Ground rules in Online Psychotherapy

(Part One)

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To my parents,

who made this project possible

This work contains 140,000 words since it is based on two researche studies. The first study refers to the common denominator of ground rules in various kinds of psychotherapy and the second refers to the assimilation of ground rules in online psychotherapy.

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Abstract

Online psychotherapy dates from 1995 and is still in its infancy. This research focuses on the therapeutic qualities of online psychotherapy and the role of ground rules in creating a secure frame for the therapeutic relationship in this new medium.

Chapter 1 presents the history of online psychotherapy and a description of the main modalities for therapeutic interaction, namely, e-mail therapy and chat room therapy.

Chapter 2 reviews the literature dealing with the psychotherapeutic relationship, with regard to the definition of ground rules. In this chapter I identify seven categories of ground rules that are common to all approaches to psychotherapy. These categories will serve as a prism in evaluating the options for creating ground rules in online psychotherapy.

Chapter 3 explores the therapeutic qualities of e-mail and chat room therapy according to the seven categories of ground rules. It also presents a survey of 236 therapeutic web sites. According to the findings of this survey, online psychotherapy is not a substitute for face-to-face psychotherapy, although there is a potential for creating a secure frame in a virtual clinic, which does not yet exist.

In Chapter 4 I present my limited experience with online psychotherapy and the virtual clinic which I have developed according to the guidelines of the seven categories of ground rules. It is too early to draw conclusions based on this limited experience, but it opens several options for further research.

Introduction

The Internet is the main medium of the third millennium. It enables hundreds of millions of people to communicate with each other without territorial limitations. The revolutionary advantage of the Internet is not technological. It is the integration of all kinds of communication technologies in a simple device that is available to everyone.

More accurately, the Internet is available to hundreds of millions of people who have computers and access to the Internet and who have sufficient education for written communication. This definition is similar to the definition of Western psychotherapy, which is limited to certain parts of the population, particularly the middle class.

Paradoxically, the integration of the Internet and psychotherapy, which are both limited to certain populations, does not reduce the percentage of people who are suitable for this combination. Online psychotherapy also undermines the stigma and limitations of psychotherapy and extends its boundaries. The sense of anonymity, the low fees, the convenience and the informative manuals enable people who have no access to psychotherapy to experience it for the first time in their lives.

In 1995, when online psychotherapy was first experienced by a few therapists and clients, it aroused wonder and resistance due to fear of innovation and the breaking of the conventional image of psychotherapy. The year 2005 sees online psychotherapy as

an existing fact. Hundreds of therapists offer their services on more than 200 therapeutic web sites, some books and dozens of papers concerning online psychotherapy have been published and the term "online psychotherapy" has become conventional. Nevertheless, it still arouses resistance, mainly on the part of professional therapists who are not familiar with this new option, but also on the part of therapists who are actually doing online therapy.

Researching online psychotherapy is not a simple task. The field is still in its infancy and has no comprehensive definition, theoretical assumptions, valid training or systems for inspection, examination and methodology. There are few therapists, some case studies and limited professional literature. In this early stage of development, any kind of research even subjective introspection by means of questionnaires, would be insufficient.

Research objectives

The main goal of this research is to explore the option of creating a "secure frame" for forming a therapeutic relationship through the Internet. I will do this in four stages:

a. **Description.** This stage (the first chapter of this work) describes the history of online psychotherapy and the main modalities for psychotherapeutic work online and reviews the existing literature.
b. **Potential.** This stage (the third chapter of this work) analyses the technical devices that are available online and their therapeutic qualities, according to the creation of a "secure frame".
c. **Survey.** This stage (the third chapter of this work) reviews all the therapeutic web sites that could be found at the end of 2005 and rates them according to the characteristics of a "secure frame".
d. **Personal experience.** This stage (the fourth chapter of this work) presents my experience with online psychotherapy, especially in an experimental "virtual clinic" that I developed according to the results of my research.

Research methodology

The term "secure frame" refers to the common goal of all kinds of therapeutic approaches, which is the precondition for creating therapeutic relationship and starting the therapeutic process.

The conventional guideline for creating a secure frame for therapeutic relationship is formulated by "the ground rules of psychotherapy". I use the ground rules of psychotherapy as a prism for exploring the adaptation of traditional ground rules in online psychotherapy or for developing new ground rules for the new modalities of online therapy.

In order to do so, I try to define a common definition for ground rules in all kinds of psychotherapeutic approaches. In the second chapter of this work, I review the literature concerning the ground rules of psychoanalysis and psychotherapy, and try to define the common denominator of ground rules in various approaches.

This common denominator serves me as a measure for inspection and for evaluation.

Since the subject of this research is still nascent, it is too early to develop expectations for comprehensive and unequivocal results. Understanding the nature of this developing field and defining its limitations would be a much more realistic aspiration.

Consequently, the presentation of the documentation and findings is phenomenological and elucidates the setting of online psychotherapy from various perspectives.

The main part of my work is therefore descriptive. In the third chapter of this work, I present a survey of 236 therapeutic web sites. In addition to the phenomenological exposition I analyse this survey according to objective and subjective measures of observation.

The resources of information

My experience with online psychotherapy and running online support groups has enabled me to collect data which can be explored in my research. The Internet medium demonstrates special data collection qualities, which have enabled me to save many kinds of therapeutic encounters on my own computer.

In recent years I have collected three kinds of data:

1. **Case Studies of Online Psychotherapy.** These case studies of individual therapy are different from traditional case studies since they are not subjective descriptions written by the therapist. The online case study constitutes a full documentation of the therapeutic process, which can be examined and re-examined by the therapist, the client or any other observer, without this affecting the data. All the case studies involving my online clients are

documented on my computer.

2. **Online Support Groups.** These groups, conducted in online forums ("discussion groups"), differ from one other in the number of participants, the degree of confidentiality and their goals. Like online case studies of individual therapy, in online support groups the whole process is documented. I have collected more than 35,000 messages, classified according to the names of the regular participants, in an open forum for PTSD victims that I have run for the past six years. I have also documented 2,000 messages in a secure forum for a small group of PTSD victims that I run on my web site.
3. **Online Peer Supervision Groups.** Although online peer forums are not "therapeutic", as in any supervision process, therapeutic processes among participants are easily identified. I have collected more than 2,500 messages in a secure professional forum for therapeutic forum leaders in which I have participated for the last four years, while more than 5,000 messages were collected in a secure forum for professional therapeutic discussion.
4. **Information.** The Internet is an extensive source of information and although there are not a lot of printed resources for Online Psychotherapy, I have been able to collect many papers, discussions and cyber-books on this subject. Some books concerning the psychology of the Internet and online psychotherapy have been published during the last ten years.
5. **Therapeutic web sites.** There are more than 200 therapeutic web sites on the Internet. These sites present the actual work of online psychotherapy and constitute a rich resource for observation and analysis.

The huge amount of documented material from my personal experience in support groups and online psychotherapy has helped me shape my view on the subject of my research, while the therapeutic web sites and the literature of online therapy and the therapeutic relationship were the main material for exploration.

The nature of this work

In this research, I describe the history of online psychotherapy, the present situation of online therapy and the gap between the potential therapeutic qualities of the new medium and their actual realisation.

In order to explore ways to create a secure frame for relationship in online psychotherapy I paid special attention to the various components of ground rules and particular modalities of online therapy.

This research is partial and limited and aims to open further fields for exploration and investigation.

Chapter One:

The History of Online Psychotherapy

It is conventionally assumed that professional fee-based online individual psychotherapy started in 1995 (Ainsworth, 2002: 205, Grohol, 2004: 60, Anthony, 2003: 25), but one cannot ignore the context in which this process is still developing, or the therapeutic characteristics of the Internet.

Online individual psychotherapy is a natural development of the rapid increase in online support groups since the 1970s (Grohol, 2004: 54) and free advice-giving by professional therapists in the 1980s (Ainsworth, 2002: 205). It is also an evolutionary process, derived from telephone psychotherapy (Rosenfield, 2003: 93), telephone helplines and psychiatric videoconferencing (Simpson, 2003: 109, Gibson, Morley & Romeo-Wolff, 2002: 69).

Earlier influences on the development of online psychotherapy can be found in computer programmes, which replaced human psychotherapists in the 1960s (Cavanagh, Zack, Shapiro & Wright, 2003: 143), and in the practice of therapeutic correspondence, in the growing field of narrative psychotherapy (White & Epston, 1990, Freedman & Combes, 1996, Monk, Winslade, Crocket & Epston, 1997, Omer & Alon, 1997, Rainer, 1997, Roberts, 1994, Parry & Doan, 1994).

Online individual psychotherapy, therefore, is rooted in the technical and theoretical developments of psychotherapy in the second half of the twentieth century, and can be grasped as a natural outcome of these processes.

The therapeutic characteristics of online relationships

The Internet is not only a technical device that provides a new kind of communication, but also a huge generator of psychotherapeutic processes. Online communication is based on 'virtual communities', which most Internet users have experienced (Horrigan, 2001, Rheingold, 1994, Wallace, 1999). 'Despite the ephemeral and fragile nature of so many forums on the Internet, there is evidence that a very strong sense of 'groupness' does emerge regularly' (Wallace, 1999: 56).

In a way, millions of people do 'group therapy' on the Internet. 'Freud *might* well have said, were he here to take this all in: "It's very easy to find websites, groups, and

online activities and objects to which cathexis can be bound (and through which libido can be sublimated), and the Internet allows for a great deal of ease in free-association, transference, and projection"' (Fenichel, 2004: 6). Virtual communities enable their participants to train in social skills and discover their mental capacities. 'It is apparent that for many people "cyberspace" offers an alternative, of "virtual" reality that can be dissociated from other aspects of daily life' (ibid.: 7).

The interpersonal interactions in virtual communities provoke mental processes that can be therapeutic or destructive. The unique environment of virtual communities, which is based on written communication, anonymity and role play, exaggerates group dynamics and personal changes. In Sherry Turkle's words, 'When we step through the screen into virtual communities, we reconstruct our identities on the other side of the looking glass' (Turkle, 1997: 177). Patricia Wallace explains the existence of our 'online persona' (Wallace, 1999: 14) by claiming that virtual setting is different from 'real life' setting, changing our impression formation and impression management. 'These processes unfold differently in cyberspace because the cues you use to form impressions, and the tools you use to create your own, are quite different than they are in real life' (ibid: 2).

From the early days of online communication, it served as a huge playground. The first online communities gathered in MUDs (Multi-User Dungeons), some kinds of software (like Muse, Moo or Mush) that created virtual spaces where surfers could build their own world, converse with other surfers and navigate between similar virtual worlds. Actually, MUDs supplied the ultimate environment for personal reconstruction.

> MUDs are dramatic examples of how computer-mediated communication can serve as a place for the construction and reconstruction of identity... When people can play at having different genders and different lives, it isn't surprising that for some this play has become as real as what we conventionally think of as their lives, although for them this is no longer a valid distinction.
>
> (Turkle, 1997: 14)

Heidi Figueroa-Sarriera points at the new kind of identity and personality that manifests itself in virtual communication. This phenomenon contradicts the four statements that define personal identity, according to Ignacio Martin-Baro (1985): that identity exists in reference to a world, that it asserts itself in the interpersonal relationship, that it is relatively stable and that it is a product of society and of an

individual's actions. In virtual communities identity is a mask or a means for performance:

> In contrast, the performative model of the self that underlies the notion of symbolic interaction assumes that the identity is a construct that emerges in direct relation to particular circumstances. Identity is seen as "the face" that the subject shows by his or her performance within certain contexts. This leads us to a notion of identity as a strictly circumstantial and contingent construct.
>
> (Figueroa-Sarriera, 1999: 136)

The online environment provides new experiences, which involve mental implications and have psychotherapeutic effects:

> Clearly, a new psychology is emerging. Patterns of interaction are evolving from concepts like netiquette and list protocols. Aggressive, uninhibited behavior is increasing from the anonymity and the absence of social constraints in cyberspace. The self is being split in multiple directions, adopting distinctive identities and roles. Sex is being redefined as an experience of shared fantasies and virtual caresses. The simulation of reality online has become its own, unique process. And anything can happen.
>
> (Fink, 1999: xx)

Many therapists who resist the idea of online psychotherapy adhere to the claim that therapeutic relationships cannot be comprehensive and deep without the clues of non-verbal cues. This claim ignores the rapid expansion of the Internet culture, which is based on textual relationships. Even in face-to-face traditional psychotherapy one cannot understand clients' language and associations without being introduced to the Internet. The experiencing of online communication by hundreds of millions of people makes its mark on psychotherapists as well as on their clients. Virtual reality is part of everyday life, and no one can ignore this phenomenon:

> In a therapy session a few yeas ago, a patient asked me what my opinion was of Internet relationships. My first reaction was that I had no opinion, and even less of an idea of why the patient had asked the question. Invoking the time-honored, and in this case somewhat uninspired, therapeutic strategy of answering with a question, I asked my patient if he thought I ought to have an opinion. With an

> incredulous sigh and a brow furrowed with disapproval, the patient responded, 'Of course you should have an opinion. Do you live in the same world I do?'
>
> (Civin, 2000: xi)

In the new era of online communication, people develop new skills for human interaction, introspection, self-actualisation and improvement of their 'multiple-personality' system. These new skills are affecting the field of psychotherapy in some meaningful ways.

1. Clients are exposed to a wide range of information concerning psychotherapeutic theories and technique. They become more critical and sceptical, and their resistance is 'rooted' in their new online capacities.
2. Boundaries between therapists and clients are more fluid since clients know more about their therapists and can trace their private and professional activities on the net.
3. Therapeutic relationships are less exclusive since clients can be supervised in relation to their therapy by other professional therapists or by other clients in online support forums and in professional 'psychological' forums.
4. Clients can violate a therapist's privacy by exposing her through the net.
5. Therapeutic processes can be accelerated by clients' experiences in online role-play.
6. Some characteristics of online relationships are similar to psychotherapeutic relationships, since anonymity, neutrality and support sometimes qualify the online setting, as in some ground rules of psychotherapy. This means that online surfers are prepared for online psychotherapy.
7. The nature of online relationships involves therapeutic skills in everyday communication and creates psychotherapeutic processes in non-therapeutic situations.

These new characteristics of online communications affect clients and psychotherapists, illuminating certain similarities between psychotherapeutic procedures and online situations.

> MUDs encourage projection and the development of transferences for some of the same reasons that a classical Freudian analytic situation does. Analysts sit behind their patients so they can become disembodied voices. Patients are given

> space to project onto the analyst thoughts and feelings from the past. In MUDs, the lack of information about the real person to whom one is talking, the silence into which one types, the absence of visual cues, all these encourage projection. This situation leads to exaggerated likes and dislikes, to idealization and demonization.
>
> (Turkle, 1997:207)

Similar understandings were concluded from experiments in virtual support groups:

> Transference and Countertransference are important aspects of psychotherapeutic work. The very fact that these groups are held online can change the interactions. For example, because the group members and I do not see each other, members may idealize me or project their fantasies and wishes onto me. Because I am unseen and "mysterious," anger and frustration can be taken out on me more readily.
>
> (Jeri Fink, 1999: 76)

Online relationships are influenced by psychotherapeutic procedures while affecting and changing the nature of psychotherapy. In online therapy the term 'talking cure' is changing into 'corresponding cure' and this process amplifies the significance of 'text relationships' in psychotherapy.

> The Internet makes text relationships more accessible than ever before in history. The unique aspects of text relationships open up new possibilities for online clinical work: reading and writing skills shape the communication; a subjective sense of interpersonal space replaces the importance of geographical space; people can converse with almost anyone online and with multiple partners simultaneously; conversations can be saved and later reexamined; and, the environment is more susceptible to disruption.
>
> (Suler, 2004: 48)

The psychotherapeutic characteristics of online communication and its influences on clients and psychotherapists are demonstrated in the short history of online psychotherapy, which developed from telephone therapy to forum therapy.

Therapeutic correspondence in narrative psychotherapy

Online psychotherapy is naturally based on textual dialogue, which is different by definition from the traditional face-to-face interaction or even from vocal telephone counselling. But textual dialogue, particularly written therapeutic messages, were not invented during the Internet era. It was preceded by the growing field of the Narrative approach in the last two decades. White and Epston (1990), who were the pioneers of the narrative approach, were influenced by Michel Foucault, who 'asserts that those perspectives that become dominant culture narratives have to be challenged at every level and every opportunity, because their function is, in part, to minimize or eliminate alternative knowledge-positions and alternative narratives' (Corey, 1996: 409). David Epston has developed a special use for letters in his style of narrative therapy, or 'storied therapy' as defined by him:

> In a storied therapy, the letters are a version of that co-constructed reality called therapy and become the shared property of all the parties to it. Letters can be substituted for case records.
>
> (White & Epston, 1990: 126)

This formulation of 'storied therapy' can be easily replaced by online psychotherapy, in which textual dialogues 'become the shared property' (ibid.) of both therapist and client, and 'can be substituted for case records' (ibid.). Epston integrates correspondence into the therapeutic process in many creative ways: letters of invitation, redundancy letters, letters of prediction, counter-referral letters, letters of reference, letters for special occasions and brief letters (White & Epston, 1990). These applications of correspondence can be observed and researched in online psychotherapy as well.

Narrative therapists use letters as a complementary technique. 'A common practice in narrative therapy is to write a letter to the client after a counselling session that is intended as a record of the session and also as a means of building on the developments that have occurred during counselling' (Winslade & Smith, 1997: 166). Narrative therapists also claim that letters (i.e., written communication) are better than face-to-face communication. 'Some narrative counsellors have suggested that a well-composed letter following a therapy session or preceding another can be equal to about five regular sessions' (McKenzie & Monk, 1997: 82). 'David Epston has done an informal survey of people who have worked with him in which he found that on

the average they thought a letter was worth 4.5 sessions of good therapy' (Freedman & Combs, 1996: 208). 'David Nylund also did a survey of 40 people who had worked with him. His results showed that the average letter was worth 3.2 interviews' (ibid.). In a way, there is no difference between narrative correspondence and online psychotherapy, and these experiences can be a useful way of learning about the value of online therapy as well.

The importance of letter writing in Narrative psychotherapy is based on the assumption that written texts require a higher state of consciousness.

> Stories take on added meaning and permanence when they are written down. They can be re-examined, changed, and edited. The use of the written word seems to render them "more real" and open to analysis.
>
> (Parry & Doan, 1994: 167)

In narrative psychotherapy, clients are expected to take responsibility for their stories, or to be the authors of their stories. Since ordinary people might be apprehensive about writing stories or exposing their literary skills, writing letters can be a convenient way of freely expressing their narratives.

> Writing letters offers some of the same benefits as structured storytelling in that it is a known form and is not usually seen as a task as large as writing a story. Yet, letters can capture core events and themes of someone's story.
>
> (Roberts, 1994: 106)

Narrative psychotherapy focuses on the therapeutic aspects of the autobiographic process.

> For although therapy is seen as a healing science and autobiography as a literary form, there have always been intimate links between psychotherapy and the restorative powers of personal narrative.
>
> (Rainer, 1997: 14)

As a narrative psychotherapist I have found online psychotherapy the ideal setting for the therapeutic dialogue. Using written messages as the main instrument for creating therapeutic relationships (in addition to occasional online telephone) seemed

a natural move; I am still wondering why online therapy has not become the main stage for narrative psychotherapy.

Understanding the principles of narrative psychotherapy, the uses of therapeutic letters and the techniques of correspondence may clear up some important aspects of online psychotherapy, and also allay the doubts of its opponents.

Although online psychotherapy is not regarded as narrative psychotherapy, it is impossible to ignore its narrative characteristics or the way it has been influenced by narrative psychotherapy.

Psychotherapeutic machines

Online psychotherapy is associated with personal computers and is frequently misunderstood and confused with the concept of psychotherapeutic computer programmes.

In 1966, when the Internet was taking its first steps, computer scientists from Stanford University developed 'a computer program which can conduct psychotherapeutic dialogue' (Cavanagh, Zack, Shapiro & Wright, 2003: 144). During the same year, Josheph Weizenbaum, of the Massachusetts Institute of Technology, developed a software that plays the role of 'Eliza', a Rogerian psychotherapist (Weizenbaum, 1996). Some versions of Eliza can be found on the net. Following is a sample of a dialogue between 'Eliza' and myself.

> Hello, I am Eliza.

* Hi Eliza. Thank you for listening.

> We were discussing you, not me.

* Oh, I'm sorry. I always feel that no one listens to me.

> Did you come to me because you are sorry, you always feel that no on listens to you?

* Yes. I feel that no one is really interested in what I'm saying.

> Do you often feel that no one is really interested in what you're saying?

* Yes, I do. I feel that at home with my family, at work and even with my friends.

> Do you enjoy feeling that at home with your family, at work and even with your friends?

* No no. I am trying to tell you that I hate feeling not understood.

> Do you believe it is normal to be trying to tell me that you hate feeling not understood?

* Do you say that I am not normal?

> How long have you been not normal?

* Why are you blaming me? You don't understand a word I'm saying.

> Why are you interested in whether or not I am blaming you? Me don't understand a word you're saying?

(Eliza, 1999)

There are no similarities between Eliza and online psychotherapy, although both are based on computer communication. 'But what makes this computer program different, however, is that most of the initial *ELIZA* users *thought* they were chatting with another person via the computer screen' (Grohol, 2004: 52). Even today the resistance to online psychotherapy is still based on the assumption that online psychotherapy is 'mechanical', 'cold' or 'inhuman', arguments that could be attributed to the original 'Eliza'.

Kenneth Mark Colby, a psychiatrist from the Stanford University team, developed a more sophisticated software, 'Parry', which could simulate a client in therapy who exhibited paranoid behaviour. 'The Turing test results for *PARRY* showed that both scientists and psychiatrists did no better than chance in distinguishing *PARRY* from real patients' (Grohol, 2004: 53). In the transcript of this therapeutic dialogue the psychiatrist comments: 'This has to be the most persistent and patient paranoid I have ever encountered' (Parry, 1973).

The apparently computerised dialogue in psychotherapeutic software was one of the influences leading to online psychotherapy, but it could not bridge the main differences between the two. Psychotherapy is based on the unique bond between therapist and client, while computer software is not. 'Since by definition a computer program cannot form a person-to-person relationship with a client, this might be taken to imply that computerized psychotherapy cannot possibly be effective' (Cavanagh, Shapiro & Zack, 2003: 168). But the influence of computerised psychotherapy on the development of online psychotherapy was even deeper:

> The importance of *ELIZA* and *PARRY* to online counselling lies in their text-based, interactive nature of communication between human and computer. Researchers discovered not only that individuals could communicate with a computer program and feel as though they were engaging in a conversation, but

> also that they did so easily and without reinforcement. These programs illustrated some of the very first social uses for computers and demonstrated that people would willingly engage in text-based communication for therapeutic purposes.
>
> (Grohol, 2004: 53)

While online psychotherapy has made significant progress since 1995, the development of psychotherapeutic software was limited to self-help programmes for cognitive behavioural techniques like desensitisation, relaxation or problem-solving interventions. Some psychotherapeutic software programmes are presented on the net, pretending to provide online psychotherapy, whereas many other sites offer self-help programmes for mental disorders.

Psychotherapeutic machines are still far from being a reliable substitute for human psychotherapists. There are some psychotherapists who are starting to believe in the future of online therapy, but there are not many who consider the option of therapeutic software as a substitute for the therapeutic relationship.

> Humans need humans. Our interpersonal relationships shape us, ideally for the better. Completely eliminating the therapist's psyche from psychotherapy will be a mistake in many cases. Although computers have some advantages over the human therapist, they are far inferior to people in feeling and reasoning about the human condition. And that's what psychotherapy is all about. Even under the best of circumstances, with very powerful machines, computerized therapy will be second best, most likely limited to highly structured interactions, or to the treatment of mild problems and clients who are healthy enough to cope with a less than fully competent machine.
>
> (Suler, 1999)

Online psychotherapy was influenced and strengthened by the experiences of computerised psychotherapy, which nevertheless remained far behind. Although these two innovative kinds of psychotherapy follow parallel paths, it is most probable that further developments in computerised psychotherapy will change the situation, integrating it into the developing field of online psychotherapy.

Telephone psychotherapy

Although the first telephone service for psychological interventions started in the USA in the early 1900s, such services only became popular in the second half of the twentieth century. On November 2nd, 1953, the first call was made in the UK to '999 for the suicidal', and this date is still the official birth date of the 'Samaritans'.

> At the time, suicide was still illegal in the UK and so many people who were in difficult situations and who felt suicidal were unable to talk to anyone about it without worrying about the consequences. A confidential emergency service for people "in distress who need spiritual aid" was what Chad felt was needed to address the problems he saw around him. He was, in his own words, "a man willing to listen, with a base and an emergency telephone".
>
> (Samaritans, 2005)

Since the 1950s, telephone helplines have become common and non-profit organisations offer telephone help to children, abused women, breast cancer patients, etc. (the Samaritans, Shelterline, ChildLine & CancerBACUP).

> The number of telephone helplines has increased dramatically with nearly 1300 listed in the latest edition of the Telephone Helplines Association (THA) directory. The research showed the advantages of helplines are their accessibility, availability and anonymity. The telephone is also less intrusive and the caller has control, allowing them to disclose issues at an appropriate time and pace.
>
> (One plus One, 2004)

The long experience of telephone helplines has led to professional individual telephone psychotherapy and counselling. Pete Sanders (Sanders, 1996: 4) suggests some types of groups that need this kind of therapy:

1. Single parents and those with young children and no childcare.
2. People with a disability.
3. Older people who may be afraid of going into busy town centres.
4. People living in remote areas.
5. People caring for disabled or infirm relatives.
6. Those who find transport difficult.

7. Those whose personal freedom is restricted by another person such as abused women or children.
8. People on a low income or in receipt of state support who may find that transport costs are higher than the price of a 30 minute phone call.

This list also perfectly describes people who need online therapy, and for the same reasons.

The same arguments against online psychotherapy were made against counselling by telephone (Rosenfield, 1997: 3), but since 1994 the BAC acknowledges telephone counselling through its National Vocational Qualification process (ibid.). It is interesting to note that while online therapy, which is developing fast, is still controversial, telephone counselling is becoming a respectable psychotherapeutic field:

> It seems incredible that as recently as 1997, some practitioners regarded therapy by telephone, anecdotally, as "not real therapy", and even with some derision. Yet today, many practitioners use the telephone for some or all counselling and psychotherapy sessions and also for supervision.
>
> (Rosenfield, 2003: 93)

Telephone psychotherapy, as a precedent to online psychotherapy, is a reliable practice today and as such serves to promote online therapy. 'Telephone therapy has been shown to be a cost-effective, clinically-useful, ethical intervention modality in the research literature' (Grohol, 1997). The characteristics of telephone counselling and its benefits are similar to those of online counselling.

> Stuart Klein, 1997, has hypothesized that the lack of visual cues intensifies the need to listen and the ability to listen. He points out this theory is supported by information processing research. And he notes Lester's (1995) research, which reported the lack of nonverbal cues is nothing new in counseling roles in society. Psychoanalysis, where the analyst sits out of view of the patient, and Catholic confessions are illustrative examples.
>
> (Grohol, 1997)

In 1977, I volunteered for the Israeli helpline for emotional support, where I listened to anonymous callers for four hours a week for five years,. During these years I documented all my dialogues in an attempt to define the therapeutic characteristics

of these encounters. My main finding was that due to the extreme phenomenon of transference (and ground rules) a telephone relationship and trust is created in a very short time. The limited setting and the focus on time restrictions accelerate the therapeutic process and shape the goals and expectations of the client.

> People work more freely when they feel they are not being judged and feel safe and this happens quite early on in the telephone counselling relationship, thus it may take fewer sessions to achieve the goals of the therapy than would face-to-face work.
>
> (ibid.: 108)

My experience as a telephone helpline volunteer and supervisor prepared me naturally for online psychotherapy. On the one hand, my skills as a telephone counsellor served me well for online therapy, and on the other hand, I still integrate Internet telephone into my online therapy practice. Telephone counselling, therefore, was my natural training and preparation for online psychotherapy. While searching the net for online therapy services, I discovered similar processes. Many sites that offer online therapy enable their clients to choose between face-to-face therapy, telephone therapy and e-mail therapy. The adjacency of telephone and online psychotherapy is tuning and shaping the future of online psychotherapy, as can be found in the APA code of ethics.

> Delivery of services by such media as telephone, teleconferencing and internet is a rapidly evolving area. This will be the subject of APA task forces and will be considered in future revision of the Ethics Code. Until such time as a more definitive judgment is available, the Ethics Committee recommends that psychologists follow Standard 1.04c, Boundaries of Competence, which indicates that "In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm".
>
> (APA, 1997)

Telephone counselling and psychotherapy preceded online therapy and contributed to its development. The fast evolution of online technologies integrates telephone and

video communication with online written communications, and it will not be surprising if telephone psychotherapy merges with online therapy in the near future.

Videoconferencing in psychiatry and psychotherapy

The terms 'telehealth' and 'telepsychiatry' have a forty-year history, and the use of videoconferencing in psychiatry has been well researched and documented:

> We conducted a comprehensive review of the telepsychiatry literature from 1965 to June 2003, using Medline, PubMed, PsycINFO, Embase, Science Citation Index, Social Sciences Citation Index and Telemedicine Information Exchange databases. The *Journal of Telehealth and Telecare* was also hand searched for the years during which it was not included on Medline. Key words included telepsychiatry, telemedicine, video-conferencing, effectiveness, efficacy, access, outcomes, satisfaction, quality of care and costs. The first author reviewed article titles and abstracts to decide whether they applied to the theme of effectiveness. Selected articles were pulled, and references were reviewed for potential additional articles.
>
> (Hilty, 2003)

The conclusions of this review were very positive:

> Telepsychiatry appears effective, based on the preliminary data on access to care, quality of care (that is, outcomes, diagnosis and ability for users to communicate), satisfaction and education. It also empowers patients, providers and communities. It is premature to claim that telepsychiatry is cost-effective. Technology and program coordination are important determinants to its short- and long-term viability.
>
> The results of this article appear similar to a review of 66 studies that compared telemedicine with a comparison group with respect to administrative changes, patient outcomes and economic issues. Thirty-seven (56 per cent) suggested that telemedicine had advantages over the alternative approach; 24 (36 per cent) found negative issues or were unable to draw conclusions, and five (eight per cent) found alternatives to be superior.
>
> (ibid)

The Nebraska Psychiatric Institute used videoconferencing for medical consultation, training and education in 1964 (Simpson, 2003: 109). Wittson and

Benschoter (1972) published the first study about the use of videoconferencing for group psychotherapy, which was performed at the same place. Most research of the use of videoconferencing for psychotherapy took place in the USA, Australia and Scotland, testing a variety of therapeutic methods: psychoanalysis, cognitive-behavioural therapy, family therapy and video-hypnosis (Simpson, 2003: 110).

Investigators who compared videoconferencing to telephone counselling and face-to-face therapy didn't find significant differences between the three modes of psychotherapy (Wittson and Benschoter, 1972, Schneider, 1999, Hufford, Glueckaur & Webb, 1999, Day and Schneider, 2002). The findings of some studies regarding therapists' preferences (Nagel and Yellowlees, 1995, McLaren et al., 1996, Omodei and McClennan, 1998, Simpson et al., 2001, Mitchell et al., 2003) show that 'Although therapists often tend to be more cautious about video therapy than clients, this initial reluctance tends to recede with experience and practice' (Simpson, 2003: 116). Simpson (2001) found that clients preferred video therapy to face-to-face sessions:

> Some clients felt that they were more easily able to express difficult feelings via video-conferencing and that the extra distance made them feel safer. Similar results were found by Bakke et al. (2001) who treated two women with bulimia nervosa via videoconferencing, using a manual-based cognitive-behavioural model. Results showed that clients valued the privacy and anonymity of video therapy, and they commented that it was less intimidating than face-to-face sessions.
>
> (Simpson, 2003: 113)

Videoconferencing is the most similar technological-setting to face-to-face psychotherapy, since except for smell, it captures all physical gestures. Nevertheless, due to technical complications and high cost, videoconferencing was not practical for individual psychotherapy in the past. The fast development of the Internet, which makes online video-chat available to all surfers, has changed the whole situation. 'The integration of classic telemedicine and telehealth technologies with the Internet was the next logical step. Now that technology is ready for the merger, its sudden growth is staggering' (Maheu, 2000).

Although it can be assumed that online videoconferencing would be a natural development of the approved telehealth, online psychotherapy is still far from

employing this technique. In 1994-1995, when psychotherapists started using the Internet for therapeutic intervention, written communication was available to millions of surfers while, in 2005, online videoconferencing software and hardware is still complicated. Even online telephony is relatively rare, although it has become more popular in the last two years. This explains why online therapy is still based on written messages, either via e-mail or chat rooms.

Interestingly, psychotherapists' resistance to online psychotherapy can be reduced to the fact that it is not a videoconferencing form of communication (e.g., that it lacks physical cues). The history of videoconferencing in psychiatry could strengthen the development of improved online psychotherapy, which combines written sessions, telephone communication and video-conferencing. But this course of development is not guaranteed, due to psychotherapists' disregard by videoconferencing in individual therapy.

Nevertheless, comparative research on telephone communication, videoconferencing and face-to-face therapy will serve to assess and value the new options of online psychotherapy.

Online psychotherapy offers new horizons for videoconferencing, since it broadens its synchronic (simultaneous) setting with the possibilities of asynchronous (time-delayed) communication. This new kind of communication affects the therapeutic relationship and enables full documentation of the process.

Online self-help groups, support groups and group psychotherapy

The main difference between the Internet and previous means of communication (mail, telephone, radio, television, etc.) is that it enables accessible and simple group communication, which serves as a platform for the creation of online communities.

> Despite the ephemeral and fragile nature of so many forums on the Internet, there is evidence that a very strong sense of "groupness" does emerge regularly, though the magic that creates this in one group but not another is not entirely clear...
>
> Some people develop extremely deep commitments to their online groupmates and the ties may become far stronger than those that link the individual to real-life groups.
>
> (Wallace, 1999: 56, 57)

From its early days the Internet functioned as a support-group for many surfers in various ways (Colon & Friedman, 2003: 60).

