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A Frame That Bent, But Did Not Break: Understanding how change to the therapeutic frame can impact upon an established parent-infant psychotherapy and under-fives art psychotherapy service.

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Abstract

The impact of change can feel both liberating and destructive. This paper discusses the impact of change within an experienced parent-infant psychotherapy and under-fives art psychotherapy organisation, referred to throughout as the 'Service'. The change refers to the Service's loss of an established working alliance with a professional network including a Centre Manager, a team of Health Visitors, Outreach Support Workers, Nursery Teachers and Administrative Assistants. The work alongside these allied professionals ended when their organisation went through significant structural changes. Key areas to be discussed will focus on the impact of change upon the Service's organisational system, the therapeutic frame and the therapists' and clients' experiences.

Keywords: Art therapy, therapeutic frame, parent-infant psychotherapy, transitions, containment, projected processes.

Introduction

The core theme of this paper is the significance of change on the therapeutic frame and how the frame functions to contain the therapeutic relationship with the client. Understanding how disruptions to the frame can potentially disrupt the containing function of the therapeutic relationship is key.

The paper will begin by exploring relevant theoretical concepts about the therapeutic frame. These theories will be drawn upon later in the paper to understand how external changes impacted upon the therapeutic frame of the Service and the internal processes of the therapeutic relationship. An outline of the Service, its purpose and the specialised therapeutic interventions for parents-infants and under-fives will follow. The paper then continues to identify how the externally generated changes influenced the working partnership of the Service and the team of Health Care Professionals and how, in turn, this created a need to re-structure the Service. The restructuring of the Service in response to the external changes significantly impacted on and changed the therapeutic frame.

Three key areas will be explored to understand the repercussions of the changed frame upon: the organisational system of the Service; therapists; and the parent-infant psychotherapy and under-fives art psychotherapy provision. The conscious and unconscious processes that affected the institution as a whole, the therapy team, their clinical supervision and the parent-infants and young children that used the Service will be discussed to explore the parallel process that arose.

The Therapeutic Frame

The psychoanalytic understanding of the therapeutic frame describes how the regularity of the same therapy room, the same therapy time, confidentiality and the consistency of the same things inside the room create a feeling of a 'protected space' (Lanyado and Horne 2011, p. 158). Over time, the parents', babies and young children that attend therapy develop this feeling of a protected space through what Bollas calls a 'recurrent experience of being' (Bollas, 2018, p.4). This concept of 'recurrent experience of being' extends from Winnicott's theory of the 'holding environment' (Winnicott, 1960, p.591) created through the mother's ability to suspend her own subjectivity in order to create a world that is shaped by her infant's needs. Repeated acts of attuned, maternal care gradually become internalised by the infant, which in turn foster the infant's psychological and physiological growth.

Bollas describes the mother's repeated acts of nurture as a 'transformational object' (Bollas, 2018, p.4). The infant begins to develop a sense of self, not yet separate from the mother through an experience of 'symbiotic relating' (ibid), where over time these repeated acts of nurture become a process of transformation and are internalised by the infant. Bollas states: '...the first object [Mother] is 'known' not so much by putting it into an object representation, but as a recurrent experience of being – a more existential as opposed to representational knowing.' (ibid). Internalised objects, which come about through repeated contact with the mother's ability to hold, contain and transform the infant's experience provide a way of elaborating our understanding of the therapeutic frame.

In this way we understand how the therapist's repeated holding of the boundaries of space and time, and consistently providing the same toys and materials, become

known, concrete, characteristics of the therapy for both therapist and client. The felt physical holding, enables the therapist's sensitive 'attunement' (Stern, 1985, p.138) to provide a psychological holding state of mind; a mind that can effectively take-in the experience of another. Thoughts, feelings and accounts of both significant or small details shared by the client can be held in mind, remembered, interpreted and reproduced by the therapist. Both the concrete physical and psychological holding are fundamental for families in therapy to build a sense of trust and reliability within the therapeutic relationship and for the containment of parents', babies' and young children's anxieties, so emotional development can flourish.

Similarly, to the client being held in mind, a vital part of the frame is the regular practice of clinical supervision. Rowe (2017) describes how this cannot be underestimated for the containment of primitive and complex material when working in early years settings.

