Chapter 4

Mediated psychotherapy

Laura

When I agreed to a Skype session with Laura, a 19-year-old girl who sought help for panic attacks, she was very appreciative. She had exams to sit at a university that was some way from where I practised. Avoiding travelling to see me would save her time that she could use to revise *and* she need not cancel the session she also needed. On the face of it this seemed to be a good compromise given the competing needs.

At the agreed time we 'met' on Skype, Laura was in an empty room within the university. When I enquired as to whether this was a private space she reassured me that it was. As she spoke I was struck by the worried look on her face. She avoided looking at me. She said she was worried about her exams and her long-standing anxiety about not being popular with friends. She then recounted a long story about another student in her halls of residence who was feeling very anxious because someone had broken into her room. Laura now also felt unsafe and could not sleep at night. She worried that others in the halls might have been complicit in this incident. She felt panicky about the thought of being in her room.

Laura laboured over this story and her worry about her friend and about her own safety. She became tearful. She emphasised how no one could be trusted these days: 'Even people you think you know can end up going behind your back.' She then glanced to the right and leaned forward obscuring the screen, as if to check if someone was coming into the room. I asked her if she was concerned that

someone might come in. Laura replied that she was not but I noticed that her eyes were looking at something beyond the screen. She seemed distracted.

As I listened to Laura I was aware of how difficult it was to feel engaged with her. She was expressing anxiety, which no doubt was partly connected to the imminent exams, but there was also a sense that our exchange was unfolding in a space that did not feel safe, as if someone could 'break in' and intrude into her session. As her therapist I now considered that I had offered to help her by agreeing to Skype but the reality of Skype, for Laura at least, at an unconscious level, was experienced as a breach in the safety of our relationship. I had become 'complicit' in offering a therapy in a mediated setting that she now felt was not safe.

In a global fast-moving economy time and geographical distance have become key variables that determine the viability of long and more intensive therapy. Such external pressures carry opportunities as well as risks. 'Opportunities' because threats to the viability of established models of practice push us to critically revisit what we believe to be important. In turn this can lead to helpful revisions of how we work or to confirmation that what we believe in has value and needs to be protected. 'Risks' because when we are invited to consider adaptations to the original psychoanalytic setting we can be carried away with the sweep of changes that have a cultural momentum but are not necessarily helpful to the discipline we practice. Disentangling those aspects of our technique that are worth fighting for from those aspects that we hold on to simply out of comfort, convenience or habit is not an easy task.

This question is all the more difficult to approach because we are discussing here external changes that bear on how much work therapists can secure. This leads us into difficult territory. As a profession we have never had a comfortable relationship with money. At times it seems as though the fact that we are paid for what we do is incidental to what motivates us or at least to what makes it necessary for us to work. At worst we fear that we will be perceived as greedy if we express the need to be well paid. Yet economic realities impinge on all clinicians to varying degrees such that if the current trend is towards shorter, mediated therapies that

can be accessed on the go, then clinicians may be under some pressure to adapt or die. This is never a good position from which to evaluate whether our technique requires adaptation.

Mediated therapy is not new. An important component of Freud's self-analysis were the letters to his friend Wilhelm Fliess and he also highlighted the value of using correspondence therapeutically in his letters of advice to Little Hans' father (Brahnam, 2014). The use of the couch itself, we might say, is a form of meditation that suspends the visual relationship for the duration of the session, introducing a one-way screen between patient and therapist allowing the latter to see the patient but not the other way round.

What is new about mediated therapy is that we are now finally discussing it within our discipline. In this chapter I will draw on my clinical experience as an analyst and therapist and share what I have learnt through the way my work has been impacted on by new technologies. It is intended to be an exclusively personal view based on working with patients in a range of modalities: intermittent work, once-weekly psychotherapy, brief analytic therapy and four-times-weekly analysis. My work is variously carried out face to face, on the couch and occasionally via Skype with some selected patients.

I will not rehearse here all the arguments and evidence for and against mediated therapies. Two recent publications, one by Isaacs Russell (2015) and the edited collection by Scharff (2013), have very competently addressed this. Instead I will restrict myself to considering the importance of the embodied setting for the practice of psychoanalytic therapy and of psychoanalysis and the implications of this for Skype therapy. In particular I will share some thoughts about why, despite its significant limitations, Skype therapy specifically can *sometimes* work. To this end I will outline a schematic model that aims to capture what I think I do with my patients when I use Skype.

The analytic setting

In order to consider the impact of mediation in psychotherapy it is important to first set out the features of the classical analytic setting and their function. The analytic setting or frame[1] is generally thought to include the establishment and maintenance of the physical setting and of the psychoanalytic contract, which includes negotiation of the time, frequency of sessions, use of the couch and money, and the role of the

therapist (Bleger, 1967; Langs, 1998; Modell, 1989; Winnicott, 1956). Some therapists also include within this notion the delineation of 'the data of analysis', namely the patient's free associations (Busch, 1995) and the analytic attitude. Many would also include the therapist's internal setting, that is the setting as a structure in the mind of the therapist – 'a psychic arena in which reality is defined by such concepts as symbolism, fantasy, transference, and unconscious meaning' (Parsons, 2007: 1444). The therapist's internal setting provides an important anchor as it orients the therapist in a highly specified manner to the patient's communications. The internal setting is portable, we might say, and it is what distinguishes an analytic therapist from any other (Lemma *et al*., 2008).

Yet others bring into the notion the therapist's theoretical leanings (Donnet, 2005). The therapist's internal setting also provides some kind of anchor as it orients the therapist in a highly specified manner to the patient's communications. In this chapter the term 'analytic setting' denotes both the pragmatic parameters and the therapist's internal setting as defined by Parsons (2007).

The function of the setting has been written about extensively. It has traditionally been understood to be the essential 'background' that provides the necessary containment and stimulus for the gradual unfolding of the patient's transference. Within an object relational model one would add that it allows for the emergence of the unconscious phantasies that give the transference its dynamic specificity. Accordingly the role of the therapist is to be the custodian of the setting. This requires that the therapist not only pays close attention to how the patient reacts to the setting (the unconscious phantasies and resistances it may generate), but also carefully monitors her own internal processes which can both facilitate (through free-floating attentiveness) or hinder (through the therapist's own resistances and 'blind spots') the unfolding of an analytic process.

The frame acts as a container. It allows for the unfolding of the patient's story and an understanding of her internal world within safe confines. The safety or otherwise of the so-called container is communicated in practical terms through the respect of the boundaries of the analytic relationship. The safeguarding of a secure setting is a core part of analytic technique. It involves managing the physical boundaries of the relationship, namely the provision of a space where therapist and patient can meet without interruptions, where confidentiality can be assured, where the therapist can be relied upon to turn up on time, at the same time, week after week, as well as to finish the sessions on time. The thoughtful administration of

these boundaries conveys a great deal of information to the patient about the kind of person to whom he is entrusting his mind. How we set up the frame and manage it, or deviate from it, are all interventions, just like an interpretation. An intervention carries communicative intent – conscious and unconscious.

Adhering assiduously to the boundaries of the setting is not a question of being pedantic or inflexible. On the contrary, such an attitude of respect for boundaries reveals an appreciation of the importance of stability and reliability for the patient's psychic development. The setting, as agreed at the outset with the patient, becomes part of how the patient experiences the therapist. Consequently, any change to its parameters challenges the patient's subjective experience of knowing his object.

