Short Communication

Cyberanalysis: Transference and Its Management in the Cyberspace

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Objective: As psychiatrists or psychotherapists, many of us may have had contact with people by e-mail and/or through online 'chat rooms'. These people may write to us about their various problems, especially in their interpersonal relationships; discuss their queries about conflicts with their spouse, partner, and friends; or complained of low self-esteem and problems at work. In this article, we will try to discuss certain considerations and opinions about the possibility of insight-oriented psychotherapy in the domain of 'virtual reality'.
Method: This study was based on clinical observation of the first author. Two cases of 'Cyberanalysis' were described. The management of transference and countertransference, the analysis of defenses in this context, and possible reasons for success and failure of each case were discussed.
Results: We have witnessed the formation of a transferential relationship between the 'client' and the therapists after a matter of months. One of the client had a satisfactory outcome and the other represented a therapeutic failure.
Conclusion: This type of psychotherapy may provide a novel opportunity for therapists to move toward the internal world of the patient Compared to 'real world' therapies. This modality of therapy also has its own advantages and shortcomings.
Keywords:
Computer-assisted, Psychotherapy, Telemedicine, Remote consultation, ,

Iran J Psychiatry 2006; 1: 81-83

The type of life we lead since the emergence of the so-called 'informatics era' is hardly comparable with the life of our parents in any way. Amazing advances in the fields of Information Technology and Computer Sciences have led to the virtual obliteration of spaces and distances among people. We are dealing with such concepts as 'internet addiction', 'web conference', 'web party', 'cyber sex', etc.

Many individuals spend a considerable amount of their time online with people whose true identity they are not aware of, and this very anonymity can indeed set the stage for projection of conflicts. Virtual identities and virtual relationships come into existence in a virtual world, and people also bring their real-life problems and personalities along with them to their 'virtual' lives.

The delivery of nursing or medical services through the cyberspace is generally referred to as 'Telemedicine' or 'Telehealth'. The Food and Drug Administration (FDA) has defined the term telemedicine as "the delivery of health care to individual patients and the transmission of health information over distance, using telecommunications technologies" (1, 2). The FDA also includes the following services in its definition:

1) direct clinical, preventive, diagnostic, and therapeutic services and treatment; 2) consultative and follow-up services; 3) remote monitoring of patients; 4) rehabilitative services; and 5) patient education (1, 2).

Some authors maintain that e-mail could be recruited as an adjuvant in formal psychotherapy. In this model, e-mail is used for intermittent checking in on the part of the patient, a vehicle for connecting the therapist when a crisis looms up, or when the patient is out of town (3).

The questions that we discuss here are whether communication via the Internet and in the cyberspace could be used as a primary means of patient–therapist relationship; and if so, what are its limitations and how could therapists keep the boundaries of their therapeutic relationship.

In formal psychotherapy, especially in the insight-oriented type, the analysis of transference and countertransference is one of the first important steps, and the therapist should provide an environment that allows the patient's projections to surface. One of the advantages of 'virtual psychotherapy' is the providing of an atmosphere for emotions to be expressed without a face-to-face encounter, so that neither the patient nor the therapist would act on these emotions. In this manner, patients can potentially project the entirety of their internal world, and due to their inability to see the therapist, they sketch a picture that does not reflect the real self of the therapist. In the process of e-mail exchange, we have a time lag between receiving and replying messages. This delay provides an opportunity for proper contemplation and thinking, both for the

therapist and the patient, and could hence prevent the temptation to act out. Also, by recording the exchanged information, the therapist would be able to review their responses and those of the patient's in a more satisfactory and reliable manner compared to the 'real world' therapy. In this type of communication, the patient shows less resistance to speak up (write) the internal and repressed emotions. As Ben-Ze'ev has pointed out, "As long as the relationship is limited to the cyberspace, emotional closeness can be increased without risking one's privacy. When the relationship begins to involve features such as revealing real names and addresses, phone calls, exchange of pictures, writing letters, and face-to-face meetings, the conflict between emotional closeness and privacy emerges once again" (4).

This type of therapy, however, has certain limitations such as the lack of discipline and sequence that we see in formal psychotherapy. It could lead to some misunderstanding on the side of patient (which is partly due to their projections). For instance, if the therapist does not respond to the client in the expected time, (s)he may be led to think that the therapist is not taking the problem at hand seriously. Also, if the therapist cannot control the boundaries between a formal therapeutic writing and an informal intimate one, it would lead to the violation of boundaries by the patient and thus create a countertherapeutic effect.

Management of transference in the virtual world

'Transference' is the phenomenon indicating the repetition of past experiences in the current life. We could see this entity in every interpersonal relationship. There is hardly any judgment and evaluation that is exclusively based upon external realities and objective assessment. By and large, our subjectivity has an effect on our judgment, and could sometimes lead to significant distortions. In the postmodern era, we come across theories that put forward the importance of the *intersubjective* atmosphere of the therapeutic relationship and deny the existence of any basic and true reality (5). A century earlier, Alfred Adler who belongs to the modern era, discussed the concept of 'fictional goals' and 'guiding fictions' to explain the subjective evaluation and attitudes which are product of man-made reality (6).

