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The Therapist In The Face Of Psychic Pain During The Covid-19 Pandemic

Zenona Jezabel Hernandez Leyva[1], Leocadio Guadalupe Martínez Alarcón[2], Hans Hiram Pacheco García[3]

Abstract

This work has been conceived from the psychotherapeutic activity of psychoanalytic orientation carried out during the pandemic virtually, particularly with patients who, in the midst of the tension of the pandemic and confinement, had to live through major crises, and where the therapeutic process became almost the only thing, or the only thing that could sustain their psychic pain. An analysis of the elements of the framework of psychoanalytic psychotherapy that are modified in virtual work was carried out, and it is concluded that the psychotherapeutic process develops from the bond between patient and therapist, which is why crises could be attended to virtually based on Winnicott's theoretical proposal on the experience of collapse.

Keywords: *Psychotherapy, psychic pain, therapist, pandemic, COVID-19.*

INTRODUCTION

More than a hundred years after the discovery of the unconscious, the psychoanalytic method has had to be modified to meet the demands of the present times. In postmodernism we observe pathologies different from those investigated by the creator of psychoanalysis, which have forced the adaptation of the method for its understanding and treatment.

Traditional psychoanalysis assumed that those who came with the interest of starting a personal analysis had both time and enough money to attend several sessions a week to their treatment, nowadays psychotherapy with a psychoanalytic orientation is the most frequent and viable application of the psychoanalytic method, with important modifications to the framework. such as the number of sessions per week, but retaining the main objective, to discover the unconscious motivations of the symptoms that afflict patients.

The factors that have caused these changes sometimes have to do with the scarcity of economic resources, but in megacities they derive in a very significant way from the lack of time of people, who are immersed in a world that, after work, there is hardly any space left to live (Vives, 2013a, p. 5).

During confinement we see that there are elements of the frame that can be modified, as Etchegoyen (1986) points out: "The frame must legitimately be modified based on the elements of the reality to which it ultimately belongs" (p. 488), that is, when there are extraordinary circumstances and as long as we know the meaning of such modifications. Well, that extraordinary circumstance was precisely that of sustaining the psychic pain of

[1] Autonomous University of Zacatecas, Mail: jezabel.hernandez@uaz.edu.mx, ORCID ID: 0000-0002-7936-9964
[2] Autonomous University of Zacatecas, Mail: leo.martinezalarcon@uaz.edu.mx, ORCID ID: 0000-0003-2315-8284
[3] Autonomous University of Zacatecas, Mail: hanshiram@uaz.edu.mx, ORCID ID: 0000-0001-8326-1377

our patients during the extraordinary event that meant the confinement due to the COVID-19 pandemic.

The modifications that have been made in the application of the psychoanalytic method are due to both internal and external circumstances, the former due to clinical practice and research that generates new knowledge about the early psyche, the latter to the cultural, social and economic modifications of postmodernism (Vives, 2004).

The framing is defined as a series of variables that become constants such as the space, the schedule, frequency of the sessions, the fees, the roles of both the therapist and the patient, it is one of the poles of structuring the treatment (Bleger, 1985).

Before the start of the COVID-19 pandemic, some important modifications had already been made to the framing, some therapists were already working the sessions over the phone due to various circumstances such as migration, displacement in large cities, as well as political and social crises.

DEVELOPMENT

Although for several years some psychoanalysts and therapists had begun to experiment with integrating some technological resources, such as phone calls, video calls and videoconferences to carry out sessions virtually, there have always been questions about this type of remote treatment. However, the contingency due to the pandemic forced those analysts and therapists who wanted to give continuity to their patients' treatments to use these technological resources. Lutenberg (2014) points out in this regard:

Within the context of these remarks, I do not think it is redundant to reiterate two fundamental points related to telephone analytical dialogue: 1) the analyst must be convinced of the potential therapeutic utility of this method; 2) its "experimental" status must be made explicit.(p. 3/17)

The crisis that arose in terms of psychic symptoms as a result of confinement generated an increase in the demand for psychotherapeutic care, which is why creativity allowed the work to continue sustaining the framework that structures the analytical work. To give continuity to the psychotherapeutic work, face-to-face work began to migrate to virtual work, in this way patients partially recovered an intimate space that became indispensable to elaborate the losses and griefs that the confinement process implied, to these griefs was added that of the loss of analytical space, which is why: "Continuing the analysis with the same analyst does not prevent us from analysing the grief for the loss implied by not attending the clinic, the loss of bodily closeness and the analyst's direct perception" (Carlino, 2010, p. 196).

One of the main modifications to the framing of online treatments is the loss of the physical office as the meeting place for the patient-therapist duo; therefore, ensuring a space where there is enough privacy for the patient to take their session online is a shared task, as Czalbowski, Bastos, and Roperti (2014) point out:

Those of us who practice psychotherapy at a distance know that doing sessions using a landline or mobile phone, Skype with or without a video camera, chat, or email, etc., means crossing a public space to have access to an encounter that seeks to deepen intimacy and confidentiality (p. 114).

Although some analysts and therapists insist that remote treatment is questionable, those who have performed it agree, such as Scharff (2014), that:

[...] Teleanalysis, like traditional analysis, values the standard of psychoanalytic principles:
a firm framing, a non-directive stance, free association, unconscious communication, analysis of resistance, dreams, and transference-countertransference, interpretation,

listening to how the patient receives interpretation, plus interpretation, transformation, work, and development of a self-analytic function (p. 158).