The secure setting creates a space within which the patient can 'use' the therapist (Winnicott, 1971). Winnicott outlined the developmental importance of the infant's experience of destroying an object that survives the attack and does not retaliate. This allows the object to become 'objective' – that is, the infant realises that it exists outside the self. This marks the beginning, according to Winnicott, of 'object usage'. If we apply some of these ideas to the therapeutic situation, we might say that one of the functions of the analytic frame is to create a setting in which patients can experience both omnipotence and deprivation in the knowledge that the therapist will survive the patient's attacks.

It is not only the patient who benefits from the consistency of the setting. The therapist too benefits from being anchored in reality by it. The work of psychotherapy plunges both patient and therapist into what is a very intimate, intense and sometimes highly arousing relationship. The boundaries set in place by the setting help remind us that the relationship with the patient should never become a substitute for resolving personal conflicts or thwarted desires – this is a risk, I will suggest later, that is heightened in mediated therapy.

The body of the analyst may also be helpfully conceptualised as an ever-present feature of the setting, which contributes to its felt constancy and hence its containing function such that any changes may mobilise phantasies and anxieties in the patient as well as in the analyst. The therapist's physical appearance and the way she inhabits her body and physical space in the room – the way she sits in the chair, breathes, moves in the room, speaks, dresses and so on – constitute core sensory features of the setting that contribute to the containment provided by the therapist. We might therefore say that several aspects of the setting are indeed embodied (Lemma, 2014). Our nods or

glances as we greet the patient or the way we stand up at the end of sessions are part of the rituals or frame parameters embodied as 'constants'. All of these become expected features of the setting.

These are, however, 'constants' that by virtue of their embodied nature are hard to keep reliably constant, such that the patient may react to this aspect of the setting more strongly and more frequently than they do in relation to other parameters of the setting. By 'reacting' I do not just mean that the patient consciously reacts to visible changes in the therapist's body; rather I have in mind how the therapist's body acts as a powerful stimulus in the patient's internal world, as will become manifest in the patient's associations, enactments and so on, as well as impacting on the therapist's countertransference, all of which allows us to infer the patient's unconscious phantasies and internal objects.

The sensory features of the analytic setting are most likely important to all patients. The way a room is decorated may give rise to feelings of warmth and phantasies of being taken care of, or quite the converse: a patient may feel that a room is too 'bare' which may give rise to a phantasy that the analyst is depriving him. Similarly, the body of the analyst sets a particular sensory tone to the setting and mobilises particular phantasies: their voice may be experienced as 'warm' or 'cutting'; their choice of clothes may be too 'cold' or intrusively 'colourful'. These phantasies, which as Bronstein (2013) notes could be understood as 'embodied phantasies' not yet accessible to representation, may nevertheless be communicated non-verbally to the analyst, leading to powerful somatic countertransference responses in the analyst. The analytic setting can evoke a range of phantasies, including pre-symbolic ones (Bronstein, 2013), both through the patient's experience of sharing a physical space and the therapist's physical presence.

Skype therapy: The challenge of 'presence' and the importance of 'relevance'

Mediated therapy unfolds in a significantly different setting to the one I have just outlined. Let me be unambiguously clear about my position with regard to Skype therapy before discussing it in a more nuanced manner:

1 Skype therapy is practised quite widely nowadays so we need to engage with the challenges and opportunities that it poses by recognising its nature and limitations.

2 Skype therapy *is* different in several important respects to in-person therapy. By 'different' I mean that it is not just a minor modification of the classical analytic setting. It represents a fundamental modification of the process and setting.
3 The differences have implications: they make a difference to the kind of work that it is possible to undertake even if our internal setting is an analytic one. This needs to be taken into account when we assess the suitability of this medium for a given patient.
4 As a form of therapy it is therefore not indicated for all patients or for all therapists and lends itself as a more suitable medium for cognitive and behaviourally based therapies than affect-based and relational therapies.
5 It is harder for the therapist to work analytically through this medium and it carries risks, not least with respect to the enactment of counter-transferential responses.
6 Nevertheless there are several accounts of successful mediated psychoanalytic therapies (Sharff, 2013). This poses the interesting question of how we can understand how this occurs given the limitations imposed by its virtual setting.

I will now elaborate on the position I have outlined. I have worked via Skype for six years with some of my patients. I have only once taken on a patient for Skype therapy who I had not at least met a few times in person. Almost exclusively I only use Skype with established patients whom I know well and who have asked for Skype to make it possible to sustain continuity due to a move to another country or because their job involves frequent travel.

The question of whether it is better to face the reality of separation and end a therapy or to adapt one's way of working so as to accommodate a patient who would otherwise need to terminate treatment cannot be answered in any general way. It will depend on the patient and whether there are particular challenges around separation that could be better addressed by ending a therapy than by sidestepping the anxiety by prolonging the therapy via Skype. There are also practical realities in some instances: the patient might not be able to access the same type of therapy in the new country such that, on balance, it might be better to continue to work within the Skype setting despite its significant limitations.

It is important to distinguish the intermittent use of Skype to allow continuity in an ongoing therapy that primarily takes place in-person as

opposed to Skype as the form of therapy from the outset. In the former case it is possible to work more productively and to use creatively the enactments that can ensue. This is because the basic frame remains the same and the use of Skype is a deviation from it, open to ongoing analysis and interpretation. It is not the primary setting for the therapy.

It is reasonable to argue that even though the setting for Skype therapy is different it is nevertheless its own setting operating according to many shared features with the in-person analytic setting (e.g. consistency of the time, use of the couch, etc.). However, this is not in fact quite so. An essential aspect of the analytic setting is that the therapist sets it, maintains it and has primary responsibility over it. A Skype therapy operates quite differently since the therapist cannot control the environment in which the patient receives the therapy. There is no equivalence between using the couch provided by the therapist in her room and lying on a couch provided by the patient in a physical space determined by the patient. The difference is not merely that the physical space is different: it is more fundamental than this because the space inhabited by the patient has not been created by the therapist's mind or shaped by her distinctive corporeality.

Even those aspects of the Skype setting that can be controlled by the therapist are often neglected. For example, a common feature of a Skype therapy setting (as I have discovered through supervising) is that in many instances it is the patient who calls in. However, this sets up an entirely different setting to the one we have typically where the patient rings the bell and then waits for the therapist to let her into the consulting room. This may seem like a small detail but it is fundamentally important because it bypasses the patient's experience of having to wait to be ushered in by the therapist. The Skype scenario that comes closest to the real embodied experience of seeing a therapist in her consulting room is one where the patient texts via Skype to say that she has arrived and then it is the therapist who calls in (the virtual equivalent of opening the consulting room door) at the agreed hour.

Although these aspects of the setting are important and contribute to the patient's sense of being contained, the more fundamental problem in mediated therapy is the question of so-called 'presence' and the implications of the loss of the embodied setting. In her excellent book, *Screen Relations*, Russell (2015) draws on informatics and neuroscience to emphasise the importance of 'presence', which she argues is undermined in mediated psychotherapy. The idea of presence is conceptualised often in the field of virtual reality as the 'sensation of being there' in the virtual

world (Barfeld *et al*., 1995) or as the 'perceptual illusion of non-mediation' (Lombard and Ditton, 1997). Presence, however, is a social construction that is different from the perceptual illusion of non-mediation. Reality is not simply there outside people's minds but it is also co-constructed in the relationship between two people.

