ATOL: Art Therapy OnLine

The Art and Practice of Providing On-line Art Therapy to Children during the Covid-19 School Shutdown of 2020

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ISSN: 2044-7221

Date of Publication: 16 March 2021

Citation: Small, J. (2021) The Art and Practice of Providing On-line Art Therapy to Children during the Covid-19 School Shutdown of 2020. *ATOL: Art Therapy OnLine 12 (1).* Available at: DOI 10.25602/GOLD.atol.v12i1.1484

Abstract

This paper describes the author's experience of providing on-line art therapy for four months via Zoom during the school closure in Spring 2020, necessitated by the spread of Covid-19. The author describes how the shift in working style led to a change in the dynamic of the art therapy which brought benefits including the need for the client to take greater responsibility for facilitating the sessions and a renewed engagement with the art work. Despite this, anxiety in the therapist grew as the loss of the artwork and the art room led to a fear of a failure of the container and also that important transference and communication was being lost. Despite new dynamics and a shift in the work seen with several children, the quality of the connection was reducing over time as fatigue, complacency and boredom set in. The benefits to the changes could only be fully realised once we had returned to in-person art therapy and overall the author was left with the sense of her practice being compromised and reduced by the need to work in isolation. She did, however, benefit from the opportunity to reflect in depth on isolation and her responsibilities as therapist.

Six key words not used in title

Connection, isolation, barriers, vulnerability, structure, unlock

Introduction

This paper explores the challenges and opportunities created by the need to provide on-line art therapy sessions to my clients during the Covid-19 shutdown in spring 2020. I will discuss the sessions I undertook, mostly via the on-line platform Zoom, as I tried to sustain the art therapy and hold my clients during a sensitive and challenging time. I work in child mental health and from March to June 2020 I worked with four children, all of whom were already established in therapy with me and who I had seen in weekly individual art therapy for at least a year. This represents a small proportion of my usual caseload and I chose children who I had an established relationship with and who I felt had a familial structure at home which would allow and support the work to continue.

I work psychodynamically and use the art objects created by my clients to help them think about their unconscious material and their patterns of relating. I use transference and my countertransference to inform me about my clients' emotional states. Klein (1930)

describes transference as an expression of unconscious phantasy and is related to the very earliest relations to the first object, or primary caregiver. While Freud (1895) initially considered transference to be an obstacle to overcome, it is now seen within psychotherapy, as an essential tool for developing a cure.

I am a qualified art therapist employed on a permanent contract by a large primary school in the UK[1] I work three days a week and usually see 12-15 children for individual art therapy sessions as well as leading whole class art-based reflective sessions and some small groups. I provide clinical supervision to a team of Learning Mentors and I work with parents, teachers, social workers, and other professionals to provide a holistic and well-informed service to the children with whom I am responsible. I work with children facing a range of issues which affect their emotional wellbeing including bereavement, trauma, behavioural issues, depression, attachment disorders, familial drug and alcohol problems, domestic violence, as well as children dealing with persistent low moods and anger. As an established member of staff, children are often familiar with my face and job title before I begin working with them. Many have already formed impressions about me before meeting me in the therapy room and this can affect their engagement. Some are excited and relish the opportunity to 'do art and talk' in a way which is separate to the rest of their school experience while others see my presence as an indicator of failure or an admission that there are problems which need to be addressed.

As I write this, the UK is living through its third national lockdown and schools are again shut. Covid-19 has led to school closures and necessitated home learning on a national level and a shift in society on this scale deserves attention. The national lockdown has probably led to an acceleration of a trend for an increase in home working and this might be mirrored by a growth in online therapy. This paper is an initial exploration of a new and complex way of working.

I am interested in the ways the therapeutic relationship and the material which emerged were altered by on-line working and how this affected the therapeutic outcomes. The Covid-19 lockdown necessitated significant change which the children have had to

[1] I confirm I have written consent from the parents/ guardians concerned and the leader of my organisation to write about this work.

accommodate; they have been separated from school, their peers, their normal social activities and often their extended families. This change had to be managed during a time of national uncertainty and the anxiety caused will also have affected many parents and caregivers. Although I worked hard to maintain contact with my clients, I had to do so over the phone and via Zoom. I was curious to see the extent to which this reduced and restricted the therapy but was also interested to see if it brought other dynamics to the fore which had previously been hidden.

