future where different technologies form part of an 'enriched therapeutic toolbox' and explore what this might look like in practice.

We write as two Gestalt therapists working in the north of England. Neither of us had conducted remote therapy prior to COVID-19. Our thinking has been influenced by the exciting possibilities we have glimpsed in our clinical work during the pandemic, and through reflecting on our own paradigm shifts around technology in therapy. We offer these words as food for thought and discussion. We hope that they might inspire others to reflect on the creative possibilities for technology in their own practice.

A new social reality

In the UK, our social landscape has changed dramatically over the past 20 years. In 2020, 96 per cent of households had internet access, compared to 57 per cent in 2006 (Office for National Statistics, 2020).

Increasingly, the majority of our contact time is online. The average daily internet usage – across all age groups – was 5 hours 46 minutes in 2019. There are now 45 million active social media users in the UK. Scrolling through social media takes us an average of 1 hour 50 minutes daily (Kemp, 2019).

This digital world comes with brand new relational challenges. Technology is evolving far quicker than our understanding of how to use it skilfully, healthily and wisely – which has profound consequences for human society.

Therapists and clients alike are wrestling with the compulsive tendencies, complex etiquette and muddy boundaries that come with multi-technology relationships.

Many clients are presenting with complex difficulties that are tangled in the technologies they use. From the teenager who is suicidal after discovering explicit photos of herself on a revenge porn site, to the woman sacked for retweeting a controversial blog article, to the heartbroken lover who has been 'ghosted' by someone he hoped would be his future husband.

Technology is already in the therapy room, and our clients are increasingly asking how to cope in this new social reality. The question is, how do we respond?

Technology and therapy – the pre-COVID situation

All this technological change is not often mirrored in our therapeutic practice. For most of us pre-COVID, the means and form of delivering therapy had changed little since Freud: a consulting room and a therapeutic hour with what Bion (1974) called 'two rather frightened people, the patient and the [therapist]'.

Even for the more pioneering therapists among us, the decision to use technology has often been made in response to external circumstances, driven by practicality, location, or as a way of attracting clients. The technology itself often remains in the background, valued for its practical function rather than the relational, social or therapeutic impact it could have.

For a profession which prides itself on attending to *process* rather than *content* this seems a missed opportunity, especially at a time in history when technology is having an unprecedented impact on human health and relationships.

The need for a paradigm shift

We believe that in a digital age, socially engaged therapeutic practice needs to be working more flexibly and *reflectively* across the multiple technologies which form our contemporary world.

Our society desperately needs therapists who are not only skilled in *how* to use different technological platforms, but in how to use them mindfully, healthily, and with deep awareness of the impact they can have. We need therapists who are fascinated by the *character* of the technologies we use, how they change our ability to communicate and relate, and the profound influence they are having on our psychology.

Post COVID, one option for therapists is returning to a 'new normal' – offering one client face-to-face therapy, another online therapy, and another email therapy – depending on their practical needs and personal preferences.

But is that really the best we can do?

We propose that a more radical alternative is for therapeutic practice to evolve to become *blended* – with therapists working creatively and consciously across multiple technologies with each client. A blended practice would value the merits of each technology, harnessing them for therapeutic properties and awareness-raising purposes, rather than simply for convenience or practicality.

For clients struggling with the compulsive use of online messaging, what might a scheduled session on WhatsApp teach us? For those whose career is being damaged by explosive email arguments, what could a temporary switch to email therapy reveal? By continuing to only 'talk about' our client's digital lives rather than experiencing them directly, we miss out on huge opportunities for learning and growth. Blended psychotherapy opens up the consulting room to new possibilities, which can deepen the work and strengthen the therapeutic alliance.

Case study

So, what might a blended therapy practice look like in reality?

As Gestalt therapists, we practise a psychotherapy of awareness and contact, with the basic methodological tool being the experiment, which gives us 'permission to be creative' (Zinker, 2009). For us, this has felt the most natural way to integrate technology more deeply and flexibly into our practice. Yet for therapists within other modalities, there may be other, more natural ways for clinical practice to evolve and become more blended.

We share the following case study of our own approach to blended psychotherapy, to help bring

to life new possibilities, rather than showing how it 'should' be done. To protect confidentiality, the following is a fictional composite of different clients and therapists. The various technologies used and their relevance to the therapy are based on real experience.

Meet Madison

Madison is 20 years old. She's currently unemployed but enrolled on a beauty course, which isn't going well. Her presenting issues are her chaotic relationships, depression, and low self-esteem.

At our first session we confirm how we will work together, and agree that the primary mode of therapy will be face to face. As part of the process of agreeing our contract, we discuss the possibility of using different technologies to connect on our therapeutic journey, should it feel helpful along the way. Madison is open to this, but states she wouldn't like email therapy or anything involving writing, because she's 'not good with words'. We agree to proceed on this basis.

Madison is painfully shy, and it takes her a long time to open up when meeting face to face. Amid sharing her frustrations about her course and relationships, she hints at feeling ashamed about her sexual life. At various points, she seems on the brink of opening up, but expresses frustration at the impossibility of ever being able to say it 'to your face'.

After several sessions of stuckness, we negotiate experimenting with a phone session, to see how it might impact her ability to speak. Madison likes the idea of being safely in her own space, which gives her a sense of comfort and control – and means she can avoid the eye contact that she finds particularly challenging. We discuss together the boundaries, practicalities and possible difficulties of the session. The emphasis is on experimenting, just to see what happens in a different situation; there is no 'right way' for the phone session to go. Before the session, I have supervision for support with the experiment. I focus on my own sense of boundaries and how to manage the risks involved, especially the impact of the disinhibition effect.

The phone session follows in Madison's usual time slot and with all the boundaries that have been developed in the earlier sessions. From the outset, Madison seems more relaxed, and eventually finds it possible to open up about her 'shameful' sexual practices. She also shares some painful experiences from her history that give us a clearer understanding of her struggle

to hold boundaries with male partners, and how this can lead her to be taken advantage of. To her surprise, Madison doesn't feel shame after her disclosure, but a great sense of relief. The theme of 'feeling seen' becomes increasingly important in the work. I am struck by how more 'seen' Madison could feel on the telephone, despite the total absence of visuals.

These insights are explored over the next session when we meet face to face again. Madison can now more easily take in my non-judgemental compassion for her, and eye contact becomes more possible. The therapeutic contact has been graded appropriately using a remote, but intimate, means of holding the therapeutic relationship. There is a sense of a shame having lifted, the unspeakable having been spoken, and the sense of connection between us tangibly deepens.

We have more face-to-face sessions, absorbing the learning from the phone session and exploring more around her boundaries and the holding of them. What does it mean to open up to someone, what does it mean to say no?

Madison later talks about her chaotic home life. She has a room in a shared house and finds it hard to look after herself. The room is a total mess and she often loses things, frequently missing her beauty course as a result. She admits to being 'a bit of a hoarder'. I suggest a few Zoom sessions, sensing that it might be helpful for me to be with her in her usual environment. The contracting has to be gently done, given how hard Madison finds it to say 'no'. The negotiation itself teaches us a lot about her relationship to boundaries and expressing her own needs.

When we have the first Zoom session, Madison is sitting on her bed in a very untidy room. On her lap she has the house's elderly cat, Billy. She is stroking him in a caring, responsive way, which reveals a tenderness and emotional attunement I have not seen in her before. I suggest an experiment where she imagines that the cat, Billy, is herself and she is soothing and loving herself in the same way she does the cat. She cries, recognising how alien this is, and how hard she finds it to soothe herself. When we return to face-to-face therapy, Billy is often mentioned and becomes shorthand for self-care and self-love, which have always been strangers to Madison, but which she is now experiencing for the first time.

Our other Zoom sessions allow Madison to share what she hoards and finds difficult to sort out. Showing her room directly seems less overwhelming for her than when she was simply describing it: the shame and

scale is reduced. Together we work through the mess and learn much about what she holds onto ... and why it is hard to let go.

The various technologies and variety of settings have enriched the therapy. Over time, Madison develops firmer boundaries and finds new ways of practising self-care. She becomes more emotionally open and able to be vulnerable, without losing connection to herself.

After several months of productive work, we conclude the therapy journey when Madison passes her course and gets a job at a friend's beauty parlour. In the penultimate session (held on Zoom before our ending in the therapy room) she shows off her wonderfully tidy and redecorated room. Even Billy, the cat, seems delighted with it all.

Final thoughts

As Madison's journey shows, adopting a more flexible and creative approach to technology in therapy can enrich our clinical practice and deepen the therapeutic relationship.

It is also of profound social importance. The dawning of a digital age is changing human society and psychology in ways that we are only starting to comprehend. How we choose to respond to these new technologies as therapists has the potential to make a big impact on our world, both to our individual clients and the wider communities we belong to.

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Jen Ayling is a former web developer turned Gestalt therapist and has never quite managed to quit tinkering with technology. Studying the impact of digital technologies on human behaviour, psychology and relationships is a longstanding interest of hers. She is based in Sheffield where she has a private practice and works as a senior counsellor at Sheffield Rape Crisis and Sexual Abuse Centre.

Abandonment and attachment in the virtual world: how remote working during COVID-19 helped to accelerate the therapeutic encounter

Maria Harding

Abstract

Like many other clinicians during the COVID-19 lockdown, I attended a number of webinars and online training sessions to help support me with this new way of working. Themes of technology phobia, securing a safe space, retaining the frame, avoidant clients and disinhibited sharers began to repeat, and it felt like there was little more to say about the COVID-19 phenomena.

My own frustrations with working in this way within an NHS personality disorder service as well as in private practice left me feeling as if I was little more than a caretaker of the day-to-day impact of the pandemic. My formulations and the core issues that brought clients to therapy in the first place seemed to have been abandoned and therapy had stagnated.

As we re-emerged into the world with some easing of the lockdown restrictions, I noticed a parallel 'ease' in my own thinking about this remote therapy experience. I was now able to review my clinical notes with a different level of reflection rather than just quickly catching up on what was spoken about in the last session. I was surprised and intrigued by what I uncovered about my virtual therapy experience; there was rich material after all and in some cases the remote medium had offered an opportunity for an acceleration of therapeutic experience rather than a stalling of something.

The area of enquiry that I wish to explore is how the experience of abandonment and attachment was mediated through virtual contact. I will examine how being lost in the virtual world triggered a visceral encounter of abandonment which allowed for an amplification of an understanding of childhood experience.

Important note: The client details and information described have been changed to provide anonymity.

Understanding the client's internal world

I met Jenny for the first time on Zoom. She was the first client during lockdown that I worked with remotely without having any previous face-to-face sessions. She sought help for a crisis in her relationship. There had been a pattern of 'mini fractures' in her seven-year marriage which she somehow managed to glue back together. But the COVID-19 lockdown had not only sealed her into her home but also trapped her in a relationship that she said felt like a 'pressure cooker'.

Jenny smiled her way through our initial assessment session as if we were having a 'Zoom catch-up'. There was nothing congruent in her 'recital' of the difficulties in her life and there was an absence of affect. I searched through the screen for some sign of the distress that her story surely warranted. She glossed over the disparaging comments she made about herself and hardly paused in her urgency to explain her understanding of her husband's mind.

A few weeks later we were at the stage of Dynamic Interpersonal Therapy (DIT) that requires focused attention on helping the client report interpersonal narratives. Consequently, I was listening out for patterns in Jenny's relationships that would help develop a schematic picture of her internal world. DIT conceptualises the presenting symptoms of depression and anxiety as 'responses to interpersonal difficulties/perceived threats to attachment (loss/separation) and hence also threats to the self' (Lemma, Target and Fonagy, 2011).

The use of the attachment style questionnaire (Bartholomew and Horowitz, 1991) to elicit a sense of the client's characteristic stance towards relationships highlighted Jenny's propensity for a preoccupied style of attachment, associated with intense but anxious relationships, which may also be ambivalent and unstable.

