

The Loss of the Shared Space: Process Issues in Telepsychotherapy

Himani Kashyap¹, Jyothsna Chandur², Rajakumari P Reddy¹

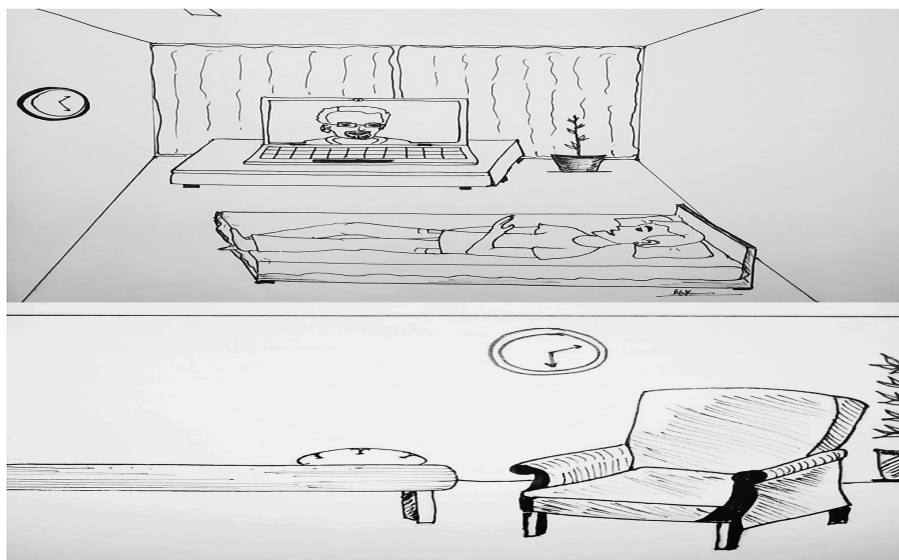
Telepsychotherapy (TP) refers to the delivery of psychotherapy through telephone, videoconferencing, or other remote means.¹ Research has demonstrated the effectiveness of TP for psychological disorders.² Although TP has been used for a few decades now, it

nothing of the essence of psychotherapy except the mode of delivery, the transition is by no means smooth and uneventful. This article documents therapist observations and reflections on what the loss of the shared therapeutic space may mean to the clients, viewed through the lens of

attachment and psychodynamic models of psychotherapy and social and affective neuroscience. The observations are framed within the context of intensive TP during the COVID-19 lockdown in India, with clients having multi-axial diagnoses (history of family conflict, abuse/neglect/trauma, and personality disorders/traits), in therapy informed by psychodynamic theory, for 1–5 years, in both private practice and tertiary settings.

The Loss of the Space

The abrupt onset of lockdown necessitated overnight decisions about temporarily suspending therapy or shifting it to telemodes. The client's emotional responses regarding this abrupt change could not be processed with the therapist in the same room. The "holding environment,"⁴ or the therapeutic space that potentially allows the clients to self-regulate, was lost without warning. Client responses to the loss of space, and therapist reflections on these, seemed critical to the working alliance, comprising goal, task, and bond.⁵ One of the most crucial shared tasks in psychotherapy, emotion coregulation, occurring through the client's own internal emotional state and the emotional states of "the other" (i.e.,



has never been as critical as during the COVID-19 pandemic. For the first time ever, therapists and clients alike were faced with a non-negotiable shift to TP—or nothing. This sudden, widespread, and forced shift to TP has raised several

unique challenges in the therapy process. Process issues, unless reflected on and addressed in therapy, may contribute to adverse outcomes in psychotherapy such as resistance, dropout, or increase in clinical risk.³ Although TP is expected to alter

¹Dept. of Clinical Psychology, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India. ²Meraaki Center for Psychotherapy and Research, Bengaluru, Karnataka, India.

HOW TO CITE THIS ARTICLE: Kashyap H, Chandur J, Reddy RP. The loss of the shared space: Process issues in telepsychotherapy. *Indian J Psychol Med.* 2020;42(5):469–472.

Address for correspondence: Himani Kashyap, Level 3, MVG Building, NIMHANS, Bengaluru, Karnataka 560029, India. E-mail: himani@nimhans.ac.in

Submitted: 24 Jun. 2020
Accepted: 2 Aug. 2020
Published Online: 31 Aug. 2020



Copyright © 2020 Indian Psychiatric Society - South Zonal Branch

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/0253717620952313

the therapist) with whom the client is interacting,⁶ now had to be accomplished via a screen or telephone.

