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The Analyst's Identity and the Digital World: A New Frontier in Psychoanalysis

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It is undeniable that the digital world poses problems and ever more cogent questions, not only for the scientific disciplines and the humanities in general, but also for psychoanalysis and the ethical dimension. If we take for granted a long-standing interest in the psychopathological characteristics of internet addiction and an exploration of possible theoretical and therapeutic approaches to it, what is less often assumed is the fact that, via cyberspace, we are entering the virtual world and using it as a possible perspective for thinking about psychoanalysis itself and the mind's virtual spaces, their possible existence and their possible meaning, the internal role of the setting, the comparison of virtual space with dream-space and with fundamental concepts in the making of psychoanalytic theory, the consequences of all this in the psychoanalytic relationship and the psychoanalytic field, and the possible distinctive characteristics of the analytic encounter in this field.

For at least two decades, our discipline has been taking an interest in the world of information technology from various vertices: individually, at conferences, and even at the level of the IPA[1], with opposing and intense emotional and affective responses. This gives us the opportunity to study the world of information technology in depth to see if, among its many aspects and with its distinctive characteristics, it may have some influence on our capacity for symbolisation and on the constructionof identity, and hence of the analytic identity.

The Identity of the Analyst

Given the vast scale of this subject and the many points of view adopted towards it over a considerable arc of time, we can make no claims to exhaustiveness. There are various possible ways to reflect on this, but we shall start by immediately leaving in

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1 For details of this lengthy process, I hope I may be permitted to cite a volume written and edited by me, *Psicoanalisi, Identità e Internet. Esplorazioni nel cyberspace* (Franco Angeli, Milan, 2013 - English translation *Psychoanalysis, Identity and the Internet. Explorations into cyberspace.* Karnac, London, 2016) in which I have explored in depth the theoretical and clinical interface between the psychoanalytic world and the digital dimension, and which includes various chapters going into particular detail about the analytic meaning of virtual reality and cyberspace.

the background the *mare magnum* of the subject of Identity as a whole, with its history, the variety of ways in which it has been conceived, and so on. However, I would like to consider at least the conception of identity as a personal condition, which expresses the sense of its own continuity over time, distinct from all other conditions, made of invariant elements but also of elements open to change. It is frankly impossible to exhaust the subject of the psychoanalyst's identity completely, once and for all, because this is a mobile and changing terrain which also depends on its historical context.

To put it in context, the problem of the psychoanalyst's identity has to be linked first of all with the current *Zeitgeist*, especially as it is embodied in post-modernism and its effects on culture, on society, and inevitably on psychoanalysis.

The interweaving of identity and the specific nature of analysis in relation to the contrast (and/or conflict) between psychic reality and external reality seems equally central, and closely connected to what I have just said.

Hence reflection can be extended to include the relationships which, in such a socio-cultural *humus*, flow back and forth between the psychoanalytic role and the external institutional role. In this context we meet the difficulty of maintaining the psychoanalyst's identity when faced with the variables and demands of social reality: for example, the changes produced by patients' requests and demands and the complex problem of the number of sessions. Connected to this there remains the problem of conflicts deriving from the immanent ambivalence towards the analytic object, which nowadays sometimes seems to result in a disquieting *cupio dissolvi*.[2]

It is of course true, as Massimo Vigna Taglianti **(2015)** suggests, that it is one thing to speak of the *analyst's identity* as that totality of characteristics which makes up the personality of an individual psychoanalyst which, bound up with his clinical experience, his theoretical models, and his personal ethical convictions, will all contribute to forming the subjective and constitutional components of that individual analyst's Self; these last aspects reminding us more or less implicitly of the fact that some common basic characteristics can be identified in the personality, or in the deep unconscious urges which belong to all psychoanalysts.

It is another thing, however, to define *psychoanalytic identity* as that common and invariant element which enables the individual psychoanalyst to feel and believe himself to be one when he compares himself with other psychoanalysts (who are, after all, a highly heterogeneous group) and to be acknowledged by the other psychoanalysts as belonging to that specific «tribe» or «people».

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2 All these points which are so important to psychoanalytic reflection have recently led me to propose the formation of a study group within the SPI (Italian Psychoanalytic Society) to address this question of the psychoanalyst's identity. One outcome, among others, is one of the «Multiple Seminars» (*Seminari Multipli*) in Bologna (2015). Gabriela Gabriellini, Gregorio Hautmann and Massimo Vigna Taglianti also took part in this group.

Furthermore, it is also necessary to emphasise how in this milieu we run the risk of «implicitly binding together models that are not always compatible, in way that can confuse the goal of understanding our construct» (**Hautmann Gr., 2015** - translated by the translator of this article).

It is a path for investigation, especially concerning the first point (the analyst's identity), which we could grasp as inherent to an aspect *in interiore homine*, drawing on the singularity of the individual, on his original characteristics which make him a unique subject.

On the other hand, psychoanalytic identity is also connected to the analyst's relationship with the other, whether another subject or an institution, and naturally to the educational process that leads the candidate towards his overall training and psychoanalytic qualification.

It is unrealistic to think of identity *in interiore homine* as something ontological and therefore irreducible, resistant to any influence from the spirit of the age. Widlöcher **(1983)** realised this, when he emphasised that the «experiential» conception of analysis had (for some time) been making progress compared to other more traditional conceptions.

Grinberg **(1983)** makes an effort to give this condition a more precise content, and claims that the psychoanalyst's identity is a process of integration between three conditions which he theorises as follows: a *spatial integration* consisting in the relationship between different aspects of the cognitive equipment and the analytic experience, coherently with other experiences and in comparison with them. A *temporal integration*, which by contrast corresponds to the assimilation of the relationships between different behaviours and experiences developed over time, with continuity in their uniformity and acknowledgement of essentially analytic experiences and insights. Lastly, a *social integration* which includes assimilation into a given group or institutional community based on selective identifications. All this should have as its aim the differentiation and individuation of the analyst as himself.

The features defined here would find further containment and realisation in the «psychoanalytic function of the personality», a typical characteristic of the psychoanalyst. The concept obviously recalls what Giovanni Hautmann previously claimed about the «analytic function of the mind», which testifies to a simultaneous convergence of conceptions that underline the substantial rooting of identity in the internal world. In this way, we could also take a systematic approach to some specific features of the psychoanalyst:

- o a particular type of curiosity about given aspects of human beings, the mind, and psychic reality, including that of the analyst himself;
- o a capacity for introspection and self-analysis;
- o creative ability;

- o an ability to think in adverse circumstances, in the midst of the storm, so to speak;
- o a capacity for discretion and ethical behaviour towards patients, avoiding acting out and traps created by Transference and Countertransference;
- o tolerance of a certain kind of frustration, such as isolation, lack of immediate results, occasional inability to understand;
- o an ability to wait and to maintain free-floating attention;
- o negative capability (in the Bionian sense).

To these characteristics, Kernberg (**1987**, **1996**) adds an inner faith in the possibility of using introspection as a tool for comprehension and change, and also a sort of parental stance, holding or containing the chaotic-conflicting characteristics of the intrapsychic.

Meotti (1980) had earlier stressed that the analyst's identity is the end point of multiple processes of projective and introjective identifications completed in the distant past, of which recent identifications and present creativity are the echo. A central point of this reflection is the fact that the «internal object» of identity is anchored to a sufficient introjection of the fundamental parental figure of psychoanalysis: that is, Freud's scientific work understood as a symbol of the primary object. This would be responsible for the analyst's mobility and creativity.

Wille (2006) enters at this point and centres his reflection on the fact that the nucleus of analytic identity resides in the psychic representation of analysis itself in the analyst's internal world. Psychoanalysis becomes one of the analyst's internal objects, the qualities of which form the nucleus of his analytic identity, with all the conscious and unconscious cognitive and emotional features of the subject's internal position in relation to psychoanalysis itself. It follows from this that the connection to psychoanalysis cannot be other than an object-relation. In this object various internal objects, both past and brand-new, are rediscovered.

According to this view, the internal psychoanalytic object is constituted thanks to the coalescence of three elements: a questioning stance towards introspective and interactive knowledge as a source of internal change; faith in the existence of an unconscious, unstructured communication process; and lastly, faith in the analytic setting as an elective condition for a psychic transformation. In order to be stable, this tripartite nucleus of analytic identity needs to be continually subjectively experienced as true and accompanied by a work of reflection undertaken individually or with others.

In this context, a possible confrontation is glimpsed during training between the analytic capacity, strictly attributable to the sphere of the individuality, and analytic competence which instead draws on the personal/public dimension. At present there is an ever more obvious bias in favour of the latter, which is turning out to be preferred **(Garella, 2014)**. Here, the analyst's identity seems to encounter a tormenting ordeal:

the demand for a constant dynamisation of theory and practice creates a controversial space in which it is possible to lose contact with a psychoanalytic essence that is certainly hard to define, but which we nevertheless feel to be present. Moreover, the vehement defence of change at all costs, necessary and unchallengeable, sometimes seems to embody an obligation to confrontation, one that looks more likely to lead to the denaturing of psychoanalysis rather than to its enrichment, without a real synthesis, now that even institutions sometimes tend to overemphasise change.

Furthermore, relationships in the institutions sometimes tend to concern themselves more with primordial modes of relating (the dualism of good/bad, psychoanalysis/not psychoanalysis, for example), almost tribally, as is still the case between «young» and «old»; or even towards a sibling-style egalitarianism (the captivating but mendacious egalitarianism of eternal peers) that then risks making matters worse, more or less covertly exacerbating intergenerational rivalry.

Diluting analysis, but also caging it in excessive dogmatism **(Grinberg, 1983)**, are two of the harmful factors that undermine the evolution of psychoanalysis and the stability of psychoanalytic institutions, and threaten the cohesion and identity of the individual and the group. The psychoanalytic community must therefore ask itself not only about the nature of the attacks on it from outside, but above all of those coming from within psychoanalytic circles, even when they are masked by tendencies towards a broadening of perspective or «liberation» from the bonds of «outmoded» theory, with the well-known and now worldwide attitude that whatever seems new, or seems to be going in an opposite direction to the «old», is by definition right, especially if it has an «anti-establishment» flavour.

Psychoanalysis and the Digital World

I have previously noted at length (Marzi, 2013, pp. 29ff) the way that the digital world is of concern to psychoanalysis, which still adopts a variety of approaches to it.

We have, nevertheless, become progressively more aware of how the arrival of the digital age, by influencing the way in which one is a subject, may consequently influence the practice of psychoanalysis and the analytic relationship and setting, and thus induce a possible dynamism in the analyst's own identity. This can be brought about by the increase in his level of relational suffering faced with unfamiliar phenomena in the session, but also by reorienting and probably enriching his capacity to approach «new» patients, thereby avoiding the scotomization of the cognitive power of psychoanalysis. Fundamentally, psychoanalysis has every right (and I would say duty) to challenge those forms of sociality and of mentalisation which put themselves forward as new (Egidi Morpurgo, **2013**, 33ff). «The feeling of beingfrightened exists - in the human condition - but knowing how to tie oneself to the helm of a ship tackling the storm of towering new-unknown waves also exists» (Ferro, **2013**, XVIII).

Does coming into contact, in the session, with the atmosphere created by the information-driven climate, with its rituals embodied in the use of devices, in their irruption - even physically - into the session, in their trans-contextual presence **(Merlini, 2012)**, affect the possibility of staying within the bounds of one's own previous analytic identity? Or does it violate that possibility?Aspects of the Self, and intrapsychic, interpsychic, and intersubjective relations, are influenced and subjected to possible changes.

So here is a first point of reference for the analyst's identity in relation to the digital dimension: not only must we ask if existing psychoanalytic theories are adequate to comprehend the human condition and to constitute subjectivity during periods of rapid technological change; but also if psychoanalysis will consider it necessary to find a modulation and/or modification in theory and practice, so as to grasp the new forms of subjectivity that are currently making headway in the world, which is the same world that created cyberspace. We can also ask what the internet has produced and will be capable of producing within psychoanalysis, and at the same time what psychoanalysis will be able to make of the internet.

Psychoanalysis needs to work at reflecting on certain crucial, decisive and specific points, such as the nature of virtual reality, the world of information technology, the new media, and the potential dangers of psychopathology intrinsic to immersion in cyberspace.

In my opinion, virtual space succeeds in being mental space (and *vice versa*, we might conjecture), when it is correlated with shared experiential zones (of exchange, of superimposition) if the subject succeeds in living this space as a place where «drafts of analytic thought» (Hautmann G., **1999**, 76) are possible, using cyberspace («dreaming it») as a constant and flourishing source of thoughts (Marzi, 2016).

To succeed in this, it is necessary to undertake analytic work which evolves as much as possible towards a three-dimensional relationship: tri-dimensionality - that is, a dimension which entails the presence of space - makes possible analytic operations such as projection and projective identification with regard to space and to the (virtual) objects which exist in it.

In these cases, the subject can connect dispersed or, at least, unorganised elements - *proto-informatic elements*, we might call them - giving to them a form of life, experiences, original elaborations (even artistic ones), and adventures of the mind that are not imbued with omnipotence or destructive narcissism (Marzi, 2016).

Connected elements which connect rather than fragment. In the analytic session, this material constitutes a pabulum out of which unknown emotions, given and re-given meaning, can come to life within a movement towards the attribution of sense (Marzi, 2016).

So, it seems fundamental that we succeed in exchanging emotional-affective communications with the cyberworld that feed back into a process of symbolizationcapable of becoming a «relational flow».

Psychoanalysis in the Spirit of the Age

It is yet to be understood whether specific reflection on the identity of the psychoanalyst confronted by this world will generate genuinely substantial innovations.

Psychoanalysis is not the embodiment of an ontologically immutable entity, a perpetual invariant with the couch following in its wake, but is in reality subject to the recognition of rapid, fleeting transformations on the part of patients who are bearers of tumultuous or confused experiences of reality marked by modifications in the perception of space and time, and especially when it comes to cyberspace by the prevalence of narcissistic and autistic behaviours. This increases civilisation's discontent, but also that of the analyst himself and of the analytic relationship.

But is a new identity really being required of the analyst, or do we in some way risk mistaking a changing relational colouring for an absolute innovation?

Maybe new pathologies, new settings, new patients, and so on, are not all that new. And at the moment it is not clear that this entails a need for theoretical and technical modifications within psychoanalysis.

Coming into contact with features that we know to be already present in psychopathology, but which are transformed and moulded according to present socio-historical conditions, requires an effort of transformation on the part of the analyst, not in the sense of a «new techno-analytic man», but in his ability to utilise what is emerging from Information Technology as one element assimilable to the others already present in his analytic work.[3]

Besides, a variegated multi-contextuality is something that constantly cuts across the analytic session and takes the analytic couple into many different places, which within the distinctive dimension of the encounter and of the analytic «device» can find a new orientation, a new meaning.

This is possible thanks to the specific use of all this material as a psychic and allusive derivative for which we construct the possibility of symbolisation and comprehension. And yet the digital world, in all the variegated forms in which it presents itself, can produce disorientation in the analyst: from stories told by the patient in chatrooms, to blogs, gaming and surfing experiences transferred to the session, right down to the simple «interventions» of the mobile phone in the middle of a dialogue between the analytic couple.

We do not really know what impact this complex, lava-like condition may have on the analytic process, or whether and how it may influence the analytic field.

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3 In any case, it has been known for some time (Suler, 1998) that «Computers can be a prime target for transference because they may be perceived as human-like», thereby becoming representative elements with which to set up relationships of various kinds, from the most primitive to the more highly organised such as the Oedipal.» On the macrosocial relational level, see instead Merlini, 2012, 10; Civitarese, 2012, 36; Muscelli and Stanghellini, 2014. In this field Lacan proposed the well-known concept of the «discourse of the capitalist».

Certainly one of the central points in the unfolding of the analytic process lies in avoiding the seduction and the traps produced by a lack of or insufficiency in the elaboration of the proto-informatic elements coursing through the session, leaving patient and analyst captured or colonised by them, and feeling that there is no way out.

The effort to be made is first of all in the direction of an attunement with the everyday digital dimension in a broad sense since it is in fact obvious that many of the difficulties in this approach and form of contact reside in a preconceived mistrust that denies that all this is here already, for good or ill, and that it would be a big mistake not to take up the challenge it presents.

A Clinical Illustration

I have tried to show how it is possible to work in this way by means of a clinical reflection about a patient, Gianni (Marzi, **2013**, 119), with whom I had an important analytic experience which somehow

reversed the usual direction of the clinical cases that are reported in the literature: all the clinical cases on the subjectbear witness to this trend in particular, where elements of the psyche are projected and cannot be reclaimed. Among other things, Gianni allows me to suggest the opposite possibility and bring it to the fore: that of the return from cyberspace of what can be thought of as an object-world which had previously been evacuated into it.

Gianni, thirty years old, after a psychotic breakdown during which he has also attempted suicide, begins an analysis where he shows a psychic inner world characterized by severe depression within a narcissistic personality (a «thin skin», after Herbert Rosenfeld's definition, **1987**), and he also feels seriously stressed and attacked for complicated internal reasons. After several months, a phase of greater elaboration begins. He also begins to say that «he is thinking about indefinite things», and I feel that this might hint at the drafting of an idea.

Gradually, persecutory and threatening dreams appear, and after some time he recounts this dream:

> Alone at home I'm watching a film on my PC. The characters were behaving like those in the museum dream, in the dangerous game… The film was also interacting with me. The characters were coming into the room, they were doing things and I was frightened. I had to watch this film again so that these people would not do certain things [felt by him to be negative]. Watching it again, I manage to catch some details that allow me to finish watching it without problems, that is, preventing the characters from coming into the room…

From that moment on, the form/dream of the computer with characters that come out of it is repeated many times, in various versions of the story. So, the characters from

the screen have to be welcomed into the room, and these, from one time to the next, bring hate, competitiveness, jealousy, rivalry, and dysmorphic-phobic anxieties. It is impossible to give more details due to lack of space. It will be sufficient to underline that those objects/characters have attempted to return to the processing dreamspace by passing through the video by way of dreams and the conjoined «ferrying» force of myself and the patient. These characters succeed in returning inside this dimension, allowing the conditions for the development over time of an aggregation in the form of meaning. The space where the objects were originally located, where they «resided», split and evacuated, before their beneficial overflowing to the exterior, appears, in contrast, like a place that is still virtual, but alien, the place where those characters previously used to remain imprisoned, dumb and immobile, virtual and only hopefully symbolic. Gianni now allows himself, when on the edge of annihilating events, the possibility of setting out with trust and hope, into a psychic land that manages to promise a mental existence in several dimensions, including that of internal time. In the experience with Gianni, all these objects flow out of the computer because the patient lets them emerge, just as from the triage of his split psychic elements. A place of dual potential: of annihilating ruin but also of vital manifestation.

With this brief vignette I aim above all to underline how it may be fundamental for the analyst, and for keeping his identity solid and dynamic when in contact with the digital dimension, to be able to keep open the three-dimensional space with the patient, a virtual and psychic space where it is possible to carry out analytic operations that are at the same time a confirmation of his own identity. This process does not occur without anxiety, turbulence, and fear.

This is, above all, the case when the qualitative and quantitative condition of the cyberworld which bursts into the consulting room exceeds the capacity of the analyst and/or the analytic couple to metabolize it, as is sometimes the case with a marked internet addiction. And yet here too, beyond the variation from case to case, it is possible to glimpse the possibility of analytic work: this is what David Rosenfeld tells us in the long clinical case history of Lorenzo **(Rosenfeld, 2016)**.[4] Besides, the democratic attention to pluralism (with a consequent enlargement of one's own identity) cannot be allowed to turn into anarchic eclecticism, and ultimately the notorious (and definitely postmodern) dimension in which «anything goes» which I too have addressed many times, identifying its dangers and its problematic character.

Even in the presence of conditions that are in themselves new, or at least different, flowing into the consulting room, what turns out to be decisive and to reaffirm constantly the analytic identity is the rediscovery, igniting and re-experiencing of what can variously be called the analytic function of the mind, the central activation of the

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4 Without inviting us into a careless eclecticism about boundaries and the limits of psychoanalytic methodology. It is still necessary to question whether the analyst's work is really like this, or whether instead we are in the presence of repeated attempts to flee from a still adequate analytic process.

psychoanalytic object, or even, according to a more classical theoretical vision, the validity of the analyst's introjection of his function and of the Freudian scientific work active in his mind.

I realise that all this leaves many aspects of this subject unresolved, partly because there are still many «holes» in our knowledge of this area, prompting us to further thought, research, and change.

Identity and Remote Analysis

This uncertainty tends to increase when the analyst's identity finds itself challenged by the vast, fluctuating field of remote analysis, known more commonly as teleanalysis. We know that, thanks to the use of sophisticated current technologies which allow almost instantaneous video and audio connections, many psychoanalysts now agree to treat patients over the internet, aiming to grant this mode of treatment a future as a likely co-protagonist within the setting.5

We are called upon to develop a better and greater understanding of this additional new frontier, to grasp the possibilities of its use and to make a critical evaluation of an evident tendency for certain practices to proliferate so far that they risk becoming no man's lands.

In this experimental phase of study, several areas are emerging which need further understanding, and they concern not only technique in itself but also the theoretical and technical reverberations on the identity of the analyst getting to grips with this territory.

I wonder if this kind of clinical relationship, whether telephonic or conducted via video-conferencing, is adequate for every type of patient, or whether it is specific to certain cases, and if it is functionally equivalent to analysis in person by prioritising dreams, free associations, resistance, and the experience of the oscillation between transference and countertransference.

It seems that this mode is not possible if the patient does not possess the ability to preserve the therapeutic alliance and to share responsibility for the management of the setting, or if the analyst fosters doubts about this method, if he feels «disconnected» by the lack of a physically present analytic couple: that is, if this is going to undermine the maintenance of his identity in relation to the patient. It is therefore fundamental that we use remote analysis only when there are no alternatives, when there have previously been periods of physically present analysis, and if the analytic couple is convinced and confident that the analytic process can continue even at long range.

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5 For a careful examination of this field, seethe three volumes edited by Jill Savage Scharff, *Psychoanalysis Online* (Karnac). If I may refer to the first part of volume three, this contains a chapter by Marzi-Fiorentini, «Light and shadow in online analysis», which addresses the topic at length.

My personal experience underlines the fact that this mode of working is quite adequate on the whole, and that an analytic relationship can be obtained that is to a large extent congruent with the classical model, provided that certain requirements are respected, such as the presence of a previous analytic history with the subject, precise agreements on the setting, the patient's consent, consideration of the possible technical difficulties, no over-dramatizing, and plenty of good sense.

What seems fundamental is the willingness of the analyst (and obviously the patient) to accept every manifestation of the «remote» setting within the analytic elaboration of the couple at work, which includes troublesome interactions with the technological problems that can occur and which are as fundamental as they are neglected by investigations in this field.

Teleanalysis (which may include the telephone) brings out, intact, all the complex and intricate characteristics intrinsic to the analytic relationship, but here they are increased by the presence of the problems provoked by the communication medium. This unavoidable variable of the setting therefore constrains us to think about the meaning of a specific communication by the patient in a certain moment of the analysis, but also the fact of the possible impact on that communication and on the analyst's listening from

what is contributed by the active presence of the telecommunications medium, by its inescapable technological presence, its disturbances, crashes, and so on. This is a «third» which is neither a third ear nor an analytic third: it is a «datum» in the etymological and literal sense of the term, an element which exists separately from the couple at work but which nevertheless keeps coming right into the work of that couple. It is simultaneously an external and internal element, and because of all this, it can (must) necessarily be elaborated and managed as an element of the analysis itself, becoming in fact second nature to it, and because of its fragility can, for example, produce real and random disruptions of the setting. What comes into the picture here are not only the features that classically belong to the analyst-patient relationship, but also all those of what we might call the «telecommunicative field» which, viewed jointly from the complex but stimulating perspectives of clinical practice and theoretical investigation, form a sort of analytic-digital field. All of this further challenges the identity of the analyst.

Needless to say, here too it is fundamental to create a genuine relational three-dimensionality in which the field can contain and transform these processes. Access to this dimension also depends - and this definitely concerns the analyst's identity - on a particular inner capacity of the analyst himself, who must always take into account the fact that the quintessence of the unstoppable dematerialisation which is one of the founding characteristics of cyberspace, sometimes shows the danger, when it collapses, of making the opposite phenomenon excessively present, a hyper-materiality which risks not being metabolized by the couple. It follows from this that even thinkability and long-range work can be developed if the need for creative exchange is satisfied,

whereas their collapse may be due to the breakdown of such relating. These are characteristics which create contiguity with, rather than divergence from, the dimension of the analytic relationship in person.