Description of on-line sessions

Technology has transformed the way society communicates and the ease with which we can connect with people we are not physically in contact with, and this has brought myriad changes to society. Zoom, Skype, MS Teams and other programmes allowed work to continue around the world despite severe restrictions on travel. Without this technology my contact with clients would have stopped. Having never heard of Zoom prior to February 2020 I quickly became both familiar with it and reliant on it.

It began with an agreement of a regular time with each client when we would 'meet' on-line and I would email a link to a Zoom meeting for that time. The client and I would each click on the link at the agreed time and our computer screens would connect, allowing us to see one another. I do not relish using technology but I was relieved to see each client and I think this feeling was mutual. This was often quickly followed by the disappointment of accepting the limits of working over computer screens. I had to accept the contradiction that working over screens was a barrier in many ways but also essential if the work were to take place at all.

Creating a reliable and predictable structure to sessions provides a containing function for clients which allows the therapeutic relationship and transference to develop. I therefore established a new format for on-line sessions, beginning with a brief verbal 'catch-up' so I could ascertain general wellbeing and reconnect with the child. This was especially important because I had no contact with the child at other times in the week, unlike a more usual working structure where I might see them around school and would hear news about them from their class teacher. After a brief conversation, the children generally chose to draw and then after about 20 minutes, we would look at the image together and think about the feelings and meaning contained in it.

Practical issues relating to boundaries needed to be resolved, including gaining renewed consent from parents and carers, ensuring privacy, and deciding how long I would wait if a client failed to connect at the agreed time. There were technical barriers including poor Internet connection and I was simply unable to work with children who did not have consoles at their disposal.

The wish to overcome the barrier created by the physical distance creates a new openness and greater emotional intimacy

The urge to connect with others is primal and the isolation created by the Covid-19 shutdown brought this need into sharp relief. When describing communication on-line we use the word 'connect'. We *connect* with others, we despair when the connection fails, and we search for better and faster connection. We also connect in therapy and establishing a therapeutic alliance is a key component of therapy and essential to the success of the work. Technology provides an extraordinary bridge between people separated by geography but the need to overcome the barrier created by the screens remains.

French philosopher, Weil (1953), wrote "Two prisoners whose cells adjoin communicate with each other by knocking on the wall. The wall is the thing which separates them but is also their means of communication". I found this conundrum a useful way to understand the process of working across computer screens. The need to use technology created barriers which delayed and inhibited the transference yet using technology was essential to allow the sessions to take place at all.

The non-verbal or interpersonal communication which is shared during a therapy session, including facial expressions, body language and gestures, tone of voice and eye contact are standard exchanges in therapy and are also essential for developing a therapeutic relationship, transference and countertransference. It was as if the screen acted as a sieve, removing significant parts of the interpersonal communication and I worked hard to remain fully present. Time and again I expected the sessions to feel thin or lacking but despite experiencing those feelings sometimes, there were times when I was surprised by the depth of feeling which manifests in the artwork. The loss of intimacy and physical presence meant any child who wanted to deny my presence could. They could refuse to recognise my role, push me away or procrastinate, yet when the child chose to engage,

the time became precious, like a stable rock in a churning sea and a resource to be used. One client seemed more at ease at home; she was proud to show me her room and by showing me her favourite possessions she was inviting me to draw closer to her. The screen became a shared, balanced space because we were both in our own separate rooms, rather than 'my' therapy room. We achieved an equilibrium which was simultaneously comforting and daunting for the client.