A 'virtual abandonment'

Jenny 'attended' this session in her car and on her phone; she said she could not find a confidential space in her home and was parked in a lay-by somewhere. Her image filled the screen and I was taken aback by how intimate it felt to see her in this way. I felt exposed and scrutinised by her gaze and wondered what iPhone image of me she was experiencing. Jenny began to recall interpersonal narratives of her childhood: the cruel brutality of her stepfather, the helplessness and lack of availability of her mother, the rejection from her father. I shared with her my experience of how she was telling me things that I imagined were upsetting and distressing in a 'matter-of-fact sort of way' and that I was curious about that. Jenny smiled a lovely smile and said, 'Gosh, you're right, I am! But they are just things that happened and I know lots of people who have had much worse happen to them.' As she said this, the faultless 'newsreader' voice that typified earlier interactions began to quiver a little.

There was an uncharacteristic silence from her; she gazed further into the screen and I tried to hold this, hoping that meaningful eye contact could be felt through the pixilated image of each other. Jenny said, 'You know Maria, I hadn't thought about this before but ...' It took me a few moments to realise that this wasn't a natural silence or a pause to collect her thoughts. Jenny's image was frozen on screen. An 'unstable internet connection' notification jolted me out of my state of confusion. Not only did I feel that I had abandoned Jenny but I also felt a terrible sense of dread; my own abandoned feelings. In this suspended moment we were both lost somewhere in this virtual world. My mentalising collapsed as this awful feeling generated panic and I frantically tried to reach her by phone that went straight to voicemail.

Attachment, separation and loss

Bowlby's theory of attachment holds within it the importance of separation and loss (Bowlby, 1973). Attachment is crucial for the child's emotional and physical survival. Separation, a temporary loss of the attachment figure, is therefore impactful. Walin (2007) suggests that a client's feared loss of the therapist (permanently or temporarily) 'will evoke feelings or defences against feelings that are directly related to the patient's attachment history'. He suggests that it can be difficult for patients with a history of attachment trauma to differentiate between total abandonment and a temporary separation. When I eventually managed to reach Jenny by phone, she said that she had had a panic

attack when the internet connection was lost – she described hyperventilating, sweating and dizziness. When I tried to explore this with her she was rather abrupt. She said she was frustrated with the internet and said that there was no point talking any further as the signal was poor and I was 'breaking up'.

The strong counter-transferential feelings I experienced could not be processed at the time but, on later reflection, offered a valuable way into understanding the activation of a specific representation of self in relation to other. I wondered about what type of internal working model Jenny had developed in terms of her experience of the availability of her attachment figures and how these related to those strong feelings of abandonment in our moments of virtual separation. An internal working model of a rejecting and abandoning other could potentially 'evolve a complementary working of the self as unlovable, unworthy and flawed' (Fonagy, 2001). I mused over this as a possible formulation of Jenny's difficulties evolved in my mind.

The dilemma now was how I was to share my working hypothesis (in the DIT model known as the Interpersonal Affective Focus or IPAF) in a way that Jenny could receive. The DIT model carves a particular use for transference interpretation, primarily for the purpose of exploring the IPAF formulation (Lemma, Target and Fonagy, 2011). I needed to handle this interpretation sensitively and give careful consideration to how it supported the emerging formulation of Jenny's dominant unconscious interpersonal pattern. Jenny's narratives revealed her own sense of 'not mattering/ being worthless' and her repeated experience of others leaving and not being available. Yet there was such an absence of affect in Jenny's telling of her story and the screen between us seemed to offer yet another protective layer to Jenny's natural defences. The 'way in' seemed to be available via what had occurred between us in that moment and my sharing of that visceral experience in our 'virtual abandonment'.

Gaining understanding through transference dynamics

Jenny came promptly to her next Zoom session as usual. She launched into how her week had been and shared her frustration with working from home and with her manager, who she felt was leaving her to 'get on with it' now she wasn't physically in the office. 'I spoke to my husband about it, but he said that is just how it is now with this way of working; I guess I annoyed him as he was busy with his own work.' She went on to say that she felt she was being

unreasonable in her frustration, but she couldn't shake these feelings. Furthermore, she found herself being preoccupied with how much time her manager gave to her colleagues in online meetings.

As we settled into the session and I was able to draw together some of the 'here and now' with the narratives over the past weeks, we finally got to the place together where we could explore the experience of the 'virtual abandonment'. Jenny shared that after her initial feeling of panic she felt anger, which surprised her; it felt 'irrational'. I asked, 'I wonder if you felt that I had somehow just left you there?' Jenny nodded and became silent for a few moments; I thought I saw a tear on her cheek but wasn't sure. I checked this out with her. She nodded again and brought her face closer to the screen. 'I felt terrible inside. You were gone and it was like it was deliberate. I saw that you called but I thought you were just going through the motions. And then I thought well, what does it matter anyhow?'

It is well known that transference dynamics can be powerful and can offer a more immediate experience of the interpersonal dynamics the client experiences in his/her 'real world'. Thus, from this moment, Jenny and I were on our way to making sense of how her childhood experience got 'mapped' onto something in the here and now between us (and how this connects to her experience of her adult relationships). Another avenue had opened up and what I had pondered over and tried to make sense of in these early sessions had been pulled together and could be offered to Jenny as a tentative sketch of her interpersonal experience. Despite the screen between us, the lack of physical presence and our often blurry images of each other, we managed to get to that place where a meaningful formulation of a recurring configuration of 'self' and 'other' representations could be expressed. It could change, and be refined – it was a working hypothesis after all. Nevertheless, there was something in Jenny's response to it, her feeling 'moved' that I had understood her experience, that enabled me to feel that we were on the right track. Working in a short-term psychodynamic model has its challenges and a sense of anxiety can quickly creep in when you feel you have not grasped the client's core difficulties in a way that can help them with their symptoms of depression and anxiety.

“For the patient in psychotherapy, every break in the continuity of the relationship is a potential trigger for old feelings and defences – and a potential opportunity to address unfinished business around separation and attachment.” (Walin, 2007)

So as I came to reflect on this episode I was appreciative of what my 'virtual abandonment' experience in this new remote way of working had brought; it felt as if something had been accelerated in our therapeutic relationship and the work. Jenny and I now had a meaningful focus for the next phase of our therapeutic journey.

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Thoughts on moving from working in a designated therapy room to online as a psychotherapist working with children aged between 4 and 11 years during the COVID-19 pandemic

Jo Gaskell

This was written at the end of May 2020, when the UK had been in lockdown for two months. For ease of reading, I will refer to therapists as female, clients as male, and 'parents' to mean parents or carers.

Introduction

One of the fundamental roles I have as a psychotherapist is to set and maintain the key boundaries, which are:

- To provide and maintain a safe and confidential space.
- To ensure that the space is consistent, and has the same furniture, equipment and toys each week, that have been carefully chosen to be therapeutic.
- I am the keeper of the room, ie I open the door and let the child in, make sure there will be no interruptions. I also keep the time, and open the door to allow the child out.
- The work revolves around interactions that often, and I think need to, have a physical grounding: games of catch, sharing crayons, playdough, doing 'together' activities, exchanging figurines.
- There are three 'people' in the room, the child, me and the toy(s), all constantly physically interacting, changing, manoeuvring, taking different roles, exchanging.

Therefore, I am providing regular, reliable, continuous holding and containment in order for the child to build up trust in me as a safe and reliable person who will be able to manage, hold and contain his overwhelming or frightening emotions and any thoughts that may be troubling him. This enables the work of the therapy to take place.

The importance of having parent(s) on board

For some children, their situation at home is not conducive to having any form of online therapy there. Parents may be hard to reach, and do not/did not ever engage readily with meeting up with the therapist, and in these circumstances may well be resistant to their child having online sessions. There may be domestic

violence or problems relating to alcohol or drug abuse at home, and the child may not feel safe enough to talk or play about this in an online session. A child whose difficulties relate in some way or form to a family member (or members), may feel very inhibited talking or playing about this in their own home with family members in rooms nearby, in actual or imagined earshot. It is possible that a child may in fact be overheard and the parent afterwards indicate that they have heard, which could potentially be very damaging to the therapeutic work. A parent may find it difficult to grasp the importance of the boundaries around confidentiality and talk to the therapist about the child or his behaviour in front of the child in a way that makes it hard and potentially detrimental to the child's session. Many children come from deprived areas, are vulnerable and live in overcrowded accommodation, so there will be very little privacy if any at all.

Complex decisions for therapist and child

Assuming that the conditions at home are workable, moving to online sessions is clearly a big adjustment and needs to be thought about extremely carefully in other ways too. A therapist would need to feel comfortable and confident in quite radically changing the way that she works, and adjusting aspects of her role. Furthermore, what is not so often talked about is the therapist who, for whatever reason, is not comfortable or confident working online with children, and yet is feeling pressure to do so, for example from a school, a peer group, colleagues or their supervisor (with possible accompanying feelings of guilt). The therapist needs to have 'permission' to choose to not work online. It is equally important to respect the child's wishes, and have the opportunity to talk with the child about whether he wants, and is feeling comfortable with, a change to online sessions from his home, or whether he would rather wait until it is possible to resume his therapy in the usual form.

Changing from face-to-face to online sessions; the child in his home, the therapist in hers

As well as the considerations already mentioned, there are further challenges that need thought:

- For this young age group, a therapist will need to rely on the parent/carer to answer/sign in to the online session, and probably to end it too.
- The therapist will need to have the parent/carer's mobile number so she can phone them if during the session the child is in a situation that is unsafe or inappropriate.
- A therapist can ask that the child has a private space that is confidential, but she cannot control that. She may not know if someone else is in the room, or another member of the household comes in, either with or without the child's consent. The child may have a sense of family members being close, even if out of earshot, which may have a considerable impact, complicating and confusing the work.
- The child has control of his video and microphone, being able to switch them off and on at his will. Consideration also needs to be given to what would happen if the child decides to carry the phone, iPad or computer out of the room and around the home, possibly where other family members or friends are.
- The toys in the room belong to the child, so to imbue them with his difficult, sometimes powerful feelings could feel overwhelming or frightening to him when at the end of the session he is still left with them in his room. Whereas in the therapy room he leaves them in the safe contained space, and the therapist is the keeper of them, and ensures that they are there again next week.

Moving to online work involves the role of the therapist changing

The therapist may be able to work online from the usual therapy room, which could feel reassuring to a child, but equally not being able to use the familiar space and contents together in person could feel tantalising and disturbing. In other cases, it may be that the therapist needs to be in a different room, at her home for example, with an unfamiliar backdrop on her screen. In either case, a lot of thought would need to be given to how to manage and work through this with each child, and what it may bring up for both child and therapist. It would be much harder, if not impossible, for the child to keep his therapy and therapist separate from his home life. The boundaries and frame would have changed, and in part are now

shared with the parent, for example, beginning and ending sessions and maintaining the privacy and timing of the sessions.

I have heard from colleagues that some children having online therapy have found it confusing, causing them shame, worry or increased anxiety about what the therapist sees or hears in his home. For a child whose world already is or has been confusing, inconsistent or traumatic, the change to working online could very likely have the detrimental effect of his losing his trust in the therapist, or adding to his confusion about relationships and boundaries. I know that some therapists are happy and eager to make this change and have found training and support to help them, and with the right circumstances in the child's home, the sessions have been beneficial.

What happens to the therapy if online sessions are not possible or appropriate?