Two further considerations of the frame's function are how the regularity, frequency and consistency of the sessions 'impact the sense of continuity and holding on to the possibility of change' (Baradon, 2016, p. 42). This model when working within the realms of parent-infant psychotherapy also mirrors a parental function, which the parents can use to develop consistent and reliable care for their babies, in order for their own dyadic relationship to develop and flourish. Secondly, the therapist's attention in holding the frame consistently communicates the importance of the clinical work and the therapists' own professional commitment to the parents, babies and young children they work with.

Cherry and Gold (1989) focus not only on the importance of the therapeutic frame for the client, but also the significance for the therapist. They state:

'The structure permits the therapist the unique opportunity to participate in an intimate relationship which is to be understood and utilized for the benefit not of the self but of the other. Most important, the frame assists the therapist in placing the client's interest consistently above all other considerations.' (p.167).

The therapeutic frame enables the therapist the necessary distance from his/her own personal life experiences, which are not to be brought openly into the therapy space,

albeit they may consciously and unconsciously be present in the therapist's mind at times. Similar to Winnicott's previously described theory of a mother who can suspend her own subjectivity (1960), the frame supports this significant function for the therapist. When the therapist is held by the therapeutic frame this in turn helps the therapeutic relationship to develop. The theories of containment, holding and a secure base are key theories significant to the therapeutic relationship that will briefly be outlined below for the purpose of this paper.

The Therapeutic Relationship and the Functions of Holding, Containment, and a Secure Base

Holding

Winnicott 's theory of a holding environment (2005) is a prominent idea that draws a parallel between motherhood and therapy. Winnicott describes how a mother instinctually provides physical and psychical holding for her infant in the early stages of the development when the infant is completely dependent on the mother. This environmental holding function enables ego development to occur. Developmentally, the infant acquires the ability to sooth itself via the introjections from its mother fostering intellectual and emotional growth. Winnicott saw the therapeutic encounter as analogous to the mother-infant relationship. The therapy room remains largely unchanged and serves the function of conveying consistency, reliability and stability which are inherent in the concept of holding. The notion of holding is also extended through the act of confidentiality and the therapist's ability to hold in mind and reproduce accurate details and accounts shared by the client.

Containment

Bion's model of container-contained (1962) explains how a mother receives and contains unwanted and overwhelming projections from her infant, processes them so they can be re-introjected by the infant in a digestible and modified way. Psychoanalytic theory observes how the therapist provides a containing function like that of a mother for her infant, by receiving, processing and then making available their client's thoughts and feelings for reintroduction.

A Secure Base

Bowlby compared the containment a mother provides for her infant as analogous to the therapeutic relationship. In Bowlby's 1988 work entitled 'A Secure Base' he addresses this in the first of five tasks that underpin a framework of the therapist-patient relationship:

'The first task is to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance.'(Bowlby, 1988, p.138)

These three concepts of holding, containment and a secure base will be drawn upon throughout this paper in relation to the concept of the therapeutic frame and deviations and distortions to the frame.

Deviant and Flexible Frames

Langs' theory of the 'deviant-frame' (Langs, 1998 p.76) describes any diversions from the basic therapeutic ground rules as irrefutably detrimental to the therapeutic encounter. Controversially, Cohen provokes further thought by suggesting the need for flexibility when faced with the idiosyncratic nature of therapeutic interaction. She describes a number of moving clinical accounts where the therapeutic relationship, and in some cases the development of psychical growth, were enhanced by adopting a frame that could flex. (2017). Cohen states: 'We begin each new therapy telling the patient about the traditional frame, and as the therapy unfolds, we negotiate the frame together. We hope to seek a frame that bends but does not break.' (p.69).

This idea of a frame that can be flexible has been explored in art therapy literature by Coles, Harrison and Todd, (2019). The authors describe an art psychotherapy group which they facilitated in a museum setting rather than in a traditional art psychotherapy group setting. Interestingly, their findings describe how moving out of the private art making space and into the public viewing arena became a significant factor in arousing both client and therapist anxieties (Coles et al, 2019). The Coles et al, paper aligns with

Cherry and Golds (1989) description of a changed frame impacting upon the therapist. Coles et al express the felt impact upon their roles as therapists. They write:

'In moving out of this space it felt as if there was more emphasis on the psychological boundaries of the therapist in holding the therapeutic frame; we wondered about how much more we were holding and containing, psychologically.'
(Coles et al, 2019, p 61).