The therapist holds responsibility for the therapeutic setting and must protect it. Lemma (2017) argues that this wish to hold therapeutic boundaries is necessary for safe practice and indicates the value placed on the client's psychic development. Lemma adds that any changes to the setting will affect the client's subjective experience of knowing both therapist (or object) and understanding of the therapy. We should not underestimate the challenge for the client of moving the therapy from in-person to online, in fact it could be experienced as a catastrophic change. Any level of participation needs to be valued with respect to the loss of the ordinary in person connection.

Another client, Sam, who I describe more fully later in this paper, began a session by drawing a blueberry. He had drawn fruit in previous sessions and I initially thought he was struggling to engage but he took the paper away from the screen again and continued working and when he showed me his work a second time he showed the blueberry had exploded after being "stomped on by a boy". The blueberry, now in tiny pieces, returned to avenge its attacker and then protect the other, smaller blueberries around it. As the image developed, our conversation twisted and weaved through the session and it led him to admit to a longing to protect his family and a fear that he could not live up to the responsibility of this task. During this session we experienced particularly poor Internet connection and the screen repeatedly froze and the sound dropped out. I had feared the session would be reduced in quality, with a flattened affect when in fact, possibly because of the distance between us, he was willing to use the time to admit to frightening and painful feelings with an honesty which was greater than was usual for him.

We provide containment (Bion, 1962) for our clients because doing this helps them feel safe, enables them to trust the process and allows transference to develop. It also transforms habitual ways of thinking, feeling and relating into new, less conflictual ones. The therapist's willingness to take temporary responsibility for her client's emotional

wellbeing while the client is in the therapy room, enables the client to risk sharing and ‘resting in’ feelings which they find uncomfortable or which induce feelings of vulnerability. The therapist’s ability to help the client feel safe means they can risk thinking about feelings they might deny and push away in other contexts.

Further to this, the artwork provides containment for the therapist and I felt the loss of the artwork acutely. The important role of storing and protecting the artwork was stripped from me and I felt distress when children told me they had lost artwork from previous sessions. In Our Lady of the Queen (Case, 2000 p.15), Case describes the transference she allows to develop with a copy of Holbein’s painting of Queen Jane Seymore, which hung on the wall in her therapy room, and how over time she felt the painting become a third person in the room who could affect and even invigorate the sessions. She describes the image in the painting as being ‘a disciplined holder of analytical boundaries; an imaginary supervisor’ who ‘accompanies’ her within the therapy even ‘nudging me at moments of inattention’. The idea of artwork acting as a container for the therapist which holds the anxiety during the times when it is hard to do so is useful, however during my times of frustration, I felt more like the painting itself, trapped as an image, disabled and separated from the client and the action of the session. During these on-line sessions, when I was physically separated from both clients and their artwork, I became acutely aware of this loss. I was physically separated from the artwork and had lost my role of protector of the work. This mirrored the feeling that I was prevented from discharging my full obligation to the client.

The ability to relate demands a willingness to engage from both parties. This is also true with technology and a common problem we had was when the internet connection was poor and screens froze or went blank, sound dropped out or we misunderstood each other. Background noise, interruptions from the child’s family and even the possibility that a parent was listening just out of shot all interrupted and impacted the development of the transference.

As the number of sessions held increased, I noticed a curious trend. It seemed that the wish to connect, or relate, increased in some clients to a greater degree than I had been aware of in the face-to-face meetings. I was conscious of a longing to be present and available to the children and I also noticed a similar wish in them. One child who I had

known for two years and who had an ambivalent and sometimes hostile attitude towards me admitted the sessions had become a highlight in her week. We had missed two sessions because a poor internet connection prevented the sessions from taking place and in the third week, as the screens connected but we were still waiting for the microphones to begin to transmit, I realised I could see her sitting waiting with her fingers crossed as if urging the session to begin. This experience heralded a new stage to the work and helped her overcome her hesitancy in trusting me. In fact, it seemed that the wish to overcome the barrier created by working on-line created a new openness and willingness to work together which led to a greater emotional intimacy.