A regular check-in might help a child to have a sense that his therapist is still alive and able to keep herself, the room with its contents, and all that the child has played and spoken about safe and confidential until they are both able to return. The check-ins could be in the form of a regular postcard or brief phone call. They would not relate to the therapeutic work as confidentiality cannot be ensured. It would be important to be clear about frequency of check-ins, and how they might take shape. But it is worth thinking about children who may find it unbearably tantalising, or even alarming, to have any contact with their therapist outside their usual session time and place. In such cases the therapist can communicate to the child, preferably during a session prior to lockdown, or through a staff member or a parent, that the sessions will resume when everyone is able to return to school safely, explaining that there won't or needn't be any communication until then. In a school setting the therapist would need to liaise with the school about the kind of contact made with the child in their home if there is to be some, as each school will have its own protocol and General Data Protection Regulation considerations.

It is very possible that a child and his family may need emotional and psychological support at this extraordinary time. Knowing that sessions are going to be either on hold or online, a therapist may be able to offer to support, by way of working with the child's school or social worker, in thinking about what help is available in these circumstances for family and child in lockdown. A therapist will have to

carefully consider how much contact to have with a child's parent and then explain to the child what, if any, contact will be made. This can help him to feel that his unique relationship with his therapist has not been compromised, and that the therapist remains consistent to him. If a child knows that the therapist is in contact with his parent in a different way or more frequently than was originally agreed, he could feel envy or betrayal in a way that is very difficult for him to manage without his usual therapy sessions. He may of course feel supported. This is a judgement call that would need to be thought about very carefully.

Conclusion

I have highlighted what I think are the main considerations for the move to working online with primary school aged children. The list is not definitive. For each therapist, child and situation, there may be different answers and solutions. Sometimes school protocol, the family situation or lack of space and privacy at home will dictate whether online therapy is possible.

My key message is the importance of giving time, considered thought and discussion to the question of whether to move from face-to-face to online sessions with primary school aged children. I think that this is absolutely paramount, and especially at this time of emergency and panic when it can be extremely hard to focus and take time for considered thinking. The current crisis can put huge pressure on us to think quickly, make decisions and act.

At the school where I work my priority has been to discuss and liaise with the school and my supervisor about what is and is not possible in order to continue the therapy sessions with the children I see.

Together we decided that the conditions and lack of privacy are not conducive to online sessions, and for me it is important that I maintain my role as a psychotherapist who sees the child in person in the room that has by now become very much a part of their therapy. I hold the boundaries, space and confidentiality. During lockdown while I am not able to do that, I maintain regular contact with each child by sending a postcard monthly, to let them know that I hold them in mind, and that our sessions in the room will resume when we are all able to return to school. I offer my skills to help school staff to think about what support children might need during these unprecedented times, and what support the staff might need and how this can be put in place.

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Translating the group online

Chris Rose and Camilla Matthews

Psychodynamic groupwork has always been underpinned by the social and the systemic. As a therapy of the 'group' rather than the 'individual', it rests upon the mutual interconnectedness and interdependence of human existence. Its therapeutic effectiveness lies in its ability to draw on this interdependence to promote new understandings and ways of relating. A group member relates to other members, to the group as a whole, and to the facilitator, and this enables explorations and enactments of significant relationships – siblings, family and authority, for example – while always located within the wider socio-political context.

How is this affected when the group no longer meets physically but is online? How does the different setting affect the therapeutic factors? We explore this question here through concepts that have traditionally been used in psychodynamic/analytic group theory to identify the processes of group relating.

Challenging our concept of 'place'

In the context of psychotherapy, 'group' implies a secure environment, bounded by time, membership and place, within which defences can be relaxed and new growth develops. In most process or analytic groups, members are used to constraints; they meet probably once a week for a limited time in the same place, and otherwise have no contact with each other. They sit in a circle and rarely touch; bodily movements are restrained – the point is to try to find words, not actions, for self-expression.

Moving online supports some of these boundaries but has profoundly challenged our thinking about place. Instead of one room, controlled by the group conductor or facilitator, there are multiple environments that are outside her or his control. People other than group members appear on screen, pets are being displayed and admired, incoming emails ping into the conversational flow, distracting noises are heard from other rooms, the screen freezes or goes blank, members video in from cars and bus shelters, eat meals in front of the group – these are just some of the examples that might make it seem impossible to construct a 'safe place' online. But although physical space is clearly important, it is the network of relationships in the group that form

a containing web; it is this 'safe space' that we have seen survive and thrive online.

Creating new group norms

Those groups established prior to lockdown have had the advantage of a pre-existing network to rest into, while they explore for themselves the impact of the disruption of physical place. In these circumstances the group as a whole is able to talk about the impact of these breaks with traditional boundaries, and think together about new norms for the new context. The facilitator cannot dictate circumstances but can be proactive in drawing the group's attention to these boundary issues, and establishing a context in which the group can process the impact of the new space. In a new group, the facilitator will usually provide guidance and suggest ways to work in the online environment, and play a key part in establishing norms of behaviour. The new online group is given more responsibility in the creation of a safe space than its offline counterpart, which is able to rely initially on the facilitator and the group room. This early devolution of power can be a valuable experience, facilitating the members' sense of responsibility for the group's functioning and their interdependence on each other.

It is one of the central tenets of group analysis that it is a 'form of psychotherapy by the group, of the group, including its conductor' (Foulkes, 1975). The pandemic has engulfed facilitators as well as group members and their own responses are embedded in the matrix of the group. Processing fears and anxieties, maintaining the capacity to think, and being willing to embrace and explore the new group situation facilitate what Yalom terms 'the installation of hope' (Yalom and Leszcz, 2005).

Cohesiveness is necessary for the new group to establish itself – a sense of 'we're all in this together' which is clearly aided by the context of a global pandemic. The paradox is that both the pandemic and the online group environment expose the limitations of togetherness and the inequity of resources to cope with it. Differences in home environments and material circumstances are more visible online, and the group needs to move from 'cohesiveness' to 'coherence', where the web of connection can incorporate difference and

remain intact. The facilitator has a key role here in enabling the group to acknowledge and talk about difference, to help articulate what can be seen rather than collude with a selective blindness. This in fact seems to be a characteristic of online working – that the facilitator is required to be more actively engaged in the work of naming, linking and thinking about what is happening in the group.

Mirroring and resonance

One of the great strengths of group therapy lies in its capacity to provide mirroring experiences, where members see in others aspects of themselves that have been denied or repressed. Mirroring develops from the earliest interactions; looking and being held in the gaze of another, we come to see and understand ourselves through the eyes of the other. Attachment, attunement, and empathy are all processes that rest upon our mirroring capacity. The centrality of gaze in the online setting can support this mirroring process despite the lack of physical presence.

We search each other's faces, interpreting each other's state of mind, looking for nuance, meaning and recognition. Each member is 'close up', all held together in the frame of the screen, in a potentially intense emotional connection. This feeling of intimacy can foster transference relationships and fantasies of closeness or merging, while moments where eye contact is broken or disrupted can trigger experiences of abandonment and rejection. All this is powerful material for the group and facilitator to process.

At first it seemed as though we were locked into staring at each other, unable to redirect the gaze. However, with confidence and familiarity, facilitators and group members become able to look away from the camera and concentrate on an internal reality. It then becomes possible to develop a shared capacity for reverie and imagination.

Resonance is related to mirroring, and refers to our human capacity to tune in to psychological and physiological states of the other. We resonate with bodily states, feeling, narrative, drama and patterns – a complex of shared experiences. But what happens online? Anecdotal evidence suggests that resonance is still very much alive in the online group, but with some caveats.

Some facilitators have found it much harder to 'read' or resonate with what is happening in the group through sensing the energy; others acknowledge that there is a difference but the energy can still be picked up and worked with online. Perhaps the higher incidence of

interventions to link and name what is taking place points to this struggle to resonate together online. It seems intuitive that a physically present group gathered in the same location would resonate with a much fuller, noisier, richer vibration. Online it can seem as though the energy falls into the black spaces that surround each participant's image, and is attenuated.

The following vignette, a composite based on a long-term group that has moved online, demonstrates both mirroring and resonance in action. It begins with a familiar online experience where the delay in sound transmission causes a collision of words, which triggers some important experiences of not being heard.

There was a theme emerging of disabling anxiety regarding performance and appreciation in the workplace. People quickly identified with each other, and the technological problem of speaking over each other became magnified. The group seemed chaotic and noisy as the audio dissonance increased and no one seemed able to listen. Sarah in particular took each contribution and added an anecdote of her own, assuming empathy but denying any difference. Peter had shuffled back in his seat after he closed his bedroom window and he looked suddenly cut off. Susie's dogs were barking in the background so she shouted at them to go out, adding to the cacophony and sense of competitive demands. Julian said he wanted to 'spill out his week'. I interrupted, noticing that the group seemed agitated and I wondered how satisfying it would be for Julian to do this. He sat back from the screen and looked away briefly.

Lucy commented on the clamour for time and attention in the group, a fear of there not being enough space. She added that she didn't know if she was entitled to get her needs met and that she often felt invisible. Peter leant forwards and was nodding. Kate told Julian that his stories were very detailed and left no space for a reaction; she felt shut out, which was painful as she cared about him and wanted to be responsive. Thoughtfully Julian observed that, in trying to be understood, his excessive words created a self-fulfilling prophecy whereby no one understood him.

The mood of the group changed with this insight and a more reflective discussion ensued of family stories about them as babies and mothers with post-natal depression. Following a moving exchange of narratives Kate hypothesised that she, Lucy and Peter were like traumatised babies who were now 'good' and had learnt not to ask for time or help. Julian recognised how he had prevented any exchange or examination of meaning in his stories, and therefore comfort and intimacy.

He wondered if he was repeating in the group his experience of an unavailable mother. Susie was tearful and added that she felt I was more absent because of meeting online. I thought this experience would be useful to explore and asked if others felt this too?

Containment and vulnerability

There are many ways to look at what is happening here, but one concerns an anxiety about being emotionally held. Employers, mothers, therapists, each other – who can reliably understand, support and contain us? These are fundamental questions at any time, but the current pandemic and our awareness of fragility throws them into relief. In the initial lockdown, we saw clearly that society was held together by those who are undervalued – nurses, carers, delivery drivers, cleaners, refuse collectors, shop assistants. Collectively, they were providing the container and we were (briefly perhaps) extremely grateful and appreciative. But who was containing the workers themselves?

We saw that the divisive lines of privilege – class, age, race, ethnicity, ability – ensured disproportionate suffering. There was an open acknowledgment of the huge inequalities and injustices that our society rests upon. Somewhere in our minds we already knew these things, but pushed them aside because they were too disturbing and seemingly impossible, or costly, to change.

That awareness may again slip away as the pandemic situation becomes familiar and even normal. But we say in the group that once something has been articulated, even if the discussion ends, it is alive in the matrix and will resurface. The awareness may dissipate but the anxiety does not. If those doing the holding are not held then we rightly fear that we are all vulnerable. If the divisions between those with and without security, food, shelter, income, employment, gardens, smart phones, internet access, mobility and opportunities remain and grow, the threat of a system collapse is always present. The pandemic is in itself frightening but has also brought into view perhaps more disturbing features of the way our society functions.

Final thoughts

For those with internet access, online relationships have provided another version of containment. But here also there is vulnerability – the screen goes suddenly blank, speech becomes unintelligible, or the connection dies. The screen both brings us together and underlines our physical distance. It constrains us into boxes and allows us only windows through which

to communicate. Online group psychotherapy contains all these paradoxes; its therapeutic power lies in its ability to articulate and share these complexities to promote connections and resilience.

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At-risk groups

Homelessness in a time of COVID-19

Jenny McCann

Homes have been at the heart of the response to the COVID-19 pandemic. The government has instructed us to 'stay at home' to save lives. The importance of a home for an individual's physical and psychological wellbeing has long been recognised in our society, and this appears to have been highlighted even further during the pandemic. So what happens during a pandemic when you are homeless or the concept of home evokes disturbing memories or emotions of fear and distress? Homelessness can be defined as 'not having a home', which includes rough sleeping, as well as not having permanent or secure housing, such as staying in a hostel, living in unsuitable accommodation, or sofa-surfing. In March 2020, the government took unprecedented action, insisting that local authorities bring 'Everyone In', providing accommodation for all homeless people.