1. From the 1960s to the 1980s, before the creation of the Web, the Usenet functioned as a discussion area, in which numerous newsgroups were conducted.

> Newsgroups are also public discussion forums on the Internet. Unlike mailing lists, you access them through special software called a "news reader"... Newsgroups' advantages over mailing lists are that the format naturally supports 'threading'. A threaded discussion is one where you can read all of the messages on a particular topic more easily because they follow one another in order under that topic's title.
>
> (Grohol, 1999: 9).

Newsgroups with the suffix 'alt.support' were dedicated to peer support groups, and 'thousands of people participated, and continue to participate in this mutual aid community' (Colon & Friedman, 2003: 60). One of the first online support group, alt.support.depression, started on the Usenet, and until 1995, hundreds of such groups founded. (Grohol, 2004: 55).

2. The use of personal computers in the 1970s was followed by the world's first BBSs (Bulletin Board Systems). 'A bulletin board is a program or location on the World Wide Web in which participants can read and write messages at any time that can be read by any other participant. The messages remain for the duration of the group, posted sequentially and usually organized by topic' (Colon & Friedman, 2003: 60). The BBSs increased rapidly. '*Boardwatch* magazine estimates that sixty thousand BBSs operated in the United States alone in 1993, fourteen years after the first BBSs opened in Chicago and California' (Rheingold, 1993: 9).
3. Bitnet Relay Chat was used from the early days of the Internet, and enabled users to correspond in real-time (synchronous). It became a practical instrument for the public in 1988, when Jarkko Oikarinen (Oikarinen, 2000) developed the IRC (Internet Relay Chat), a multi-user programme for group communication.

> Text-chat allows you to communicate dynamically with somebody in realtime via the Internet. Whereas Email requires that you send a message in a big chunk, text-chat communications proceed line by line.
>
> (Zack, 2004: 106)

Actually, an online chat imitates a face-to-face conversation. There is only one essential difference: the text stays there, on the screen, as silent witness to the whole process.

> Although some rooms open up for a short time and then disappear, many have been in existence for years. Conversations go on 24 hours a day, 365 days a year, and the "regulars" bearing well-known nicknames, frequent the places.
>
> (Wallace, 1999: 6)

4. Mailing lists (listservs) are different from chat rooms, in that they constitute asynchronous correspondence and can be 'moderated' (the group 'moderator' can read the message and aprove its content before it is published).

> A mailing list is a private email subscription in which each subscriber receives a separate copy, via email, of each message that is posted, either in individual or digest form each day, week or month. Through these messages members can maintain ongoing communication with other list members who share a particular diagnosis or common concern.
>
> (Colon & Friedman, 2003: 61)

5. The 'forum' has been the main platform for online groups since 1996, and several hundred thousand forums function as self-help groups. The forum integrates the characteristics of a chat room and a BBS, and it can be synchronous or asynchronous. Threads in a forum are either flat (posts are listed in chronological order) or threaded (each post is made in reply to a parent post).

Online groups can be 'open' to all surfers, who can be anonymous and choose a pseudonym, or secured by password to a group of recognised members. Some of them

are dedicated to a special topic, which is shared by all members (cancer, depression, etc.), and some reflect the characteristics of the members (students, single mothers, etc.).

Online self-help groups preceded online psychotherapy by two decades. These groups were helpful for people who could not attend traditional meetings, due to physical disability, transportation difficulties or lack of a suitable face-to-face group. Online self-help groups offer 24-hour availability, anonymity, and accessibility from home:

> The last few decades have seen an enormous growth of self-help groups. The principle at the core of this approach is the sharing of experiences, strengths and hopes between members in order to solve their common problem. These groups offer both an alternative and adjunct to the traditional psychotherapy approach. A summary of what online self-help groups offer its members is provided by Madara (1990). Madara explains that social support, practical information, shared experiences, positive role models, helper therapy, empowerment, professional support, and advocacy efforts are all factors that operate online, just as they do in face to face groups.
>
> (Castelnuovo & Gaggioli, 2003)

Although some researchers claim that it is still difficult to conduct qualitative research, concerning self-help groups (Eysenbach, Powell, Englesakis, Rizo and Stern, 2004), most research studies identify the phenomena of online self-help groups as a substitute for professional help.

> In general the effectiveness of online self-help groups is high: different researchers proved their efficacy as support tools in the treatment of eating disorders (Zabinski, Pung, Wilfley, Eppstein, Winzelberg, Celio and Taylor: 2001, Celio, Winzelberg, Wilfley, Eppstein-Herald, Springer, Dev, and Taylor: 2000), depression (Dyer, K.A. and Thompson, C.D.: 2000) and headache (Stroem, L., Pettersson, R. and Andersson, G., (2000).
>
> (Castelnuovo & Gaggioli, 2003)

Online support groups were developed at the end of the 1990s, facilitated by trained group leaders. They have usually been sponsored by official organisations. Yvette Colón (Bellafoire, Colón & Rosenberg: 2004) facilitated an experimental

group in 1993 for people who committed to participating in a three-month online psychotherapeutic experiment for eight participants. Participant feedback indicated that most felt the groups had helped (ibid., 198). Colón continued with support groups for cancer patients and caregivers, on bulletin boards and listserv.

> An informal data analysis of this inventory indicated that participants' psychosocial distress, especially anxiety and depression, lessened over the span of the group. Overall, participants found the online group experience to be a positive one.
>
> (ibid.)

Donna Bellafiore (ibid.) started a self-help group in 1998 for people dealing with infidelity. It was an 'open' bulletin board, operating 24-hour a day, seven days a week. In a short time there were more than 900 participants daily. In 2001, due to disruptive and destructive behaviour of some participants, Bellafoire changed it to a traditional membership group.

Online group psychotherapy, run by professional therapists was the last stage in this development, preparing the ground for online psychotherapy.

> On-line self-help support groups were the precursor to e-therapy; the enduring success of these groups has firmly established the potential of computer-mediated communication to enable discussion of sensitive personal issues. Local computer bulletin board systems began to develop not long after the introduction of the first personal computers in 1976; it is not unreasonable to assume that small, informal support groups gathered on some of them.
>
> (Ainsworth, 2001)

The growth in online groups, most of which function as self-help groups, makes a significant change in the international culture of the third millennium. This change cannot escape the psychotherapeutic community, signs of which can be found in the slow adaptation of psychotherapists to the Internet era.

> What all of these online forums shared was the ability to bring together individuals from around the world into a virtual community. Although the technologies of these communities differed significantly, their basic social underpinnings were similar, bringing together people from around the world to

> communicate through computers. People found it simple, rewarding, and nearly limitless in its potential to change many social conventions.
>
> (Grohol, 2004: 57)

Experiencing online support groups and online group psychotherapy, therapists started to discover the new setting. Although online groups are different from face-to-face groups, as it is difficult to identify the presence of participants who are not active, therapists could examine the differences and the similarities of the two modes:

> Therapists who have worked in an online setting are usually surprised at how quickly and how much they can learn about clients through the written word. Emotions and feelings become easily recognizable. The therapist can often discern when a client is ill, intoxicated, or depressed, and may even uncover untruth by "reading between the lines". Therapists have discovered that levels of intimacy and trust may be greater because participants feel more comfortable disclosing and discussing their most intimate concerns. In asynchronous communications, clients are able to give the time and thought to their writings, which provide richer and more meaningful responses.
>
> (Bellafoire, Colón & Rosenberg: 2004)

These new experiences with work groups prepared psychotherapists for the previously threatening idea of online psychotherapy and served as preliminary training for future online psychotherapists.

Online free advice-giving

The Internet is the main source of information for the 'global village' and it naturally enables clients to learn more about psychotherapy, mental illnesses, their own feelings and their therapists.

Where a need appears, there is always someone to fulfil it. Support groups, facilitated by professional therapists, were the first source of psychotherapeutic information. In a way, the Internet replaces traditional publishing procedures, and enables psychotherapists, as well as anyone else, to publish their material directly for their clients without the mediation of a publishing house.

It is difficult to know when psychotherapists started to interact with clients online, since this sort of professional communication is confidential. One can assume that when therapists started offering their services on the net in 1979, 'when the first national online services (The Source and CompuServe) allowed nationwide online communication for personal computer users' (Ainsworth, 2002: 205), clients started asking them for their advice. The first organised service providing free advice-giving by psychotherapists through the Internet was at Cornell University in Ithaca, NY. Jerry Feist, the Assistant Dean of Students and former Director of the Cornell Counselling Center, and Steve Worona developed a system named 'Dear Uncle Ezra':

> Two dozen public computer sites around campus provided free access to students to ask and read *Uncle Ezra* inquiries (as a part of the campus-wide Cornell University Information System, Cuinfo). The queries were answered by university workers and posted on the university's proprietary computer system for all to read. The service (still in use, having been transferred to the Web in the 1990s) is free but only provides simple, advice-driven answers; in-depth consultations aren't available through the system.
>
> (Grohol, 2004: 58)

John Grohol, the author of *The Insider's Guide to Mental Health Resources* (Grohol, 1999), wrote the first professional guide to the virtual world. A graduate student in psychology, he formulated an intimate relationship with the net in 1991 by answering mental health questions when participating in a Usenet newsgroup. He created the first online index of mental health support groups and, in 1995, he established his own site, Psych Central, and started a free weekly chat (psychcentral.com/chats.htm) that continues to this day.

Ivan Goldberg, a psychiatrist and psychopharmacologist, started to answer online questions about the medical treatment of depression in 1993. He did this as unofficial advisor to an online depression support group, 'Walkers in Darkness'. In 1996 he created his own site, 'Depression Central'.

The charity organisation, 'the Samaritans', has given free-advice over the telephone since 1953. In 1994, they set up an e-mail address to answer e-mails from suicidal individuals worldwide. In 2003 this e-mail service replied to 99,000 queries (Samaritans, 2003).

Free advice-giving can be technical, cold and formal, efficient and impersonal, as is the case in many non-therapeutic free-advice online services. Psychotherapeutic

advice-giving has always involved emotional aspects and no advice can escape a kind of therapeutic intervention. The tendency towards therapeutic intervention is a trap for therapists who give advice through the Internet but, at the same time, it serves as a natural process of involvement in online therapy. I can testify to my own experience in such a situation.

In 2000, together with a psychiatrist, I facilitated a public forum for psychiatry and psychotherapy. The forum was part of a 'doctors' site, one of dozens, led by professional health experts. Although the psychiatrist's answers were phrased in unambiguous, impersonal messages, I could not avoid being empathic, responding to personal needs and encouraging relationships and support between participants. Within a short time this open forum became a dynamic group with psychotherapeutic characteristics. This was my first introduction to the therapeutic aspects of online relationships, and it subsequently shaped my skills as an e-therapist.

For the last four years, I have participated in a forum for professional psychotherapists, most of them clinical psychologists who volunteer as facilitators for 'psychological' public forums. There are no more than two or three online therapists in Israel (myself included), and most of the psychologists are resistant to the idea of e-therapy. Our forum has about forty members, most of whom reject online therapy. Nevertheless, their experiences with online support groups and their coping with inevitable therapeutic intervention, have diminished their prejudices and have brought them closer to some manifestations of online psychotherapy. Some of them integrate e-mail exchange with face-to-face psychotherapy, or create therapeutic relationships with new clients through online correspondence.

On the other hand, contemporary clients are more educated, and online psychotherapeutic information causes them to be better prepared and ready to start therapy. They have wide knowledge of therapeutic approaches and techniques and are aware of the differences between various kinds of therapists. Online self-help groups and online support groups introduce them to therapeutic processes and allow them to learn from other participants' experiences. They can even consult with professional therapists or group members about their own therapist's work and capacities. Sometimes, this well-informed and semi-professional knowledge can interfere with face-to-face traditional therapy, and therapists must be prepared for a new generation of clients.

Online free-advice giving is changing the world of psychotherapy. It not only influences the attitude of conservative therapists towards the fast evolution of online

therapy but also has implications for therapeutic relationships in traditional settings. Educated clients need more educated therapists and the role of therapists as professional authorities is being replaced by more egalitarian relationships.

Online fee-based psychotherapy

In the 1990's the Internet moved into the commercial era and, naturally enough, psychotherapists, like many others, would try to reap financial benefits from their efforts in this area.

Martha Answorth (2002: 205) claims that the first fee-based mental health services started in 1995, while John Grohol (2004: 59) believes that it all started in 1994.

> There was no single "first" psychotherapist who began offering his or her services online for a fee; many professionals began around the same time in different parts of the world. A few therapists, however, are repeatedly mentioned and recognized as being among the first online counselors.
>
> (Grohol, 2004: 59)

The first fee-based services were similar in style to online advice-giving ('mental health advice'). They offered answers to all types of questions for a small fee. Dr. Leonard Holmes was the first to offer 'Shareware Psychological Consultation', meaning that he answered questions by e-mail on a 'pay if it helps' basis. The service was based on a single interaction and did not establish a 'therapeutic' relationship. Two other services were launched at the same time, namely 'Help Net' and 'Shrink Link', which also offered fee-based mental health advice.

Dr. David Sommers was the first online psychotherapist to offer an ongoing therapeutic process through the Internet. From 1995 through 1998 than 300 clients from all over the world utilized his services (Ainsworth, 2002: 206). His practice was based on e-mail correspondence, real-time chat (IRC) and video-conferencing.

Ed Needham was the first therapist to work exclusively as a chat-room therapist. In August 1995, he started his site, 'Cyberpsych counselling service', charging $15 per one-hour session. From 1995 to 1998 he worked with 44 clients, but in 1998 he closed his online service.

Richard Sansbury started his online practice in 1997 and, to this day, provides e-mail therapy for 1$ per minute of his writing time (www.headworks.com).

I have been practising online psychotherapy since 1999. I started with e-mail therapy, experienced chat-room therapy and developed a virtual clinic, which is a

special forum that is meant to be a 'secure frame' for the therapeutic process (sometimes integrated with online phone). I practice 'forum therapy' in a way that is similar to my face-to-face practice and my online fees are almost identical with my face-to-face fees.

Following the steps of the pioneers in fee-based online psychotherapy, many other therapists became involved in online therapy, and founded online clinics.

> In the fall of 1995, when I did my own search, I found 12 e-therapists practicing on the Internet. My database has now grown to include over 300 private-practice Web sites where e-therapists offer services and the newer "e-clinics," which represent, collectively, nearly 500 more e-therapists. And the number is growing.
>
> (Ainsworth, 2002: 206)

The evolution of e-clinics enabled many therapists, having no knowledge of online technologies, to join the new venture for a considerable monthly fee. On the other hand, clients could visit these sites and choose the appropriate therapist from a list of online therapists. Some e-clinics, like 'HelpHorizons.com' (www.helphorizons.com) and 'Find-A-Therapist' (www.e-therapyelper.com) are still operative, while other e-clinics, like LifeHelper.com and etherapy.com could not afford the huge investments involved and closed down.

In 1997, professional online therapists and consumers, like Martha Ainsworth, founded ISMHO (International Society for Mental Health Online), to promote online psychotherapy. In June 2005 there were about 200 members. Members use ISMHO's logo as a stamp of approval on their private sites.

The increase in online therapy sites at the end of the 1990s, was followed by a decrease at the end of the dot.com. period.

> Today, e-therapy has found a niche. It is not a large niche, nor one that will attract millions of dollars in investment capital. Some small online networks of mental health practitioners continue to thrive and will likely gradually grow as more and more people learn of the benefits of online mental health services.
>
> (Grohol, 2004: 65)

My experience has taught me that the slow progress of online psychotherapy is the consequence of most conservative psychotherapists' ingrained resistance to it. It is not coincidental that ISMHO includes consumers and therapists. Clients play an indispensable role in the development of online psychotherapy. Clients' satisfaction is the main fuel for the progress of this new field. Martha Ainsworth (2001), in her pioneering site (ABC of Internet Therapy: Metanoia.org), offered advice for e-patients and e-therapists.

> Over the course of 4 years, I have offered on my site a consumer satisfaction survey, which has yielded some interesting information. In May 1999, out of 619 total responses, 452 respondents (73%) had tried e-therapy. Of those, 416 (92%) said that it had helped them, and 307(68%) said that they had never been in therapy before contacting a therapist via the Internet.
>
> (Ainsworth, 2002: 208)

The methods of online psychotherapy

Since 2005, the Internet has made it possible to imitate face-to-face psychotherapy, moreover, there are no longer any technical limitations regarding therapists' and clients' communication through videoconference.

However, videoconferencing does not actually play a central role in online psychotherapy and although online telephony is also accessible to all Internet surfers, most therapists and clients prefer written interaction.

This is a paradoxical phenomenon. On the one hand, the main argument that is generally presented against online psychotherapy by most online psychotherapists is its lack of physical cues. On the other hand, they tend to stick to written communication. This can be explained by therapists' conservatism, their fear of new technical devices or their clients' preference for written sessions.

> As broadband Internet connections become available to more consumers, videoconferencing and Internet phone are increasingly available. Even so, many consumers continue to prefer the nonvisual, nonvoice, low-tech environment of e-mail and chat, finding it easier to communicate about sensitive issues without visual or voice connection.
>
> (Ainsworth, 2002: 207)

The natural and basic environment of the Internet is textual (e-mail and chat room) and it is reasonable to assume that online psychotherapy will also be based on text. It could have been changed and extended to other ways of communication in accordance with the technical development of the Internet, but it has definitely ignored these possibilities and stuck to the written setting. I assume that the textual option was chosen for its special qualities, which were exposed accidentally due to the nature and history of the Internet. I will attempt to explore this phenomenon later.

The textual nature of online psychotherapy is realised in three main types of online settings. The first one is based on asynchronous communications by electronic mail (e-mail), and the second is based on synchronic communication through a chat-room. The third integrates both e-mail and chat therapy, functioning in support groups or group psychotherapy but not in individual therapy.

1. Chat room psychotherapy.

This form of online psychotherapy imitates the linear dialogue and the time limitations of face-to-face psychotherapy. It is based on a synchronised dialogue between therapist and client, e.g., for fifty minutes once a week, at a fixed time. Chat software programmes are based on a split screen. On the upper screen both therapist and client can read the last sentences of their dialogue and on the lower part each of them can type his next sentence. Clicking the 'enter' key sends the text to the upper screen, but participants cannot send more than one paragraph at a time. There is another option for chat programmes whereby both parties can see everything they type as it is type it, including mistakes and corrections. This architecture influences the nature and tempo of the dialogue, which is based on a swift and segmented process. Due to the nature of chat room therapy, the therapeutic process always focuses on the last sentence, or the last minute (the 'here and now') and demands concentration, active participation and an immediate response, all of which make the option of 'evenly-hovering attention' (Freud, 1912: 324) impossible. It could be like the following fictional dialogue:

Therapist: This is the first time you are talking about your father.

Client: I didn't mean to, well, I did and I didn't. I mean, I didn't want to talk about him today, and now that you're asking I can't think about anything else. :(

Therapist: I see..

Client: No, YOU DON'T.

Client: I hate this 'I see'! He always said that, when I needed his advice. He would never tell me what he thought, never support me. He'd just sit there, like

you, saying nothing and then this cold and distant 'I see'. (I can see you now sitting on your chair, playing Solitaire while listening to me, and saying 'Aha', or 'I see', so I think that you're listening, but you aren't).

Therapist: That was a very powerful and touching image of your father and the way you direct your anger at me. While reading, I momentarily felt like your father, experiencing the frustration of wanting to hug you and at the same time being scared of your reaction.

While this sort of dialogue is based on support and empathy, referring to the 'here and now' situation, there is no room for silence, and it is difficult to 'bracket' (Spinelly, 1989: 17) spontaneous feelings and just 'be with' the client. This condensed situation can prevent listening, reflecting, containing and interpreting. The chat programme does not create a feeling of a 'secure frame' since it is impersonal, with no special characteristics that can resemble intimacy, privacy, exclusivity and confidentiality: Thus, it could be compared to a therapeutic session taking place in a coffee shop.

There is an essential difference between chat room therapy and face-to-face therapy. Written interaction is by definition a conscious process and as such it is more intense and deep. The written text stays there, on the screen, a silent witness to the whole process, and both parties can read it all again and again. They can also 'save' the text to their computers and document the whole process. The documentation replaces the classical case study with the exact data of the session and is not subjective as are classical case studies.

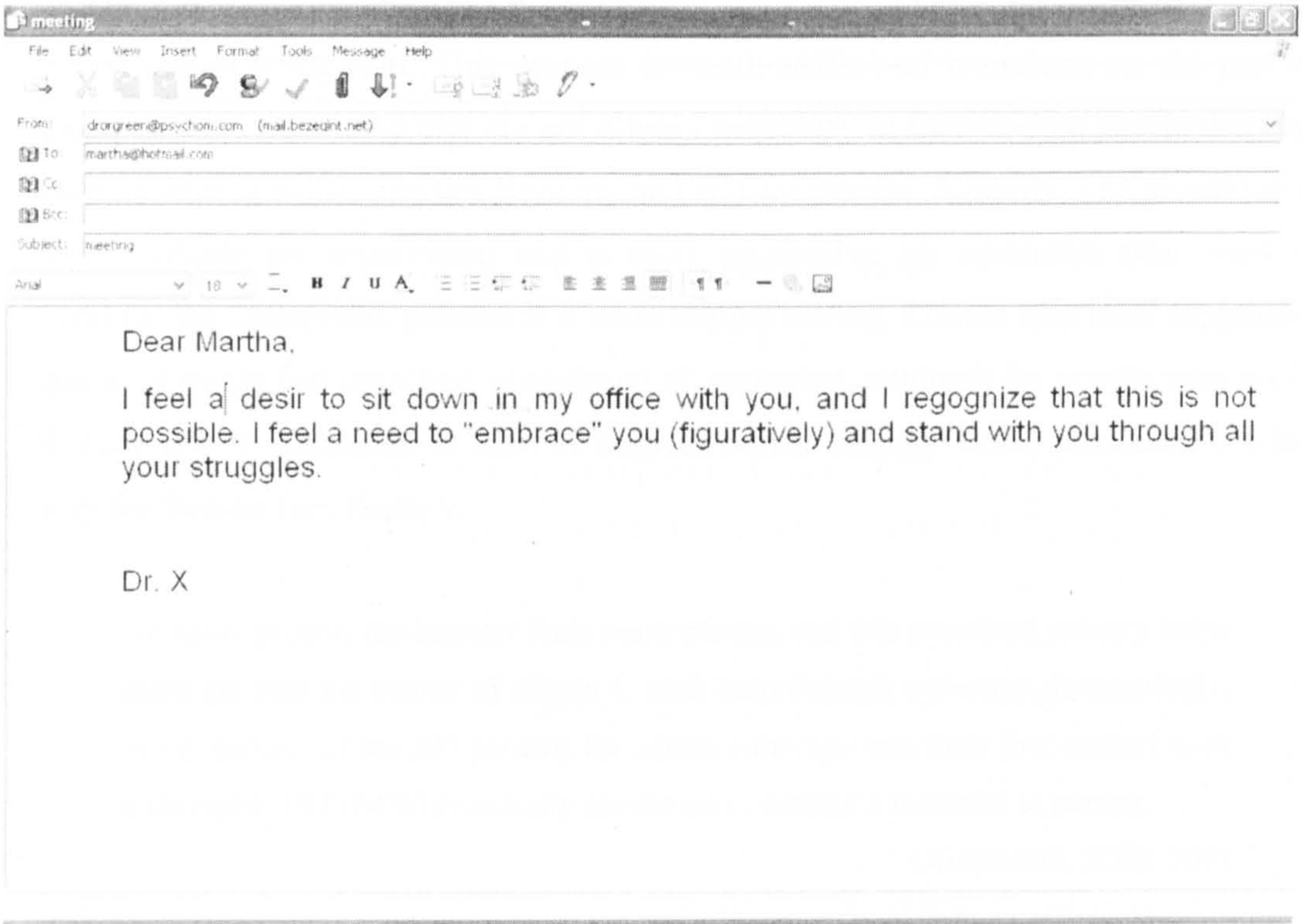
2. E-mail therapy.

E-mail psychotherapy is the main setting for online psychotherapy. It consists of a written correspondence between client and therapist; in fact, there is no principal difference between e-mail therapy and the use of therapeutic letters in narrative therapy. E-mails have some advantages. First, sending an e-mail is cost free. Second, they are received almost immediately. This means that a therapist can promise to send an e-mail to his client at an exact time. Third, e-mail correspondence can be confidential, so that no one knows about or sees the correspondence. A copy of each e-mail is kept in the sender's computer and the whole correspondence is documented on both parties' computers.

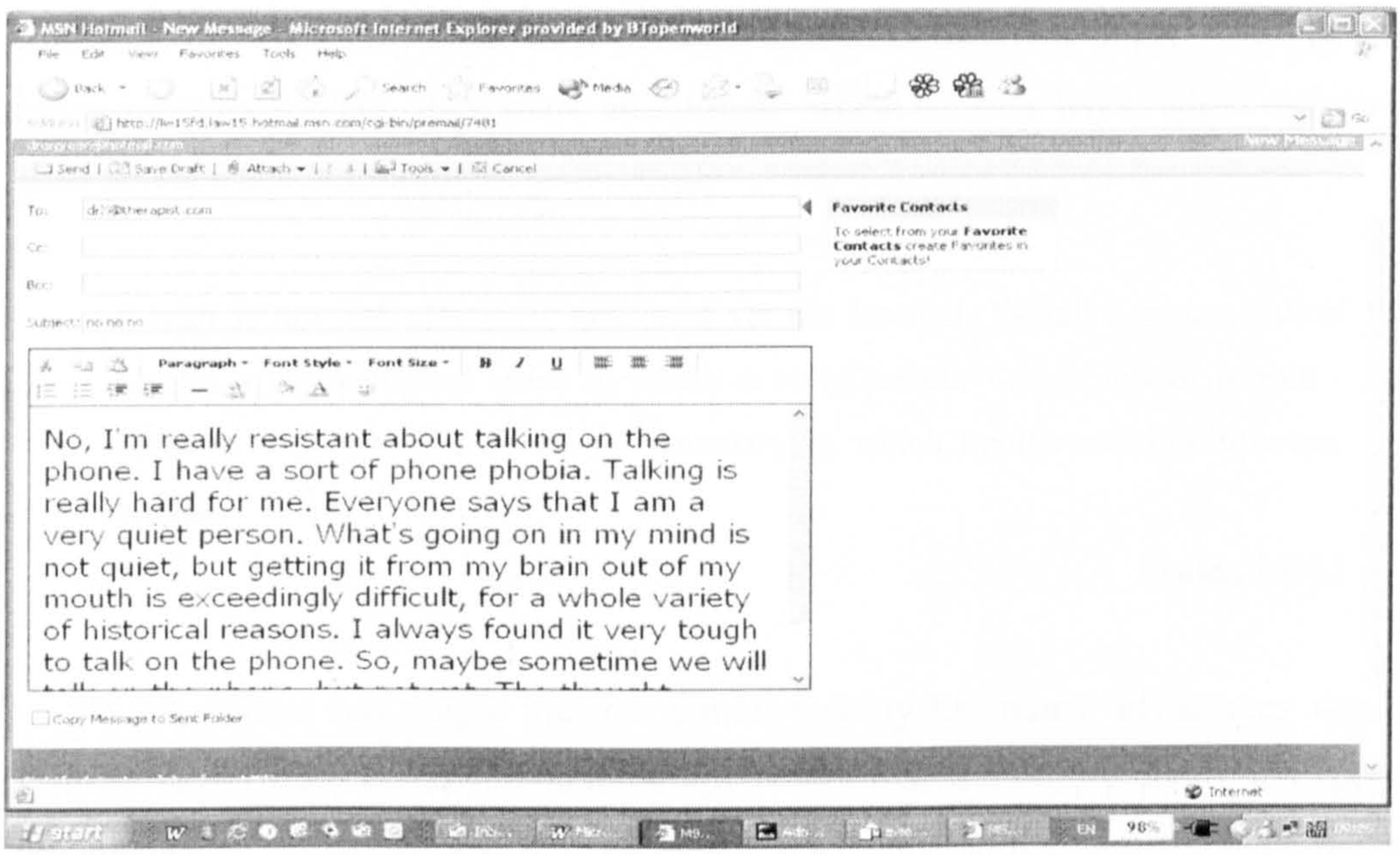
E-mail therapy is an asynchronous interaction, which is entirely different from face-to-face therapy. Actually there is no real dialogue, but an exchange of two

monologues. There are different time frames, different settings and different personal processes.

There is no shared setting for e-mail psychotherapy. Each participant uses his own e-mail software, which has a particular design and form. While the therapist might use Outlook Express,



the client could reply with Hotmail.



This is a parallel communication in which there are two sets of therapeutic environments. Each participant saves the therapeutic message on his private computer, under his own control. At the same time, each participant knows that the other keeps the same information in another computer that is less secure as far as he is concerned.

There is no spontaneity in e-mail therapy and each e-mail is probably re-read and edited before being sent. This process demands skills and intentions on the part of therapist and client alike that are not always necessary in face-to-face psychotherapy, such as writing skills, analytic thinking and self-awareness. Actually, this technique is more suitable for supervision and is more productive for ex-clients who want to continue the therapeutic process in a more remote setting. Clients who need support or guidance might feel detached, abandoned or neglected, although for people who avoid therapy due to questions of trust or stigma, e-mail therapy could possible pave the way for face-to-face therapy.

> To many people, the Internet feels more private, and this perceived privacy helps them get past the barrier of stigma to seek help through e-therapy. Interestingly, in my survey, of the 307 persons for whom e-therapy was their first contact with a therapist, 197 (64%) eventually moved on to consult a therapist in person.
>
> (Ainsworth, 2002: 209)

E-mail psychotherapy differs from face-to-face or chat psychotherapy in that it creates a new type of communication. It can be compared to two people sharing a notebook in which they write their personal diaries at different times. Although they never meet each other, they share an intimate aspect of their lives, while maintining their privacy and autonomy.

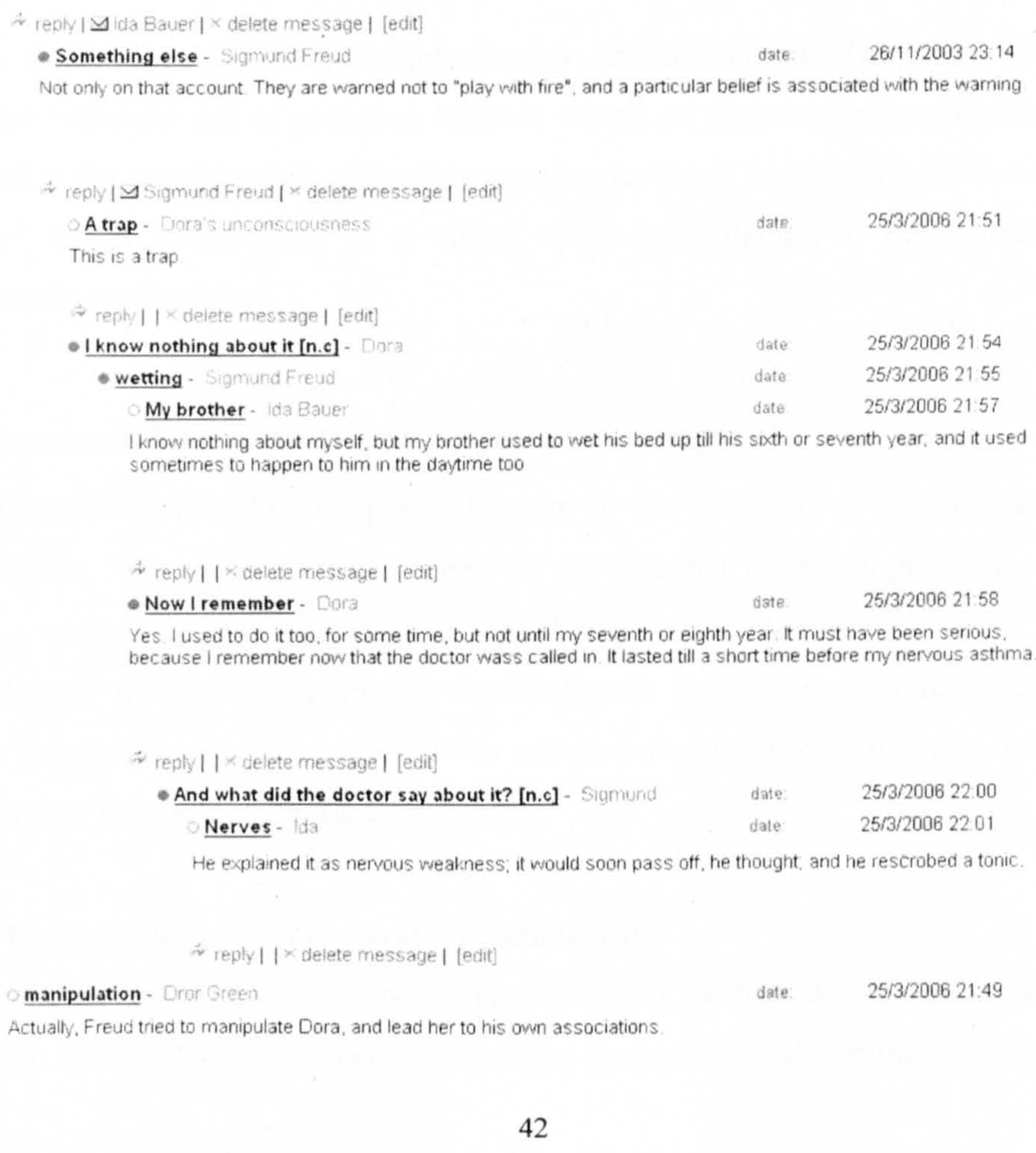
> E-mail is not just electronic mail sent via the Internet. E-mail communication creates a psychological space in which pairs of people - or groups of people - interact. It creates a context and boundary in which human relationships can unfold.
>
> (Suler, 1998)

My experience has taught me that e-mail therapy has many advantages when it follows face-to-face therapy. When therapy is terminated abruptly due to unexpected circumstances, e-mail therapy is a practical tool for concluding the therapeutic process

and preparing for separation. In other cases, e-mail psychotherapy creates a secure framework for people who need to preserve their anonymity. In most cases these are professionals who cannot contact other therapists due to parallel relations in the intimate professional milieu of a small country. E-mail psychotherapy is characterised by the special qualities of online psychotherapy. Written narratives create a high degree of self-awareness. The text, as objective data, has a new status in the psychotherapeutic process. The equal access of both therapist and client to past narratives, which are kept on their computers, create a new kind of therapeutic relationship.