The idea of a flexible frame is helpful when thinking about the impact of a changed frame on the Service, as the reshaping of the frame was felt by the therapist to be unavoidable. The concepts presented here of the psychical and physical holding function of the frame will be drawn upon throughout this paper to illustrate how the frame of the Service was bent but not broken, (Cohen, 2017).

Background History of the Service

Since its conception in 2010, the Service has been financed by generous, charitable donations, to be used specifically for children aged from birth to five years old. The primary aim of the Service was to fill an identified gap in the local Child and Adolescent Mental Health Services (CAMHS) for psychoanalytic and psychodynamic interventions for infants and children within this age range. A key strength of the Service was that families could be seen quickly, without being placed on long waiting lists, which was vital for small babies who could not wait. The therapy intervention was not restricted by a limited number of sessions, as so many services are, and provided families and professionals with various interventions such as parent consultations, nursery observations, working with a sibling whilst the parents and their infant received separate therapy, training and supervision for various members of the Health Care staff, workshops and trainee Art Psychotherapy posts.

For eight years the Service worked in partnership with a network of Health Care professionals to provide Parent-Infant Psychotherapy and Art Psychotherapy to over a hundred families in the district and surrounding areas. The benefits of this partnership were numerous, as the Service could signpost families attending therapy to specific areas of additional support and liaise with the appropriate teams.

An example of this was the Outreach Team supporting parents and their young children to engage in play groups when families were at risk of being isolated. For new parent-infant dyads that were of particular concern to the Service, Health Visitors would provide extra home visits to ensure concentrated support was in place within the home as well as therapeutically. The Service was fortunate in working with highly skilled and dedicated colleagues who brought a wealth of knowledge and experience in working with early years and families.

The Service provided two and a half days a week parent-infant psychotherapy to parents and their infants, and art psychotherapy to under-fives. The families, babies and young children referred to the Service were often from emotionally and financially deprived backgrounds with little or no external support network. The potential for psychological trauma to transmit generationally is significant for families such as these, (Fraiberg et al, 1975). A core aim was to catch these generational traumas and to provide a psychodynamic intervention that enabled families to work through painful and debilitating relational difficulties. Understanding these parents' experiences was key, and more importantly understanding their babies' experiences and what happened between the parents and their babies, was paramount to the work the Service undertook. This understanding was crucial and enabled healthy and robust parent-infant relationships and infant development to flourish.

An agreement was set up from the beginning with the Manager of the Health Care team, that provided the Service with a large therapy room, a separate office space, waiting area, ample car parking for families and access to a computer with a Service email address. In addition, lockable storage space for confidential artwork and a separate unit for confidential case material were provided. Additional space to store art materials and toys was also available to use. As the therapeutic work progressed, demands for the service grew and a regular stream of referrals created a need for a further room at another nearby Centre.

Through generous funding, the Service was able to offer therapy to families with no incurred cost to them, due to the understanding that there would be no charge to the Service for the rooms that were used for therapy. In short, this meant that the families

who were in need had access to the professional and experienced interventions that could help them, and this was not dependant on their ability to pay.

Over the years the Service adapted to significant changes, for example, the relocation of the Health Visitor team. As a great number of referrals came from the Health Visitors, this meant that the Service no longer shared the same building and access to shared communication was greatly affected. During this process key professionals endeavoured, by meeting together once a month, to update each other on potential and existing referrals.

Transitions and changes

In 2018 a major transition of the Health Care team took place due to significant changes in Government policies. The Health Care organisation evolved to take on a wider remit of care in the community, was submitted for tender which was subsequently won by a company primarily unrelated to early years interventions. This process took many, many months, creating uncertainty and anxiety for all involved.

The repercussions from this change of management were considerable. The Health Care team became fragmented and subsequent personnel losses were unavoidable. Key and highly experienced members of the Health Care team were made redundant or had to find new jobs. The Service's key contact, the Manager of the Health Care Team, was made redundant and left, as did experienced members of staff from the Outreach Team who had worked closely alongside the Service to support many families in need. The Centres themselves were overhauled and re-organised adding to the chaos and uncertainty, as rooms were thrust into a constant state of interruption and disarray. Menzies Lyth's seminal paper on the defensive effects of organisational change within health and social care describes 'social defence systems' as the link between the individuals psychic defence and the institution, (1960, p.115). The impact of the chaos and uncertainty was that different divisions within the newly formed organisation became split, causing anxiety and resulting in areas of the buildings becoming territorialised. The partnership, which had grown over the past eight years, came to an end. A significant outcome of this was that the Service was unable to continue to use the therapy space it had valued for the past eight years. The physical containment of the 'known' space was lost (Bollas, 2018).