However, it was reported that at the end of June these contracts for emergency accommodation ended. Some authorities extended the provision, while others reverted to applying the exclusion criteria for housing that was in place before the pandemic. The government has announced further funding for rough sleepers, but there are concerns about when this provision will be available and who will be helped. Individuals with challenging behaviour can be deemed too 'high need' or not 'suitable' for certain schemes. Homeless organisations, such as Crisis and St Mungo's, have campaigned for the government to fund further emergency accommodation to prevent lives from being lost over the winter. Yet as the pandemic continues it seems to become more apparent that the idea 'we're all in this together' applies to some more than others, based on socioeconomic status.

Physical and psychological notions of 'home'

Responses to homelessness are often based on political agendas and focused on physical provision, without acknowledgment of the intrapsychic factors which cause social exclusion. There is a range of research linking homelessness to complex trauma and interpersonal difficulties (National Mental Health Development Unit et al, 2010), but in many areas there is inadequate funding for resources and a lack of access to specialist services. Gaining a safe place to live is often viewed as an essential first step, as advocated

in Maslow's hierarchy of needs and the Housing First movement. Yet many individuals are involved in repetitive cycles of gaining accommodation and then losing it, or refusing to accept accommodation altogether. My colleagues working in outreach roles said that during the initial lockdown some individuals chose to leave emergency accommodation, returning to life on the streets. It is crucial to take into account that the notion of 'home' for many people consists of both physical and psychological elements, such as shelter, safety, comfort, identity and belonging. Literature has explored the ways that a home can be seen as a metaphor for the body and mind, consisting of an external physical structure and an internal private dwelling space. An individual's first experience of home usually consists of their early environment, which builds expectations and beliefs about the nature of a home and one's relationship to self and others. A child who grows up in a disturbed and uncontained environment may associate 'home' with feelings of danger or abandonment. Campbell (2019: 58) suggests that for some, 'home is a dangerous place whose meaning is laden with anxiety, through trauma and memory, and whose form, in the shape of a house, is constantly sought, and constantly lost, abandoned, or destroyed'.

People who are homeless tend to experience marginalisation, deprivation, isolation, and suffer from physical and mental health problems. The nature of the pandemic is likely to compound these issues, especially with a reduction in support services and closures of night shelters and soup kitchens. People defined as homeless are not a homogenous group, but present with diverse histories and needs. My work has been predominantly with individuals described as chronically homeless, who have complex needs and experiences of compound trauma. I am currently employed by a charitable housing organisation to work as a counsellor within a residential hostel for people who are homeless. I offer counselling to individuals living in the main hostel, as well as those who have moved on to shared or independent housing through the resettlement scheme. The clients that I work with often describe childhoods lacking in physical and emotional safety, where experiences of abuse, neglect, and rejection were common. These homes were not havens for protection and comfort, but places of harm, distress and loneliness. A lack

of mirroring and attunement from caregivers, in conjunction with traumatic experiences, results in the development of extremely fragile and fragmented senses of self. My clients often present with insecure attachment strategies, usually with characteristics of the disorganised unresolved state of mind. I believe that trauma in the early environment can be seen as one of the key contributory factors in the lives of many individuals experiencing homelessness. According to Brown (2019: 122) homelessness can be seen as a 'psychic solution, where preoccupations of daily survival, addiction, criminality and 'revolving-door' homelessness become attempts at self-cure and mastering early trauma'.

Social distancing – the loss of a therapeutic home

The hostel is a high-risk environment similar to a care home, housing 31 residents, many of whom have weakened immune systems and multiple health issues. Recovery, creative and social groups, as well as face-to-face counselling, have largely been suspended due to concern over risk of transmission. Consequently, I have been predominantly working from home since the start of the pandemic, offering telephone and Zoom sessions. A number of my clients do not own smart phones or have access to the internet, so phone calls have been the only option. Many counsellors and therapists have experienced a sense of loss with remote working, including the absence of non-verbal communication, the lack of embodied presence, and impairment of the transference. The importance of a therapeutic space, traditionally in the form of a consulting room, has long been seen as an essential component of therapy. Yet, in work with individuals with disturbed and fragile senses of self, the physical environment can take on even greater significance.

Homeless people have been described as being 'psychologically unhoused', or having an 'unhoused mind', as the inability to secure a physical home can mirror not finding a psychological home in the mind of another during development (Scanlon and Adlam, 2006: 10). Difficulties with containment, boundaries and self-regulation can be seen to be demonstrated in behaviours such as self-harm, addiction, and self-neglect. The clients that I work with can exhibit powerful transference enactments and defensive strategies of projective identification, splitting and acting out. I have found that creating a 'secure base', physically as well as psychologically, is crucial to work with this client group (Bowlby, 1988/2005). The counselling service is housed within the hostel, offering psychological containment in conjunction with

the physical containment of the building. The hostel staff offer support for generic and practical issues, which enables my focus to be on the individual's inner world. In this way, there is the opportunity for clients to have their physical and psychological needs met 'under one roof'. I have a designated counselling room within the hostel, which can be seen as a 'holding' environment. The consistency of the space helps to facilitate feelings of reliability, while the physical boundaries of the room help clients to feel contained. The pandemic has taken away the security provided by the walls of the consulting room; therapists and clients have been evicted from their therapeutic homes. The loss of this accommodating space is likely to have a greater impact on individuals who find it challenging to feel housed within their own minds and practitioners who feel housed within organisations.

Technology can enable communication, but from a therapeutic perspective, it can be seen as a barrier to deeper connection. Signal problems, causing time lags, frozen images and sound distortions, impact on the flow of the session, the level of attunement, and the intensity of responses. Telephone sessions rely on verbal communication and pauses can be interpreted as absence, prompting the question 'are you still there?'. Winnicott (1971/1974) spoke about the importance of the maternal mirror, where an infant begins to develop a sense of self through seeing their reflection in the mother's gaze. A similar process of mirroring and attunement is offered in the therapeutic setting. So what is the impact when the maternal mirror is seen through a flat screen or not visible at all? I have noticed that, compared to those who engaged before the pandemic, newly referred clients, or clients who have not been engaging in counselling for very long, have tended to drop out fairly quickly. Clients themselves have cited remote working as being the problem or a barrier, preferring to wait for face-to-face sessions. The clients that I work with often have severe issues with trust, intimacy and dependency; the act of engaging in counselling can be extremely challenging, triggering fight-or-flight reflexes and defensive strategies. Consequently, there is a need to sensitively adapt responses and contain enactments to help clients establish a sense of safety in the therapeutic relationship. I believe that new clients have not had the opportunity to establish this sense of security, leaving them unable to sustain the impingements of remote working. The absence or disrupted maternal mirror is likely to emulate traumatic early experiences with unavailable or unresponsive caregivers, potentially leaving the individual feeling abandoned and annihilated.

Coping with the disruption of therapeutic boundaries

Remote working has resulted in changes to the therapeutic frame and additional pressures on the client, such as managing the challenges of having therapy within their home environment. These changes can be seen as requiring mentalisation, in terms of holding the therapeutic relationship and boundaries in mind. Many of my clients have difficulties understanding their own and others' mental states and at times of stress can revert back to early developmental stages. Some clients have struggled with the concept that I am 'working from home'; apologising for not coming to see me, perhaps unable to imagine me anywhere else than 'in my room' as it is often referred to, or asking if I have been bored at home 'doing nothing'. Clients have found it difficult to maintain appointment times, requesting that I 'call them back later', as if I am available all the time. The pandemic has evoked traumatic feelings of fear, helplessness, isolation, uncertainty and mortality; the external structures appear unstable and the people in charge seem inconsistent and unreliable.

These experiences have been difficult for many, but are more challenging to manage when they trigger early trauma and primitive defences. My clients have increasingly presented in states of avoidance, hypervigilance, despair and confusion, and have had thoughts of suicide or returning to using drugs and alcohol. Routines have slipped away, with individuals neglecting to eat regularly, wash, dress, take exercise, or access healthcare. Some clients feel unable to speak about difficult subjects due to the distance between us and others are unable to enact their distress in the same way, such as revealing self-harm or bringing strong odour into the room. I have noticed, in terms of countertransference, that it has seemed more challenging to contain projections and enactments from a distance, rather than in an intimate, shared setting. Despite the challenges of remote working, it has felt crucial to continue to offer some consistency to my clients during this turbulent time.

Conclusions

My experiences have reinforced my beliefs about the importance of a facilitating environment, physically and psychologically, to enable the growth of an integrated and resilient sense of self. The current climate has provoked discussions about the potential of psychotherapy to affect social and political issues. I believe that relational and psychoanalytic theories have significant value in conceptualising the intrapsychic world of homeless individuals and guiding psychotherapeutic interventions, in conjunction with

the provision of practical support. However, support and care for the most vulnerable in our society is dependent on funding, governed by political ideologies, which may not be aligned with the values of therapy such as helping all people to actualise their potential.

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COVID-19 disproportionality and the BAME community

Sonia Winifred

A member of the Windrush generation, I arrived in the UK in Brixton, Lambeth, in September 1965. I travelled with my brother who was a year older than me; aged 12, he had the responsibility not only of taking care of himself on a ship with strangers during a four-week journey, but also taking care of me. I often think back on that journey: the loneliness which consumed me every day, the long voyage, my grey surroundings on a grey ship, at times feeling so angry and so lost! Grieving for the grandparents and two sisters left behind in St Lucia. Wondering what lay ahead for me and at the same time a feeling of curiosity and dread.

After almost nine years, I would be reunited with my parents, whom I barely knew or remembered. I wondered whether anyone really wanted me. My grandparents didn't put up much of a fight to keep me with them. They had received a letter from my parents in England saying they were now in a better financial position to care for us and therefore we were to travel to England to be with them. I wanted to remain with my grandparents, but my voice went unheard – I was a child after all. I felt alone and at times questioned my grandparents' love. Klein suggests that in the earliest states of mind, persecutory anxiety is met by processes which threaten to (and do) fragment the mind (Hinshelwood, 1994). The infant's good experiences (ie being held and cared for) are attributed to the good and loving mother; the bad experiences (neglect, hunger) are linked to the bad and hated mother.

Now, as a psychotherapist, clinical supervisor and Cabinet Member for Equalities and Culture in the London Borough of Lambeth, I have often thought about my own self-preservation, given my position as a black woman within the local authority who is putting measures in place in order to keep communities safe. Wearing so many hats, supporting individuals in private practice, and children and young people in schools, yet falling victim to COVID-19 and experiencing personal loss on a scale as never imagined. For these reasons I am addressing you about a paradox.

All in this together?

On the one hand, with COVID-19 we are all confronted with an epidemic unlike anything we have experienced before. At the time of writing, November 2020, we have already seen its impact on our health and mortality, and our social and economic lives, on a scale quite beyond our grasp and previous experience. We are rightly adhering to government guidelines on how we need to conduct ourselves and we are all conscious of the government's message that essentially we are in this together.

And yet ... It is simply not possible for me to stand before you as a black woman and fail to point out the cruel fact that while the epidemic confronts us all, it is nevertheless frighteningly inequitable in the way it affects different parts of the community in Lambeth.

We all carry our own personal burdens and losses from this epidemic, and if I quickly mention mine now – my aunt Mary, my uncle Hugh, my friend Marlene and my friend Rita – it is not as part of some grim competitive game. Rather, I list these people here because – and here I return to my paradox – despite the universal tone of the government's public health rhetoric, there are profound and frightening inequalities emerging in the way that different communities and ethnicities in Lambeth and the UK as a whole are experiencing this crisis. At a time in which we have been deluged with statistics daily, hourly, and minute to minute – statistics that are often political and therefore either deliberately incomplete or else wilfully misleading – I almost hesitate to subject you to yet more. But these statistics are shocking and need to be acknowledged. They are taken from the Office for National Statistics (ONS) coronavirus data published in May 2020 (Office for National Statistics, 2020).