Neuroscience and developmental psychoanalysis converge on the importance of embodied perception and interaction with others for the development of a sense of self and Russell's critique of mediated therapy is embedded in this literature. This focus on the role of embodied experience is important. The body is central to the development of attachment (Lemma, 2014). Schore (2000) suggests that in the infant's first year, visual experiences are centrally implicated in social and emotional development. The mother's emotionally expressive face provides a compelling visual stimulus. The choreographed tactile and visual dance between mother and baby creates a mutual regulatory system of arousal (Trevarthen, 1998; Tronick and Weinberg, 1997).

The intentions of the other person, and the embodied possibilities of the interacting infant, can be directly read in the face and physical actions of the other. The quality of the embodied experience with the caregiver and, we might add, between patient and therapist is vital. During such non-verbal exchanges, in which both parents and infants express their minds and respond to the other's mind mainly without awareness and often through the body, the parent's ability to make sense of the infant's *non-verbally expressed internal world* is key to laying the foundations for developing the capacity to mentalise experience. The non-verbally expressed internal world of the patient is a critical aspect of what the therapist tries to understand and verbalise over the course of the therapy.

Riva and Mantovani (2014)[2] have cogently argued that we feel 'present' if we act in a shared temporal and spatial framework with external objects, that is our capacity to locate ourselves in space depends on the action(s) we can perform within it:

> Presence is the pre-reflective sensation of 'being in an environment' real or virtual, which results from the capacity to carry out intuitively one's intentions within that environment. (2014: 14)

In other words I am present in a real or virtual space if I manage to put my intentions into action. In this sense presence is the perception of successfully transforming an intention into an action. Of course 'actions' are not

restricted to ones that we discharge physically. Projective identification, for example, is a form of action on the mind and behaviour of the other when they identify with the projection. We can also act on the mind of another once removed, as it were – if this were not so cyberbullying, for example, would have little impact (though of course cyberbullying does not necessarily stop short of embodied action and might indeed be the virtual amplification of fully embodied bullying). Even virtually we are therefore still 'acting' in a world of actual interpersonal consequence for better and for worse.

Riva et al. (2014) also describe the importance of *social presence* that allows for interaction and communication through the understanding of others' expected intentions and perceived actions. This permits the evolution of the self through the identification of what they call 'optimal shared experiences'. This leads us to a crucial point: the subjective experience of 'being there' is influenced by the ability of 'making sense there' and by the possibility of learning by living real experience(s) even if in a virtual environment (Villani *et al*., 2014). This is highly relevant to understanding why mediated therapy can work because an exchange between a therapist and patient that enables the patient to 'make sense' of his experience with the therapist can still be a mutative learning experience irrespective of the setting in which it takes place.

In order to understand what transpires during a Skype mediated process it is thus helpful to consider two axes of communication that operate consciously as well as unconsciously: the *embodied presence* axis and the *relevance* axis.

The *embodied presence* axis refers to whether the embodied experience of both therapist and patient is located in the same physical space or in virtual space. When it is located in a shared physical space both participants can make full use of *implicit communication* and the ostensive cues (i.e. the signalling of communicative intent) that take place as a part of communication. Non-verbal communication is pervasive in any human interaction and accompanies every utterance. Non-verbal behaviour is the unconscious made visible, especially when there are discrepancies in messages between channels, such as facial expressions, verbal communication, tone of voice, gestures, and so on.

To pick up these unconscious communications, Freud claimed the therapist 'must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone' (1912: 115–16) and 'turn his own unconscious like a receptive organ towards the transmitting unconscious

of the patient' (ibid.: 115). Freud called this state of attunement 'evenly suspended attention' (ibid.). According to Freud the body always gives away the unconscious:

> If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore. And thus the task of making conscious the most hidden recesses of the mind is one which is quite possible to accomplish. (ibid.: 69)

When therapist and patient do not share the same physical space the therapeutic process is taking place in a context of *virtually embodied presence*. Computer and network technologies configure the self that participates in Skype: communication is transformed by digital mediations. In the virtual encounter both participants have access to primarily *explicit communication* and they are less able to make use of implicit communication. This is not only because the two bodies are not in the same physical place but also because technology is far from perfect: it introduces delays and distortions that undermine each party's confidence in what they can infer from what would otherwise be valuable cues such as the look on someone's face or the tone of their voice (aspects of communication that can be distorted via Skype).

However assiduous we are in how we structure the Skype setting some aspects are beyond our control: body language, facial expression and the pheromones (released during face-to-face interaction) are all fundamental to establishing human relationships and they are all missing with most forms of modern technology. Some media such as Skype allow for the exchange of richer information due to the number of cues and channels available for communication. Richer cues (e.g. face-to-face) allow for less equivocal and therefore more effective communication. In most teleconferencing systems available today, however, synchronisation of audio and visual channels is imperfect, images can be distorted and there are noticeable delays. In general, misalignment of audio and visual cues has been found to be confusing to viewers and to elicit negative emotions (Bruce, 1996). A range of mismatches can and frequently happen on Skype:

> These audio/video mismatches and discrepancies can be unconsciously deceptive and disruptive, perturbing the feeling tones produced by the patient's subtle and unconscious communications. (Brahnam, 2014: 132)

I am intentionally referring to therapy mediated by Skype as a type of *embodied presence* because, as I emphasised in Chapter 1, in cyberspace we are still embodied: what changes is our experience of our own and the other person's embodiment. Even via Skype there is still some kind of presence given that the medium is both visual and auditory. It is therefore not an entirely sensorially deprived exchange. Interestingly adding a visual channel to virtual communication does not enrich the experience of presence. Research suggests that, unlike face-to-face interactions, when a visual channel is available, it is used primarily to situate the interaction. However, it is the audio channel that becomes the focus of attention, much like with the telephone (Cukor *et al*., 1998). Bandwidth and screen size have little effect on people's preference for the audio channel in videoconferencing (O'Donnell, 1997). This may be because video conferencing is missing some subtle yet unidentifiable elements without which the visual channel is impoverished and sterile.

Psycholinguists who subscribe to an interactionist view believe that a successful interaction is one that is characterised by moment-to-moment collaborations between the participants who cooperate to establish and maintain mutual understanding commonly referred to as 'grounding' (Clark and Wilkes-Gibbs, 1986). This relies on the possibility of reading non-verbal signals – a position that resonates with a psychoanalytic view, which would add to this the unconscious dimension of communication via the body. Visual cues such as gaze, facial expression and body movement all add to the subjective sense of proximity or distance to another individual. It is not unreasonable to suggest that this is largely missing or, at the very least, significantly depleted and open to misreading during Skype. Studies generally suggest that despite the fact that non-verbal signals, usually gaze, are available through teleconferencing and people attempt to use the visual cues provided, they appear to encounter problems with the quality of information contained in those cues (O'Malley, 1996).

Schore's work (2000) is relevant here. He provides evidence that subtle and implicit bodily interactions involving elaborate exchanges with others of corporeal expression matching, synchronizations and rhythmical patterning form the core of intersubjectivity. Beebe notes that:

> Interactions in the nonverbal and implicit modes are rapid, subtle, co-constructed, and generally out of awareness. And yet they profoundly affect moment-to-moment communication and the affective climate. (2004: 49)

A crucial difference therefore between Skype and in-person therapy is that in the former both participants lose access to the full range of implicit aspects of communication that are available in a shared physical space. This can conspire to leaving the patient feeling less contained, neglected or misunderstood. By contrast in the in-person setting the therapist can draw on her somatic countertransference to understand what the patient cannot yet put into words. The patient can also draw on a broader range of non-verbal cues to assess the *relevance* for him of what the therapist has to offer and to infer the trustworthiness of the therapist. The *relevance axis* thus refers to the extent to which the patient perceives the help that the therapist provides to be relevant.