The Impact on The Organisational System of the Service

The organisational system relates here to the structural collective parts of the organisation, which integrate to accomplish an overall goal, i.e. the continual provision of Parent-Infant Psychotherapy and Art Psychotherapy to families and young children in need.

The impact on the organisational system of the service was manifold. However, three core effects on the organisational structure were identified by the service as:

- The loss of a consistent and reliable therapy space that offered flexibility, surety and autonomy for the Service
- Greater financial costs
- Loss of an experienced and well-developed network of Health and Early Years Professionals, and the subsequent impacts from this

Despite efforts to secure a reliable and consistent new therapy space, the Service became geographically fragmented and two months after leaving the Centre a new secure base to work from had yet to be obtained. The Service no longer had access to emails, a computer or confidential storage space.

What was secured for three hours a week was one small room within a busy and vibrant Nursery, which was situated in the main Nursery building. A suitably rented space in the area, at cost, for four hours per week was also found. A reduced rate cost was negotiated with the new organisation for work to continue at one of the smaller Health Care Centres for half a day a week. In addition to this, work with one of the under-fives children was re-located to take place within the child's school.

Subsequently the therapists could work in up to four locations in one working day, transporting the necessary toys and art materials around. Despite the investment of time and effort as therapists to find alternative places to work, it was imperative that the

provision of parent-infant psychotherapy and under-fives art psychotherapy interventions were sustained, as existing work continued and referrals to the Service continued to be made. The impact on the Service was that it did not have a regular and reliable therapy room, confidential information was secured at the therapists own separate homes in locked storage to ensure data protection and security of personal information. The toys and art materials were also shared and loaded into bags and carried to each location. The physical fragmentation of information, and the tools used, added significantly to the sense of anxiety and uncertainty and the task of holding the service together.

The Impact on the Therapists

A reactive process occurs for individuals when they are confronted with major organisational change, which has been argued to initiate four responses:

- Initial denial
- Resistance
- Gradual exploration
- Eventual commitment

(Scott and Jaffe, 1988, cited by Bovey and Hede 2001, p.534)

Initial denial and resistance to fully accept the situation were key unconscious defences which affected the therapeutic team who, despite working on the transition of the therapy space in the therapeutic work with their families, had not created time to reflect *together* on the impact for themselves, their work and the Service. One therapist described:

“It suddenly hit me that I had had my last therapy session in the centre where I had worked for the past eight years. I had just spent the last few weeks working through this with the children and families I saw for therapy, but I still had not fully realised the impact on myself until my colleague said, “I suppose we should say goodbye to our room.” The process had taken so long up until this point, I think I had been in denial, hoping for a miracle solution to appear at the last minute, which of course, did not.” (Therapist personal comments, 2018)

The loss and fragmentation of a safe and reliable space, which had contributed to a 'recurrent experience of being' (Bollas, 2018 p. 4) for both client and therapist, created significant repercussions within the team and was felt by the therapists to undermine their ability to provide therapeutic containment.

The loss of the physical frame meant that time for team communication became difficult to manage as the therapy team worked in different locations and became physically isolated from each other. The anxiety the therapists felt from this became diverted into keeping the service going, which acted as a defence against thinking about; the loss of the old therapy room; the isolation of the team and the emerging split in the therapist's thinking about the best way to keep the Service going.

The impact of the loss of the secure base rippled into the wider team, as the differences in thinking within the therapy team and in supervision arose. Should the Service keep going despite the unpredictability? Or pause therapy sessions until a secure base and effective containment had been re-established? Parallel processes of uncertainty and anxiety experienced by the Health Care team as their own service disbanded appeared to mirror the therapists' own fears of the possible disintegration of the Service.

