CHAPTER FOUR

What happens in the consulting room

Elements of therapeutic effectiveness

Some years ago a general practitioner spoke to me of her mystification about what happens in psychotherapy. She said, with rather vehement frustration, "I tried to find out about it when I was training, but whenever I asked to observe what happened in the consulting room they just wouldn't let me sit in!" It was interesting to think about her rather circular problem, because without knowing what happens in therapy, it is difficult for a non-therapist to imagine why the process would not lend itself to a third party observer. Of course, like the old joke, if you got three therapists together to try to explain it to her, each explanation would differ.

Yet, determining just what happens in the consulting room is important when we want to consider the relationship between the therapeutic processes in single-environment sessions and technologically mediated sessions. What elements specifically constitute therapeutic action and are required for therapeutic effectiveness? The answer to this question is perhaps much less straightforward than it appears, as assessment of what is precisely therapeutic about psychoanalysis has changed over the years and still is a matter of fierce

debate. Recent developments in the analysis of what constitutes therapeutic action have expanded from Freud's original concept of the exclusive use of transference interpretation to create insight, and "transform what is unconscious into what is conscious" (Freud, 1916–1917, p. 294).

Freud developed the concept of the fundamental rule of free association in which the patient is required to verbalise whatever thoughts or feelings come to mind, without censorship or editing, in order to enable the emergence of a form of communication which makes the unconscious material more accessible:

> Say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside. (Freud, 1913c, p. 135)

The emphasis here is on a verbal transaction between the patient and analyst to which the analyst can respond with articulated interpretations of unconscious content to enable insight. For Freud, interpretation was the main mutative technique in psychoanalysis.

The Hungarian psychoanalyst Sandor Ferenczi, whose association with Freud would end in rupture, was one of the first to draw attention to the transformative impact of the reciprocal relationship of analyst and patient at both conscious and unconscious levels. He stressed the positive aspects of the relationship as central to the therapeutic process, rather than to be regarded as a failure of analytic neutrality. Bass (2003) points out,

> From the beginning of the talking cure, there was a strong tendency within classical circles to exclude action, in fact and theory, from a process that was regarded as verbal to the core. The distinction between talk and action, word and deed, was at the heart of Freud's theory of the mind and his development of analytic technique. (p. 659)

This tension between word and deed is a hallmark of the debate between the classical and relational schools of thought that has continued to the present day, particularly in the USA (Wallerstein, 1988).

In 1960, Loewald foreshadowed the broadening view of what effects psychic change in psychoanalysis by noting that change "is set in motion not simply by the technical skill of the analyst, but by the fact that the analyst makes himself available for the development of a new 'object-relationship' between the patient and the analyst" (Loewald, 1960, p. 17). British object relations theorists such as Donald Winnicott emphasised the analyst's establishment of a safe "holding" or facilitating environment in which the patient was able to internalise a new affective relationship between self and object (Winnicott, 1965). As a result of this groundwork, multiple modes of therapeutic action are now taken into account, so that there is no longer such a sharp demarcation between interpretative and relational aspects of therapeutic elements in psychoanalysis. Gabbard and Westen (2003) suggest,

> Insight into aspects of the relationship itself that are corrective may foster further change, and the content of interpretive comments may at times be less important than the often unconscious meanings, including relational meanings, transmitted in the course of the interpretation. (p. 824)

The expansion of the definition of therapeutic action in the "talking cure" to something more than verbal is significant in considering the elements that must be included in technologically mediated treatment for it to be considered feasible. If the curative properties of psychoanalysis continued to be considered purely verbal, then communication via computer, or telephone, for that matter, would not raise any questions for exploration. However,

> . . . contemporary analysts have come to appreciate the degree to which the transformative power of the psychoanalytic relationship is largely between the lines. While theorists of all persuasions strive to articulate the source of therapeutic action and change, daily clinical experience often reflects the powerful effect of what can be located in inchoate experience, the often preconscious resonance we have come to regard as enacted in the transference–countertransference. (Bass, 2003, p. 658)

Contemporary literature on the elements necessary to forward the therapeutic process therefore includes requirements comprising both the explicit interpretative action of the analyst and the more implicit aspects of the analytic relationship. We need to establish some historic clinical and theoretical ground from which to extend our consideration of the recent practice of technologically mediated psychoanalysis

and psychoanalytic psychotherapy. If we can attempt to develop a framework to understand what actually happens in the consulting room, we can then begin to apply that to the practice of screen-to-screen treatment.