The initial reactions of the clients to the forced shift to telemodes included extremes of responses. Some opted to “take a break,” dismissing therapy as not an “essential service.” Others responded by requesting more frequent sessions, raising many new concerns, or reporting more distress, anxiety, and even suicidal ideation (despite showing no objective worsening of clinically assessed risk). Some also reacted by calling and emailing frantically if an appointment was missed or the session interrupted by a technical malfunction. Still others displayed anger and resistance—missing many scheduled appointments (claiming they had forgotten or citing “something more important”), apologizing exaggeratedly, or not responding at all to the follow-up emails from the therapist. From the attachment model, the therapist–client relationship is a re-enactment of the attachment patterns of the past. An attuned mother–infant interaction, balanced between intimacy and exploration, is critical to forming secure attachment; if this is disturbed or absent over an extended period during infancy, individuals may develop insecure attachments—either extreme dismissiveness of intimacy as in the first description above (avoidant/dismissive attachment, developed apparently as a consequence of frequent rebuffs from a “predictably unavailable” mother) or intense preoccupation with intimacy and heightened expression of distress and anger as in the latter set of descriptions (ambivalent/preoccupied attachment, in response to an “unpredictably responsive” mother). The “secure base” provided by the therapist–client relationship enhances the client’s awareness of existing patterns and facilitates the formation of new adaptive attachments.⁷

Secure attachment facilitates the ability to tolerate separation, through an internal representation of the self, interacting with an attuned caregiver. “Internal representations” entail multiple interlinked neural structures, thereby turning the entire human brain into a “neural attachment system.” Sensory information (for the infant—the look, feel, and smell of

the mother) is linked to the hippocampus and amygdala, playing a role in familiarity, recognition, and emotional correlations of internal states and contextual environmental stimuli.⁸ The prefrontal cortex (PFC) mediates both “automatic” responses to attachment figures and internal representations in working memory.⁹ The characteristics of working memory in general—holding and working with information no longer perceptually present and susceptibility to fading¹⁰—also hold true for internal representations of attachment. Secure attachment makes the insecurity of detachment/loss bearable, but internal representations of attachment may fade if not reinforced¹¹; those with disturbed childhood attachment may find it particularly harder to access internal representations—either because they are absent or dysfunctional. Some of our clients needed to re-engage with the therapist in the new space in order to renew the internal representation of safety, for example, giving the therapist a tour of their homes or introducing us to pets or infants. Others were “living on fumes from the past,”¹² reconnecting with the “remembered” sense of security and attempting to recreate it tangibly in their own living spaces—for instance, buying the same potted plant and glass water pitcher as in the therapist’s office. For a few clients, culling out a space that would be safe, private, and uninterrupted for the one-hour therapy session was a tremendous challenge. Victims of domestic violence, abuse, or trauma showed intense distress with the loss of the safe space in therapy. As Parsons¹³ points out, security in the external space makes the security in the internal space possible. This lack of felt security in our clients was demonstrated in-session as furtive, desperate attempts to protect their therapy space from inconsiderate/intentional interruptions by family members—frequently shifting devices, changing locations, intermittently switching off audio or video, dissociative episodes, and dysregulated behaviors.

Individuals in attachment relationships coregulate emotion, not just in the metaphorical sense but also at the neural level. In humans, the mere presence of another person is sufficient to diminish autonomic responses to aversive

events.¹⁴ Developmentally, affect regulation is first performed by a responsive mother and only then acquired by the infant. The responsive caregiver’s emotionally expressive face triggers sympathetic and parasympathetic activity that is responsible for regulating affect. Internal representations of an attuned caregiver in fronto-limbic circuits continue to serve as biological affect regulators¹⁵ and help individuals tolerate, modulate, and express difficult emotions.⁷ TP seemed to entail altered internal representations—the pixelated therapist on the screen, the mismatched audiovisual of the therapist’s response, and the far-away voice on the telephone felt very different from the real therapist previously experienced in the room. Many clients responded with distress—fussing over the audio/video, demanding multiple adjustments from the therapist, holding devices very close to their faces, hyperfocusing on the therapist’s expression, and almost never looking away. Over the telephone, this sometimes evinced as clients talking very loudly, as if to ensure the therapist was focused on them. From the attachment perspective, the quality of communication determines the security of attachment—attuned communication is characterized as collaborative and contingent “signal-response,”¹⁷ that is, one party signals one’s need and the other party responds to the communicated need. Individuals with ambivalent attachment, growing up with unpredictable responsiveness on the part of their mothers, tend to be preoccupied with the mother’s response and persistently communicate emotional needs, “as if keeping up the pressure might keep up the care.”¹⁷ Screen-hyperfocus was an impediment to emotional exploration in teletherapy and had to be consciously worked through, by both therapist and client gazing away at intervals to cocreate a reflective space. In some cases, the absence of the video appeared to facilitate emotional processing—one client said she noticed a change in the sessions and really felt “heard” (although the same content had been discussed many times before).