Relevance theory (Sperber and Wilson, 1995; Walaszewska and Piskorska, 2012) claims that what makes an input worth picking out from the mass of competing stimuli is not just that it is relevant, but that it is more relevant than any alternative input available to us at that time. This means that communications that yield many positive effects are from the recipient's perspective worth not only being comprehended but also accepted as true beliefs. Relevance is thus about positive cognitive effects that are true and worth having and that can be 'used' by the patient to challenge himself and to learn something new about how he functions in the world.

I would add that relevance also contributes to a positive *affective* experience. Relevance is determined by the extent to which we feel we are in a relationship with an 'other' who relates to us as an agent with a valid subjective experience worthy of engagement. This is vital in any therapeutic process whatever the brand of therapy and irrespective of its setting. It consolidates the patient's level of engagement and the perceived trustworthiness of the therapist. The relationship between presence and emotion is important. There is a circular interaction between the two: the feeling of presence is greater in emotional environments (Riva *et al*., 2007) and the level of presence influences emotional state (Wirth *et al*., 2012). Moreover, emotional involvement influences presence in terms of assigning relevance to the mediated environment.

The aim of all communication is to generate *epistemic trust* (Fonagy *et al*., 2015), that is an individual's willingness to consider new knowledge from another person as trustworthy, generalisable and relevant to the self. Epistemic trust is there to ensure that the individual can safely challenge and potentially change his way of thinking and feeling; it triggers the opening of an *epistemic superhighway* (Fonagy *et al*., 2015), that is an

evolutionarily protected mechanism that signals the individual's willingness to acquire knowledge.

In the best of circumstances when a patient and therapist have worked together in a shared space the patient has an experience of whether what the therapist says is of relevance to the problems he needs help with. Relevance results partly from the extent to which the therapist, drawing on the shared embodied experience in the consulting room, is attuned to the patient's embodied internal world and experience in the transference. Repeated exchanges with a therapist whose interventions are experienced as relevant builds up a store of trust that can compensate to a degree for the losses incurred when there is no access to embodied co-presence in a shared physical space. The greater the felt-to-be relevance, the greater the patient's epistemic trust and hence the greater the tolerance for the limitations and frustrations of mediated therapy. This, of course, assumes that patient and therapist have benefited from in-person sessions before transitioning to Skype.

In any mediated therapeutic encounter *epistemic vigilance* towards deception and misinformation is heightened. Relevance, we might say, relates to the truth-value of the therapist's interventions and hence the trust that the patient can place in the therapist. In mediated psychotherapy a crucial relational dynamic that reinforces or undermines the perceived relevance and corollary trust is the patient's experience that the therapist is telling the truth about the nature of the Skype therapy and how it impacts on the patient. In other words when working in a mediated therapeutic setting it is incumbent on the therapist that she communicates to the patient how this medium is experienced by him and how it intersects with the prerogatives of his internal world. The therapist thus facilitates the conditions for the relaxation of epistemic vigilance (i.e. the self-protective suspicion towards information coming from others that may be potentially damaging or deceptive) through the creation of an experience of feeling thought about (i.e. our experience and needs are anticipated) in relation to the mediated therapy the therapist is offering the patient.

If the patient's experience is not validated by the therapist, perhaps because the therapist believes that Skype therapy and in-person therapy are functionally equivalent, or because the therapist is not attuned to the patient's unconscious experience of Skype, then the risk is that the therapist's interventions will not be experienced as relevant to the patient and the therapeutic process becomes corrupted. Instead of being experienced as genuine attempts to arrive at the patient's truth about his experience the therapist's interventions are experienced as lies.

I will now illustrate through my work with Martin why when working via Skype it is important to listen to the patient's experience of this medium and to articulate its implications for how the therapist is experienced by the patient.

Martin

Martin was one of the first patients with whom I used Skype in the context of an ongoing in-person therapy three times weekly on the couch. When his job changed and demanded regular travel such that his three sessions were frequently at risk, he asked if we could make up the sessions by Skype. After much consideration, and given how committed he was to his therapy, we decided that it would be worth trying to use Skype so that he would not miss too many sessions.

Martin's original reason for seeking therapy was his unhappy marriage to a woman who though kind and supportive of him experienced significant inhibitions around her sexuality. Martin was also very troubled by his own sexuality that he struggled to integrate into a loving relationship. We had come to understand how he had 'chosen' his wife because he knew that her difficulties would ensure protection against his own profound anxieties about being sexual and emotionally intimate. He felt his wife was a reliable companion on whom he could 'download' his work worries and discuss the children but the relationship nevertheless felt 'dead'.

Now that their children were older and had left home, Martin was aware of emptiness in the marriage and he was concerned about his split off sexuality. He frequented prostitutes and while at first this had felt very exciting he was increasingly left feeling that this activity was 'dirty' and dangerous because he feared being exposed at work.

When we started using Skype the first thing that became clear was not only that we were not meeting in the same shared physical space, but also that due to being in different time zones, even if the session time was set at the usual UK time, Martin was not actually having his session at the same time as me. Similarly, although I was still in the same consulting room where we met physically when he

called, he was in a distinctly different physical space, typically his hotel room or office and both varied.

We had discussed the importance of finding a private space free from intrusions but this proved difficult and sometimes served his own need to be interrupted: his office space could never feel entirely safe and private. He also inhabited the space differently: he was not my patient on a couch and I was not sitting behind him listening. At work he was his professional self, sitting opposite a computer screen and this often contributed to exchanges between us that were interesting to him but that I thought approximated at best a kind of 'coaching' relationship. There is nothing wrong with coaching if that is what the patient seeks. But if the patient has committed to an analytic process then it is the therapist's responsibility to provide this.

After two Skype sessions I noticed the impoverishment of our dialogue: it all felt rather superficial and I struggled to remain connected to him. Martin seemed cut off from this change and consciously reported finding the Skype sessions helpful. What I could see of his upper body recounted a different story. Martin was leaning away from the screen as if he wanted to interpose more distance between us. His arms were crossed and he was rocking in the chair. I recalled that when on the couch he seemed more relaxed and less agitated. The comparison I could make between what I had experienced with him physically present in the room with me is one of several types of information that I could draw on to make sense of what was transpiring between us virtually. Had I never shared a physical space with him, this would not have been accessible to me.

I invited Martin to reflect on how different he was and how I seemed to have become like his wife: a companion he 'downloaded' on but the exchange between us was emotionally distant, dead. Martin responded with silence and then reported a dream that he had the night before the second Skype session:

> *I am in a deserted bar and I am drinking pint after pint of beer. Strangely I don't feel drunk but when I get up from the bar stool I can barely stand up. I fall over and I am unconscious. I wake up days later and my body is in a state of decay.*

Martin associated to the dream and told me that when he was travelling he got into bad habits like going to sleep late, watching Internet pornography and drinking more than he should. He was troubled by his use of pornography, the 'compelling yet cheap images of sex', as he put it, that he downloaded on his screen. He thought that perhaps this was his way of also rebelling against the mundane routines he abided by when at home with his wife such that when he was away he could 'let rip' and indulge in excess. He recognised that it left him feeling bad about himself.