The cyberspace is an excellent medium that allows the subjective feelings and thoughts of people to surface efficiently. Anonymity, distance, absence of body language and eye contact (except when using a webcam) and the delayed responses all lead to the development of a therapeutic atmosphere that enables people to view each other through their personal filters. In such a medium we observe a stronger and more persistent transferential relationship that provides a suitable ambience for confrontation and interpretation. But how could we manage this raw material to reach therapeutic effects? We could see two types of relationship in 'virtual psychotherapy' via e-mail transaction. In the first type, there has been no real face-to-face relationship between the therapist and the client in the past, and the selection of the therapist is completely based on data obtained on the Internet. In the second instance, the therapeutic dyad had begun the process of therapy a few months earlier, and is continued via e-mail. In practice, we have noticed the former type of treatment to have a greater rate of therapeutic stalemates and dropouts. On the other hand, when the initial phase of therapy is started in the real world, the resultant rapport and therapeutic alliance is powerful enough to enable the patient to adhere to therapy.

In the following examples, two cases of 'Cyberanalysis' will be described by the first author, one with a satisfactory outcome and the other representing a therapeutic failure. The possible reasons for success and failure of each case will be discussed subsequently.

Case 1

A 40-year-old, married, housewife referred to me, complaining of a feeling of emptiness and depressed mood that had started a few months earlier. She told me that she did not know the real cause of that feeling. When I asked her about her marital relationship, she explained that love was not an important factor in her selection. "I was always looking for a man who would make my heart beat faster. However, I made my decision by my brain rather than by my heart." To me, it was somewhat clear that she was experiencing a midlife crisis, and unable to accept her fate. She had a histrionic character and I found a strong attachment between her and her father during childhood.

I saw her in three weekly sessions and she talked about herself and her past experiences during these sessions. However, she said to me that they were going to leave the country and emigrate to Europe. I started no specific therapeutic interventions for her except prescribing an antidepressant. After a few months, I received an e-mail from her explaining about her condition. I found that she had become more depressed than before, and that also due to the stress of immigration, her dependency traits had been reinforced. She wrote to me that she had only had a few sexual contacts with her husband and felt more emotionally distanced from him. I advised her to see a psychiatrist, but she told me that she was not able to communicate with the local psychiatrists. "They do not understand me and I would rather continue with you, if you would allow me to." Within a few months, I gradually witnessed the formation of a positive transferential relationship, but also noticed deterioration in her marital relationship. I tried to interpret the essence of her therapeutic relationship with me in the light of the triangular battle in her oedipal phase, her identification with her father and her attraction toward inaccessible

men. I explained to her that I am a "tabula rosa" upon which she sketches her internal world; and our distance, lack of face-to-face relationship and the time lag between questions and responses all lead to the intensification of this impression. Gradually, she was able to overcome her ambivalence toward her husband, and came to terms with the realities of her life.

Case 2

A 26-year-old, married, woman contacted me by e-mail and asked if I could help her; explaining that she had read my weblog and then decided to write to me. She was an immigrant who had left Iran a few months earlier to live in a Scandinavian country, and seemed to be experiencing a 'cultural shock', which had reached an intolerable peak. "I am looking for somebody to understand me." Initially, I tried to assume the role of a counselor, and help her to transcend this transitional stage in a supportive manner. However, I found her becoming increasingly demanding and manipulative. If I were not able to respond to her immediately, she would be annoyed and complain of my irresponsibility. The use of confronting techniques and interpretation of her behavior proved to be unsuccessful; and having reached a therapeutic impasse after a few months, her e-mails dropped in number and eventually stopped. As Peterson and Beck have noted (3), an already established therapeutic alliance helps to the maintenance of therapeutic relationship in the e-mail therapy. I had no previous "real" contact with that patient and a virtual relationship was not firm enough to establish a strong engagement that could lead to a persistent relationship. This does not mean that every 'purely' remote therapy is doomed to failure, but shows us the importance of proper rapport at the beginning of therapy. The power of projected thoughts —which is stronger than the similar thoughts in a real relationship— acts as a barrier for proper therapeutic alliance. The therapist faces a more difficult task in the 'purely' remote therapy to establish a firm and solid base to guarantee a suitable outcome.

Conclusion

E-mail, as a type of therapeutic communication, has the potential to aid the therapist in expanding his/her vision and clinical capabilities. Under some special circumstances, such as in the case of immigrants, it is an invaluable tool for helping the client. However, as with other modalities of therapy, 'virtual therapy' should also be based on its corresponding principles. Although we have only recently embarked upon using this mode of therapy, through further clinical observation and discussing its different perspectives, we could be able to adopt a disciplined and well-sequenced framework for such therapies. Its pros and cons, indications and contraindications, and supportive or expressive approaches all need further illumination. Lastly, we also need to determine the manner in which patients should pay the therapy fees. The American Medical Informatics Association has written guidelines for physician–patient relationship via e-mail (7). The Association suggests the use of written guidelines that are shared with patients and documented via a signed consent form. The guidelines should answer questions such as which subjects are appropriate for e-mail discussion, how quickly clients can expect responses to their messages, and methods to protect confidentiality.

In the above examples, it was seen that the establishment of the therapeutic alliance is a factor that leads to a fruitful conducive outcome. The process of engagement is a more difficult task in the purely e-mail form of therapy, although it can be facilitated by the use of a webcam or an audio device, which could make the therapeutic sessions more of a humanized experience. Like any other type of therapy, if we take our first steps along the correct path, we will be able to overcome the difficulties encountered later on the way. If the patient can develop a genuine trust and establish a rapport in the initial phase of the interview, he (she) can tolerate the subsequent turmoil which is inevitable in the course of 'remote therapy'. This type of psychotherapy provides a novel opportunity for therapists to move toward the internal world of the patient; but also compared to the 'real world' modalities of therapy, subjects them to more powerful emotional reactions that arise from the correspondingly more overt projections of the patient.

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