Bovey and Hede, (2001) describe how conscious acts of change can lead to anxiety on both conscious and unconscious levels. Anxiety can then lead to defensive reactions within each individual informed by the individual's own personal historical experiences around transitions. This is particularly relevant when there is an absence of containment for the anxiety provoked.

Menzies Lyth discusses 'detachment and denial of feelings' (1959, p. 445) as a defence against anxiety through the absence of effective containment, which feels relevant here. The loss of the therapists' own psychological containment and ensuing anxiety of not having the physical security of a consistent therapeutic frame, contributed to the denial and resistance of working together to understand the polarisation of views and the subsequent divide within the wider team.

Interestingly, one break over a holiday period became significant in enabling a shift within the therapy team to begin to address this rupture. The break could be thought about as providing the therapists with a 'break' in holding the families and children's anxieties around change and their loss of the therapeutic frame. This 'break' seemed to enable a fissure in the therapists' defences, where painful communication could begin to be shared around the therapists' feelings and personal experiences about the loss of the therapeutic frame. The Service provided external supervision, where each therapist received regular, individual supervision from the same Clinical Supervisor. A joint supervision meeting was set up, where both therapists met together along with their shared Supervisor. Key issues could then be brought into conscious thought and understood.

Case describes how 'Breaks in therapy furnish important material for understanding painful inner feelings', (2000, p.18). This is relevant not only for the client's inner feelings, but also the potential for therapists' feelings to be reflected on too. The joint supervision acted as a container for anxiety, whilst offering a space to explore formulations together, not unlike Winnicott's 'potential space' (2005, p. 144), where a mindful capacity between experience and understanding could be thought about then translated into human interaction. The parallel process of rupture within the wider Health Care team partnership and the Service and the rupture that occurred within the therapy team could be acknowledged and brought into the therapist's joint supervision, catalysing unconscious anxiety into conscious thought.

It was at this point that a surge of new referrals from the Nursery enabled a successful negotiation to occur. For one day a week a small room at the Nursery was allocated for the under-five's art psychotherapy sessions. Over a few weeks, storage for both art materials/toys, and confidential information was negotiated and new emails for the Service were re-established. The parent-infant work continued at this time in the smaller Centre, and in another suitably rented therapeutic space in the area.

One thought that emerged from this transformational solution was that the coming together in supervision facilitated what Rayment describes as a 'layer of thinking' (2017, p.187) where a change in the therapist's thinking outside of the therapy room can occur. Rock's description of the 'triadic relational system' (1997, p.16) where positive

processes in supervision consciously and unconsciously affect the supervisee and subsequently the therapy, could help explain the timely solutions from the nursery that suddenly occurred after the therapists stuckness had been addressed consciously.

Impact on the Under-Fives Art Psychotherapy

Interestingly, the containment of the therapists' own anxiety; led the clients to feel contained again. Through supervision the therapists' understanding of unconscious defences became conscious thought, which led to the clients being more able to know the unknown.

Adam's experience of a frame that changed

A very young child called Adam (a pseudonym) had been referred by the nursery having witnessed disturbing acts of violence in his home. The therapy initially had taken place in the Nursery setting and after eighteen months of working together had moved to the Service's therapy space in one of the Centres. This move coincided with Adam leaving nursery to start primary school. When the changes to the Service occurred and the Centre room could no longer be used, a room within the Primary School was negotiated for the therapy to continue, creating another transition period.

Adam had experienced many difficult transitions in his young life and this further change to the therapy space had understandably been challenging for him. Adam had been unable to directly verbalise any feelings around the loss of the previous therapy space, despite enacting this through his play. For example, for many weeks he created an intricate network of 'lasers' from string and blue-tac around the therapy room; he informed the therapist this was to stop intruders coming in and taking over their room.

It was when the therapeutic frame was restored, and the therapist again felt contained, that Adam after many, many weeks of defending against verbalising any thoughts around his loss wistfully announced, "I miss our old room". Adam's simple statement evokes significant thought about the importance of the therapy setting and what it symbolises consciously and unconsciously to the client. Brown describes the art therapy setting as akin to Winnicott's facilitating environment where he states, 'There is no relationship without a setting' (Brown, 2008, p.14) arguing that the therapy setting embodies the concepts of maternal holding and containment.