Even when clients readily agreed to TP, the boundaries of this new space presented challenges from the outset. The

loss of meaningful rituals marking the therapy space was starkly experienced. Previously, clients had traveled to the therapist's office and sat in the waiting room, having ample time to gather their thoughts. At the scheduled time, they had been greeted at the door, invited into the therapy space, settled in, and, toward the end, wound down with small talk and shown out by the therapist. Now, a single click signaled the start and end of the session. Clients were in therapy one minute, and the next minute, taking a work call from the same desk or device. The abruptness of transition between the reflective space and "real-life" (both entering and leaving) was experienced as jarring. One client explicitly requested 2–3 minutes of silence after we have finished "talking"; that she "sign out" rather than the therapist "end meeting." Other clients tested the boundaries of this new online space—the lines between "me, you, and us"—by attending sessions in nightwear (or in a bathrobe as in the case of one young client) or eating or drinking elaborately during the session (a three-course meal or a leisurely cup of *chai* brewed and sipped throughout the session). Other therapists have reflected on how a shared presence in a room entails boundaries different from a screen presence; the screen may be treated as if it is a wall, lowering inhibitions.¹²

Stability and consistency of sessions are important to the "secure base" in therapy—so that the inconsistencies, the unpredictabilities, and the technical breakdowns may catalyze corrective emotional experience and sometimes even make way for unexpected but important experiences to surface. Disorder and disequilibrium are natural phenomena that elicit transformations crucial for development, including adaptation to environmental pressures.¹⁶ For instance, technical malfunction abruptly terminated a session with a client and prevented appropriate resolution of conflictual content. This evoked painful rejection experiences from childhood, but rather than displaying her usual avoidance and withdrawal, the client was able to confront the experience and express anger about the unavailability of those she needed, including the therapist. In another instance, for a client with a history of many

unresolved losses, a communication gap of a few days unearthed anxiety about another potential loss—of the therapist succumbing to COVID—which she was able to verbalize for the first time. Insecurely attached individuals may tend to conceal expressions of distress and anger, fearing that the attachment object will be lost forever.¹¹ Like any other life event, the sudden loss of space may have provided an opportunity to speak about "the unthought known"¹⁷—nonverbal experiences that shape us, but are inaccessible to verbal expression, because they occurred either before the development of "the neural equipment to encode them linguistically or because this equipment was temporarily disabled by overwhelmingly intense painful emotion."⁷

The Challenge for the Therapist

For the therapist, during the pandemic, the task was to keep the ongoing therapy process smooth, consistent, and reliable, with minimal disruptions, while monitoring risk to clients. It seemed that the loss of the "copresent experience," not being in the room together, in some ways forced the therapists to focus harder, often leading to exhaustion, perhaps even "zoom fatigue."¹⁸ Other authors¹² have also noted that the narrow, intense focus required by technology is the opposite of what is required in a therapy session—free-floating, "calm receptiveness" or "reverie." The task then is to acknowledge the new experience and make space to address it, rather than simply expecting ourselves and clients to adapt.

Ways Forward

Along with the uncertainty in every domain of life comes the experience of being in a long transition period, not knowing when normalcy will return and in what form (masks, face shields, PPE suits?). Once the mandatory lockdown was lifted, the end of sessions was always punctuated with "Are we meeting in person next session?" Even though in the past some clients had shifted between online and in person sessions, it was less acceptable when viewed as the only option for a foreseeable future.

In India, TP may present significant advantages with regard to reducing the large treatment gaps—by bridging geographical distances, lowering travel and related expenses, and balancing the skewed ratio of trained psychotherapists to consumers. Nevertheless, despite the convenience of long-distance access minus the travel costs, it has only formed a minority of delivered psychotherapeutic interventions across the world.² This may perhaps be partly explained by therapists' own concerns about TP as possibly being less effective, the lack of nonverbal cues, privacy and confidentiality, difficulty intervening in case of a crisis, and lack of specific training.² In India, the problem is further compounded for many sections of the population by poor access to uninterrupted internet and telephone connectivity, finding a suitable and user-friendly videoconferencing mode, and lack of familiarity with the technological tools. It is probable (but by no means certain) that, for logistic reasons, internet-based TP may be more favored by urban populations while telephonic therapy may be more preferred by a rural/low education demographic. Although there may be variations in content, process issues are likely to evince in psychotherapy across different client demographics and therapy settings, although perhaps more prominent in clients with personality disorders, particularly emotionally unstable personality disorder (EUPD).