When adjusted for age, the figures show that black males are 4.2 times more likely, and black females 4.3 times more likely, to die from COVID-19 than white ethnicity males and females. When also adjusted for socio-demographic characteristics and health issues, they show that black males and females are 1.9 times more likely to die of COVID-19 than those of white ethnicity. South Asian people are 1.6 times

more likely to die of COVID-19 than those of white ethnicity. The ONS concludes that while the difference between ethnic groups in COVID-19 mortality is partly a result of socioeconomic disadvantage, a remaining part of the difference has not yet been explained. So, why is it that black, Asian and minority ethnic (BAME) people are not dying at this rate in their own countries? In Africa and the Caribbean, black people are not dying at anything like the rate they seem fated to do in England and the United States. Perhaps unsurprisingly, the disproportionality of BAME deaths to COVID-19 seems to reflect the disproportionality of the inequalities experienced by black people in UK society.

Despite making up only 14 per cent of the population, these groups are most likely to be on the frontline, whether as care workers in the NHS, shelf stackers in supermarkets, or bus and cab drivers. In the NHS around 40 per cent of doctors and 20 per cent of nurses are from BAME backgrounds, while a staggering 60 per cent of the adult care workforce comprises people from BAME backgrounds. This employment demographic alone places their communities at much greater risk. There is additional evidence that families who live in cramped accommodation, who are without access to outdoor spaces and who comprise large multi-generational units are also at far greater risk of transmission; again, we know that these are the housing characteristics of many BAME people living in Lambeth.

Our disappointment continues as we grapple with everyday eventualities surrounding new measures and restrictions to survive this pandemic. We are told that tests are readily available and easily accessed. This was certainly not the case when my grandson was sent home from school a few weeks ago displaying COVID-19 symptoms. In our haste to get him tested, we followed due procedure. However, the NHS support line did not recognise our postcode, and we were then referred to a test centre no less than 72 miles away.

Living with the reality of risk and loss

BAME communities are constantly informed of the risks. Several of my friends have lost friends and loved ones to COVID-19; they continue with their lives, moving almost robotically in a trance. Life goes on. In my own work, as a psychotherapist who is also involved in local politics, I find myself in a constant state of internal conflict, attempting to maintain a sense of self and coping with my own personal losses while at the same time supporting members of the community who look to me for support and advice. As a psychotherapist I am equipped with the ability to

be empathic, to listen, to recognise what is mine and what belongs to the client. Local politics has some similarities; however, I am required during monthly councillor surgeries to provide advice with a degree of caution to residents who view me as their last hope for resolving their problems and restoring order to their lives. My internal conflict is heightened by an unavoidable enmeshment, where psychotherapeutic boundaries and local authority boundaries become permeable and, as with attachment within the therapeutic alliance, the attachment within the local councillor surgery becomes unavoidable, leading to unrealistic expectations from the resident that I will make it all go away.

My worries and concerns are becoming a constant daily occurrence. At the time of writing, in November 2020, my daughter has tested positive for COVID-19 and I must self-isolate as I have been in contact with her. I have particular cause for concern because of the prevalence of diabetes in my family; my daughter, now 26, was diagnosed with type 1 diabetes at the age of 14 and my mother, uncle and one of my siblings are living with type 2 diabetes. A report by Public Health England (2020) has noted that comorbidities, occupation and obesity weren't analysed against race, but that these were 'important factors' of risk. Each was covered in a brief separate section of the report, including a mention that diabetes was listed on 21 per cent of COVID-19 death certificates and that BAME groups represented a higher percentage of COVID-19 diabetes deaths than white ethnic groups. A report on diabetes in BAME communities by Johnson & Johnson (2014: 4) stated that people from BAME backgrounds are much more likely to face socioeconomic problems and this can have an impact on health outcomes. The most deprived people in the UK are over two and a half times more likely to develop diabetes than the rest of the population. Moreover, the complications of diabetes, such as heart disease, stroke and kidney failure, are three and a half times higher in lower socioeconomic groups.

Loss of income, lack of green space

The recent review conducted by Baroness Doreen Lawrence (2020) states that past economic crises have tended to exacerbate existing racial inequalities, with BAME workers bearing the brunt of job cuts. There is already evidence of similar effects in this crisis, as some surveys have found that BAME workers are more likely to report losing their jobs, losing hours or being furloughed. Concerns have also been raised about the almost 1.4 million people who do not have recourse to public funds – a high proportion of whom are from BAME backgrounds.

In Lambeth, I am responsible for keeping our parks and open spaces available and accessible to all in the borough. During the lockdown, parks and open spaces became a lifeline for so many members of our community who do not have access to a garden or balcony. Adding to the recognised disproportionality in existing inequalities, a study conducted by Friends of the Earth (2020), which mapped out for the first time the availability of green space for people living in communities across England, found a strong correlation between green space, deprivation and ethnicity. If you are from a BAME background, you are more than twice as likely as a white person to live in areas in England that are most deprived of green space; 42 per cent of people from BAME backgrounds live in neighbourhoods with the least green space, compared with 20 per cent of white people. Lambeth was identified as the local authority with the second lowest level of access to green space in England.

A legacy of inequity

If we were to drill down behind the headline statistics, we would also find that these are the same generations of BAME people who have been subjected to inadequate education, unemployment, little or no representation in the workplace and exacerbated health and mental health issues. Would you not feel depressed if you were living in this environment day in, day out, generation after generation? Is COVID-19 to be these people's cruel and discriminating harvest? I would argue that on top of all the other horrors and hardships that coronavirus has subjected our country to, and in the way that it has singled out our BAME communities, this virus is sending us a message about the profound inequalities that still persist in our society, affecting our families, our mums and dads, our brothers and sisters, aunts, uncles, grandmas and grandads. All of us.

The disproportionate effect of COVID-19 on BAME communities continues to overwhelm, with reports, reviews and statistics being released at such an alarming rate that one begins to question the motives behind these reviews, as when we delve deeply into each report, we are confronted with the same findings. I question whether the BAME community is in danger of losing its identity and fast becoming a statistical factor in a global pandemic. Public Health England's review of disproportionality of BAME casualties to COVID-19 concludes that black people face shorter lives and greater disadvantages. This is not new or news, it is a well-established fact. So, I speak on behalf of our communities in saying that we are disappointed that in 2020 our national leaders have failed to act or show any genuine inclination to find meaningful solutions.

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Stay home: migrant responses to lockdown through a psychodynamic lens

Emmanuelle Smith

The beginning of the COVID-19 pandemic was accompanied by an emphatically clear message: 'stay home'.

'Stay home, protect the NHS, save lives' was repeated endlessly, in UK government addresses, on the radio, on the television and on social media platforms. We all heard it – but how did it resonate?

While a pandemic is by its very nature a collective experience, we know that it has affected and continues to affect us all differently, highlighting and amplifying existing social and health inequalities. But our internal worlds and personal stories too shape our responses. Here, we will look at how the early lockdown and 'stay home' message, along with the closure of borders and sudden difficulty of international travel, was received by people with a history of migration. How was being told to stay at home experienced by those for whom a sense of home might be elsewhere, shared between countries, or indeed nowhere? And what happened in the context of the therapeutic relationship, itself displaced by the need for social distancing?

Drawing on clinical examples, personal experience, and existing literature on border psychology, migration and transgenerational transmissions, I will begin to make sense of lockdown for this group, through a psychodynamic lens.

First, for the client who moved to the UK from a European country as an adult, with all of her family still overseas, the experience of lockdown was anxiety provoking, particularly in the context of Brexit. Next and conversely, for the client who moved here as an infant, and lived with family during lockdown, it proved to be a period of unexpected growth and creativity. Finally, for those, including myself, born here but with a family history of migration and exile, lockdown might have served to heighten inherited traumas.

In order to protect client anonymity in line with the UKCP Code of Ethics and Professional Practice, the clinical examples used here are fictional, non-identifiable composites. Background research included extensive discussions with psychotherapy colleagues,

who were generous in talking to me about their experiences of working with clients who had a history of migration over this period.

Zoya and border psychology

Zoya is in her early thirties and first came to therapy in 2019 in part to explore how hurt and confused she felt following the Brexit vote. Zoya is from a southern EU country but had been living in London voluntarily for six years before the referendum.

Zoya used her sessions to explore how the political climate in the UK and what she experienced as rising xenophobia might be reawakening an older feeling of not being 'welcomed' by her parents, who had expressed vocal disappointment throughout her childhood that she had not been a boy. A year into the therapy, Zoya was feeling more settled in London, and planned to stay and retrain as a nurse. But the emergence of the COVID-19 pandemic made Zoya very anxious.

At the start of our first online session, I asked Zoya if she had somewhere safe and private to talk in her shared house: 'Yes, it is private. But I don't feel safe. At home [Zoya's country of origin] they are dealing with the crisis much better. I am stuck here in this nightmare.'

Volkan (2017: 100) writes that under stressful conditions, physical borders assume high psychological significance: 'The border, perceived as a gap, clearly separates the two groups, a division that allows them to feel uncontaminated.'

Zoya felt keenly that she was on the wrong side of this gap, the side she perceived to be 'contaminated' by the virus, hence not feeling safe or at home where she lived.

We can understand the splitting that occurred ('they are dealing with the crisis much better; I am stuck here in this *nightmare*') as a sort of projective identification:

Members of one large group in conflict may attempt to define their identity through externalising unwanted parts of themselves onto the enemy,

projecting their unwanted thoughts, perceptions and wishes. For example, it is not we who are troublemakers, but them. (Volkan, 2020: 65)

As the months went on, Zoya found herself preoccupied with the language of the pandemic – which echoed that of a conflict – and related it to her feelings surrounding Brexit: ‘This feels like the worst place I could be. First they were telling us [immigrants] to “go home”. Now it’s “stay at home” all the time, and I can’t stay at home. And I can’t go home either.’

Eventually, the anxiety of being separated from her whole family under such circumstances led Zoya to decide to ‘go home’ to her country of origin permanently, and to pursue her nursing studies there. The end of Zoya’s time in London, five months after the initial lockdown, marked the end of our work together; I find myself wondering whether she feels at home and welcome now.

Jerome and mourning

Jerome is in his late twenties. He was born in Eastern Africa but moved to the UK with his family when he was eight months old. His parents spoke to him only in English, and he has never been back to his birth country; he has no conscious memory of it. Jerome’s mother died when he was 16. He came to therapy one year after a relationship break-up that Jerome felt he should be ‘over’ by now. Over a few weeks, we had begun to explore how some of Jerome’s intense feelings of loss and grief surrounding the break-up might be connected with the earlier loss of his mother. Unlike Zoya, when Jerome was directed to ‘stay home’ with his father and siblings during lockdown, he felt safe and secure.

From the containment of his family home, Jerome began to expand his social life – including in ways that connected him to his country of birth. A month into the lockdown, he said, ‘I have started learning my mother tongue, I’m taking language lessons online and it’s incredible, there are people from all over the world in the class, all wanting to learn it together.’ I noticed that rather than naming the language, Jerome had used the term ‘mother tongue’, and together we wondered whether a process of reconnecting, both with his mother and his motherland, might be at play.

Over the following few sessions, Jerome told me of other ways he was getting closer – at least virtually – to that country, including taking online exercise and cookery classes that were broadcast from the city he was born in but had never returned to.

Moro (2002: 55) writes that the children of migrants are ‘vulnerable’ at three stages of development, one of which is adolescence, which is pertinent here. At an age where Jerome might have been particularly at risk of psychic suffering anyway, he lost his mother. We could understand, therefore, that the task of mourning, ‘an obligatory response to a significant loss’ (Volkan, 2017: 13), was not completed for Jerome.