A safe, facilitating environment

Winnicott based his understanding of the establishment of what he called a "holding" environment in the analytic relationship on his observations of the mother–baby relationship. He described the "holding" or "environment" mother as a carer who provides continuity, stability, and a sense of "going on being". She offers her "reliable presence" and, in continuing to be herself, to be empathic, and to receive the infant's spontaneous gesture, she allows the infant to achieve the stability to develop towards independence (Winnicott, 1965, pp. 76–77). This maternal holding environment is carried over into the analytic setting. The setting promotes a "good-enough" environment enabling the patient to heal early psychic damage. In his 1955 paper, "Metapsychological and clinical aspects of regression within the psycho-analytical set-up", Winnicott began to separate aspects of interpretation and setting. He outlined "the material presented by the patient to be understood and to be interpreted", as well as, ". . . the setting in which this work is carried through" (p. 20). He listed twelve requirements for a safe setting in which to do analytic work, which he believed were Freud's intuitive choices for the original psychoanalytic setting:

1. At a stated time daily . . . [the analyst] puts himself . . . at the service of the patient. (This time was arranged to suit the convenience of both the analyst and the patient.)
2. The analyst would be reliably there, in time, alive, breathing.
3. For a limited period of time prearranged (about an hour) the analyst would keep awake and become preoccupied with the patient.
4. The analyst expressed love by the positive interest taken, and hate in the strict start and finish and in the matter of fees. Love and hate were honestly expressed, that is to say not denied by the analyst.

5. The aim of the analysis would be to get in touch with the process of the patient, to understand the material presented, to communicate this understanding in words. Resistance implied suffering and could be allayed by interpretation.
6. The analyst's method was of objective interpretation.
7. This work was to be done in a room, not a passage, a room that was quiet and not liable to sudden unpredictable sounds, yet not dead quiet and not free from ordinary house noises. The room would be lit properly, not by a light staring in the face, and not by a variable light. The room would certainly not be dark and it would be comfortably warm. The patient would be lying on a couch, that is to say comfortable if able to be comfortable, and probably a rug and some water would be available.
8. The analyst (as is well known) keeps moral judgment out of the relationship, has no wish to intrude with details of the analyst's personal life and ideas, and the analyst does not wish to take sides in the persecutory systems even when these appear in the form of real shared situations, local, political, etc. Naturally if there were a war or an earthquake or the king dies the analyst is not unaware.
9. In the analytic situation the analyst is much more reliable than people are in ordinary life; on the whole punctual, free from temper tantrums, free from compulsive falling in love, etc.
10. There is a very clear distinction in the analysis between fact and fantasy, so that the analyst is not hurt by an aggressive dream.
11. An absence of talion reaction can be counted on.
12. The analyst survives. (Winnicott, 1955, p. 21)

While Winnicott stressed the analyst's behaviour is central to this environment, none the less, he included the physical environment, specifically describing its characteristics, as part of the provision the analyst made for the patient. He called it, "The provision of a setting that gives confidence" (1955, p. 22).

Providing a safe holding environment to foster the possibility of psychic change has become part of the psychoanalytic clinical tradition (Balint, 1979; Langs, 1979; Milner, 1969; Modell, 1976). This concept is comparable to the "secure base" in Bowlby's attachment theory. In the therapeutic treatment, the therapist establishes an environment informed by consistency, responsiveness, and attunement. This does

not only consist of the therapist him/herself, but also the therapist's frame, including consistency of time, place, room, and technique. "... there has to be a safe space, both literally in the therapist's room and also an 'internal' space in his or her mind" (Holmes, 2010, p. 90).