In one of the first sessions via Skype, due to her moving far away, Cecilia - who has been in analysis in person for a few years - brings this dream:

> Treatment of a woman. Many attempts, experimental things, some kind of epidural catheterization. I discuss it with somebody, I do not know who. An attempt outside the box. Something that has never been done for someone in great suffering. Then, as if we are in a kitchen, with many people, a party, and the woman is lying in the room next door, she feels unwell and we decide to carry out this experimental treatment.

The analyst tries to tell her that she is still talking about the Internet… Some «heroic» attempts are carried out, which have never been made together… Who knows what will happen? Experimental stuff… Perhaps the party appears because there is still nourishment in the analytic setting, but there is also an attempt to «commit to» having fun, which often happens to her [a defensive and elusive characteristic of the patient]. Then there is the sick woman: she is the needy patient and lies in a «separate» room (just as she actually is now, far from the known place of analysis), and she needs to be «rescued» through these «experimental procedures». After all, the catheter goes to the Central Nervous System, and the tube is like the microphone cable that somehow connects us with the voice without a presence.

Later on in the analysis she dreams about a character who is «*swimming over to help her at the Reception Centre, where there are many people in need*»….

It is certainly true that I am swimming with her in cyberspace and have become just as much a net-surfer as she is, swimming in the virtual sea but not giving up on her, coming to her aid because I am aware of her need and am accepted by her.

So one of the central points of the analyst's identity resides in the possibility of better understanding the nature of teleanalysis and the stance to be adopted in relation to it: an analyst who should come across as well-motivated, animated by a spirit of inquiry and experimentation, but attuned to the fact that the digital world necessarily enters the analytic field, asks to be accepted and elaborated, offers itself as important material to be listened to and metabolized within a signifying chain.[6]

When conducting a remote analysis we nevertheless notice that, in the majority of cases, the analytic method has its own internal energies and capacities able to absorb this new characteristic into its «digestive» force, thanks perhaps to the possibility of construing itself as a tool of cognition connoted by a certain distance adopted in relation

6 An analyst, moreover, who should be aware of the risks represented by desires for omnipotence which would denature the analytic relationship, and which include the analyst's own insidious worries about earning a living.

to historical contingency, from which would arise an applicability to very diverse historical situations thanks to the «referent» represented by the centrality of the subject's psychic reality (Ceserani, 1998). This represents a condition directed towards an emotional experience of high value which can be used by the analytic couple for genuine psychic growth. It is also what is proposed by, among others, Ogden (**2009**, **2010**), discussing the three forms of thought (magical, dream and transformative) which are very suitable for the field of remote analysis.

The creation of this space, the energizing of emotions and emotional experience which become thought, and the transformation of the (dangerously) inanimate and a-symbolic into animated and symbolic flow, are also constituent features of what may occur in the remote analytic relationship, and it is exactly how my patient described it to me, with surprising oneiric intuition, as she and I together grappled with this new experience.

Summary and Keywords

It is undeniable that the digital world invites in-depth studies of psychoanalysis itself and of the virtual spaces of the mind. all this pertains to the patient who brings «computerized» baggage into the session, but also to the analyst, who is subjected to currents that intensely stimulate his preexisting frames of reference, reinforcing his identity. trying to better understand this latter condition requires first examining the definition of the analyst's identity and then the nature of virtual reality, with its impact on the psychoanalytic field and on the analyst's identity itself, seeking possible integration. some clinical illustrations are used in an attempt to deepen the field of reflection on this topic - not only in general, but also in regard to the frontier of **distance analysis**.

KEYWORDS: Analyst's identity, cyberspace, clinical psychoanalysis, computerization, **distance analysis**, identity, psychoanalysis, teleanalysis, virtual reality.

IDENTITÉ DE L'ANALYSTE ET MONDE NUMÉRIQUE: UNE NOUVELLE FRONTIÈRE DE LA PSYCHANALYSE. Il est indéniable que le monde numérique stimule des approfondissements sur la psychanalyse elle-mĕme, et sur les espaces virtuels de l'esprit. Tout cela concerne le patient qui apporte un bagage «informatique» dans la séance, mais l'analyste aussi, pressé par des courants qui sollicitent fortement ses précédentes coordonnées de référence, en en stressant l'identité. Essayer de mieux comprendre cette dernière condition exige que nous examinons préalablement la définition de l'identité de l'analyste, et ensuite la nature de la réalité virtuelle, avec ses conséquences dans le champ psychanalytique et sur l'identité mĕme de l'analyste, en cherchant une possible intégration. Certaines illustrations cliniques visent à approfondir le champ de réflexion sur cette question, non seulement en général, mais aussi par rapport à la frontière de l'analyse à distance.

MOTS-CLÉS: Analyse à distance, cyberespace, clinique psychanalytique, identité, identité de l'analyste, informatique, psychanalyse, réalité virtuelle, télé-analyse.

IDENTIDAD DEL ANALISTA Y MUNDO DIGITAL: UNA NUEVA FRONTERA DEL PSICOANÁLISIS. Es innegable que el mundo digital estimula la profundización sobre el psicoanálisis mismo y sobre los espacios virtuales de la mente. Todo esto tiene que ver con el paciente que lleva un bagaje «informático» a la sesión, pero también con el analista, sujeto a corrientes que solicitan con fuerza sus precedentes puntos de referencia, poniendo a prueba la identidad. Tratar de comprender mejor esta última condición exige que entremos primero en la definición de identidad del analista, luego en la

naturaleza de la realidad virutual con sus consecuencias en el campo psicoanalítico y en la identidad misma del analista, buscando una posible integración. Algunas ilustraciones clínicas se esfuerzan en profundizar el campo de reflexión sobre este tema, no solo en línea general, sino también respecto a la frontera del análisis remoto.

PALABRAS CLAVE: Anàlisis a distancia, ciberespacio, clinica psicoanalítica, identidad, identidad del analista, informàtica, psicoanàlisis, realidad virtual, teleanàlisis.

DIE IDENTITÄT DES ANALYTIKERS UND DIE DIGITALE WELT: EINE NEUE GRENZE DER PSYCHOANALYSE. Es ist unbestreitbar, dass die digitale Welt Vertiefungen über die Psychoanalyse selbst und über die virtuellen Räume der Psyche anregt. Das betrifft nicht nur den Patienten, der eine Fülle an «Computerwissen» in die Sitzung bringt, sondern auch den Analytiker, der unter Strömungen steht, die stark in seine früheren Referenzkoordinaten eindringen und seine Identität auf die Probe stellen. Der Versuch, den letztgenannten Zustand besser zu verstehen, erfordert, dass wir zuerst die Definition der Identität des Analytikers anschauen, dann die Art der virtuellen Realität, mit ihren Folgen auf dem Gebiet der Psychoanalyse und auf die Identität des Analytikers selbst, um eine mögliche Integration zu versuchen. Am Beispiel einiger klinischer Fälle wird sich bemüht, den Reflexionsbereich dieses Themas zu vertiefen, nicht nur im Allgemeinen, sondern auch in Bezug auf die Grenze der Fernanalyse

SCHLÜSSELWÖRTER: Cyberspace, Computerwesen, Fernanalyse, Identität, Identität des Analytikers, Psychoanalyse, psychoanalytische Klinik, Tele-Analyse, Virtuelle Realität.

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Comparison of In-Person and Screen-Based Analysis Using Communication Models: A First Step Toward the Psychoanalysis of Telecommunications and Its Noise

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As the popularity of computer-mediated psychoanalysis rises, it is important that analysts and researchers undertake a more comprehensive investigation of the parameters involved in mediation and their effects on the psychoanalytic setting, the analytic field, and the unconscious of the analytic couple. The primary aim of this paper is to offer a series of communication models that visually lay out for comparison purposes key aspects involved in both in-person and mediated psychoanalytic communication. Particular emphasis is placed on the nonverbal channels of unconsciouscommunication, so vital to reverie, and on the attenuation and distortion of these channels when electronically mediated. Also addressed are the disruptive capacities of communication devices and the mediation artifacts that are inevitably introduced by telecommunication systems, whose overarching goals of efficiency, clarity, and expediency conflict with those of analysis. The paper ends with a call for the psychoanalysis of telecommunications.

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Jill Savege Scharff. 'Clinical issues in analyses over the telephone and the internet'. *International Journal of Psychoanalysis*, 2012, 93, pp. 81-95.

Review by:
David Hewison

Jill Savege Scharff is an internationally respected individual, couple and family psychoanalyst who works in Chevy Chase, Maryland, just outside Washington DC. She is the author of many books and papers on the theory and technique of analytic work and has a strong interest in the line of object relations thinking after Fairbairn, a fellow Scot. She is the editor of a new book on the use of communication technology for analytic treatment and professional training **(Savege Scharff 2013)**. This current paper reviews the kinds of clinical issues that arise when conducting analysis over the telephone or the internet and is a very good introduction to what is an increasing phenomenon generally, and certainly a part of the work that Jungians and psychoanalysts are doing in enabling the development of analytic trainings in countries without a home society.

I have taught and conducted consultations to professional colleagues by video link across time zones and have had a small number of telephone analytic sessions, but I have never conducted an analysis in this way, so I was fascinated to read about the kinds of issues that it raises. I was also impressed that telephone analysis was already being written about in the early 1950s **(Saul 1951)** though it is only really in the past 13 years that it has become a professional talking point, with an increasing number of papers being published and another book on the topic in 2011 **(Carlino 2011)**.

The basic argument seems to be that analysis over the telephone and the internet (for example using video links such as Skype) works, but does it work properly or enough? Proponents of it suggest that it can uphold the standard tenets of analytic work: **Hanly (2005)**, for example, found that 'responsive holding, witnessing, and interpretive functions can be sustained, free association occurs, and the expression of paternal and maternal transferences are not compromised' (Savege Scharff **2012**, pp. **84-85**). Others found that it aids the analyst's suspended attention and allows a silent-but-holding presence, and can facilitate an intense affective experience—including the surfacing of hidden transferences in patients who had previously had analysis in person—yet minimize the risks of impulsive action. Those analysts who think it does not work properly or enough point out the losses involved in it: the loss of the bodily presence of both analyst and patient, the loss of the consulting room, the risks of regression, the difficulties in organizing joint care with psychiatrists when needed. **Argentieri and Mehler (2003)** concluded that it was traumatic and not compatible with psychoanalytic procedure because it simultaneously provokes and denies loss; **Yamin Habib (2003)** felt it was a paternalistic, action and information-privileging exercise in inauthenticity.

Yet listening out of sight has been an essential part of psychoanalytic technique ever since Freud tired of being looked at by his patients, and

some analysts close their eyes when listening to their patients so as to better catch the drift of the unconscious so that neither analyst or patient is seen. This echoes Freud's instruction that the analyst 'must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone' (Freud **1912**, pp. **115-16**) and highlights the process of analytic contact rather than the setting (though the debate of course is about the degree of sufficiency of the setting in non-present analysis). Analysts who listen on the phone make visual images of what is happening, and where, and how, in exactly the same way that they do in person; these can form part of the 'picture' of the session and influence the nature of internal thinking and external comments and interpretations. **Mirkin (2011)** and Savege Scharff's colleagues in a teleanalysis working group compared process notes from an in-person session and a teleanalysis session with the same

patient and were unable to tell which session was which. This may well have been to do with the analyst's style (of work and of writing) and may also have been influenced by having had both types of experience of the patient. But it may not have been, and Chodorow's **(2004)** comment that the commonly held view that in-person sessions are better, *despite a lack of research data*, is important to keep in mind. Here's the rub: analytic thinking about changes and developments in technique tend to be theory-driven and rely on idiosyncratic case-reports that tend to confirm the broad components of the theory which then only change slowly as the new ideas spread **(Dreher 2000)**. As teleanalysis is increasing in prevalence, this suggests that many analysts will begin doing it without a fully-formed idea of what it is they are doing. This only matters if they think they are doing something wrong, or second rate, in which case their own transference to the process will get in the way of effective work. An analogy is the development of psychoanalytic psychotherapy as a disputed 'watering-down' of proper analytic work—with an argument not dissimilar to that about teleanalysis now; I think few analysts would argue against the provision of such therapy, even if they prefer to do more intensive work. Instead, we think about what provision might be helpful for which patient. It means that we need to continue the discussion about the experience and I would suggest that it is unhelpful for the IAAP to have deemed sessions delivered by **distance analysis** as counting for less than sessions in person towards the training analysis requirement for developing group trainees or routers.

Savege Scharff's paper includes guidance as to what to attend to in doing **distance analysis** by telephone or by video link; she discusses such things as whether the video is one- or two-way (can the patient see the analyst too?); is the camera pointing at a couch and if so, what can be seen? She also notes both contraindications and indications, sensibly pointing out that if the patient doesn't have the capacity to maintain the alliance and share responsibility for the management of the setting (we might imagine, for example, not having a session in an internet café or on the phone in a clothes shop). Similarly, if the

telephone or internet connection isn't strong enough, or if a patient must have a physical presence on clinical grounds. She also includes an account of a case where the **distance analysis** worked well—particularly in getting to an area of the patient's experience that would have been kept out in person. It was certainly not all smooth sailing, as her description of a failure in her telephone headset shows: from her side, she felt that the patient's silence was an increasing resistance and so began to comment on it; from the patient's side, he felt he was in the presence of an increasingly irritated analyst (of course he would have known before her that there was a technical problem). The fault was discovered and fixed, and the incident worked through, and the analysis continued. Breaches in contact such as this are not only the province of **distance analysis**, of course; sometimes analysts mishear what is said to them by their bodily-present patients, at other times they are asleep. **Distance analysis** is growing: it's probably time we learned much more about it and this paper is a good place to start.

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A Review of 'A Very Dangerous Conversation' by Aisha Abbasi

Catherine Chabert

Preface

Before turning to the discussion of Mr F's treatment with Aisha Abbasi, I would like to mention the intense interest aroused in me by a careful reading of the text relating to his treatment. This is a document of exceptional quality, in the sense that the 'story' of the treatment is constructed and written in such a way as to transport us onto the very scene of the analysis: this is due, presumably, to the magnetic pull of the transference in operation, as it is conveyed by the analyst's words.

The freedom of expression in the text immediately conveys the engagement of the two partners (or, should I say, the two protagonists, at least as far as the beginning of the treatment is concerned), whose authenticity, in the essential sense of the word, is striking. The material is there, open to reading, transparent and in plain sight; it offers itself up to the reader's freedom of association as no doubt it offered itself up to the analyst's. In such a way some very lively themes of identification are mobilized and resonate in the distinctive analytic experience, and this is what has prompted me to offer my comments.

What I mean is that, to begin with, the transference is also conjured up in this paper in very particular forms which I will briefly highlight: the analytic materialunder discussion is in written form and I have access to it through reading; I shall set out my thoughts about this material in writing and, thus, it will be received through someone reading it. One can immediately notice how the resonance with a highly developed pattern in the text emerges in an exchange system which is not established or active in the presence of the participants, but rather *in absentia*, since after a while the treatment was continued over the telephone. This might be a commonplace or trivial element; however, I feel it is necessary to mention it in the context of this paper.

The second point of this preface concerns the almost paradigmatic character of the issues raised by Mr F's analysis: about these I will now offer my personal thoughts.

These issues concern a kind of analytic situation which raises many questions for contemporary analysts in terms of both practice and theory: the clinical presentation of the transference appears quite different from the more classical form of transference found in Freudian psychoanalysis.

In particular, much emphasis is placed on the 'new indications' of psychoanalysis and on the changes that are implied. These shifts in orientation determine certain trends of thought to which the evolution of clinical work and of psychopathology lend support: the latter might explain the major

upheavals taking place in psychoanalytic practice, in the sense of a massive growth of narcissistic and depressive distress. Such changes might need some radical reshaping of theory and practice, with the introduction of an uppermost emphasis on the field of beginnings, of early relationships and of their manifestations. In this respect, some confusion arises in the concept of the 'archaic', because of an inadequate evaluation of regression on the one hand, and of the afterthought on the other, which leads to submerging difference into otherness.

The problems inherent in limits and the states which signify them can be defined by the precariousness of the boundaries between inside and outside, by a porousness in the envelope which exposes the mind to intrusions, to projections and to confusion: in such contexts the analyst's attention and interest must be focused on the differentiation between me and other, between subject and object, without using these specific terms.

The confusion of time, which can be so valuable in the course of the analysis when it is understood as a product of the transference, loses its dynamic quality and dwindles into a fixation on certain points within a chronological time frame.

The Other then comes to represent what is not me, the external, the person to be rescued or the stranger, identified as a 'non-me' whose sexual aspect is obliterated. The difference between the sexes becomes somehow of secondary importance, pushed into the background, and with it is removed its main, but also its most trivialized and thus distorted expression, the Oedipus complex.

In support of this contemporary tendency in psychoanalysis, many papers which deal with narcissism and depression often condemn an approach which is too centred on sexuality. The critics of this approach highlight a lack of consideration of the earliest times in life, and this trend curiously resonates with cultural pressures. Such transformations in the clinical field soon lead to Freudian metapsychology and to the need to point out its deficiencies, to bring it up to date or even to abandon it due to its obsolescence.

If we take this route we are at danger of forgetting the two great themes which move through Freud's work, governed by the two paradigms of hysteria in the first place, and narcissism and melancholia in the second. The former produces the first topic and the first drive theory concerning the conflict between the drive for survival and the sexual drive; the latter bears on the second topic — the conflict between the life instinct and the death instinct. The former tends towards the path of pleasure, the satisfaction of desire and healing; the latter manifests itself in masochism, in pain, in repetition compulsion and in the refusal to heal. No analyst can deny this double path, nor the necessity to accept its double nature, without excluding one or the other.

There must be no rejection, no abandonment, rather a continuously present and active dialectic, which is necessary for a theoretical reflection on clinical practice and in order to make place for a genuine metapsychological approach. We know the pitfalls of divorcing theory from analytic experience, we know the inherent dangers of abstraction and disembodiment in

such a procedure, as well as the threat presented by narcissistic stumbling blocks. But we also know the dangers which threaten practice divorced from any reflective thought and the eventual deviations which reduce the method to a simple *praxis.*

The way has been opened up for us by Freud and by many 20th century psychoanalysts: the work must be pursued without disowning its antecedents, by making use of our legacy and capitalizing on the transformations it will inevitably undergo.

It is true that tributes to Ferenczi (1932) and **Winnicott (1975)** have had considerable influence on approaches which stress the maternal environment: does this mean that these writers relegated the father complex, forever, to the arcane dimension of psychoanalysis?

The positions they took can only be understood in the context of a dialogue, a way of addressing Freud's points of view and a deep knowledge of those views. It seems to me that this is the journey described by Abbasi, a journey which testifies both to a solid attachment to the most fundamental principles of the psychoanalytic method and also to a specific emphasis on developing a contemporary treatment: this journey resonates, I feel, with the focus of her reflections, which places cultural and religious difference at the centre of the transference and of the analytic process. It is this theme which I wish to follow in the course of my discussion of Mr F's treatment.

The Beginning

Mr F's presentation is striking: he begins by recalling his brother's suicide, a suicide which just as immediately takes on the significance of a murder. Thus the scene is set for a melancholic crime, which triggers off in the analyst an inner turmoil and a thought of rejection, each as violent as the other. The reader is also gripped, not only by the scene of the first meeting between Mr F and the analyst, but, beyond that, by the vivid and immediate style of the paper — the instantaneous establishment of transference in its different interlocking forms between the analyst and the reader.

I have to say that I was particularly gripped since I had just experienced a similar situation with a young woman who had come to see me for analysis, and that an empathic movement drew me quickly to Abbasi

because of our identical reactions — an interesting coincidence regarding the impulse of rejection and, at the same time, a gap between us because I was surprised by her response to her patient: “How dreadful!”

This comment, however, was fruitful since it activated one of the essential characteristics of Mr F's psychic functioning, the apparent lack of affect. We might ask ourselves whether this lack is a product of isolation, of splitting or, more specifically, of a traumatic reaction to an event which has not been psychically registered. This might be a selective form of anaesthesia, caused by fragmentation and overwhelming pain; or else, taking a more structural perspective, it might reflect an incapacity to experience feelings because the inner dimension of a private psychic space is either precarious or non-existent.

In 1977, in *Birth and recognition of the self*, J. B. **Pontalis (1977)** recalls the impetus provided by H. Deutsch in 1942, when she described the 'as if personalities **(Deutsch, 1942)**. I take up this rather ancient reference to demonstrate its clinical relevance on the one hand, and, on the other, in order to dismantle the idea that borderline types of functioning are an exclusive product of contemporary psychopathology. Deutsch points out the relatively vague character of the clinical picture, when compared with the picture characteristic of neurosis. In neurosis, the symptom ensures a compromise in the treatment of the intrapsychic conflict; in the case of 'as if personalities what is observed are a form of passivity and submission to the environment and a remarkable feature in the transference: *the distress and anxiety are felt by the partner in dialogue*, by the analyst.

This peculiarity must be given attention insofar as it reveals, in the operation of the transference itself, a way of treating affects which indicates a lack or failure in the capacity to provide *internal perceptions*, meaning the perception of what is experienced by the subject within his psychic space. This failure goes together with a propensity to put into the other what cannot be actually kept within oneself. Difficulties in containment may trigger off this mechanism, but without repeating the peculiar object relation modalities in terms of quantity, or economics, or in terms of quality, or dynamics. Is this a suppression of feeling, a ban on feeling any attraction towards the object of the drive, which is definitely considered a source of frustration and disappointment, a prohibition of feeling aimed at preventing the acknowledgement of the internal source of the drive generating this attraction? A prohibition of feeling because of some crime, some transgression, and, if so, what crime?

Are we dealing with projection mechanisms of expulsion, in the Freudian sense of the word, which consist in expelling into the other any impulses which are hard to contain due to the excessive displeasure or excitement they carry?

The operation seems more complex; there is not, properly speaking, a projection of affects in the sense that this would imply an effort of distinguishing between subject and object, in an attempt to mark clear boundaries between the internal and the external: ‘It's not me, it's the other’. Here, the dumping of the affect on the other implies, rather, a loss of differentiation, an obliteration of the boundaries between the two, which comes closer to M. Klein's projective identification (Klein, **1946**, **1955**). Nevertheless, one ought to focus less on the projection than on the perception of affect, which would fit in with Pontalis's clinical discussion of the 'as if personalities: these patients use external reality to compensate for the emptiness of their internal space:

> They do not expel what is inside outside, as the psychotic does in an eminently defensive process of projection, denial and omnipotence; they do not stage, as the hysterical patient does, a scenario already organized into fantastical scenes. One would suggest, rather, that they find their psychic scene in the external world, that they need a scriptwriter to exist.
>
> (Pontalis, **1977**, p. 166)

The scene exists, but it is partly occupied by fragments of external reality — by perceptions — which help to disguise the emptiness of an internal reality which is not experienced as such.

The issue is raised, of course, about the origins of this lack of recognition and belonging. Dependence on the environment is a classic feature in the description of patients with compulsive behaviours. The effect of compulsion is to mask the depressive affects or even actual distress, leaving in its place a kind of smooth, unruffled indifference. The dependence is obvious, as it is each time that addictive behaviours appear as

the primary symptoms: visible, sometimes perceptible symptoms, which are completely involved in the dialectic of exchanges between inside and outside.

There, too, one can find that peculiarity in the transference described by Deutsch: the distress is felt by the partner or partners in dialogue as a corollary or complement to a denial of the perception by the subject himself. This happens because reduction and restriction infect the whole psychic functioning. There are no developments which can move from one point to another; there are no dynamics providing investments on several levels. On the contrary, what can be observed is an immobile narcissistic self-focus, locked in a restrictive chain of problems, hostile to change, massively static and repetitive, in accordance with what it tries to hide in the depth of the self: a huge, infinite, incommensurate expectation, with no limits, in absolute contrast to what is shown in the restriction, the reduction and the contraction of the self.

A Melancholic Transference?

This 'beginning' brings up for me, almost inevitably, the melancholic theme which it reveals. I return to Freud and to the process of melancholia, to the narcissistic inward turning and to the double attack — on the self and on the object — which it implies. By blaming and mortifying the self, by imputing the worst crimes to oneself, the ego attacks just as fiercely the object which is confused with the self. This is in fact the process which appears in the first sessions of Mr F's analysis.

The 'secondary gain' of this self-blame is lost in the depths of the unconscious; in my view, it is embodied in the reversal of passivity into activity, which can be seen in a double perspective; by blaming himself for 'killing' his brother, Mr F gains an active role which prevents him from confronting the impotence to which his brother's suicide makes him captive. For the time being, he shields himself from the actual experience of grief ensuing from his loss; he can avoid acknowledging the violence done to him by his brother. The traumatic image of death and blood, the horror of such images is not linked to feelings: it is the analyst who names those feelings.

The second dimension of melancholia appears in the type of identification: a narcissistic identification, but also a melancholic identification with a dead object, which threatens to sweep him along in the funeral procession dragging behind him — to make him lifeless or, rather, one of the living dead, with no spirit or hope. Except that, maybe, beyond all this, hope or the wish to survive continue and result in the visit to the analyst.