Therapy begins when therapists and their clients form a mutual agreement to explore and reflect on psychic pain and patterns of relating which are damaging to the client in order to enable the client to process and resolve these issues. The responsibility to hold or contain the client rests with the therapist and this continues to be true as the work moves online. The context has changed because we have moved out of the therapy room but the usual ethical and legal requirements remain. The privacy and confidentiality of the container has altered however, and the physical separation means the clients, in my case children and their families, are required to take on some of the containing function. In a practical sense this involves the client clicking on the Zoom link at the agreed time and for families, it involves providing a private, confidential space where the client can think. For at-risk children and families, this container might not be reliable or predictable and the therapist is required to work with the client to protect and maintain necessary boundaries. The psychological sphere is also altered and the therapist must work carefully to continue to provide psychological containment without the physiological and kinaesthetic feedback we have in person.

Feelings of dependency mean engaged clients are committed to maintaining the therapeutic relationship too and online working provided opportunities to see this happen. For example, when we had a weak internet connection, children often suggested moving on to the ‘chat’ function, which is typed, to bypass the need for verbal communication and allow the session to continue. Lemma (2017) suggests we could think again about the value we place on our clients’ ability to see us, when we remember Freud required patients to lie on a couch so as not to contaminate the material. I would argue, however,

that within psychotherapy, mirroring and visual contact are needed and they continue to engender the two-way psychological space.

For art therapists, working with both resistance and barriers to thinking are a common part of most sessions and it is well recognised clients often erect psychic barriers or deny the difficulties exist at all. These barriers to thinking are replicated and increased by the technological barrier of working across computer screens. There is, however, an urge to connect and it seemed that the barriers created by on-line working led to a wish in my clients to overcome the obstacles in ways which they might not usually have to do. Working online puts new power in the hands of the client because they could end the session literally at the touch of a button. A threat of “if you push me, I’ll switch you off” entered the work. It felt that getting involved with negative material became risky because flight was so easy. This is a new kind of defence so in recognising this we realise therapists must continue to be as forthright with the material as usual.

The need to work across screens also created a barrier in the sense that the lack of kinaesthetic contact means it can be difficult to recognise a lack of engagement. A poor image can make facial expressions hard to read and a lot is missed if a face is in shadow and signals like a tapping foot indicating anger might not be visible. It is the responsibility of the therapist to be aware of this and to admit and acknowledge ‘not-knowing’ when this is true.

This new way of working raised interesting questions about my core practice. I began to wonder if the therapist’s efforts to provide containment for their clients might in fact rob the client of something useful. Is it possible there are times when therapists inhibit their clients by taking too much responsibility? Do we infantilise the client when we assume too much control of a session and could online work put some of this right because the client must take more responsibility for the running of the session? By clicking on the link, choosing to prepare by finding paper and pens, closing the door to their room to ensure privacy all lead to active participation and are tasks the therapist usually takes on. By doing so, might the client grow? Thinking again about the opportunity clients have to end sessions at the click of a button, reminds me there is no opportunity for the therapist to give permission for or to negotiate for the session to end if the client has already gone.

And further to this, are there times when our clients contain us? Does the artwork they create and the feelings they are willing to engage with create a performance, a way of being a 'good' and 'well-behaved' client in order to keep their therapist and perpetuate the therapy? Does a 'good-enough' therapist (Winnicott, 1965) need 'good-enough' clients to continue? When clients decide to adhere to the 'rules' of engagement (to attend, work, listen, etc.) they are in the process of forming a therapeutic alliance and when clients do this they are showing they want to continue in the therapy, with the hope this will lead them towards personal growth and feeling better. Online therapy might challenge the boundaries of the session but these ideas remain.

Vignettes

Sam is a quiet and thoughtful eight-year-old boy. He has experienced multiple breakdowns in foster care provision and his current living arrangements are in jeopardy again. He was removed from his mother's care at birth and placed with several foster carers until he was placed with his maternal aunt, with whom he has lived for four years. He has elder siblings who have been adopted and with whom he has no contact but he and two sisters are currently living with their aunt, who was herself brought up in care. Social Services have supported him and his extended family for many years. He is adept at eliciting care from adults but often experiences poor relationships with peers and he has been known to antagonise and upset the children around him. We have worked together weekly for three years and he presents as a child who enjoys art therapy, consistently attends and seems to value the opportunity to make artwork and spend time with me. Despite this, his artwork can seem perfunctory and sometimes vacuous, as if he is avoiding serious and meaningful thinking.