When considering the application of the concept of a safe holding environment to technologically mediated treatment, we hit an immediate snag. A safe holding environment cannot be established in the traditional way in the screen-to-screen relationship. Many analysts I interviewed, such as Bella, whose patient had to withdraw to a broom cupboard, expressed great frustration over their inability to provide a safe space for their patients. The patients I interviewed, such as Lucy, who missed having some of her basic needs met by her previously co-present analyst, felt the impact of having to provide for themselves in the analytic relationship. When the patient is in a separate setting no longer provided and managed by the practitioner, we have seen that there are serious challenges to the safety of the holding environment. Indeed, the requirement that the patient provide his/her own space could ultimately limit the therapeutic experience, just as the foreclosure of potentiality does. The patient is never allowed to have the experience of truly depending on the analyst in a place where he/she can "simply be" without impingement.

Evenly suspended attention and reverie

While Freud recommended that patients be encouraged to follow the fundamental rule of free association (Freud, 1913c), he suggested that the analyst adopt a complementary attitude of "evenly suspended attention" in which he

> could ... surrender himself to his own unconscious mental activity ... to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix anything that he heard particularly in his memory, and by these means to catch the drift of the patient's unconscious with his own unconscious. (Freud, 1923a, p. 239)

Bion extended this concept of analytic listening, using the term "reverie". Like Winnicott, he based his observations on mother–infant behaviour: "... [the] state of mind which is open to the reception of

any 'objects' from the loved object ... therefore capable of reception of the infant's projective identifications whether they are felt by the infant to be good or bad" (Bion, 1962, p. 36). This state of readiness to contain the infant's intolerable emotions and return them detoxified, he termed "maternal reverie". Likewise, he encouraged the analyst to be open (as container) to holding the patient's projections, working in the present moment "without memory or desire" (Bion, 1967). This echoes Freud's injunction that the analyst "should simply listen, and not bother about whether he is keeping anything in mind" (Freud, 1912e, p. 112).

Ogden (1996) reconsidered and elaborated upon the necessity for reverie by describing it as a shared process between analyst and patient in which the unconscious interplay of both their states of mind creates an overlapping intersubjective experience. He emphasised the need for a shared space in which both the analyst and the analysand have the freedom and privacy each to turn their unconscious "like a receptive organ towards the transmitting unconscious" (Freud, 1912e, p. 115) of the other.

We have heard from both analysts and patients that this kind of free thinking, which is key to the analytic process, is a challenge to maintain in technologically mediated treatment. The limitations of the technology and the absence of the implicit cues normally available in co-present sessions tend to create a focused attention that hinders reverie. It is difficult to surrender oneself to the privacy of one's own unconscious when not assured of the presence of the other.

Provision of a new relational experience

As early as 1934, James Strachey theorised that patients internalised their analysts' neutrality in a way that softened a harsh superego (Strachey, 1934). Loewald, in his groundbreaking paper, "On the therapeutic action of psycho-analysis" (1960), spoke of structural changes in the patient's psyche that cause a resumption of stalled ego development dependent on a relationship with a new object, the analyst.

> I say new discovery of objects, and not discovery of new objects, because the essence of such new object relationships is the opportunity they offer for rediscovery of early paths of the development of

> object relations, leading to a new way of relating to objects as well as of being and relating to oneself. (Loewald, 1960, p. 18)

This echoes Winnicott's extensive work based on his paediatric experience with infants. The patient is enabled to use the analyst as a separate object, if the analyst is able to provide a facilitating environment (the "good-enough" analyst) in which the patient can begin to experience the analyst as a resilient, non-retaliating object (Winnicott, 1965, 1969).

The therapeutic relationship offers a different experience of relating in which the patient internalises various functions and attitudes of the analyst.

> *[Interpretations] combine with the material setting provided by the analyst* to form the analyst's affective contribution to the formation of a trial relationship, within which the patient can recapture the ability to make contact and communication with external objects. (Rycroft, 1956, p. 472, my italics)

The patient is enabled "to find himself in the therapist's mind and integrate this image as part of a sense of himself" (Fonagy & Target, 2000, p. 870).

Of particular significance in the consideration of the therapeutic relationship as a conduit of therapeutic action are the non-verbal effects of the analyst's presence and the reciprocal perception of analyst and patient's non-verbal cues, which can operate relatively independently of both language and consciousness. The subject of non-verbal communication has become particularly pertinent for psychoanalysis, especially in view of recent research in cognitive neuroscience, which I will discuss later. It has been said that 60% of communication is non-verbal (Burgoon et al., 1989), and the analysis of that body-to-body exchange must be relevant both in the consulting room and in screen relations.