We eventually understood this dream as directly connected with the change to our setting: despite the continuity in the sessions and how grateful he was consciously for my willingness to adapt to his needs, unconsciously there was a very different narrative. Martin actually felt that by agreeing to Skype I had 'deserted' him. The computer screen that he watched pornography on and that left him feeling at the mercy of 'cheap images' was the same as the one on which my image appeared. This seemed to provide a powerful metaphor for how degraded the analytic process had become. Once we were able to acknowledge this the session became more alive and seemed to approximate our in-person sessions.

On another occasion, some weeks later, Martin had the session from his hotel room. He acknowledged that it seemed strange to speak to me from his 'bedroom' but that he felt this was not a problem. I was less than persuaded by this, but since I was then still relatively inexperienced with Skype, I was stymied and at first said nothing. As the session progressed, however, I grew increasingly uncomfortable about the quality of the exchanges between us: Martin's manner was unusually flirtatious as he laughed off how strange it would be if the hotel cleaner walked in and overheard him talking to me about his sexual problems.

I was mindful of the complex issues around confidentiality that need to be borne in mind when we work with Skype, represented here by the third-party figure of the cleaner in his associations. I was clear that Martin did not feel safe but interestingly this anxiety was here managed through sexualisation: we were now in his bedroom essentially having a threesome. This was exciting to him but it was clearly not therapy and just like he felt bad about himself downloading

porn, I sensed that our corrupted exchange did not actually feel helpful. The use of Skype had turned the consulting room into a bedroom and I had colluded with this.

Once interpreted this dynamic was helpful and re-established the frame of the therapy as Martin was relieved that I recognised what I had enabled by agreeing to Skype therapy and how he then used it to enact a familiar dynamic. Re-establishing this reality, and taking my share of responsibility for colluding with this, allowed us to consider the conditions under which Skype therapy could best operate for Martin. It reassured him that I was attuned to what he felt about Skype.

After a few months of intermittent Skype sessions we nevertheless reached the conclusion that it was better to miss sessions than to use Skype. This felt like a more truthful position in so far as it was attuned to Martin's idiosyncratic experience of Skype and how it primarily served his defensive needs. This might not be so for all patients, which is why it is the therapist's responsibility to carefully track any given patient's unconscious experience of mediated therapy, but it was so for Martin.

Tuning into the body

Psychoanalytic therapy that is carried out *exclusively* by Skype compromises many features of what it means to work psychoanalytically such that, as some colleagues suggest, it begs the question of whether we can call it a psychoanalytic therapy at all. I am not saying that it cannot be helpful. That is an entirely separate question. But the setting is so altered that the therapist cannot reliably and effectively draw on the full range of competences required to work analytically, namely using the transference-countertransference matrix as the fundamental frame for understanding the unfolding of the patient's internal world (Lemma *et al*., 2008). This matrix is embedded in implicit procedures of self-in-interaction-with-an-other that are often expressed by the patient and received by the therapist through their non-verbal exchanges. The loss of the embodied setting is a vital aspect of the analytic frame that is severely undermined through Skype and that deprives us of vital information.

Russell (2015) suggests that when we eliminate the experience of 'being bodies together' we constrain and limit what is therapeutically possible to 'states of mind' rather than 'states of being'. As a result, reflective introspection is undermined. She carefully and persuasively documents significant differences between Skype therapy and physically co-present therapy across a variety of therapeutic processes such as providing a facilitating, holding environment, adopting a stance of evenly suspended attention or developing conditions for shared reverie.

When the therapist works through virtually embodied presence she is deprived of the full range of her *somatic countertransference* to orient herself in relation to the patient's unconscious communications. The therapist's capacity to tune into the 'body wavelength' (Pugh, 2016) is severely curtailed. This is a significant loss with all patients. It is especially so with those patients who have difficulty in establishing and maintaining a stable differentiation from the object and who typically present with marked difficulties in symbolisation and may therefore powerfully project into the analyst's body. These patients, in my experience, are not suited to mediated therapy.

The analyst's somatic reactions may be understood to result from projective processes that bypass verbal articulation and that are deposited in the body, as it were. The patient's 'bodily states of mind' (Wyre, 1997) inevitably impact on and are impacted on by the analyst's bodily states of mind: the patient communicates through his body and the analyst receives such communications in their body. Such bodily experiences need to become 'thoughts with a thinker', to play on Bion's (1967) turn of phrase, and eventually shared with the patient in order to support the development of a capacity to symbolise. However with some patients the analyst's 'sensory acceptance' (Lombardi and Pola, 2010) of the patient's projections may be an essential prerequisite before interpretations can be helpful – this is nigh impossible on Skype.

Despite the significant limitations placed on the therapist's capacity to use the somatic countertransference I have also experienced moving developments in my work with patients via Skype. How can we understand this? In order to make sense of positive outcomes there are two closely connected issues that need to be considered beyond the question of relevance that was discussed earlier.

First, when therapist and patient have a history of working together in the same physical space prior to transitioning to Skype (permanently or intermittently) then the therapist can draw on this prior shared embodied experience. This allows her to use embodied and affectively charged *somatic markers* to reconnect with the patient despite the virtual working conditions. Such markers are polysemic and can cross-reference to multi-layered transference experiences encountered in the in-person setting. They can be very powerful and help to viscerally ground both patient and therapist despite the virtual space in which they meet when on Skype. For example, the therapist can reference when working virtually the past *in situ* experience of the patient's use of the consulting room, of his posture, of his breathing. This can help to reconnect the patient to a shared historical understanding of his internal world gleaned from these somatic manifestations.

Memories of our experiences are likely characterised by representations in the form of neuronal activity. Activity among a network of neurons represents a code for the experience of, say, 'when my therapist understood why I get anxious'. When this network is activated by some cue that triggers a re-experience of that intersubjective event, we have recollected that experience. I am suggesting here that the somatic marker acts as such a cue, as I will illustrate shortly through my work with Mala.

Second, because the shared embodied experience *in situ*, at its best, allows the therapist to understand the patient's non-verbally expressed internal world with greater specificity and accuracy, the somatic markers drawn from shared in-person experience re-evoke, and in turn reinforce, the perceived relevance by the patient of what the therapist offers in the virtual setting. In other words the memory of the in-person experience via the somatic marker reconnects the patient to an experience of feeling known and understood by the therapist in a unique way specific to this particular relationship. This deepens the felt emotional bond between patient and therapist through the use the therapist makes of the memory in order to understand the patient, hence it increases perceived relevance.

The virtual setting and the Skype medium that makes this connection possible can be experienced as the 'uncanny third' (Dettbarn, 2013). Somatic markers, however, offset or relax the epistemic vigilance mobilised by the virtual setting.

Mala

Mala, a successful business woman in her thirties, was posted abroad after 18 months of working with me three times weekly on the couch. The comparatively small country she was relocating to had CBT therapists and some psychodynamic counsellors but no one who was fully analytically trained. After much discussion we decided that it was better, on balance, for us to continue working together via Skype with an understanding that she would visit London three times per year for two weeks and have in-person sessions during those six weeks each year.

Before sharing some of our Skype exchanges I want to give a flavour of the in-person experience. Mala had originally sought help because of a very difficult relationship with her mother whom she had experienced as intrusive into her body and mind. She spent the first nine months of the therapy enveloped in long periods of silence that I felt were intended to keep me at a distance and to protect herself from my anticipated intrusion.