3. Discussion group therapy.

This option serves online support groups or online group psychotherapy and preceded individual online therapy, as described above. Discussion groups, or forums, integrate the qualities of chat room and e-mail therapy. They provide an organised space in which information can be stored and easily retrieved. Participants can ask a question or send a message to other participants, while all messages are documented in the same order. Some forums are linear, i.e., all messages are presented successively one after the other in chronological order. More sophisticated forums


reply | Ida Bauer | × delete message | [edit]

● **Something else** - Sigmund Freud date: 26/11/2003 23:14

Not only on that account. They are warned not to "play with fire", and a particular belief is associated with the warning

reply | Sigmund Freud | × delete message | [edit]

○ **A trap** - Dora's unconsciousness date: 25/3/2006 21:51

This is a trap

reply | | × delete message | [edit]

● **I know nothing about it [n.c]** - Dora date: 25/3/2006 21:54

● **wetting** - Sigmund Freud date: 25/3/2006 21:55

○ **My brother** - Ida Bauer date: 25/3/2006 21:57

I know nothing about myself, but my brother used to wet his bed up till his sixth or seventh year, and it used sometimes to happen to him in the daytime too

reply | | × delete message | [edit]

● **Now I remember** - Dora date: 25/3/2006 21:58

Yes. I used to do it too, for some time, but not until my seventh or eighth year. It must have been serious, because I remember now that the doctor wass called in. It lasted till a short time before my nervous asthma.

reply | | × delete message | [edit]

● **And what did the doctor say about it? [n.c]** - Sigmund date: 25/3/2006 22:00

○ **Nerves** - Ida date: 25/3/2006 22:01

He explained it as nervous weakness; it would soon pass off, he thought, and he rescrobed a tonic.

reply | | × delete message | [edit]

○ **manipulation** - Dror Green date: 25/3/2006 21:49

Actually, Freud tried to manipulate Dora, and lead her to his own associations.

have the architecture of a catalogue tree. Each member can send a new message, which is then presented as a new branch of the catalogue tree and each participant can reply to this message in a hierarchical order. Each message indicates the time it was sent and participants can reply to new and old messages whenever they decide to do so.

Discussion groups are located on a remote computer on the web, which is not dependent on the therapist's or participants' computers. This special architecture enables both synchronous and asynchronous communication. There can be scheduled sessions, when participants and therapist communicate in real-time, while participants can reply to messages or read previous messages at any time.

The characteristics of discussion groups, or forums, integrate the advantages of chat room and e-mail communication, and they seem to create an appropriate setting for online psychotherapy, which could replace the aforementioned two common types. This has not yet happened. Chat room and e-mail programmes are more accessible; furthermore, psychotherapists are accustomed to them. A secure forum (with a password) for private use is available to therapists, but adjusting it to therapeutic uses might require an investment of time and money.

These three types of online psychotherapy are text-based. They all represent a psychotherapeutic use of common Internet means of communication, which are not adapted to the special needs of the therapeutic encounter. Later I will present the 'New Forum', which I developed as a virtual clinic and adapted to the demands of a therapeutic environment.

Controversial aspects of online psychotherapy

The adaptation of traditional psychotherapy to the new era of the Internet is not self-evident. The technological aspects of the Internet (and computers in general) evoke a wide range of resistance from both therapists and clients.

Although the psychotherapeutic establishment is becoming more accepting of online psychotherapy, it is important to examine the arguments for and against this new kind of psychotherapeutic environment.

Body language and the therapeutic relationship

The main argument against online psychotherapy is the lack of eye contact and body language. Many clients and therapists believe that non-verbal communication, and its

interpretation by the therapist, plays a central role in the therapeutic situation.

> As complex and meaningful as text communication can be, it lacks the amount of robust and rich information that can be conveyed via the integration of talking, facial expressions, voice intonation, body language, and physical contact.
>
> (Suler, 1998b)

This is true. There is no non-verbal communication in online psychotherapy, as it is based solely on textual dialogue. However, some online therapy experts believe that this is not a disadvantage:

> In the typed text of e-mail, you can't see other people's faces or hear them speak. All those subtle voice and body language cues are lost, which can make the nuances of communicating more difficult. But humans are creative beings. Avid e-mailers have developed all sorts of innovative strategies for expressing themselves through typed text. A skilled writer may be able to communicate considerable depth and subtlety in the deceptively simple written word. Despite the lack of face-to-face cues, conversing via e-mail has evolved into a sophisticated, expressive art form.
>
> (Schneider, 1995: Chapter Two)

Body language is part of any sort of human relationship, and it is not unique to the psychotherapeutic relationship. The conditioning of body language and psychotherapy is natural and self evident, but it has nothing to do with the therapeutic situation, which is different from any other human interaction. Psychotherapeutic relationships are synthetic and artificial, and serve as a laboratory for investigation. Eye contact and body language can be investigated as part of this artificial intercourse, but they are not, in themselves, the goal of the psychotherapeutic process.

Sometimes, the physical dimension of psychotherapy is diminished as part of the theoretical assumptions. The main characteristics of Freud's psychoanalytic setting (neutrality, transference, and the couch) do not involve physical interaction. Freud's setting is a non-physical situation, in which body language plays no role at all. The couch indicates the boundaries of this non-physical setting, prevents visual and physical contact between patient and analyst and provides a neutral platform for free association and 'pure' transference.

> Since, while I listen, I resign myself to the control of my unconscious thoughts I do not wish my expression to give the patient indications which he may interpret or which may influence him in his communications. The patient usually regards being required to take up this position as a hardship and objects to it, especially when scoptophilia plays an important part in the neurosis.
>
> (Freud, 1913: 354)

Actually, Freud could not eliminate all aspects of physical interaction, such as space, smell and voice intonation. Freud ignored these aspects of physical interaction, and one may guess that he would be interested in neutralising them in order to create the ultimate neutrality. By that he could explore the role of transference in a neutral scientific environment.

Since such an environment was impossible in Freud's times, it was forgotten, and pure transference was never achieved or explored. Later developments in psychoanalysis were focused on 'real relationship' (Greenberg and Mitchell, 1983: 156), 'through which the capacity for making direct and full contact with real other human beings is restored' (ibid.). In other therapeutic approaches, such as the behavioural approach, physical interaction plays a central role in the therapeutic process.

While an absolute neutral setting was impossible in Freud's times, the new online setting is the first opportunity to research and explore Freud's assumptions concerning transference and neutrality.

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Since this ideal situation was impossible in Freud's time, it was forgotten, and pure transference was never achieved or explored. The new online setting is the first opportunity to research and explore Freud's assumptions concerning transference and neutrality:

> Analysts sit behind their patients so they can become disembodied voices. Patients are given space to project onto the analyst thoughts and feelings from the past. In MUDs, the lack of information about the real person to whom one is

> talking, the silence into which one types, the absence of visual cues, all these encourage projection. This situation leads to exaggerated likes and dislikes, to idealization and demonization.
>
> (Turkle, 1997: 207)

Conservative psychotherapists who are not familiar with online therapy, like Gaby Shefler, the Chair of the Ethical Committee of the Association of Israeli Psychologists, sometimes resist the idea of online psychotherapy with the circular claim that 'therapeutic theories are based on a face-to-face encounter' (Psycho-Actualia, 2005: 41).

Experienced online therapists believe that textual interactions create their own virtual 'body language':

> As human factor engineers will tell us, the visual interface of our communication software also affects how we think, perceive, and express ourselves. Clinicians might be wise to compare software before choosing one for their work.
>
> (Suler, 2004: 25)

This new kind of 'body language' expresses itself in the 'body' message, in Suler's words, which reflects the personality of the writer 'between the lines'.

> Messages can vary widely in length, organization, the flow of ideas, spelling errors, grammar sophistications, the spacing of paragraphs, the use of quoted text, caps, tabs, emoticons and other unique keyboard characters, as well as in the overall visual "feel" of the message. As I mentioned earlier I this chapter, the structure of the email body reflects the cognitive and personality style of the individual who creates it.
>
> (ibid)

I can add to this that text-based psychotherapy is not equal to a textual presentation of a recorded face-to-face therapeutic session, which isolates the words from their physical context. Online text represents a new type of therapeutic message, which may be associated with the virtual setting by hypertextual links. Hypertext constitutes a rich embedding of associations and hidden unconscious messages, which reflect the multilevel structure of the human mind.

The claim that the lack of physical cues in online psychotherapy is an intrinsic

disadvantage denies the significant role of case studies in supervision and psychotherapeutic theories, since these cannot present the physical dimensions of the therapeutic process. It also denies the value of case studies based on textual documentation, like Freud's 'Godiva' (1907), 'Little Hans' (1909) and Schreber (1912).

Ethical considerations

The difference between the technical environment of online psychotherapy and face-to-face traditional therapy raises certain ethical dilemmas concerning the practical and theoretical aspects of online therapy. Some of these dilemmas have found their way into a new code of ethics, which has been formulated for online therapy by the International Society for Mental Health Online (ISMHO, 2000), as well as leading to changes in the ethical codes of therapists' organisations (ACA: 1999, HONcode: 1997, AMIA: 1997, APA: 1997, nbcc: 2001, ETHICS code: 1999).

1. Competency

Online therapy is not yet an independent profession, and it is difficult to define the professional skills of an online therapist. An online therapist can be a trained face-to-face psychotherapist, a clinical psychologist, a psychiatrist, a social worker, a drama therapist or art therapist, but these credentials do not guarantee that the therapist will be competent to practice online psychotherapy.

Although there are some training courses for online therapists (OnlineCounsellors, e-Therapy Training), these private courses are not yet accredited by academic institutions or professional organisations. ISMHO members copy its logo onto their sites as a stamp of approval, but ISMHO is not a professional society, since it includes therapists and consumers, and 'does not endorse or hold any official position about the legitimacy or usefulness of e-therapy' (ISMHO, 2005).

The new formulations of certain codes of ethics concerning online psychotherapy can guide psychotherapists in adapting their professional code of ethics to their online work, but do not require them to prove their competency as online therapists.

Due to the textual characteristics of online communication, competency in online psychotherapy means more than therapeutic skills.

> We must keep in mind the nuts and bolts of providing online psychotherapy – the therapist must be able to type; to spell; to use appropriate grammar; to be able to get around online. As mentioned above, even the most renowned and respected

> therapist won't get too far in this process if they can't type, spell or at a more basic level navigate on the computer.
>
> (Stofle, 1997)

Actually, there is no way of guaranteeing professional competency for online psychotherapy, since there is not enough experience in the field, and there are no comprehensive training programmes that can provide such competency. This means that online psychotherapists have to inform their clients about this gap in online training and give them detailed information, concerning their own experience and training in this new field.

Before they choose to practice online psychotherapy, it is important for therapists to examine whether they are suitable to practice this type of therapy.

> First and foremost, online practice is for those who love it. If you are deeply skeptical about making emotional connections through the written word in the absence of visual cues, then online counseling is not for you. Being nervous around technology, a laborious typist, or feeling reluctant to explore the Internet are other examples of not being suited to the medium.
>
> (Zelvin & Speyer, 2004)

To be competent in online psychotherapy, practitioners have to take responsibility for their own professional training. They have to be aware of their writing capacities and their mastery of computers and Internet technology. Online therapists have to be flexible and open-minded, since they cannot adapt their face-to-face approach to online practice without effecting certain changes.

2. Confidentiality.

As is true of face-to-face psychotherapy, online therapists are committed to confidentiality as stipulated by their written therapeutic contracts.

> Everything which you disclose to me will remain confidential, except in exceptional circumstances (see below).
>
> As a BACP (British Association for Counselling and Psychotherapy) member I am bound by BACP's Code of Ethics and Practice and its Complaints Procedure. Regarding confidentiality, the BACP states that counsellors must offer the highest possible levels of confidentiality in order to respect the client's privacy and create the trust necessary for counselling. However, in exceptional

circumstances, where there are good grounds for believing that serious harm may occur to the client (i.e., you) or to other people (including children), and / or where there are good grounds for believing that the client is no longer willing or able to take responsibility for his / her actions, confidentiality may be broken. I would attempt to discuss this fully with the client first.

Although this service is confidential, I cannot give a 100% guarantee of internet and telephone security by the operating companies or other users.

(123counselling.com)

Confidentiality plays a central role in face-to face psychotherapy, and online psychotherapy might arouse considerable apprehension in this area. The technical devices and information transportation of online communications amplify these feelings, making it difficult to create a trusting relationship between therapists and clients.

> Confidentiality is not an absolute. It never has been in the real world, nor should it be held up to an impossible or ideal standard in the online world.
>
> (Grohol, 1999)

The question of confidentiality is connected to clients' understanding and experience of the new media. I have found that experienced Internet surfers have no difficulties with confidentiality in online psychotherapy, while face-to-face 'fresh' clients need some time to create trust.

> Talking to a therapist online is probably **as safe as** talking to one in person. Both are very confidential, and neither is 100% perfect.
>
> (Ainsworth, 2001a)

Actually, there is nothing therapists or clients can do against someone who intentionally plans to steal their secrets. This can be done by breaking into the therapist's clinic or his house, as well as hacking into his computer. Online therapists invest more energy than face-to-face therapists in protecting their clients' confidentiality. This is accomplished by encrypting client' e-mails or by using secure web-based messaging systems. Online individual therapy is more protected than public mental health institutions, where sensitive information about patients is available to other therapists and administrators.

One of the online therapists' duties is to educate their clients and teach them how to increase the confidentiality level. They can do this by encrypting their e-mail, using a password to access their personal files, not printing their therapeutic sessions on paper, not using public computers for therapeutic communication and, checking addresses before sending e-mails, etc.

My experience has taught me that the level of online confidentiality is not high enough for famous clients. Any mistake can endanger their privacy, and it is better not to offer them online psychotherapy.

While confidentiality is associated with subjective beliefs of therapists and clients concerning the security of the therapeutic interaction in face-to-face or online psychotherapy, online therapy is associated with technophobia, and this intensifies the objective limitations of security in online communication. This means that online psychotherapists should be aware of the technological aspects of each kind of online communication and inform their clients about the level of security they can offer them. 'There are security measures such as using a secure socket layer (SSL) for the submission of sensitive material and financial information. Widely available encryption software can be used to safeguard email and protect client records' (Chechele and Stofle, 2003: 44).

The most confidential online communication is a chat interaction in a secure site, on which the texts are not stored. 'All messages must be encrypted at 128-bit cipher strength, and the computer servers of the provider of the chat software must not be used to store the messages' (Derrig-Palumbo and Zeine, 2005: 205). Actually, such interaction happens in a secure location, and there are no transfers of texts out of the site.

Although e-mail communication can also be encrypted, it always involves information transfers between computers, which can be viewed by third parties. 'Finally, e-mail is not secure. Even "secure" e-mail has vulnerabilities… There are too many ways for confidentiality to be breached when using e-mail' (Ibid.: 206). On the other hand, 'although security systems are never totally perfect, when the client and clinician both use encryption while communicating, privacy is increased' (Kraus, Zack & Stricker, 2004: 134).

The relations between the level of security in online therapy and the subjective sense of a 'secure frame' is not self-evident, since 'experience shows that many clients do not worry much about confidentiality when using regular email' (Kraus, 2004: 134). Text documentation may not be 100% secure, but it has other benefits for

creating a secure frame. Paradoxically, e-mail communication is less secure than chat room psychotherapy, but nevertheless it is the most popular setting for online therapy. This means that the technical devices of creating security are less important than the subjective sense of confidentiality, which is created by a certain combination of the elements of the therapeutic relationship (the ground rules).

3. Benefits.

The first command of any code of ethics is a commitment to promote the clients' well being (or to 'do no harm'). Does online psychotherapy promote clients' well being?

There are several answers to this question. Conservative psychotherapists who resist the idea of online psychotherapy believe that this is not psychotherapy, since it lacks physical cues. If physical cues are essential for competent therapeutic work, online therapy cannot be sufficient to fulfil clients' needs.

Resistance from the professional field can shift the question of benefit from its main target, the client. Online psychotherapy is not beneficial to all clients, and therapists should consider this when interviewing new online clients.

> Online therapy will not be appropriate for all people seeking help. In these cases, the online practitioner should have the skills and resources to make appropriate referrals. When the practitioner determines that high risk or other factors indicate that a person is best served by seeking immediate treatment within his or her locality (e.g., for suicide prevention, medication assessment, etc.), such a referral or assistance in finding an appropriate referral should be provided.
>
> (ISMHO, 2001)

Online psychotherapy is not beneficial to clients who cannot type or operate a computer, clients with pathological symptoms or clients in crisis, clients with medical problems, famous clients, clients with no writing and reading skills and clients who are still engaged in face-to-face psychotherapy.

Online psychotherapy can be beneficial to clients with physical disabilities, those who are looking for a special therapist they cannot find locally (language, religion, gender, etc.) those who are apprehensive of the stigma of face-to-face psychotherapy or anyone who wants to explore his/her inner life and is interested in personal growth.

4. Legal aspects.

The Internet has no territory and its global accessibility blurs national borders and legal boundaries. Internet surfers gather together with other surfers in a virtual

community that has no legal authority, but is guided by the unenforced code of ethics for written behaviour on the net, the Netiquette (Netiquette, 2004).

This situation, in which online "Netizens" (citizens of cyberspace) have no common regulations for their virtual interactions, while each of them is bound by his country's (or state's) laws, is frustrating and sometimes dangerous. This situation is even more confusing for online therapists, many of whom will refrain from any professional online activity until such time as the legal aspects of online psychotherapy are defined:

> One of the inherent qualities of the Internet is the way that it dissolves geographical boundaries. The physical distance between two persons is irrelevant to Internet communication. The Internet makes it possible for counselors to reach underserved populations who might otherwise have little or no access to care. It potentially allows everyone access to mental health care, regardless of his or her geographical location or that of the provider. A psychologist in Maryland can treat a depressed patient above the Arctic Circle. An isolated Nebraska farmer can talk to a therapist in New York City. An American in Kuwait can get help from a counselor back home. These are exciting possibilities, but existing licensure laws were not designed to account for such global interactions.
>
> (Holmes & Ainsworth, 2004: 264)

While in some countries psychotherapists do not need a licence to practise, there are regulations for practising psychotherapy in other countries and American therapists 'practice under a government-issue license that authorizes them to practice in a specific state' (ibid.). This means that I can live in Israel and treat a client in Japan, but an American psychologist from Virginia cannot serve clients in Ohio.

The question of licensure is one of the main difficulties in online psychotherapy.

> In the absence of national licensure and with few state reciprocity policies, the lawful practice of e-therapy is considerably hampered by state licensure laws and, equally as important, by the practices of the state boards that investigate and discipline doctors and other therapists.
>
> (Terry, 2002: 171)

In order to avoid lawsuits and professional discomfort many therapists do not define their practice as psychotherapy or counselling and abstain from any

commitment of this kind. Instead, they formulate a cautious contract that makes the client partially responsible for the process.

> I consent to the conditions of e-mail counseling (services and billing) as described above, and to the confidentiality limitations. I understand that this is not psychotherapy but a service for support and coaching.
>
> (Counseling Cafe)

Other online therapists differentiate between psychotherapy and counselling by claiming that psychotherapy is more directive than counselling.

> Online counseling is considered experimental at this point. Because a therapist cannot see or hear clients in cyberspace, there are many important clues that are missing using this medium. These visual and auditory clues include, facial expression, body language, and the tone of voice. Therefore, the therapist's perceptions are limited by the written information the client supplies. Because of this limitation, online consulting is not a therapy. Therefore people in need of a therapeutic relationship must seek treatment from a licensed professional within their own community.
>
> (The Counseling Connection)

Some online therapists do not hesitate to offer "therapy": 'While in internet therapy, or cyber therapy, you will be chatting live to a professional therapist. You will be receiving this service in the privacy of your own home' (The Cyber Shrink), but they also add some restrictions:

> Internet Therapy and Phone Therapy is not intended to replace face-to-face therapy with a professional therapist. The pros and cons of using this service need to be fully considered when determining if cyber therapy is right for you.
>
> (ibid.)

5. Insurance.

The unsolved question of licensing overlaps the question of insurance and malpractice. Online psychotherapy is still new, so many professional liability insurance companies do not cover this sort of practice.

Although some companies do cover such activities, they stipulate that they must fall within the limits of the professional licence. This limitation can narrow therapists'

possibilities if the license does not recognise online psychotherapy or if it is limited to a geographic area, as holds true in the USA.

These limitations supply another explanation for online therapists' tendency to protect themselves by declaring that online therapy or online counselling is not real 'psychotherapy'.

How these evasive statements affect the creation of therapeutic trust between therapists and clients has not yet been examined.

6. Anonymity.

In online psychotherapy, where therapists do not meet their clients face-to-face, clients can keep their anonymity and avoid revealing their personal details to the therapist.

> On the other hand, it is an alternative which offers confidentiality (to the extent allowed by law) and anonymity if that's the only way the client will seek help.
>
> (The WebCounseling Site)

The option of preserving clients' anonymity enables clients who avoid psychotherapy due to the stigma to start psychotherapy. Although anonymity is one of the characteristics of online communication, it has some disadvantages in online psychotherapy. Clients' anonymity can postpone the creation of trust and weaken therapeutic relationships.

But there is another kind of anonymity in the new setting of online psychotherapy, the anonymity of the therapist, which resembled Freud's recommendations to psychoanalysts:

> The physician should be impenetrable to the patient, and, like a mirror, reflect nothing but what is shown to him.
>
> (Freud, 1912: 331)

The reason for Freud's recommendation was that

> Realistic knowledge about the analyst interferes with the formation of transference illusions. The analyst is expected to be a relatively blank 'screen' upon which the patient can freely project his or her infantile fantasies.
>
> (Smith, 1991: 180)

Therapists' anonymity can enhance the phenomenon of transference, in psychoanalytic terms, or guard clients from frame deviations by practitioners, in communicative psychotherapy terms:

> The reason for this appears to be that at the very least self-revelations violate the "patient-centered" component of neutrality – the non-anonymous analyst "hogs" the therapeutic space – and at worst involves an implicit role-reversal and appeal for psychotherapeutic help from the patient.
>
> (ibid.: 181)

In online psychotherapy clients' anonymity is of similar value. This anonymity derives from the lack of the physical dimension, which focuses therapists' attention on clients' narratives. In a way, this anonymity may be associated with the Freudian couch by helping online therapists to bracket their personal beliefs, judgements and prejudices.

7. Technical difficulties.

In online psychotherapy there is always a third party that significantly influences the therapeutic process. This is the technical device, without which the therapeutic interaction cannot exist.

The role of computers, telephone lines and Internet providers is central and its image significantly influences both client and therapist. This third party can be a threatening factor for online clients and can deter potential clients, therefore it has to be discussed and interpreted privately and in public.

The role of technology in online psychotherapy changes the classical structure of the therapeutic setting and forces therapists and clients to cope with the never-ending development of the web.

8. Crisis management.

The intimate therapeutic relationships between therapists and clients in face-to-face psychotherapy create a delusion regarding care and safekeeping. Some therapists share these delusions by being ready to break the therapeutic framework and help their clients in times of crisis in their everyday lives.

Actually, psychotherapists are always remote from their clients and cannot be accessible whenever needed. In times of crisis, they probably ask the help of other professionals who can take care of the clients.

Online psychotherapists do the same, but the image of virtual communications has shattered delusions about the omnipotent therapist and raised another claim against online psychotherapy.

I cope with this dangerous delusion by exploring it with my clients in the first session and by keeping a record of clients' information (address, telephone number, etc.) for potential crisis intervention.

Online psychotherapy and scientific research

The psychotherapeutic process is difficult to research since it is based on subjective impressions of therapists (case studies) and clients (questionnaires). It is impossible to collect data concerning inner mental processes, and the therapeutic procedure, which includes physical setting and body language, is too complicated to explore.

Since therapists cannot really manipulate their clients' minds, as physicians do with clients' bodies, the therapeutic process is always limited to the relationships between clients and therapists. The goal of this relationship is to create a 'secure frame', in which clients can explore the issues they bring to this situation and develop their own capacities to confront their weaknesses

Online psychotherapy is limited to a narrow situation in which nothing exists but written messages (narratives). These written messages, which are the only evidence of the therapeutic process, can serve as objective data for scientific research in online psychotherapy. Such objective data has never been accessible in traditional psychotherapy.

The availability of these data for both therapists and clients constitutes the revolutionary aspect of online psychotherapy. Thus, earlier dialogues are always accessible to both sides. This aspect changes the therapeutic relationship and has to be considered in any further thinking concerning the future of online psychotherapy or traditional psychotherapy.

The documentation of online therapy sessions replaces the traditional case study. Unlike the subjective style of classical therapeutic case studies, written correspondence between therapist and client represent the exact therapeutic process in an objective manner.

Since the case study is available to therapists in the process of communicating with their clients, they can use it as a didactic instrument to enrich their work by self-supervision and by sharing their conclusions with their clients. This will change the nature of the therapeutic encounter and increase conscious processes that can

accelerate the therapeutic process.

Conclusion

Although online psychotherapy is the youngest branch of psychotherapy, celebrating its tenth birthday (10), it is rooted in the long history of telemedicine, which started half a century ago. Telephone help-lines and videoconferencing systems paved the path to online psychotherapy and prepared the ground for assimilating accumulated experience into the psychotherapeutic field.

The short history of online psychotherapy is surprising and unexpected. There is no explanation for why psychotherapists were not influenced by telepsychiatry and telephone help-lines long before the Internet revolution. There is no explanation for why they don't adopt some of telemedicine's achievements in ethical codes and licensing.

Although the main argument against online psychotherapy is its lack of physical cues and body language, online psychotherapists have ignored the advanced technical options that allow the reproduction of face-to-face psychotherapy through the Internet, instead choosing to stick to the primitive options of online correspondence or chat-room interaction.

This surprising course in the evolution of online psychotherapy can be explained as coincidental or interpreted as an expression of conservatism, but it also can be understood as a remarkable shift in the history of telemedicine. Perhaps the qualities of textual interactions, still the main actor in the Internet information revolution, have defeated sophisticated audio-visual online devices.

It would appear that text-based communication is the natural selection for online psychotherapy, which brings us back to the origins of the talking-cure.

The present situation of online psychotherapy, which mainly consists of e-mail asynchronous correspondence and chat room synchronised interaction, indicates several innovations in the field of psychotherapy. Written psychotherapy enhances consciousness, provides full documentation that may serve as scientific data and is accessible to future clients who are unable to apply for face-to-face psychotherapy.

It would appear that online psychotherapy is ready for the natural merging of e-mail therapy and chat-room therapy, in order to create a virtual clinic that will provide clients with a secure frame for online psychotherapy.

Chapter Two:

Ground Rules in Traditional Psychotherapy

In psychotherapeutic jargon the term 'ground rules' has not yet been professionally defined, although it encompasses the main aspects of the therapeutic procedure and relationship.

There are three cycles of professional commitment for psychotherapists: legal, ethical and procedural (ground rules). These three cycles, or dimensions, partly overlap in an area representing professional responsibility or accountability.

1. **The legal dimension.** This is a given which obligates psychotherapists as a pre-condition to any steps they take. 'The law tends to specify the minimum of what you should or should not do. It sets a standard of conduct below which you must not fall' (Sim, 1997: 7).

   The law is more than a series of dictates, and it can serve as a source for knowledge about the cultural and moral context for the psychotherapeutic encounter. 'The law is an increasingly significant source that needs to be taken into account as it represents a form of national morality within a democracy' (Bond, 2000: 51)

   The law influences therapeutic relationships prior to the first session and its implications are applicable to any therapeutic encounter. Legal issues can be associated with the content of therapeutic encounters that involve clients' lives and relationships. In addition, they can relate to the therapeutic relationship, institutional procedures and professional regulations. Therapists' awareness of the legal implications of psychotherapy must override any professional or ethical consideration.

   The law determines regulations and terms for professional licensing, as well as rules of behaviour between therapists and clients. Some of them, such as the disallowance of sexual relationships, are shared with the professional code of ethics. In other cases, such as the duty not to disclose clients' privacy, they contradict the basic principles and values inherent in various therapeutic approaches.
2. **The ethical dimension.** Professional ethics define practitioners' standards of

behaviour in relation to the public, clients and colleagues. It organises 'the rules of conduct recognized as appropriate to a particular profession' (Oxford, 1995). These rules are needed for any 'distinctive human activity' (Casher, 2002: 15), since professional activities are not natural activities and since professional ethics may not be naturally deduced from human morality. Psychotherapists are bound by codes of ethics determined by their professional organisations in the same way that the law obligates all citizens. 'Licensed Clinicians, regardless of training, theoretical background, personal philosophies, or cultural or religious beliefs, are still obligated to follow laws and regulations that govern their profession' (Kraus, 2004: 126).

Professional activity is based on a body of knowledge, which is the source of theoretical and practical applications. Professional ethics set the boundaries for learning and training and outline the rules of conduct for practising. This is essential for any kind of psychotherapy in which human relationships are integral components:

> Mutually agreed ethics and acceptable standards of practice in any profession provide the bedrock whereby those practitioners and clients are safeguarded and served within a defined framework and agreed boundaries. In this way the professional search for integrity and credibility is validated.
>
> It is the mark of a responsible professional body to define its Ethical Principles and furnish its own Code of Practice for the discipline of members and the welfare of the clients served by these members. Each body of practitioners in the field of counselling and psychotherapy within the United Kingdom, the European Union, the United States of America, Canada and elsewhere, eventually benefits from the spectrum of ethics and codes corporately provided. In this way, the life and practice of each professional body is enriched and diversity and difference valued.
>
> (Cosca, 2005)

Although ethical frameworks for healthcare are based on the premise of *'primum non nocere'* (S

Latin: Above all, do no harm), meaning that the clients' well being is a precondition of all professional activity, the code of ethics represents the interests and beliefs of a group of practitioners and serves as the stamp of

approval of the professional community. Codes of ethics for psychotherapists are focused on the unique relationship between therapist and client and on the risks inherent in this relationship:

> There is characteristically an imbalance of power and expertise in this relationship, with the patient occupying a relatively dependent role, even in cases where an apparently equal partnership exists between patient and practitioner. This creates a need to protect and/or promote the interests and dignity of patients (within certain limits) in circumstances in which they are unable to do so fully themselves.
>
> (Sim, 1997: 5)

Codes of ethics are formulated by therapists and their organisations in order to protect their interests and strengthen their professional image. 'At the simplest level one might consider ethics to be the best risk-management strategy' (Francis, 1999: 9).

Tudor claims that 'such codes then, may be viewed as both reflecting and representing a wider social contract in which social context counselling is defined and mediated' (Tudor, 1997: 208). Codes of ethics reflect and represent common social contracts, albeit in a paternalistic way. They are formulated from therapists' and organisations' point of view, in order to protect their interests. Therefore, a code of ethics is not a social contract between therapists and society, but rather a declaration of values and objectives of a professional organisation.

Clients can submit complaints to ethics committees, but have no representatives in these committees to defend their interests.

> Complaints procedures cannot by themselves protect the ethical standards of counselling. It is not simply that many complaints do not reach them. Many clients may be deterred because they do not expect to be taken seriously. Alternatively, they may fear that a professional organization will be primarily concerned with protecting its own members rather than considering a grievance from a member of the public.
>
> (Bond, 2000: 14)

Codes of ethics represent the values of each organisation and differ from one other. While the code of ethics of the Israeli association for psychotherapy

forbids sexual relationships with clients for a period of three years after termination (Shefler, Achmon & Weil, 2002: 694), the UKCP code of ethics determines that psychotherapists 'must take care to not exploit their clients, **current or past**, in any way, financially, sexually or emotionally' (UKCP, 2005: 2.5).

The ethical framework for psychotherapy 'is a conceptual structure... that envisages counsellors taking different stances in the spaces within the essential framework. It is also capable of adjustment as required by the circumstances in which it is being used' (Bond, 2000: 53). While the law represents the public interest, the code of ethics represents professional interests, which correspond to the limits of the law.

3. **The procedural dimension.** The psychotherapeutic encounter is different from any other human relationship. This is an artificial framework in which each participant knows his special role. It is the psychotherapist's responsibility to facilitate this framework and clarify its rules and techniques.

The procedural management of the therapeutic frame is the infrastructure for therapeutic relationships. Differentiated from legal instructions or ethical regulations, the procedural management is based on a bilateral relationship. Although it represents therapists' assumptions and theoretical foundations, it always depends on clients' co-operation.

Freud coined the term 'ground rule' (or 'the fundamental rule') (Freud, 1912: 328), which defines the psychoanalytic condition of free associations. This 'ground rule' was followed by a series of technical instructions concerning the therapeutic relationship, as presented in Freud's 'Papers on Technique' (ibid.). These instructions refer to time management, payment, the couch and the practitioner's remote attitude towards his patients ('evenly-hovering attention', neutrality, 'coldness', impenetrable, reflects like a mirror, abstinence and indifference).

Freud didn't claim that his recommendations should be accepted by all therapists. 'I must, however, expressly state that this technique has proved to be the only method suited to my individuality; I do not venture to deny that a physician quite differently constituted might feel impelled to adopt a different attitude to his patients and to the task before him' (Freud, 1912: 323).

However, in spite of the above statement, Freud's recommendations became the core of the psychoanalytic and psychotherapeutic process. 'Freud wrote a

number of short but highly informative papers from 1911 to 1915 on technical aspects of analysis, that can be found together in his *Collected Works*. In them he sets out a number of vital ground rules that inform the therapeutic attitude' (Jacobs, 1997: 39).

Years later, while most therapeutic efforts were focused on the creation of relationships and the provision of a 'secure frame', ground rules became substantial elements in the therapeutic process. 'The ground rules are clearly among the most essential determinants of the modes of relatedness, cure, and interaction between the patient and therapist, and influence the entire unfolding of the therapeutic experience' (Langs, 1982: 489).

Ground rules can be comprehended as a set of technical instructions concerning the management of the therapeutic encounter. Most therapists, unaccustomed to the term 'ground rules', replace it with 'the therapeutic frame' or focus on one of its components: the setting, the contract, etc.