Interpretation and insight

Interpretation, which is aimed at promoting insight, is also fundamental to analytic activity. It is an explicit intervention by the analyst whereby he/she expresses an understanding of the patient's inner

world, Freud's (1916–1917) method of bringing the unconscious into consciousness. Interpretations may be based on the patient's descriptions of memories, fears, wishes, fantasies, expectations, and other expressions of psychic conflict formerly unconscious or only partially known to the patient.

These observations may include extra-transferential material not directly exhibited in the therapeutic relationship or transference interpretations that involve "here and now" explanations of repetition and distortions in the therapeutic relationship that the patient replicates from past experiential patterns (Moore & Fine, 1990). A well-timed interpretation, in which the analyst is able to meet the patient at a point of readiness to hear and internalise the observation, can lead the patient, through understanding his or her internal world, to make a shift in feelings and behaviour.

Interpretations are explicit communications that certainly can be transmitted via technological mediation. Questions will arise, however, when we explore the genesis of the well-timed interpretation. If the verbal message is rooted in an embodied implicit experience of the other, how well can we participate in this joint implicit process screen-to screen?

Other types of intervention

Several subsidiary methods of intervention can contribute to significant psychic change. Many kinds of challenge contain implicit or explicit suggestions for change. Although the analyst attempts to refrain from being directive, simply pointing out a patient's patterns of behaviour can imply areas that are unresolved and require exploration. Related to this is direct confrontation that might be required to overcome an analytic impasse and the exploration of impaired, distorted, or irrational beliefs, with the implication that the analyst may have a differing point of view (Stewart, 1990). Handled sensitively, this strategy can be a useful method of helping the patient to begin to see the potential for two separate minds operating in the same space. Mutual problem solving, involving the therapist and patient thinking together about new conscious ways of decision making, can also redirect the trajectory of a patient's growth (Gabbard & Westen, 2003).

A therapist's circumspect self-exposure for damaged patients with impaired capacity for mentalization, both explicit and implicit affirmation, and finally "facilitative strategies", which include those forms of social and communicational processes that serve to enable a satisfactory working alliance, all have their places in a psychoanalytic treatment (Castonguay & Beutler, 2006; Gabbard & Westen, 2003, p. 836). These auxiliary practices, which are cognitive and largely language-based, and the primary elements such as the centrality of the therapeutic relationship outlined above, are also highlighted by the Task Force of Division 12 of the American Psychological Association and the North American Society for Psychotherapy Research as principles of therapeutic change in their comprehensive review, *Principles of Therapeutic Change that Work* (Castonguay & Butler, 2006).

Having outlined what psychoanalysts propose happens in the consulting room to promote therapeutic action and change and begun to consider whether or not this might be realised through technological mediation, we will now turn to the recent contributions that neuroscience has made to widen and deepen our understanding of communication between therapist and patient.

CHAPTER FIVE

From the first laboratory: neuroscience connections

No enquiry into the nature of the mechanisms of communication in the consulting room, much less the forms it might take when mediated through a technological device, can ignore the recent attention that psychoanalysts are giving to the non-verbal aspects of practice and the underlying neuroscientific hypotheses and research. There is a body of neuroscience and cognitive science that is of great interest to psychoanalysts wishing to find some sort of explicative bridge between daily clinical experience and theoretical inheritance. While there are a number of competing explanatory models in neuropsychoanalysis, they share many commonalities that are useful for thinking about possible communicative processes.

Freud said that "the ego is first and foremost a bodily ego" (1923b, p. 26). Winnicott wrote that if a baby reaches a state in which it has a sense of wholeness, then it is "living in the body" (Winnicott, 1975b, p. 264). Yet, as Jacobs (1994) points out, although Freud was historically a perspicacious observer of his patients' non-verbal behaviour, he did not develop this area of his analytic work, and his theories advanced more in relation to verbal communication. As psychoanalysts have become increasingly interested in non-verbal communication, what Grotstein (2005) calls "body rhetoric", they have begun to