An even earlier loss, that of a whole country, preceded Jerome’s loss of his mother, and was also not mourned. Indeed, for very young migrants, there has been no ‘stabilised object constancy of people, pets, and things lost’ (Volkan, 2017: 36) – and in Jerome’s case, I would also add language.

The stillness and enforced weeks at home during the lockdown, along with hitherto inexistent opportunities to connect via online classes, enabled Jerome to begin to interiorise the language and culture of his motherland and to begin to stabilise it as a constant object, something he had not had a chance to do in infancy.

Anne Frank and transgenerational transmissions

When schools closed in the UK in March 2020, my daughter started to keep a diary. She is interested in history and believed that a record of this period, through the eyes of a young person, might be ‘of interest to future historians’. She also began reading diaries, and one day exclaimed, ‘Wow, we’ve only been in lockdown for 42 days and so far, Anne Frank has been in lockdown for five whole months!’

I had been experiencing a sort of nameless dread (Bion, 1962) since the start of lockdown, and out of nowhere, my daughter’s words harrowed me, speaking directly to that dread. I too had read the diary of Anne Frank as a child – and know that it ends in tragedy. I realised then that I had made unconscious connections between Anne Frank’s story, her hiding in the annex, and the ‘lockdown’ that required us to hide away at home.

Months later, I would learn that a client of one of Volkan’s supervisees had also brought Anne Frank to one of his sessions during the lockdown period (Volkan, 2020:119). I was able then to name that nameless dread as inherited historical trauma, which Anne Frank and her diary had come to symbolise.

Frosh describes inherited traumas as hauntings: **It just meant that there was always something in the background that haunted the present ... something**

like a mist that slightly obscured the details of everyday life, fading the colours a little, infiltrating the small nooks and crannies of our imagination ... Something that is supposed to be 'past' is experienced in the present as if it is both fantastic and real. This is especially the case with suffering. (Frosh, 2013: 1–2)

Moreover, as a dual national and second-generation immigrant with a long family history of displacement, like Zoya I had felt uneasy about the closure of borders. Although I was at home in London and had no desire to go anywhere, the knowledge that I couldn't easily leave the country was nonetheless difficult to bear. Perhaps a need, 'both fantastic and real', to know I could leave the country in a crisis may have been transmitted to me, wordlessly, through the generations.

Conclusion

I have been interested here in reflecting on the early lockdown and 'stay home' directive as experienced by those with a history of migration, because of my work over this period and also my own story. But I hope I have demonstrated that even within these parameters, there is such diversity – and so much more that hasn't been touched on and to continue to think about. For example, how might a refugee who has arrived in the UK in search of safety respond when the present danger, COVID-19, knows no borders? Will the combination of Brexit and the pandemic affect European citizens, like Zoya, in particular ways?

Crises can be unifying, and over the past few months I have observed a trend, among psychotherapists and more widely, to repeat that 'we are all in this together'. Of course, to some extent that is true. We have all been subject to the same government measures to prevent the spread of the virus. All of us might have lost or feared the loss of loved ones. The therapeutic encounter itself has been transformed, exiled from the consulting room and conducted instead online or by telephone. All of us are living with uncertainty.

But in trying so hard to find commonality, we risk losing sight of the different meaning that each one of us gives to events, based on the imprints of our pasts and our unique ways of viewing the world. So while COVID-19 will be experienced by some as either a first trauma, or the repetition of one, for others, like Jerome, it will be something else entirely. In making generalisations, we could impede our capacity to truly listen to our clients. In saying, as I have done, that all of us are 'living with uncertainty', or 'in anxious times', aren't we erasing the experience of many of our clients, for whom both of these statements were already true?

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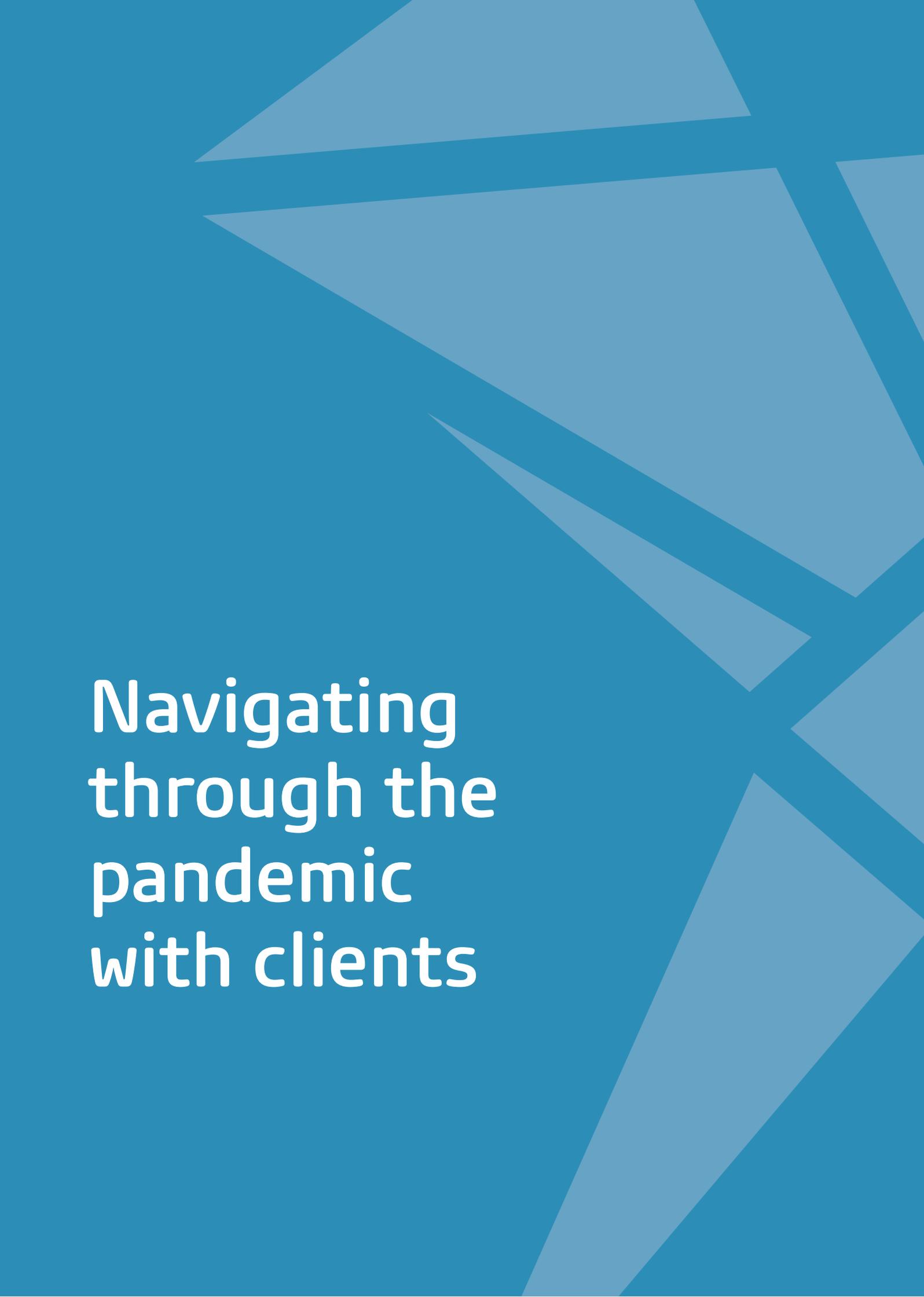
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Navigating through the pandemic with clients

Locked down, locked in, locked out: the experience of staying at home from the perspective of relational integrative psychotherapy

Garthine Walker

In my therapy practice, which I moved online in mid-March 2020, my clients have shared their hugely different experiences of lockdown. Because I work relationally, their experience has impacted on mine. We already know from numerous media reports that people's experience of lockdown has varied. We are aware of many material and mental health challenges arising from attempting to juggle home working, home schooling, and maintaining a relationship with our partner while being together 24/7. Charities meanwhile have reported an increased incidence of domestic violence. While some people have experienced heightened loneliness, others have found that staying at home and adhering to social distancing measures has provided relief from the pressures of social and professional interaction. In this article, I want to explore another contributing factor to individuals' experience of lockdown that has emerged in my clinical work: that is, the significance of past experiences of having one's freedom restricted, being told what one can and can't do, the potential threat posed by strangers, and so on. For many of us, the last and possibly only time we experienced anything similar was when we were children or adolescents.

For some of my clients whose childhood and adolescent experiences were traumatic, lockdown conditions have been especially triggering. Exploring those issues in therapy has made sense of what were otherwise bewildering responses and has allowed a holding or working through of salient issues. In some cases, awareness alone has made all the difference, but for others, new, rich areas of work have presented themselves as our therapeutic relationship has deepened and changed along with the circumstances in which we found ourselves. It is difficult to imagine a time when a therapist and all their clients were affected by the same 'field conditions', to use a Gestalt term. As a relational integrative therapist, I have been very aware of what my work has meant for me as well as for my clients. I have used my own personal therapy and clinical supervision to track my own needs. Just as a parent's self-love creates a secure child, tracking my own internal stability during the months of lockdown was essential to, and partly a consequence of, my client work. In what follows, the

'clients' whom I discuss are composites of more than one person, with identifying features changed to preserve confidentiality and protect anonymity.

The emotional impact of lockdown

In the weeks following the introduction of the national lockdown, the impact of coronavirus, lockdown and social distancing were figural in almost every therapy session. At the beginning, several clients were affected in immediate and intimate ways. More than one was a keyworker delivering frontline services; another was separated from the rest of their family who lived abroad in one of Europe's worst-hit areas; others faced redundancy, or the prospect of what turned out to be months alone in a tiny bedsit with no garden.

For some clients, the regularity of weekly therapy, albeit online rather than face to face in the therapy room, was the only continuity with their pre-lockdown lives. For certain individuals I was their only regular personal contact. Even for those who now worked from home, I could be the sole person outside of work meetings with whom they spent time. And clients who were locked down with family, including those with young children, found that their therapy slot comprised the single hour in the week they had to themselves. As a therapist, I found 'holding' clients in ways that promoted co-regulation personally exhausting but also stabilising for me.

Lockdown produced in several of my clients intense and overwhelming feelings. From a psychotherapeutic perspective, the enormity of the demands placed on individuals produced a profound felt sense of vulnerability, helplessness, and lack of control. Such conditions have the potential to be trauma-inducing. As Judith Herman (1992: 33) explained, 'Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.' Yet here we were in a situation where a swathe of the population had lost the ordinary systems and routines that provide individuals with just those things. Moreover, the ongoing uncertainty around when (or if) lockdown, social distancing and other measures would end created a context that

struck me as having similarities with those which in early life are associated with the development of complex trauma and insecure and disorganised attachment styles. I was therefore not surprised to find clients sharing in therapy their bewilderment at finding themselves re-embodiment or intensifying adaptations that we understood as responses to early relational needs not having been met. In these early weeks, therefore, we spent much time on grounding and stabilising techniques and resource building within a context of steadfast contact-in-representation (Erskine, Moursund and Trautmann, 1999).

Exploring the relationship between past and present

As clients stabilised, I invited them to be curious about their experiences. By turning their attention inwards and focusing on their embodied experience, new information about the developmental territory we were in came to light. What was the 'texture' of their felt sensation? If the sensation had an 'age', how old would it be?

Jayne likened her frustration to that of a toddler who was prevented from exploring the world and had had her toys taken away. She felt the urge to have a tantrum. By welcoming that toddler 'part' into the therapy room and acknowledging its frustration, we were able to explore together how Jayne might alleviate the pressure of frustration in the here and now. Yet we were also able to explore how it was for her growing up in a family where, it turned out, she literally did have her toys taken away in punishment for expressing anger, and the impact of that on her relationships in the present.