The statement “I miss our old room” expressed something of Adam’s conscious loss of the familiar, but also, unconsciously, the loss of feeling fully held in the containing space of the therapist’s mind during the transition period whilst the therapist was feeling anxious and less contained. When the therapist again felt contained, Adam was able to express and share his sense of loss overtly, and his experience could then be thought about in a conscious way by both the therapist and the client.

Interestingly during the transition from the Centre to working in Adam’s school, Adam’s two-dimensional image making provided a surrogate frame for the temporary upheaval of the therapeutic frame: unusually for Adam he became very focussed on working with the two-dimensional art materials every week.

Asserting his need for control, Adam instructed the therapist each session what image he wanted the therapist to create alongside him. At the end of the session he would then Sellotape both the therapist’s and his images together, the therapist’s image was a mirrored version of what Adam had created, and then Adam would fold them together. Words could then be given to Adam about his feelings of loss of the therapy room, the uncertainty and his fear of losing his therapist and also of his own past experiences around separation and painful change. Thoughts were shared about how important it felt that Adam and his therapist could ‘stick together’, despite the changed therapy room and his fears that he might have lost this very important space. The mirrored images also seemed to convey something of his internal experience of being reflected within the therapist’s mind.

Bion’s previously mentioned model of container-contained feels relevant here. In this sense, the therapeutic setting can be further recognised as a meaningful part of the therapeutic frame, playing a vital role in enabling the therapist’s capacity for maternal functioning, as aroused primitive states in the therapist are contained by the holding environment of the setting. Hosea describes a systemic conceptualisation of containment of a Sure Start parent-toddler painting group, where she names ‘concentric circles of containment’ (2017, p.114) to explain the many layers of holding in mind that are required for dyadic work, which fits well with the holding environment of the

therapeutic setting. This includes the organisational aspects of the setting and its relationships with partners.

The Image as a Frame

In the vignette of Adam, the transition to the school created a brief absence of a containing therapeutic frame, and during this period art making supplied a surrogate frame. The image acted as an alternate frame that held something together, symbolising an integrated sense of experience. Stott explores this concept in-depth in her paper 'Copying and attunement: the search for creativity in a secure setting' stating: 'The copied image holds the patient's experience and creates an opportunity for the therapist to attune to the patient by acknowledging the experience through discussion and responsive art making' (2018, p.50).

Here we can understand Adam's image to function as both a psychological and concrete container as he could not find words to voice the threat of unbearable loss and separation. Transferring these conscious and unconscious fears into his imagery meant words and understanding could then be found. Dalley, (2000) describes this phenomenon of the image communicating something of the incommunicable:

'The image holds the transference and countertransference responses – the idea that within this the image can act as a container of intolerable and unbearable feelings that can be held, processed and thought about which leads to the experience of being contained and understood' (Dalley, 2000, p.84).

Rudnik, (2017) refers to the concrete containing quality of the art box, the art materials and the trolley she used in her work on a children's hospital ward. In the absence of a traditional therapy space Rudnik explains 'these concrete things that stay the same, offer continuity and allow a sense of trust and containment to develop...' (p.48).

In addition to the concrete aspect of his art images, Adam's art box, folder and art materials provided an experience of something unchanged in the face of overwhelming change. These significant items that belonged to him within the therapy space contained something concrete and reliable that could anchor him through the adversity. The image making and the art box offered Adam concrete containers for unconscious

processes to be held. In retrospect these valuable creative tools were integral in the role of holding the frame, when the therapy was in a state of flux, and provides an example of Cohen's description of 'a frame that can bend but does not break' (2017, p.69).

The Impact of a changed frame on Parent-Infant Psychotherapy

A vignette from a parent-infant psychotherapy session below demonstrates how the transition of the setting affected one mother-baby dyad, that had been referred due to the mother experiencing post-natal depression. Alongside the depression, the mother had suffered a significant loss, as her own mother had died the year before she fell pregnant. Despite careful planning and thinking with the mother and baby around the transition from the therapy room at the Centre to a new therapy space, the move caused the mother and baby distress.

Not only had the therapy room and location changed, but also the day, due to room availability. The vignette below describes the first session in the new therapy location. The session also took place at a different time of day; as we were in the winter months, this meant that mother and baby arrived in darkness rather than daylight.

Parent-Infant Vignette

Mother and baby were unusually late, the building where the new therapy space was located was busy with lots of families coming in and out, there was a lot of noise and I felt my own anxiety rise as I wondered if this mother was finding it difficult to park.