Because Mala said very little my interventions were often based on my somatic countertransference. As Mala walked in and out of my room she would keep her head bowed low as she shook my hand. The hand-shaking, which was culturally consistent with Mala's background, exposed me to her invariably sweaty palms. Curiously when we shook hands the very first time – and this made a lasting impression – I had the association that she was wiping her sweat on me as if to penetrate me. I had experienced a strong urge at the time to wash my hands.

During the many months when I sat behind the couch waiting for Mala to speak I reflected on this paradoxical visceral experience: on the one hand it felt as if Mala seeped into my skin through her sweaty palms and this felt intrusive; on the other hand, Mala shut me out of her mind through her impregnable silence. The only movement, as it were, came from the way she flexed her left foot backwards and forwards for extended periods of time, always in the same direction, as she lay otherwise very still on the couch. This had an autoerotic quality that had an unsurprisingly distancing effect on me.

I was often sleepy during sessions. My mind wandered easily as she could spend 40 minutes in total silence, not even responding to my attempts to engage with her. I was thus penetrated and shut out with equal force.

A few months into our work Mala lay on the couch and suddenly got up panic stricken. She turned round apologetically and explained that she was worried that she might have stained my couch because she had just 'come on', as she put it. She checked the cover on the couch for stains and then relaxed as she said that it had been a 'false alarm'. Once again in the supine position she told me that her mind was blank. I observed that her mind a few minutes earlier has been filled with panic and alarm at the thought that she might have left a bloody stain on my cover. Mala was silent for a long while and then said that the thought horrified her, that if she had stained the cover she would have struggled to come back such would have been her shame. She thought she could now smell an unpleasant odour and she feared it was coming from her body and that I would think it repulsive.

As I listened I was mindful that her sweaty hands and now the fantasy of her menstrual blood staining my cover and her body odour were powerful visceral ways in which she leaked into my space/body. I thought that her fear that she might have 'come on' was a displaced reference to her longing to 'come on' to me and be sexually intimate with me. But her erotic longing elicited a toxic mixture of excitement, anxiety and shame.

Through my descriptions of Mala's body and physical experience as she related to the setting of my consulting room I have illustrated how the primary source of communication and information that I had to work from for some months was primarily sensory in nature (visual, olfactory, tactile and kinaesthetic). This type of interaction could never be observed and processed by a therapist in a mediated therapy with the exception of some very limited visual information. Yet, over time, in the in-person setting these somatic reactions and the associations they elicited in me allowed us to make some sense of Mala's most likely pre-verbal experience with her mother, a woman who had suffered several severe psychotic breakdowns. She alternated between periods when she was very high and intrusive

into Mala's body and periods of severe depression when she became completely inaccessible to Mala.

The transition to Skype therapy was not easy, not least because Mala was deeply unsettled by the move as her mother had also recently died. She felt she had lost all moorings. Mala tried to replicate as much of the original therapy consulting room setting in the new country by creating a private space in her flat with a couch. She would lie on the couch with the iPad next to her head (out of her sight but within ear reach). We Skyped without the visual function activated except to say hello and goodbye largely because the use of the visual function led to frequent technical breakdowns that interrupted the session.

As we worked through the Skype medium I was conscious that I needed to work very hard to represent her in my mind, for example to imagine her lying on my couch and recall the bodily movements that I had grown so accustomed to. When I rooted myself back in my somatic memory of her I felt more attuned. This was not just an internal process. I frequently also checked with Mala how she was feeling (more so than I would do in an in-person setting) and tried to encourage her to describe her bodily experience to me so as to root *her* in her bodily experience.

Where appropriate I would draw on familiar somatic markers. For example, by the time we transitioned to Skype we had openly discussed her sweaty hands and how exposed she felt when she shook my hand as it betrayed her anxiety about being received by me 'warts and all'. We also understood a bit more about her wish to leak into me. On one occasion, when discussing via Skype an incident that pointed to her own intrusiveness, I 'marked' my intervention with a reference to the somatic expression of both anxiety and intrusiveness that we had experienced in person when we shook hands.

Mala's response to this 'marker' was of note: she became quite tearful and then made reference to how she missed my room and its distinctive smell. She told me that she had recently searched for a candle that smelt like my room. She had felt low as she shopped as she could not find anything that approximated this and she wished I would tell her the brand of candle that burned in my room.

We were able to then reflect together on how as soon she recalled our hand-shaking she was back in my room and she wanted to recreate it where she was now located. I said that I thought she was asking me to offer her the 'brand' of therapy that is rooted in real smells, not its virtual adaptation. Mala was relieved to hear me say this, she replied.

Unlike Martin, it seemed possible to continue with Skype with Mala, not least because she had permanently relocated so that the options were even worse by comparison. In my work with Mala it was important to acknowledge the loss that our virtual work carried and that despite her gratitude for being able to continue our work together, she recognised that it was not the same. Crucially she needed me to recognise this too, as I discussed earlier in relation to Martin.

The slippery slope of Skype

The analytic relationship unfolds in the context of a paradox that defines the analytic setting: it is a relationship that relies on the establishment of mutuality in the context of a vital asymmetry (Aron, 1996; Celenza, 2010). The commitment made by patient and therapist to work together holds out the hope for and promise of continued acceptance and understanding for the patient of even the most hated aspects of the self. This is a powerful interpersonal experience that taps into a universal longing to be loved 'warts and all' without the requirement to give anything back to the one who loves us.

It can be said that the treatment setting both stimulates and frustrates these universal wishes. Moreover this peculiar mix intensifies the experience and longing for intimacy and mobilises erotic longings in the psychoanalytic dyad. Indeed the analytic setting is stimulating, seductive and frustrating for the therapist too. The analytic contract is defined by the asymmetric distribution of attention paid to the patient by the therapist. The requirement of the therapist to dismiss personal need is frustrating and depleting. This deprivation sets the scene, as it were, for how the therapist may therefore be partially 'gratified and titillated' by the moments of attunement that the patient offers:

> It might be said that *the frustration of asymmetry is counterbalanced by the seduction of mutuality and momentary attunements; 'we're in*

> *this together differently' mistakenly becoming 'we're in this together the same.'* These vicarious identifications evoke and temporarily unsettle the analyst as he or she decenters and resonates with the analysand's experience. (Celenza, 2010: 64, original italics)

Psychoanalytic therapy thus takes place within the highly seductive context of therapeutic asymmetry. This contemporaneously depleting and seductive structure means that the therapist needs both professional consultation and a stable setting in which to maintain or re-establish equilibrium. The embodied setting is an important anchor in this respect: it contains the therapist as much as the patient.

A significant risk posed by new technologies in the context of a therapeutic process is that they are seductively informal such that the therapist can all too easily find herself on the *slippery slope of Skype*. The so-called slippage arises partly because Skype engenders a relaxation of the boundaries of the setting. Indeed, sometimes the very notion of 'setting' becomes increasingly loose. For example, it is not uncommon for patients to use Skype via their cell phones and carry out their session in the most unlikely of places (a park, a taxi). Likewise for therapists: they may start to offer Skype sessions from locations other than their own office. I have done this too on one occasion, rationalised in terms of 'keeping continuity' when I was working abroad, only to quickly learn why I would never do so again when I found myself struggling to adjust the screen to avoid any evidence of the bed in my hotel room. It was a disturbing and sobering experience that helped me to realise how I had lost sight of the setting and had been drawn into an enactment.