The clinical narrative in the first sessions plunges into Mr F's life and into his childhood history. The issue of his origins appears in the turmoil they seem to create during 'external' events such as moving house and in the patient's constructs regarding the major or minor importance of members of his community being present at those times; but the issue of his origins also appears in his relationship with his body, made obvious by the almost traumatic dimension given to a cosmetic operation on his nose, a nose which he feels is too Jewish and embarrasses him by allowing him to be racially identifiable.

The link with castration anxiety is abundantly obvious here: by trying to excise the sign of his original affiliation, Mr F perceives himself quite definitely as feminine. I emphasize this detail because it is in her account of this same session that the analyst mentions Mr F's choice of an analyst who should not belong in any way to his own community, and should be practically excluded from it: it is in fact the analyst's Pakistani origin which guides his choice, as it has to be someone who is a complete stranger, different from him, potentially dangerous: a woman, perhaps?

A Paradoxical Transference?

Curiously enough, the narcissistic and melancholic dimension go hand in hand, in Mr F's treatment, with certain ways of establishing the transference which strongly recall what has been termed 'the paradoxical transference' by Didier **Anzieu (1975)**. Abbasi gives a clear and penetrating account of this situation: whatever the patient's spoken expectations and the analyst's potential answers may be, there is no way out: the analytic situation seems condemned to an insoluble contradiction.

Anzieu finds, in the notion of paradox, the key to problems encountered in the course of psychoanalytic treatments, when certain kinds of transference bring about, in turn, certain emotional reactions in the analyst:

> This transference/countertransference combination re-creates a repeated and prolonged situation in childhood, where contradictory messages have been communicated by the parents, and which has had traumatic repercussions in some particular ways on the development of the subject's psychic apparatus. […] It is only by being aware of the main types of pathogenic communication that the psychoanalyst is able to carry out the work required and to open up, in consequence, the path of release to the patient.
>
> (Anzieu, 1977, p. 50)

In such a context, the whole analytic situation becomes a reality which confirms to the subject the correctness of his projective system. The only way for the psychoanalyst to handle a situation of this kind is to introduce some changes in reality: to conduct the session face to face, to make an intervention which discloses his personal experience, etc., in such a way as to introduce a *contradiction* to the projected persecution. In Mr F's treatment this intention can explain the analyst's acceptance of the idea of long-distance sessions.

Since Freud, psychoanalysts have been working in terms of psychic conflict, that is to say, with the preponderance of contradictory positions, in

logical terms. This kind of contradiction allows the subject to choose *either* one *or* the other of these positions.

In neurosis the solution is offered by a symptom which partially or symbolically satisfies *both* one *and* the other; this is based on a sense of ambivalence and compromise.

The reasoning in a paradox is different: the two contradictory arguments operate in succession to each other and not at the same time. They do not belong to the same system because they are not placed at the same level of abstraction. A paradoxical command places the person it is addressed to in a *concrete* dilemma. The psychoanalyst's awareness of double bind phenomena and the ability to locate such phenomena in the patient's history does not allow him in any way to dispense with the paradoxical transference/countertransference.

The stakes are all important since logical paradoxes are illustrations of the death instinct. To place someone in a paradoxical situation and then to reproach that person for contradicting him/herself in his/her speech and feelings represents an unconscious move to pervert secondary processes through primary processes. The aim is to maintain power over another through an economic reinforcement, that is, by causing the self-destructive impulse to increase. A kind of negative therapeutic alliance is forged between the unconscious drive of the transmitting person, aimed at the other's death, and the self-destructive impulse of the person who is targeted.

Anzieu defines the characteristic features of these patients, together with the peculiarities of the countertransference, and this leads him to reflect on what he himself finds paradoxical in the analytic situation. The first paradox appears in the analytic approach: because of its open-mindedness, rather than encouraging the expression of repressed or inhibited aggression, as it does in neurosis, in these cases it intensifies the self-destructive impulse. The second paradox appears in the course of the development of the treatment: to begin with, a fruitful analytic progress is made, but the longer the treatment, the less these patients understand of it and the more they misunderstand. As a result, a paradoxical countertransference is a normal, *necessary* response to a paradoxical transference.

To sum up, the pattern involved in inner conflicts is psychoneurotic, whereas the pattern involved in paradox creates narcissistic inadequacies and borderline states.

Good and evil are in contradiction, and the corresponding positions are mainly concerned with desires. The confusion between true and false sets up a different pattern, which transfers from desire to sensation, perception, memory, judgement and, more generally, to thought itself.

The paradoxical relationship between the mother (or the father) and the child represents the symmetrical opposite of the stage described by Winnicott as the stageof transitional phenomena and illusion, when a bond of trust is established between the mother, the infant and the world, as well as a potential to create, through thought, a congruence between external and internal reality.

> Paradox, on the contrary, encourages mistrust and splitting: it undermines the sense of truth and the very being of the subject. I propose a definition of the paradoxical relationship as the negative illusion.
>
> (Winnicott, **1975**, p. 68)

The ambiguity and confusion, which lie at the root of every paradoxical action, treat truth and falsehood, good and evil, love and hate, life and death not as contradictory positions which exclude each other, but as terms which can be switched round, along an endless circle.

Finally, Anzieu turns his attention to the phenomena of the negative therapeutic reaction, in the light of the paradoxical transference. Taking as his starting point different papers by Freud and by his successors (W. Reich, K. Horney) concerning this issue, he suggests that we think of the negative therapeutic reaction as the effect of a paradox: success is experienced as a removal or loss of the ideal, which leads to a major depressive reaction. This reaction is not to be identified with a guiltreaction associated with the transgression of prohibitions emanating from the superego or with the realization of oedipal and incestuous desires. It takes on, rather, the aspect of a narcissistic depression, with the ego ideal being paradoxically crushed by success. According to this perspective, the aims of analysis, and especially its therapeutic aims, are revealed as unbearable: unbearable because of the potentially fruitful effects of the analytic work, and because of the recognition of those effects in the transference.

I am not sure that I can consider Mr F's decision to move away from his analyst and to take up residence in a different town as the result of a negative therapeutic reaction, since this decision was taken very soon after the treatment began. As we know, a negative therapeutic reaction takes place after a period of ‘success’ in the analysis, after the patient has experienced its beneficial effects. Nevertheless, it is possible that he may have foreseen this success or that, quite simply, when the attraction in the transference seemed to assuage his anxieties about intimacy, he felt obliged to set a limit to it.

In this respect, I feel that the position taken by the analyst was very fair: she suggested referring her patient to someone else. By doing this, she let him know that she did not consider herself omnipotent, she did not behave possessively and she respected the patient's choice to move away from her. In the same way, her insistencethat the patient needed to carry on with analysis, that this would be in his best interests, showed a clear concern for him and for his problems, devoid of authoritarianism and of a desire for personal ascendancy.

The repetition, in the transference, implied in the flight from the analyst, is no doubt to be understood in terms of an identification with a mother fleeing from her child's excitation, which she cannot contain; but at the same time the analyst offers the experience of a mother who sets a framework and boundaries: a way of telling the patient that she is not indispensable, and that he can go and seek elsewhere what he has decided to forgo here. In this sense, what is allowed is a removal of investment, a removal which is necessary in respect to an omnipotent attachment and an extreme dependence towards the mother. The identification with a fatherdevoid of

affect, from this point of view, represents a precarious and costly change of investment, since it does not really allow a movement or flow between the parental imagos.

Finally, still regarding Mr F's departure, the analyst acknowledges her own ambivalence towards her patient, something she makes quite clear from the very first session. What is more important, in my view, is the way she makes use of this ambivalence and especially of its negative side: if the object is born in hatred, in this sequence of events there is enough hatred to allow separation to occur. One might almost think that, if the patient had not departed and created a distance, the analysis could not have continued. And another paradoxical implication in this disconcerting treatment is this: it is just at the time when he feels ready to engage fully on a basis of five sessions a week that Mr F is obliged to move away. The greatest intimacy demands the greatest distance.

The Treatment Continues: An Unexpected Development

It is very interesting to notice how Abbasi's paper is organized through the division between different periods in Mr F's analysis: the first part, dealing with the beginning, takes up the patient's clinical history, the polymorphic ‘symptomatology’, some significant features of his childhood and, at the same time, the

beginning of the history of his treatment, the first meeting and the first impacts of the transference. The second part, which is now described, takes a different form: whereas the beginning was presented in a rather concise, though precise and meticulous way, the following section focuses mainly on describing the sessions and the associations which came up in them.

A Long-Distance Analysis

Mr F could not make up his mind to shift his commitment to another analyst, which is a remarkable fact in many respects: while freeing himself from the previous pattern of repetition, which compelled him to leave all his previous analysts, he was obliged to acknowledge Abbasi's special commitment to him. Nevertheless, according to the pattern by which he operated (even though this was beginning to change), he kept his distance and imposed his own version of the treatment on his analyst. Here, too, I am struck by the analyst's flexibility: hers is a flexibility which does not turn into laxity, but takes into account the patient's constraints (internal constraints which he acts out in the transference by demanding a change in the frame to suit himself); her adaptability does not dispense with the firmness which is needed to maintain the essential principles of the psychoanalytic method, without which the process would not be able to develop.

A Long-Distance Transference

The method employed seems to me to mirror in some way the dynamics of the two opposites: activity and passivity. As I see it, while Mr F visibly presents a rather passive behaviour in his real life, unconsciously he is strongly motivated

to fight against passivity and what it represents: to accept passivity means to accept being excited by the other, which in the analysis means to accept being changed by the other's actions. When Mr F decides to move away he is of course motivated by the anxiety raised in him by intimacy with his analyst, but this happens because such intimacy is too exciting for him, because he may fear how the analyst might affect him, the possible changes brought about by the analyst's actions, so that he feels obliged to leave.

When he demands long-distance analysis, he is operating from the pattern of compromise: he can acknowledge his commitment to analysis and above all to his analyst — he accepts their influence on him, but at the same time he attempts to maintain control by demanding long-distance sessions. The analyst's response reflects her usual pattern: she responds in part by showing herself partially available, and at the same time she holds on to some control of the frame, a strategy evidenced by alternating between regular and movable sessions.

I have highlighted this opposition between activity and passivity since, apart from the features which relate very precisely to the management of the analysis as well as to the frame, the associations reported by the patient are based on the same set of problems. The work done on the basis of his associations to the film, *A Prophet* **(Audiard, 2009)** makes it obvious that we are dealing with relations of power and submission, of allegiance and independence, in the very particular context of prison life. What a powerful portrayal it seems to provide of this patient's view of analysis: a prison, reflecting the constraints which imprison the patient inside his psychic functioning. Beyond the reverberations of his ‘symptom’, that is, his criminal culpability in respect to his brother's death, one might speculate that this is a very long-standing imprisonment, anchored in childhood, perhaps brought about by the younger sibling's birth or even earlier. In any case, what interests us is the projectionof this feeling of being imprisoned, which takes place in the analysis itself.

The greatest closeness and the extreme violence associated to it arise therefore at a distance, based on an external fiction (a film). The patient may or may not know whether the analyst has seen the film; in any case, he gives his own meaning to the film. I shall not discuss the very pertinent interpretations offered by the analyst — pertinent for the patient and for herself — but I will mention the emergence of a manifold range of polarities: one between a young and weaker man (a son figure) against an older, powerful man (a father figure); another between two men of different ethnic and religious backgrounds; a third which, at the same time, links the most violent aggression with the crudest sexual seduction.

The third type of contrast is relevant to my argument: I think that the problems raised by ethnic and religious difference mirror those raised by the difference between the sexes.

Long-Distance Countertransference

Although the distinction between transference and countertransference can be rather arbitrary and questionable, I would like to voice some thoughts

about the analyst's ways of functioning in the situation of long-distance analysis. I have been in the position of experiencing this very situation with patients who were bedridden. The impressions left upon me by these experiences can be summed up as follows: the stimulation produced by this adjustment was made obvious by these patients' massive death anxiety (in contexts where there was no ‘objective’ danger of death). This death anxiety, on an unconscious level, was concerned with the analyst and the fear of her disappearance or annihilation. We know those analytic patterns (or patients) showing clearly the correlation of absence with death; such patients undoubtedly have difficulties in internalizing the object and feel unsure of their own continuity of existence. In short, all this illustrates the experiences and lessons we learn from psychoanalysis in theory and in practice, applied to the alternation of presence and absence.

In this respect, long-distance psychoanalysis becomes a kind of laboratory, allowing us to defuse the dangers linked to absence, but also — this needs to be emphasized — the dangers linked to presence: it is a vehicle for analysing confrontations with threatened break-ups as well as confidence in an eternal bond with the analyst.

I believe that Mr F's analysis is exemplary in terms of its temporal dimension, its length and the freedom made possible in respect to the perceived and concrete constraints of spatial location. One brief comment: I have often noticed that in borderline patients' narratives, space replaced time in their construction of their history, as if the spatial location came to compensate for a lack of representation of time. In telling the story of his childhood, Mr F proceeded in this manner, distinguishing two periods — a happy and an unhappy period — by recalling his family's change of place of residence.

The other feature of long-distance analysis which I find most awkward is the fact that, each time I have engaged in it, sooner or later I found myself losing some of my capacity to associate: as if distance, by separating the two partners, created too forcible a distinction between two places and prevented the creation of the double scene, which is so essential to psychoanalysis. Of course, this is a personal experience; however I was struck by this idea when I discovered the experience recounted by Abbasi in connection with the film described by her patient: she had not seen the film when he told her his version, which became the object of intense processing on both sides. She then decided to go and see *A Prophet*, which allowed her to discover the distortions imposed on the film, especially by omission, by her patient.

I very cautiously ask myself, for the question should be asked, whether this search outside the treatment for material associated with it was not determined, at least in part, by the countertransferential distance, even though seeing the film did provide the analyst with some substantial findings. More brutally, I would suggest the idea that seeing the film made up for not seeing the patient. On a deeper level, I wonder about the double visual and auditory dimension of the analytic attention, probably because, in my case, the hallucinatory reverberation of the visual element plays an important role. After all, my internal ‘cinema’ is linked to my capacity to

associate and, strangely enough, the physical absence of the patient seems to prevent this process.

Finally, and very briefly, I will speculate on the possible feelings generated by the absence of the body in long-distance analysis, the effects of which are hard to gauge: excessive repression, excessive excitement, the danger of distancing oneself from sexual feelings, acute distress? So many paths opening up: Such questions emphasize once more how appealing Abbasi's paper is both on the clinical and on the metapsychological level.

Material from the Sessions

From Melancholia to Jealousy

The clinical material quoted by the analyst gives her an opportunity to pursue her work on the effects of ethnic, religious and cultural boundaries on the analytic process. I have already referred to this subject in the

previous paragraph, when discussing long-distance analysis, but I wish to come back to it from a different perspective.

For the analyst, the story in the film, where the hero is an Arab, is significant: the tragic events and the overcoming of his destiny represent the actual playing-out of a confrontation, in the transference, between two persons who are powerfully distinct from each other, especially in terms of their religious affiliation. Finding the meaning of this confrontation allows her to show how the patient's most hostile feelings towards his analyst were able to emerge thanks to the roundabout path made possible by the fiction in the film and the game of identification it allows.

In one of the following sessions, it is political events which function as the plot in the development of the transference: the war between Israel and Palestine takes up the same themes as the film, as if two families were battling to gain the coveted place which each claims as its own.

In each situation, Mr F identifies alternately with the weaker and the stronger character, with the terrorists and with their victims. This alternation allows him to get in touch with fragments of memory from his childhood: the activist and terrorist is the patient himself, with his outbursts of rage; but he is also the abandoned, neglected, betrayed child, when faced with his close enemy, his little brother.

This development conjures up for me the passage from melancholia to jealousy which is caused by the hatred generated by too close a proximity, and especially by sibling rivalry. It reminds me of Daniel Mendelsohn's **(2007)** fine book, *The Disappeared*, and of the connections and disconnections it uses: the hatred of the Ukrainians for their Jewish neighbours, the hatred of his grandfather for his great-uncle whom he failed to save, and, finally, his own hatred and jealousy for his little brother.

When jealousy is experienced, it is bound to expose the harmful effects of idealization and of denial of difference, because it often attaches itself to an obsessive desire for what the other has and the self is deprived of. The person who is closest — the friend, the brother — becomes the enemy, becoming the chosen target of hatred; his qualities, insofar as they reveal something about him which the self lacks, become dangerous and threatening as soon

as their seductive power is exercised. Repulsion is the faithful companion of attraction and terror lurks close by, changing this other person who is different into a persecutor. The biblical story of Cain and Abel opens up the chasm of an unfathomable repetition, precisely because it seems to bypass sexual rivalry. It only seems to, because what creates the gap, the difference between the two brothers, is in fact that ‘little bit more’ love given to one against the other in a configuration which is still triangular. One might truly say that it is in the partiality of love, in what is, in the imagination, taken away, that hatred of difference takes root. What would prevent the discovery, in Abel and Cain, of marks left by actual sexual identifications, one being more feminine than the other, one the innocent victim and the other the executioner?

It seems to me that these are the dynamics which characterize the analytic process in Mr F's case. From his initial melancholic position, he gradually progresses to a gnawing jealousy towards his younger sibling, a jealousy which gives projection its place and its function of differentiation, allowing in this way a countercathexis of the excessive inwardness fostered by the grip of melancholia. Jealousy, intertwined with homosexuality, is blatantly apparent in Mr F's processes of association; it allows a kind of compromise between narcissism and the acknowledgement of small differences. This is the price to be paid if his fascination with death and the risk of being carried away by it are to be quelled; but this is also the prize to be won by obtaining a separation which has now become a possibility. It is in connection with these issues that I understand Mr F's arguments about the payment for missed sessions and about discriminating between those sessions which belong to him — the regular sessions — and those which belong to others: a situation which, in the transference is a paradigm of a mother's dispensation of love.

Towards an Oedipal Triangulation?

The last sessions described in the paper, which concern the dinner at Mel and Nancy's home, finally open up a new direction: they depict an Oedipal type of configuration where the attraction for one person is intertwined with rivalry with the other. Of course, this is a fragile structure for the time being, but in my view it has the advantage of showing intimations of the nuclear complex in the passage from sibling rivalry towards rivalry with a more sexually charged male: what is at stake is not only a mother's (or a father's) love, but the love of a woman who is shared between two men (in Mr F's fantasies). The Oedipal

aspect is made obvious by the fact that Nancy has had an affair with Mr F before her marriage to Mel, while the latter is Mr F's great friend. This Oedipal dimension arouses a rivalry with the analyst's other patients and a resistance to the rules which govern the analytic relationship.

Nancy is the first figure, representing a woman as object of desire, who appears in the analysis without the patient succumbing to terror. In my view, a modicum of relaxation has been facilitated, which is illustrated by the debate about money and the possibility of conflict with the analyst: rules

are there to protect from a closeness which is too powerful and too exciting; they allow limits and the establishment of boundaries; they contain the danger.

In this pattern I see, as I mentioned earlier, the sign of the sexual issue, by which I mean the difference between the sexes in the transference. Without contradicting the demarcation lines highlighted by Abbasi, this represents an important boundary line and a potential for a major investment in the transference. I think of Freud's **(1918)** paper, *The taboo of virginity*, and of his startling affirmation, which emphasizes man's terror as he comes face to face with woman, with the danger which her foreignness and her radical difference conceal (well beyond the idea of castration).

To Conclude

My encounter with Abbasi's paper has placed me face to face, as an analysis does, with the experience, which can be so disconcerting, of intimacy mingled with estrangement.

I think that this is the dynamic which constantly drives it forward: an extreme kind of intimacy runs alongside a radical estrangement, and this double movement is embodied in the two partners: a fact which in turn widens the division and the confusion of these two opposites. The internal and the external, the beloved and the enemy, whose multiple combinations can be mobilized in accordance with the developments in the analysis, are not enough to account for the difference. In this respect, I do not believe that the sex of the analyst, like the sex of the analysand, are a matter of indifference: not because they would stamp a particular label on the transference, making it maternal or paternal, definitely feminine or masculine — the condensation of identifications is there to signal the infinite complexity of the event; but at the same time some aspect of sameness and of difference is present from the start. This difference cannot be solely embodied in the representation of another who is simply described as an outsider; it bases itself, when this is possible, fundamentally on the difference between the sexes.

The phenomenon of intimacy does not belong to us; if its impetus is fostered more strongly by an impulse towards expressing feelings, it still remains not open to interpretation in terms of the transference. Its paradoxical power is lodged in the fact that, while it reveals secrets, it keeps hidden the secret of the intention which drives it. By doing this, it seems to me that, in its power to create a ‘being together’, intimacy takes an active part in building the history of an analysis in its singularity. This unique history created by the dyad, the patient and the analyst, represents in my view the kernel of intimacy, which is so difficult to convey or communicate without the immediate fear of betrayal.

Within the dyad, intimacy is able to establish a receptivity to dreaming, expressed in words: it indicates the boundaries between the I and the object, signifies the meeting of the familiar and the alien, but also that of masculine and feminine. It creates a private theatre and stages productions to which the analyst is invited as a sole and privileged spectator: she is invited because of the discovery of her humanity, her status as a ‘human witness’

snatched away from the divine sphere of omnipotence by her sexual connotations. The limits in being able to convey, the distortions implied in this difficulty, and its incomplete nature make intimacy perpetually and fatefully indescribable.

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Telephone Analysis[1]

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American, Argentinian, and British panelists presented the arguments for and against teleanalysis (a kind of remote analysis) and shared their experimental work in the practice and teaching of psychoanalysis using the telephone and Skype with video-camera. Audience members eagerly joined in a large group discussion to explore, challenge, argue against, and support the usefulness of teleanalysis in the practice and teaching of psychoanalysis. The panel held that psychoanalysis must adapt to the current social reality posed by the global economy and use its supporting information technology in order to consider the individual, exceptional needs of analysands in training who live in rural areas and in repressed cultures, as, for instance, Eastern Europe and China, executives who travel for work, and young adults who have grown up on technology. Technology enables psychoanalytic clinicians to relate to such analysands and to maintain the optimum frequency of analytic sessions for in-depth analytic work with analysands who are far from psychoanalytic centers. The panel objected to the claim that psychoanalysis is chasing after technology as an alternative to in-depth in-person work and that telephone analysis is not analysis. They asserted that psychoanalysts continue to value the study of the in-person analytic dyad but are adapting to cultural shifts by experimenting with the supplementary use of the telephone, videoconference, and Skype in their practice and teaching of psychoanalysis. Psychoanalysis has been responding to cultural developments since Freud, and then, as now, this responsiveness opens up new pathways of understanding.

The main questions explored were: Can psychoanalysts whose work depends on the harmonics of human interaction work in depth with a person in a circumstance in which they are alone in an office with a communication tool? Can they develop an image of the internal world of the analysand without nonverbal cues? Can there be effective affective attunement, an appreciation of resistance, work with transference and counter-transference? Can a training analysis on the telephone prepare a candidate so that the analysis of their own analysands is at a level of competence equivalent to that of a candidate in traditional analysis?

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1 Panel held at the 46th Congress of the International Psychoanalytical Association, Chicago, Illinois, USA, 1 August 2009. Panelists: Geoffrey Anderson (Division 39), David Scharff and Jill Scharff (USA), Neville Symington (Australia); Asbed Aryan, Sara Berenstein, Ricardo Carlino, Pablo Grinfeld (Argentina) and Jaime Marcos Lutenberg (Argentina).

The Spanish-speaking group from Buenos Aires spoke first in turn. They said that telephone analysis is similar to traditional analysis in using the analyst's suspended attention to free association, working with the unconscious and its derivatives and repressed childhood sexuality, and in analyzing dreams and transference. There is a difference in the space and time of the setting but they are similar in that both require a circumscribed setting. Telephone analysis is different from traditional or shuttle analysis in that there is no bodily presence and the contact is exclusively auditory: Without the libidinal presence of the body, the telephone privileges semiology of voice and permits analysis in one's native language. In the 21st century there has been a social and personal transformation of the mind, transcending specific cultures, and therefore calling for a change in international psychoanalytic culture appropriate to this new reality. The resulting new subjectivity and mentality require fluidity in contemporary thinking. Referring to Kant, the Argentine group said that a sophisticated psychoanalytic understanding of the changing dimensions of time and space must be developed in theory and practice to comprehend the reality of the 21st century. In essence, telephone analysis is a response to this challenge. They asked psychoanalysts to stay attuned to sociocultural changes, to

do research into indications and contraindications, and to be open to transformation, as occurs with every living language and culture. They called on the IPA to use technology to broaden the reach of psychoanalysis.

