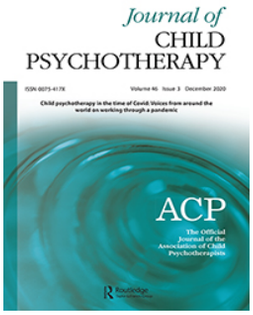

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Psychotherapy with no body in the room

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ABSTRACT
This paper, partly written in the first person, describes the struggle and also the gains made by both an adolescent patient and her therapist when they had to move to a digital platform for their therapy sessions. The particular focus is on the shift in the countertransference and what became possible for both in their responses, when forced to move to digital work.

KEYWORDS
Digital work; physical distance; online countertransference; no body; self-harm; gender identity; Covid-19; lockdown; India

Introduction

India had a stringent Covid-19 lockdown enforced on its population in March 2020, necessitating an abrupt move to offering psychotherapy on digital media, which had not at all previously been part of the repertoire of this New Delhi based Child and Adolescent Mental Health team.

Child and Adolescent mental health work, especially with supervision, still remains nascent, even in metropolitan cities in India. Adult psychiatry services tend to step in for serious issues of self-harm and suicidality, whereas behavioural issues are sometimes referred to school counsellors, but are mostly dealt with within the family, using force if needed. Emotion and relationship-based early intervention or preventative psychotherapeutic work are virtually non-existent in the country (Paiva, 2018), whether in public-funded spaces or private practice, though the need for such services is immense, with suicide rates in India being extremely high (Snowdon, 2019).

The context in which the work described below takes place, in the private sector, refers to a team, 'Family Tree', that focuses exclusively on emotional and relationship difficulties in children, adolescents and families. The 'Family Tree' was founded in 2018 in response to the aforementioned huge gap in services.[1] The staff is trained in psychodynamic infant observation and psychoanalytic psychotherapy. Some of the adolescent patients whom we see come in experiencing severe distress, sometimes having harmed themselves through suicide attempts or cutting. Along with initial assessments, team meetings and supervision, all long-term psychotherapy interventions recently had to move online in the context of Covid related distancing. This created significant anxiety for both the patients and the therapists at Family Tree.

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The effect of greater physical distance

Due to my background within the British NHS, my experience in community CAMHS settings in the UK and a public-funded university clinic in New Delhi, I can state with some conviction that in-depth emotional work requires the presence of the physical body. After all, we live in our bodies and feel through them, feelings being physiologically and hormonally mediated events, not abstract concepts (Damasio, 1999; Ekman, 1992; Ekman & Davidson, 1994).

When India went into lockdown in the third week of March 2020, we were given only four hours' notice. However, the team had pre-empted the lockdown, expecting that a strict diktat to be physically distanced would be put in place soon; we had thus sent staff on leave for a three-week period which had begun the week before, pushing all appointments and assessments to mid-April. We did not predict at the time that we would still be working digitally ten months later.

Each one of our patients reacted differently to the idea of moving the work online. The younger children with whom we'd had long-standing relationships were disappointed – they were clear that they missed the space, the books, the possibilities created in the therapy room. Other young children, those who were more ambivalent or less articulate, enacted their preference by not showing up on the screen at all or by being detached and zoned out in sessions. Similarly, some adolescents, especially those with whom we had not yet established a solid relationship, took this opportunity to disappear completely.

The biggest challenge for our small, privately funded, unusual-for-India Child and Adolescent Mental Health Team was the question of new patients. As the lead clinical psychologist and psychotherapist, after years of trial and error, I had worked out a system that included a family session as part of the initial assessment meetings. This in itself had been a challenge – orienting a family away from the belief that the difficulty resided in the child who needed to be 'fixed'; we endeavoured to introduce the idea that different parts of the family system interacted to create a problem. We thus used to routinely offer work with parents who we saw as needing support too, in addition to the support the children needed.

In 2020, suddenly, all the information we used to take in from the presence of the family-in-the-room and our observations of the family dynamics, was gone. Everyone became one-dimensional, disembodied and digital. We were lucky if sentences came through clearly, without interruptions or lags. For a period of time, we stopped taking on young children altogether, while we learnt and un-learnt how to navigate this flat one-dimensional space of eleven inches. In order to contain their distress, we started working with parents of young children online and worked through them, rather than trying to engage directly with young children on a screen. Perhaps we were being equated, by these children, with online-school teachers, because we found that they appeared detached from us, often playing games independently on an adjacent tab. Clearly, there are more available ways to avoid engaging when someone is online than there are in-person (also see Paiva, 2020).