During the confinement due to the pandemic, in the sessions with our patients, a recurring theme was related to losses, from the restriction of freedom due to the limitations imposed by confinement to the death of loved ones, whether due to COVID-19 or other circumstances, these have taken on a different meaning:

We are presented with moments of embezzlement, ruptures of family and social coexistence, and other economic circumstances that will be accompanied by cracks in our individual and collective identity. And that, as with the wound caused by the death of significant people—a child, a sibling, a partner who are also part of one's identity—we must face grief to suture the wound generated (Sunyer, 2020, p. 490).

To sustain the therapeutic work we had to make a series of modifications to the framework, but these changes are not new, psychoanalysis is a discipline that since its beginnings has been in constant development, Freud himself was modifying his theories according to his clinical discoveries and in that same sense many authors after him have been in charge of continuing to develop it, expanding and enriching theoretically and clinically. Contemporary psychoanalysis studies the symptomatic manifestations of our time, which has expanded the alternatives in working with patients with pre-structural psychopathological conditions. As society changes, so do the symptoms, and therefore so do our work as therapists/analysts.

The contemporary perspective offers a new way of understanding and exercising analytical work, one of the most important elements is the place that affects have in the understanding and analysis of the unconscious, a fact in which the role of the therapist is also recognized not so much as a representational figure but as a subject who establishes an interpersonal and intersubjective relationship with the patient.

By situating the place of affects as fundamental to understanding what happens in the intersubjective patient-analyst relationship, not only does it generate an epistemic shift from the paradigm of drives to affectivity (Orange, Atwood, & Storolow, 2012), but it also gives a place to the subjectivity of the therapist, his history, and the theoretical and technical body that give consistency to his work. This recognition of the subjectivity of the therapist questions the abstinent, cold and distant figure that has been rigidly and erroneously transmitted in some classical psychoanalytic formations and frees the ideal of the analyst/therapist who denies his affections and distances himself from his patient or attributes them to countertransference reactions, from that same logic provoked by the transference of the patient.

For example, the provocative stance of Bion (1978/2010) in the conference held in Paris on July 10, 1978, is interesting because in it he questions the extent to which the concern for giving scientificity to psychoanalysis has generated a practice that is not very affective, his invitation to ask ourselves what kind of artist we are as analysts:

I suggest that it would be worthwhile to consider it not as your office but rather as your workshop. What kind of artist are you? Are you a ceramist? Are you a painter? A musician? A writer? In my experience, a vast majority of analysts don't really know what kind of artists they are. (p. 31)

This questioning brings us closer to the position of analyst/therapist from the relational and intersubjective point of view, listening to our patients from their affective suffering and not as a set of symptoms that we must diagnose and cure, but from the collapse, defined in Winnicott's words as "That unthinkable state of affairs that is below the organization of defenses" (p. 113). The intolerable experiences that lead our patients to the search for analytical listening, are gradually tolerated because the analytic space allows both the patient and the therapist to feel and think together.

In the same line of Bionian thought, Eekhoff (2020) proposes that "Psychic pain is not only devoid of sensations, but is non-verbal. Psychic pain stops time and collapses space, making thinking difficult" (p. 135). The author allows us to reflect on one of the reasons for consultation that as therapists can generate more anguish, suicidal ideation and attempts, those patients who are suffering but who cannot verbalize it and whom we, as the mother at the time with the baby, have to accompany and feel with them to be able to think about the pain together:

As analysts, we intuit or imagine the pain of our patients without being able to name or define it. Using our rêverie, we approach the suffering patient in a similar way to how the good enough mother of a newborn intuits via rêverie what her baby experiences. (Eekhoff, 2020, p. 140)

REFLECTION

In the confinement due to the COVID-19 pandemic, we continued to treat patients that we attended in person, migrating to virtuality, but we also received new patients, whom we did not previously know in the context of the clinic and with consultation reasons triggered on many occasions by crises generated by the same situation of confinement. In these circumstances we see that the analytical process takes place in a place that is not the doctor's office, the place where it takes place is precisely the patient-therapist relationship, so that despite the technical difficulties we can finally listen, accompany, feel and think together with the patient.

When we moved our work to virtuality, one of the main questions was whether we could really feel the patient, if we could identify their affective tones despite not having their body language, if the affective bond was sustained in virtuality. With the patients we previously treated, the feeling was different from what happened with new patients with whom we started the process virtually, since without the reference of having met each other physically, we felt that we might not be able to empathize with them.

The psychic pain of our patients during the pandemic triggered several crises that as therapists we had to attend to in an emergency, the pain of seeing our patients suffer and our concern for them, having felt and thought together with them about their pain is what contributes to the modification of the image of themselves, In this experience of collapse where they are now not alone as in the past, since they are now accompanied in a therapeutic relationship where their affections are validated, especially suffering and psychic pain:

Bion reminds us that in order to be human, one suffers. Suffering is not only inevitable, it is formative. Suffering also interacts with who we are to create who we will be. The degree to which we can suffer can almost be equated with the degree to which we can display our humanity. The process is ongoing as long as we are alive. (Eekhoff, 2020, pp. 168-169)

CONCLUSIONS

Disastrous events have an impact on different areas of human life and cause physical and psychological suffering. The COVID-19 pandemic forced people to modify their social and individual lives, confinement and other effects produced psychological symptoms and triggered crises that had to be addressed virtually. This allowed us to sustain the crises of our patients based on the empathy and affective bond that is established in the psychotherapeutic process.

Although some of us had already tried online intervention taking advantage of technological advances, during confinement it became the only way, or the most practiced by us, and although we try to maintain the technical devices of face-to-face work, it is clear that some underwent changes, one of the most outstanding is the framing, that although it

remained in the basics, it is more subject to being violated because the patient has a part of control over those changes.

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