Ground rules refer to the practice of psychotherapy. Their components can be changed according to the therapeutic approach, but they always refer to the small details of the therapeutic relationship. Their aim is to create trust, which is the precondition of any therapeutic process or, in other words, to provide a 'secure frame'.

The first two areas of professional commitment for psychotherapists have been discussed and researched by many authors. Books and articles have been devoted to the legal and ethical aspects of psychotherapy, but the question of ground rules is often forgotten. While most authors were occupied with fragments or segments of 'ground rules' (the contract, the setting, confidentiality, etc.), Robert Langs created a comprehensive set of psychoanalytic ground rules, and adapted it to his 'communicative psychoanalysis' (Smith, 1991).

There is no comparative literature concerning ground rules and their diversity in various psychotherapeutic approaches. In this chapter I will review the history of ground rules and examine their common denominators.

The role of therapeutic relationships

Since the early days of psychoanalysis, more than four hundred psychotherapeutic approaches have been developed and practised (Green, 2003). These approaches

differ from one other regarding their basic assumptions and psychotherapeutic techniques.

This phenomenon, which distinguishes psychotherapy from medicine, points to the unresolved question concerning the nature of psychotherapy. It is difficult to find an accepted definition of the psychotherapeutic process or to research what kind of approach is more effective and which theory is better. Some authors claim that:

> There is research indicating that theoretical orientation makes no difference to the effectiveness of outcome in counselling and psychotherapy, that training makes no difference – a beginner may well be as effective, if no more so, as an experienced practitioner; even that personal psychotherapy for the therapist/analyst makes no discernible difference to successful outcome!
>
> (Clarkson, 2000: 173)

Surprisingly, in all approaches there is no disagreement regarding the central role of therapeutic relationships. 'Now the bulk of research points to the fact that the most important factor in effective psychotherapeutic work is the relationship between the client and the psychologist' (Clarkson, 2000: viii). Many therapists phrase this convention in their own words. 'The relationship between the two people is a two-way affair and in so far as one is concerned with demonstrating that relationship it is not a matter of talking about analyst and analysand; it is talking about something *between* the two of them' (Bion, 1978: 12).

The convention concerning the central role of therapeutic relationships can be regarded as a reaction to Freud's recommendations to psychoanalysts 'to take as a model in psycho-analytic treatment the surgeon who puts aside all his own feelings, including that of human sympathy' (Freud, 1912: 327). This convention is based on the assumption that 'there is probably no rule more controversial in Freud's technical papers than the one concerning the restraint of human sympathy. This injunction has been used by some as a justification for aloofness in analytic behavior and by others as a condemnation for Freud's alleged coldness as a clinician' (Thompson, 1994: 150). This claim may be supported by Freud himself:

> To the sceptic one says that the analysis requires no faith; that he may be as critical and suspicious as he pleases; that one does not regard his attitude as the effect of his judgement at all, for he is not in a position to form a reliable judgement on the matter; his distrust is but a symptom like his other symptoms

> and will not interfere if he conscientiously carries out what the rule of the treatment requires of him.
>
> (Freud, 1913: 345)

Freud also suggested that 'the physician should be impenetrable to the patient, and, like a mirror, reflect nothing but what is shown to him' (Freud, 1912: 331). He denied any kind of mutual relationships with patients:

> One would expect it to be entirely permissible, and even desirable, for the overcoming of the patient's resistances, that the physician should afford him a glimpse into his own mental defects and conflicts and lead him to form comparisons by making intimate disclosures from his own life. One confidence repays another, and anyone demanding intimate revelations from another must be prepared to make them himself.
>
> But the psycho-analytic relationship is a thing apart; much of it takes a different course from that which the psychology of consciousness would lead us to expect.
>
> (Freud, 1912: 330)

This firm perception was associated with Freud's theoretical stance and his models of the mind that were focused on the individual patient and her inner mental processes. 'The relationship itself, sometimes contemptuously dismissed as 'bedside manner', was considered irrelevant. Sigmund Freud and his coworker Joseph Breuer were physicians, with the attitude and assumptions that implied' (Kahn, 1991: 5). Later developments in the history of psychoanalysis, by Freud's followers shifted the focus from personal processes to relationships (from 'one-person-psychology' to interpersonal psychoanalysis and inter-subjectivity). 'They [interpersonal psychoanalysts] also shared a common belief that classical Freudian theory underemphasized the larger social and cultural context which must figure prominently in any theory attempting to account for the origins, development, and warpings of personality' (Greenberg & Mitchell, 1983: 80). Sullivan claimed that 'the personal relationship between patient and therapist is the most important determining factor, positively or negatively, in the fate of the patient' (Greenberg & Mitchell, 1983: 85).

Winnicott suggested that 'the setting becomes more important than the interpretation. The emphasis is changed from the one to the other' (Winnicott, 1954: 286). This means that psychoanalytic theory and technique is less important than the

maternal setting:

> Winnicott sees the curative factor in psychoanalysis, not in its interpretive function, but in the manner in which the analytic setting provides missing parental provisions and fills early developmental needs. The function of psychoanalysis is to compensate for parental failures in adaptation, and "to provide a certain type of environment" (Winnicott, 1948: 168). The person of the analyst and the analytic setting "hold" the patient; in the reliability, attentiveness, responsiveness, memory, and durability of the analyst, the aborted self of the patient becomes unstuck and continues to grow.
>
> (Greenberg & Mitchell, 1983: 201)

If we place Freud on one side of the scale, concerning therapeutic relationships, Kohut will find his place on the other side. 'It is extremely important', Kohut argues, for the analyst to allow the patient to dwell in and consolidate his relationship with the analyst, which makes possible the recovery of the lost developmental momentum blocked by early selfobject failures' (Greenberg & Mitchell, 1983: 356).

While focusing on therapeutic relationships was the consequence of an historical shift in psychoanalysis, it was the starting point for humanistic and existential approaches. 'The two traditions are the humanistic psychologist's concern for a warm and empathic clinical relationship and the psychoanalyst's interest in bringing to the surface the unconscious aspects of that relationship, that is, the phenomena of transference and countertransference' (Kahn, 1991: xiv).

This description of the shift in psychoanalytic views, concerning the status of therapeutic relationships, is based on the assumption that Freud ignored the role of the special bond that were created with his patients. This assumption can be re-examined by analysing Freud's relationships with his patients and some of his statements that reflect a different point of view.

In a way, Freud anticipated Kohut by preparing the basis for empathy in therapeutic relationships. 'Another suspicion may tell us that we are far from having exhausted the problem of identification, and that we are faced by the process which psychology calls "empathy [Einfühlung]" and which plays the largest part in our understanding of what is inherently foreign to our ego in other people' (Freud, 1921: 137). As a physician, he was aware of the implications of personal influence on his patients:

> Besides the intellectual motives which we mobilize to overcome the resistance, there is an affective factor, the personal influence of the physician, which we can seldom do without, and in a number of cases the latter alone is in a position to remove the resistance. The situation here is no different from what it is elsewhere in medicine and there is no therapeutic procedure of which one may say that it can do entirely without the cooperation of this personal factor.
>
> (Freud, 1895: 368)

Evidently the phenomenon of transference does not contradict the 'concern for a warm and empathic clinical relationship', as Kahn claims (Kahn, 1991: xiv). Freud emphasised the importance of 'positive transference' in creating therapeutic relationships.

> In the second place, we must not overlook the fact that all measures of this sort would oblige the analyst to behave in an unfriendly way to the patient, and this would have a damaging effect upon the affectionate attitude upon the positive transference – which is the strongest motive for the patient's taking a share in the joint work of analysis.
>
> (Freud, 1937).

Freud never claimed that therapeutic relationships are always a kind of transference. On the contrary, he emphasised the importance of empathy (Einflühlung), sometimes introduced as 'understanding' in the English translation.

> It is certainly possible to forfeit this primary success if one takes up from the start any standpoint other than that of understanding, such as a moralizing attitude, perhaps, or if one behaves as the representative or advocate of some third person, maybe the husband or wife, and so on.
>
> (Freud, 1913: 360)

Empathy, therefore, is a practical instrument for everyday practice. 'A path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude at all towards other mental life' (Freud, 1921: 140). This is self-explanatory, if we examine Freud's relationships with his patients, and particularly with Dr. Ernst Lanzer, the 'Rat Man' (Freud, 1909). In his private notes about Lanzer, Freud wrote: 'In this connection

I said a word or two upon the good opinion I had formed of him, and this gave him visible pleasure' (Künstlicher, 1998: 145, Hawelka, 1974: 21).

Many writers criticised Freud for breaking the therapeutic frame. Künstlicher claims that laughing in front of his patient is an abusive counter-transference. 'Here we see how a counter-transference reaction on the part of the analyst becomes a surrender to his own feelings and an infringement of the frame that makes all associations vanish into thin air' (Künstlicher, 1998: 146-7). But Freud knew how to distinguish between the role of transference and simple human relationships. By presenting his patient's position, he suggested the opposite. 'Furthermore, he added, not every good relation between an analyst and his subject during and after analysis was to be regarded as a transference; there were also friendly relations which were based on reality and which proved to be viable' (Freud, 1937: 219).

Patrick Mahony believed that 'Freud's giving a meal to the Rat Man on December 28 was a technical deviation with far-reaching results' (Mahony, 1986: 118). Lohser and Newton state that 'Freud engaged in other deviations from the basic model technique in addition to filling in some of the blanks in his patients' utterances' (Losher & Newton, 1996: 197). Peter Gay is even more rigorous:

> This was a heretical gesture for a psychoanalyst: to gratify a patient by permitting him access to his analyst's private life, and to mother him by providing food in a friendly and unprofessional setting, violated all the austere technical percepts that Freud had been developing in recent years and was attempting to inculcate among his followers.
>
> (Gay, 1989: 267)

Matthis and Szecsödy claim that 'much of Freud's technique ran directly counter to his own technical instructions' (Matthis & Szecsödy, 1998: 148), and 'thus the Rat Man and Freud from the very beginning were involved in an intensive interplay, where Freud's unconscious motives and conflicts also came to contribute to the fact that his interventions at times overstepped the boundaries of the psychoanalytical space' (ibid.: 149).

Robert Langs analysed Freud's deviations from analytic ground rules:

> There are two types of deviations from current classical technique. The first

> concerns the nature of the interventions that Freud made and, in general, reflects deviations in Freud's neutrality, level of activity, and degree of anonymity. The second includes specific deviations in technique such as feeding the Rat Man and lending him a book.
>
> (Langs, 1980: 215-216)

Langs also wrote of the 'misalliance between Freud and his patients, and its relationship to deviations in technique as measured by the template of current psychoanalytic standards' (ibid.: 215). But Freud's technical recommendations were only supplements to the ground rule of free associations and can be interpreted from another point of view. Actually, Freud's empathic attitude towards Lanzer characterises his relationships with most of his patients. The case of Dora (Freud, 1905) was exceptional, and was terminated by the patient after three months. The reason for Freud's failure in the case of Dora, which started with an empathic description ('Dora was by that time in the first bloom of youth -- a girl of intelligent and engaging looks' (ibid.: 53), was his severe reaction to her resistance which caused him to lose his empathy (Green, 1998). 'A male adult forced himself upon a young female who afterward was forced by her father into therapy sessions where the therapist elected to force or "direct" her associations, the pursuit of his own theories perforce interfering with his free-floating attention' (Mahony, 1996: 143). Other critics compared Freud's lack of empathy to cruel rape. 'The narrative of the analyst's probe into the patient's unconscious being -- reads like an assault, almost like a rape; we cannot but feel outraged as Freud describes the girl's desperate attempts to elude him while he obscenely moves in on her' (Malcolm, 1992: 24). Freud's hostile attitude towards Dora was antithetic to his warm and even loving relations to the Wolf Man (Freud, 1918), with whom he maintained a life-long relationship (Green, 1999: 14), and his other patients: Little Hans (Freud, 1909b) and his four hysterical female patients, Frau Emmy von N., Miss Lucy R., Katharina and Fraulein Elisabeth von R. (Freud, S. & Breuer, J., 1895).

Some writers link Freud's recommendation for neutrality with 'coldness' and a remote relationship. 'The programs that emphasized the relationship also encouraged the therapist to adopt a stance of cool, distant "neutrality," so as not to influence the developing relationship' (Kahn, 1991: 4). But neutrality, anonymity and abstinence can represent an unwritten ground rule of empathy.

> The anonymity of the analyst does not remove him from the patient, but enables

> him to contain in himself, as a mirror, the reflection of the patient's image. This is, perhaps, the essence of empathy. Anonymity, neutrality and abstinence are, therefore, the unwritten ground rule of the psychoanalytic practice, which enables the existence of empathy as a precondition for the therapeutic relationship.
>
> (Green, 2004: 124)

This option is parallel to Freud's metaphorical notion of resonance, which was adopted by some of his successors:

> All these rules which I have brought forward coincide at one point which is easily discernible. They all aim at creating for the physician a complement to the "fundamental rule of psycho-analysis" for the patient. Just as the patient must relate all that self observation can detect, and must restrain all the logical and affective objections which would urge him to select, so the physician must put himself in a position to use all that is told him for the purposes of interpretation and recognition of what is hidden in the unconscious, without substituting a censorship of his own for the selection which the patient forgoes. Expressed in a formula, he must bend his own unconscious like a receptive organ towards the emerging unconscious of the patient, be as the receiver of the telephone to the disc. As the receiver transmutes the electric vibrations induced by the sound-waves back again into sound-waves, so is the physician's unconscious mind able to reconstruct the patient's unconscious, which has directed his associations, from the communications derived from it.
>
> (Freud, 1912: 328)

The case of the Rat Man could be regarded as a model for the therapeutic alliance, in which relationship is the goal of the therapeutic process and not its medium. This model influenced and encouraged the development of various therapeutic approaches. Ferenzi and Kohut's new kind of analytic thought on one hand, and humanistic and existential approaches on the other.

Freud's recommendations concerning anonymity, neutrality and abstinence were always implicit and vague. Strachey incorrectly translated the German term 'Indifferenz' (indifferent) as 'neutrality'. 'Freud used neutrality to suggest that the analyst should neither encourage nor discourage his patients from "falling in love" with him but, instead, should simply accept whatever feelings they happen to

experience' (Thompson, 1994: 233).

Freud assumed that 'the young and eager psycho-analyst will certainly be tempted to bring his own individuality freely into the discussion', and he urges him to 'be impenetrable to the patient, and, like a mirror, reflect nothing but what is shown to him' (Freud, 1912: 330-331). This anonymity enables the psychoanalyst to contain the image of his patient like a mirror. This is the essence of empathy.

Freud also clarified that 'by abstinence, however, is not to be understood doing without any and every satisfaction – that would of course not be practicable' (Freud, 1919: 396). Abstinence limits the analyst's influence on his patients, but it doesn't limit his empathy. Freud phrased the goal of the therapeutic process thus: 'the first aim of the treatment consists in attaching him to the treatment and to the person of the physician' (Freud, 1913: 360).

An understanding of Freud's special relationships with his patients contradicts the assumption that he ignored the importance of therapeutic relationships and that later developments in psychoanalysis put more emphasis on this issue. The confusion about Freud's position concerning therapeutic relationships could be explained by the contradiction between his medical practice and his warm personality. While the structure of Freud's definitions was still medical and 'scientific', his therapeutic behaviour was experiential and almost humanistic. This means that Freud's theoretical formulations were remnants of his medical thinking and that his practical empathic model was the subtext or the unconscious motive for his psychotherapeutic approach.

Although some psychoanalysts interpreted Freud's recommendations as a call for 'nonresponsiveness' (Kahn, 1991: 9), one might say that, from the early days of psychoanalysis, the therapeutic relationship was the main therapeutic instrument. The only difference between Freud and contemporary psychoanalysts is that the latter discussed these special relationships with their patients. 'Their [Gill and Kohut's] therapies were built around the conception of the unconscious, and they held fast to the psychoanalytic notion that *working with the relationship* between therapist and client was of central importance' (ibid.: 14).

In the 1940s Carl Rogers established a new kind of therapeutic relationship (Rogers, 1942). His person-centred counselling approach was based on the principle that 'the counsellor's concern to relate to her client on a basis of equality, and not to get caught in the role of the diagnostic or treatment expert, means that she will do all in her power to demystify the counselling process' (Mearns & Thorne, 1995: 29). This

approach expressed resistance to psychoanalytic assumptions.

> Contrary to the opinion of a great many psychotherapists, I have long held that it is not the technical skill or training of the therapist that determines his success – not, for example, his skillful dream interpretations, his sensitive reflections of feeling, his handling of the transference, his subtle use of positive reinforcement. Instead, I believe it is the presence of certain *attitudes* in the therapists, which are communicated to, and perceived by, his client, that effect success in psychotherapy.
>
> (Rogers, 1994: 10)

Rogers's revolutionary views on psychotherapy, claiming that the therapeutic process is based on the counsellor's 'friendly, interested, receptive attitude' (Rogers, 1995: 68), were the first steps towards humanistic psychotherapy. Existential psychotherapy, which started in Europe and was established in America in the late 1950s, influenced humanistic psychotherapy as well. It was based on the assumption that 'in the therapeutic hour a total relationship is going on between two people' (May, 1969: 16):

> As I sit now in relationship with my patient, I am assuming that this man, let us say, like all existing beings, needs to reach out from his own centeredness to participate with other persons. Before he ever made the tentative and oft-postponed steps to phone me for an appointment, he was already participating in imagination in some relationship with me.
>
> (May, 1983: 20)

While Rogerian therapeutic relationships were based on empathy and 'unconditional positive regard' (Rogers, 1995: 225), existential therapeutic relationships were based on authenticity. An existential therapist provokes his clients and confronts them with his existential anxieties. 'It is not support and acceptance that the existential counsellor provides, but the encouragement to think through the unthinkable' (van Deurzen-Smith, 1994: 29).

Although therapeutic relationships are the core of any therapeutic approach, these relationships are derived from different theories, beliefs and assumptions. Each therapeutic approach has its own method for establishing such relations as a basis for creating trust and providing a secure frame for the therapeutic process:

> Since psychotherapy is so centrally determined by the quality of the relationship between patient and psychotherapist, tools are usually welcome which improve our "self-as-instrument" and enable us to match more accurately the kinds of psychotherapeutic relationship we can offer to what our clients may need from us.
>
> (Clarkson, 2000: 226).

Although the manifestations of therapeutic relationships rely on theoretical assumptions, therapeutic relationships are at the same time a result of personal and interpersonal qualities:

> Perhaps here it is worth stating something that is obvious and yet tends to get lost in arguments about theory, and this is that all practitioners, whatever label they put to their practice, are individuals, and the way in which they behave in their consulting rooms may owe less to theoretical ideas than to the sort of people they are. We all have to discover for ourselves which particular school we wish to follow, what sort of training we want, and how we will work with clients. The way in which the therapeutic relationship is established and maintained is not simply about theory – it is about the experience itself.
>
> (Gray, 1997: 2)

Is it true that therapeutic relationships are always spontaneous and unique, or are there procedures and ground rules for establishing relationships? Do therapists have to be trained and qualified in therapeutic relationship since, 'in successful therapy the therapist provides for the client a relationship unlike any the client has had before' (Kahn, 1991: xiii)? Kahn's story about his teacher encapsulates this confusion: '"But why so much attention to the relationship?" I asked. He looked puzzled for a moment. "Because the relationship *is* the therapy," he said' (ibid.: 1).

Therapeutic relationships and ground rules

Like any human relationship, therapeutic relationships are defined by their structure, their frame, their boundaries or any set of agreed rules that enable such interactions. 'In humans, rules and laws of behaviour and conduct, moral and otherwise, govern actions and interactions with others' (Langs, 1998: 4). This is self-explanatory. Every

aspect of human social life is associated with laws and boundaries, frames and contracts, structures and alliances. Social life has no existence without rules, political and religious laws, marriage agreements and business contracts.

Robert Langs claims that rules and frames are basic human needs deriving from the nature of the existential death anxiety.

> Rules are essential to the creation of a relatively stable and predictable environment of a kind that sustains life, protects an individual from harm, and supports adaptive efforts – rules define and safeguard self, relationships with others, and interpersonal transactions. Every situation and relationship that an individual comes upon is affected by a contextual set of biologically, socially, and individually determined ground rules.
>
> (ibid.)

A psychotherapeutic relationship is an artificial setting for human relationships, which enables clients and therapists to reconstruct meaningful relationships for use as a therapeutic instrument. This means that the therapist is responsible for creating the appropriate setting that can function as a 'secure frame', in which clients can re-experience earlier traumas. 'The setting of analysis reproduces the early and earliest mothering techniques. It invites regression by reason of its reliability' (Winnicott, 1954: 286). Langs's 'frame' and Winnicott's 'setting' represent a secure environment, designed to meet the needs of clients. 'The behaviour of the analyst, represented by what I have called the setting, by being good enough in the matter of adaptation to need, is gradually perceived by the patient as something that raises a hope that the true self may at last be able to take the risk involved in its starting to experience living' (Winnicott, 1955-6: 297).

While Langs concludes that 'secure frame' is the answer to death anxiety, Winnicott links the 'good enough setting' with the lack of maternal functions. 'Winnicott believed that the psychoanalytic setting possesses a maternal function, that it "reproduces the early and earliest mothering techniques". Regression is fostered by providing a safe, reliable "holding" analytic setting which induces an "unfreezing" of the environment failure situation' (Smith, 1999: 156).

If the therapeutic relationship is the core of any therapeutic process, this means that the appropriate setting (or ground rules) is a pre-condition for such a process:

> Psychoanalytic treatment is not simply a process of making the unconscious

conscious or of giving increased strength and autonomy to the patient's ego. It is vital that the analyst provide a setting in which the analytic process can occur and connections with split-off aspects of the self, which have been defended against, can be set up again. Rycroft has underlined the fact that the ability of the analyst to provide such a setting depends not only on his skill in making "correct" interpretations but also on the analyst's capacity to maintain a sustained interest in, and relationship with, his patients.

(Sandler, Dare & Holder, 1992: 21)

It is hard to find therapists and authors who object to the view that therapeutic relationships and the creation of "secure frame" are essential factors in psychotherapy, but one should admit that in practice many therapists focus on other components of the therapeutic process.

Some therapists emphasise the negative reflection of the "secure frame" by focusing on their clients' feelings of anxiety and insecurity. There are therapists that grasp their role as being tolerant of their clients' feelings of insecurity, and there are approaches, like the existential approach, that encourage clients to cope with such feelings. 'An existential approach to counselling does not attempt to eliminate anxiety but it encourages people to face it' (van Deurzen-Smith, 1994: 39). In some approaches, such as Victor Frankl's Logotherapy and cognitive-behavioural psychotherapy, therapists provoke their clients and create a sense of insecurity in order to challenge their value systems.

While such views shift the focus of the therapeutic process from the creation of security, they do not undermine the value of the "secure frame". Other approaches, such as rational emotive behaviour therapy, do not promote the creation of a 'secure frame', since 'too much warmth and understanding can be counterproductive by fostering a sense of dependence for approval from the therapist' (Corey, 1996: 327).

My research, according to its nature, is based on a general agreement concerning the central role of creating a sense of security in any therapeutic encounter. Since this view is sometimes latent, I tried to uncover the terms of creating a 'secure frame' even in cases where such attempts are not manifestly declared.

Although most therapists are aware of the importance of therapeutic relationships and the role of a "secure frame" and "ground rules" in establishing such relationships, there are no training courses in therapeutic relationships. Understanding one's narrative is not enough to generate a change in clients' lives, just as being aware of the role of a secure frame is not enough to ensure the provision of such an environment

for clients. It is difficult to 'manage' the therapeutic frame, as Winnicott called this procedure (Smith, 1991: 166), without practising and experiencing the use of ground rules.

> Most beginning clinicians understand that it is important to live by the basic ground rules of therapy. Confidentiality must be honored, and the boundaries of the therapeutic relationship must be respected, which means remembering every moment that our clients are neither friends nor lovers. Most therapists know these rules, but until one has grasped just how subtle and complex the relationship can be, and how important the therapist becomes to the client, one is likely to seriously underestimate how easy it is to damage the therapy. The slightest breach of confidentiality can be magnified by the client into a major betrayal; a chance encounter with a client outside the consulting room can evolve into a problematic social situation and have serious repercussions. An offhand remark or thoughtless joke can cause pain or confusion the client may not be able to acknowledge. None of these slips is likely to cause irreparable harm, but a sophisticated alertness to the vagaries of the relationship will minimize the chances of such slips occurring and will put the therapist in a stronger position to rectify the oversights should they occur.
>
> (Kahn, 1991: 2)

Freud's recommendations for physicians (1912) can be regarded as ground rules for the management of the therapeutic frame. Langs claims that 'it has been clearly documented clinically that patients are exquisitely sensitive to the therapist's management of these tenets. Because ground rules constitute the basic core of the therapeutic relationship...' (Langs, 1998: 26-27). His views regarding psychoanalytic ground rules are more definitive than Freud's, and as such they can serve as a manual for creating an appropriate therapeutic frame.

> If therapy is conceived of as an interaction between a patient and therapist within the confines of a bipersonal field, the ground rules may be thought of as the *frame* of the field. They are the conditions of relatedness that give psychotherapy its distinctive properties, and the psychotherapeutic relationship its unique and therapeutic valence.
>
> (Langs, 1982: 305)

Similarly to Winnicott, Langs believed that 'the therapist must offer a holding

environment to the patient, a basic relationship that provides the latter with a sense of security, respect, and as noted above, trust and safety' (Langs, 1982: 28). Some therapists believe that ground rules also force therapists to follow ethical codes and legal obligations:

> The very nature of a one-to-one private therapeutic encounter is an environment in which one can only trust that therapists will behave professionally and ethically. If, however, there are no specific ground rules, then we as therapists may be prone to behave in ways that foster our own comfort but may not always be appropriate for the clients.
>
> (Holmes, 1998: 5)

Therefore, ground rules are practical guidelines for creating the therapeutic frame in order to create a 'secure frame' for the therapeutic encounter, which is based on trust and safety. One might say that ground rules constitute a bridge between theoretical assumptions and the practical management of the therapeutic frame. They can refer to transference and containment as well as to holding and empathy. They may appear as technical recommendations, but they are 'clearly among the most essential determinants of the modes of relatedness, cure, and interaction between the patient and therapist, and influence the entire unfolding of the therapeutic experience' (Langs, 1982: 489).

The use of ground rules may seem paradoxical. On the one hand, it strengthens clients' trust and creates firm boundaries for the therapeutic frame. On the other hand, it can be experienced by clients as rigid and laboured, and may stimulate clients' resistance. In this case the therapist's role includes keeping the balance between frame management and sensitive attention to clients' needs. Langs believes that frame deviations are inevitable, and that the therapeutic process is always based on clients' responses to therapists' deviations from the frame, which serve as useful supervision for the therapist. This view means that ground rules are more than just technical instructions and that they actually serve as a criterion by which therapists can evaluate the therapeutic process and the therapeutic relationship as an ongoing procedure.

Frame, setting and ground rules

Although Freud coined the term "ground rule" in reference to free associations, it was

not a ground rule for relationships, but rather a technical instruction for use with his patients. He never presented his technical recommendations concerning the therapeutic relationship as ground rules and he emphasised that 'a physician quite differently constituted might feel impelled to adopt a different attitude to his patients' (Freud, 1912: 323).

Marion Milner was the first to describe the therapeutic setting as a "frame", which is defined as a 'structure that outlines, limits, and defines the therapeutic environment and relationship, thereby distinguishing it from other kinds of environments and relationships' (Holmes, 1998: 9).

> The frame [of a picture] marks off the different kind of reality that is within it from that which is outside it; but a temporal spatial frame also marks off the special kind of reality of a psychoanalytic session. And in psychoanalysis, it is the existence of this frame that makes possible the full development of that creative illusion that analysts call transference.
>
> (Milner, 1952: 183)

Milner's "frame" is a metaphor that outlines the boundaries of the psychoanalytic session and defines the therapeutic procedure. This means that the frame is something that contains a unique therapeutic communication and enables the creation of the therapeutic content, such as the 'illusion that analysts call transference' (ibid.). This definition is not far from Freud's ground rule of free associations, which directed the therapeutic procedure so that patients could supply these unique allusions to their inner worlds.

The metaphor of the therapeutic session as the artist's canvas means that content receives its meaning by defining the difference between the content of the frame and everything outside the frame. In other words this means that the frame defines the unique characteristics of the therapeutic relationship. This idea can be interpreted in various ways. Some views concerning the therapeutic relationship focus on certain qualities of the therapeutic frames: 'It is important to point out that there is no consensus regarding the frame of which particular elements can be included under this term' (Gray, 1997: 7).

Winnicott regarded the therapeutic framework as a container that represents primal maternal holding. 'Winnicott sees the curative factor in psychoanalysis, not in its interpretative function, but in the manner in which the analytic setting provides missing parental provisions and fills early developmental needs' (Greenberg &

Mitchell, 1983: 201). For Winnicott, the setting is 'a certain type of environment' (Winnicott, 1948: 168). This is a structural view of the therapeutic framework, in which the therapist's role is to manage this setting so that it can 'safeguard a therapeutic repression' (Smith, 1991: 165). In this special situation the setting functions as a "third party". 'The setting comes to represent the mother with her technique, while the patient is an infant' (Langs, 1976: 128), The setting is the physical environment in which the therapeutic process takes place. Winnicott believed that in this environment the analyst may merge with the setting: 'The setting may merge with the analyst, the couch becoming the analyst and the pillow the breast' (Langs, 1976a: 406). This original view, associating the setting with the therapist, gives new meaning to the therapeutic relationship. 'These ideas suggest that the manner in which the therapist structures the environment can demonstrate and reveal to the patient the type of relationship that the therapist intends both explicitly and implicitly to establish with the patient' (Holmes, 1998: 10). Winnicott's setting is, by definition, a frame for a parental therapeutic relationship. Other therapists adapted this term to different views of therapeutic relationship, but most views are based on the assumption that the setting has to provide a secure frame for the therapeutic interaction.

> It is important to be considerate in providing an environment for consultation that suits the purpose of a confidential, intense, in-depth conversation with a vulnerable person. It may be well to keep in mind that clients look for psychotherapists who have established a solid foundation for their own life and whose working environment reflects such robustness, inner confidence and joy in living. It does not matter what the particular style of the therapist is, whether he or she works in small or large premises, in the public or the private sector, amongst functional or more lavish surroundings, in casual or more formal dress. What matters is that he or she is at ease, genuine and solid, and that there is an atmosphere of confidence and welcome in the consulting room.
>
> (van Deurzen-Smith, 1997: 190)

For many therapists the framework of the therapeutic relationship is defined by the terms "contract" or "alliance". The therapeutic contract, which is usually framed in the first or the second session, is more than a technical list of procedural terms. It is the frame for expectations and boundaries, which make the therapeutic encounter a unique alliance.

The therapeutic alliance, or 'treatment alliance' (Sandler, Dare & Holder, 1992: 23) is the authentic relationship between client and therapist which precedes the phenomenon of transference:

> Terms other than "alliance" have also been used. Fenichel (1941), for example, writes of "rational transference", Stone (1961) of "mature transference", and Greenacre (1968) of "basic transference"; Kohut (1971) refers to "the realistic bond" between analyst and analysand. Zetsel (1958) puts it as follows: "It is also generally recognized that, over and above the transference neurosis, sucessful analysis demands at its nucleus a consistent, stable relationship which will enable the patient to maintain an essentially positive attitude towards the analytic task when the conflicts revived in the transference neurosis bring disturbing wishes and fantasies close to the surface of consciousness".
>
> (Sandler, Dare & Holder, 1992: 24)

Freud stated that 'there were also friendly relations which were based on reality and which proved to be viable' (Freud, 1937: 219). These 'friendly relations' (Ibid.) were the precondition for the therapeutic bond. 'The concept has been used in reference to aspects of what is familiar to many as the "therapeutic contract" (Menninger, 1958) between the patient and his therapist' (Sandler, Dare & Holder, 1992: 24).

The concept of "contract" became a conventional manifestation of the therapeutic relationship in various approaches to psychotherapy. 'The working alliance is the *sine qua non* of all counselling and psychotherapeutic work no matter what the orientation' (Clarkson, 2000: 32). The contract indicates the boundaries of the therapeutic relationship. 'In counselling, it is the agreement between counsellor and client about their work together; the mutual undertaking to enter into a therapeutic relationship' (Sills, 1997: 3). The contract integrates practical guidelines concerning payment, time management and setting with essential elements such as confidentiality and declaration of expectations, which are the basis of a secure frame:

> Contracts or agreements represent one way in which the counsellor and client define the *nature* of the relationship, e.g. this is counselling and not a friendship, as well as the *boundaries* of the relationship, e.g. if we happen to meet socially we will acknowledge each other but not engage in conversation. However, initial contracts are based on initial assessments (which we both modify and develop)

and will therefore need to be renewed and renegotiated over time.

(Tudor, 1997a: 125)

Some segments of the therapeutic frame/setting/contract are more popular and widespread than the entire concept of the therapeutic encounter. The most frequent are "confidentiality", "boundaries", "containing", "neutrality", etc. Mitchell believes that nothing is more fundamental than confidentiality (Mitchell, 1993: xi). Laplanche and Pontalis claim that the ground rule (of free association) constructs the analytic situation (Laplanch & Pontalis, 1985: 178). Szasz (1962) argued that 'inviolable privacy is a cardinal feature of the analytic situation' (Langs, 1976: 258). Winnicott (1958), Khan (1960), Bleger (1967) and Green (1975) referred to the psychoanalytic setting and its importance for the analytic process (Langs, 1976: 440).

One may assume that Freud's vague recommendations, later called 'ground rules', gave rise to the assumption that ground rules are merely structural and technical devices that have a subsidiary role in the psychotherapeutic process. 'Although structure is fundamental to counselling, structure is often a neglected dimension of the counselling process' (Day & Sparacio, 1989: 17).