The English-speaking group from the United States and Australia showed that telephone analysis developed as an alternative to emigration, shuttle analysis, or losing the analysand, and they examined resistances to its use. The group members then compared telephone analysis (with no visual clues) with **Skype analysis** (in which the analysand is seen lying on the couch in a remote location) in both of which the frame, though flexible, is firmly maintained. Illustrating work on the telephone without visual clues, they gave vignettes of good affective attunement, of technology-based interruption that felt like an empathic failure, and of the analyst's reception of an image which curiously did not fit the verbal description being given, a discrepancy that led to the recovery of dissociated material. Referring to mirror neuron research they explained that other channels become more sensitive in the absence of vision, and that the voice creates an image of the body in the analyst's mind. In this way, experience is conveyed for analysis in the here-and-now. Transference and countertransference occur as in a traditional setting, and sometimes more vividly. For instance, in one member's experience, the dislocation of the telephone sessions revealed a delusion in the transference which had not been evident in in-person sessions, and telephone sessions provided the route for its understanding and resolution. Referring to **Skype analysis** using the web camera, they described an analysand's choice of setting that readily displayed aspects of early experience. They closed with a reminder that psychoanalysis is primarily the encounter with an understanding mind in whatever setting that may occur, and they expressed appreciation for the newly minted IPA policy on remote analysis.

There were many insightful comments in the large group, of which a few stand out. Audience members trying to comprehend telephone analysis

tended to refer to their experience of shuttle analysis, an adaptation for training candidates in remote locations with which the Paris society has had experience over 10 years. Dr Alan Gibeault said that he had been pleasantly surprised to find that an analytic process could indeed develop sufficiently to ensure that the analysand could become a good analyst, and his colleague who trains candidates in Lebanon added that it is time to think of a combination of in-person and telephone sessions to lessen disruption in the lives of their candidates who otherwise have to travel one week a month to a foreign city. Two ILAP candidates spoke: Dr Yolanda Varela mentioned that the direct delivery of the voice into the mind of analysand and analyst via their headsets made it easy to internalize the internal image of the other, and Dr. Betty Benaim reported that she would have preferred in-person analysis but had found value both in shuttle analysis and in telephone analysis, and thanked the IPA that, by training her and her colleagues, psychoanalysis in person could come to the next generation in Panama. Concern expressed by many analysts of silent patients who might feel abandonment in telephone sessions led to a discussion of indications, contraindications, and the need to analyze the countertransference as one would in traditional analysis. Dr. Albert Mason had a countertransference response of needing to see the analysand but he acknowledged that speech inflection conveys unconscious communication, in which case telephone analysis is a viable, immediate, and humane service. Dr. Ana-Maria Rizzuto mentioned the ubiquitous use of the cellphone to avoid loneliness and intense emotion, which caused her to wonder whether telephone sessions could allow analysis in depth. Others joined in to question the analyst's financial motivation, the analysand's right to choose the format of sessions, and the analyst's ability to see the resistance that might underpin the choice.

The use of the telephone and Skype in psychoanalysis is an important issue in the development of psychoanalysis in areas where those seeking psychoanalysis for treatment or for training live in areas far from psychoanalytic training centers. The use of telephone and Skype for the practice of psychoanalysis has been acknowledged and was debated in the pages of the International Psychoanalytic Association newsletter in the summer of 2005. But its use is much wider than generally admitted because of analysts' guilt about acting without full authority, fear of sanction, and concern about income. This panel on telephone analysis in psychoanalytic training proved to be timely. On Friday 31 July, 2009 the International Psychoanalytic Association issued a new policy to the effect that remote analysis by telephone or Skype may be approved as supplementary analysis by the Education Committee and International New Groups Committee in exceptional circumstances for the purpose of training candidates. The experimental nature of the undertaking must be acknowledged by analyst and candidate who must be convinced of its value and should review its efficacy from time to time with consultants who will explore whether candidates analysed in this way can meet the standards of functional equivalence. In his concluding

remarks from the Chair, Dr. Charles Hanly clarified that this approval for remote analysis may be given only where there is no alternative, significant time of in-person analysis has occurred to establish an analytic process and

both analyst and analysand are confident that the analytic process can be continued by telephone. This decision of the IPA was welcomed as a spur to the outreach of psychoanalytic thinking. Now that teleanalysis may be undertaken in approved circumstances, the next step is to engage in a clinical research project to evaluate its indications and effectiveness.

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Psychodynamic Treatment, Training, and Supervision Using Internet-Based Technologies

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For several years, the China American Psychoanalytic Alliance (CAPA) has provided treatment, training, and supervision to Chinese mental health professionals over the Internet. The lack of Chinese analysts and mentors has created an intense demand for psychodynamic psychotherapy trainingand treatment that CAPA is addressing using Skype™ and other distance communication technologies. This article describes the project, its history, scope, and activities, and the experiences of CAPA teachers and clinicians in exploring and developing the usefulness and power of this very new teaching method. Some particular characteristics of Chinese culture have become apparent as a result of the teaching experience. Aspects of the transference and countertransference that are shaped by the virtual nature of the technology are discussed, using case material. Our hope is that, in helping to train our Chinese students in psychodynamic psychotherapy, they will go on to train future generations of clinicians. This model of teaching and training could also be applied in other underserved areas.

This article will introduce the work of CAPA (China American Psychoanalytic Alliance), and explore the implications of the use of internet-based

audiovisual protocols in psychoanalytic and psychotherapeutic treatment, teaching, and supervision.

Telephone analysis has a long history. There is a wide range of opinions about the efficacy and specific strengths and weaknesses of telephone contact in contrast to in-person meetings with psychoanalytic patients (**Bassen, 2007**; **Leffert, 2003**; **Zalusky, 1998**). Telephone analysis limits the interaction between analyst and patient to verbal communication, although some nonverbal cues may be present even during phone calls, such as alterations in the prosody, volume, and speed of speech, as well as the presence of sounds not arising specifically from articulated speech.

Much of the literature on telephone analysis is concerned about the ways in which this change in the treatment frame may make a treatment easier or more difficult, by modulating the intensity and characteristics of the transference **(Zalusky, 1998)**. There is no literature about the efficacy of telephone analysis compared to in-person treatment except for a handful of case reports (**Bassen, 2007**; **Leffert, 2003**; **Zalusky, 1998**). Telephone analysis creates a specific restriction in the treatment frame by privileging verbal over nonverbal communication.

The development of the wide-band Internet has made it possible for private individuals to use audio-visual technology. “Telemedicine” refers to the use of videotelephony in the practice of general medicine, in which it is extensively used in emergency treatment and in providing care to individuals living in geographically inaccessible areas **(Vanden-Bos, 2002)**. In mental health arenas, telemedicine has been confined to assessment, since its use in treatment is still controversial (**Bee, Bower, Lovell, Gilbody, Richards, Gask et al., 2008**; **Kessler, Lewis, Kaur, Wiles, King, Weich et al., 2009**; **Lynch, Tamburrino, & Nagel, 1997**; **Miller & Weissman, 2002**; **Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004**).

The use of audio-visual protocols appears indispensable for mental health treatment and training in regions where there are no trained psychoanalysts and few are trained in psychoanalytic psychotherapies **(van Deurzen, 2006)**. One such place is China. CAPA developed specifically in response to China's need for

psychoanalytically trained professionals. However, CAPA became possible only with the availability of secure, free, audiovisual Internet protocols.

CAPA began accidentally in 2001 when Dr. Elise Snyder, an American psychoanalyst, was invited to China to present two papers on psychoanalysis at literary conferences in Beijing. She learned of a group of academics and clinicians in Chengdu, a city in southwestern China, who were interested in psychoanalysis and was invited to visit them. Shortly after she arrived, a member of the group invited her to a tea-house.

He described a variety of problems: conflict with his father, problems in relationships with women, and difficulty completing his work. He said, “I need analysis.” She said, “I agree, but there are no analysts in China.” What to do?

In early 2004, another CAPA analyst (UL) was introduced to the Chengdu group. They started discussing clinical material over the Internet first by email, then using Skype™, which had just been released in 2003. Skype™ appealed to the Chinese because it was totally free. The first Skype™ analysis began in January 2005 using its audio-only capacity, along with the visual capacity provided by another protocol. In December 2005, the first version of Skype™ with video capability became available. The analysis was then continued using only Skype™, which now permitted fully encrypted and confidential communication.

During subsequent visits to Chengdu, Elise Snyder lectured on psychoanalytic theory and technique and provided numerous clinical consultations and supervisions. She learned of the critical shortage of trained mental health professionals throughout China. During the Cultural Revolution (1966-1978), all schools were closed. Almost no one was trained as a psychiatrist, psychologist, or counselor. Thus, those who would have been the mentors and clinical teachers of the current generation did not exist **(Kirsner & Snyder, 2010)**. Dr. Snyder returned to Chengdu year after year. Many members of the group and people in other cities she visited asked to begin ongoing supervision and treatment with American analysts. In 2006 CAPA was incorporated as a 501-(c)-(3) nonprofit. It now has almost 300 members, psychoanalysts and psychoanalytically oriented psychotherapists. Most are Americans, but there are also Canadians, Australians, Europeans, Central and South Americans, and Israelis. As CAPA's work has become more widely known in China, its teaching, training, and supervisory programs have grown exponentially. It now has training programs in ten cities. This article will explore these three areas of CAPA's work, all made possible by Internet technology, mainly Skype™ but also WebEx© and ooVoo©.

Skype™

As mentioned in the previous section, Skype™ technology has been instrumental in bringing psychoanalytic treatment, supervision, and teaching to China. Skype™ was developed in 2002 as software that

would allow “all the world to talk free.” An audio-only version was released in August 2003. The special feature that made Skype™ exquisitely suitable for psychotherapeutic treatment is its still unbroken security. Skype™ uses a proprietary encryption protocol, which makes it impossible to eavesdrop on any computer-to-computer call (T. Berson, personal communication, 2010). There is no central server. Encrypted packets of data are exchanged between many computers so that at any given moment, there is a virtual network, fluid and continually changing during the same call. This technology is so solidly secure that it is nearly impossible to detect even whether Skype™ is in use at any given time. Other audio-visual communication protocols (e.g., instant messengers such as Microsoft©, Yahoo©), and ooVoo© and WebEx© are not secure. On the other hand, their quality of communication is often better. Since they are not encrypted, they use less bandwidth.

Low Cost Treatment

CAPA has been providing low cost psychoanalysis and psychodynamic psychotherapy to Chinese patients (primarily mental health professionals involved in CAPA training programs) via Skype™. These treatments are conducted almost exclusively in English. (CAPA does have two Mandarin speaking analysts and one who is learning it.) Proficiency in spoken English is a requirement for acceptance into the program.

Patients are seen in analysis three to five times weekly, and in psychodynamic psychotherapy, one to two sessions a week. The therapist and the patient together determine the frequency of sessions.

As of this writing, CAPA has arranged psychoanalytic treatment for more than 40 Chinese patients, and psychodynamic psychotherapy for almost 30. Psychoanalysts and psychodynamic psychotherapists are recruited from psychoanalytic institutes mainly in the United States. Clearly, geography is not a limiting factor! The major limiting factor is access to high-speed Internet connections for both therapist and patient. Many recent computers already have embedded cameras, microphones, and speakers. For older models, this equipment is not expensive to purchase. Technophobia, of course, is another limiting factor.

Chinese Skype™ patients are predominantly mental health professionals. CAPA strongly recommends, just as American psychoanalytic and psychotherapeutic educational programs do, that students undertake personal treatment. Applicants to the low fee CAPA treatment program are screened for suitability for analysis or psychotherapy, and then referred to an analyst or psychotherapist for further evaluation. If accepted, the patient makes a therapeutic contract with the therapist

before treatment begins. Only the beginning and ending dates, the number of sessions, and the fee are reported to CAPA. The parameters of treatment via Skype™ are not significantly different from those in a local setting. If anything, Chinese patients are more highly motivated than their American counterparts, because they feel fortunate to be able to participate in the CAPA program. CAPA is applying for grants to fund a major study of Skype™ analyses.

For psychoanalysts, listening to the "music" is as important as listening to the words. We pay attention to the rate and rhythm of what is said, to spontaneity or to its interruptions, and to tonal qualities in order to appreciate defenses, resistances, and the state of the transference. We "listen" to our own feelings, thoughts, and fantasies, in order to identify and use our countertransferences. We tune into the expression of emotion in all of its nuances, to convey wholeheartedness, tentativeness, or even feelings opposite to the words being spoken. Skype™, per *se*, is neutral with respect to these phenomena. Given a good connection and equipment of decent quality, Skype™ neither adds nor detracts from the therapeutic endeavor. But, it does change some familiar characteristics—changes that we must learn to identify and become familiar with.

Alterations in the analytic process are, of course, the result of other factors: vocabulary, language, education, and a myriad of macro- and microcultural individualities. These have always challenged psychoanalysts in the course of their search for empathy and clarity. Overall, the work of analyzing people in China goes a little slower than in local analyses. In working with Chinese patients, language and pronunciation in some cases can be challenging. One must be alert to subtle deficits in affective precision and, occasionally to a lack of congruence between the meaning of the words one hears and the meanings that are intended. When the inevitable pauses occur, the analyst must learn to differentiate between the patient's search for the right English word and the need to disguise or distort. The extra care necessary in making interventions may add ponderousness to the interaction and rob it of some emotional immediacy.

There are other aspects of virtual treatment that are different from local treatment in an office setting. First, the portability of the laptop and the worldwide access to the Web allows both patient and analyst to continue treatment from a variety of locations. Any room in the home, any place in the world, a hotel room, even an Internet café, may be used for sessions. One Chinese patient had a job that entailed frequent travel. She was able to maintain the continuity of analytic psychotherapeutic work from the remotest areas of China, where her job took her. Another patient has one of his sessions at his home in the evening. The seldommentioned

spouse (who occasionally complained about the patient's busy career) could occasionally be heard scratchily practicing the violin in the next room while waiting for the session to end. On the other end, the analyst, by switching from room to room in the course of treatment, may stimulate transference fantasies about the analyst living in a mansion. Skype™ gives each participant a direct look into the other's world. We need to learn a whole new vocabulary of appropriate behavior for each analyst-patient dyad.

Some factors result in a change in the quality of connection and attention in the analytic relationship. Skype™ may not improve or worsen the analyst's attention, but it may cause changes. The analyst must be aware of the tension between "free floating attention" and "attention floating free." The fact that so much is

available at the analyst's fingertips—the entire world via the Internet, coupled with his or her facility at multitasking, may tempt the analyst to turn his mind away from the patient during heartfelt but, nonetheless, haltingly expressed emotions. The analyst sits in front of his computer with multiple icons and folders calling for his attention. The temptation to succumb to these distractions offers a whole new way of identifying and analyzing one's counter transference. The countertransferences and defenses exposed by this new medium can become as evident to the analyst using Skype™ as they would to the analyst sitting behind the patient. This issue of the analyst beingdistracted from his task is not new. During a training analysis, a candidate often noticed the sound of his analyst picking up and riffling through a throwaway journal from the pile beside his chair that the candidate had seen. The candidate wondered if the “um hmm's” coming from the analyst meant that the analyst was really tuned in or if the analyst was on autopilot. The candidate worked up the courage to confront his analyst, who acknowledged his reading, but rationalized it as “free floating attention.” The candidate brought in his copy of Greenson's book **(Greenson, 1967)** and read the relevant paragraph to the analyst, who then stopped the practice. Analytic rigor can be enhanced by simple steps. Eliminating the pile of journals next to the chair is a simple measure. Increasing the size of the Skype™ window to fill the entire screen eliminates the distractions from email programs showing newly arriving messages.

This new medium raises other issues as well. The virtual boundary between analyst and patient, a boundary that simultaneously exists and doesn't exist, is different from the boundary when patient and analyst are together. The analyst can learn a great deal by paying attention to the countertransferences revealed by his awareness of this virtual boundary. When the analyst and patient are in the same room, either can reach out and touch the other. With actual touch, it is apparent to

both parties that a boundary crossing has occurred, even if it is rationalized. But, in a virtual medium the analyst or the patient can “reach out and touch” the other's image with the cursor, while the other remains oblivious. This is a secret, covert boundary crossing, representing a fantasy that can and should be recognized, analyzed, and used constructively. With Skype™, the enactment of such fantasies may be more difficult to recognize as such. Does the medium intensify such phenomena? Can it objectify and clarify their existence? Such phenomena, and how to bring them into the analysis, remain to be explored and reported. A rich lode of analytic material is awaiting discovery as Skype™ analyses become more common.

What follows is a brief description of an analysis being conducted via Skype™ in China: Several years ago, when I (LF) was invited to join CAPA, I was barely computer literate. The prospect of treating a patient in China, let alone conducting an analysis there, seemed incomprehensible. How would it be possible to develop a therapeutic process on a computer screen? Surely this project was folly! I was completely ignorant of Skype™. I was skeptical, but agreed to evaluate a new patient who lived in China and wanted to undertake an analysis under the auspices of the CAPA treatment program. I had by then learned that there are very few, if any, opportunities for psychological treatment of any kind (let alone psychoanalysis), in that vast country.

The initial meeting with my prospective patient was both similar to any assessment for analytic treatment that I've done in the course of my professional work, and at the same time unlike anything I had ever experienced. The patient's image was electronically conveyed from a vast distance, yet the interaction between us, “screen-to-screen,” seemed surprisingly intimate. The patient, J, during several sessions, provided a history as I made my usual assessment for analyzability. The sessions were, of course, conducted in English, as I spoke no Mandarin. He seemed quite appropriate for undertaking analytic treatment; he was motivated to explore his conflicts, and was eager to begin. It was difficult to realize that my new analysand lived thousands of miles away, in a foreign country and culture, and that we were working together on a computer screen in real time!

The Skype™ analysis has been ongoing for several years. Initially, we met “face to face” on the computer screen. After several months, I asked my patient about taking a more “analytic” position, although there certainly is divided opinion as to whether the couch is required for the proper conduct of an analysis **(Schachter & Kaechele, 2010)**. He moved to his bed, and repositioned his computer screen behind his head, so that it more closely resembled an analytic session that he might have had with a local analyst. I instructed him to say anything

that came to mind. An early transference expression was his insistence on referring to me deferentially as “Professor,” despite my demurral. The meaning of such a designation, despite his awareness that I am not in

academic psychiatry, has not yet been analyzed. His uneven facility with the English language has occasionally been a limiting factor in the treatment, mostly on my side. I have had to be careful to avoid slang and colloquial expressions, as more often than not his response has been polite puzzlement, and a request for an explanation. The vast cultural differences between Chinese and American society, and how they might impact on the treatment of Chinese patients by American analysts, are beyond the scope of this brief discussion. What is far more remarkable are the similarities between the development of an analytic process in this Chinese patient and the analytic process in my American patients.

As we settled into a routine, J began to speak freely about his conflicts and anxieties. The content of our sessions felt very familiar and analyzable. One area of exploration that has been conspicuous by its absence concerns sexuality. Issues around aggression have been much more in evidence. I have wondered if this is a cultural rather than a psychological restriction, but have continued to wait patiently for its emergence in the treatment.

An event that occurred about a year and a half into the analysis was the opportunity to meet my patient in person in China. A CAPA study tour in which I participated took me to the city where my patient lived. It was difficult to contain my excitement and sense of anticipation! We arranged to meet in a private room in a teahouse adjacent to my hotel. For the price of a pot of tea, we had a completely soundproof, comfortable, private room, tastefully furnished with two facing leather couches. We conducted a somewhat extended analytic session, not unlike our regular Skype™ sessions. I asked him how he felt about meeting me in person. His response was both surprising and reassuring. He commented that, although he was delighted to meet me, it didn't seem all that different from our Skype™ sessions. In that setting, via the computer, he felt able to discuss anything that was on his mind, and being with me in that teahouse felt very familiar. He stated that he felt “totally comfortable” with me, and grateful that he had the opportunity to undertake an analysis. I finished my tea, and we concluded our session. Upon my return from China, two weeks later, we resumed our Skype™ sessions uneventfully.

Internet technology has expanded clinical opportunities beyond our wildest dreams. Successfully treating patients in China has enabled me to recommend this modality to several local patients who, for reasons of distance from my office or professional obligations, have had difficulties

arriving on time for appointments. Interspersed with in-person sessions, Skype™ sessions utilized in this manner have been helpful and convenient for both patient and therapist. It permits fewer disruptions, and therefore facilitates therapeutic progress.

Culture and Teaching in China

Successful use of the Skype™ classroom requires mastery of some minor technical issues. The more technically proficient CAPA faculty train beginning faculty and students in the basics of Skype™, and also WebEx© and oo Voo©, which, because they can accommodate multiple sites simultaneously, are used for teaching but not for treatment. The biggest problem faced in this arena is the technophobia of some analysts. Some charismatic teachers find little difference between teaching live in a classroom and teaching live on Skype™. Alas, not all are gifted teachers. All teachers and supervisors are invited to join a specially created Yahoo© Group, where they can discuss technical and clinical problems and share solutions, in order to make the teaching as personal and lively as possible. From this material, a teacher's handbook has been written that includes discussions of cultural and technical issues, teaching tips, and the responsibilities of faculty.

Seminar style teaching is almost unknown in China. Therefore, it is important for the faculty to establish a relationship with the students that will facilitate the kind of interaction that should occur in a seminar. Before the start of each semester, teachers receive photographs of their students and other information about them that will facilitate acquaintance. Many students have chosen English names and prefer to be called by them. Others prefer to use their Chinese names, and the teachers and supervisors are encouraged to learn how to pronounce their Chinese names. Some students are shy and others are inhibited about speaking English. This problem can be addressed by reaching out to them by email, or by calling on them in class in ways that do not cause shame. Careful arrangement of the seating in the classroom so that all can be seen sends the message that all are expected to contribute and to interact with the teacher and other students.

Issues of culture have a large effect on teaching and are a fascinating and continuing subject of investigation. For example, Chinese students do not feel free to ask questions in class about information they

do not understand. It is considered shameful not to understand the material, and, the students are concerned that the faculty member may take offense at the possibility that it was his/her poor teaching ability that interfered with the student's understanding **(Chan & Rao, 2010)**. Thus,

faculty encourage students to ask questions, explaining that American teachers like students to ask questions because that this means that students are listening closely, and thinking about the material being taught. The students, who are still fearful that their classmates might think they are slow, are encouraged to send questions to the faculty by email.

Dealing with language difficulties has been greatly aided in several ways. CAPA offers an online English course to help students having difficulty in class or in supervision, and to help otherwise qualified incoming students with deficiencies in English. CAPA students come from different educational backgrounds. Psychotherapy is not yet common in China, so that there are few advanced students. Some students are already psychologists and psychiatrists, or trainees in those fields. Others are counselors with some background in psychology, but who are often in transition from disciplines such as economics, business, teaching, and others academic fields. They work as counselors in university settings and businesses, similar to our Employee Assistance Programs (EAPs). In the classrooms, this diversity could be handled by starting with very basic information, and then moving into more sophisticated concepts after it was clear that all the students understood the basics.

The curriculum contains a lot of intentional repetition. So, for example, if a student does not understand fully the concepts of defense and compromise formation in the first trimester, they are covered again in the second trimester from the perspective of ego development and its role in defense, and again in the third trimester in connection with techniques to deal with defenses and resistances in order to deepen the treatment.

Students with less experience are enabled to keep up with the more advanced students by means of periodic pauses during the class to allow the students to talk among themselves in Chinese. After such discussions, the teacher asks what they have talked about to make sure that they have reached a good understanding of the topic, and to enable them to ask questions or make observations about the topic being discussed. As a teaching aid to make the sometimes dry definitions come alive for the students, the teachers are encouraged to use clinical examples, to model for the students the judicious scrambling of the identifying information in order to preserve patient privacy, and to ask the students to provide similar examples from their own clinical cases that are appropriate to the topics under discussion.

Supervision

The CAPA psychotherapy training program offers weekly individual supervision of an ongoing psychodynamic psychotherapy patient. The cost is included in the tuition. Psychoanalysts and psychodynamic psychotherapists, all members of CAPA, donate their time to work with a CAPA student for the two-year period of the course work. The first few months of the supervision is devoted to an individual tutorial, where the student learns what long-term treatment is, what sort of patient is suitable, how to conduct an evaluation, the nature of individual supervision, how to take process notes and present a patient, etc. Often the supervisor will present his own case material during this period.

Interferences with the process, which must be addressed by each supervisor, pertain to Chinese culture and English comprehension. For example, these two problems converged in a supervisory session, when a student didn't understand a supervisor's English, but considered it “disrespectful” to comment on it, as if he were noting an inadequacy in an honored teacher. Instead, he smiled and nodded, as though in agreement after each of the supervisor's comments. The supervisor belatedly suspected that something was amiss, and challenged the student to paraphrase what had just been explained to indicate his full understanding. To the supervisor's chagrin, the comments had sailed right over his head. He explained that in China it is not respectful to question a teacher, particularly an “elder.” The student and the supervisor subsequently came to an agreement that they would henceforth work by American rules, assuring the student that it would be an intellectually gratifying experience for the supervisor to see the supervisee grow as a clinician. He has since become bolder and, always with a gentle smile, indicates when he hasn't understood the supervisor's comment.