There were various other issues: working with older adolescents, issues of payment, questions around communication and confidentiality with parents all led us into murky water that we had not previously had to navigate. Unexpectedly, some of the

adolescents with whom we had long-standing relationships and who also had internal conflicts around 'being seen' were relieved by the distance that digital work provided. It is these teens who have engaged best over the screen and who have made the most use of online therapy. Somehow, talking and engaging when there was nobody in the room was easier for them. As it turned out, the patients were not the only ones who found it easier. The aim of this paper is to explore the effect of being the only person in the room on me as a therapist, and on some of my patients.

The client: hiding and honest

Quinn and I had been working together for almost three years in twice-weekly therapy, since the time that she (pronoun used at the time) had been referred at the age of thirteen with self-harm and suicidal thoughts. She had questions about her gender, and struggled with a severe depression, a level of anxiety, and self-loathing thoughts about herself, with pronounced anger towards her biological body. Over time, what was considered body dysmorphia coalesced into a clarity about gender identity, with Quinn realising that he was most comfortable presenting as masculine and using the pronouns *he/him*. Our face-to-face sessions had been difficult for Quinn. He struggled to trust me to be a compassionate adult, and to allow 'herself' (as was) to be seen, often hiding his face in his lap and later both hiding behind and expressing himself through many words, an art sketchbook, wit and sarcasm. It was difficult to allow me to witness his feelings.

When we transitioned to online sessions in March 2020, the screen allowed Quinn to hide in a much more honest and open way – I would simply not be able to see his face. I would be treated to the sight of the ceiling fan or the curtains; or the lighting would be such as to ensure that the figure on the screen was grainy and unclear. Yet, through this visual hiding, words began to emerge – gradually more certain and less vague. Quinn came out to me with a decision to adopt a non-binary gender position. I found that both of us worked harder and with greater honesty – what we came to know as 'going out on a limb' – to keep our relationship alive. For example, I would have to clearly put my thoughts and feelings into words when Quinn missed a session, instead of waiting in silence. More had to be said out loud in words now, since words were all we had to communicate with now that the video was turned off and my silence could be misinterpreted as censure, leading to a spate of apologies and self-attack. Much to my surprise, this visual hiding proved to be helpful, since the body was such an ambivalent space for Quinn anyway. It was as if Quinn could speak an internal truth when not looking at himself as he spoke. Since I did not turn off my video, Quinn could see me. I could not see him though, and he could not see himself. Acknowledging his own *body* created special problems for Quinn. It seems that it had become easier because the digital setting only allowed me to know about feelings in words and not in body.

This came to a head at a specific session, after three years of work, after we had agreed that we were getting more done working in the safe distance phone calls provided, than we had on video or face-to-face. Quinn was now sixteen and, having come out to me, his parents and a few friends regarding his preferred pronouns (he/him), was now going through a menstrual cycle. Menstruation had started at age

thirteen, and continued to create conflict in him that led to severe self-loathing, phrased as 'I hate myself'.

> *I struggled with my response then – noticing my concern for this courageous and conflicted young person and his self-abandonment. I sputtered out a protest at this treatment of himself. We managed to reach a re-frame –*
>
> *I hate my biologically ascribed gender at birth. There – I said it. I don't know why this is so hard, he said.*
>
> *As we spoke more, he was able to state out loud: 'I feel uncomfortable the way that a grown Indian man is uncomfortable talking about periods!'*
>
> *We began talking about the voice of the Grown Indian Man that Quinn carried in his head. About how patriarchal Indian society moves in and occupies masculinity as well as social hierarchy, about how this voice does not permit Quinn to be comfortable with being transgender or with menstruating. This created room for him to notice that much of his discomfort with his menstrual cycle was learnt and was due to a social discourse. The self-loathing was in fact because of the identification. There was immediate relief, palpable even on the phone. Now what remained was the physical discomfort of living in a body that has menstrual cycles and hormonal dramas.*

It was only after this session that I began to understand the difficulty seeing himself on video had created for Quinn. His gaze, thoughts and self-observation were hijacked by an identification with the *Grown Indian Man* when using video and, in turn, all this was often projected onto my gaze. Being the only body in the room, with me as a disembodied, supportive voice on the phone, made it easier for Quinn to take his own side.

Abandoning the self

There are those of us who have been consistently socialised to give ourselves up when in the presence of others. This is the basis of a collectivist society like India's. Roland's (1988) argument is that there is a 'familial self', rooted in the subtle emotional hierarchical relationships of the family and group (Roland, 1988), and it is nowhere more prevalent than when it comes to the socialisation of women who almost exist only to look out for the demands and needs of others, be it their parents, spouses or their children. For us then, being the only body in the room is freeing.