Bearing in mind how often I struggled to connect with him significantly in face-to-face sessions, I wondered how we could connect on-line. I was concerned as to how his experiences of loss due to the failures in his care were being replicated by the loss of in-person therapy and I was unsure if he would be willing to risk following me on-line. Holliday (2008: 59) describes confidence in the power of art therapy and its ability to instil in children a belief in their inherent worth, saying that within art therapy, the "imagery can offer a safe arena for expression and recovery". My hope was that if Sam were prepared to engage in making art then despite being physically absent the therapeutic alliance would continue to hold him sufficiently because he would be making art in my presence

and under my gaze. Indeed, the value he placed on the therapy became clear when he attended every session, on time, weekly for three months. Each week he would sit in the same room and diligently produced pages and pages of images, working with care and attention. He often worked with his back to me but the effort he put into his images indicated the value he placed on the work and on the therapeutic relationship we had built. I would wait, mostly in silence, until he was ready to show his work which he would do by holding it up to the screen.

While drawing, the device on which he could see me repeatedly fell over and he spent a lot of time trying to prop it back up. Each time it fell the image on the screen slipped sideways and I had a curious sense of lying on my side. As Sam was working with his back to me I needed to catch his attention and found myself saying ‘Oh no, I’ve fallen over’. He patiently propped me up again and returned to his work only for the device to slip again. We both found this tiresome but persisted and on one occasion he propped the phone up against a teddy bear with soft, curly wool so my view was framed with fuzzy teddy bear fur, as if I were cocooned in a teddy bear hug.

It became clear we had developed a dynamic whereby I was physically absent yet available, distant yet interested in him. As I – or the device - kept falling over he showed he wanted me back. He became an agent in the sessions in a way which he had previously refused to do. I was pleased he was looking after aspects of the relationship which I was unable to do due to my physical absence but I began to wonder if there was a danger that, like the child of a depressed parent, he might take on the burden of making the relationship a success. Was he prepared to accept a diminished relationship rather than none? Was he prepared to take responsibility for the therapeutic relationship so that at least some of his needs could be met?

Something was emerging in the context which had previously been lacking and this is no doubt of value. We were unable to capitalise on this change however, until we met again in person. When the new academic year began in September 2020, we were able to re-start face to face art therapy and the sense of partnership continued. I found Sam was willing to use his time with me to admit to feelings he had previously concealed and there was a sense of solidarity, as if we had emerged from a trial together.

Katie

I began the on-line art therapy sessions in March 2020 and Katie was one of the first children to which I felt able to offer the on-line therapy. I began with children with whom I had long-standing relationships, and I was concerned her emotional wellbeing might suffer without the boundaries and support which school offered. I thought the sessions might provide some structure to her week and offer stability in uncertain times. The established nature of the work also meant that I knew her parent and trusted she valued art therapy and would support it.

Despite this I was unsure how Katie would respond and wondered if we would be able to maintain the discipline and structure required to make therapy a success. Katie can present with challenging behaviour in class and is often involved in grievances with peers. Her attendance in school was patchy and her presentation was characterised with uncertainty and hostility. She has an ambivalent attachment style and often distanced herself from me emotionally while continuing to attend the art therapy in person. During art therapy sessions I worked hard to establish a therapeutic alliance but always felt on edge, knowing from experience that if the session touched a subject which she found painful or challenging she was liable to storm out of the room. The sessions were also characterised by her persistence in telling 'tall stories' and I often felt she was using these stories to erect a barrier between us and keep me and the feelings I engendered in her at bay. Despite this she continued to attend the sessions and there were indications she valued the time. In an early session she spent time mixing oil pastels together in the hope of creating a lipstick for me. She was often interested in the way I looked and how I was different to her. The time had become important to her but it sometimes felt as though this dependence created a vulnerability for her which led to painful feelings and she fought against feelings of dependence and against me.