The individual weekly supervision offered by CAPA is unusual in China. More commonly, mental health professionals primarily have access to monthly group supervision, or simply to peer supervision with no senior mentor available. In fact, the students are often unable to grasp the concept of presenting one ongoing patient in long-term psychotherapy, using process notes from each session. They are more accustomed to presenting specific problems with their patients, and they request advice about solving these problems in the treatment. They frequently need to be educated about how they can identify an appropriate patient to undertake psychodynamic psychotherapy. The three-month tutorial at the beginning of each supervision should alleviate some of these difficulties.

Students sometimes attempt to use their supervision to discuss personal problems. Treatment opportunities are not readily available in China, so the temptation is great to get some help from the supervisor in this way. Some of them have had contact with another training program that offers “self experience,” five or six individual meetings with an analyst. This appears to be some combination of brief supervision, taking the student's personal history and very brief therapy. Supervisors must tactfully explain that supervision is not treatment or “self experience” and refer the supervisee to CAPA's low fee clinic.

Curriculum

Creating and refining a beginning psychotherapy curriculum for students with varying levels of experience on the opposite side of the world, being taught in virtual classrooms in a language not their own has presented fascinating challenges.

CAPA started with a typical curriculum template for a psychotherapy training program: two years of classes, with sections on theory, technique, and continuous case conferences, given in parallel. Initially, in the first year of the program, teachers chose their own readings and arranged for PDFs to be made for those readings not on PEP Web©[1] (all students receive a subscription to PEP Web when they join CAPA). They taught from a list of required topics that included introductory psychodynamic concepts, psychological development, psychoanalytic assessment, beginning psychotherapy, and psychotherapy technique. By the middle of the first year, however, a Curriculum Committee was charged with evaluating and improving the curriculum, as well as putting together a reading list for the second year of the program. The discovery that some classic psychotherapy texts had been translated into Chinese greatly helped curriculum development. The most obvious challenge was to select readings that would not overwhelm the English capacity of the students. Many were fluent in spoken English; while others could read English better than they could speak it. But for almost all students, reading was slow and required the help of a dictionary.

Another task was integrating the readings and the teaching with the students' variable levels of sophistication in psychoanalytic theory and English. This disparity was addressed by teaching each course on

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1 PEP Web© is a fully searchable digital archive of all major psychoanalytic journals and classic texts, including the complete works of Freud. It is available through individual or group subscription and in many university libraries.

several different levels using optional readings of greater difficulty for those students who had already a good reading knowledge of theory. Since most of them had had very little experience practicing psychotherapy, more elementary readings were used for the technique course. Students were encouraged to email the faculty with questions about these advanced readings that were often not discussed in the classroom.

Conclusions

CAPA has undertaken the challenging task of educating Chinese mental health professionals in psychoanalytically oriented psychotherapy and treating them in psychoanalysis. CAPA's mission is to alleviate the urgent need for state of the art psychological education which arises from the rapid development of Chinese society. CAPA, in this challenging work, had to grapple with issues of geographical distance, cultural differences, and technological naiveté.

As of this writing, CAPA has established psychotherapy teaching programs in key regions of China, has offered low-cost, Internet psychoanalysis and psychotherapy, and is continuing its pioneering work. CAPA, a not-for-profit NGO, is manned entirely by volunteers. In the process of carrying out its mission, CAPA is promoting a deeper understanding of virtual psychotherapeutic treatment and training. The hope is that by training its students, CAPA will be able to fulfill its mission and that the CAPA students will assume the position of teachers and leaders of tomorrow.

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Marco Conci and Ingrid Erhardt interview Horst Kächele

Marco Conci, *Ingrid Erhardt* **and** *Horst Kächele*

Introduction by Marco Conci

I had the good luck to meet Horst Kächele for the first time more than 20 years ago, in May 1990, in Venice, in the context of the very first conference held in Italy on psychotherapy research. I was so fascinated by his approach to psychoanalysis that I volunteered to translate into Italian one of his latest articles, "*Psychoanalytische Therapieforschung 1930–1990"* (Research in psychoanalytic therapy 1930–1990), which had appeared in the June 1993 issue of the Milan journal *Setting* (Kächele, **1993**).

Before meeting him, I had already read, in the original German, the two volumes of *Lehrbuch der psychoanalytischen Therapie* (1985, 1988), the *Textbook of Psychoanalytic Therapy*, which he and Helmut Thomä had written together. One of the reasons I could appreciate their work so much had to do with the fact that Johannes Cremerius (1918–2002) and Gaetano Benedetti had already, during my training at the Milan Scuola di Psicoterapia Psicoanalitica, put me in touch with the "German tradition" from which such a textbook came. For example, Cremerius had been very much influenced by Michael Balint (1896–1970), as Thomä himself had been. It had also been through Cremerius that I had come into contact with the German tradition of analytically oriented psychosomatic medicine – a medical field in which Thomä and Kächele worked – that is, with the legacies of Alexander Mitscherlich (1908–1982) and of his own mentor, Viktor von Weiszäcker (1886–1957). Helmut Thomä had worked in Heidelberg under Mitscherlich before coming to Ulm in 1968.

Last but not least, through Gaetano Benedetti, Helmut Thomä had come into contact with the Italian group that published the journal *Psicoterapia e scienze umane*, founded by Pier Francesco Galli in 1967. In the context of the journal's network, I met Thomä in Bologna in June 1991 at the International Workshop organized by Galli and centered around papers given by Morris Eagle, Robert Holt and Frank Sulloway.

Since our very first meeting in Venice, Horst Kächele had been very friendly toward me and soon invited me to attend the yearly "Workshop on Empirical Research in Psychoanalysis" that he and Helmut Thomä regularly organized in Ulm in the spring time. I remember attending these workshops several times during the 1990s and meeting there a whole series of German and foreign colleagues. The atmosphere of these meetings was so pleasant, direct, and personal as to activate my fantasies of what the very first circles of enthusiastic psychoanalysts might have been like. But, for a number of reasons, I never actively worked in the field of empirical psychotherapeutic research, and our directions parted from each other again. However, even though I did not go into Horst's field, I at least came closer to him by emigrating to Germany and becoming a "German psychoanalyst." This allowed me to keep following his work from fairly close quarters and to have the chanceto keep appreciating the direction in which he was moving.

And this is the reason why, as coeditor-in-chief of the *International Forum of Psychoanalysis*, I decided to interview Horst and give him the opportunity to reach out to our international readers. In other words, let me declare from the start the "positive bias" behind this interview, that is, how worthwhile I believe it is to listen to Horst Kächele. Listening to him may even have a crucial importance for the future of psychoanalysis, for how we can change its course for the better by dealing with our profession and with our science in a more constructive and useful way. Horst has in fact spent most of his life as analyst and as researcher dealing with this problem. But since I have not had the chance to work in his field – of empirical research – Ingrid Erhardt helped me to conduct this interview. She is a young analyst in training and a researcher in the field in which Horst works.

The interview took place in Munich on February 15, 2013. It was tape-recorded and transcribed by Ingrid Erhardt and by me, prepared for publication

by me, and then approved by Horst Kächele – who added to it a whole series of very useful bibliographical references. It centers around 40 questions (Q) and answers (A), divided into four groups.

The interview

Q1:

You are today an internationally fairly well-known German psychoanalyst, psychotherapy researcher, and professor in our field. How did you come to psychoanalysis as a young medical doctor?

A1:

My interest in psychoanalysis started before I became a medical student. At the age of 16, I worked for a bookshop in Stuttgart, which enabled me to peep into meetings of clergymen and psychotherapists. One side effect of this student job was an entry ticket into a very exciting personal environment: that of artists, writers, homosexuals, and psychoanalysts. So, by the time of the *Abitur* (the German high-school diploma), I had already made up my mind that psychoanalysis would be my field. I did not know many details about psychoanalysis, but I knew already a lot about the societal context of psychotherapy. These were the kind of people I wanted to be with.

Since I was a very serious young person, I went to my father, who was an economist, and told him that I wanted to enter this field, that I needed a costly training, and that I wanted to make the application immediately, at the age of 18. I applied for an admission interview at the Academy of Psychotherapy in Stuttgart. Professor Bitter, the chair of the institute, accepted me for psychoanalytic training, but when I realized that such a training would tie me down to my home town for quite a while, I cancelled such a premature move.

My decision to study medicine was based more on my familiarity with poets such as Gottfried Benn or writers like Arthur Schnitzler, who had themselves been medical doctors, than on a real familiarity with the field. At the *Gymnasium*, I had been good at mathematics and sports, and I loved to read poetry. I knew little about medicine, but it later turned out to have been a good decision. Marburg was the German university town where I started my medical studies.

In order to acquire some real knowledge about the "facts of life," I applied for a job as a "cleaning woman" in the department of anatomy. But I didn't tell my parents about it; especially my father wouldn't have approved of it [Laughs]. But one day, the professor of anatomy came to me and asked me whether my family was so poor that I had to earn my living. So I said to him, "No, I do this just out of curiosity!" He was so impressed that he recommended me for the *Studienstiftung des deutschen Volkes*, a famous German foundation to which only about 1% of students were admitted. I used the money I received from this to buy second-hand books on psychoanalysis and other related fields, while my father paid for my medical books. My first book was *Medizinische Psychologie* (Medical psychology) by the famous German psychiatrist Ernst Kretschmer, a book published in the 1920s.

Being in this program meant that you belonged to the elite of students, and it made it particularly easy to have direct access to a whole series of professors and researchers. It was a door-opener for my academic career. Another thing I remember is that, in our elite student group, I once presented Freud's concept of affects from his 1895 *Project for a scientific psychology*.

Q2:

Is there any other aspect of your medical studies that might be interesting for us and for our readers?

A2:

My doctoral dissertation at the University of Munich, whose title was "Concepts of psychogenic death in the medical literature." This topic had been suggested to me by Dr. S. Elhardt, a psychoanalyst at the psychosomatic outpatient department of the University of Munich, where I had done an internship. In connection with this, I went to the UK, to the University of Leeds, for seven months, with a grant from the *Studienstiftung*, and there I started looking for the literature.

Having returned to Munich for personal reasons, I entered psychoanalytic therapy with Dr. A. Houben (supported by the *Studienstiftung*). As my nearly finished dissertation resided only in my head, I had the first wonderful opportunity of experiencing the power of psychoanalysis as we overcame this working inhibition very quickly.

What I did in my dissertation was conceptual analysis, conceptual research, a term that was not used then. At that time, I was deeply convinced that I would have never done any empirical study. The people I met in connection with my work at the dissertation were well educated and inspiring, but were not researchers. So the background I myself came from was not science; only the people from the *Studienstiftung* were scientists.

However, recommended by one of the editors of the *Zeitschrift für Psychosomatische Medizin und Psychoanalyse*, my doctoral dissertation became my first publication (1970).

Q3:

The theme of the psychological problems of those German adults who had been children during World War II has only recently become a topic of discussion in Germany. Michael Ermann, a pioneer in the research work on this topic, has called it the *Kriegskinder*, "the children of the war." You were

born in 1944, so you are also a *Kriegskind*. How has this influenced your growth and development?

A3:

I would not call myself a "war child" because my parents lived in fairly favorable circumstances. My father had joined the airplane factory Heinkel in 1939, before the war started. He was an economist and had been hired for his competence in administration. He first worked in Rostock (in the north-eastern part of Germany), where he met his future wife – my mother. Two years later, they moved to Jenbach, a little village on the River Inn in Tyrol (Austria). My father, in a rather quaint way, was even proud to have acted "unpolitically," although he was running a factory that produced machinery for the Heinkel airplanes. The place was staffed with many foreign workers with connections to the war, and my father was especially proud of the way he treated them to keep them working. Later, we had many quarrels about his way of being "unpolitical" in such dark times.

I have three brothers. My eldest brother was born in Innsbruck in 1942, I was born in Kufstein in 1944, and a younger brother was born in March 1945 when the Third Reich collapsed. I think he was a *Kriegskind* as he hardly survived. Five years later, my youngest brother was born.

In March 1945, the French troops marched into the small town of Jenbach and interrogated my father because of his position in the factory. The Austrians then hired him to put the factory back to civilian production. So he was not in trouble because he was not involved in politics. Later, after his death, I hired a historian to check the story of these years. I wanted to know whether the reports of the young family's life during the war could be substantially confirmed. And it turned out that what my parents told us children was fairly correct. My family stayed one more year in Jenbach; then the Austrians suddenly wanted my father, with his wife and three children, to leave the country within a week. So, in 1946, we left overnight with two suitcases (1946). And thus it was that my parents lost everything and moved to Heilbronn (a pleasant old town between Stuttgart and Heidelberg), where my grandparents made a decent living by running a bakery.

After one economically difficult year, my father was hired by the American army as a public attorney in the de-Nazification campaign. This not only brought a full salary and a nice four-room flat, but was at the same time concrete proof to us as adolescents that he had not been actively involved in the Nazi system. However, when I once presented my psychoanalytic treatment of the daughter of an SS officer to the Israeli Psychoanalytic Society, I pointed out to the audience that, in principle, I shared with my patient the longlasting insecurity that, one day, a politically incriminated document might turn up.

Q4:

Another question that we feel is important, in order to understand you and your work better, is: who were your models and mentors? Who were the people, in both your youth and university time, who influenced you most? To put it in another way, or to connect it to an earlier period of your life, we could ask you: who were your heroes?

A4:

My family was not very religious, but as a younger person I was a "tough" Protestant. When I was 14 or 15 years old, I was a fervent member of a youth group called "dj.1-11" – a subgroup of the *Wandervogel*, a famous German youth movement. Hitchhiking through Europe and regularly attending a choir for international folk-singing in Stuttgart at the *Institut für Völkerbeziehungen* (Institute for International Relations) provided some kind of alternative culture to my bourgeois family climate. As I mentioned before, meeting in the 1950s highly educated adults with a strong personalized view on post-war Germany, who were

not interested in making money but were committed to the cultural rehabilitation of our country, was very formative for me. These were my heroes.

Q5:

As psychoanalysts, we are of course also interested to hear something about your mother.

A5:

My mother came from an artistically tinged, financially unstable bourgeois family that ran a shop dealing with musical instruments. Based on her childhoodrecollections, she had a lot of fun with her four brothers. My father, as a young doctor of economics, met her after his successful application for the directory staff of the Heinkel Airplane Company in Rostock. He was a fairly shy and quiet person, and a friend from his student days provided him with the opportunity to meet this woman, eight years younger than him. She had worked as an office secretary, and they got married very soon after.

For her, being a housewife and mother was fully satisfying. She was proud of her four sons. I learned cooking from her, and I was the one who would take care of others, in school as well as at home.
My father had suffered from chronic tuberculosis since his early adolescence. In 1954, when I was 10 years old, he had to undergo major lung surgery, and his life expectancy was not very high. At that time, he consulted a psychotherapist who recommended that he give up his demanding and stressful job at Heinkel and change to a smaller company, which he did. Due to a very disciplined lifestyle, he was able to work until 65 and survived for more than 40 years after his operation. My mother was a very strong and powerful person. She did also beat us up,

although we laughed about it and we weren't traumatized by it.

What is interesting for my personal development is that my eldest brother was somehow not accepted by my father. Time and time again, my father brought up the story that he must have been exchanged in the hospital after his birth. So people often assumed that I was the eldest son, even though I was the second. In my training analysis with Dr. Roskamp, I had an initial dream that I was a Red Cross officer in Siberia who was looking for someone. This image is clearly taken directly from the first scene of the famous movie *Doctor Zhivago*. After three years, my training analyst said that he did not understand the dream and suggested that I should ask my mother about it. I did this, and my mother cried and told me her secret, which turned out to be the first time that she had spoken about it with one of her sons. She had had a relationship with an artist before she met my father and had had a child with this man. She had given this boy away in order to save her marriage to my father. So my father did not accept his own first-born because he obviously did not initially feel safe with the young, vital woman my mother was – because of what he thought she might have experienced before meeting him.

Q6:

How come you went to Ulm for your residency and psychoanalytic training?

A6:

Doctoral students at the psychosomatic outpatient department in Munich were encouraged to attend the *Lindauer Psychotherapiewochen*, a very good psychotherapy training conference lasting a week that took (and still takes) place in Lindau, on Lake Constance. This was a truly formative experience. Similar to the experience of being a member of the *Studienstiftung*, the chance to meet influential representatives of the psychotherapy world at an early academic age was crucial. Many lecturers pointed out that the medical school, which had been newly established (1968) in Ulm, had not only a very good natural science orientation, but also an explicit program for the development of psychosomatics and psychotherapy. Professor Thure von Uexküll (1908–2004), the head of the psychosomatic department, had invited Professor Helmut Thomä from Heidelberg to co-chair the new department.

I knew Professor Thomä as the author of an important book on anorexia nervosa that had been published in 1962; while working on my doctoral dissertation, I had read his book, I had liked his style of writing a lot, and I had expressed by letter my naïve wish to work with him, which he dryly rebuffed: “Wait and see!” Yet I knew that he and my first analyst, Dr. Houben, had worked together in Heidelberg on the topic of validation in psychoanalysis.

Q7:

You worked with Helmut Thomä for more than 40 years. Can you tell us something about your working relationship and what connects you to him?

A7:

The leading psychoanalysts at that time in Germany – Mitscherlich, Heigl, Görres, and Thomä – had in 1964 published a memorandum about psychoanalysis, arguing that the Nazis had destroyed it. As a consequence, the *Deutsche Forschungsgemeinschaft* (DFG; the German Research Foundation) decided to establish a research program for rebuilding psychoanalysis. This program included scholarships for training analysis and grants for research.

As my wife and I had to plan our medical residency, we went to Ulm (from October 1969 to September 1970). During my residency in surgery – together with K. Köhle from the department of psychosomatic medicine – we initiated a Balint group for nurses (Köhle, Kächele, Franz, Urban, & Geist, **1973**). During the second part of the residency, which was in internal medicine, I had ample opportunities to probe my skills in interviewing hematological patients. During this year, I also applied for psychoanalytic training at the Ulm Psychoanalytic Institute. Maybe due to his impression of me in my application interview, or maybe because of my intensive involvement in the then still small psychosomatic group, Professor Thomä offered me a position as research assistant, covered by a grant that he had received from the DFG.

I started my research job in October 1970. As my task was to analyze tape-recorded treatments from psychoanalysts from Ulm, I made the decision to do my training analysis in Stuttgart with Dr. Roskamp, and I started working with him in February 1971. As an aside, this was also a very good idea.

Focusing on your question about how our working relationship developed, it seems to me that we both shared a theoretical curiosity and a pleasure in working on unsolved issues. Helmut Thomä was a well-established, leading German psychoanalyst, at that time even president of the *Deutsche Psychoanalytische Vereinigung*(DPV; the German Psychoanalytic Association), whereas I was a true beginner, 23 years younger. I never had to act as an Oedipal rival; I was more in the role of a grandson with a grandfather who enjoyed his grandchild's progress. Dr. Thomä′s enjoyment over the small steps in developing our research agenda, his generosity in providing me with a research team, his inclination to continue his own clinical and theoretical interests, and his not interfering with the daily research process were absolutely crucial for my development. I also could observe and see how he handled his real

Oedipal entourage, colleagues like the later professors Henseler, Ohlmeier, Radebold, and so on, which was an amazing experience. One of the important pieces of advice I received from a female colleague was: “Do not make your self-esteem depend on Thomä′s opinion of you.” Indeed, he could be very critical of others, because, I would say now, he was so self-critical.

On the other hand, when we were writing together, it was amazing how relaxed he was in handling my criticisms of his clumsy style and how mercilessly he would criticize my own productions. It was like a good fight on the tennis court. This is how working and writing together has been the title of a small paper we once published in the *IPA Newsletter* (Kächele & Thomä, **1993**).

Q8:

Another crucial point for us is the following: treading in Helmut Thomä's footsteps, you had the chance to unite the career of the psychoanalytic clinician with the career of the psychoanalytic researcher. From this point of view, you really realized Freud's concept of the psychoanalyst as a professional capable of treating patients and, at the same time, of doing research starting from his own clinical work.

A8:

The difference between Thomä's and my career is that he was a clinical researcher. He wrote many masterful case reports covering a diversity of clinical issues, but he never did any formal empirical research himself. In contrast, his colleague Professor Adolf-Ernst Meyer from Hamburg was the first psychoanalyst in Germany to be a top leader in empirical research in psychotherapy and psychosomatics. This is why I would not use the expression that “I followed in Thomä′s footsteps.” Instead, I added the extra-clinical dimension to our work.[1] We both valued and shared theoretical discussions and debates, and I identified with his deep commitment to working with difficult patients. Right from the start, we agreed that I would do things that he did not do, did not want to do, or could not do. So together we were such a good and powerful team.

But of course, I learned from him as a very experienced clinician, as he was 25 years ahead of me in terms of clinical experience.

Q9:

What about coming now back to your statement that – at the time of your medical dissertation – you were sure you were not interested in empirical research? What made you change your mind?

A9:

In my first year in Ulm, I sifted the empirical research literature and made suggestions where to go with the research. I became very excited about what kind of interesting research avenues had fairly recently been started. For example, the Society for Psychotherapy Research, which would have become my home base for research topics, had been established in 1967. This job gave me the unique chance to read and study the research literature on my own. There was not much available at that time in terms of research on psychoanalytic treatment. Still, I was surprised about what I could discover just by reading. The few analysts truly interested in empirical research wrote impressive stuff; for example, in 1952 Kubie presented a research agenda of the problems and techniques of psychoanalytic validation and progress that is still relevant today (Kubie, **1952**).

I looked for colleagues who would help me to implement a research program. Very early in my job, I wrote letters to Hans Strupp, Lester Luborsky, and Hartvig Dahl asking for advice. Meeting the right people helped me to get involved with and become attached to them and to the theory research agenda. To study the masters first, before finding one's own track, is as important in art as it is in science. These personal relationships promoted my change from conceptual to empirical research. Today, I can certainly appreciate detailed conceptual work, yet research should go back and forth between concepts and data. I built the bridge between clinical and empirical research, and Thomä built the bridge between clinical and conceptual work, in our 40 year-long research enterprise. And of course, Helmut Thomä set a role model for hard and ambitious work.

Q10:

As far as we know, the systematic tape-recording of analytic sessions was initiated at that time.

A10:

Yes. It is very interesting that Hartvig Dahl in New York, Merton Gill in Chicago, and Adolf-Ernst Meyer in Hamburg started at the same time as Helmut Thomä in Ulm with tape-recordings in psychoanalysis. You may call this phase "From the reconstructed to the observed world of psychoanalysis." To tape-record my first psychotherapy and psychoanalytic training cases from the very start would have been impossible in any other psychoanalytic institution in Germany. Still, the whole psychoanalytic field moved "from narration to observation." This was also the title of my presidential talk in front of the Society for Psychotherapy Research in 1990 (Kächele, **1991**).

Q11:

Whom would you consider to have been your mentor in your early career?

A11:

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1 Here I follow M. Leuzinger-Bohleber's usage of contrasting clinical and extra-clinical research.

My mentor in research in Germany was Professor Adolf-Ernst Meyer, chair of the department of psychosomatic medicine in Hamburg. I met him in 1972 at a psychoanalytic conference in Baden-Baden. He became my role model as a researcher–clinician. He studied psychology while he was acting as chair – can you imagine that? He felt the need to perform detailed data analytic work himself. He conveyed to me the idea that the crude albeit tedious work of typing data on to punched cards was a necessary step in learning how-to-do-research. He was often one of my peer reviewers in the service of the DFG; he was quite outspoken, not sparing critique when it was indicated. From him, I learned that it is possible and feasible to remain friends and still be critical about each other's work.

My clinical mentor was certainly Helmut Thomä; we had regular supervisions for a long time, and we even played tennis on a weekly basis. But for 40 years, we did not use the personal *du* for "you": we

continued to use the formal *Sie*. It was only when our laudator for the Mary Sigourney Award, Fred Pine, realized that we had been on this formal level for all these years that he insisted that we change and eventually use the informal *du*.

A12:

Let us now come to the first of our *second set of questions*. Its formulation will require a longer set of premises. Not all our readers know that German psychoanalysts have the unique – almost incredible – good luck of working not only with affluent private patients, but also with patients who in any other country in the world would not be able to pay themselves for our work. Since 1967, the German *Krankenkassen*, the state-supervised insurance companies, have covered the cost of psychoanalytic and psychodynamic therapy. In 1987, psychoanalysts recommended also including cognitive-behavioral therapy in the scheme. Analytic psychotherapyis covered for up to 300 sessions, two or three times a week, and once-weekly psychodynamic and cognitive-behavioral therapy for up to 80–100 sessions. In addition, because some German colleagues seem to have mixed feelings about this system, it is important for me to ask you your opinion about it. I believe that our readers would be very interested in your point of view on this. In other words, what are in your opinion the advantages and the disadvantages of such a system of financial coverage?