Different media are experienced on a continuum from formal to informal with a spectrum of legitimations and rationalisations of what each medium adds to the person's idiosyncratic mix of unconscious association within personal communication. The portable nature of various media is an important feature since the laptop used for Skype therapy may be the same one used for downloading pornography, for example. Where the media is used may also be relevant: Skype when sitting at a desk may be felt to be formal but not when using a smartphone in a hotel room, for example. Importantly such media encourage a kind of chummy friendliness or casualness that is typically more reigned in when working in-person. This creates a context ripe for enactments on both sides.

We do well to remember, as Freud (1919) emphasised, the importance of abstinence in our work. He proposed that once the therapist becomes an important object to the patient, that is once she becomes invested as the

target of transference wishes, the therapist should leave these wishes ungratified and instead analyse the defences that develop. Clinical experience repeatedly demonstrates that affect soon emerges in response to the experience of frustration along with the accompanying phantasies that are elicited and the defences to manage this. This allows the therapist to help the patient examine his conflicts. In other words, abstinence gives rise to a state of deprivation crucial to treatment.

As I suggested in Chapter 3 we now live and work in a world where a 'state of deprivation' has little currency, if any at all: desiring, waiting and frustrations are encumbrances rather than states of mind that bear their fruit when tolerated. This shapes the expectation patients have of therapy and that therapists can sometimes also share: that therapy should be provided no matter what or where, when needed. Like anonymity, that optimal state of deprivation that Freud regarded as crucial to treatment is undermined in our current practice. Mediated therapy can be experienced as deeply gratifying. It can feed into fantasies of greater intimacy and of ease of access to the therapist. These may be left unexplored because the use of the virtual medium can be all too easily rationalised in a world where mediation is the order of the day.

It is not only because the setting is potentially felt to be more 'relaxed' and in some respects more gratifying that it is more possible to slip into enactments when working through the virtual medium. The absence of the two bodies in a shared physical space also plays an important part. Some argue that a virtual relationship protects the patient who may be anxious about sexual or aggressive transgressions by the other. Paradoxically, however, it is precisely because of the physical proscription imposed by the fact of mediation that problems arise. When the actual bodies are not directly implicated, the relationship that unfolds in a virtual space can more readily become seductive: the fact that 'nothing can happen *really'* (i.e. 'I am in love with my therapist but we can never consummate the relationship because we are not in the same room') seduces both patient and therapist away from reflecting on what *is* nevertheless happening between them at the level of fantasy. The frame of a physically co-present context is vital, I am suggesting, for protecting patient and therapist from the slippery slope of Skype. When both bodies share the same space the somatic countertransference can be more easily noted and relied upon with greater confidence and this can minimise enactments.

Suler (2004) has written about the 'online disinhibition effect' that is characterised by the following: dissociative anonymity (what I do cannot

be traced back to me); invisibility (no one can see what I look like); asynchronicity (my actions do not occur in real time); solipsistic introjection (I can't see the other(s) so I have to guess who they are and their intent); dissociative imagination (these are not real people); minimisation of authority (I can act freely). Several of these features are not relevant to Skype therapy because it is a visual medium where both participants are known to each other. However, the last two features, 'dissociative imagination' and 'minimisation of authority', pose risks precisely because virtual communication does not require our embodied presence in the same space as that of the patient: as the body becomes unmoored it can precipitate action rather than reflection.

Indeed it could be argued that erotic excitement – a normal and expectable response in an analytic dyad – can function as an alert by locating our experience in our bodies. When such excitement occurs through mediation, where the body of the other and one's own can be dismissed and the whole experience can be written off as 'virtual' and hence not real, the risk of transgression can be minimised and the therapist may consequently be less attuned to it. The danger is that the virtual meeting encourages a 'pretend' state of mind (Fonagy and Target, 1996) in both participants where the mental world is decoupled from external reality. And yet even if the therapist and patient do not physically act on each other's bodies they can still act powerfully on each other's minds with detrimental consequences for the patient if the therapist does not remain watchful of the transference-countertransference. Co-presence stands a better chance of helping the therapist to identify and analyse physical sensations that protect against acting out on loving and erotic longings in particular.

The technological medium thus acts in one (limited) sense as a protective physical shield since the therapist or the patient cannot actually touch each other, but psychically the technological medium can precipitate simultaneously disinhibition and minimisation with respect to erotic longings that when left unchecked pervert the course of therapy. The evidence for this is often subtle and defences are typically mobilised against conscious awareness of this in the therapist and patient. Yet the patient's unconscious narrative tells a very different story, as I will illustrate in the following brief clinical vignette of a case I supervised. I should add that the therapist was an experienced clinician, trained as a psychodynamic therapist, who learnt a great deal through this case – as did I – as she was very inexperienced with Skype.

John

Dr B., a female therapist, had been working once weekly with John, face-to-face, for about six months before he was promoted and had to relocate abroad. He had originally sought help following his separation from his wife and the acceptance of this new job coincided with his painful realisation that the marriage was irretrievable.

During the first few weeks of Skype therapy John expressed his gratitude to Dr B. for continuing to work with him. He said that he felt lonely and dislocated in the new country. Dr B. was quick and correct to observe that the Skype medium left him feeling dislocated from her and John reassured her that this was a lifeline for him irrespective of the limitations.

Dr B. felt very identified with John's sense of loss because she had also recently divorced. She was aware of the risk this posed and was able to reflect on it with me in supervision. However, I noted that since John had moved abroad and they communicated via Skype, Dr B. seemed keen to emphasise to me his urgent need for support and attunement. She agreed to change his session time twice without any exploration of what this might mean, which struck me as somewhat at odds with how careful she was typically. Then she reported to me that John had texted her on his way to work because he had felt anxious and needed to feel connected to her and she had replied with some reassuring words. Dr B. acknowledged that this was 'unusual' but she also felt that John was very alone and needed to draw on her support. I sensed that she was too quick to explain instead of being curious about what this might mean. It seemed as though the greater the physical distance between them the more inclined she was to narrow the field of her analytic vision.

I encouraged her to explore with him this 'unusual' behaviour in their next session, from which I have permission to share the following brief excerpt:

J: Thank you for replying to my text … it really helped me to get through the day … I am struggling right now and I feel you are the only person who knows me … I am surrounded by strangers or work colleagues …feels quite lonely …

T: You don't feel seen … recognised for who you are …

J: Yes, that's exactly right … it's like I'm invisible … I have no roots here, and it feels so strange to say that I'm separated when people ask me about my wife … I called my mother last night, tried to Face Time her but she is hopeless with this technology (laughs) and so she said I should just use the telephone …

T: You felt rejected by her suggestion of the phone instead of actually seeing you …

J: Well, you know, it's nice to have some more substantial connection … like now … I mean seeing you on Skype at least makes it more real … I had this urge today to be held … I thought I might even pay for sex just so as to be held … but then I remembered that we had a session and I thought this was more important …

T: More real …

J: Yes, because I know that you care about me … that text I sent you … I really thought you would not reply … I thought I might have overstepped the mark but when you did … just the few words you wrote made me feel better …

T: You didn't trust that I would respond to your pain … you anticipated rejection like with your mother who did not want to use Face Time …

(Silence)

J: I dreamt last night that I had gone to my meeting with my old boss and he was behaving strangely. I kept thinking that it was not him, but some kind of impostor … he looked familiar but I was not comfortable. He offered me a new job in Asia and said I would be a fool to turn it down. I really don't like Asia, but he said he would move there too and I could work with him and we could make lots of money.

I will not go further into this session but I would like to draw attention to a few aspects pertinent to this discussion.