This dynamic was one we had been working with for some time and I wondered how the move to on-line working would affect us. If the time together were important to her but our physical proximity sometimes overwhelming, would the separation caused by on-line working help?

The technology allowed each session to go ahead because we could see one another on screen, but the barrier of being physically separate was there, nonetheless. I quickly

discovered, however, that the physical barrier had created an urge to overcome it and connect.

Katie and I had several sessions which could not go ahead because we failed to make Zoom work. One time we could not hear each other and spoke on the phone instead. Other times the connection dropped out and the screen froze, another time we could not get the password to work which prevented the session from even starting. It appeared the frustration of being unable to connect properly was such that the client put down the unconscious barriers which had previously prevented her from relating to me. It seemed that the physical separation reduced some of her anxiety and she experienced our relationship as less threatening.

Working on-line means a lot is lost but it can unlock something else: working in two dimensions not three

If our goal, as therapists, is to support our clients and help them process issues which trouble them, then one of the ways we do this is by being available. We are present and listening, ready to reflect on and process material on their behalf until they are ready to absorb and accept these elements for themselves. Physical proximity, eye contact, body language and facial expressions are all needed to show we are interested and are the tools we use to indicate we are at hand. Despite the presence of the screen and our ability to see each other, working on-line reduces the quality of communication and creates a barrier which impedes our ability to receive material from the client and in return, to show we are interested. In addition to this, our normal physical presence allows therapists to support clients in practical ways including finding art materials, clearing up mess or reaching out to steady a fragile structure or model. I found it particularly challenging to realise I could not help clients store artwork and I view this as a useful way to show care. It was hard to see clients toss images to one side or claim they had lost work from previous sessions. I felt the losses acutely and my countertransference towards the loss of the art room replicated my feelings of loss towards my clients.

Providing art therapy sessions on-line felt comparable to the decision during lock down which some theatres and music venues around the world have made to replace live performances with pre-recorded shows on screens. The image might be the same, but the effect is flattened and the quality of the interaction between protagonists, both actors

with one another and between the actors and audience, is reduced. Discussing the merits of this work in The Guardian, Felix Barrett, founder of theatre company Punchdrunk, said "I really believe, particularly in the digital age, that the tactility and proximity to your fellow man that theatre offers is electric." He suggests that being present brings the connection alive in a way which is impossible when recorded. He goes on, however, to suggest that even though pre-recorded shows are a poor imitation of live performances, there are times when it might be better than nothing, adding, "But if you can't have that, because of the world we find ourselves in, then I think screening is great. Make it accessible." (Barrett, 2020) This willingness to accept something rather than nothing is about survival and is a distant second to flourishing, growing or developing in the way we would normally aspire towards. Continuing to be accessible to our clients during the pandemic is vital but doing so online should not become the norm and is a poor match for in-person work. It risks feeling more like pausing or holding something in a static form rather than moving forward or resolving entrenched problems.

Physical barriers inhibit communication: there is a parallel between the PPE worn by doctors and the barrier created by working across a screen

One distinctive feature of the Covid-19 pandemic has been the increased use of masks in public or any space where people come together. The term which arguably sums up the national response to the pandemic more than any other is 'isolation'. Those who are ill are expected to self-isolate. We fear for the loneliness of people isolated at home and the profoundness of these feelings. The wearing of masks and the move to home working has led to a significant loss of intimacy and inhibits communication at a time when many have needed more support, not less.

I was also working in isolation. Despite being the only clinician employed by the school I work in, I work closely with my teaching colleagues and value their knowledge and skills. I was cut off from them and the team work which we enjoy. My clinical supervision was on Zoom, as were meetings with my line manager.