A12:

Well, only a few – maybe prominent – German colleagues have disagreed with third-party payment by the German health system. To ask for *advantages and disadvantages* gives a wrong impression; maybe you should ask for main effects and side effects. Only a training analyst or someone who has a very good reputation in a big city can nowadays in Germany afford to make a living without treating insured patients. There are hardly any real private patients in Germany.

The background of the present system is the German insurance system, which goes back to Chancellor Bismarck in the 1880s. It was a political move that everybody had to be insured. This was not to the result of a moral position but instead a strategy of the German state to counteract the expansion of the Social Democratic Party. So the only issue after World War II was why had it taken so long to include psychoanalysis and psychotherapy in the existing system. It took so long because – as everywhere in the world – psychotherapy has, for whatever reasons, difficulties acquiring a good reputation. Another aspect, in my view, has been a tendency of psychoanalysts to convey to the public the impression that everybody needed at least 500 sessions and should attend therapy four times a week. If they had said that the majority of patients could be seen once a week in about 30–50 sessions, that would have facilitated the inclusion of psychotherapy in the system.

The founding of the Central Institute for Psychogenic Illnesses (an institute that was financially sponsored by a local insurance society) in Berlin after the war was the first step in the recognition of neurosis as illness by a German public institution (Dräger, **1971**). This institution published the first large-scale empirical study on outcome in psychoanalytic therapy in 1962, reporting impressive data on the outcome of medium-intensity analytic psychotherapy (Dührssen, **1962**). In Germany, this whole insurance issue is tied to an invisible division of psychoanalysts into a more pragmatic group (Schultz-Hencke, Dührssen, Heigl-Evers, Rudolf) and – as I would call it – a “more IPA-oriented group”. Although A. Mitscherlich actively endorsed the realization of the inclusion of analytic psychotherapy into the insurance system, the leaders of his society, the DPV, were quite reluctant to do this. Much more active in this direction were the colleagues of the *Deutsche Psychoanalytische Gesellschaft* (DPG; the German Psychoanalytic Society) and those working at the universities. DPG colleagues had more jobs at the universities, and they knew that psychoanalysis is easier to establish as a science if you promote psychoanalytic psychotherapy.

The findings of the Dührssen study helped greatly in incorporating psychoanalytic therapy into the insurance system. As the insurance system has certain operating principles, psychoanalysts had to find a way to fit into the system. One needed ideas about etiology, psychopathology, differential indications, and so on. To medicalize psychoanalysis meant to bring it into the frame of a normal medical intervention,

which implies research on process and outcome, quality assessment, and so on. This German development actually fulfilled and still fulfills Freud's 1918 prediction – the formulation of the necessity to bind together the gold of psychoanalysis with the copper of psychotherapy, if we are to be able to

reach out to and to offer our form of therapy to society at large.[2] For me, it is difficult to grasp the fact that there are still European countries without financial coverage for psychotherapy (Kächele & Pirmoradi, **2009**).

Q13:

Do we understand you correctly if we say that the advantage of the system is the possibility for all insured people to have access to it, whereas its disadvantage can be the medicalization of psychotherapy?

A13:

I do not think that these two arguments are on the same level of discourse. Critics from other countries too often turn the term "medicalization" into something negative, without knowing the details. We have a fairly well functioning peer review system, and patients from all walks of life have access to psychotherapy. The university departments of psychosomatic medicine and clinical psychology have successfully implemented research. So, in my view, medicalization really means moving psychoanalysis into a normal science and making it available to everyone, and not only to the unhappy "happy few."

I really wonder about this issue: if psychoanalysis were only available for the affluent section of the population, how could one ever substantiate the claim of psychoanalytic theory to be relevant for all people? I do understand that the term "medicalization" sometimes, for example, conveys the fact that doctors tend to medicalize manifestations of distress by only prescribing tablets and so on, and that people are made the object of a medical intervention. Yet I have never heard that someone successfully prescribed psychotherapy or even psychoanalysis. And there is no evidence that self-payment improves the outcome of psychoanalysis.

Q14:

Another important point we would like to discuss with you is this: from our point of view, we see a connection between the "focal concept of therapy" that you and Thomä developed, as opposed to therapy in terms of a "process without a preconceived termination," and the German insurance system, which was the frame of your work. What do you think about this? A subquestion could be: in what ways did this aspect come together with the way in which your definition was based on Balint and on your empirical research?

A14:

In general, it is obvious that the cultural psychoanalytic experiences that any therapist has impacts on his or her thinking. Likewise, Dr. Thomä's one-year Fulbright fellowship at Yale Psychiatric Institute in 1955–1956, and his one year long training analysis with Dr. Balint, shaped his clinical and scientific thinking. Another source of inspiration for us was the work of Thomas French from the Chicago Institute (French, **1954**). In his model of psychoanalysis, the focus is conceptualized as a region of interchange between day residues and unconscious elements that condenses the inputs and the data coming from both realms. A treatment process has to maximize the connections between the here-and-now and past experiences – only then will it work. Our focal conception of psychoanalytic therapy is a mixture between the two authors. From Balint stems the notion of focal therapy which counteracted the idea that severely disturbed patients always need very long treatments; what they need is a step-by-step working process. Although the number of steps is not predictable, each step may count. The Chicago focus concept stresses the current transference and its stepwise working-through.

The German insurance frame that you mentioned in your question might well also be of some pragmatic importance. If psychoanalytic treatments have to be planned in chunks of 80 sessions, this will of course have an impact on one's clinical thinking. The French expression "*une tranche d'analyse"* also points to a similar stepwise procedural thinking. So the focal concept might be understood as a modest concept that helps to modify and to adapt one's psychoanalytic treatment to the real world.

The third influence came from studying the analytic process by scrutinizing it with tape-recordings. At any moment, a therapist makes selections and choices concerning both the patient's free associations and the data coming from one's own process of evenly hovering attention. We can reflect on only a few topics at any one time. And at the same time, we constantly have to make a selection about which aspect to focus on. It is inevitable that we will focalize.

Q15:

The useful handling of free associations was a critique point that had already been made by Harry

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2 Here are the concluding remarks of the paper "Lines of advance in psycho-analytic therapy," which Freud gave at the Fourth Congress of the IPA held in Budapest in September 1918: "It is very probable, too, that the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion; and hypnotic influence, too, might find a place in it again, as it has in the treatment of war neuroses. But, whatever form this psychotherapy for the people might take, whatever the elements out of which it is compounded, its most effective and most important ingredients will assuradely remain those borrowed from strict and untendetious psycho-analysis" (Freud, **1919**, p. 168).

Stack Sullivan in the 1940s. In particular, he criticized those colleagues who would let patients free-associate without an end and without interacting with their free associations.

A15:

"Free association" is one of the fairytale concepts of psychoanalysis – much beloved yet little studied. It is here, in the domain of what analysts really do, where our work and the work of all recording analysts need more clarity. The acknowledgment that psychoanalysis as a therapeutic and scientific enterprise deserves basic groundwork, for example by discourse-analytic studies, is still fairly rare (Peräkylä, **2008**).

Q16:

Let us now come to our next question, through which we will introduce a new theme. In 1989, the analytically trained sociologist Edith Kurzweil published a book with the title *The Freudians. A comparative perspective* (Kurzweil, **1989**), whose very first sentence was: "Every country creates the psychoanalysis it needs, although it does so unconsciously." In her book, she then tried to present the cultural, social, and national influences to which psychoanalysis was exposed in a whole series of countries – including Germany – whose analytic communities she had visited, according to the methodology of "participant observation." In other words, she was one of the first people to clearly say something that not all our colleagues yet see or agree with – that psychoanalysis is not the same everywhere. What do you think about all this? How do you see German psychoanalysis from this point of view?

A16:

Yes, I know Edith Kurzweil's work, and I agree with her. It is easy to realize how psychoanalysis is embedded in a country. To my mind also comes Morris Eagle, who recently connected Western psychoanalysis with the important cultural phenomenon of the Enlightenment (Eagle, **2011b**).

As far as post-war German psychoanalysis is concerned, one important input was certainly provided by the Frankfurt School and its "critical social theory." People in the late 1960s heavily embraced psychoanalytic theory, especially its dimension of cultural and social critique. Another important favorable factor in the German reception of psychoanalysis after World War II was the field of anthropological medicine, as articulated by Viktor von Weizsäcker, Mitscherlich's mentor at the University of Heidelberg. At its roots still lay the traces of Romantic medicine, as had been elaborated in the writings of Dr. Carus from Dresden. Starting from Romantic medicine, a pervasive anthropological point of view was developed within German internal medicine, which also influenced Alexander Mitscherlich.

This tradition was also endorsed by Professor von Uexküll, who cultivated a friendly attitude towards psychoanalysis that influenced the appointments of the first generation of chairs of psychotherapy, psychosomatic medicine, and psychoanalysis. He was responsible for the reform in the organization of our medical studies, which in 1970 brought about the inclusion of medical psychology, medical sociology, and psychosomatic medicine.

From this point of view, it is not by chance that, in Germany, psychoanalysis and psychosomatic medicine fertilized each other for two or three decades. We should also not forget that the German antipsychoanalytic psychiatric tradition facilitated the establishment of psychoanalysis and psychosomatic medicine as alternative, collaborative fields.

Q17:

To now go back to the general theme of the social and cultural specificity of psychoanalysis, according to the single country in which it takes roots and develops, we would like to ask you: do you see any difference among psychoanalysts coming from different countries and cultures?

A17:

First, I am inclined to see more differences between clinicians and researchers, independently of their country of origin. But at the same time, yes, there are differences, for example in the way of writing about psychoanalysis. Rather typical, for example, is the way in which our French colleagues write. And our Italian colleagues are often very poetic, to a degree that would not be as easily accepted in Germany. In addition, the diversity inside groups is also quite substantial. As an empirically minded researcher, I would say that not only national identity, but also personal character makes a difference.

Q18:

We would now like to deal with the fascinating theme of "international psychoanalysis" by formulating a more personal question. We were always impressed by how easily both you and Thomä can address an international audience, by how both of you can address it in English. What lies behind this capacity of yours is, in our view, your having been able to elaborate the Holocaust, and this to a greater extent than many other German colleagues. If this is true, what was your own way of elaborating the Holocaust?

A18:

I think it is fair to say that, as I mentioned before, one important achievement of Thomä's was to apply for a Fulbright scholarship at Yale Psychiatric Institute in the mid-1950s, a place dominated by Jewis colleagues. In the early 1980s, I was at the National Institute of Mental Health in Bethesda (Maryland) and I realized how it must have been in for him the 1950s. For Thomä, it was crucial to meet

as a co-resident at Yale the former Austrian Jewish emigrant, now immigrant, John Kafka. When John Kafka came to Ulm the first time, he was the first Jew I met, and I developed a personal relationship with him.

For Thomä, it was very important that Ulm should be part of the larger scientific psychoanalytic community. This is why our textbook had to come out in English at the same time as in German. And this is why in Ulm we always had many foreign visitors. These visits by foreign guests and colleagues shaped our range of critical thinking.

Q19:

And what is your feeling about how the elaboration of the Holocaust still plays a role in the relationship between the German and the international analytic communities?

A19:

When I started working in the field, there were only a few German voices in the international debate. But this did not depend only on the Holocaust. We are ashamed of having destroyed many other people, not only seven million Jews, but also many millions of Russians. As a German, I truly feel that my personal and professional life is overshadowed by this cruel history. So it might not be a surprise that German voices were low-key in post-war international psychoanalytic circles.

Checking for papers by German authors in the *International Journal of Psychoanalysis*, it is only recently that we find an increase in their number. Thomä and W. Loch were for years the only German voices that international colleagues would hear. Since neither H. Argelander nor A. Lorenzer went abroad, their important work is very little known outside of Germany.

From this point of view, it was of course also very important to have had the international analytic community come to Berlin for the IPA Congress in July 2007. And indeed, it takes – and not only for German colleagues – a continuous exposure to international contacts to keep an international dialogue developing.

If I were to speak about the general issue of international dialogue from an empirical point of view, I would ask the following question: how many people, for example from the USA or Brazil, are ready to expose themselves to the international scene? This would be the empirical way in which I would address the problem. From this point of view, we have to do with a general problem that goes beyond our specific German case.

Q20:

And how would you characterize German psychoanalysis? How would you present it to our readers? How pluralistic is it? And what is specific about it?

A20:

There are different aspects of this very complex problem. Although Otto Kernberg speaks fluent German and often visits us, he seems to know only three kinds of psychoanalysis: English, French, and North

American. This is what you can read in the several papers he has written on international psychoanalysis. Our journal *Psyche* (Frankfurt) has 7000 subscribers and comes out once a month, but only a few colleagues outside the German-speaking world know about it. But the same could be said about Brazilian psychoanalysis: what do you know about Brazilian psychoanalysis?

What is new is that there are in Germany many, as I call them, "Indians," meaning Freudians, Kleinians, Bionians, and so on. In other words, in each group you find people going in a new direction. Take Ogden, for example: so many analysts are now interested in his work. These diverse interests testify to the enormous capacity for renewal, but also speak to the process of Babelization (Jiménez, **2008**). By this, I mean that there is no debate, no effort at a comparative evaluation. This is also the conclusion to which Paul Stepansky came in his book *Psychoanalysis at the margins* (**2009**). Psychoanalysis as a cultural field loses its identity, so that anything goes. Without debate and a comparative approach, we do not create any science. Psychoanalysis thus becomes a *façon de parler* – a lot of theoretical sketches without empirical confirmation!

To now mention a really specific aspect of German psychoanalysis, meaning a specific German contribution to the field of psychoanalysis, I can think of the concept of "scenic understanding," as Argelander defined it in the early 1970s. This is also a concept that is very little known outside Germany – in terms of the way it was conceptualized in our country.

Q21:

Your answer in terms of the way in which psychoanalysis is nowadays diluted in a whole series of different points of view reminds us of Robert Wallerstein's famous concept of "common ground," which he repeatedly dealt with, starting with the paper he gave in Montreal in 1987 under the title "One psychoanalysis or many?" (Wallerstein, **1988**).

A21:

I appreciate Robert Wallerstein's attempt to keep psychoanalysts together, but what we actually need is a series of clearer concepts. As long as we do not have clear definitions, there cannot be a psychoanalysis as science. From this point of view, common ground is what I would call "common underground," a kind of a vague agreement on some basic assumptions. We should work more on protocols and create more of a shared culture. What we need is a set theory, based on a mutually agreed upon definition of concepts. When I can start out from a

transcript, I can speak about psychoanalysis much better. See, for example, how good a contact any psychoanalyst can keep with his patient. This is how we can also better understand how a therapist listens and how another one does.

Q22:

We would now like to come to the first of a *third series of questions* directly concerning your research work. You differentiate between six phases in psychoanalytic research (1 – clinical case studies, 2 – descriptive studies, 3 – experimental studies, 4 – clinical controlled studies, 5 – naturalistic studies, and 6 – patient-focused studies). Besides the many research fields you have been working in, you are an important ambassador for (psychoanalytic) process research. What paradigm will be in the focus of future research, and what should be focused on to further develop psychoanalytic theory and contribute to the establishment of psychoanalysis in the scientific community?

A22:

The most important task still consists in furthering analysts' interest in research findings, in furthering their ability to critically evaluate the results of research and to implement it in their own practice. If the field continues to develop as a loose collection of tribal partisans, organized psychoanalysis will sooner or later disappear. The challenge for today and the near future resides in the impact of multimedia developments on our field. Telephone analysis is no longer a taboo. But what about **Skype analysis**? Sooner or later, psychoanalysis will increasingly have to take place in virtual environments.

Are psychoanalysts in a position to respond to the needs of a multimedia-oriented society? The majority of analysts limit themselves to just espousing a critical attitude towards these "brave new worlds." But this will not be enough. Taking up the field of communication research, especially conversational analysis, we

might be in a position to better understand what analytic dialogue can achieve in the context of the new media (Kächele & Buchholz, **2013**).

"Shuttle analysis" has been discovered as a means to provide adequate personal experience in far-off regions of the world; it could be an incentive to rethink the evidence for the still strict position on the required formal training analysis, although much evidence has been accumulating that training analysis does not create more satisfaction than privately organized analytic experiences (Schachter, Gorman, Pfäfflin, & Kächele, **2013**).

As in any other profession, normal MDs do not do research; still, the participation of analysts in office networks could improve the quality of transfer from real world to research agenda. We need university-based work and research. The IPA-sponsored Open-Door Review (Fonagy, Kächele, Krause, Jones, Perron, & Lopez, **1999**) has been a good step in assembling what we have and what we do not have at hand. In the early 1950s, there was only the Menninger study; we now have about 30–40 research projects and/or centers. As an aside, very few studies focus on high-frequency treatments. In terms of research policy, this makes sense: first establish that once-a-week therapy has enough evidence, then compare twice-weekly with once-weekly therapy, then twice-weekly with three times weekly, and so on.

A recent nationwide study conducted in Germany confirms what we all know: only 0.5% of treatments take place four times a week; three-times-a-week therapy covers 1.5% of all treatments, and twice-a-week treatment 8%. This means that 90% of the treatments run once a week, with half of the therapy behavioral and half of it psychodynamic (Albani, Blaser, Geyer, Schmutzer, & Brähler, **2010**).

Single-case research is a very important learning device. But the famous Freud cases are good old friends to whom we should say goodbye so that we can create our own new specimen cases, well-documented cases that are publicly available to all "students of psychoanalysis."

Q23:

Let us now come to the Ulmer Textbank. It was the largest archive of therapy documents in the world. There were several thousand treatment documents and several hundred sessions of audio and transcripts. Can you describe how the Textbank was developed?

A23:

At first, Dr. Thomä recorded one analytic case, then another. When I also started to tape-record my training cases, I realized that we would soon run into simple storage problems. In the early 1970s, computers became a research tool across all social science fields due to their capacity to store and analyze data. Donald Spence was, to my knowledge, the first psychoanalyst to teach a PI-1 software program at the Pisa summer school for computational linguistics in 1973, which I attended. Soon afterwards, I learned about an exciting computer-based content-analytic study on a tape-recorded analysis by our New York colleague Hartvig Dahl (Dahl, **1974**).

Realizing that this trend had developed across many social science fields, I finally hired Erhard Mergenthaler as a student of computer science. In Germany, we clearly were the first to promote this kind of research. When asked what a textbank is, the most simple answer is that it works like a blood bank. Some people – the donors – provide the materials, and others – the recipients – receive them. The project was funded with a large grant from the DFG

(Mergenthaler, **1985**). The main issue is and will be how to assure anonymity.

Q24:

In the analytic community and in analytic training, the traditional case study or vignette is still the gold standard for describing and evaluating the analytic processand progress, and serves as the most important means to demonstrate analytic technique and concepts. How did the empirical single case study develop out of Freud's "analytic novels"?

A24:

Take, for example, Freud's discussion of the Schreber case. Here, Freud had a published document at his disposal. In the 1950s, Elisabeth Zetzel discovered that Freud had forgotten to destroy the notes he had made about the first nine sessions of the Ratman case (Zetzel, **1966**). This made people curious about how Freud really worked and was an important stimulus in the direction of collecting more data on the way we all work.

Of course, by destroying all his material, Freud wanted to make it more difficult for people to challenge his work.

Q25:

And now a question concerning the future. What questions – according to you – should our work of research in psychoanalysis deal with in the future in order for psychoanalysis to meet its scientific challenges, and in order for our profession to gain in credibility?

A25:

First, I would point to the role of clinical contributions as true gold mines if they could be available via databanks. With Mattias Desmet from the University of Gent, we have now established the Single Case Archive as such a tool (Desmet et al., **2013**).

Another important topic that has moved into the center of attention is the therapists‘ contribution. Instead of competing the therapies against each other, as in a horse race, some researchers like Lester Luborsky (Luborsky, McLellan, Woody, O'Brien, & Auerbach, **1985**) and Rolf Sandell (Sandell, Carlsson, Schubert, Grant, Lazar, & Broberg, **2006**) study the amount of variation between therapists and the impact of training analysis on therapeutic proficiency. These findings are impressive. It seems that we spend too much effort on dissecting treatments instead of identifying relevant parameters like patients' and therapists' contributions.

The most recent field of research I have started is what we can call "the culture of errors." The problem in our field is that we have very little understanding about how treatments fail. One out of three treatments does not go well. In the USA, 30–40% of patients leave treatment for reasons that we do not yet know. The data on training analysis show of course only 20% premature terminations (Schachter, Gorman, Kächele, & Pfäfflin, **2013**).

There are big sins and small sins, but we do not know yet exactly what they are.

Q26:

This reminds us of the theme of rupture and repair studied, for example, by Jeremy Safran (Safran, Muran, Samstag, & Stevens, **2002**). What do you think about this?

A26:

Ruptures are indeed inevitable and we should know more about them and how to repair them.

Q27:

The topic of side effects is an important topic not only in pharmacology, but also in other branches of medicine. What about our field?

A27:

Yes, we should create something similar – a list of side effects of psychotherapy. We also have to talk about "informed consent": no patient signs any informed consent papers in Germany. This is a new topic in our field. As far as side effects are concerned, one of the first second-hand books I bought in Marburg as a medical student related to medical side effects. In other words, I have always thought that it is a feature of the maturity of a field that it is able to openly disclose its side effects and dissect its failures.

Q28:

But how can we do research in this field?

A28:

You cannot of course expect colleagues to denounce themselves. We can only go about the problem indirectly. A typical example of indirect measure is sexual sins: if you ask, "Have you ever molested a patient sexually?," only 2% of analysts will answer yes. If you ask, "Have you ever treated a patient who has been sexually molested?," you get a positive answer of about 12%. On these topics, you only get indirect measures and/or anonymous reports.

Q29:

But let us now come to the problem of analytic training. What advice would you give to candidates who are interested not only in analytic training, but also in empirical research in psychoanalysis? Considering how hard it is to work in both fields at the same time, should candidates not rather chose only one of the two paths? And what conditions do you see as necessary in order for them to be able to pursue both paths and to combine them?

A29:

It is not realistic to expect people who do clinical work also to do research in a systematic way. In German psychosomatic hospitals, a certain amount of research is still possible, but you need a frame, somebody to go to for advice. I did much work to try to support empirical research in South America, in Russia, and so on. You need to create specific networks; this is the basic preliminary condition for people to have the chance to start, and to keep, working in the field of empirical research in psychotherapy.

Q30:

And what could analytic institutes do to make more space for empirical research?

A30:

Candidates should know about research. Hartvig Dahl was for 20 years the director of research at the New York Institute, but only a very few people were really interested in his work. Candidates should be informed and should be up to date with the research being done in the field. There is a growing body of very interesting data, for example some papers, that candidates should also know about. The first one I can think of is the paper by Leichsenring and Rabung (**2011**) detailing the evidence for longer treatments. From an ethical point of view – in terms of resource allocation – as well as from a scientific point of view, the burning question today is: who needs more than 40 sessions or more than a year of treatment? Another important thing would be to attend a course on the state of the art of psychodynamic research, the significance of which has recently been very clearly shown by Levy, Ablon, and Kächele (**2012**).

I have little interest in the private practice of psychoanalysis as some kind of a lifestyle enrichment. My real concern is the above-mentioned message of Freud's Budapest paper. This is still also the common ground of German psychoanalysis, that is, identifying those people who really need analytic treatment. When I read a paper about a discovery made by an analyst in the tenth year of analysis, I do not find it interesting. On the basis of my long-term clinical experience with patients treated by bone marrow transplantation, I learned to appreciate the medical perspective that provides evidence for treatments that can be life-saving.

Q31:

How should we change psychoanalytic training so that young analysts can combine the analytic tradition with today's scientific challenges? They could potentially learn to do this well enough that they could personally contribute more than colleagues do today to the scientific and professional status of psychoanalysis. What do you think?

A31:

Some years ago, Helmut Thomä and I (Thomä & Kächele, **1999**) wrote a memorandum on the issue that we should take the training analysis out of the trainingsystem. The atmosphere created by the training analysis damages a relaxed learning process. I strongly feel it to be more in line with a proper psychoanalytic spirit to make the personal experience of psychoanalysis part of the candidate's personal responsibility, and I would give more space to clinical work done under adequate supervision.

Q32:

When did you start having this opinion about training analysis?

A32:

I can recall a substantial paper about this topic by Thomä in the *Annual of Psychoanalysis* in **1993**. I personally had the chance to analyze the data on the length of the 300 training analyses that took place in the DPV over three decades. It was astonishing how the number of sessions kept increasing year by year. However, there are no empirical data connecting the length of the training analysis with its quality and effects (Von Rad & Kächele, **1999**).

Q33:

And what is your feeling, your point of view, of the survival of our profession?