Although Marion Milner (1952) created the metaphor of the frame and was the first to refer to ground rules as the framework of the analytic relationship, it was Robert Langs who identified the therapeutic qualities of the frame itself. He broadened the term 'ground rules' to constitute a comprehensive perspective of the therapeutic interaction:

> In terms of positive holding and containing, the secure frame offers the patient a sense of basic trust of the therapist who is able to establish clear boundaries, a cohesive sense of self and a strong hold for the patient. It enables the patient to see the therapist as reliable and in related fashion, provides the patient with a strong and clear sense of reality, clear and precise interpersonal (and self object) boundaries, and otherwise offers an ego - and self-enhancing experience and image of the therapist.
>
> (Langs, 1984: 7)

Langs's definition of ground rules is different from Freud's "recommendations". While Freud's ground rule and recommendations were technical aids, associated with the fictional therapeutic relationship 'in terms of safeguarding the transference' (Langs, 1976: 436), Langs's ground rules were the precondition for establishing 'an

interpersonal relationship with the patient that is relatively stable, separate, realistic and based upon appropriate elements of healthy frustration and gratification' (Holmes, 1998: 27). While Freud's frame was subsidiary to the content of the therapeutic encounter, Langs suggested 'that the framework is the basic vehicle for the therapeutic hold, which provides the stability, security, and boundaries that are necessary for the patient properly to relate and communicate in the therapeutic situation' (Langs, 1976: 444).

The main contribution of Langs' definition of ground rules is its unified structure, in which all components are part of a shared goal: the establishment of a secure frame. 'The ground rules and setting of analysis are referred to as the "frame"' (Smith, 1999: 196). This definition of ground rules sheds light on the role of therapeutic relationships, offering a method of creating a secure environment for the therapeutic encounter. The meaning and role of the secure frame can be interpreted in various ways depending on theoretical assumptions and beliefs, but with some adjustments, the structural concept of Langs's ground rules can be adapted to any school of psychotherapy. Langs himself defined a set of ground rules that may be adapted to psychoanalytic theory, as well as a set of ground rules appropriate for the unique frame of the communicative approach.

Langs's definition emphasises the common denominator of all therapeutic approaches, which, although it is formulated in psychoanalytic terminology, is the central role of the therapeutic relationship. His concept of ground rules is based on a threefold structure.

1. The assumption that 'for humans, a sound frame acts as a safe and supportive, highly stable backdrop and container for coping and surviving' (Langs, 1998: 7).
2. The definition of the psychotherapeutic frame as a unique environment where the psychotherapist can provide his clients with a sense of confidentiality and trust.
3. The postulation that the frame is furnished with a fixed set of ground rules, which together create a "secure frame". 'Handling the ground rules of therapy is a continuous activity of a therapist, even when a particular rule is neglected or goes unenforced' (ibid.: 12).

According to Smith (1991: 173) Langs's ground rules offer the patient a sense of basic trust; clear interpersonal boundaries between patient and therapist; unconscious

support for the patient's contact with reality; the foundation for a relationship that entails a healthy therapeutic symbiosis; the basis for a mode of cure; a situation in which the unfolding dynamics and genetics will centre on the patient's madness rather than that of the therapist; an unconscious image and introjection of the therapist as having a sound identity; an image of the therapist as sane; a powerful sense of being held well and a situation of appropriate frustration and healthy satisfaction.

Langs's ground rules (Langs, 1988: 43-46) include Freud's recommendations and his own formulations of the therapeutic encounter: the setting; the time, length, and frequency of sessions; responsibility for sessions; fees; the absence of censorship; the fundamental rule of free association; the use of the couch; total privacy and total confidentiality; the relative anonymity of the therapist; the use of neutral interventions; and the rule of abstinence.

Although this concise and unified definition of ground rules sheds new light on the therapeutic relationship and serves as a practical guideline for managing the therapeutic frame, one notices that Langs's concept is influenced by his own beliefs concerning the role of decoding unconscious messages in the therapeutic process. In my research I will adopt Langs' definition of the frame and ground rules, but I will try to ignore theoretical terms and refer to the basic structure common to all therapeutic approaches.

Bleger (1967) contributes to the evolution of this subject by differentiating between the analytic frame, which represents the structure of the analytic interaction, and the therapeutic process. He claimed that 'we should apply the term "psycho-analytic situation" to the totality of phenomena included in the therapeutic relationship between the analyst and the patient' (Ibid.: 511). The "therapeutic situation" comprises the analytic process, which is active, and the analytic frame, which is a "non-process", or "silent". Bleger's definition of the therapeutic frame (or the ground rules for creating a secure frame) emphasises its structural role, which is different from the active role of the therapeutic process (analysis and interpretation). Milner's (1952) metaphor of the therapeutic frame as the artist's canvas defines the difference between the content of the frame and everything outside the frame. This metaphor keeps the content of the frame vague. Bleger's definition of the same metaphor outlines the boundaries between the frame and the process. He claims that 'The frame is then an institution within whose bounds certain phenomena take place which we call behaviour' (Bleger, 1967: 512). His perception of the frame as a 'silent

institution' or as 'the receiver of the psychotic part of the personality' (ibid.: 511) opens a new field of investigation of the therapeutic qualities of the frame.

Ground rules in psychoanalysis

The meaning of the words 'but the psycho-analytic relationship is a thing apart' (Freud, 1912: 330) appears simple and self-explanatory. Like any therapeutic relationship, psychoanalytic relationship has idiosyncratic characteristics that distinguish it from any other kind of relationship. The ground rules of psychoanalysis should regulate this special kind of relationship. But Freud's words have a confusing double meaning concerning his 'recommendations' (Freud, 1912) and his 'fundamental ground rule'.

Freud's writings reveal two sources of this confusion. The first one concerns the contradiction between some formulations regarding his recommendations. There is a contradiction between the 'cold' image of the psychoanalyst as a 'surgeon who puts aside all his own feelings' (Freud, 1912: 327) or Freud's statement that 'analysis requires no faith' (Freud, 1913: 345) and his confession that 'there is an affective factor, the personal influence of the physician, which we can seldom do without' (Freud 1895: 368).

The second is the contradiction between his successors' rigid interpretation and application of his recommendations and Freud's warm and friendly relationships with most of his patients. Most of Freud's critics blamed him for feeding Ernst Lanzer (Freud, 1909) or sending money to Sergei Pankejeff (Freud, 1918). Even Langs, whose own approach is based on on Freud's contribution to the field of ground rules, interpreted this confusion as a demonstration of Freud's weaknesses:

> At the same time, however, Freud showed a distinct laxity in his applications of these tenets, as have most analysts. This attitude is the source of considerable confusion regarding both the nature and function of the ground rules themselves, as well as their proper clinical application. As a sign of these difficulties, it may aptly be stated that Freud had the genius of defining a set of valid ground rules and boundaries for the psychoanalytic experience despite the fact that he himself never made definitive use of them.
>
> (Langs, 1982: 304)

Regarding Freud's views and his followers' concepts, defining psychoanalytic ground rules as being confusing or contradictory seems rather superficial and shallow. This criticism is based on the assumption or belief that there is one definite set of ground rules which functions as a religious maxim. Langs's claim that Freud 'was in most respects a frame-deviant psychoanalyst' (Langs, 1998: 37) reflects his own assumptions and ignores the existance of more than one framework of psychoanalytic ground rules.

The bipolar system of psychoanalytic ground rules

The confusion about the contradictory concepts of ground rules in psychoanalytic literature can be clarified by identifying two sets of analytic ground rules. The first is the fundamental rule of free association, which is accompanied by technical recommendations whose objective is to isolate the therapeutic situation from any other kind of relationship. The other is a series of insights and demonstrations concerning humane relationships that are based on support and affection, in order to prepare a fundamental basis for trust.

On the surface, these two sets of ground rules represent the opposite poles of the psychoanalytic relationship. However, in-depth investigation will reveal that there is no contradiction and that the two sets of ground rules reflect different aspects of the same therapeutic frame:

> A distinction has always been made within clinical psychoanalysis between "transference proper" and another aspect of the patient's relation to the doctor which has been variously referred to as the "therapeutic alliance", "working alliance", or "treatment alliance" - i.e. an alliance between patient and analyst necessary for the successful carrying out of the therapeutic work.
>
> (Sandler, Dare & Holder, 1992: 23).

The bipolar system of ground rules is settled with a similar complexity of Freud's models of the mind. Freud developed a few models of the mind, some of which overlap while others do not co-exist comfortably. Psychoanalytic thought is an affiliation of clinical theory whereby 'each model corresponds to a different clinical theory' (Gedo & Goldberg, 1976: 22). Since they are bound to the context of investigation, 'each of these models may represent only those aspects of mental life having the greatest importance for that specific phase of development' (ibid.: 11).

Two of these models, the 'Topographic Model' (Freud, 1900: 509) and the 'Structural Model' (Freud, 1923: 1), are similar in some aspects, but have different implications with regard to the therapeutic relationship. This means that each model refers to a different set of ground rules.

The topographic model represents the intra-psychic relations between consciousness, pre-consciousness and unconsciousness. The therapeutic encounter is focused on this structure and, according to this model, the technique of free association is imperative for any psychoanalytic process. The appropriate set of ground rules is based on the centrality of the fundamental rule of free association, whose goal is to differentiate between intrapsychic processes and interpersonal 'normal' relationships.

The structural model is a metaphoric representation of a multiple personality psychic structure. 'The ego as an agency is central to the structural frame of reference. Unlike the terms id and superego, the term ego was used by Freud from the earliest days of psychoanalysis' (Sandler, Holder, Dare & Dreher, 1997: 181). This model relates to the relationships between these three agencies of the mind, as well as to real objects in the world, such as the therapist. This aspect of the psychotherapeutic relationship was later developed into the relational model and interpersonal theories. With regard to the structural model, the therapeutic encounter focuses on the phenomenon of transference and the multilevel relationships between patients and psychoanalysts. 'Two dimensions of the relationship between patient and analyst have been neatly separated: transference and transference interpretation providing insight constitute one dimension; a preliminary working alliance resulting in a new relationship constitutes the other' (Greenberg & Mitchell, 1983: 395). The empathic set of ground rules is relevant to this model.

The two sets of ground rules serve different functions in different clinical situations. Sometimes it is difficult to differentiate between them and they merge with each other. This is not surprising as the evolution of psychoanalysis is not linear and successive. 'Psychoanalysis developed to a very great extent in and through the work of Freud but, during the course of its evolution, Freud himself frequently modified his formulations, revising concepts and adding new dimensions to technical procedures. This has also been true of psychoanalysis after Freud' (Sandler, Dare & Holder, 1992: 3).

The fundamental rule of free association and its accompanying recommendations, later entitled 'the ground rules of psychoanalysis', represent the secondary role of the

therapeutic relationship in psychoanalytic technique. Freud 'viewed these tenets as a means of "safeguarding the transference", or assuring that the analytic work would unfold at the behest of the patient's needs and psychopathology' (Langs, 1982: 303). This manifest set of ground rules conceals the latent set of ground rules, the ground rules of empathy. These rules, originally considered minor, were based on the priority of therapeutic relationships in any therapeutic process. In later developments of psychoanalysis and psychotherapy they took their place at the front of the stage.

Both sets of ground rules determine the structure of frameworks for psychotherapeutic relationships. They share some overlapping components, while being contradictory regarding others. They take different routes, although their goal is the same. Identifying their different roles in the psychoanalytic practice clarifies the status and development of ground rules and therapeutic relationship in the history of psychoanalysis and its influence on the history of psychotherapy.

In Freud's time there was a clear distinction between these two sets of ground rules. While the fundamental rule of free association and its accompanying 'recommendations' were exclusively dedicated to therapeutic interaction, the ground rules of empathy served to define the special kind of non-therapeutic relationships. Although one could say that in contemporary psychotherapy 'the relationship *is* the therapy' (Khan, 1991: 1), the role of the empathic ground rules in latter-day psychoanalysis and the distinction between therapeutic and non-therapeutic relationships is not so clear, thus requireing more investigation.

The fundamental rule of free association

The fundamental rule of free association is the main psychoanalytic technique, whereby the patient 'expresses to the therapist everything that comes to mind – thoughts, feelings, images, and whatever. This rule is designed to maximize the conscious and unconscious expression of the patient's psychopathology, and to make available for interpretation the critical meanings of the patient's Neurosis' (Langs, 1982: 306).

This technical rule is the main principle underlying Freud's psychoanalytic method and is a precondition for any therapeutic process. 'So say whatever goes through your mind. Act as if you were sitting at the window of a railway train and describing to some one behind you the changing views you see outside. Finally, never forget that you have promised absolute honesty' (Freud, 1913: 355). The resemblance to the legal

oath (the truth, the whole truth, nothing but the truth) is not coincidental, since trust is the basis of any psychoanalytic process. The authoritative formulation of the 'oath' is an artificial effort to ensure a secure atmosphere.

The method of free association is not easy to perform, and is not a passive task. It forces the patient to refrain from his normal way of speaking and expressing and to overcome his habits and linguistic patterns. It also forces him to split his mental processes and report his associations while experiencing them.

The fundamental rule of free association has a twofold structure that brings together the therapeutic relationship and the structure of the mind. The technique of free association is designed in accordance with the topographic model. It processes the content of the pre-consciousness, so that the analyst can interpret and decode it in order to transform unconscious content into conscious content. This process is focused on the interrelationship between the patient's conscious and unconscious systems. At the same time the terms of this rule (the 'oath') define the therapeutic relationship between analyst and patient, which were limited to the boundaries of this process. It obliges the patient to give a phenomenological report of his feelings and thoughts, a complete and sincere report that hides nothing from the analyst.

Since the ground rule of free association represents only the patient's part of the psychoanalytic contract, Freud phrased his recommendations to represent the analyst's part of the contract.

> All these rules which I have brought forward coincide at one point which is easily discernible. They all aim at creating the physician a complement to the "fundamental rule of psycho-analysis" for the patient. Just as the patient must relate all that self-observation can detect, and must restrain all the logical and affective objections which would urge him to select, so the physician must put himself in a position to use all that is told him for the purposes of interpretation and recognition of what is hidden in the unconscious, without substituting a censorship of his own for the selection which the patient forgoes. Expressed in a formula, he must bend his own unconscious like a receptive organ towards the emerging unconscious of the patient, be as the receiver of the telephone to the disc. As the receiver transmutes the electric vibrations induced by the sound-waves back again into sound-waves, so is the physician's unconscious mind able to reconstruct the patient's unconscious, which has directed his associations, from the communications derived from it.
>
> (Freud, 1912: 328)

This passage is unequivocal. It states that the 'recommendations' have the same status as the fundamental rule of free associations, so they can justifiably be entitled 'the ground rules of psychoanalysis' (Smith, 1999: 196). 'The technical rules which I bring forward here have been evolved out of my own experience in the course of many years, after I had renounced other methods which had cost me dear. It will easily be seen that they may be summed up, or at least many of them, in one single injunction' (Freud, 1912: 323). These rules may also be divided into two types:

A. The technical rules derived from the topographic model of the mind direct the analyst to tune his own unconscious 'organ' to his patient's unconscious.

1. Free association and interpretation. The first task of the psychoanalyst is to present the patient with the rule of free association. Freud suggested that except for presenting the fundamental rule 'one lets the patient talk, and explains nothing more than is absolutely necessary to keep him talking' (Freud, 1913: 343). Freud had also refrained of presenting the analyst's corresponding technique of interpretation and suggested that the analyst postpone his intervention and wait for the exact moment.

> The next question with which we are confronted is a main one. It runs: When shall we begin our disclosures to the patient? When is it time to unfold to him the hidden meaning of his thoughts and associations, to initiate him into the postulates of analysis and its technical devices?
>
> The answer to this can only be: not until a dependable transference, a well-developed *rapport*, is established in the patient. The first aim of the treatment consists in attaching him to the treatment and to the person of the physician. To ensure this one need do nothing but allow him time.
>
> (ibid.: 360)

Here Freud emphasised the special role of the therapeutic relationship in preparing the ground for transference.

2. Evenly-hovering attention. This unique state of mind, which is similar in some ways to Buddhist meditation, is the analyst's equivalent of the patient's free-associating. 'It will be seen, therefore, that the principle of evenly-distributed attention is the necessary corollary to the demand on the patient to communicate everything that occurs to him without criticism or

selection' (Freud, 1912: 324). This technique enables the analyst to tune himself to the patient's unconscious, and at the same time it 'disclaims the use of any special aids, even of note-taking, as we shall see, and simply consists in making no effort to concentrate the attention on anything in particular' (ibid.). This rule helps the analyst to concentrate on the therapeutic process, dealing with nothing but the therapeutic encounter.

3. Neutrality. This is the ground rule of 'emotional coldness' (Freud, 1912: 97), which directs the analyst to behave like a surgeon 'who puts aside all his own feeling, including that of human sympathy' (ibid.: 327). The term 'neutrality' is substituted for Freud's original term, 'indifference' (Freud, 1915: 383).

> It is crucial to note here that when the psychoanalysts speak of being *neutral*, they do not mean being cold and inhuman. Neutrality implies keeping a respectful distance so that patients can find their own way and so the analyst's ideas are not imposed upon them. It means respecting the patient's autonomy and integrity.
>
> (Kahn, 1991: 8)

The concept of neutrality is similar to the existential-phenomenological concept of 'bracketing', which is known as 'the rule of epoché. This rule urges us to set aside our initial biases and prejudices of things, to suspend our expectations and assumptions, in short, *to bracket* all such temporarily and as far as is possible so that we can focus on the primary data of our experience' (Spinelli, 1989: 17). This neutrality has nothing to do with the humane relationship between analyst and patient, and it is limited to the therapeutic mode of the analytic process. Neutral setting is a condition for prolific transference.

4. Anonymity. Just as the rule of neutrality stops the analyst from revealing his belief system to the patient, the rule of anonymity prevents him from revealing his personality and private information. 'The physician should be impenetrable to the patient, and, like a mirror, reflect nothing but what is shown to him' (Freud, 1912: 331). Freud's patients knew him and his family and visited him in his private house, but while they were lying on the couch, he functioned as a mirror. He could do that by limiting his interventions to interpretations and by avoiding any references to his private life.
5. Abstinence. This is the third of the three 'major' ground rules

(neutrality-anonymity-abstinence). This rule means that 'extratherapeutic satisfactions for either patient or therapist are to be avoided' (Langs, 1982: 308). The rule of abstinence was designed for the therapeutic process only, so that the analyst would not be tempted to satisfy patients' needs:

> The treatment must be carried through in a state of abstinence; I do not mean merely corporal abstinence, nor yet deprivation of everything desired, for this could perhaps not be tolerated by any sick person. But I would state as a fundamental principle that the patient's desire and longing are to be allowed to remain, to serve as driving forces for the work and for the changes to be wrought, and that one must beware of granting this source of strength some discharge by surrogates.
>
> (Freud, 1915: 383)

The logic behind this rule is that patients' needs and frustrations can serve as motivation in the therapeutic process.

> Although Freud tended to concentrate on the patient's ability to cope with frustration as a realistic principle, he also refers to the psychoanalytic tenet of "truth", which requires the maintenance of a neutral attitude to ensure that the patient's material remains uncontaminated by the therapist. The therapist's ability to tolerate frustration is therefore considered to be a vital factor in the development of a realistic and truthful relationship.
>
> (Holmes, 1998: 24)

It is important to distinguish between abstinence and empathy, since simple gestures represent reality-based relationships, whereas abstinence prevents seduction and exploitation, which can violate the therapeutic process.

6. Self-analysis. Freud claimed that 'anyone who wishes to practise analysis of others should first submit to be analysed himself by a competent person' (Freud, 1912: 329). This means that the psychoanalyst himself serves as a therapeutic instrument and that his theoretical knowledge is not enough. 'Impressions and convictions are received in one's own person which may be sought in vain by studying books and attending lectures' (ibid.). On the one hand, this learning process enables analysts to experience the psychoanalytic process fwhile on the other hand learning about the therapeutic relationship. 'In

addition, the gain resulting from the lasting personal relationship which usually springs up between the learner and his guide is not to be estimated lightly' (ibid.).

7. Non-directive attitude. Since psychoanalysts are naturally inclined to educate their patients in order to accelerate their healing, Freud urged them to limit their ambitions and follow their patient's capacities and pace.

> It is but a natural ambition for him then to endeavour to make something specially excellent out of the person whose neurosis has cost so much labour, and to set up high aims for these impulses. But here again the physician should restrain himself and take the patient's capacities rather than his own wishes as his standard... A physician must always be tolerant of a patient's weakness, and must be content to win back a part of the capacity for work and enjoyment even for a person of but moderate worth.
>
> (ibid.: 331).

This rule is derived from the rules of anonymity, neutrality and abstinence. It is meant to clarify the difference between the advantages of educational ambitions in non-therapeutic relationships, and their destructive role in the therapeutic process. This ground rule can also include the recommendation to avoid intellectualisation, since it contradicts the process of free association.

> It is incorrect to set the patient tasks, such as collecting his memories, thinking over a certain period of his life and so on. On the contrary, the patient has above all to learn, what never comes easily to anyone, that such mental activities as thinking over a matter, or concentrating the will and attention, avail nothing in solving the riddles of the neurosis; but that this can only be done by patiently adhering to the psychoanalytic rule demanding the exclusion of all criticism of the unconscious or of its derivatives.
>
> (ibid.: 332)

It can also include the recommendation to avoid preliminary discussions before the beginning of the treatment. Although Freud agreed to see new patients for a week or two as a preliminary relationship before starting analytic treatment, he insisted that 'on the whole one lets the patient talk, and explains nothing more than is absolutely necessary to keep him talking' (Freud, 1913:

343). By so doing he demonstrated the importance of the fundamental rule at any stage of analysis and the danger to this process of other kinds of communication or relationship:

> Lengthy preliminary discussions before the beginning of the treatment, previous treatment by another method, and also previous acquaintance between physician and patient, have certain disadvantageous consequences for which one must be prepared. They result in the patient entering upon the analysis with a transference already effected, which must then be slowly uncovered by the physician; whereas otherwise he is in a position to observe the growth and development of it from the outset.
>
> (ibid.: 344)

8. The couch. This is the only ground rule that directly relates to the setting of the psychoanalytic encounter. The couch itself was the setting for the therapeutic process, while the physical surroundings in the analyst's room were part of the non-therapeutic setting. Freud's patients could regard the couch as the physical boundary for the treatment. 'In this way they make in their own minds a division of the treatment into an official part, in which they behave in a very inhibited manner, and an informal "friendly" part, in which they really speak freely and say a good deal that they do not themselves regard as belonging to the treatment' (Freud, 1913: 360).

Freud was not aware of this 'division', and he tried to 'tear down the partition' (ibid.) in order to make a sense of what his patients said when not on the couch. At the same time Freud appreciated the advantages of the couch as a neutral setting where he could distinguish between the patient's free association and the phenomenon of transference. 'I persist in the measure, however, for the intention and result of it are that all imperceptible influence on the patient's associations by the transference may be avoided, so that the transference may be isolated and clearly outlined when it appears as a resistance' (ibid.: 354).

B. Free-associating is difficult or almost impossible, since any verbal account is slower than the stream of consciousness. The destructive process of free-associating evokes anxiety. Patients are required to expose their most sensitive secrets, so that trust is a precondition for such activity. The rules of the therapeutic relationship guide the analyst in creating a secure frame for his patient. This set of ground rules has two

functions. While supporting the technical therapeutic method, it also parallels some components of the ground rules of empathy (the 'non-therapeutic' relationship).

1. Fixed time. Later concepts of ground rules claimed that 'the issue of time is a crucial aspect of the therapeutic relationship as it is an area for patients to test the therapist's trust' (Holmes, 1998: 21). Freud was more specific and his special definition of time boundaries must be considered advertently. He claimed that his clients hired his time and must pay for it. 'I adhere rigidly to the principle of leasing a definite hour. A certain hour of my available working day is appointed to each patient; it is his, and he is liable for it, even if he does not make use of it' (Freud, 1913: 346).

   This means that the patients are responsible for the psychoanalytic hour or, in other words, that they are equal partners in the therapeutic procedure and even in the therapeutic process. This ground rule has a contractual function and plays a central role in creating a secure frame.

   Freud also referred to the length and frequency of the analytic session ('the average time of an hour a day'. (ibid.: 347), and refused to fix the length of the treatment. 'The question of the probable duration of the treatment is hardly to be answered at all' (Ibid.: 348). Only five years later, in the case of Serge Pankejeff (Freud, 1918), Freud limited the duration of the treatment for the first time and found it efficient.

   Freud was also sincere enough to admit that fixed times and clients' responsibility for attending their sessions were important for his own interests. 'Under a less stringent régime the "occasional" non-attendances accumulate so greatly that the physician's material existence is threatened' (Freud, 1913: 346). This frank statement means that the analyst's interests are part of the therapeutic relationship and have to be seriously considered.
2. Fixed fee. The payment is also a contractual element of the therapeutic relationship. It concludes the agreed rate for a session, the mode of payment and responsibility for cancelled sessions.

   Since the fee reflects the psychoanalyst's professional self-evaluation, this subject can evoke confusion and produce complicated explanations. Although Freud had no difficulty stating that the analyst must protect his 'material existence' (ibid.), he claims that

> the analyst does not dispute that money is to be regarded first and foremost as the

means by which life is supported and power is obtained, but he maintains that, besides this, powerful sexual factors are involved in the value set upon it; he may expect, therefore, that money questions will be treated by cultured people in the same manner as sexual matters, with the same inconsistency, prudishness and hypocrisy.

(ibid.: 351).

Freud attributed this to his patients, and refrained from self-observation. He connected the financial relationship with his revolutionary theory of sexuality.

He is therefore determined beforehand not to concur in this attitude, and in his dealings with patients to treat of money matters with the same matter-of-course frankness that he wishes to induce in them towards matters relating to sexual life. By voluntarily introducing the subject of fees and stating the price for which he gives his time, he shows the patient that he himself has cast aside false shame in these matters.

(ibid.).

Freud admitted that giving treatment gratuitously 'would rob him of a quarter or a third of his earning capacity, which would be comparable to the effects of some serious accident' (ibid.: 352). Here, again, Freud found theoretical explanations for his objection to free treatment. 'Gratuitous treatment enormously increases many neurotic resistances, such as the temptations of the transference-relationship for young women' (ibid.: 353).

The ground rule of payment raises some sensitive issues in the psychoanalytic relationship, since it involves elements that relate to the private interests of the analyst and the patient, concerning their financial situation.

3. Privacy and confidentiality. Whereas the patient exposes his most intimate secrets in the analytic encounter, the psychoanalyst maintains his privacy and confidentiality. This mutual commitment creates the therapeutic contract that protects the analytic situation.

We form a pact with each other. The sick ego promises us the most complete candour – promises, that is, to put at our disposal all the material which its self-perception yields it; we assure the patient of the strictest discretion and place at his service our experience in interpreting material that has been influenced by the unconscious. Our knowledge is to make up for his ignorance and to give his

ego back its mastery over lost provinces of his mental life. This pact constitutes the analytic situation.

(Freud, 1940: 173)

Freud's recommendations concerning privacy and confidentiality are rather vague. For him the rule of confidentiality was self-evident, since as a doctor he was committed to the Hippocratic Oath. Therefore, he focused on the question of third parties.

'It will then soon be time to recommend the patient to treat the analysis as a matter between himself and his physician' (Freud, 1913: 357). Furthermore, Freud advised his patients 'that as few persons as possible shall be informed of it, one protects patients to some extent from the many hostile influences seeking to detach them from the analysis' (ibid.).

Therapeutic relationships with relatives and friends are forbidden. 'Special difficulties arise when friendship or acquaintance already exists between the physician and the patient, or their families. The psycho-analyst who is asked to undertake treatment of the wife or child of a friend must be prepared for it to cost him the friendship' (ibid.: 345). The same is true about relationship with patients' relatives. 'The most urgent warning I have to express is against any attempt to engage the confidence or support of parents or relatives by giving them psychoanalytical books to read – either on an introductory or of an advanced kind. This well-meant step usually has the effect of evoking prematurely the natural and inevitable opposition of the relatives to the treatment' (ibid.: 333).

Avoidance of writing during the analytic session is another recommendation that is meant to preserve patients' confidentiality and privacy. Writing during a session deviates from the rule of privacy, and gives rise to the 'unfavourable impression which this makes on many patients' (Freud, 1912: 325). It also interferes with the analysts evenly-hovering attention. 'The same considerations as have been advanced in regard to attention also apply here' (ibid.). Freud also claimed that it is worthless to write during the session, since 'the exact reports of an analytic history of a case are less valuable than might be expected' (ibid.: 326).

Freud's fundamental ground rule of free association and his 'recommendations' can be

formulated as two sets of ground rules that refer to the two aspects of the psychoanalytic encounter: the psychoanalytic process and the therapeutic alliance. Some of these rules originated in Freud's technical writings, while others were mentioned in later publications. Freud never related to them as ultimate instructions, and they were continuously changed and developed.

During the evolution of psychoanalysis one can observe two paths concerning the definition of ground rules. The first fixed Freud's recommendations as a rigid set of instructions for clinicians, while the second shifted the focus from psychic processes to interpersonal relationships. One may guess that most psychoanalysts adapted these rules to their own needs and personality and kept changing them as Freud did.

The ground rules of empathy

There are no ground rules of empathy in Freud's recommendations, but the exploration of his relationships with his patients and the subtext of his writings reveal a solid conception of the humane ingredient in the therapeutic relationship.

While the fundamental rule of free association, its accompanying set of ground rules and the ground rules of therapeutic relationship all serve to secure the psychoanalytic frame, the ground rules of empathy establish the non-therapeutic professional relationship between analysts and patients.

The ground rules of empathy are part of the psychotherapeutic session and, although they resemble everyday human relationships, they are bounded to the therapeutic environment and based on the ground rules of therapeutic relationship (time, fee, setting, etc.).

The main task of the ground rules of empathy is to create a 'secure frame', i.e., to establish trust between therapist and patient and to prepare the ground for the therapeutic process. 'There is no therapeutic procedure of which one may say that it can do entirely without the cooperation of this personal factor' (Freud, 1985: 368).

1. Empathic attention. This ground rule, which actually includes all the other rules, has a twofold structure. The first one is the ability of the therapist to bracket his own beliefs, assumptions and judgements, so that he can listen to the patient without any personal bias. This does not mean that the analyst has to hide his own views from his patients, but that he must be aware of them and not let them interfere with him as a non-judgmental listener. The other one is

the therapist's effort to 'look through the patients' eyes', so he can see their point of view without agreeing or disagreeing with them. Empathic attention is more than just passive listening since it also requires the analyst to suspend his theoretical knowledge and practical habits.

In a way, empathic attention is parallel to Freud's 'evenly-hovering attention'. 'One has simply to listen and not to trouble to keep in mind anything in particular' (Freud, 1912: 324). By doing this, the analyst may 'bend his own unconscious like a receptive organ towards the emerging unconscious of the patient' (ibid.: 328).

Since 'the first aim of the treatment consists in attaching him [the patient] to the treatment and to the person of the physician' (Freud, 1913: 360), friendly relations are a legitimate way to obtain this task. 'There were also friendly relations which were based on reality and which proved to be viable' (Freud, 1937: 219).

Freud's treatment of Ernst Lanzer (the 'Rat Man') was a demonstration of empathic attention. 'He took a genuine interest in Ernst's life, his symptoms, and his feelings and tried to explore these with his patient. When the ruptures threatened the treatment, Freud recovered the tie, usually through some act of concern, affection, or generosity' (Kiersky & Fosshge, 1993: 131).

As is evident in most of his case studies, Freud never tried to hide his empathic attitude towards his patients. This sort of relationship did not contradict his technical recommendations, but rather enriched them:

> The uncovering of origins, we now recognize, is not an archaeological expedition that can be curative simply by virtue of what is brought to light. And the meaning of the various elements of our patients' lives and histories is truly to be found not in any search for their origins, but in an empathic understanding of the dynamic use that they serve.
>
> (Magid, 1993: 199)

Freud's notorious failure in the case of Ida Bauer ('Dora') is the only case study in which he lost his empathic attention. When she came to see him fifteen months after leaving him, he didn't want to listen to her. 'One glance at her face, however, was enough to tell me that she was not in earnest over her request' (Freud, 1905: 121). Although in this case Freud demonstrated two brilliant dream interpretations which were 'a model for students of psychoanalysis'

(Jones, 1955: 257), he had 'neither respect nor sympathy for Dora' (Mahony, 1996: 143).

2. Containing and holding. Freud's relationships with his patients had three dimensions, each of them relating to a different set of ground rules: the couch (the fundamental ground rule), therapeutic relations in the analytic session (the ground rules of the therapeutic relationship) and his friendly relationship with his patients (the ground rules of the non-therapeutic relationship). It is difficult to control these three dimensions and to manage the boundaries of each set of ground rules. To accomplish this complicated task one needs to function as a container, in which the patient is held and protected in this confusing situation. Freud was an expert in containing and holding his patients, as we can see in the case of Lanzer and in his life-long relationship with Pankejeff.

Freud never used the terms 'containing' and 'holding', which became conventions of later psychoanalytic developments, but he was aware of the parental functions of the analyst, and admitted that 'sometimes one has to be both mother and father to a patient' (Roazen, 1995: 192). Winnicott interpreted this concept as the strength and stability of the analyst 'as a relatively mature person' (Langs, 1976: 128).

Containing and holding means that the special empathic relationship between analyst and patient is limited by the boundaries of the ground rules. Although Freud had non-therapeutic relationships with his patients, he contained and held these relationships, protecting them from external interruptions. He did so by separating them from other circles of relationships. 'He had specified that when she was in analytic treatment with him, she would have to sacrifice contact with the Freud family for that period of time' (Roazen, 1995: 159).

The concepts of containing and holding were later reflected in the works of Winnicott, who introduced the importance of the 'reliable "holding" analytic setting' (Smith, 1999: 156), and Bion (1970) 'an analyst who extended some of Klein's ideas, proposed that the mother's role is to act as a container for the baby's destructive impulses' (Holmes, 1998: 44). The concept of the container has practical implications for the therapeutic relationship. 'Furthermore, clear-cut interpersonal guidelines benefit the patient, as he is given the opportunity to appreciate and experience the gratification and frustration of being appropriately contained by the therapist' (ibid.).

3. Mutuality. Psychotherapeutic relationships are non-egalitarian by definition.

They are based on substantial power differences between the authority and self-confidence of the analyst and the fragile and sensitive mental state of the patient. In this state of affairs it is almost impossible to create mutual relationship.