Given that TP may be the way forward, what might be the impact of a "copresent experience" vs. a two-dimensional "screen experience" on therapeutic interactions?¹² It is clear from the literature that clients have differing abilities to form and utilize internal representations from memory for emotion regulation; these differences in client variables are likely to have a bearing on clinical outcomes in TP. Assessing client suitability for TP is important; nevertheless, during a pandemic, it may be neither feasible nor ethical to withhold TP from clients traditionally deemed "unsuitable" due to their complex histories. This aspect raises the need, in India, for further research on the effectiveness, problems and pitfalls, training, ethical and professional aspects, systemic issues (e.g., a compre-

hensive mental health system with minimal gaps in addressing psychiatric emergencies), and attitudes toward TP. While we await such a research base, therapists cannot afford to turn mindlessly to TP, driven by “economic anxieties and professional obsolescence,” ignoring process issues with the assumption that “copresence will seamlessly transport into telesessions.”¹² Although the challenges are ongoing with every session even after close to six months of TP and lockdown, it is imperative that nonverbal aspects are given due importance in sessions—as one author says, “to speak to my patients about a lack that they will not notice unless I am aware of it.”¹⁹ The loss of the therapy space, the altered boundaries and internal representations of the new space, the need to coregulate affect through a two-dimensional screen or disembodied voice on the telephone—all constitute yet another difficult experience that needs to be verbalized, processed, and navigated in the (albeit virtual) presence of the therapist; an ongoing journey that could allow one to experience loss and be found in the process.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

References

- American Psychological Association. *Guidelines for the Practice of Telepsychology*. Washington, DC: APA, 2013.
- Poletti B, Tagini S, Brugnera A, et al. Telepsychotherapy: a leaflet for psychotherapists in the age of COVID-19. A review of the evidence [published online May 27, 2020]. *Couns Psychol Q* DOI:10.1080/09515070.2020.1769557.
- Lambert MJ. *Bergin and Garfield's handbook of psychotherapy and behavior change*. Hoboken, NJ: John Wiley & Sons, 2013.
- Winnicott DW. The capacity to be alone. In: *The maturational processes and the facilitating environment: studies in the theory of emotional development*. London: The Hogarth Press and the Institute of Psychoanalysis, 1965.
- Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. *Psychother Theory Res Pract* 1979; 16(3): 252–260.
- Soma CS, Baucom BRW, Xiao B, et al. Coregulation of therapist and client emotion during psychotherapy. *Psychother Res* 2020; 30(5): 591–603.
- Wallin DJ. *Attachment in psychotherapy*. New York: The Guilford Press; 2007.
- Kennedy PJ and Shapiro ML. Retrieving memories via internal context requires the hippocampus. *J Neurosci* 2004; 24(31): 6979–6985.
- Coan JA. Toward a neuroscience of attachment. In: Cassidy J, Shaver PR, eds. *Handbook of attachment: theory, research, and clinical applications*. New York: The Guilford Press, 2008.
- Baddeley A. Working memory. *Curr Biol* 2010; 20(4): 136–140.
- Holmes J. *Attachment, intimacy, autonomy: using attachment theory in adult psychotherapy*. Lanham: Rowman & Littlefield Publishers, 1996.
- Russell GI. *Screen relations: the limits of computer-mediated psychoanalysis and psychotherapy*. London: Karnac Books, 2015.
- Parsons M. *Living psychoanalysis*. East Sussex: Routledge, 2014.
- Qi Y, Herrmann MJ, Bell L, et al. The mere physical presence of another person reduces human autonomic responses to aversive sounds. *Proc R Soc B* 2020; 287(1919): 20192241.
- Schore AN. *Affect regulation and the origin of the self: the neurobiology of emotional development*. New York: Routledge, 2016.
- Rosen H. Piagetian theory and cognitive therapy. In: Arkowitz H, Beutler L, Simon K, eds. *Comprehensive handbook of cognitive therapy*. Berlin: Springer Science and Business Media, 2013.
- Bollas C. *The shadow of the object*. London: Routledge, 2017.
- Sklar J. “Zoom fatigue” is taxing the brain. *National Geographic*. <https://www.nationalgeographic.com/science/2020/04/coronavirus-zoom-fatigue-is-taxing-the-brain-here-is-why-that-happens/> (accessed May 2, 2020).
- Verma M. Screen relations: the limits of computer-mediated psychoanalysis and psychotherapy. *Psychoanal Psychother* 2018; 32(3): 315–320.