Through therapy and supervision, I am aware that as a woman socialised in India I struggle to pay attention to my feelings and to draw boundaries at times. Professionally, I am aware that I need to protect my energy, resist identifying with the maternal transference and also resist being pulled in by the sheer quantities of emotional neglect of children in our society. I countered this by refusing to take on patients from other cities. By insisting that they came to see me in person and not work online, I hoped that their commitment was at least as much as mine. Because this meant there were some people I would simply never work with, I restricted their access to me. This was partly also a projection, that I needed to restrict *their* access to me was, in fact, the flipside of my need to *increase my access* to parts of myself – access to my aggression toward the patient, which is based in –

> … identifications and tendencies belonging to an analyst's personal experiences and personal development which provide the positive setting for his analytic work and make his work different in quality from that of any other analyst (Winnicott, 1984, p. 195).

I needed access, therefore, to my assertiveness, the stuff that boundaries are made of, so that I could be present for myself and not lose my own intent and potency as the psychotherapist in the room.

Being the only body in the room, with the patient at the other end of a screen, made it possible for me to attend to my own bodily reactions, to access my feelings and my countertransference and to use them to further the work with more intent. Whether it was the patient's unacknowledged grief, rage, or their own struggle in being seen – I found that I had much more clarity to notice it and address it to greater effectiveness.

The therapist: freer and honest

Dev and I had worked together for three years, finishing in 2017 when he left India to attend a university abroad (Paiva, 2018, p. 25), but after an emotional crisis forced him to drop out, Dev returned to individual therapy with me in March 2020 during the Covid-19 lockdown. This time, therapy had to be exclusively on a digital medium. In our work together, I have found myself freed up to honour my honest emotional response to this young man struggling against a history of childhood physical and sexual abuse, severe self-loathing, cannabis dependence and depression.

Dev's self-neglect had always been visible – unwashed and unshaven, slouching, sitting in bedclothes, overweight and eating unhealthily. Accessing this at a distance, via the screen, made it possible for me to attend to my own mixed reactions – not just my anxiety at the quantities of work we might have ahead of us, but also distaste as well as empathy for his state.

As he became able to reach the trauma of his childhood experiences, I was alone at my end, freed up to experience the horror I was feeling in my gut. As he fought against and hid the enormous quantities of pain of his experiences, pushed away therapy and considered giving in to suicidal thoughts, I found myself shutting the computer after sessions, curling up against the wall and weeping copiously, giving in to his deep grief. When Dev denied his rage against his mother and hid it in the transference with me, covering and conveying his anger with a dismissal of therapy and a dismissal of his own desire to have healthy relationships, I found myself furious at his self-abandonment, his rejection of me, and his invitation for me to abandon him.

As an Indian woman, I have been socialised to hide anger in relationships, which made acknowledging fury in the countertransference unprecedented for me. In a particularly difficult session with Dev, who was struggling to notice how his will, choices and work in therapy had led to him having made significant progress between March-September 2020, I asked him if he would be willing to consider concrete evidence of his change – a video clip from April 2020.[2] It was an unusual move on my part – this was me standing up for the quality and intensity of psychotherapeutic work that we had done together previously as a working team and, unusually for me,

I was refusing for this work to now be dismissed. Seeing what he looked like then and now had a huge impact on Dev. Seeing the video, he expressed that he could not believe how far he had come. In that moment, it had been important for me to remind him, somewhat courageously, that this was the case. The visual evidence worked more than my words, which were easy for him to dismiss as lies or as the manipulation of a woman.

I have always been aware that emotions can permeate across the boundary of physical bodies. Now it seemed that the computer screen had become permeable too. Six months later, the reality of the cleanly shaven, self-aware, articulate young man I interact with in twice-weekly therapy makes me aware of my feelings of warmth, pride and delight toward his growing emotional capacity. He has also started a Bachelor's Degree at university.

Conclusion

The particular focus in this paper has been on the shift in the countertransference, looking at what became possible for both patient and therapist in their responses when forced to move to working digitally. For Quinn, being in his own room was freeing and empowering, as it was for the therapist, who found it possible to work with greater clarity and intent.

While Winnicott's (1984) classic paper on hate in the countertransference is directed at work with the psychotic patient, it most helpfully points out that treatment is incomplete if it has not been possible for the analyst/psychotherapist to tell the patient all that was done for them in the early stages of treatment. 'Until this interpretation is made, the patient is kept to some extent in the position of infant – one who cannot understand what he owes to his mother' (p. 202). Showing Dev the video evidence of his growth is something I see as analogous to this – not allowing him to stay in his fantasy of the helpless infant, with an all-powerful fantasy-mother, but instead showing him what he and I had achieved together.

It is ironic that in the physical distancing of lockdown some of us found freedom in being the only body in the room, which enabled us to connect more meaningfully with ourselves, and in turn with one another.

Notes

1. www.thefamilytree.in
2. Sessions are video recorded for supervision with certain high-risk clients, with written informed consent.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Nupur Dhingra Paiva is Chartered Clinical Psychologist and Lead Child & Adolescent Psychotherapist at Family Tree. She worked in a community CAMHS team with the Tavistock & Portman NHS Trust from 2007 to 2012. She founded Family Tree in 2018.

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