The therapeutic/analytic situation evokes stress and anxiety, and the rule of mutuality must make therapists and analysts aware of the danger of abusing their power and exploiting their patients. Mutuality helps therapists to create non-therapeutic relationships with their clients as a preparation for establishing a secure therapeutic frame.

The ground rule of mutuality reproduces a characteristic of everyday relationships between the boundaries of this unique non-therapeutic relationship. Freud demonstrated the ground rule of mutuality by shaking his patients' hands when he met them or when they departed. 'Freud regularly shook hands before and after every analytic hour. A handshake can be not only a social ritual but a means of human communication and support, and some of Freud's patients remembered the special significance of the handshakes with Freud' (Roazen, 1995: 36). Freud never treated this non-therapeutic habit as 'seductive', as some of his followers did. When his patient left something on the couch, 'he held on to her hand looking back at what she had forgotten' (ibid.). He could also compliment his patients, and 'comment on a dress she wore' (ibid.). These gestures made his patient feel that 'he was a "warm" man, that you could feel it as he passed his children in the corridor' (ibid.).

In these mutual relationships, Freud listened to his patients' everyday reports and gossip and shared his human feelings with them. 'By his talking with Hirst about cocaine Freud was implicitly enhancing, even if unknowingly, his own standing as a powerful physician' (Roazen, 1995: 9).

Freud made his patients feel equal. He sent a postcard to Lanzer and signed it with the word 'Cordially' (Mahony, 1986: 116). He was criticised for lending a book (Emil Zola's *La Joie de Vivre*) to Ernst Lanzer (ibid.: 121), but he lent books to other patients as well. 'During her analysis Freud had once lent Levy a book about archaeological excavations in Crete, referring to the Minoan culture that formed a deeper layer under Greek History... Book lending was clearly not part of ordinary orthodox psychoanalytic technique, but Levy was aware that Freud had been exempt from "strict rules"' (Roazen, 1995: 157). This was not an educational effort, since his patients did the same. Edith Jackson brought him a

best-selling novel, *Ramona*, by Helen Hunt Jackson, her father's first wife. 'Freud read it "that night" and the next day was able to discuss anything about it' (ibid.: 92). The ground rule of mutuality provoked criticism against Freud, especially concerning his relationship with Ernst Lanzer. But most critics ascribed his 'faults' to the strict ground rules of psychoanalysis, and ignored the differences between therapeutic and non-therapeutic relationships:

> Lipton (1977) maintained that Freud separated his technique from his personal relationship to the Rat Man and that such a separation even furthered the analytic process. In this light, Lipton insisted, Freud's personal response to sudden contingencies, such as giving a meal to the Rat Man, did not interfere with treatment, for the patient's real object relationship and its new investiture could by duly analyzed (See also Lipton, 1971). I would side with Stone's position that Freud's early naturalness is superior to the robotlike anonymity of many American analysts in the 1950s.
>
> (Mahony, 1986: 118)

In later developments of psychotherapy, the ground rule of mutuality became more accepted. In existential psychotherapy mutuality is considered to be the source of the therapeutic relationship. 'This raises interesting questions for psychotherapy, as it suggests the need for a considerable level of mutuality between therapist and client' (van Deurzen-Smith, 1997: 76).

4. Collaboration. Although psychoanalysis is associated with the medical model, in which practitioners manipulate their patients, collaboration between patients and therapists is essential in creating non-therapeutic relationships. As Freud suggested, this is not the same sort of collaboration that is needed in the therapeutic process or the medical process. 'The situation here is no different from what it is elsewhere in medicine and there is no therapeutic procedure of which one may say that it can do entirely without the cooperation of this personal factor' (Freud, 1895: 368).

The ground rule of collaboration applies to the pre-therapeutic relationship, in which analyst and patient engage. Freud didn't recommend that the analyst 'bring his own individuality freely into the discussion' (Freud, 1912: 330), but it is important to notice that this was only true for 'the psycho-analytic relationship' (ibid.). In the pre-analytic relationship he did freely express his own individuality with his patients. 'Emma Eckstein and Freud stayed "friends"

for as long as she lived, but the physician-patient relationship between them was over' (Roazen, 1995: 11).

Sometimes collaboration contradicts anonymity, when the analyst talks about himself. 'He talked about "everything under the sun" – but he "analyzed" her, "too." He got on so well with her that he once joked about himself in the third person: "Everybody tells you things, even Freud".' (Roazen, 1995: 174). On another occasion, when the patient talked about Mozart's *Don Giovanni*, 'Freud indicated how much he loved it and, although he was "not musical", he would begin to hum some of the opening bars' (ibid.: 100).

Freud claimed that he disliked 'resorting to analytical writings as an aid to patients' (Freud, 1912: 332), but he did share his theoretical enthusiasm in his non-therapeutic relationship with them. 'These notes show Freud explicitly asking himself questions, posing hypotheses, reflecting some and accepting others. He did this not merely in private but also collaboratively with the patient. At times Freud was openly appreciative, even admiring, of the patient's good psychological ideas' (Losher & Newton, 1996: 197). Serge Pankejeff, the famous 'Rat Man', stated in his memoirs that 'in my analysis with Freud I felt myself less as a patient than as a co-worker, the younger comrade of an experienced explorer setting out to study a new, recently discovered land' (Pankejeff, 1989: 140). Freud even gave support to this feeling of collaboration. 'This feeling of "working together" was increased by Freud's recognition of my understanding of psychoanalysis, so that he even once said it would be good if all his pupils could grasp the nature of analysis as soundly as I' (ibid.).

The ground rule of collaboration is part of the pre-therapeutic contract, in which both sides agree regarding their common expectations and commit themselves to working together. 'The treatment approach developed by Freud is based on an explicit division of labor, about which analyst and analysand, as coworkers, can and should talk, just as colleagues must talk in other forms of work' (Losher & Newton, 1996: 207).

5. Provocation. Although in psychoanalytic therapy, analysts are almost passive, abstaining from almost any intervention that is not purely analytic (interpretations), provocation can be effective in obtaining patients' collaboration in the pre-therapeutic stage of relationship.

Provocation can be a deviation from proper psychoanalytic practice when it is part of the therapeutic process. Freud demonstrated this kind of provocation

when he tried to manipulate Dora's associations by an experiment (while stopping her 'free associations'):

> I opened the discussion of the subject with a little experiment, which was, as usual, successful. There happened to be a large match-stand on the table. I asked Dora to look round and see whether she noticed anything special on the table, something that was not there as a rule. She noticed nothing. I then asked her if she knew why children were forbidden to play with matches.
>
> (Freud, 1905: 106)

But usually, Freud 'never reproached or contradicted' (Roazen, 1995: 127) his patients. When he did so, he tried to provoke his patients in the context of their relationship. In the case of Serge Pankejeff, with whom he kept a close relationship for many years, Freud limited the length of the analysis for the first time in his career. In 'Analysis Terminable & Interminable' (Freud, 1937) Freud admitted that this provocation is a 'blackmailing device: it is effective provided that one hits the right time for it' (ibid.). This provocation was not part of the therapeutic process and could only endanger non-therapeutic relationships.

On another occasion 'Freud recommended to a pupil that, in the case of an apparently aloof and detached patient, the analyst should arouse the patient's envy by making some show of approval about another patient in analysis (The device worked)' (Roazen, 1992: 126).

In later developments of psychotherapy, provocation became part of the ground rules of the therapeutic process, as in Victor Frankl's 'paradoxical intention' (Frankl, 1984: 146).

6. Unconditional positive regard. Since patients enter the psychotherapeutic process worried and insecure, and since they are obliged to reveal their most intimate secrets, the analyst has to support and accept them in a non-judgmental manner.

During analytic sessions, Freud was interested in his theoretical assumptions and the search for truth and he behaved like a police investigator. 'He insisted on the validity of his explanations in the fashion of an infallibly clever detective who had already solved the puzzle of who committed the crime and now simply had to prove it and had to have the "suspect" accept his conclusions' (Ornstein, 1993: 66). Thus, the technique of free association created an intimidating and insecure setting for the patient. The ground rule of unconditional positive regard

fan play a balancing role in this difficult situation.

This explains Freud's warm relationships with his patients while they were off the analytic couch. 'It showed Freud behaving too much like a caring human being as opposed to how a so-called classical analyst was supposed to act in Eissler's view of things' (Roazen, 1995: 37).

When Freud told Ernst Lanzer 'a word or two upon the good opinion I had formed of him, and this gave him visible pleasure' (Künstlicher, 1998: 145; Hawelka, 1974: 21) he didn't contradict the rule of abstinence. He had to support and strengthen his patient, so the latter could cope with the tough demands of the therapeutic procedure.

When Hilda Doolittle first met Freud she felt uncomfortable. Her previous analytic experiences had been unsatisfactory and she was disappointed. Freud identified her resistance, and knew how to deal with her bad feelings.

> He has a real fur rug, and I started to tell him how turtle [Sachs] had none, he seemed vaguely shocked, then remarked, "I see you are going to be very difficult. Now although it is against the rules I will tell you something: YOU *WERE* DISAPPOINTED, AND YOU ARE DISAPPOINTED IN ME." I then let out a howl, and screamed, "But do you not realize you are everything, you are priest, you are magician." He said, "No. It is you who are poet and magician".
>
> (Doolittle, 1988, in Lohser & Newton, 1996: 41)

The concept of unconditional positive regard was adapted by Carl Rogers and became the core of his new therapeutic approach, 'person-centred counselling'. 'When the counsellor is able to embrace this attitude of acceptance and non-judgmentalism, then therapeutic movement is much more likely. The client is more able to feel safe to explore negative feelings and to move into the core of his anxiety or depression' (Mearns & Thorne, 1995: 14).

7. Love. When Freud stated that 'sometimes one has to be both mother and father to a patient' (Roazen: 1975: 192) he was comparing the therapeutic relationship with the parental relationship. 'To be both mother and father' is more than being an object of transference for the patient. This metaphor for the therapeutic relationship is similar to Winnicott's definition of the therapeutic setting as a reconstruction of early mothering techniques.

   Parental relationships are based on the integration of authority and love. In

psychoanalytic terms, parental relationships are the combination of therapeutic ground rules and the ground rules of empathy. Love can be defined by the separate ground rules of empathy, containing, holding, mutuality, collaboration, unconditional positive regard and even provocation. 'As a therapist, however, Freud was often acting as a parental substitute. Freud could be giving with one hand while taking away with the other; he offered the ideal of autonomy and self-determination at the same time as he was laying down certain rules for the procedure of psychoanalysis' (Roazen, 1995: 276).

Attributing parental relationships to Freud's psychoanalytic theory explains the unique nature of the relationship he established with his patients. As a parent, Freud could be rigid, while drawing the boundaries of the therapeutic relationship, and at the same time he could be humane and loving. Like a parent, Freud was never his patients' friend, although he kept close and warm relationships with them after their treatment was terminated.

Freud didn't love his patients as friends or partners, but as if they were all his children. He explicitly denied any kind of sexual love between analyst and patients. 'For the physician there are ethical motives which combine with the technical reasons to hinder him from according the patient his love' (Freud, 1915: 389). This resulted from the rule of abstinence. 'I have already let it be seen that the analytic technique requires the physician to deny the patient who is longing for love the satisfaction she craves' (ibid.: 383).

However, at the same time, Freud didn't renounce the importance of love (parental love) in the non-therapeutic relationship, as he wrote to Jung. 'Essentially, one might say, the cure is effected by love' (Freud/Jung, 1979: 50). The analyst's love for his patients can serve as an educational instrument. 'One principal aim of analysis is to provide realistic lessons in love and bring its two currents into harmony' (Gay, 1989: 291).

Freud differentiated between the patient's love for the analyst, which was 'transference-love', and the analyst's love for the patient, which was a kind of parental love. The difference derived from the incest taboo. 'The incest taboo in psychotherapy is clearly important because of the intense intimacy of the counselling/psychotherapy relationship' (Clarkson, 2000: 24). This differentiation enables psychoanalysts and psychotherapists to separate between their patients' therapeutic needs and their own. 'We are required to act constantly in the arena of love, yet renounce all personal gratification; we work in one of

the most potent cauldrons of intimacy, yet we are prohibited to drink from it' (ibid.: 25).

One can relate to Freud's 'deviations' from what were later called 'the ground rules of psychoanalysis' as manifestations of parental love. He was aware of these non-therapeutic gestures and never tried to hide them. Freom reading the famous case studies and other reports one can almost see Freud's patients as his children. He loved them while treating them and for many years afterwards, and he was always interested in them and in their lives. He could help them when they needed help, or be happy with their successes. He even loved Dora, his 'defiant daughter' who provoked his anger and frustration, when he 'promised to forgive her for having deprived me of the satisfaction of affording her a far more radical cure for her troubles' (Freud, 1905: 164).

The role of love, or parental love, within the unique boundaries of therapeutic and non-therapeutic relationships took a central place in later developments of psychotherapy. 'Privately, many other clinicians would admit that it is indeed only a deeply "loving" motivation that sustains a psychotherapist through the turbulent vicissitudes of the healing relationship over time' (Clarkson, 2000: 23). Rogers' 'unconditional positive regard' was interpreted by some therapists as love. 'I recognised instantly that to offer clients the kind of relationship characterised by the presence of the core conditions was, in practice, to love them' (Thorne, 1991: 180).

The ground rule of love is the consequence of the sum total of the ground rules of empathy. It defines the therapeutic relationship as a kind of parental relationship within the unique boundaries of patient-analyst relationship.

Further implications of the bipolar system

The fundamental rule of free association defines the special qualities of the psychoanalytic situation and the unique mechanism of the therapeutic relationship. It represents the patient's role in deconstructing his mental content through non-directive associations, and the analyst's part in reconstructing them (Spiegel, 1975). It demonstrates the structure of unconditioned talking and active listening, which characterises the innovation of the talking cure. Spiegel claims that this new kind of communication contributes 'to the development of a psychoanalytic culture in which both patient and analyst participate' (Langs, 1976: 594), and that 'these

complementary attitudes tend to induce mutual identification because they place both participants in related attitudes toward the analytic material, making feasible not only the analyst's empathic understanding of the patient, but probably the analysand's empathic understanding of the analyst as well' (ibid.).

The technique of free association influenced Freud's relationships with his patients, and led him to define the fundamental ground rule of free associations, which let to some recommendations. Unfortunately, contrary to his intentions, this rule and its accompanying recommendations were accepted by his successors as one of the ultimate ground rules of psychoanalysis.

Relating to Freud's recommendations (or, more accurately, 'pieces of advice,' Losher & Newton, 1996: 14) as taboos or as rigid rules is understandable, since 'in humans, rules and laws of behaviour and conduct, moral and otherwise, govern actions and interactions with others' (Langs, 1998: 4). At the same time it is understandable that other psychoanalysts rebelled against these taboos and defined new ground rules. Nevertheless, this view of the natural process in the history of psychoanalysis ignores and blurs a fundamental quality in Freud's perception of ground rules.

1. **Elasticity.** Freud's recommendations were 'a complement to the "fundamental rule of psycho-analysis" for the patient' (Freud, 1912: 328), and undoubtedly served him as ground rules, but he applied them flexibly, adapting them to his needs. 'Considering the strong emphasis Freud placed on flexibility in the application of his procedural guidelines, it is interesting to note, as Roazen pointed out, that many of his followers treated them as rigid rules' (Losher & Newton, 1996: 15). In a letter to Ferenczi Freud complained that 'the result was that the docile analysts did not perceive the elasticity of the rules I had laid down, and submitted to them as if they were taboos' (Jones, 1955: 241).

This elasticity or flexibility derived from Freud's belief that the result of the treatment is more important than technical devices, and that the relationship with his patients is the source of any therapeutic process. 'There are many ways and means of practicing psychotherapy. All that lead to recovery are good' (Freud, 1905: 259). Freud was task-oriented. 'It seems that his interest was in creating a treatment situation that would be most conductive for achieving the goal of the analysis rather than in establishing rigid rules or standards of conduct for their own sake' (Losher & Newton, 1996: 22). The importance of Freud's concept of elasticity is essential. It emphasises that the structure and role

of ground rules in creating the secure frame are more important then their content. This means that ground rules have to be considered and adapted to the purposes of each treatment and patient.

Ferenczy devoted his paper, 'The elasticity of psycho-analytic technique' (Ferenczy, 1928), to certain modifications of the technical recommendations and activity of the analyst, but most of Freud's successors ignored this concept and preferred to view ground rules dogmatically. 'In a seeming paradox, Freud was both more authoritative and more collaborative than many modern analysts' (Losher & Newton, 1996: 197). The misinterpretation of Freud's concept of the ground rules influenced the history of psychoanalysis:

> The tendency of modern psychoanalysis to make procedure itself so all-encompassing had important consequences for the entire analytic situation. For example, it tended to shift the emphasis from the task of the treatment to the analyst's behavior so that his or her interventions were no longer evaluated in terms of treatment outcome but against abstract theoretical standards.
>
> (ibid.: 178)

2. **The bipolar system.** Freud's manifest ground rules and the subtext empathic ground rules create a bipolar system of ground rules that together establish the secure frame. This concept of ground rules explains what one can interpret as deviations or contradictions in Freud's theory and practice. Actually there are neither deviations nor contradictions, but different sets of ground rules relating to different kinds of relationships between Freud and his patients. There are the fundamental ground rule of free association and the ground rules of therapeutic relationship, which help the analyst to promote the therapeutic goal, and there are the ground rules of empathy, which establish the non-therapeutic relationship. 'Freud's attitude toward the work helped establish the formation of a strong therapeutic alliance and made the pursuit of the task a collaborative effort, in contrast to the unilaterality in the analytic relationship that came to be accepted in the 1950s' (ibid.: 161). Freud related to the multilevel structure of his relationship with his patients, and adapted his ground rules to their needs. 'In focusing on the physician-patient relationship, Freud called attention to the true locus of all therapeutic efforts, whether they were surgical, internal, or psychotherapeutic' (Boss, 1979: 257).

> Thus, in contrast to the basic model technique, Freud's approach is more natural. Analysts speak in a normal voice in a normal manner to their patients. Analysts are not required to hide their beliefs, feelings, and values, though they are free to do so. They need not fear – and patients need not preoccupy themselves with provoking – a personal revelation.
>
> (Losher & Newton, 1996: 205)

Freud's followers, rigidly applied the ground rules, ignoring the ground rules of empathy or criticising them as technical deviations, relinquished the humane factor of psychoanalysis and the curative qualities of the therapeutic relationship. 'In the 1950's, the theory of technique in the United States lost some of this richness and the polarity collapsed into a theory that emphasized the rational, objective, impersonal, scientific, and rule-bound aspects of the original' (ibid.: 23).

The importance of the bipolar system is its integration of therapeutic and non-therapeutic relationships and the recognition of creating the relationship as a precondition to any therapeutic process. 'One of the first tasks of treatment is to attach the patient to the analyst, a development that is promoted by an analytic stance characterized by empathy, serious interest, and acceptance. This, together with instructions about free association and the removal of initial resistances, is sufficient to help patients express themselves more freely' (ibid.: 20).

Denying the integration between technical and empathic rules in Freud's model of ground rules led to debates and divisions in the psychoanalytic movement. 'The banished pole of tact, empathy, intimacy, and spontaneity – "intersubjectivity" in its most recent garb – tended to split off from mainstream psychoanalysis into separate schools' (ibid.: 23).

3. **The couch.** In Freud's practice the couch was not only a 'vestige of the hypnotic method' (Freud, 1913: 354) but a device that separated the therapeutic from the non-therapeutic relationship. The couch illustrated the boundaries of the setting for the psychoanalytic process.

> Thanks to the use of the couch, Freud felt, the patient does not have too much reality to cope with, and therefore encounters little interference in developing his fantasies about the analyst: hence a more efficient build-up of transference. The analyst's distance from his patient not only facilitates the analyst's rational

insight, which might be impeded in a more commonplace setting, but also, Freud thought, expands the range of kinds of patients accessible to analytic influence.

(Roazen, 1992: 123)

Freud's recommendation concerning the couch was his only reference to the psychoanalytic setting. Without the couch there is no meaning to 'neutrality', 'anonymity' and 'abstinence'. 'The use of a couch can also help the analyst avoid emotional intimacy with patients' (ibid.). This explains Freud's strict adherence to the couch as if it were also a fundamental ground rule. 'I know that many analysts work in a different way, though I do not know whether the main motive of their departure is the ambition to work in a different way or an advantage which they gain thereby' (Freud, 1913: 354).

Most of Freud's critics ignored the importance of the couch as a secure frame, referring to the superficial claim regarding eye contact:

> There are, however, other ways of avoiding eye-to-eye contact besides lying on a couch, while maintaining some sense of an ordinary, real relationship. Karen Horney, for example, allowed her analytic patients to choose between the couch or the chair. Sullivan never used the couch, choosing instead to position the chairs at right angles to avoid eye contact. Similarly, R.D. Laing abandoned using the couch soon after his analytic training, opting instead to situate the chairs at opposite ends of his consulting room, keeping eye-contact to a minimum.
>
> (Thompson, 1994: 165)

The necessity of the couch for the technique of free association, the fundamental rule of psychoanalysis, explains why it was so fundamental for Freud. In later developments in psychoanalysis the focus shifted from the technique of free association (to make the unconscious conscious) to analysing the transference. 'In modern discussions technique, such as analyzing the transference, is often unwittingly lifted from the status of a method to the level of a goal' (Losher & Newton, 1996: 22). This shift made the technique of free association unnecessary, thus the use of the couch became marginal.

This course of events, that diminished the use of the couch also abolished the special kind of analytic setting and its important role in creating the relationship and establishing a secure frame. In later developments of psychoanalysis, the

difference between therapeutic and non-therapeutic relationship disappeared and the analyst's clinic was considered the setting, which included all interactions between analyst and patient. This new definition of setting had a significant effect on the psychoanalytical endeavor. Conservative analysts adapted a rigid stance towards the setting, including an extreme application of neutrality, anonymity and abstinence. They worked in a private clinic in an office building, avoiding any physical contact with their patients or any other communication.

The couch as a unique setting for the analytic process, and its advantages in creating relationship with patients, is not discussed in psychoanalytic discourse or in new developments of psychotherapeutic ground rules. In the psychoanalytic literature authors refer to 'the role of the couch as a component of the analytic framework' (Ogden, 1996: 884), but they never discuss the couch as the psychoanalytic setting itself.

The disregard of the unique quality of Freud's bipolar system of ground rules prevented further developments in this field. The structural role of ground rules in psychotherapy demands further investigation.

Ground rules in psychotherapy

While Freud established the corner stone in the field of ground rules, one can say that Robert Langs shaped the concept of ground rules and set it as the main definition for the therapeutic frame and interaction. He was not the only one who related to the frame and the ground rules, but his extensive writings and comprehensive view 'heightened psychoanalysts' awareness of the role of the frame' (Smith, 1999: 206).

Langs claimed that 'there is, in all, a broad agreement that a secured framework of a psychotherapy creates a background of safety and a holding environment for a therapy patient, but the definition and properties of a secured frame have eluded a clear consensus' (Langs, 1998: 17). In order to create a clear definition, Langs tried 'to define the ideal set of ground rules for a therapeutic experience' (ibid.: 22) which is universal. This ambitious effort had a paradoxical outcome. Langs succeeded in presenting the structural model of the psychoanalytic ground rules and their morphological qualities, but his 'universal' set of ground rules was based on his own assumptions, concerning communicative psychotherapy.

Langs 'ideal framework of psychotherapy' (ibid.: 42) has a threefold structure:

A. The relatively fixed frame.

1. The setting.
2. The time.
3. Responsibility for sessions.
4. Fees.

B. The relatively fluid, but firmly held, ground rules.

1. The absence of censorship.
2. The fundamental rule of free association.
3. The use of the couch.
4. Total privacy and total confidentiality.
5. The relative anonymity of the therapist.
6. The use of neutral interventions.

C. Implied Ground rules.

1. The rule of abstinence.

This structure introduces the differences between procedural rules (setting, time, responsibility for sessions, fees) and 'fluid, but firmly held' rules that are associated with the technique and contents of the therapeutic process. The 'implied ground rules' indicate that the structure is flexible and more ground rules can be added.
While some of these ground rules are independent of any therapeutic theoretical approach (the relatively fixed frame), others are associated with the psychoanalytic approach (free association, the couch).

Langs ignored Freud's distinction between the therapeutic and non-therapeutic relationship, as well as the use of the couch as the therapeutic setting. Instead, he emphasised the importance of the setting, in which he included all sorts of 'physical-structural contexts of the treatment experience' (Langs, 1998: 108). Langs referred to the 'features of the psychotherapy setting, listed with the ideal frame' (ibid.).

1. The location of the office.
2. Who uses the office.
3. The status of the waiting-room.
4. The bathroom arrangements.
5. The soundproofing.

6. The nature of the decor and appointments of the space.
7. Reading material in the waiting-room.
8. Telephone arrangements.

This description of the therapeutic setting is totally different from Freud's view, but it is still rooted in psychoanalytic theoretical assumptions. 'The *unconsciously validated*, ideal setting for a psychotherapy experience entails a location in a professional building at some distance from the therapist's residence – if possible, each should be located in a different town or section of a city. The office door has a room number, but possibly no nameplate. The office is used exclusively by a single therapist, and the waiting-room is private and not used by anyone else, professional or otherwise, even when the therapist is not in the office. It is plainly but tastefully furnished with simple appointments...' (ibid.: 112). This rigid definition of the therapeutic setting is not appropriate for many kinds of therapeutic approach, but the detailed description stresses the importance of the setting for all therapists.

Although Langs's detailed definition of ground rules is too concrete and, as such, cannot serve as a universal model for all therapists, his structure of ground rules influenced the discourse regarding ground rules and opened up a new field of investigation.

No one else besides Langs has made such an effort to define the role of ground rules in the therapeutic encounter, and there are not many references to the structure of ground rules in the theoretical literature of various therapeutic approaches. I will refer to certain indications and theoretical assumptions in order to present the ground rules of the main therapeutic approaches.

Psychodynamic psychotherapy

The theory and practice of psychoanalysis has changed since the days of Freud in accordance with the views and personalities of the main characters in the psychoanalytic scenario. Some of them, such as Rank, Adler and Jung, created a new kind of psychoanalysis, while others, such as Ferenczi, Klein, Winnicott, Sullivan and Kohut, added new insights and viewpoints of their own to Freud's ideas. These changes affected the characteristics of therapeutic interaction and relationship, and influenced the structure and role of ground rules.

Contemporary psychodynamic psychotherapy is based on various psychoanalytic approaches and implement basic ground rules, with appropriate modifications.

> The analyst remains anonymous, and clients develop projections toward him or her. Focus is on reducing the resistances that develop in working with transference and on establishing more rational control. Clients undergo long-term analysis, engage in free association to uncover conflicts, and gain insight by talking. The analyst makes interpretations to teach them the meaning of current behavior as related to the past.
>
> (Corey, 1996: 467)

Langs's concept of the framework influenced the practice of psychodynamic psychotherapy. 'One of the most powerful features of psychoanalytically oriented therapy is that the consistent framework is itself a therapeutic factor, comparable on an emotional level to the regular feeding of an infant. Analysts attempt to minimize departures from this consistent category (such as vacation, changes in fees, or changes in the meeting environment)' (ibid.: 117).

Certain principal tenets of psychoanalysis are reformulated in psychodynamic psychotherapy.

- The therapy is geared more to limited objectives than to restructuring of one's personality.
- The therapist is less likely to use the couch.
- There are probably fewer sessions.
- There is more frequent use of supportive interventions – such as reassurance, expressions of empathy and support, and suggestions – and of self disclosure by the therapist.
- There is more focus on pressing practical issues than of working with fantasy material.

(ibid.: 116)

There are some similarities between the ground rules of psychoanalysis and the ground ruled of dynamic therapy. These ground rules are relatively fixed.

1. Fees. There is a set fee.
2. Responsibility for sessions. The client should pay for all scheduled sessions and the therapist should be present for all scheduled sessions.
3. Privacy and confidentiality. Although therapists can not promise total privacy and confidentiality, they are committed to honouring their clients' rights in

accordance with the law.

Other rules were essentially changed.

1. The setting. Many psychodynamic therapists do not provide a neutral setting, since they work in institutional setting or at home.
2. The time. Most psychodynamic therapists meet their clients once or twice a week, for fifty minutes, for an average period of 6-15 months. This changes the density of therapeutic encounter, and the depth of the therapeutic relationship.
3. The couch. Psychodynamic psychotherapists rarely use the couch. They sit face-to-face with their clients, and sometimes an angle is created between the chairs, in order to avoid direct eye contact.
4. The technique. Although dynamic therapists enable their clients to free-associate, this is not an absolute condition for the therapeutic process. Free association and the use of the couch are part of various therapeutic means for the therapeutic process.
5. Relationship. The rules concerning the therapeutic relationship are not as rigid as in psychoanalysis. Although therapists avoid social relationships with their clients, they do not distinguish between the therapeutic and non-therapeutic relationship. They are not anonymous to their clients and they will sometimes reveal details of their personal life if this serves the client's therapeutic needs.

The ground rules of psychodynamic psychotherapy are similar to the ground rules of many other approaches to individual psychotherapy. They usually share some relatively fixed rules, while there are differences in the contents of the other rules. There are only a few exceptions. In Lacanian psychoanalysis, the ground rule of time is fluid and the analyst decides when to terminate each session. In communicative psychotherapy, clients have the option of choosing 'empowered psychotherapy' (Langs, 1995: 24), in which the duration of the sessions is 90 minutes.

Humanistic psychotherapy

Humanistic psychotherapy, known as the 'third force' (following psychoanalysis and behavioural approaches) was developed by Carl Rogers in the second half of the twentieth century. 'But excluding those by Freud, it is hard to name another set of books that has had an impact on clinical practice equal to Rogers' (Kahn, 1991: 36).

Rogers' person-centred therapeutic approach was the first of many Humanistic

approaches that nurtures the concepts of freedom, values, choice, autonomy, personal responsibility, purpose and meaning. These approaches are less dogmatic and manipulative than psychoanalysis and behaviourism and are based on the assumption that there is a potential for self-actualisation and growth in every human being.

The humanistic frame is based on the same relatively fixed ground rules as the psychodynamic frame, although there are material differences in the therapeutic encounter and relationship.

The person-centred approach emphasises the role of the therapeutic setting as a supportive environment.

> In a sense the counsellor attempts to provide different soil and a different climate in which the client can recover from past deprivation or maltreatment and begin to flourish as the unique individual he or she actually is. It is the nature of this new relationship environment and the counsellor's ability to create it that are central to the whole therapeutic enterprise.
>
> (Mearns & Thorne, 1995: 14).

There are six 'core conditions' which are *'necessary* to initiate constructive personality change, and which, taken together, appear to be *sufficient* to inaugurate that process' (Rogers, 1995: 220).

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

(ibid.: 221)

Rogers' frame is based on the assumption that there is no positive personality change without a relationship. His 'conditions' are the ground rules for therapeutic relationship. In Rogers' words, the therapeutic process happens when 'each makes

some perceived difference in the experiential field of the other' (ibid.: 230).

Rogers believed that the above six conditions were not essential for client-centred psychotherapy, but that they apply to any sort of psychotherapy, including psychoanalysis, Adlerian psychotherapy or any other approach. He also claimed that psychotherapists do not need 'special intellectual professional knowledge' (ibid.: 231).

Actually, Rogers remarked that there are no other ground rules that follow on from his six conditions. There are no rules of theoretical assumptions or technical devices or any rules concerning pre-therapeutic relationships or diagnoses. It seems that many of the conditions commonly regarded as necessary to psychotherapy are, in terms of this theory, nonessential. In the 1960s Rogers les encounter groups and sensitivity-training groups. 'He saw these groups as offering the sort of training that developed the attributes he thought essential to a therapist' (Kahn, 1991: 46).

It is important to note that Rogers ignored the physical setting of the therapeutic interaction. The questions of time and fee are as relevant to this approach as to any other approach, but Rogerian therapists deal with them according to the six conditions, with no special rules to define them.

Gestalt therapy is a unique humanistic approach to psychotherapy, although it can also be regarded as an existential approach. 'The emphasis in Gestalt therapy, however, is on the present moment, the here and now, and that present-centeredness influences every moment of the therapeutic environment' (Bankart, 1997: 318). It was started in the early 1950s in New York by Fritz Perls, who stated that 'every individual, every plant, every animal has only one inborn goal – to actualize itself as it is' (Perls, 1969: 19). In Gestalt therapy 'the emphasis from the outset is on encouraging the person to recognize his own expert status – i.e., that he is the author of his own life' (Parlett & Page, 1995: 174).

Gestalt psychotherapy has an active and provocative style:

> The therapist does not interpret for clients but assists them in developing the means to make their own interpretations. Clients are expected to identify and work on unfinished business from the past that interferes with current functioning. They do so by reexperiencing past traumatic situations as though they were occurring in the present.
>
> (Corey, 1996: 468)

Gestalt psychotherpists 'aim to provide a relationship and setting which supports

and provokes the person's exploration of her "here and now" experience, that is, what she is aware of in the actual, present context of being in the therapy room, relating to another person, the therapist' (ibid.: 187). This is a "dialogic" relationship that involves some strategies and technique, such as "the empty chair", "topdog-underdog dialogue", "unfinished business", "the shuttle technique", etc.

There are two guidelines that are common in most Gestalt techniques, and can be regarded as Gestalt ground rules.

1. Confrontation. Although most Gestalt therapists are not as dramatic and harsh as Perls was, confrontation is the motif of the Gestalt dialogue. Confrontation is a provocation that invites clients to take part in the dialogue and to collaborate in the therapeutic relationship.
2. Respect for the client. Gestalt therapists respect their clients' autonomy and choice, and don't force them to participate in any technique they offer to them.

Some guidelines for Gestalt experiments can be viewed as suggested ground rules.