It was pitch dark when they arrived late for their session. Entering the room, mother appeared harassed, carrying baby who held an anxious, confused, frozen look on his face and in his tensed little body. Mother looked exhausted, yet relieved to have finally got here. Taking some moments, they approached the floor mat, toys and cushions that I had laid out. I had used as many of the familiar things and mirrored our previous space as much as possible. Baby who normally settled quickly, and usually often smiled and approached me to make physical contact, instead clung to his mother with a sense of fear. Mother sat down and sighed loudly, then began to say "this is different we couldn't find you...there was nowhere to park." (Therapist's own notes, 2018.)

In this vignette all the physical factors of the therapeutic frame were altered; the room, the location, the day, time of session and reliable parking space. The therapist made

careful attempts to replicate the old therapy room as much as possible to capture something physical of the previous 'holding environment' (Winnicott, 1960) or 'known' experience (Bollas, 2018). Despite this attention to replicate the previous therapy space the impact on this dyad and the therapist was profoundly challenging. The mother and her baby son were anxious about the loss of the old room and anxious about re-finding a containing space in the both the room and the therapist's mind.

Briggs relates Bick's theory of second skin to a 'muscular holding of the self' (Briggs, 2005, p.189) to dispel psychic fragmentation. This seems to describe well this baby's muscular holding onto his mother in the face of change and the loss of the familiar 'skin' of the therapy room. The muscular, tight grip was perhaps an attempt to dispel his anxiety and enable him to dissipate in an urgent way his (and his mother's) confusion and anxious distress. The loss of the containing and known therapy space had perhaps linked unconsciously into mothers' own sense of maternal loss. In the transference relationship, mother was expressing something of her unconscious fear of losing her therapist as she had often expressed her relief in finding a therapist whom she felt could contain her anxiety, depressed feelings and worries about her relationship with her baby son.

Mother's expression "this is different, I couldn't find you..." felt similar to an infant who does not feel held in its mother's mind, who instead finds an absence or a space too full to take in their experience. The comment, "there was nowhere to park", seemed to echo this thought further, of the mother feeling there was no space left for her and her baby, both practically in the lack of physical space and psychically in the therapist's mind: both had already been filled up. Understanding this communication and creating meaning that could be re-introjected was imperative to enable the mother-baby-therapist a space to repair the rupture in the therapeutic relationship. Re-establishing the frame and attending to the relationship allowed the dyad to experience the unknown becoming the known again and to feel both physically and psychically contained.

Conclusion

Over many months the alliance with the Nursery team developed and the Service became established in the new locations leading to the reestablishment of the

therapeutic frame, which enabled greater containment and consistency. Existing work settled and new referrals continued in both the parent-infant and under-fives work.

This paper has attempted to reflect on the importance of the therapeutic frame and the impact upon this during times of organisational change. The external change in Government policy created profound organisational ruptures for the Health Care team and subsequent parallel ruptures in the therapeutic frame of the Service and dynamic internal processes of the therapeutic relationships. Consequently, both the Health Care team and the Service did not feel held in mind by these changes in policy, which in turn permeated the therapeutic alliance. The significant loss of the union with the Health Care team and original therapy space has been discussed to show how symptoms of fragmentation were introjected into the organisational structure of the Service, which then filtered into the therapy team and the parent-infant and under-fives experiences.

Reassuringly, like the interpersonal ruptures and repairs between parents and their babies that come into therapy, ruptures in the therapeutic frame can also be repaired and are survivable, (Broughton, 2016). The therapeutic frame is paramount, it provides parent-infant dyads and young children an experience of a protected space that is secure, reliable and containing. For therapists, the containment and constancy of the therapeutic frame is vital in order to have a mind that can consistently take in the experience of another.

Biography

Sally Sayers is an experienced Art Therapist whose interest in infant development led to a further master's degree in 'The Psychodynamics of Human Development' with The British Psychotherapy Foundation. Having had CAMHS experience she continues to specialise in working clinically with children and adolescents from the ages of birth to eighteen. Currently Sally works as an Art Therapist in two services; a parent-infant psychotherapy and under-fives art psychotherapy service and also in an adolescent inpatient hospital in north London, specialising in treating adolescents with severe eating disorders.

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