By contrast, Pete was reminded of how he used to feel every Sunday throughout his teenage years. In the small town he grew up in, all shops and recreation activities were closed for the whole day, and his parents adhered to the chapel's rules of no frivolous pursuits on the Sabbath. He grimaced as he remembered the tedium of waiting for Monday to come around so he could go to school and have something to do. Lockdown for him was effectively several months of Sundays, stretching out before and behind him. Lockdown provided us with an opportunity to experiment with how it was to 'be' in the present rather than rush to focus on what was to happen next.

Stacy is a client in her forties with whom I have been working for almost three years on issues relating to complex trauma. Stacy believed that the national lockdown was necessary and desirable. Working from home, she had no desire to return to the office or to meet friends indoors or outside. Yet she was

perplexed by a felt sense of disquiet about having to stay at home and having to abide by rules about how often and for what purpose she might leave the house. In our curiosity about if, and when, she had experienced something similar in the past, specific memories of her lack of agency throughout her childhood and adolescence began to come into her awareness. We had previously touched on aspects of the restrictions her parents had imposed upon her where they related directly to other facets of our work. However, we had not yet explored them in depth in their own terms. Now, Stacy realised that the emotions and felt sensations she was experiencing were similar to those of her everyday life until she had left home aged 18. While living with her parents, she had not been permitted to take an apple from the fruit bowl if she were peckish, nor to enter the kitchen and make a drink if she were thirsty. Even the temperature and depth of her bath water, and when and how often to wash, were determined for her. She had spent many hours alone in her room, was rarely permitted to leave the house for any reason other than to go to school, or to have friends to visit. Rather than being retraumatised by these memories, Stacy and I explored them in the context of what it had meant to her to have had so little opportunity to identify her own needs and learn how to meet them. Building on the work we had already done, and by introducing at first low-risk experiments, Stacy became more confident in identifying her needs and preferences and establishing healthy boundaries with family members and colleagues. With a new-found courage to try out trusting herself, her experience of lockdown became – paradoxically – liberating. In her words, she began to give herself permission to make choices that her parents had denied her.

Another client could not at first understand why they felt a constant sense of dread even in their own home, where they usually felt very safe. This person had grown up in a household environment dominated by one parent's coercive control from which escape had not seemed possible. During lockdown, being 'trapped' in the house, being prohibited by Welsh law to leave home more than once a day even for exercise, reactivated a familiar past sensation of lack of safety within the home and a renewed tendency to dissociate. Our work returned therefore to a focus on phase one stabilisation (Rothschild, 2017), but also to an exploration of 'how old' they felt in those moments. By getting in touch with a particular developmental stage – in their case around 12 years old – they shared and processed in therapy the lasting impact on them of a particular episode. We did this without discussing the details of the episode itself. Our work took a

new direction as we explored the ways that an inner 12-year-old continued to negotiate the client's adult friendships. Consequently, the client, now in their mid-twenties, found themselves making different choices in how they related to the friends with whom they shared their home. They were thrilled to discover that being more open enriched their connection. Rather than resulting in greater feelings of vulnerability, they in fact felt more supported. In addition to the stabilising techniques that they had reintroduced during and out of our sessions, this new awareness and behaviour helped the client re-establish and develop their tacit sense of the difference between 'then' and 'now'. In turn, this allowed them to celebrate their sense that they had survived, that things could change, and that they had access to a strong part of themselves who could continue to keep their vulnerable part safe, even in the midst of a pandemic, without dissociating or hiding in other ways. During subsequent lockdowns, their experience was noticeably different from the first.

Acknowledging shame

Attending to how our childhood and adolescent experiences inform our experience in the present provided an opportunity for increased awareness. But I do not wish to give the impression that my therapy room has been filled simply with enrichment and growth during the pandemic. Although there is insufficient space to develop the points here, it is important to acknowledge that for many people, lockdown has been accompanied by an intensification of shame. Of course, we know that shame is a common response to attachment deficit, lack of attunement, abuse and neglect. Indeed, complex trauma itself may originate in the shame of early relational trauma (Schore, 1998). But all around us, the coronavirus has brought shame into the field: the shame of being made redundant; the shame of having reliable employment while others struggle; the shame of loneliness, or of being fearful. I could go on.

Shame is above all a social emotion. It exists in relationships and the pain of being out of connection, of being isolated and exiled (Lee and Wheeler, 2013). The shame work I am doing with my clients is slow and delicate. It cannot be rushed. Its pace and depth must be carefully regulated so as not to overwhelm. One path to children's recovery from traumatic experiences is the support from caregivers who enable them to feel safe, secure and protected. For adults, being in a relationship with a therapist may facilitate and support similar healing. Naming their shame has already provided some relief for my clients. But I suspect that shame-induced trauma and trauma-induced shame will be present in the therapy room for some time to come.

Final thoughts

I continue to reflect in my personal therapy upon my own ability to hold firm in such choppy seas. I feel anchored and safe enough in myself to do this work. For me, lockdown and social distancing have not triggered my earlier traumas and shame. I acknowledge how far I have come, for it has not always been so. I grew up with nothing firm to hold on to, and experienced time and again what was dear to me being snatched away and destroyed. I have experienced being locked in by restrictions and locked out of safety and relationships, having been abandoned by caregivers and been made homeless as a teenager. Exploring the impact on me of my clients' experience of lockdown, I feel much gratitude for my own healing achieved through long-term relational psychotherapy, reparative personal relationships, and good fortune.

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Unprecedented! The COVID-19 pandemic risk maze and what psychotherapy can offer

Dr Helen Molden

Holding different aspects of risk, defined as the likelihood of an event happening with potentially harmful or beneficial outcomes for self or others (Morgan, 2007), is paramount in the collaborative work we do with our clients.

COVID-19 slid invisibly into our therapeutic spaces early in 2020, and proceeded to elevate risk assessment and management to an unforeseen level. New terms such as 'lockdown', 'shielding', 'self-isolating' and 'social distancing' were adopted into the vernacular, old assumptions challenged, and issues such as safeguarding made more difficult. Services where clients could turn for support were soon at reduced capacity or under financial threat.

The dynamics of risk, how we communicate, and signal to others, are now figural. On the personal and interpersonal level, we draw boundaries according to health circumstances, values and beliefs – client and therapist included. On the societal level, as human beings we routinely underestimate risk as a species, and fail to act pre-emptively towards more effective outcomes, finding ourselves mid-disaster (Ord, 2020). On the psychobiological level we are human beings, primed for relationships (Fairbairn, 1952), who now harbour the possibility of illness or even death – the existential fear of annihilation writ large.

As clinicians, we assess matters of safeguarding, suicidal intent, trauma and fear, acknowledging that our essentially uncertain human state means risk cannot be eliminated, nor harm minimised. Though recently, rhetoric and planning around COVID-19 has arguably given the opposite impression – for example, that it is possible to be 'COVID secure'.

Below I consider the first nine months of 2020 and how as psychotherapists we are well placed to support clients through the pandemic risk maze, and inform debate at multiple levels of society – asking important questions such as, 'How is individual risk tied to context?' and, 'Whose risk is it?'

Beginning – an uninvited guest

COVID-19 crept unseen into my consulting room in children's outpatients throughout January and February 2020. My work at the hospital involves providing therapy to young people and their families living with acute or chronic physical illness. The changes to practice in early March were sudden and surreal: the focus of my practice, where, how and who I was to see all shifted. COVID-19 demanded that I move to remote working, running clinics, workshops and team meetings from home, peering into my patients' homes, holding sessions while they juggled family life, with children no longer attending school.

On a personal level, COVID-19 forced me to recognise that my genetic lung condition placed me (and my family) into the shielding category. (The image below is one of several art projects I undertook to help process the range of emotions involved in shielding.) In this acute phase of learning about and living with COVID-19, the layers of life for all of us were stringently peeled back to their essence, with long hair, local exercise walks, family quizzes on Zoom. In the therapeutic space, issues around family, health, work and self entailed sometimes intensely painful choice-points for clients – if I go to work, what will I bring back to my family?

Two aspects within my clients' processes struck me in lockdown (both similar to my work with families processing an acute or chronic health diagnosis): the first a pull to fix, to control the risks, and the second, an immediate focus on what really matters.

The pull to fix, to do, to control the unwanted situation often comes alongside bargaining, anger, denial and other strong emotional themes. Supporting the client in reaching expanded levels of awareness about their position, from which they can choose to move forward, remains central.

The second process concerns values, and a focus on what is at risk – who you care for and what really matters to you. Keyworkers excepted, the initial lockdown allowed many of us an unparalleled opportunity to pause and reflect, when the usual

more than Zoom can offer, good though it is to have that option. The missing embodied piece, especially between family members in different settings, has been one of the hardest aspects of the pandemic, particularly as we enter the winter period.

COVID-19's shadow across my NHS work and private practice has made me more watchful for the families I and my colleagues work with, whose children may be facing extra difficulties at this time, with parents out of work, or reduced support for their physical or educational needs.

For some parents working from home, there is a potential risk to sense of self, occupying a 'double articulation of space'. This phrase, coined by media geographer Roger Silverstone (1999), refers to people conducting their lives and wider social engagements across online and offline spaces using media technologies. For some the complexity of roles and boundaries, or the demands of work versus home life, have led to increased anxiety, lack of sleep and other signs of stress. This complexity seeps into family attachment configurations, such that strains occur, previously mitigated by individual family members having wider day-to-day social contact, or managed through self-care strategies such as the gym or hobbies. This is particularly the case when a family has suffered bereavement through COVID-19, where loved ones are often physically detached and unable to say goodbye in hospital.

As therapists seeing these attachment dynamics under increasing strain, we should perhaps have a lower threshold for consideration of how we might offer clients or colleagues in our lives support. For example, attending to a client's basic needs through signposting to local services/projects is a key part of actively considering the ways we might help mitigate risk.

Ending – reframing the COVID-19 nemesis narrative

COVID-19 keeps us all in the pandemic maze as the ground shifts. Health and educational risks have increased as the pandemic moves into a more chronic, endemic phase, having a long-term impact ranging from unemployment and missed educational opportunities to non-COVID related healthcare. Working in paediatrics, I am particularly aware of those missing out on developmental milestones once taken as fundamental: exams, birthday parties, family weddings.

Together with these losses, it seems appropriate for me, as psychotherapist and parent, to practise

and model Winnicott's 'good enough' (1973), make time for self-compassion, and help to scaffold young people's emotional and cognitive journeys as ordinarily expected life events shift. With parents often anxious about missing or disjointed childhood experiences, it is helpful to remind them of the benefits of fluidity around developmental experiences, efforts and achievements.

We don't yet know how the COVID-19 narrative will end, or whether there will be an end in a meaningful sense. One strand of the story, at least in an economic sense, ended once we realised that continual lockdown may kill rather than cure. Progress towards a possible vaccine promises a potential medical end, or at least a significant reduction in the virus's fatality. We hear phrases from journalists and commentators such as 'back to normal', resonating in our psychotherapeutic work where, after experiencing loss, clients often desire life 'to return to how things were'.

Yet, it can be argued the risk is greater in wishing for life as before; we miss the chance to benefit from the shift. Instead, we can use the heightened awareness of living alongside COVID-19 as a way to reframe, reset and recalibrate our lives, professional and personal, positioning ourselves within our own narrative. This was something that shone through the stories presented in the Channel 4 television series *Grayson's Art Club*, which encouraged celebrities and viewers to create their own lockdown art and experiences.

Early on in the pandemic, Balick (2020) envisioned COVID-19 as a 'disruptor' to the psychotherapeutic profession, arguing we should be thinking about 'getting back to business as unusual' and 'open to revisioning psychology itself for a new era'. I agree with Balick that if psychotherapy as a profession chooses to return to the traditional therapeutic hour in the therapist's office, it risks losing the opportunity to offer the flexibility and increased accessibility of a blended approach. With attention to boundaries, working alliance and risk assessment, therapy by text, phone, laptop, or even within a game such as Minecraft, can reach new audiences.