A33:

Let me cite Peter Fonagy's interview with Eliott Jurist in the *Psychoanalytic Psychology* journal (Jurist, **2010**). He said that IPA psychoanalysis will be dead in 40 years, with psychoanalysis absorbed into other fields. For example, good concepts such as transference, countertransference, and defense will probably be absorbed into other approaches. There is the clear feeling of a decay. Enthusiasm is diminishing. It is a

cultural phenomenon. How can psychoanalysis adapt to a changing world? What are the Chinese peoples doing with psychoanalysis?

Q34:

We come now to the first of the fourth and *last group of our questions*, a series of questions of a more general character. One of the problems that we would very much like to discuss with you is, of course, the scientific status of psychoanalysis. Many people – many colleagues among them – not only criticize psychoanalysis as a science, but also even deny it a scientific status. One of the mostly formulated critical observations is that our psychoanalytic work and/or the psychoanalytic relationship are so complex that no empirical research, quantitative nor qualitative, can rightly account for it.

A34:

I would like to start answering this question with a quotation of John Bowlby's that I like very much. I take this from a paper he presented in front of the Canadian Psychoanalytic Society in 1979 (Bowlby, **1979**). Here are his words: "The task of the clinician is to increase complexity, the task of the researcher is the opposite, he has to simplify."

The object of research is *not the whole* of psychoanalysis. This is not a sensible question. A researcher has to find out certain aspects over which he has some kind of control. A ghost is very difficult to make the object of science. Ghosts are usually the object of narrations; you can tell stories about ghosts. For me, research is not the same as science. The science of psychoanalysis encompasses more than empirical research. Psychoanalysis is a field with a peculiar scientific discourse. There are scientific aspects of psychoanalytic therapies in which only a weakly contoured methodology will be able to grasp certain phenomena, for example those of countertransference

(see the article on "Countertransference as object of empirical research?" by Kächele, Erhardt, Seybert, & Buchholz).

There are theoretical concepts such as the notions of the unconscious, the preconscious, regression, and so on, that are partially operational and partially not. Psychoanalysis is a field with a mixed scientific discourse. Ricoeur distinguished in 1970 a "how it works" discourse and a "why it works" discourse. George Klein (**1970**) made the same distinction. In his clinical work, an analyst wants to understand the motivational issue of "why"; he does not care for "how motivation works." A research analyst, however, studies the "how question;" he or she may use, for example, the methodology of conversational research and raise the issue "how does an analyst frame his ideas so that the patient is able to assimilate them?" (Peräkylä, **2004**). How dreams are generated is a question a clinician cannot answer. The same is true for the nature of the relationship between helping alliance and transference, which has been studied for decades in the field of psychotherapy research. The clinician, together with the patient, creates understanding, makes sense, creates sense – he limits himself to assuming that this is helpful in the long run.

There are experimental studies on defense; there are experimental studies on dreams, like the one the research group in Frankfurt has been conducting, in which they experimentally tested Freud's theory of the preconscious (Leuschner, Hau, & Fischmann, **2000**). Or take the theory of microworlds developed by the Swiss psychoanalyst and professor of clinical psychology Ulrich Moser (**2008**). Psychoanalytic science is a rich field with many different aspects. In my view, it is basically no different from other fields in which a profession is anchored in a basic science, but the science aspect only partially maps out what is needed for its practical application (Buchholz, **1999**).

From this point of view, one of my favorite topics is the use of the voice in psychoanalysis. No one has ever systematically studied this topic and the variety of vocalizations in psychoanalysis. Why have analysts been so blind to the use of their own main instruments for more than a hundred years? Another theme could be the following: how feminine must a man be in order to be a good analyst? These are all scientific issues, and research consists in finding ways to investigate them empirically.

Q35:

To put the problem in different terms: even with a growing interest in research work done in the field of the effectiveness of psychoanalysis, there still are colleagues, that is, psychoanalysts, who openly criticize and question the significance of such research work, with particular regard for the empirical. What would you say to these colleagues? How do you deal with them?

A35:

Of course, people are free to be as blind as they want to be. Our colleagues are only practitioners; this is fine, this not the point. The problem is how the government deals with the problem, whether or not the government finances research. For example, the Swedish government recently decided that there is no longer any money for psychodynamic research.

Q36:

Psychoanalytic therapy was recently dismissed from the service catalogue of the Dutch public health service. In Germany too, the number of the psychoanalysts who are full university professors has been greatly diminishing over the past few years. On the other hand, the cognitive-behavioral point of view has kept gaining followers and academic space. Is this a sign of the "impending death of psychoanalysis" that Robert Bornstein (**2001**) has talked about?

A36:

The problem is that cognitive-behavioral therapy is no longer cognitive-behavioral therapy. Leading representatives of the approach are borrowing and integrating core concepts of psychoanalysis into their own theoretical body. Take for example schema therapy: the basic concept is clearly psychodynamic – the difference resides in more active treatment strategies. Names may disappear, but good concepts will not. The names are changing, but less so the concepts.

On the other hand, it is true that traditional psychoanalysis has usually been much more interested in investigating motivation for feeling and thinking than in searching for what induces change (Luborsky & Schimek, **1964**). And this is the price we now have to pay for this.

Q37:

Do you mean that you favor a patient-focused approach as opposed to a technique-centered approach?

A37:

Yes, I do. From an empirical point of view, an important question we should try to answer is the following: which are the patients who need more than 50 sessions? Psychoanalysis is not for everyone. This is also the direction taken by Kernberg in terms of his work with personality disorders. For me, the work of Fonagy and his group is also an application and implementation of key psychoanalytic concepts. Psychoanalysis needs to be developed in different directions and dimensions. "This is no longer psychoanalysis!," people said of Kernberg's work in the 1970s, and some are still saying it now.

Q38:

One important problem in our field is that there are not enough candidates. Young MDs and young psychologists do not chose psychoanalysis,

but seem to look for more training in more established therapies.

A38:

It is true that they are not as attracted to psychoanalysis as they used to be. It is too rigid. From this point of view, psychoanalysis is going to dry out for biological reasons, for the lack of young people training in it. We need to create an environment that makes psychoanalysis more attractive for young people to come in and join us.

From this point of view, the whole debate around the scientific status of psychoanalysis is not the real problem. The deadly gun is the age issue. If young people do not join us, psychoanalysis will be running out of business. It would not be the first field of science that is running out of business.

Q39:

But this is fortunately not the only face or aspect concerning the present status of psychoanalysis in the world. Psychoanalysis is now being discovered and/or talked about in the countries of Eastern Europe, and also in countries where people had never previously heard of it. We know that you have been traveling widely, that you have had the chance to see your handbook translated into more than 15 languages. We would be curious to know how you can explain this opposite phenomenon, that is, such a growing interest in psychoanalysis in other parts of the world, especially those which do not have a psychoanalytic tradition.

A39:

Well, you have to differentiate. Eastern Europe has always been part of Europe. It was under political repression, and the population have been recuperating their old European identity. The same happened in Russia. Educated European people have no problem reconnecting with their European thinking. This is a world of its own, although this might be less true for countries such Armenia, Georgia, Kazakhstan, and all the other former Soviet Union countries. In these, the interest in psychoanalysis covering both therapeutics and cultural aspects fits into a move towards Westernization. The really interesting new fields are the Asian countries like India, Japan and China, and the Arabic and Islamic countries.

India was the first of these regions to discover psychoanalysis, but these far-off activities were hardly perceived by the West. And Freud, who had corresponded with the first Indian psychoanalyst, did not appreciate his deviant ideas.

With regard to China, it is interesting to remember that there was already an interest in psychoanalysis in the 1920s in the field of literature, the arts, and poetry. There is informative documentation about this early period; at that time, the first translations of Freud into Chinese had already been made. Now that the upper middle class, with its higher education level, has discovered psychoanalysis as way of thinking, I am pretty sure that they will explore and maybe utilize psychoanalysis as a therapy. This is also true for other parts of the world; everywhere where there is a higher educated class, they are open to psychoanalysis.

A different issue is represented by the Islamic countries. In an Islamic country, it is hard to imagine that a man can analyze a woman. But why not women with women? Again, educated people are interested in psychoanalysis there too. Last year, our textbook came out in the Persian language. We had an introductory seminar in Isfahan with a group of 50 women and men, mainly psychologists and social workers. In Teheran, there is already a psychoanalytic institute. It all comes down to the question of how much education there is, and of how Westernized such an education is.

You also have to keep in mind that what psychoanalysis stands for in the world is not primarily the specific treatment it offers, but the message that Freud stands for – a cultural message, a cultural symbol.

Q40:

Another way for us to deal with the same topic is the following: we know that you travel around the world not only to present the growing number of translations of your handbook, but also to teach and to do research. For example, we know that you train researchers in South America and future analysts in Eastern Europe. What are your goals from this point of view? How do you see your role in this development?

A40:

When I am invited, I bring to people the Ulm Triadic Model, which consists of theory, research, and practice. This is a unique mixture, and people seem to like it. Even if you only talk about theory or practice, you talk differently with a research background. I think that it produces a more reflective and modest way of dealing with psychoanalysis. This is a modesty that comes from research and from the need to better understand patients' points of view.

The Ulm message wants to activate critical thinking. Our textbook is a critical book of psychoanalysis. In German, you cannot call it a "critical theory" because that would make people think of the Frankfurt School. But it is critical in a way. It is a "non-believing" textbook; I would say we are "non-believing psychoanalysts."

There is a British statement saying that "Theories – like soldiers – never die, they just fade away." This

may happen to a fair number of psychoanalytic terms. Concepts arise, peak, and disappear – depending on the backbone in terms of scientific underpinning. There is an interesting book by Morris Eagle on contemporary psychoanalysis, which I can recommend. It is called *From classical to contemporary psychoanalysis. A critique and integration* (Eagle, **2011a**). This is rich in critique and full of integrative ideas. It talks about what is useful in present-day psychoanalysis and what is no longer viable. It is a way of looking at the state of the art of psychoanalysis which – in my mind – is a useful way that points to a creative future.

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Treatment Research

Feasibility Study of a Psychodynamic Online Group Intervention for Depression

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Dynamic Interpersonal Therapy (DIT) was originally developed as a brief psychodynamic intervention for the treatment of depression and anxiety. More recently it has become the psychodynamic protocol for depression specifically within Improving Access to Psychological Therapies services across the U.K. The aim of the present study was to pilot and evaluate the feasibility of a group online version of DIT—Online Group DynamicInterpersonal Therapy—and the perceived helpfulness of psychodynamically informed self-help materials. Twenty-four participants were randomly assigned to three groups. Participants in Condition A (n = 8) took part in an online DIT group, with self-help materials, facilitated by a therapist. Participants in Condition B (n = 8) were given access to a closed virtual group space where they could interact with each other and were supplied with the same self-help materials used by participants in Condition A, but without online therapist facilitation. Participants in Condition C (n = 8) received no instructions or facilitation, but had access to an online mental well-being site where they could meet virtually in a large, open, moderated virtual group space to discuss their psychological difficulties. This feasibility study was underpowered to detect significant differences in rates of change between facilitated and unfacilitated provision of material, but decline in symptoms appeared to be superior to control only for the facilitated group when the groups were considered separately. The response of the combined treated groups against control suggests that the DIT self-help materials may be helpful and appear to support the process of change. Further work is required.

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Depression is both a common and often complex condition that typically manifests early in life: 40% of depressed people experience a first episode by age 20 **(Eaton et al., 2008)**. It interferes with social and occupational functioning, is associated with considerable morbidity, and carries a significant risk of mortality through suicide **(Üstün et al., 2004)**. Incomplete recovery and relapse are all too common. Following the first episode of major depression, people will go on to have at least one more episode **(Kupfer, 1991)**, and the risk of further relapse rises sharply to 70% and 90% after the second and third episodes, respectively **(Kupfer, 1991)**. Anxiety disorders are also prevalent, especially social anxiety and phobia. It has also been shown to be common for depressed people to have a comorbid psychiatric diagnosis (e.g., anxiety; **Kessler et al., 2003**).

Within the public health sector in the U.K. (and elsewhere) the current emphasis on evidence-based practice has privileged Cognitive Behavior Therapy (CBT) as the treatment of choice for depression and anxiety. This "one size fits all" approach to treatment has strongly marginalized psychoanalytic interventions. The superiority of CBT in this respect has been rightly questioned, not because it is not helpful to many patients—it evidently is—but because it is not helpful to *all* depressed patients.[1] Our CBT colleagues have nevertheless also set the precedent for creatively developing a range of applications for CBT so as to maximize its outreach potential, not least in the form of computerized CBT interventions.

In the U.K. the updated NICE Guideline (CG90) on the management and treatment of adults with a primary diagnosis of depression in primary and secondary care stated that for patients with mild to moderate depression who decline other treatment modalities, the clinician may consider brief psychodynamic psychotherapy. In light of this revision, brief psychodynamic therapy has now been recommended as one of the therapeutic approaches *for depression only* provided through the Improving Access to Psychological Therapies (IAPT) initiative in England. Dynamic Interpersonal Therapy (DIT) has been selected as the protocol for its delivery (Lemma, Target & Fonagy, **2011a**, **2011b**).

DIT is a time-limited (16 sessions) intervention that is specifically designed to address depression and other mood disorders (Lemma et al., **2011a**, **2011b**). To explore DIT's potential as a "low-intensity" type of intervention, and to address the need to consider both more accessible and more cost-effective early interventions given current economic pressures on mental health services **(Kazdin & Blase, 2011)**, here we discuss the application of DIT in a modified format for delivery online in a group setting. We do not consider that this is a viable alternative to face-to-face therapy for many patients. However, for those individuals who find it hard to contemplate face-to-face interaction with a therapist, either for reasons of accessibility or by virtue of their own psychological difficulties, online therapeutic interventions have a potentially significant role to play in increasing access to psychological therapy.

Traditionally, the psychoanalytic community has been highly skeptical of online interventions, concerned that any alteration to the standard analytic frame compromises the analytic relationship. Yet, several psychoanalysts over the years have been using

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1 In the United Kingdom, the Improving Access to Psychological Therapies Programme (IAPT) has committed itself to an expansion in the range of psychological interventions on offer to patients, beyond just CBT. This now includes DIT.

various forms of communication for treatment, including correspondence (e.g., **Hofling, 1979**), telephone, (e.g., **Leffert, 2003**; Lindon, 1988; **Rosenbaum, 1977**), and more recently e-mails, videos and Skype. A survey of psychoanalysts' practice in the U.K. (n = 62), carried out by the British Psychoanalytical Society, revealed that 31% of respondents had conducted analysis via telephone/Skype **(Fornari-Spoto, 2011)**. Those analysts who do use new technologies to communicate with patients, for example via texts, or those bold enough to have braved **Skype analysis**, are nevertheless careful not to advertise the fact too widely, with a few notable exceptions(**Carlino, 2011**; **Dini, 2009**; **Ermann, 2004**; **Fiorentini, 2011**; **Lingiardi, 2008**). Consequently, the psychodynamic psychotherapy literature in this area is very scarce. Practitioners of other therapeutic modalities have been far more enterprising in this domain, not least cognitive-behavioral therapists, who have developed a range of guided self-help resources and made creative use of new technologies to deliver online interventions (e.g., **Hedman et al., 2011**).

From a psychoanalytic point of view, the emphasis with regard to new technologies has been placed on the requirement to understand more about how these technologies interact with the prerogatives of an individual's internal world, how they may alter psychic structure itself in fundamental ways, and the implications of this for the individual's functioning **(Lemma & Caparrotta, in press)**. Equally important, however, is the exploration of how new technologies could help individuals with mental health problems to access help informed by psychoanalytic views and the extent to which online adaptations of psychodynamic treatment models may be feasible and effective.

There are some encouraging signs that, as technological advances fundamentally alter the way we relate to each other in our daily lives, a more active and open engagement with new technologies, and how they may be integrated within psychodynamic ways of working, is emerging. It is in this spirit of openness that we set about to study whether facilitated Internet applications of DIT are possible. As we know that depression and anxiety often arise in the context of interpersonal difficulties, we propose that an online intervention that addresses the patient's interpersonal functioning and that uses a group format to maximize the benefits of also receiving support from peers may yield promising results.

Online Group Dynamic Interpersonal Therapy

The assumptions informing the online Group DIT (OLDIT) protocol are similar to those of the standard face-to-face protocol, and are the same as those that underpin other brief dynamically oriented approaches: (i)

that behavior is unconsciously determined, (ii) that internal and external influences shape thoughts and feelings and therefore inform our perception of ourselves in relationships with others, (iii) that adult interpersonal strategies and ways of relating are generated by childhood experience, particularly within the family, (iv) that unconscious processes including defenses and identifications (projective and introjective processes) underpin the subjective experience of relationships, (v) that thinking about behavior and emotional experience in terms of mental states has significant therapeutic effects, and (vi) that therapy should focus on the patient's current relationships, including the relationship with the therapist (**Fonagy & Target, 2008**; **Lemma et al., 2011a**).

DIT's starting point is interpersonal. It is based on the common clinical observation that patients who present as depressed and/or anxious invariably also present with difficulties in, and distress about, their relationships. The approach focuses on presenting

distress/symptoms, which are jointly formulated as possible responses to interpersonal difficulties/perceived threats to attachments (loss/separation) and hence also as threats to the self. In the course of these discussions it is recognized that perceived threats can both result from, and cause, difficulties in thinking clearly and realistically, not only about the external world, but also about the internal world, one's own thoughts, feelings, and experiences with others. It is assumed that improving the patient's ability to reflect on his own and others' thoughts and feelings will improve his ability to understand and cope with current attachment-related interpersonal threats and challenges (**Allen, Fonagy, & Bateman, 2008**; **Bateman & Fonagy, 2012**). Mentalization is one of a family of concepts, drawing on social cognitionresearch, that is increasingly finding its way into the psychotherapeutic lexicon (**Dimaggio et al., 2011**; **Lecours & Bouchard, 2011**; **Liotti & Gilbert, 2011**; **Lysaker et al., 2011**; **MacBeth, Gumley, Schwannauer, & Fisher, 2011**; **Vanheule, Verhaeghe, & Desmet, 2011**).

We can envision that this type of discourse may be implemented in the context of group as well as individual treatments, face-to-face or across digital media. Lemma (unpublished) created an online group adaptation of DIT. In this implementation participants are given self-help materials over an 8-week series of virtual group meetings that aim to support a reframing of the individual's symptoms of depression/anxiety as manifestations of a relational disturbance. The online implementation is based around self-help materials that aim (a) to assist the individual to understand the connection between his presenting symptoms and what is happening in his relationships by identifying a core, unconscious, repetitive pattern of relating, which becomes the focus of the therapy; and (b) to encourage the individual's capacity to reflect on his own states of mind and so enhance his ability to manage interpersonal difficulties. The intervention attempts to create an online group process consisting of exchanges between group members and with the therapist, with the potential to provide fertile ground for the exploration of interpersonal patterns as they evolve within the group. The therapeutic objective remains the same: enhancing the patient's capacity to understand the interpersonal problems they appear to be struggling with, which they currently either cannot fully understand or understand in a maladaptive way, attributing—often unconsciously—unlikely or unhelpful motivations to others as well as to themselves.

The structure of the OLDIT program mimics to some extent the structure of face-to-face group psychological treatment. On the same day each week, the participants are sent self-help materials for that week via e-mail. These provide some background information and invite them to reflect on questions that are pertinent to the week's focus, which are all in the interpersonal/relational realm. Participants are actively encouraged to discuss their thoughts about this with other group members. The first 3 weeks focus on working toward the “formulation” of a relational pattern that is felt to be currently problematic for the individual and setting some realistic, interpersonal goals. Weeks 4-7 focus on encouraging the translation of insight into interpersonal change, with emphasis placed on supporting the individual participants', and the group's, mentalizing capacity **(Bateman & Fonagy, 2012)**, their capacity to think in terms of the subjective states that underpin their current relationships, and their attempts at addressing these difficulties in the course of the OLDIT therapy. As in the face-to-face implementation of DIT, the final week is identified as focusing on the affective experience of ending the group and planning for the future.

An important feature of the online intervention, which sets it aside from its face-to-face counterpart, is the very active encouragement incorporated in the self-help material to make use of the group, in addition to guiding the participants' own “private” self-reflection, and encouragement to achieve their goals. Members of the group can exchange

messages with each other, nonsynchronously, in a closed group, which is monitored by personnel ("guides") of the provider of the online service, Big White Wall (BWW).[2] Activities on the online site are monitored 24 hours a day so members of the OLDIT group can be assured that should any exchanges between them prove to be unhelpful/abusive this will be addressed. This is very important to ensure the participants feel safe at all times.

The purpose of the present pilot investigation was to establish whether a facilitator ("therapist") was necessary for the establishment of a therapeutic group process. The design of therapist-facilitated OLDIT calls for the therapist to be available to respond once per week, for 1 hour, at a predetermined time and day, to the interactions between group members, and to issues addressed to the therapist. The exchanges with the therapist are nonsynchronous, like those between members of the group, but if the group members are online at the same time as the therapist they can exchange messages fairly rapidly during that time period. The therapist's identity is known by the group members but, in keeping with the general policy on BWW, the participants use "avatars" to preserve anonymity. For many of the individuals who use BWW the promise of anonymity is one of its attractions.[3]

The present study was designed to establish the acceptability and feasibility of OLDIT. This included assessing the accrual rates, the feasibility of randomization, the drop-out rates, the possibility of intensive outcomes monitoring, and the experience of self-help materials. A key question that needed to be answered before further development of the model could be undertaken was whether a trained facilitator was needed to oversee the group. Clearly, if the intervention is feasible without a facilitator, and can rely simply on (a) the self-help material, which could be automatically distributed, and (b) the BWW "guide," who intervenes only in the case of obvious abusive behavior, then the facility will be considerably more economic than if the administration of OLDIT requires a therapist. Self-help materials on their own have been made available as part of the IAPT program **(Clark et al., 2009)** but randomized controlled trials suggest that without the involvement of a support worker the impact of self-help computer programs such as "Beating the Blues" may be limited **(Kaltenthaler, Parry, Beverley, & Ferriter, 2008)**.

Method

Design

The overall study comprised two phases. The initial phase comprised a very small-scale (n = 5) qualitative feasibility study looking at the possibility of an online application of DIT and piloting the guided self-help materials to evaluate their acceptability and relevance to individuals presenting with depression and/or anxiety. The participants who took part responded to an online advertisement on BWW and received the 8-week OLDIT facilitated by a therapist (one of the authors). They completed an evaluation questionnaire at the end of the 8 weeks. The user feedback, and the therapist's experience of facilitating the group, led to some modifications both to the guided materials and to the delivery of the intervention in the second phase of the study.

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2 BWW is an anonymous, online mental well-being site that facilitated this study. In 2008, BWW in partnership with the Tavistock and Portman NHS Trust began to offer an early intervention online for those experiencing psychological distress.

3 Interestingly, as the group progresses, participants have been observed to "lapse," as it were, into revealing their "real" identities.

The second phase involved randomly allocating 24 users of BWW who responded to an online advertisement about OLDIT to 3 conditions:

- *Condition A:* 8 people who received 8 weeks of therapist-facilitated OLDIT in a closed group. The participants also had access to the main BWW site.
- *Condition B:* 8 people who were offered a closed virtual space within BWW where they could come together as a group, along with the same guided materials as Group A. This group,

however, was without therapist facilitation. The participants also had access to the BWW main site.

- *Condition C:* 8 people who acted as controls and had access only to the general support provided by BWW main site.

The participants in Conditions B and C were offered the opportunity of receiving therapist-facilitated OLDIT at the end of the study period.

Participants

Twenty-four individuals who were currently using the BWW main site were recruited through an online advertisement posted on the site explaining the purpose of the study. To be eligible to take part in the study, participants had to meet the following inclusion criteria:

- Over 18 years of age
- Not in any other formal therapy at the time of applying
- Scored no less than 5 (mild) on PHQ-9 and GAD-7.

The exclusion criteria were as follows:

- Scoring above 19 on PHQ-9
- Scoring above 14 on GAD-7.

Demographic data are challenging to collect in the context of Internet anonymity. Twenty-four percent of the participants declared they were male and 76% female; 46% of participants gave their age as 20-40 years, 50% as 41-50, and 4% as 51+. In terms of ethnicity, 38% identified themselves as White British, 10% Asian, 10% White other, and 42% "Not stated."

We also collected demographic data about employment and living arrangements: 38% of the participants were employed (including part-time employment), 24% unemployed, 5% students, 5% off work for medical reasons, and 28% not stated. In terms of living arrangements, 24% lived alone, 41% were living with children and/or a partner, 2% were living with parents, and 33% not stated.