- It is important for counselors to be sensitive enough to know when to leave the client alone.
- To derive maximum benefit from Gestalt experiments, the counselor must be sensitive to introducing them at the right time.
- The nature of the experiment depends on the individual's problems, what the person is experiencing, and the life experiences that both the client and the therapist bring to the session.
- Experiments require the client's active role in self-exploration.
- Gestalt experiments work best when the therapist is respectful of the client's cultural background and is in good contact with the person.
- If counselors meet with hesitation, it is good idea to explore its meaning for the client.
- It is important that counselors be flexible in using techniques, paying particular attention to how the client is responding.
- Counselors should be ready to scale down tasks so that clients have a good chance to succeed in their efforts. It is not helpful to suggest experiments that are too advanced for a client.
- It is helpful for counselors to learn which experiments can best be practiced in the session itself and which can best be performed outside.

(Corey, 1996: 240)

Existential psychotherapy

Existential psychotherapy started in Europe in the 1940's and 1950's and has been developed in various directions by Ludwig Binswanger, Medard Boss, Victor Frankl, Ronald Laing, Rollo May and others. One could say that existential psychotherapy is the inversion of psychoanalysis, or that it is similar to humanistic psychotherapy, but existential psychotherapy is unique in that it involves philosophical investigation.

> The existential approach is first and foremost philosophical. It is concerned with the understanding of people's position in the world and with the clarification of what it means to be alive. It is also committed to exploring these questions with a receptive attitude, rather than with a dogmatic one: the search for truth with an open mind and an attitude of wonder is the aim, not the fitting of the client into pre-established categories and interpretations.
>
> (van Deurzen-Smith, 1995: 149)

Existential psychotherapy is focused on the "here and now" of clients' lives and in their "being in the world". Existential psychotherapists provoke their clients' views and challenge them, thus helping them to face the anxieties of life. While humanistic psychotherapy is based on optimistic assumptions regarding the individual's capacity to grow and flourish, existential psychotherapy confronts existential anxiety, and aspires to self-awareness, freedom, authenticity and responsibility.

> The therapist's main tasks are to accurately grasp clients' being in the world and to establish a personal and authentic encounter with them. The relationship is seen as critically important. Clients discover their own uniqueness in the relationship with the therapist. The human-to-human client/therapist relationship and the authenticity of the here-and-now encounter are stressed. Both the client and the therapist can be changed by the encounter.
>
> (Corey, 1996: 467)

The vague definition of existential psychotherapy, the sophisticated philosophical background and theoretical assumptions and the lack of therapeutic technique have given rise to the development of various existential methods of psychotherapy, which differ regarding their style and attitude to frame issues. 'The crucial significance of the existential movement is that it reacts against the tendency to identify therapy with a set of techniques. Instead, it bases therapeutic practice on an understanding of what

makes men and women *human* beings (Corey, 1996: 172).

Some existential psychotherapists adopted Husserl's phenomenological method as a guideline for their work. This method presents three ground rules of investigation.

1. The rule of epoché. This rule 'urges us to set aside our initial biases and prejudices of things, to suspend our expectations and assumptions, in short, *to bracket* all such temporarily and as far as is possible' (Spinelli, 1989: 17). It also has similarities with Freud's 'evenly-distributed attention'.
2. The rule of description. This rule means: 'Describe, don't explain' (ibid.). The existential psychotherapist is interested in 'what and how', and not in 'why' (i.e., not in interpretations). 'In this way, it is argued, clients can more easily reflect upon their experience *as it is occurring in the present* rather than be generating unprovable hypotheses as to how they might have dealt with or understood their experience at various points in the past' (ibid.: 131).
3. The rule of horizontalisation (the equalisation rule). This rule 'further urges us to avoid placing any initial hierarchies of significance or importance upon the items of our descriptions' (ibid.: 18). This means that the therapist listens to his clients in a non-judgmental mode.

Emmy van Deurzen-Smith, one of the leading existential therapists and authors in the UK, responded to Langs by proposing a parallel set of existential ground rules. 'None of these guidelines, therefore, are rules that are written in stone. It is of the utmost importance that existential psychotherapists should adapt their mode of operating to their own personality and style, as well as being flexible in relation to the particular requirements of their clients' (van Deurzen-Smith, 1997: 189).

A. The Setting: the physical dimension of the relationship.

Since clients 'look for psychotherapists who have established a solid foundation for their own life' (ibid.: 190), the therapist's way of creating 'an atmosphere of confidence and welcome in the consulting room' (ibid.) is significant.

1. Consulting room. The room has to be pleasant, sound-proofed and private. Van Deurzen-Smith claims that a personal touch can change the atmosphere even in a strange or hostile environment. She objected to a neutral setting, since 'it smells of nothing but anonymity and hospital sterility' (ibid.).
2. Disturbances. Although disturbances of the regularity and security of the therapeutic frame are part of everyday anxiety and mistrust, existential therapists try to reduce disturbances as much as they can. When such a

disturbance occurs they refer to it and treat it as a trigger for the client's response to such distress.

3. Seating. Clients are invited to sit on chairs, so they can feel comfortable, but not too comfortable, since it disturbs 'the sense that work has to be done' (ibid.). Clients can choose their preferred position or arrangement.

B. The social dimension of the therapeutic relationship.

Although existential psychotherapy is based on a 'real' relationship with clients, there are boundaries that distinguish this relationship from everyday ones. In a way, this is similar to the manner in which Freud distinguished between therapeutic and non-therapeutic relationship in his interactions with his patients.

1. Contract. The therapeutic contract includes agreements concerning the duration of therapy, a fixed fee and consistency of the sessions. To avoid any ambiguity, Van Deurzen-Smith recommends a written contract.
2. Professional protection. Existential therapists have to inform their clients that they have no legal or medical responsibility for them, although they have professional insurance.
3. Extra-therapeutic contact and gifts. Existential therapists do not meet their clients outside of the therapeutic setting and they prefer not to receive gifts from their clients.

C. Personal dimensions of the therapeutic relationship

An existential therapeutic relationship is different from friendship, although it is close and intimate. Existential therapists confront their clients and challenge them in order to help them identify their value systems.

1. Equality. Existential therapists consider themselves equal to their clients, and share their human dilemmas with them. At the same time they are alert and vital, so that they can inspire their clients.
2. Openness. Clients and therapist are committed to discuss everything that matters to them and to explore it together. Sometimes they can contradict each other or disagree.
3. Commitment to truth. Existential therapists are required to search for truth, and always see the other side of every statement the client makes.
4. Resonance. This term, which refers to therapists' ability 'to lend themselves to temporarily identify with the client's position' (ibid.) is almost similar to empathy, or, in van Deurzen-Smith's words, 'co-pathy' (ibid.).
5. Boundaries. There is no physical contact between client and psychotherapist.

Privacy and confidentiality are agreed between them.

6. Screening. In the initial interview the psychotherapist can decide if she can work with the client, or if existential therapy is indeed suitable for the client.
7. Initial interview. In the initial interview therapists can tune themselves into clients' needs, and clients can interview them and decide if they wish to choose them as their therapists.

Victor Frankl's logotherapy 'is the only school which has evolved psychotherapeutic techniques' (Frankl, 1988: 116). The main technique of logotherapy is 'paradoxical intention', which resembles the unwritten ground rule of existential psychotherapy, that of provocation: 'This technique requires or encourages the patient to intend, if only momentarily, that which is anticipated with fear' (Patterson, 1986: 447).

Paradoxical intention is apparently based on Emil Coué's concept of autosuggestion and the 'law of converted effort'. 'It is always the *imagination* which gains the victory over the *will*, without any exception' (Coué, 1922: 9).

Cognitive-Behavioural psychotherapy

In the 1960's, behavioural psychotherapy began to broaden 'to include cognitions as legitimate behavior that could be learned and modified' (Corey, 1996: 318). There are some models of cognitive behavioural therapy which are based 'on a structured psychoeducational model, and they all emphasize the role of homework, place responsibility on the client to assume an active role both during and outside of the therapy sessions, and draw from a variety of cognitive and behavioral strategies to bring about change' (ibid.: 319).

There is a fundamental difference between cognitive-behavioural therapy and other approaches to the 'talking cure':

> Cognitive therapy rejects the views of the three major therapeutic schools: psychoanalysis, which posits the unconscious as the source of emotional disturbance; behavior therapy, which regards only overt behavior as significant; and traditional neuropsychiatry, which considers physiological or chemical disorders to be the cause of emotional disturbances.
>
> (Patterson, 1986: 33)

Cognitive-behavioural therapy (and Rational Emotive Behaviour Therapy) is directive, educational and problem-oriented:

> In REBT the therapist functions as a teacher, and the client as a student. The therapist is highly directive and teaches clients an A-B-C model of changing their cognitions. In CT the focus is on a collaborative relationship. Using a Socratic dialogue, the therapist assists clients in identifying dysfunctional beliefs and discovering alternative rules for living. The therapist promotes corrective experiences that lead to learning new skills.
>
> (Corey, 1996: 468)

In most therapeutic approaches, the relationship between therapists and clients has meaningful therapeutic value. In cognitive-behavioural psychotherapy, 'the client explicitly develops new self-awareness in relation not only to the therapist but also in occupational, family, romantic, and social setting' (Bankart, 1997: 262). It can be said that in cognitive-behavioural therapy, the relationship between therapists and clients is important for creating trust and collaboration, but not as a constant component of the therapeutic process. 'During the critical first sessions the focus is on building rapport and creating the kind of client/therapist relationship that will encourage the client to talk freely. Once a collaborative and therapeutic alliance is formed, the relationship aspect is given less emphasis' (Corey, 1996: 325).

In addition to the common procedural ground rules, there are two categories of ground rules in cognitive-behavioural psychotherapy.

A. ***Preliminary relationship rules.*** These rules promote the collaborative relationship that is needed for the therapeutic/educational process by creating a secure frame. These rules are similar to Rogerian ground rules. 'As a collaborator in the therapy, the therapist should be accepting, warm, and empathic' (Patterson, 1986: 39).

1. Listening. 'Cognitive therapists need to have good listening skills, to be able to reflect accurately the cognitive and emotional components of the client's communication and to demonstrate an active and warm interest in the client' (Moorey, 1995: 236).
2. Empathy. 'Good therapists seem to be able to get inside the client's cognitive world and empathize while at the same time retaining objectivity' (ibid.).
3. Full acceptance (tolerance). 'The basic idea here is to help clients avoid

self-condemnation' (Corey, 1996: 327). This rule is similar to Rogers' 'unconditional positive regard'.

4. Non-authoritative behaviour. 'Therapists must avoid authoritative methods that lead, on the one hand, to blind acceptance of interpretations and suggestions by some patients but, on the other hand, to resistance and rejection by others' (Patterson, 1986: 39).
5. Genuineness. 'Therapists are often open and direct in disclosing their own beliefs and values. Some are willing to share their own imperfections as a way of disputing the client's unrealistic notion that therapists are "completely put together" persons' (Corey, 1996: 328).

B. ***Collaborative relationship rules.*** The cognitive-behavioural technique is based on collaboration with the clients. 'Collaboration gives the client a say in the therapy process and so reduces conflict. Collaboration fosters a sense of self-efficacy by giving the client an active role. Collaboration encourages the learning of self-help techniques which can be continued when therapy is ended. Collaboration allows an active input from the person who knows most about the problem (Moorey, 1995: 237).

1. Contract. 'The patient and the therapist must agree on the problem to be dealt with, the goal of the therapy, the methods of achieving the goal, and the duration of the therapy' (Patterson, 1986: 39).
2. Active working. Therapists 'challenges clients to validate their ideas' (Corey, 1996: 325).
3. Provocation. Therapists challenge their clients by using 'absurdity and humor to confront the irrationality of clients' thinking' (ibid.).
4. Planning. 'At the beginning of each session an agenda is set, with the client and therapist both contributing to this' (Moorey, 1995: 237).
5. A message. 'Two or three times through a session the client or therapist will summarize what has been going on so far. This helps to keep the client on track' (ibid.: 238).

There are some modifications to these sets of ground rules in various cognitive-behavioural approaches. 'REBT [rational emotive behaviour therapy] does not place a premium on personal warmth and empathic understanding, on the assumption that too much warmth and understanding can be counterproductive by fostering a sense of dependence for approval from the therapist' (Corey, 1996: 327).

Beck's cognitive psychotherapy, on the other hand, is based on the assumption that 'genuine warmth, accurate empathy, nonjudgmental acceptance, and the ability to establish trust and rapport with clients' (ibid.: 340) are necessary for successful counselling.

Eclectic-Integrative psychotherapy

There are about 400 therapeutic approaches and 'no single theory is comprehensive enough to account for the complexities of human behaviour, especially when the range of client types and their specific problems are taken into consideration' (Corey, 1996: 449). This was the motive for the formation of eclectic and integrative approaches to psychotherapy. 'Surveys of clinical and counseling psychologists consistently reveal that 30% to 50% of the respondents consider themselves to be eclectic or integrative in their therapeutic practice' (ibid.: 448).

The evolution of psychoanalysis and the other central approaches (the humanistic approaches, the existential approaches the behavioural and the cognitive approaches) force all therapists to integrate theoretical assumptions and techniques into their practice and to form their own style of psychotherapy. 'For it is probably true that different therapists of a particular approach have differing views of that approach' (Dryden, 1995: 273).

Since the 1970s many psychotherapists have professed an eclectic orientation. There is no unequivocal definition for eclecticism:

> Eclecticism is simply a more comprehensive, loosely organized theory than a formal theory and attempts to be all-inclusive. If there is an underlying consistency and integration of the phenomena encompassed by an eclectic position, then, as the position or stance is developed or becomes supported by research and experience, it becomes more systematic and more tightly organized. In other words, it becomes a formal theory. Most of those who call themselves eclectics are actually syncretists.
>
> (Patterson, 1986: 461)

Psychologists like Thorne (1967) and Hart (1983) tried to create a comprehensive eclectic therapeutic method, while others, like Garfield (1980) or Beutler (1983), avoided any theoretical integration and advocated matching the right therapeutic procedure to the needs of each client.

The goal of many eclectic approaches (functional eclectic psychotherapy) is personality change. This goal influences the frame and the ground rules, since some clients are interested in a supporting frame more than in personality change. 'For some clients support, reassurance, and a return to their previous level of less-distressed personality functioning is the real goal of the therapist' (Hart, 1983: 187). The ground rules of eclectic approaches are, by definition, less definitive and structured than in other approaches, since they have to be flexible and adaptable to each client's needs. 'The counseling relationship develops most favorably when the counselor is passive at the beginning, while the client becomes familiar with the situation at his or her own rate. However, with clients who are doubting, negative, and resistant, more active methods may be necessary' (Patterson, 1986: 501).

While 'technical eclectisism' (Corey, 1996: 448) is based on a collection of different techniques, 'theoretical integration' (ibid.) is a synthesis of various techniques and theoretical assumptions that produce a 'conceptual framework' (ibid.). Both demand of a therapist to have comprehensive knowledge and much experience.

Since there are differences between the ground rules of various psychotherapeutic approaches, it is difficult to define the ground rules of eclectic-integrative approaches. While most approaches 'share common ground in accepting the importance of the therapeutic relationship' (ibid.: 456), in others, such as cognitive behavioural approaches, this is less important.

Integrative psychotherapy is more flexible than other approaches, thus it can be adapted to clients' needs. This effort is goal-oriented and it causes therapists to become more active, so they can 'teach clients a range of coping skills that they can use in solving their problems. Clients also contribute to the relationship with variables such as their motivation, cooperation, interest, concern, and expectations' (ibid.: 457).

The special fluid structure of eclectic-integrative psychotherapy emphasises some special ground rules.

1. Sensitivity. Therapists should listen carefully to clients' needs, and tune themselves into clients' capacities. 'I recommend sensitivity in assessing what your clients need, along with good judgment about the appropriateness of the match between you and a potential client' (ibid.).
2. Authenticity. The multilevel theoretical and technical structure of the therapeutic interaction can confuse the clients, so the therapist should be solid and authentic. 'It is important that you *be yourself* as you meet clients' (ibid.).
3. Preparation. This ground rule is different from the ground rule of empathy,

since it demands an enhanced empathy. Therapists should try to see the world through their clients' eyes not just as a metaphor, but as a practical preparation. This can help the therapist in multicultural psychotherapy, as well as in creating relationships with all sorts of clients:

> You must ask yourself how well prepared you feel to counsel clients from a different cultural background. To what degree do you think you can successfully establish a therapeutic relationship with a client of a different race? Ethnic group? Gender? Age? Sexual orientation? Socioeconomic group? Do you see any potential barriers in yourself that would make it difficult to form a working relationship with certain clients?'
>
> (ibid.)

4. Openness. Eclectic-integrative approaches are based on the assumption that there is no "true" approach to psychotherapy, and that therapists have to be open to their clients' beliefs and views, and to offer them the appropriate therapeutic techniques. 'Beware of subscribing exclusively to any one view of human nature; remain open and selectively incorporate a framework for counseling that is consistent with your own personality and your belief system' (ibid.: 457).
5. Competence. This ground rule is based on the code of ethics that instruct therapists to acquire professional skills according to the requirement of their professional organisation. In the case of eclectic or integrative psychotherapy, it is difficult to define such requirements, since there is no accepted body of knowledge behind this approach. 'If, on the other hand, the counsellor was randomly eclectic, there might well be no criteria for determining whether the intervention was competently executed' (Bond, 2000: 120). This means that an eclectic-integrative psychotherapist 'requires much reading, thinking, and actual counseling experience. Unless you have an accurate, in-depth knowledge of these theories, you cannot formulate a true synthesis' (Corey, 1996: 462).

Narrative psychotherapy

Narrative psychotherapy was developed at the end of the twentieth century. The term 'narrative psychotherapy' is associated with Michael White and David Epston's (White & Epston, 1990) approach to family therapy, but it was preceded by certain ideas

concerning the use of literature and storytelling in psychotherapy. Milton Erickson used therapeutic stories as a central technique in hypnotherapy (Rosen, 1982). The role of therapeutic metaphors (Gordon, 1978, Barker, 1996), and the process of re-framing (Bandler & Brinder, 1982) also constituted explorations of the narrative qualities of psychotherapy.

The main goal of narrative psychotherapy is to find new meaning in clients' life stories. 'When persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enables them to perform new meanings, bringing with them desired possibilities – new meanings that persons will experience as more helpful, satisfying, and open-ended' (White & Epston, 1990: 15). This goal is common to many approaches, but narrative approaches have special techniques that explore life experiences and personal capability through the process of telling and re-telling:

> Narrative approaches to counseling invite clients to begin a journey of coexploration in search of talents and abilities that are hidden or veiled by a life problem. Unlike the passive soil that is excavated by the archaeologist's tool, the client is engaged as an active collaborator in the reconstruction of something of substance and value. The narrative therapist draws on her own patient and thoughtful persistence to help the client rediscover the remnants of favored experiences in his life.
>
> (Monk, 1997: 3)

The therapeutic relationship in narrative psychotherapy is quite different from that in other approaches. Although the relationship is as meaningful for the therapeutic process as it is in other approaches, narrative therapists try not to play the central role in this relationship. 'As a narrative therapist I attempt to relate with warmth, acceptance and genuineness with persons I see for therapy. But I believe that persons' therapeutic relationships are with the people who are actually important to them in their "real life", and that this is how it should be' (Payne, 2000: 213). Paradoxically, they even try not to create significant relationships with their clients:

> Certainly I have been told by many a person that friends' and relatives' attempts to help have been counterproductive: they are too optimistic, or give a lot of unwanted advice, or try to make the person approach the problem as they themselves might. It is tempting for the counsellor to concur – to believe that

> professional knowledge is needed, and a special relationship with a professional. Only in narrative therapy have I come across a questioning of this idea – a contrasting concept that the professional's role is more productive and ethical as a facilitator of the therapeutic actuality and potential of "real-life" relationships rather than as the provider of a "therapeutic" relationship with the counsellor himself.
>
> (ibid.: 212)

This new concept of the therapeutic relationship creates rather different ground rules concerning the role of the psychotherapist and the setting.

1. Time. 'There is no set convention for the length of narrative therapy sessions. My own counselling tends to stay within the conventional frame of 50 minutes, but I have observed White and his colleagues hold sessions lasting over two hours, not just with families but also with individuals and couples' (Payne, 2000: 9).
2. Privacy and confidentiality. One of Michael White's innovations in narrative psychotherapy is the presence of 'witnesses' in the therapeutic session. 'White has increasingly emphasized the importance of an "audience" for the person's telling and re-telling... Audiences might consist of friends, relatives, peers and so on.' (ibid.: 16).
3. Ending therapy. When clients decide to end their therapy, they celebrate it at the final session with their therapist and with invited guests. At this celebration the clients present their re-telling.
4. Transparency. This rule is similar to existential "openness". 'White's transparency practices are also self-monitoring, but his focus is on the impossibility, in conversations with persons, of a therapist's completely escaping from culturally and socially formed assumptions, beliefs and behaviour. Transparency is a means of promoting accountability by openly acknowledging these limiting factors for the person, and attempting to escape their worst effects through this sharing. White stresses the ethical priority of therapists decentring through openness with the person' (ibid.: 216).
5. Two-way process. This rule is similar to the existential rule of equality. 'I have an ethical commitment to bring forth the extent to which therapy is a two-way process, and to try to find ways of identifying, acknowledging, and articulating the extent to which the therapeutic interactions are actually shaping of the work itself, and also shaping of my life more generally in positive ways' (White,

1995: 168).

6. Additional communication. White and Epston recommend integrating between oral and written psychotherapy. 'It would seem that the written tradition, insofar as it facilitates the mapping of experience onto the temporal dimension, has much to offer to those activities defined as therapy' (White & Epston, 1990: 36). They accomplish this by using letters in the therapeutic process (letters of prediction, counter-referral letters, letters of reference, letters for special occasions and brief letters).

The common categories of ground rules

In all the therapeutic approaches, there is a common agreement regarding the central role of the relationship between clients and therapists, but there is no common set of ground rules which is accepted by all approaches. Each therapeutic approach has its own ground rules. Some of them are parallel to those of other approaches and some are unique. The ground rules of therapeutic relationship reflect special aspects of theoretical assumptions and different therapeutic techniques.

Some effort has been made to define the common denominators of ground rules in all therapeutic approaches. Such a definition has practical implications.

1. Identification and evaluation. A structural model of ground rules, which is common in all therapeutic approaches, may help therapists to identify typical ground rules in their therapeutic approach and evaluate their adaptation in their personal therapeutic style. Many therapists are not aware of their own ground rules or the differences between them and the ground rules of other approaches. Some therapists use psychoanalytic terms concerning ground rules, although their practice is based on different theoretical assumptions.
2. Training. A common model of ground rules can serve as a practical guide and technical device for therapy students. By being trained in ground rules, students can simulate the psychotherapeutic relationship from the first stage of their training.
3. Practising. Awareness of the function of ground rules in creating a secure frame would help practitioners to create therapeutic relationship, interpret clients reactions to modifications of the frame and regularly examine and improve their use of the ground rules.

4. Research and development. A common model of ground rules may serve as a method for comparing and evaluating various approaches to psychotherapy. It can provide a perspective for viewing different styles of therapeutic relationship and a guide for creating therapeutic frames for new approaches or settings for psychotherapy, such as online psychotherapy.
5. A new perspective on ground rules. The traditional stance concerning ground rules in psychoanalysis or other approaches grasps ground rules as a fixed set of conventions. Defining the common structure of ground rules outlines the boundaries of relationships and enables therapists to furnish each therapeutic session with the appropriate ground rules for a constantly changing situation.

Robert Langs claimed that patients and therapists 'conform to the general patterns of framing' (Langs, 1998: 11) and that 'frames, boundaries, and containers are more fundamental than their contents' (ibid.). He also claimed that there are '*universal, unconsciously sought for, and validated set of ground rules for an optimal therapeutic experience*' (ibid.: 42). Actually, Langs never defined the 'general patterns of framing' (ibid.: 11) but offered a set of psychoanalytic ground rules. These rules contradict certain basic assumptions and techniques in other humanistic and existential approaches.

There has been almost no attempt to define the common structure of ground rules in psychotherapy. 'Many theories note the importance of the personal qualities of the therapist without, however, specifying their nature. But some qualities that enter into the relationship have been identified, defined and even measured' (Patterson, 1986: 548). Carl Rogers proposed six conditions 'which seem to me to be *necessary* to initiate constructive personality change' (Rogers, 1995: 220). Like Langs, Rogers defines specific rules that represent his special terminology and beliefs.

Patterson formulated four of Rogers' conditions as universal truths about therapeutic relationship.

1. All therapists manifest a real concern for their clients.
2. A second characteristic of all effective therapists is honesty, or a genuineness and openness.
3. Empathic understanding is a third aspect of a therapeutic relationship.
4. These attitudes of characteristics of the therapist lead to a therapeutic relationship only if they are recognized, perceived, or felt by the client.

(Patterson, 1986: 548)

Windy Dryden presented 'the therapeutic alliance as a framework for comparison' (Dryden, 1995: 273). He based his comparison on Ed Bordin's (1979) three components of therapeutic alliance: bonds, goals and tasks. These three elements exist in any therapeutic relationship, although they are not identified with any specific ground rules.

Petrūska Clarkson has developed the most comprehensive structure of therapeutic relationship. She has identified 'an integrative psychotherapeutic framework containing five possible modalities of client-psychotherapist relationship as being present in any effective psychotherapy' (Clarkson, 1995: 6).

1. The working alliance.
2. The transferential/countertransferential relationship.
3. The reparative/developmentally-needed relationship.
4. The person-to-person relationship.
5. The transpersonal relationship.

(ibid.: 7)

Clarkson's five modalities of relationship represent different dimensions of the therapeutic relationship. She demonstrates this through metaphor.

1. The working alliance 'can be likened to that between cousins' (ibid.: 9). By the word cousins she means uncle/aunt/niece/nephew relationships. 'The notion is meant to convey a metaphoric distance from the family of origin (different parents) but kindred loyalties to each others' welfare' (ibid.).
2. The transferential/countertransferential relationship 'can be compared to that of step-parent or godparent' (ibid.: 10). This kind of therapeutic relationship may be found in psychoanalytic and psychodynamic approaches, although one can recognise them in other approaches as well.
3. The reparative/developmentally-needed relationship represents the metaphor of 'a real parent and child relationship' (ibid.: 13). This metaphor, which is commonly applied to the therapeutic relationship (Green, 2003), may represent any kind of therapeutic approach.
4. The person-to-person relationship represents the real relationship. 'This psychotherapeutic relationship modality shows most continuity with the healing relationships of ordinary life' (ibid.: 14). This kind of therapeutic relationship is typical of the humanistic/existential tradition.
5. The transpersonal relationship 'refers to the spiritual or inexplicable dimensions

of relationship' (ibid.: 18). This kind of relationship reflects the humanistic/existential and also Jungian approaches.

Although Clarkson claims that these five modalities are 'present in most approaches to psychotherapy or psychoanalysis' (ibid.: 21), it is not difficult to notice that each metaphor resembles specific therapeutic approach or approaches. Clarkson's five modalities, like Bordin's three components of therapeutic alliance, play an important role in exploring and researching the field of therapeutic relationships. Since they are both abstract and based on generalisations, they do not refer to the practical role of ground rules in creating the therapeutic relationship and the secure frame.

The evolution of the concept of ground rules started with Freud's recommendations concerning the practical aspects of therapeutic relationship, which were later known as ground rules. The metamorphosis of these recommendations into ground rules changed their original meaning. The practical guidelines for the maintenance of the therapeutic session were generalised into a fixed set of rules, which served as dogma, as demonstrated in Langs's definition of the ground rules.

There is no disagreement about the central role of the therapeutic relationship in the therapeutic process or about the role of ground rules in creating a therapeutic relationship. The dispute concerning ground rules refers to the transformation from the first assumption to the second. I will explore this transformation and suggest another method for establishing the common denominator of ground rules. This concept will serve as a practical method for creating a therapeutic relationship and as a research method.

The practical aspects of ground rules

It is conventional to refer to the ground rules of psychotherapy or to the therapeutic frame as a relatively fixed or fluid set of instructions (Langs, 1998: 43), which represents the theoretical and practical foundation of each approach concerning the therapeutic relationship. From this perspective the content of the ground rules is essential.

Reviewing ground rules according to their content emphasises the essential differences among psychotherapeutic approaches and hides the broad view of their

common structure. Ignoring content by reviewing ground rules through abstract and generalised categories, as Bordin and Clarkson do, may cause one to overlook the significant role of ground rules in any therapeutic relationship.

The confusion that arises when attempting to define a common model for ground rules may be explained by the fact that the literature about the therapeutic frame and ground rules focuses on the therapist's role in managing the therapeutic frame while ignoring the temporal unique interaction and the client's part in designing its structure.

In practice, each therapeutic session is a unique interaction between therapist and client, and both are responsible for its maintenance. The term 'psychotherapeutic relationship' refers to a succession of such therapeutic sessions; by definition such a succession is always dependent on the special structure of each session. This structure, the outcome of collaboration between therapist and client, is also influenced by the practical nature of each session.

If there is any common denominator between different single sessions, it can serve as a model or a common structure for ground rules. In order to define such a model, one has to give up presuppositions or general definitions concerning ground rules and concentrate on the direct and current relationship that is established and re-established in each therapeutic interaction.

Similarities and differences in ground rules

It can be useful to explore the specific ground rules of various therapeutic approaches and examine their role and significance in the actual encounter.

Some ground rules that represent distinctive theoretical assumptions and techniques of specific therapeutic approaches, while others refer to the therapeutic relationship. The differences between these two categories are not always unequivocal.

A. The particular ground rules of each therapeutic approach.

These ground rules result from specific theoretical assumptions and relate to practical and technical therapeutic methods. They are specified by their content.

The fundamental rule of free association represents the basic therapeutic technique of psychoanalysis, based on Freud's model of the mind. This ground rule and its collateral ground rule of evenly-hovering attention influence the therapeutic relationship, but both reflect a theoretical assumption which is unilaterally implied by the therapist. Although this ground rule clearly refers to psychoanalysis,

therapists who are not psychoanalysts and who do not accept psychoanalytic theory can also apply it. For example, free association is sometimes a useful technique for narrative psychotherapy. While helping to create empathy as in client-centred therapy, the ground rules of neutrality, anonymity and abstinence also represent the psychoanalytic code of therapeutic behaviour.

The ground rule of privacy and confidentiality is typical of psychodynamic psychotherapy, although it can be present in many other approaches as well.

The ground rule of unconditional positive regard is the main characteristic of the person-centred approach, which concentrates on therapeutic relationships, but it is also applicable to cognitive-behavioural psychotherapy, in which the therapeutic relationship is not so important.

The ground rule of confrontation is typical of Gestalt psychotherapy, but was also applied by Freud, as demonstrated in the case of Dora (Freud, 1905).

The ground rule of epoché (bracketing) is unique to the phenomenological-existential approach, but can serve the same goal as the ground rules of neutrality and anonymity.

The ground rule of collaborative relationships is essential to the cognitive-behavioural approaches but it is also a pre-condition for any other approach.

The ground rule of competence is vital for eclectic-integrative approaches, but since all therapeutic approaches in the third millennium are integrative in one way or another, this ground rule is important for all therapists.

The ground rule of additional communication is typical of narrative approaches. In most therapeutic approaches additional communication is regarded as frame deviation, but no therapist can escape such communication in telephone calls, letters or unplanned meetings with clients, which should all be considered.

There are many theoretically based ground rules, which are imposed by therapists and influence their relationships with their clients. Although these ground rules are either generalised or planned for a particular therapeutic approach, no set of ground rules can exist without them. Sometimes they can be practically applied to more than one therapeutic approach, but their differential content has no common denominator. Hence a common denominator must be found and defined within the structural functions of the ground rules.

B. The procedural ground rules.

These are the ground rules that facilitate and nurture the therapeutic relationship in

practice. They outline the boundaries and define the actual procedure of each therapeutic session. Some of these ground rules also reflect different theoretical assumptions that will not be discussed here.

Most of the procedural ground rules are common to various therapeutic approaches, but there are many variations and alterations that shape and adapt specific ground rules to match the nature and limits of each approach, therapist and client.

There are five categories of procedural ground rules.

1. Practical rules. These rules deal with the practical questions of 'where', 'when' and 'how much'.

   The ground rules of the setting deal with the question of 'where'. They refer to the concrete location of the clinic and its possibilities (a neutral office, an institution or a private clinic in the therapist's house), the architecture (design and decoration of the clinic and furniture) and the clients' use of facilities (entrance and exit, waiting room, toilet, etc.).

   The ground rules of time deal with the question of 'when'. They refer to the regular meeting day (the fixed day of the week), the time (the fixed hour), the length of each session and the length of the whole therapeutic process ('open' or time-limited psychotherapy).

   The ground rules of the fee deal with the question of 'how much'. They refer to the cost of each session (including payment for cancelled sessions, index linkage, reductions, etc.), payment modes (by cash, cheque, or bank transition) and the time of payment (at the beginning or the end of each session, monthly in advance, etc.).

2. Rules of conduct. These rules deal with the therapist's responsibilities concerning clients' rights. Although these rules have been defined as psychoanalytical ground rules, they resonate in many other approaches.

   The rules of confidentiality refer to the legal and ethical obligation to secure all details concerning client privacy, the therapist's view of total or relative confidentiality, the therapist's commitment to secure his files and the question of exposure (e.g., presenting case materials in supervision or lectures, writing and publishing case studies, etc.).

   The rules of anonymity deal with therapists' policies concerning disclosure of their personal life, their therapeutic approach and their personality, and with respecting clients' wishes not to expose details of their

personal life.

The rules of abstinence deal with non-therapeutic relationships between clients and therapists. They question therapists' benefits from the therapeutic relationship, the meaning of parallel relationships, therapists' authority, accepting or rejecting gifts from clients, etc.

3. Technical rules. These rules refer to practical ground rules concerning the specific techniques of every therapeutic approach. Some of them are associated with only one therapeutic approach and some are applicable to many approaches, but there are always some kind of technical ground rules in any therapeutic interaction. These ground rules refer to the therapists' role in the therapeutic relationship.

All therapeutic approaches include ground rules regarding listening. There are passive listening techniques such as psychoanalytic listening, and active techniques of listening such as may be found in some interrogative and directive methods.

There are unique ground rules like the couch, free association and paradoxical intention, and there are common techniques such as role play, planning and therapeutic messages.

There are ground rules concerning clients' roles such as learning, practising and training.

4. Emotional rules. These are the ground rules that enable therapists to explore and accept clients' feelings and involve them in collaboration.