Prior to the session John texts his therapist in a manner that suggests he is relating to her more as if she was a friend or lover. In fact he tells her that he was not expecting her to reply (i.e. he recognises that he has crossed a boundary) but when Dr B. replies she gratifies his longing to be

close to her and to find his surrogate partner in her. Instead of taking this up in the session, as we had agreed in supervision, and reflecting on her own enactment, Dr B. instead plays on the register of attunement and focuses on how John does not feel seen by the other: on what he is missing that she instead now provides. This arouses John who then tells Dr B. how he longs to be touched and how he almost went to see a prostitute but then recalled that he had his Skype session with Dr B. Here we can see the beginning of John's unconscious representation of his therapist: she is equated with a prostitute: someone who gets paid to provide sexual comfort.

Dr B.'s response is not to take up either the perversion of the analytic setting that she has contributed to or the erotic longing in the transference. Instead she links her response to how John felt rejected by the mother who, as it happens, stands as the figure who will *not* use a virtual medium. Dr B. responds very seductively by reinforcing that his encounter with her was 'more real' – though paradoxically this encounter is in fact virtual. This leads John to elaborate further the seductive dance when he says: 'I know that you care about me.'

Through his dream John, however, is beginning to represent unconsciously the meaning of the gratifying exchange and to communicate this to Dr B. In this dream John meets his boss – a familiar figure with whom in theory he has an asymmetric relationship – who is now, however, behaving 'strangely' and invites him to go to Asia with him but where John does not really want to go (i.e. the therapist has agreed to work with him in another virtual setting/country which is not the setting that John wants to work in). We might say that Dr B., like the boss in the dream who entices him with the lure of money, is experienced as seductive. The dream thus vividly encapsulates John's experience of not actually recognising his 'old' therapist in this new Skype setting turning her into some kind of 'impostor'.

The peculiarity of the analytic setting with all its conventions might be odd and frustrating at times, but it does at least ensure that the boundaries of the analytic relationship are clearly demarcated as different to a social relationship. As such any longings for attachment or erotic feelings that either party might have are more reliably constrained by the setting that serves here as a reminder that the analytic relationship is different to any other kind of intimate relationship even when it gives rise to familiar and compelling feelings.

Concluding thoughts

We can think of 'place' as fixity, for example a location on a map or where our consulting room is, in relation to 'space' as 'a practiced place' (De Certeau, 1984: 117). A street, for example, is transformed into 'space' by walkers. A room in a physical and virtual location is transformed into the 'analytic space' by patient and therapist and the contract that binds them together for the 50 minutes in that space. Therefore places come into being by people engaged in a given activity. Places are 'constantly being performed '(Creswell, 2004: 37). Rethinking place as performed and practised in radically open ways provides another means of investigating the embodied experience of therapy in an actual consulting room versus in a virtual place. Place in this sense becomes an event marked by the quality of the communication between two people rather than the boundedness or permanence of the actual space of meeting with the attendant advantages and limitations that pertain to the absence of the bounded space of the actual consulting room. The latter may be more or less important depending on the psychic state of the patient. As such the question of whether mediated therapy is 'good' or 'bad' really needs to be a question about whether it works or not for a specific patient–therapist dyad that practise psychoanalysis together.

As I have explored in this chapter there are significant challenges to mediated therapy. The ever-present question in my mind is whether it would be more honest to refuse to do Skype therapy given the losses and risks that I have outlined. Based on my experience I am of the view that analytic therapy offered via Skype is always the poor relation of the actual in-person experience. We cannot replicate a fully shared embodied experience in virtual space: at best we can approximate to it and compensate for what is lost when we are not in shared physical space. It is vital to know this with integrity and base decisions about Skype therapy with this knowledge in mind. Being truthful is always important in our work. Truthfulness relates to a state of mind towards the other and not only to a statement of fact. Being truthful is about intentionality and, as such, lies at the core of the patient's experience with his therapist: it determines whether the patient can trust her intentions towards him.

The question of the trustworthiness of the sources of information has become more prescient today because we live in what has been aptly termed a 'post-truth' world (Pomerantsev, 2016). It is not only that we are fed lies by politicians through various media outlets, for example, but also,

and even more corrosive, is the fact that lying itself is seemingly not considered to be a problem. This is the context that made it possible for British politicians to stage a Brexit campaign in 2016 with promises such as 'Let's give our NHS the £350 million the EU takes every week' but, on winning the referendum, the claim was dismissed as a 'mistake' by one Brexit leader while another dismissed it as no more than 'an aspiration'.

Does technology exert an influence on our relationship to truth? I am of the view that it does. There are two reasons for this. First, new media with its many screens and streams of information allow us to escape into virtual realities and fantasies where the felt-to-be truth of one's internal world is isomorphic with external reality and impervious to any other version of reality. Second, there is increasing awareness that the so-called information age allows lies to spread very rapidly. The sheer volume of 'disinformation cascades' makes it hard to distinguish truth from lies (Pomerantsev, 2016). All that matters is that the lie is clickable, and what determines that is how it feeds into people's existing prejudices. Google and Facebook have developed algorithms that are based around our previous searches and clicks: with every search and every click we find our own biases confirmed, feeding us only the things that make us feel better, irrespective of whether they are true or not. We are being manipulated on a daily basis and we are unaware of how complicit we are in this process since we are suppliers of the personal data that make the manipulation possible in the first place.

In an external climate where truth is thus debased, lying is of no consequence and where it supports self-confirmatory biases, the provision of psychotherapy through the same media that promulgate lies requires careful consideration. As Churcher (2015) has compellingly argued privacy, for example, cannot be safeguarded via Skype. If we extol the fundamental importance of confidentiality and then work through a medium that cannot protect it what are we actually communicating to our patients? We are fudging the truth. The only way to restore integrity is to keep open a dialogue with the patient about what is lost or compromised through this medium for working therapeutically instead of relating to Skype as if it were no more than the next 'new' adaptation of how we work, something that we merely have to take in our stride.

On balance, and given the culture we now operate in, I have decided that I need to engage with this medium but to do so only on certain conditions:

1 It is important to meet the patient in person several times before embarking on Skype and ideally to have worked with them in person over a more extended period before transitioning to Skype.

2 It is essential to be explicit with the patient about the limitations of Skype and to assiduously listen for what this unconsciously means and interpret this.
3 Patients have to be carefully selected for this medium. Unsuitable for this medium are patients who have body image disturbances, those who are borderline and/or perverse, those with limited capacity to represent experience, those who experience difficulty with differentiating from the other and those whose grasp on reality is tenuous. What these patients have in common is a need to be rooted in their own bodies as they relate to the embodied setting provided by the therapist's actual presence in order to work through their conflicts.
4 It is important to be firm with those patients whose needs would not be met by working in this way even if this means turning away work.
5 This way of working requires that the therapist carefully monitors her behaviour when using Skype because it is a much harder medium that deprives the therapist of access to her somatic countertransference and hence, counter-intuitively, there are greater risks of erotic enactments via this medium.

Notes

1 I am using the terms setting and frame interchangeably.
2 Riva and Mantovani (2014) outline three features of presence: it locates the self in an external physical and cultural space, it provides feedback to the self about the status of its activity and it allows for the evolution of the self through the incorporation of tools. They also outline three levels of presence – *proto*, *core* and *extended presence* – with the most evolutionary superior being extended presence. The latter is defined as the 'intuitive perception of successfully acting in the external world towards a possible object'.