The need to prevent the spread of Covid-19 has led medical clinicians to wear PPE (Personal Protective Equipment) on a scale not usually seen. Masks and protective clothing which cover the face stop patients from seeing doctors and other health professionals in the way they normally would. In May 2020, Doctor Rachel Clarke wrote

movingly (Clarke, 2020) about the challenge of providing care to patients while wearing protective gear which covered her face and clothing and the impact it had on her ability to show care and communicate concern for patients and their families. “I am a doctor with neither a name nor a face. My hospital badge is hidden from view and my eyes – the only part of my face still visible – are obscured by a layer of Perspex. So much for the healing presence of the bedside physician. I scarcely look human.” She goes on to describe caring for a man who was dying from Covid-19 and her attempts to support his family and counsel them as they came to terms with his impending death.

Wearing PPE is essential to contain the virus but it prevents communication in an intimate and important way. Being unable to read someone’s facial communication or see their eyes or mouth strips away the ability to show care and comes at a time when that care is particularly important. If a patient, or their family can connect with a doctor or nurse personally then it might make it easier to digest and accept the difficult news they are bringing. I often felt frustrated in on-line art therapy sessions when I felt I did not fully understand how a child was feeling or that I was missing nuances in their self-expression. On-line working prevented me from being fully present in the way I would usually aim to be.

Returning to in-person art therapy

As the new academic year began in September 2020, schools reopened and it has been interesting to see how our time apart has affected the therapeutic relationship I have with each of my clients. In my third in-person session with Katie she was cheerful when she came into the art therapy room and settled more quickly than usual. She chose to work in watercolours and chatted comfortably while painting the corners of a sheet of white A4 paper in aquamarine, gradually working in from the edges until she had created a large oval shape in the middle. While painting she talked about her family, interactions with peers and her new class teacher. She also talked about me, commenting on my lipstick and other aspects of my appearance in addition to various personal questions which I gently declined to answer.

Katie looked at her art work and suddenly exclaimed, “It looks like a place for a baby!” and when I looked at her image, I realised I also thought the oval looked curiously like a blue womb. She decided to draw in a baby and reached for the brown pencil saying,

“That’s my skin colour”. As she worked the image changed and it became a baby asleep under a blanket in a cot. The image replicated the warm and comfortable mood in the room and the intimacy in our conversation. The feelings held in the artwork changed again as she taped paper straws to the underneath side of the paper to act as legs for the cot, but was disappointed to find they were unbalanced and too weak to support the weight of the painting, which seemed to hint at an idea that the weight of the baby, or the baby’s needs, were too great to be sufficiently contained. Katie also worked repeatedly at the baby’s face and her rubbings out removed some of the paint from the paper so the baby appears to be sleeping with one eye open, as if watchful and wary.

Katie’s willingness to engage with the art materials and create a meaningful image are a significant change and step forward from her previous time with me. Katie now seems more able to trust the therapy, to use the art materials intuitively and allow unconscious material to emerge. My decision to maintain weekly contact during a challenging time has been recognised and is valued by this child.

Conclusion

This paper describes work done in unusual times and the sessions took on value and became special because my clients and I were working together to overcome adversity. The change in working style altered the dynamics of the sessions significantly and by working together we were able to create something new. The wish to overcome the barrier of the physical distance created a new openness and a greater emotional intimacy. The transference changed and new elements came to the surface. We were, however, only able to realise and capitalise on this new depth once we had returned to in-person work.

Working on-line was frustrating and I struggled with a constant nagging fear that I was missing communication offered by my clients or that they were missing mine. Much of our common rapport was lost and I was left with the feeling that the sessions were both more difficult and less rewarding than in-person work. The physical barrier of a computer screen inhibited communication, transference and my ability to show care. On-line working was, however, an answer to an unusual problem in that the Covid-19 global pandemic forced schools to close and this in turn prevented much of my work from taking place.

Strong mental health is important for everyone and spending time together, feeling both in tune and connected with others is essential. Spending time with other people balances us and feeling connected to our communities is important for individuals, for society, and in particular for these at-risk children. The irony that the need to self-isolate to protect oneself physically led to a loneliness born of that separation, is something that perhaps spending time with others again can resolve.

About the Author

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