Psychotherapy demands a forensic examination of language, pace, phenomenology and tone to help us better understand our clients and what they bring. Through these skills too, building hypotheses from detail and context, and, within a trusted working relationship, we can discuss positive risk taking, even when lost in the maze. One excellent model that offers a discussion of balance and risk, where participants identify their strengths, resilience and skills within

a whole person view, is the narrative therapy group approach Beads of Life (Portnoy, Girling and Fredman, 2016), within the context of living with cancer.

The variety of strands of life are acknowledged through the Beads of Life group peer workshop (an approach I have adapted for group and individual support of teenagers with type 1 diabetes). Adapting such workshops for a wider audience in future years will be critical as we rebuild our sense of identity as individuals and as a community, supporting our clients as they face the processes of rupture and repair happening in their lives as a result of the pandemic. Working from an integrative theoretical base using metaphor and narrative around illness as an uninvited family member, I often ask what kind of ending the client (and their family) would choose if COVID-19 joined them uninvited at home and in their lives, and what that might look like.

Thus, offering people an opportunity to come together physically, when we can, and reflect in group settings on the impact of COVID-19 on their lives, will be an important role for psychotherapy. In addition to the excellent online and telephone work offered by counselling and psychotherapy colleagues in charities at this time, my hope is that we can extend this work into the outdoors. Offering accessible community group-based encounters in local parks, forests and green spaces, gaining the advantages of a nature-based therapeutic background, as we consider loss, connections and climate post COVID and how we want collectively to move forward.

This has been a brief consideration of risk, through a psychotherapeutic lens, at a specific time and place (October 2020, UK) when COVID-19 dominates almost every aspect of how we relate. My hope is that it has provoked some thoughts for you and your practice, as we all take a deep breath and move forward.

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Using trauma-informed principles to develop short-term, relational approaches to psychotherapy

Beth Glanville

Research into people's recovery following major disasters or trauma suggests that more than 70 per cent will not experience severe psychological impacts due to the COVID-19 pandemic (Robertson, nd). For those who will experience greater levels of distress, it is vital that we consider how best to work in a way that provides effective support and sustainable improvements in health. And we need to do this within resource limitations that will prevent us from providing the depth of support we might ideally like.

Trauma-informed approaches

Psychotherapists working within a trauma-informed framework are tuned in to how current difficulties can be contextualised through a client's history. Practitioners recognise that trauma survivors commonly, although of course not exclusively, seek support because of contemporary difficulties rather than past trauma itself. They understand that 'trauma is viewed not as a single discrete event but rather as a defining and organizing experience that forms the core of an individual's identity' (Fallot and Harris, 2001), although not necessarily in an inflexible manner that cannot respond to intervention.

They recognise the longstanding and far-reaching impacts of childhood trauma on individuals, families, communities and society. They foreground the likelihood that their clients have at least some level of trauma in their histories, regardless of their presenting issue, given that 'adult survivors of childhood trauma account for a majority of individuals seeking or required to seek clinical services' (Knight, 2014).

Many clients do wish to undertake the in-depth and exploratory therapeutic work that allows for greater recognition and understanding of the impacts of past trauma on their present life situations. However, this does not mean that all clients are necessarily looking for, or need, trauma-specific therapy, ie to work directly on processing specific traumatic incidents themselves. In cases where clients do not make, or do not wish to make, links with early experiences that remain unintegrated, attempting to push them to do so can feel

threatening. Indeed, to those who have experienced abuses of power, it can be reminiscent of past experiences. This can potentially worsen symptoms and in turn increase the risk of decompensation.

Without taking such findings fully into account, therapeutic practitioners, as well as wider service staff such as allied professionals and administrators, can inadvertently hinder, or even re-traumatise, those they are supposed to be helping. This can happen when, for example, clients are asked to talk prematurely, and/or in too much detail, about an overwhelming experience, or when clients become retriggered, perhaps by loud noises, inflexible policies, or conversations that can be experienced as retriggering of abuse dynamics. It can happen when individuals are questioned extensively about previous traumatic experiences and become flooded, or when clients 'spill' about further difficult experiences in their past and are not contained.

These phenomena are particularly dangerous in services that can't provide the longer-term support that would be needed to safely work through trauma histories to the point of integration, as will be the case with many clients seeking therapeutic support due to the pandemic. Such experiences can also increase the likelihood of premature termination of therapy, with services operating under 'revolving door' policies as underlying trauma responses get retriggered and play out time and again, yet never become contained or get worked through. This can impede, or completely stymie, any sense of progress, and of course incurs major and wide-reaching social, welfare, and economic costs.

As the findings cited above suggest, it is likely that many people seeking support during and in the aftermath of the pandemic will carry complex psychological backgrounds. In my recent clinical practice I have seen an increase in referrals of such clients, who have – for years, maybe even decades – found solace and support in, for example, work, social support, community groups, religious communities, volunteering, and the regular rhythms

of their weekly routine. Many of these clients are now struggling to manage with the disruption to and disintegration of such holding environments, and report feeling untethered, directionless, isolated, and lacking meaning.

In such instances it is not uncommon to see a retriggering and resurfacing of previous trauma histories and attachment difficulties, with clients struggling with the intense affect and potentially confusing emotional responses that accompany such phenomena. Many of these clients have been far too triggered, ungrounded and vulnerable at the time of referral to work through deeper and more historic trauma. Even to consider doing so would require treatment for much longer than the service is able to provide.

SPACES approach

My original training and experience as a long-term, integrative practitioner has enabled me to develop a particular means of working within short-term approaches. In this way I will hold and contain many of the complexities of an individual's presentation in the frame, in a way that informs my interventions and the trajectory of the work, but will not necessarily explore and work through this material in a way that longer-term therapy would permit. Thus the therapy can provide a level of trauma resolution, while resourcing and stabilisation ensure that the work remains safe and clients can be appropriately held in, and subsequently safely discharged from, short-term services.

I have conceptualised a trauma-informed model of approach, which I have entitled SPACES (safety, pacing, attunement, collaboration, empowerment, social support). SPACES integrates a set of principles within a client-focused, relational model of delivery, constantly informed by an understanding of the client's deeper dynamic. Boundaries are implemented 'as flexible standards of good practice, rather than forbidden behaviour' (Gabbard and Gutheil, 1998). I will lay out the initial conceptualisation of the framework below, incorporating a composite case study of a client whom, for purposes of anonymisation, I will call Alex.

Alex came for six sessions of therapy, struggling to reconnect with the world as initial lockdown measures eased. Assessment indicated a significant trauma history, presenting through withdrawal, and generalised feelings of let-down and anger, stemming from the transference of feelings of the 'bad parent' onto those in power.

Safety

It can take time to develop a good therapeutic relationship, and there should be no expectation of automatic trust in the therapist. Allowing myself to 'be human' with clients who appear anxious can go a long way in helping to develop a sense of safety. As Alex demonstrated an anxious attachment stance, initially I would respond to comments about the weather, or give a generic answer when asked about my weekend, recognising that Alex wasn't so much looking for answers to questions, but for contact. When I took an unplanned week off Alex was concerned about whether I had had COVID-19, and I responded that I believed so. Revealing a part of myself in this way allowed for a moment of meeting between us, and after this session Alex stopped asking about me, becoming more comfortable in taking up space in the relationship. I believe that initially responding in line with shared cultural norms supported a highly anxious client in settling into therapy, contributing to building a relationship that enabled the client to feel safe enough to engage.

Pacing

In the initial session post assessment, Alex started to talk about the past. Alex appeared disconnected from the narrative itself but in some thrall of emotion, although this did not feel 'live'. When I interrupted to ask if this felt helpful Alex answered in the negative, as expected. They stated that talking about the past always resulted in ruminating for the rest of the day, but wasn't all this talking about childhood what I, as a therapist, wanted? I explained that we were not going to jump into narratives of trauma histories due to the risks of retraumatisation and overwhelm. I said that we were here for the client, not for me, with the aim of helping the client to feel better in the present, which may or may not, at any point, involve delving into the past.

Alex said that it was a relief to know that there was no obligation to talk about the past, as all they really wanted was to be able to feel 'normal' again. Having had experiences previously of opening up too much too early on in therapy, and seeing the negative impacts of this on clients who are yet to be stabilised and resourced, I now err much more on the side of caution (Rothschild, 2017).

Attunement

As with all good therapy, attunement to the client's process remains vital, but I don't always get this right. Sometimes I mis-attune, or sometimes I feel lost in the process and struggle to 'meet' a client. I find that taking responsibility for and working through these moments can allow for re-attunement and more profound

understanding, which can go a long way with a client who has not had such reparative experiences in the past. Alex reflected that they were unfamiliar with the experience of someone giving space and time in order to ensure their understanding, and that my ability to own and take responsibility for misunderstanding, and work with the client to ensure my understanding of the experience, was significant in itself.

Collaboration

Although Alex had started therapy with the expectation that I would lead on the work and 'tell [Alex] what to do to make it all better', I spent time drawing the client out of compliance through working together on a plan of action for our sessions. With gentle encouragement, Alex led on goal setting, initially around behavioural activation and re-connecting with others in ways that felt safe and accessible for Alex in relation to COVID-19 restrictions, with both of us then 'reality checking' the goals to ensure they remained attainable. Over the course of our sessions Alex started to take sole responsibility for goals and behaviours. Thus we were able to incorporate some gentle healing into the work, which would have been missed had we not given space for this shifting of responsibility.

Empowerment

Clients should never be infantilised, and 'power-over' relationships are, of course, to be avoided. The administrative team working in the service that referred Alex to me had all received trauma awareness training. When booking the initial counselling assessment over the phone, Alex became overwhelmed and had a panic attack. Although the administrator was not aware of why this had happened, because she is trauma-informed she understood the need to give the client space and support to help manage the panic attack. When the administrator attempted to resume the conversation, Alex asked to call back later in the day to book the session, which was agreed upon. Alex later reported that had the administrator pushed on with the conversation they may have withdrawn from the service.

Social support

Trauma-informed services recognise the importance of good social support in moving towards healing. Over the first lockdown, Alex had completely withdrawn from social connection. This was in part due to the difficulties of remaining in contact with others during this time, but also because while Alex's cultural background values familial connection, it is considered important that individuals always present

their 'best self' and do not let others see when they are struggling. Alex was under the impression that talking about feelings was necessary, but did not know how to align this with their cultural background, so felt it easier to withdraw altogether. We spoke about how Alex could start to allow contact with others while deflecting attention by preparing some 'stock' answers to questions such as 'how are you?' and 'where have you been hiding?'. This increased a sense of control around being with other people, and meant Alex was able to access social support without constantly feeling the need to explain themselves.

Final thoughts

At the end of our initial sessions Alex reported feeling more comfortable about therapy overall, as well as better able to manage with the restrictions that were in place, and indeed any future lockdown measures. Alex reported that past struggles felt 'settled in the past' once more, rather than as if they were replaying in the present, as had been the case on starting therapy. Getting initial 'buy-in' from the client had enabled the creation of a space where we could remain aware of and alert to the past, and the client's deeper psychological dynamics, in order to better understand what was happening in the present.

Over the course of the sessions I used material Alex revealed, both directly and indirectly, about life context, trauma history, attachment style, patterns of relating, and understanding of psychological processes, to inform my interventions and management of sessions. While we were not able to fully process historical trauma, Alex did tap into the past and make links between prior experiences and contemporary struggles. This helped in working through some of the present difficulties from a more reflective stance, in turn providing an element of trauma processing in the therapy. Thus, within the context in which we were working together, the short-term SPACES approach allowed us to work purposefully in the present to help the client function better in the here and now, as was their initial aim.

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