Measures

The outcome measures used were the Patient Health Questionnaire (PHQ-9; **Kroenke, Spitzer, & Williams, 2001**) and the Generalized Anxiety Disorder Scale (GAD-7; **Spitzer, Kroenke, Williams, & Lowe, 2006**). These are brief, symptom-oriented reports covering symptoms of depression and anxiety, respectively, based on DSM criteria for Major Depression and Generalized Anxiety Disorder. Mild cases of anxiety or depression are indicated by scores of 5 or above on both instruments. They were administered weekly, online, on the same day for each of the groups; all participants agreed to this. In recognition of the time spent on the weekly completion of these measures, participants

were offered a £50 iTunes voucher at the end of the process. Adherence to this assessment schedule was good in Conditions A and C, but was quite poor for those in Condition B despite the incentive paid on completion of the course of treatment.

Treatment of Missing Values and Data Analysis

Missing observations were estimated by linear extrapolation in cases of single values missing between two observations and using the last value carried forward method in cases of premature termination of data collection. Because participants provided weekly data, mixed effects regression models (Statacorp, **2011**) could be applied to these reports to examine whether the rate of decline of reported symptoms could be predicted on the basis of the treatments administered. The number of individuals participating was very small but the presence of repeated measures data from the same individuals allowed valid statistical models to be constructed. We consider only the frequency with which responses were submitted to be legitimate data for inferential statistics. Statistics reported on questionnaire scores and aggregated to be represented by group means cannot be considered reliable given the small number of participants. Although we have sufficient number of observations to at least partially meet the assumptions of the statistical procedures, any kind of hypothesis testing must be considered illustrative rather than appropriate grounds for generalization beyond the small sample of individuals participating. Nevertheless, in this article we report the statistical data as

might be reported for a hypothesis-testing study, but we do not consider this to be more than illustrating the possibility of statistical models being applied to such data.

In the model we constructed, group and time (weeks) were treated as fixed effects with participants as random effects including intercept and slope. The initial observation of the symptom was included as a covariate in the model. In tests of significance both facilitated and unfacilitated OLDIT groups were referenced to the control condition. Wald chi-square was used to test the significance of the models, and the facilitated group was contrasted with both of the control groups separately and together. To increase power in some contrasts, participants in Conditions B and C were combined to examine the effect of expert facilitation.

Results

Weekly Reporting

For the purpose of this evaluation we considered the completion of questionnaires as an indication of the consideration of mental health issues by participants. **Table 1** displays the mean number of weekly reports completed by participants. The analysis of variance yielded a significant *F* ratio, indicating that the number of reports completed differed significantly across the 3 groups, $F(2, 21) = 4.08$, $p < .04$. Pairwise comparisons between the groups suggest that the group receiving no facilitation but receiving the materials

Table 1 Number of Reports Completed by Participants

	Condition A	Condition B	Condition C	Conditions B + C
eted reports (mean)	8.00	4.25	6.88	5.56
	1.41	3.49	2.75	3.33

manifested greatest difficulty in completing the forms relative to the group receiving facilitation, $t = 2.81$, $df = 14$, $p < .006$. Combining the two groups without facilitation (Conditions B and C) still showed a significant reduction in adherence to the measurement protocol relative to Condition A, $t = 1.96$, $df = 22$, $p < .03$.

Treatment acceptability for participants in Condition A only was assessed by using a 9-item, 5-point Likert scale questionnaire designed for the study, which asked a mixture of open-ended questions as well as seeking ratings about the perceived helpfulness of (a) the group, (b) the self-help materials, and (c) the therapist's facilitation. This was e-mailed by the therapist after the last session; all 8 participants responded.

Baseline Data

Initial values of the PHQ and the GAD are shown in **Table 2**. As noted above these values are displayed largely for illustrative purposes, indicating the kind of information that might be available with a larger study. We could test baseline levels of pathology and observed no differences between mean levels of either depressionor anxiety self-ratings at the start of the trial. The analysis of variance on PHQ yielded an $F < 1$, suggesting that the lack of difference was not a power issue, $F(2, 21) = 0.37$, *ns.* The GAD scores were also very similar, $F(2, 21) = 0.02$, *ns.* Clinical caseness as used in IAPT services on the PHQ is indicated by a score of 10 or above, whereas on the GAD it is indicated by scores of 8 or above, reflecting the optimal combination of specificity and sensitivity for moderate cases of anxiety and depression, respectively **(Glover, Webb, & Evison, 2010)**. All the participants in Conditions A and C and 88% of the participants in Condition B were above the clinical cut-off point on one or other of these measures in their first reports. Interestingly, in the second or third weeks a number of the participants who had reported being below the clinical cut-off point started to report clinical levels of anxiety or depression, such that all the participants were above the caseness threshold on one of the measures during the first 3 weeks of the study. However, overall the participants in this study were significantly less symptomatic on these measures than those attending IAPT programs **(Glover et al., 2010)**.

Table 2 Initial Values of the PHQ and GAD Scores

	Condition A	Condition B	Conditions A + B	Condition C

sion				
mean)	12.50	9.63	11.06	10.63
SD)	3.78	4.24	4.15	3.46
ical at outset	62.5	62.5	62.5	75.0
ical in first three sessions	87.5	75	87.5	81.25
y				
mean)	10.37	9.38	9.87	9.50
SD)	4.03	2.88	3.42	4.31
ical at outset	75.0	75.0	75.0	62.5
ical in first three sessions	100	87.5	87.5	87.5
ical on either measure at outset	100	87.5	100	93.75

End of Treatment Data

Table 3 displays the final observed values of the PHQ and GAD scores from participants. Pre-post comparisons reported here are based on the last reported value and reflect different lengths of observation. Across the sample, there was a reduction of reported levels of both depression and anxiety. While the sample is small, this reduction can be considered statistically reliable (t = 2.54, df = 23, p = .009 and t = 2.62, df = 23, p = .007 for depression and anxiety scores, respectively) between the first and last recorded observation. The reduction in reported depression and anxiety appeared quite marked for the group provided with facilitated or unfacilitated group experience and self-help materials and less so for the control group. We tested the significance of the change in Conditions A and B combined and these appeared to be above chance level for these 15 participants (t = 2.04, df = 15, p = .03 and t = 3.34, df = 15, p = .002 for depression and anxiety scores respectively). There were too few cases to validly test pre- to posteffects in the control group, but values in **Table 3** suggest that change was small. Another indicator of change was the percentage of participants scoring below the clinical cut-off (i.e., recovered) was slightly higher on the PHQ in the facilitated group and apparently substantially higher on the GAD. Because of the small sample size these contrasts were not statistically significant (recovery on the GAD $p < .10$; recovery on both measures $p < .10$) but suggest that with a larger sample a reliable difference might emerge. There was indication that the likelihood of recovery was greatest in Condition A. If we contrast this condition with the two unfacilitated groups, the likelihood of recovery appears greater and this deviation from chance is significant even when distribution free exact statistics are used ($p < .05$).

Trend Analysis

Although there may not be sufficient number of observations to consider the trend data, we nevertheless wanted to fit this type of model to our observations to see whether this procedure might yield meaningful data given a larger sample. The models' trend suggested a reduction in reported symptoms in the participants receiving online self-help materials (Conditions A and B) compared with the control group (Condition C). We also created separate contrast models for the facilitated and the unfacilitated groups (Conditions A and B). Comparison of the trend of decline of the PHQ scores for the three groups

Table 3 Final Values of the PHQ and GAD Scores

	Condition A	Condition B	Conditions A + B	Condition C
sion				

mean)	8.63	9.13	8.88	8.00
SD)	6.23	4.09	5.09	3.85
clinical in last session	62.5	50.0	56.3	50.0
y				
mean)	6.50	8.38	7.43	8.50
SD)	5.32	2.83	4.23	4.31
clinical in last session	75.0*	50.0	62.5	25.0
clinical on both measures	62.5	37.5	50.0	25.0

5 in contrast with Condition C.

yielded no significant differences. The Condition A versus Condition C contrast showed some indication of a more marked decline in PHQ scores for the facilitated group (β = −0.53, 95% CI [−1.22, 0.158], z = 1.51, p = .13) but the Condition B versus Condition C contrast of trends yielded even smaller effects (β = −0.40, 95% CI [−1.08, 0.28], z = 1.16, p = .25). Combining Conditions A and B yielded a marginally significant coefficient for the difference between the rate of decline of depressionscores for the treated versus control group (β = −0.47, 95% CI [−1.03, 0.09], z = 1.73, p = .09).

A similar analysis for anxiety scores showed slightly stronger effects. Comparison of the trend of decline for the Condition A versus Condition C contrast yielded a significant effect indicating a steeper decline in GAD scores for the facilitated group than the controls (β = −0.57, 95% CI [−1.12, −0.22], z = 2.04, p = .04), but the Condition B versus Condition C contrast of trends yielded a nonsignificant effect (β = −0.40, 95% CI [−0. 93, 0.13], z = 1.49, p = .14). Combining the two treatment groups indicated that the decline of anxiety was increased by the provision of self-help material (β = −0.49, 95% CI [−0.94, −0.05], z = 2.16, p = .03).

Qualitative Data

All the participants in Condition A completed a Likert-type rating (5-point scale) on a questionnaire administered after the end of the therapy as well as answering some open-ended questions about their experiences. They all found the self-help materials to be helpful, with 50% saying they had been “very helpful.” Participants observed that the self-help materials provided a “calming” and “structured” way to reflect on their difficulties. This contrasted with greater variation when asked how helpful the group had been, with only 33% saying it had been “very helpful” and 50% scoring in the midpoint range of the scale, suggesting greater uncertainty about the function of the group itself. All the participants felt that the therapist's input had been helpful, with 66% rating it as “very helpful.” However, when asked if they thought the self-help materials would be useful without any therapist input, 66% answered positively.

Discussion

This preliminary study has shown that facilitated Web-based applications of DIT are possible and may lead to higher rates of recovery from symptoms of anxietyand depression in individuals with mild to moderate clinical presentations than are likely without self-help materials. This feasibility study was underpowered to detect significant differences in rates of change between facilitated and unfacilitated provision of material, but decline in symptoms was significantly superior to control only for the facilitated group when the groups were considered separately. The encouraging superiority of the outcome in the combined treated groups versus control also suggests that the DIT self-help materials are helpful and appear to support the process of change. This suggests that the self-help materials warrant further study so that they can be evaluated on a larger scale as a possible alternative to computerized cognitive-behavioral therapy.

There was significant difficulty in collecting data from those who received DIT self-help materials but no facilitation from an online therapist. The rate of attrition from the trial was clearly highest for this group, and considerably higher than the group receiving no attention at all. This is surprising, especially in the light of the relatively high level of reward offered for completed response sheets. The no-treatment control group intriguingly provided data at a level comparable with the facilitated group. This suggests

that there may be some reactance associated with receiving self-help materials without facilitation. However, given that these participants were also invited to work together in an unfacilitated group, we cannot exclude the possibility that the reactance is to the unfacilitated group experience rather than the self-help materials per se. There may have been anxiety about being invited to take part in a closed group without the safety of a therapist's background presence to moderate the group process even though BWW was still providing general moderation. The results suggest that the group process may be an important confounding variable: once a closed group is set up, this may initiate certain conscious and unconscious expectations that need to be addressed and managed by a facilitator.

Because of the design of the study, with the absence of a condition where self-help material was provided without requirement for group attendance, it is not possible to reach any conclusions as to whether the DIT self-help materials require facilitation (and, if so, of what kind) to be of help, or whether it was the group dynamics that negatively impacted on the participants' experience. A study evaluating the self-help materials without any group component would provide an answer to this question.

Our understanding of the role of the therapist in the online intervention has evolved over the two groups we have run. In the first group, the therapist was very active and took up the group's transference systematically, as would be the case in face-to-face analytic group therapy. Although this appeared to be helpful, our experience was that it encouraged greater dependency on the therapist's interventions, such that the group came together largely only the day before the therapist was known to be available and on the day itself. In their feedback, the participants in the initial qualitative pilot study fed back their disappointment that they did not “get more” from the therapist.

In an attempt to explore whether the therapist's input could be minimized without affecting the participants' experience of the intervention and its helpfulness, in the randomized study the therapist was less active and largely restricted their role to (a) containing the group process by setting and managing the boundaries for the group and keeping track of each group member (e.g., inviting them into the group if they appeared to be withdrawing), (b) summarizing the relational themes that were emerging (e.g., anxieties about the possibility of trusting others or the wish to withdraw in the face of more personal inquiry), and (c) responding to difficult group dynamics when these emerged and created impediments to the group's capacity to remain supportive of each other (e.g., aggressive or excessively critical comments about a specific group member). The transference to the therapist was addressed only if it appeared to interfere significantly with the group process. This more “light-touch” approach did not appear to elicit any negative comments in the qualitative data: no reference was made by any of the participants to feeling deprived or disappointed by the relative lack of therapist intervention. We say “relative” because the therapist nevertheless plays an important role as “keeper” of the therapeutic process.

Interestingly, the nonsynchronous nature of the exchanges, both between group members and with the therapist, did not elicit the frustration one might have anticipated. Rather, several of the participants observed spontaneously that they valued the possibility to opt in and out of contact and the opportunity for self-reflection that this slower pace offered. A distinctive feature of some individuals who avail themselves of online help may be that they value not only the remoteness of the contact, but also the opportunity to pace their interactions with others: knowing that the contact is nonsynchronous may promote a greater feeling of control and safety, allowing them to titrate intimacy. Synchronous

exchanges, while gratifying on some level, may nevertheless be experienced by some individuals as too threatening, even if they take place remotely.

An important feature of this study is that all the participants had access to the BWW main site as and when required, as they were all members of the BWW online community. The study design did not control for this; we do not have a condition that indicates recovery rates without any kind of supportive experience. These preliminary observations suggest that the control participants who had access only to the main BWW

site also improved over the study period. This could mean that access to this mental well-being site can be of help as an intervention in its own right, but this cannot be assumed in the absence of a control group given access only to web experience that includes the mental health resources available to everyone without the rich set of resources offered to BWW users. Clearly, this and other limitations suggest that a further study on a larger scale is warranted with controls for specific web experience, self-help with and without group process, and group process with or without facilitation. It would also be interesting to investigate the specific characteristic of those patients who may be more drawn to an online versus face-to-face intervention (e.g., are they more schizoid or avoidant at the outset). Further, in a comprehensive investigation, it would be important to gather follow-up data to determine whether benefits from this more general peer support are sustained over time or merely reactive to the ongoing levels of support the participants receive while members of the BWW online community. Finally this study did not involve any prescreening of the participants by a trained assessor to determine diagnosis and relied on self-report measures rather than independent assessment of recovery, both of which are methodological features that could be addressed in a larger scale study.

The conclusions that may be reached from this study are limited by the nonrepresentative nature of the sample. Indeed, the inadequate information available to the investigators about the participants in this study precludes generalizations beyond the present sample. The small number of individuals participating further limits the reliability of inferences that can be made. Further, although the intervention was based on a preexisting treatment manual, applying the manual in the online group context was taking the process described in the original manual beyond its intended scope. Further work is required in providing an online adaptation of DIT that is sufficiently robust for therapists other than the developers to be able to replicate the procedures recommended with confidence. Caution is further suggested by the relatively high rate of attrition in Condition B, where facilitation was not available. Nevertheless, the study represents one of the first attempts on the part of the psychoanalytic community to respond to Alan Kazdin's challenge to develop methods of intervention that are “fit for purpose” in a digital age and contain within them the potential to deliver mental health services to populations who are in need of services but whose access is limited by their particular set of personal difficulties, their physical situation, or simply by the limited number of services that can ever be made available to a population whose mental health needs are increasing at an alarming rate while resources to address such needs are rapidly shrinking **(Kazdin & Blase, 2011)**.

Conclusion

The delivery of psychological interventions through the online medium cannot meet the needs of all patients. Moreover, there is a need to study further how to establish an effective therapeutic setting in an online environment. However, online interventions can increase accessibility and make a creative and cost-effective contribution as part of an overall strategy to support early intervention within mental health.

Further studies may show OLDIT as being able to make a contribution to this demographic clinical challenge. Despite the understandable reticence among psychodynamic practitioners to engage with the delivery of online interventions, this study suggests not only that it is possible to deliver a psychodynamic interventiononline, but also that psychodynamically informed self-help materials are potentially helpful.

Being able to offer choice is an appropriate target as part of the effort to increase access to psychological therapies. The currently available evidence-based models for online assistance are limited to a single modality and could be enhanced by approaches based on a psychoanalytic model being available in computerized form. This preliminary study also suggests that the generic support provided by an online mental well-being site such as BWW may have significant therapeutic effects, and this possibility also requires urgent investigation. These questions warrant further research on a larger scale.

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Psychoanalysis Online: Mental Health, Teletherapy, and Training. Edited by Jill Savege Scharff. London: Karnac Books, 2013, xxii +250 pp., $48.95 paperback.

Review by:

Arlene Kramer Richards

Dear reader: Before reading this review you should know that I am cited in this book, and quoted once, though briefly. I will try to be as objective as I can. You be the judge of whether I have succeeded.

This may be the most practically important book on psychoanalytic therapy published this year. It amounts to an assertion that we cannot in the name of caution ignore or defer the use of modern technology in our work. The various chapters cover the subject from points of view ranging from mild disapproval of the dangers of internet addiction as a psychological illness to recommending use of the internet for treatment at the highest, or deepest, level. All of the contributors advocate that we accept, with due caution, communication via telephone and the internet as a reality that has changed what patients today, especially younger ones, find comfortable and useful. Yet most of these authors also believe that the wisdom of accepting these parameters must be further researched, discussed, and evaluated.

Most of the contributors to this volume use the phrase “face to face” to describe treatment in the analyst's or therapist's office. Yet analysis is not “face to face” when the patient lies on the couch. And it *is* “face to face” when both participants in the conversation are looking at each other's faces on screens that are eighteen to twenty inches in front of them. It is more intimately face to face than most conversations—at times even strangely, disturbingly so. Yet Freud's innovation of having a conversation while one person looks at the wall or the ceiling, with the other looking at the top of that person's head, was surely more strange to his patients than use of the telephone or computer is to ours. Those who consider Freud the founder of a valuable form of psychological treatment may do him the greatest honor by following his example of experimenting to find what works.

I enjoyed and learned from the clinical vignettes—from analysts, psychotherapists, and especially patients. While a basic question may be

whether electronic voice and picture technologies provide as good an experience as treatment in the same room at the same time, several contributors point out that the question is really whether treatment using technology is better than no treatment at all.

Sharon Zalusky Blum reminds the reader that she first wrote about using the telephone for analysis three decades ago. Particularly for those who find it difficult to accept that this form of treatment can be valid, her reminder that it has been tested over time and is still in use is a sobering answer to the question of whether this is an untested innovation or an acceptable way of providing what a particular patient needs.

Ernest Wallwork describes an interesting practice carried out part of the year in Syracuse, New York, and part of the year in Washington, D.C. So many of his sessions are conducted electronically that he has come up against several ethical questions. He advocates discussing the pros and cons of teleanalysis with the patient before agreeing to do it. He discusses holding the frame by avoiding doing other things while on the telephone and restricting oneself to mindless repetitive acts like knitting if the deprivation involved in telephone work requires that.

Particularly interesting and moving to me is the extent to which Charles Hanly, past president of the International Psychoanalytical Association, describes his experience of yielding to a request by a patient who was relocating to continue the analysis over the telephone. What this book tells us is that it is possible to be responsible while also being responsive. And Hanly's contribution is exactly that: an example of an analyst

responding, however reluctantly at first, to what his patient needed and wanted. The response was carefully analyzed, but was also caring of the patient's feelings both in attempting the parameter and in discussing his feelings about it.

An outstanding contribution from Anna Kudiyarova, an analyst from Kazakhstan, describes her own shuttle analysis coming two or three times a year to the United States for intense sessions, with interruptions for very long months in between. She compares this with the continuity and predictability of sessions that can be scheduled four times a week with only minor interruptions for vacations or holidays. Having experienced both, she prefers the latter. She presents a vignette of a patient who repeatedly destroyed relationships but became able to express negative feelings toward her analyst without having to destroy their relationship. Despite many interruptions, she was able to use Skype sessions to resume and continue her treatment and to become able to

sustain other intimate relationships as well. The patient reported that with Skype “she felt closer to me than when seeing me in person at my office because now I came to her” (p. 190). Kudiyarova concludes that Skype may be the most cost-effective way to provide psychoanalysis and training for candidates in areas where there is no institute.

A group of four women who used **Skype analysis** in conjunction with shuttle analysis contribute a paper showing how the intensity of the group process in trainingallowed them to bond and to support one another. Betty S. de Benaim, Yolanda G. de P. Varela, Lea S. de Setton, and Anonymous all live and work in Panama. In writing conjointly, they make a mosaic of the advantages and disadvantages of using teleanalysis. But they all conclude that they are grateful for the opportunity to have experienced what they believe to have been a real analytic process.

Several contributors point out that technology-assisted treatment may have advantages over “in-person” treatment. As an analyst who has conducted treatment and supervision using these technologies, I have seen how well they can work. I have even seen examples, admittedly rare, of their working better than therapy in the same room at the same time. For instance, a supervisee who was treating an obese patient reported that when her patient did not come in for a session, she had called her to find out whether she was all right. The patient was grateful for the call, asked if they could have the session on the telephone, and proceeded for the first time to talk about the shame she felt over her obesity. I had noted earlier to my supervisee that this was an issue that had not been addressed in the patient's months of treatment. I tried humor to make it seem less like I was scolding the therapist when I called this “the elephant in the room.” The therapist said she had been afraid to bring the issue up lest the patient feel she was being scolded for overeating. The patient said she had been able to talk about it when they were not together in the same room; she felt she could not bear the therapist's looking at her while she talked about her weight. Had they not talked on the telephone, the issue might never have been brought up by either of them. And the treatment would have missed a crucial issue. That, in my opinion, would have been patient neglect.

With my own patients I have seen and heard the sort of things that are discussed in many of these papers. I have been willing to learn from them because the authors are so patently honest and interested in their experience and because they have been willing to innovate. Writing these papers took courage, Putting them together in this book took both

courage and discipline. I salute Jill Savege Scharff for conceiving and carrying out this important work.

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Intimacy in a Virtual World: Some Reflections on Spike Jonze's Film Her

Andrea Sabbadini

'The past is just a story we tell ourselves'

(Samantha, in *Her*)

Some Features of Intimate Relationships

Intimate loving relationships, in their varying combination of physical and emotional components, reflect the infinite variety of human beings: their personal qualities, their past experiences, the culture in which they have grown up, their fantasy lives…

As a precursor to such relationships among adults, the earliest bond between baby and mother is formed on the basis of primary sensory experiences: seeing, hearing, smelling, tasting and touching. Individuals involved in intimate relationships would, ideally, choose to stay in each other's proximity, *i.e*. with their bodies located in the same place and time, with their senses switched on and tuned onto one another. Geographical distance and extended temporal gaps between encounters can be painful, and major sensory disabilities in one or both partners can interfere with, or at any rate alter, the quality of their relationship.

In reality, conditions are seldom ideal and, even when they are, they are unlikely to remain so on a permanent basis. In *all* intimate relationships, be they of an erotic or of any other kind, uncontrollable internal pressures or external circumstances create the need for compromises. Let us briefly look at a few situations where some of the ingredients are missing, or have at some point been lost, and consider whether such close relationships are still possible under those conditions.

Being unable to see, hear or touch the loved one can be distressful.

The International Journal of Psychoanalysis

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Panel Report, IPA Congress Buenos Aires 2017: Intimacy and Technology: Developing a Psychoanalytic Dialogue

Guillermo Bodner

Chair: Gustavo Jarast

Presenters: Kamran Alipanahi, Jacqueline Amati Mehler and John Churcher

Reporter: Guillermo Bodner

The impetuous development of communication technologies in recent years has had an immense influence on people's lives, both individually and socially. Time zones, space, and distance are transformed as unique and novel technical devices flood the market. It is obvious that this has had consequences on our way of living or sharing intimacy and also on our way of understanding psychoanalytic treatment. Gustavo Jarast, who chaired the panel, briefly referred to these points before introducing the panellists. Jacqueline Amati-Mehler pointed out that due to a greater knowledge of primitive areas of psychic functioning, psychoanalysis has focused its attention on those areas. This greater knowledge has a powerful impact on the analyst's countertransference. The analysis of these processes requires greater containment and spatial closeness. Quoting G. Russell **(2015)** she said: “A prime concern with technologically-mediated treatment points out is that the elimination of co-present bodies largely confines the psychoanalytic process to ‘states of mind’ rather than ‘states of being’. It is when one can dwell in a ‘state of being’ that one can take part in the psychoanalytic process of communicating with oneself and the other”. Intimate relationships rely on significant implicit non-verbal components, which only a co-presence allows to be perceived. Deep vicissitudes are most likely to be evidenced in a close relationship with another, while defensive distance can elude all the evidence connected to early functions. Amati-Mehler also wondered about the impact that the “Skype-analysis” can have on our method, on the identity of candidates trained with these technical changes and on our specific practice.