The rules of empathy enable therapists to understand their clients' point of view without identifying with them. They include the rules of containing, or parenting, and the rules of holding and accepting.

The rules of dual relationship are applicable to both therapists and clients. They include the rules of mutuality and equality, as well as the rules of collaboration and cooperation.

Parental ground rules refer to almost 'real' relationships between therapists and clients, protected in the secure frame and therapeutic boundaries. These rules involve unconditional positive regard and love.

5. The rules of relationship regulate the terms of the relationship between therapist and client. These are contractual ground rules that define both clients' and therapists' stated understanding of the therapeutic process.

The preliminary ground rules refer to the first encounter between therapist

and client, sometimes in relation to the first telephone call, the beginning of each therapeutic session and the diagnosis.

The intentional ground rules refer to both clients' and therapists' conscious plans for the psychotherapeutic encounter. These ground rules define the therapeutic goals and both sides' expectations.

The behavioural ground rules refer to certain agreements concerning mutual therapeutic relationships. These ground rules define actual and optional situations of the therapeutic relationship.

These five categories of procedural ground rules sometimes overlap with Bordin's three components of ground rules and with Clarkson's five modalities. But while the first two divisions are generalised and deal with principal qualities of ground rules, the last refer directly to the actual therapeutic encounter. Although they describe some attributes of ground rules that can be found in common therapeutic situations, they are not lacking in content links. Thus they can serve as a common neutral platform for ground rules, which may be found in the structural qualities of the therapeutic interaction.

The method of categorising ground rules

Generalising and categorising the variety of ground rules in various therapeutic approaches can raise various issued regarding the different potential results of such efforts.

Each categorisation leads to certain conclusions that reflect preliminary assumptions.

1. Langs's (1998) categorisation distinguishes between a relatively fixed frame and relatively fluid ground rules and focuses on the significance of the setting. His formulation leads to a set of psychoanalytic ground rules that support the basic assumptions of communicative psychotherapy. As such, it cannot serve as a common model for ground rules.
2. Van Deurzen Smith (1997) differentiates between the ground rules of the setting, the social aspects and the personal dimensions of the therapeutic relationship. Most of her ground rules are similar to Langs's, but her different categorisation is adapted to the special goals of existential therapy and cannot serve as a common model for ground rules.
3. The two categories of ground rules in cognitive-behavioural psychotherapy, the

rules for the preliminary relationship and those for the collaborative relationship, are also typical of the special demands of these approaches.

4. Bordin's (1979) three components of therapeutic alliance may serve as a common model for evaluating the therapeutic relationship subject to a certain point of view, but it does not refer to the actual communication between therapist and client.
5. Clarkson's (1995) modalities of the therapeutic relationship open up a wide spectrum of understanding and explore certain qualities of the therapeutic interaction, but they ignore the practical shared characteristics of the therapeutic sessions.

It is not a coincidence that none of these efforts to define a common model for the ground rules of all therapeutic approaches has succeeded in achieving its goal. Since they are all based on processing and analysing the wide list of existent ground rules, they are limited to the given range of these ground rules. Such an effort is analogous to a man who tries to lift himself up by his own hair. All efforts to define a common dominator for ground rules based on specific ground rules are destined to be tautological.

To achieve such a goal one should explore the environment in which ground rules are determined and the terms and conditions necessary for defining any kind of ground rules. It may be productive to use a phenomenological descriptive method, and to explore the structure of the psychotherapeutic interaction within which ground rules are formed and nurtured.

The structure of the psychotherapeutic interaction

The ground rules of therapeutic relationships are limited by the boundaries of the actual interaction. Although these boundaries vary in different therapeutic approaches, their characteristics are common to all kinds of therapeutic interactions. Since ground rules are created within the limits of these characteristics, identifying these characteristics may lead us to a common denominator for ground rules.

The architecture of the therapeutic interaction can be described in three dimensions each of them containing various aspects of the actual encounter. I will describe the details of each dimension and link them to possible therapeutic applications. By definition, each linkage may represent a ground rule.

A. ***The physical dimension.*** The therapeutic environment involves certain physical characteristics that influence the interaction between therapists and clients.

1. Space. The physical environment shapes the boundaries of the therapeutic encounter and determines the terms of relationship.

The location of the therapist's clinic is not a technical decision. When the clinic is located in a central area, it may be convenient for clients while at the same time it raising questions about privacy and confidentiality, since clients might be identified by their acquaintances. Therapists can choose to locate their clinic at the front or the back of the building, on the first floor or an upper floor, in an office building or a residential neighbourhood. The therapist might choose to display his name prominently or leave his door blank. Each of these choices affects the therapeutic relationship, and it is reflected in the specific ground rules.

There is another aspect of the location of the clinic. The clinic can be part of the therapist's home or a private unit in his home, but it can also be located in an office building or in a medical institution. Each has a different effect on the therapeutic relationship.

Decisions concerning the location of the clinic also affect accessibility: bus and train stations, parking places, a lift, special resources for disabled clients, etc.

2. Design. The structure and design of the clinic are the metaphoric manifestation of the therapeutic 'secure frame' and express therapists' views and their suggested ground rules even before any conscious agreement is made.

The first impression of the clinic is made when clients enter the building or the house and become aware of the size and shape of the clinic. It can be big or small, a simple square room or a complicated structure. It can be painted white, or it can express therapists' approaches by the walls being painted blue or green.

The door to the clinic (which can be designed in various ways, with a bell or a little window) can open directly onto the therapist's room. It can also lead to a waiting room in a complex that includes a private toilet for the psychotherapist, another toilet for clients, a little kitchenette, the receptionist's room, a consulting room and a rear exit.

The clinic can be furnished plainly, or with rigorously designed details. There can be simple chairs or comfortable armchairs and a couch, a side table or a writing desk, decorative elements, pictures and paintings, bookshelves, a telephone and a special place for coats and umbrellas.

The clinic can be neutral, without any personal touches, and it can also express the therapist's taste and personality, with personal photographs, collections, books, paperwork and diplomas.

3. Physical contact. Although psychotherapy is based on listening to clients' narratives, with no physical contact, there are inevitable physical gestures in any therapeutic encounter.

The first contact happens when the client enters the consulting room. This simple action can be performed in various ways. The therapist can come out to invite his client inside, shake the client's hand or just lead him in and show the way to his chair. He may precede or follow him, stay close to him or keep his distance, smile or assume a blank expression.

There are many ways to locate the therapist and client's chairs in the room. They can face each other, so both therapist and client can look at each other, or be placed at an angle, so that both participants can maintain some privacy. The chairs can be close to one other, giving the impression that therapist and client share the same space, or far away from one other like two separate territories.

Body language has a meaningful role in the physical dimension of therapeutic interaction. The way therapists sit, their body postures, their facial gestures, their breathing and changing body positions can have an effect on their clients.

Departure also demands physical considerations. Should a therapist shake his client's hand or just nod his head. Should he accompany him to the door and open the door for him, or just wait until he leaves? What, if anything, do they both say when they depart?

4. Audio-vocal characteristics. There is no therapeutic interaction without vocal exchanges. Voice intonation reflects therapist' and clients' emotions and conveys unconscious messages.

The clients' intonation indicates their emotional state and at the same time it has the resonance of the therapeutic interaction. While therapists are listening to their clients' words and content, they are also sensitive to the

changes in their vocal expressions and intonation.

Therapists' vocal expression has an impact on their clients, and clients can be manipulated, calmed or challenged by variations in the volume, pitch and tempo of their speech.

There is another source of vocal presence in the consulting room, which concerns external voices that penetrate the room as an unseen third party. These can be street voices or voices of staff, family or neighbours. Therapists can ignore this disturbance and accept them as 'a fact of life' (van Deurzen-Smith, 1997: 191), or ensure that the consulting room has sound-proofed walls (Langs, 1998: 43).

B. ***Time boundaries.*** Every therapeutic session is bound by the time element. Time considerations play a natural part in any human relationship, as well as in the psychotherapeutic encounter.

1. Types of time dimensions. Time determines the boundaries of the therapeutic encounter in certain instances.

The time of each therapeutic session is defined by a starting point that is agreed on between therapists and clients, and an ending point, which in most therapeutic approaches is also agreed upon by both sides (except for the Lacanian approach, where the therapist decides when to end each session). Therapists can be flexible about the exact time of each session, depending on their own views and approaches.

In most approaches the length of each session is also fixed, although they generally range from 45 and 50 minutes to double sessions.

In most therapeutic approaches there is a fixed time for all successive sessions and a set day when these take place. In other cases, as in Winnicot's case of 'The Piggle' (Winnicott, 1991: 2), there is an option of treatment 'on demand' (ibid.).

Some therapists offer their clients 'open-ended' treatment, while other therapists and clients agree in advance regarding the length of the whole treatment.

2. Time disturbances. While time sets the boundaries of the therapeutic encounter, thereby creating a secure frame, time can also violate or deviate from the therapeutic frame.

Psychotherapists and clients can, in special circumstances, cancel a therapeutic session. In this event they agree to take responsibility for the

frame deviation and to give advanced notice within an agreed time before the expected date.

Holidays and vacations also constitute a deviation from the time frame. Some therapists agree about the dates of their vacations with their clients during early sessions, while others prefer to give notice a few weeks before the break.

3. Objective and subjective time. Although the fixed hour, date and duration of the therapeutic sessions are objective phenomena, they have a different impact on therapists and clients.

Time perception is subjective and is conditioned by the personal images of time and by the therapeutic process itself. In certain situations therapists and clients have different perceptions of time, and there is a need for clarification and adjustment in order to meet the expectations and capabilities of both sides.

Another kind of subjective time plays a central role in the therapeutic process. This is therapeutic time, which is one of the main topics of clients' narratives and therapists' interpretations. Therapeutic time can also be experienced differently by clients and therapists as subjective or objective time, therefore it may need clarification. Some therapists focus on time past, i.e., childhood memories or dreams, while other therapists are interested in the 'here-and-now'.

4. Time management. Facilitating the time components of the therapeutic encounter is a complicated task, and therapists have to maintain the time frame so that subjective and objective times are integrated, thus promoting therapeutic goals.

Therapists are responsible for defining the time boundaries of the treatment and presenting them to their clients as part of the therapeutic contract.

Therapists are also responsible for keeping the boundaries of time and reminding their clients about the beginning and end of each session.

The time of each session can be planned in advance by the therapist, or planned together with the client as part of their mutual contract.

Therapists can deal with time deviations in various ways. They can be strict about the exact starting and ending time of each session and about clients' responsibility for being on time and attending all sessions.

Conversely, they can be flexible about time boundaries and interpret clients' time deviations as part of their therapeutic technique.

C. **Communication.** This is the essence of the therapeutic interaction and its multilevel structure plays a principal role in the therapeutic process. Therapeutic communication propels the therapeutic process forward and determines the style of therapeutic relationship.

1. Emotional communication. The goal (and justification) of any therapeutic process is a kind of emotional change based on emotional communication. This means that any element of this communication is part of the emotional process.

In any session, the emotional communication starts with listening and being aware of the psycho-social background of the client. This gives the therapist some understanding of the client's emotional state and helps establish the therapeutic language.

The ongoing emotional communication is based on identifying and reflecting the clients' present emotional situation. This includes clients' everyday emotional life and their emotional reaction to the therapeutic process.

Most therapeutic approaches deal with emotional difficulties and problems, while others are interested in clients' emotional state of mind with non-pathological diagnoses. The therapist's attitude towards the client's emotional situation defines the ground rules of the therapeutic relationship.

Sometimes emotional communication deals with the emotional field created between clients and therapists concerning the therapeutic situation.

The language of therapeutic communication. It is impossible to manage therapeutic communication without creating a common language for therapists and clients. A common language is needed to define the therapeutic goals and to enable co-operation between therapist and client.

2. Language differences are part of any human communication, since each participant develops his own personal connotations and associations in relation to the basic terms of the language and since any individual brings his own personal background with him (cultural background, religious background, social background and his unique family history).

In a way, every therapeutic relationship is based on multicultural communication. Each participant brings his own terminology and his

personal connotations and associations until, by exploring and clarifying each set of personal idioms, they create a common language.

It is only when personal language differences are processed and acknowledged, that psychotherapeutic language starts to be created. A common language is essential for creating the basis for the therapeutic language, and it serves as a secure frame for trust and confidentiality. In a way, the process of creating a common language is a therapeutic process in itself and prepares the ground for advanced processes.

3. Psychotherapeutic tools and techniques. The practice of therapeutic communication integrates therapeutic tools and techniques into the interaction. In fact, this is the main activity of psychotherapy.

Therapists always use therapeutic tools in their communication with their clients and, in accordance with their therapeutic approach and beliefs, their main task is to adapt the appropriate technique to each client and each therapeutic situation.

In all therapeutic approaches, the main technique is listening, with each therapist developing his own personal listening style. There are both passive and active listening approaches, which can be followed by questions, interventions, interpretations, etc. The main advantage of therapeutic listening lies in defining the therapeutic relationship in which clients' narratives are treated carefully and seriously. Simple listening is not a natural human activity and beginners have to practice this skill carefully until they can master it.

Other therapeutic tools that fulfil different functions in various therapeutic approaches are intended to offer clients a sense of support, which is the common goal of most therapeutic approaches. Sometimes this tool is used to create a parental relationship between therapist and client, in which therapists can create a secure frame by unconditional positive regard, by containing or loving their clients.

There are also various tools for active interventions that form a part of the therapeutic communications. Therapists generally interpret, reflect or guide their clients, although these activities are implemented differently by every therapeutic approach.

4. Communicative agreements. Therapeutic communication is impossible without preliminary agreements concerning the nature of this unique

interaction. These agreements form the basic components of the therapeutic contract.

Some therapists believe that the goals of the therapeutic process are obvious since clients chose to come to therapy, but it may be useful to clarify the client's and the therapist's expectations at the start of any therapeutic communication. This clarification may significantly enhance understanding concerning the therapeutic process.

Practical agreements also constitute a part of psychotherapeutic communication. Although questions of fixed fees and fixed times are determined in the first or second session, they play a meaningful role in all therapeutic communication, and it may be productive to reassess them from time to time.

Therapists present their therapeutic approach and beliefs as the basis for therapeutic communication. Since they do not give their clients a comprehensive theoretical introduction, they demonstrate it as part of the therapeutic communication in any interaction. Awareness of this activity is needed in order to prevent misunderstandings and improve communication.

A condition for any therapeutic communication is the option that is open to both sides to end it or cancel sessions when needed. By presenting this option, the therapist strengthens the sense of a secure frame.

5. Physical communication. Psychotherapy is a non-physical treatment, which nontheless involves physical interactions that affect the therapeutic process and the therapeutic relationship.

   Most therapeutic approaches and codes of ethics agree that physical contact between therapists and clients is forbidden. This prohibition is intended to prevent any sexual abuse by therapists, but it cannot prevent sexual sensations and passionate feelings in the therapeutic interaction. These inhibited physical contacts play an important role in each therapeutic session, and therapists can interpret them as fictional or as real and natural human feelings.

   Each therapeutic session starts and finishes with a ritual of physical gestures. In some approaches this ritual can be remote and 'cold', with no physical contact, such as shaking hands or even a smile, while in other approaches it can be accompanied by a warm physical gesture like a hug.

   Although body language is not discussed between therapists and clients, it

plays a central role in psychotherapeutic communication, as well as in any other communication. Therapists are consciously and unconsciously affected by their clients' body language, and the same holds true for clients. Therapists' body language affects their clients, who can be manipulated by intentional behaviour of the part of the therapist, such as breathing or changes of sitting position.

The use of the voice is also a vital physiological component in every therapeutic communication (except for online psychotherapy) and vocal adaptation is part of the therapeutic process. Therapists listen to clients' intonations, which can serve as an indication of their emotional state. By controlling their vocal expressions, therapists can be sensitive to clients' needs and create a secure vocal frame.

6. The therapeutic message as a communicative procedure. Therapeutic communication enables therapists to present therapeutic messages to their clients. They do this consciously and unconsciously in the course of each session and they can use it as a method of control at the end of each therapeutic communication.

   The therapeutic message enables therapists to review the therapeutic process at the end of each session. It helps both therapist and client to understand the process, identify mistakes and obstacles and improve therapeutic relationships.

   The message also maintains the continuity of the whole therapeutic process, since it locates and defines future goals, thereby strengthening the secure frame.

   The message at the end of every therapeutic session enables therapist and client to examine the therapeutic contract and adapt and reformulate it when necessary.

The three dimensions of the psychotherapeutic encounter represent a structure that is common to all therapeutic approaches. Each therapist furnishes this structure with ground rules that are appropriate for a certain therapeutic approach and his personal views.

For practical reason, in presenting these three dimensions I have skipped the stage of horizontally presentating (without any categorisation) all the components of the psychotherapeutic encounter. In defining the three dimensions, I have tried to avoid

any evaluation or judgement regarding the use of ground rules, so that this structure can serve as an independent model for implementing ground rules in any therapeutic approach.

Since this division into three dimensions of the structural model for ground rules is still raw material, it is too abstract and too detailed to serve as a practical model. A model that is common to all therapeutic approaches must offer a simple structure which represents the main functions of the therapeutic encounter and by use of which therapists can create their own set of ground rules.

The structure of the three dimensions of the therapeutic encounter is an efficient way to identify and present the various elements of the therapeutic relationship. But at the same time, this structure is not identical to the principal goal of the therapeutic relationship, which is to create a secure frame for the psychotherapeutic relationship.

In order to define a structure that will serve as a common model for creating ground rules in all therapeutic approaches, one has to rearrange the many components of the three dimensions and select the main structural elements that represent the goal of therapeutic relationships.

The common categories of ground rules

The common denominator of ground rules cannot be found in the various sets of ground rules in different therapeutic approaches. Each therapeutic approach has its own set of ground rules, adjusted to its special characteristics, to its theoretical assumptions and the technical means at the therapist's disposal. In a way, ground rules are an indication of the differences between the many therapeutic approaches.

However, there is a common denominator between all therapeutic approaches. This concerns the common agreement about the central role of therapist/client relationship in the therapeutic process and the wish to create a secure frame, which is a precondition for such a process.

There are many ways of creating a secure frame and each therapeutic approach develops a unique set of ground rules that define its therapeutic frame and promote its goals and needs.

The structural dimensions of the therapeutic interaction described above serve as a container into which ground rules are poured, according to the demands of each therapeutic approach. The common model of ground rules is hidden among the many elements of the structural dimensions.

In order to identify this common model, one needs a method based on the therapeutic goals concerning therapist/client relationship and on crossbreeding between these goals and the detailed list of the structural dimensions of the therapeutic encounter.

I will present ten characteristic of the secure therapeutic frame and adjust each characteristic to the appropriate details of the structural dimensions of the therapeutic interaction. Then I will reduce the list by grouping similar details so as to create a limited list of common categories of ground rules. Each category will represent a structural characteristic of the therapeutic relationship that promotes the creation of a secure frame.

The ten characteristics of the therapeutic secure frame are trust, understanding, listening, empathy, support, safety, confidentiality, convenience, boundaries and sensitivity. I will crossbreed these characteristics with location, accessibility, design, physical contact, body language, voiced, soundproof room, fixed time, fixed day, length, schedule, planning, termination, open-ended therapy, short-term therapy, cancelling, vacations, breaks, emotions, language, culture, religious, gender, race, listening, interpretation, holding, containing, sensitivity, contract, expectations, message, management, review.

1. Boundaries. This characteristic determines the territory of the secure frame. It is associated with location, design, physical contact, soundproofing, fixed time, fixed day, schedule, length, planning, termination, holding, contract and management.

   This list can be reduced. Location, design, physical contact and soundproofing can be replaced by "setting". Fixed time, fixed day, schedule, length and termination can be replaced by "time". Planning and contract can be represented by "contract". Holding and management can be replaced by 'therapeutic tools'.

   This leaves us with "setting", "time", "contract" and "therapeutic tools".

2. Trust. This is almost the main characteristic of the secure frame and it is associated with accessibility, physical contact, soundproofing, schedule, planning, emotions, language, culture, religious, gender, race, listening, holding, containing, sensitivity, contract, expectations, message and management.

   This list can be reduced. Accessibility, physical contact and soundproofing can be replaced by "setting". Schedule and planning can be replaced by "time".

Language, culture, religious, gender and race can be replaced by "language" or by "emotions". Message and control can be represented by "message". Contract and expectations can be represented by "contract". Sensitivity, management, listening, holding and containing can be replaced by "therapeutic tools".

This reduction leaves us with "setting", "time", "language", "emotions", "message", "contract" and "therapeutic tools".

3. Understanding. This characteristic integrates the therapists' therapeutic technique and the client's felt sense concerning the secure frame. It is associated with emotions, language, culture, religious, gender, race, listening, interpretation, sensibility, expectations and review.

Language, culture, religion, gender and race are represented by "language", review can be replaced by "message", expectations can be replaced by "contract", listening, interpretation and sensibility are represented by "therapeutic tools".

This leaves us with "language", "message", "contract" and "therapeutic tools".

4. Listening. This characteristic, which is identified as a therapeutic skill, is associated with body language, voice, soundproofing, emotions, language, culture, religious, gender, race, listening, interpretation, sensitivity, contract, message and review.

Body language, language, culture, religious, gender and race are represented by "language". Voice and soundproofing can be replaced by "setting". Listening, interpretation and sensitivity can be replaced by "therapeutic tools". Message and review are represented by "message".

This leaves us with "language", "setting", "therapeutic tools" and "message".

5. Empathy. This characteristic shortens the distance between therapist and client and is associated with emotions, culture, religion, gender, race, listening, holding, containing and sensitivity.

Emotions and sensitivity are represented by "emotions". Culture, religion, gender, and race can be replaced by "language" and listening, holding and containing can be replaced by "therapeutic tools".

This leaves us with "emotions", "language" and "therapeutic tools".

6. Support. This active characteristic is associated with body language, emotions, listening, holding, containing, sensitivity and "message".

Language and emotions are represented by "language". Listening, holding,

containing and sensitivity can be replaced by "therapeutic tools".

This leaves us with "language" and "therapeutic tools".

7. Safety. Clients' safety is associated with accessibility, soundproofing, schedule, planning, holding, containing, sensitivity, "contract", "message" and control.

   Sensitivity is replaced by "emotions". Accessibility and soundproofing are replaced by "setting". Schedule and planning are replaced by "time" and "contract". Holding and containing are replaced by "therapeutic tools" and "message" replaces control.

   This leaves us with "emotions", "setting", "time", "contract", "therapeutic tools" and "message".

8. Confidentiality. This is a contractual characteristic, which is associated with location, soundproofing, listening, holding, containing, sensitivity, contract, expectations and control.

   Sensitivity is replaced by "emotions". Location and soundproofing are replaced by "setting". Listening, holding, containing control are replaced by "therapeutic tools". Contract and expectations are represented by "contract".

   This leaves us with "emotions", "setting", "therapeutic tools" and "contract".

9. Convenience. This natural need of clients is associated with location, accessibility, design, voice, soundproofing, planning, "open-ended", listening, holding, containing, sensitivity, expectations and control.

   Location, accessibility, design, voice and soundproofing are replaced by "setting". Planning and expectations are replaced by "contract". "Open ended" is replaced by "time". Listening, holding, containing, sensibility and control are replaced by "therapeutic tools".

10. Sensitivity. This vague characteristic is associated with body language, voice, "emotions", culture, religious, gender, race, listening, interpretation, holding, containing, message and review.

    Body language, culture, religion, gender and race are replaced by "language". Voice is represented by "setting". Listening, interpretation, holding and containing is replaced by "therapeutic tools" and message and review are represented by "message".

    This leaves us with "language", "setting", "therapeutic tools" and "message".

There are seven common categories of ground rules in this list: "setting", "emotions", "language", "therapeutic tools", "contract", "time" and "message". Each of these

categories can be found in any therapeutic approach, furnished with different sets of ground rules.

These categories are never "empty" and they are always furnished with ground rules. They can create a secure frame on condition that therapists furnish them with coherent and consistent ground rules that are adjusted to the needs of the client and the therapeutic situation. Without awareness of coherency and consistency with regard to ground rules, contradictions and paradoxes might occur that will result in an insecure frame.

1. Emotional interaction: the emotional aspects of the therapeutic encounter. This category refers to the main characteristic of the psychotherapeutic relationship and the main distinction between therapeutic relationships and any other relationship.

   Therapeutic relationships focus on the emotional aspects of the interaction. Each therapeutic approach has its own preferences and emphases concerning certain emotional aspects of the relationship.

   The category of emotional interaction is present in any therapeutic encounter and in every minute of each session. Awareness of this category and its implications is necessary in order to preserve the therapeutic process by creating an ongoing secure frame.

   a. Clients' inner emotional world. It is a convention that clients talk with their therapists, whatever therapeutic approach they hold, about their private emotional inner world. This convention is the unwritten ground rule of all therapeutic approaches. When Freud asked his patients to 'say whatever goes through your mind' (Freud, 1913: 355), according to the fundamental rule of free association, he established a preliminary self-explanatory ground rule of the emotional interaction based on the assumption that clients talk about their emotional associations and not about their philosophical world-view (which is a non-derivative message in communicative psychotherapy. Smith, 1991: 193). Existential psychotherapists, on the other hand, deal with the emotional encounter by exploring their clients' world-view (van Deurzen-Smith, 1997: 242, Strasser, 1999: 10).

Therapists tune themselves to their clients' emotions according to ground rules that are compatible between both parties. Freud's

complement to the fundamental ground rule, the ground rule of 'evenly-hovering attention' (Freud, 1912: 324) promotes a resonance between therapist's and patient's unconscious emotional worlds (ibid.: 328). Rogers' 'unconditional positive regard' and 'empathic understanding' (Rogers, 1995: 221) are the ground rules of conscious resonance.

Similarly, different therapists explore their clients' emotional inner worlds according to their theoretical ground rules, by focusing on the origin of emotional difficulties in their clients' childhood or present situation.

b. Clients' emotions concerning relationships with other people. Sometimes, client's relationships and emotions concerning other people play a central role in the therapeutic process. This aspect of clients' emotional state is also dealt with by therapists according to their theoretical views and unique ground rules. While in psychoanalytic approaches there is a focus on 'one person' inner processes, relationships with others are regarded in existential approaches as the essence of "being in the world".

c. Emotional aspects of client/therapist relationship. Since psychotherapy is a kind of relationship, the emotional aspects of the client/therapist relationship influence the therapeutic process.

Therapists can refer to these kinds of emotions as "imaginary" (transference or counter-transference) or as "real", according to their theoretical assumptions and specific ground rules.

2. The use of psychotherapeutic methods and tools. The psychotherapeutic interaction is different from any other type of communication in that both sides are aware of the use of therapeutic methods and tools. There are various therapeutic tools, and each therapist chooses the tools that are appropriate for his therapeutic goals and theoretical assumptions and the ground rules he has established.

There is one therapeutic tool that is common to all therapeutic approaches, since it is the rationale for the existence of the "talking cure". This tool is "listening". Listening in the therapeutic context means giving vocal space to the client or, in other words, creating a secure frame for the client.

If this is true, every intervention may be experienced by the client as a "frame violation" or "deviation" or "impingement" (Langs, 1998: 50). This means that listening and intervening are not simple tasks. Most ground rules

regarding therapeutic tools refer to these tasks and ways of elaborating on them.

Most therapists use various types of therapeutic tools in an integrative way. Sometimes they do so in order to adjust them for a particular therapeutic purpose and sometimes they do so unconsciously, out of habit.

a. Tools for listening. Therapists always listen to their clients, but there are many ways to do this, according to theoretical assumptions and different kinds of practice.

There is passive listening, such as psychoanalytic listening, with as few interventions as possible, and active listening, where therapists converse with their clients.

Listening is always followed by interventions, which promote the therapeutic process and at the same time violate the secure frame. These include interpretations, decoding of unconscious messages, questions, etc. The goal of these tools is to improve listening.

b. Tools for creating change. These tools are interventions that are not part of listening. They are designed to change the clients by various kinds of manipulations.

Such therapeutic tools include hypnosis, suggestion, relaxation, desensitisation, guided imagination, reflection and other types of directive influences.

c. Tools for creating relationship and trust (secure frame). These tools have no direct therapeutic goal, and they actually reconstruct a positive parental environment.

These tools can be defined as the "ground rules of empathy" and they include empathy, containing, supporting, unconditional positive regard and even love.

3. The language. There are no direct ground rules concerning the creation of a common language between therapist and client. But a common language is needed to define the therapeutic goals and to enable co-operation between therapist and client (a secure frame).

This common therapeutic language is always unique, since it is a result of the encounter between two individuals, each bringing to it his private connotations and associations.

Creating a common therapeutic language is more than a communicative skill. It involves active and mutual learning of personal emotional terminology, which

is in itself a psychotherapeutic process.

a. The psycho-social background. In order to understand the client's language, the therapist has to become aware of the client's background (social background, cultural background, family background, religious background and emotional background).

Exploring the client's background can be done in many ways, according to the specific ground rules of relationship. Some therapists interrogate their clients, while others associate with them.

b. Making the client aware of theoretical assumptions. To gain clients' co-operation in the therapeutic process, therapists have to present their approach and therapeutic assumptions and to explain their therapeutic technique and ground rules in a simple and comprehensive manner.

The goal of acquainting clients with the therapist's methodology does not involve learning or even understanding, but rather accepting and agreeing. Therapists do so not by forcing their beliefs on their clients, but by adapting their theories to their clients' literacy. This is a mutual process, in which a new bond involves both parties in a shared project.

c. Shared experience. The psychotherapeutic interaction is a unique encounter, whereby both parties expose themselves and learn about each other. This shared experience is the source of a created a common language, based on meaningful milestones that become the main terms of this language.

Obviously, the common language is conditioned by therapists' beliefs and ground rules concerning the therapeutic relationship. Paternal therapists may force their idiosyncratic terminology on their clients, while others, who believe in equality, would adjust themselves to their clients' language.

4. The contract. This category contains all the agreements between therapists and clients concerning the goals, terms and management of the psychotherapeutic process.

The contract is the category that contains the therapeutic alliance. It is a complicated structure, assembled out If most of the components of the other categories of ground rules.

Some therapists present their clients with a prepared contract, while others formulate the contract together with them. Again, different contracts express

different therapeutic approaches and ground rules.

Although most therapists present the contract to their clients during the first or second session, it can be re-examined and re-formulated in each session, in order to maintain and nurture the therapeutic alliance.

a. Expectations. The contract enables both therapist and client to express and clarify their expectations. By re-examining their expectations in every session, they can adapt the contract to inevitable changes in the therapeutic relationship, so it can be regularly amended and modified.

Re-examining expectations serves as a practical way to follow the therapeutic process and evaluate it. This option strengthens clients' trust in the therapeutic relationship and their sense of being in a secure frame.

b. Terms and conditions. The therapeutic contract defines the terms and conditions of the therapeutic relationship. It contains three categories of practical terms and conditions: time, space and fee.

The ground rules of time define the fixed day, the length of each session, the frequency of sessions and the duration of the whole treatment. It can be based on one session a week, which is conventional in most therapeutic approaches, or on five or six sessions a week, as in classical psychoanalysis.

The ground rules of space define the setting in which the therapeutic encounter takes place. Each therapeutic approach suggests certain ground rules that define the appropriate setting.

The ground rules of fees define the level of payment, the times for payment (for each session, at the beginning or end of each session, in advance for the whole month, etc.) and the options for cancelling sessions or scheduled holidays and vacations.

c. The categories of ground rules and the contract. While the categories of ground rules serve as a model for the therapeutic relationship, the category of the contract refers to all the other categories which make up part of the contract.

The contract, like the practical guideline for the psychotherapeutic relationship, includes all elements of this relationship. This explains why all seven categories of ground rules have to be meticulously detailed in the contract.

5. The setting. This category refers to all ground rules that deal with the physical

dimensions of the therapeutic encounter: location, design, physical contact and audio-vocal characteristics.

The setting is the manifestation of the metaphorical secure frame and it demonstrates the various concepts of a secure frame in different psychotherapeutic approaches.

a. Location. The exact location of the therapist's clinic, which affects clients' accessibility, convenience, privacy and confidentiality, is influenced by specific therapeutic approaches and ground rules.

For example, Langs claims that the psychoanalytic ground rule of anonymity (of the analyst) prohibits locating the clinic at the analyst's house.

b. Design. The architectural and aesthetic aspects of the clinic have functional roles in creating a secure frame and they derive from theoretical assumptions that represent the therapist's views.

The preference for a neutral space or a clinic that expresses the therapist's taste and personality is affected by ground rules concerning anonymity, neutrality, abstinence, etc.

c. Physical contact. The setting influences the inevitable physical contact between therapist and client (the actual encounter and departure, body language, etc.). The ground rules that refer to these phenomena reflect basic attitudes towards the existence of physical contact in psychotherapy.

d. Audio-vocal characteristics. Ground rules of confidentiality may affect certain characteristics of the therapist's clinic. The choice of a soundproofed room corresponds to the psychoanalytic assumptions, while not necessary corresponding to existential views.

6. Time management. This category of ground rules reflects certain aspects of the therapeutic contract, but it is also a central factor in managing the therapeutic relationship.

By facilitating the ground rules of time management, such as time boundaries or time disturbances, therapists create a secure time-frame for their clients. Ground rules refer to some aspects of time management.

a. Scheduling. The technical aspect of scheduling the therapeutic sessions indicates theoretical views that are reflected in certain ground rules. It refers to the exact time of each therapeutic session, its length, the

frequency of sessions and the duration of the whole treatment (open-ended, short-term, etc.).

b. Planning and managing the therapeutic hour. Each therapist plans and manages the time progression of each session in his own way. While psychoanalysts are strict about starting and ending at an exact time, Lacanian analysts have an opposing ground rule concerning ending the session. These differences affect clients' sense of the secure frame.

c. Concepts of time. Since time perception is subjective, the different concepts of time affect the therapeutic process and the sense of a secure frame. Therapists have to be aware of their ground rules concerning time management and its effect on their relationships with their clients.

The concepts of time refer not only to the procedural aspect of the therapeutic session but also to the contents of clients' narratives. Each therapeutic approach (and accompanying ground rule) refers to these contents with different assumptions and ground rules.

7. The therapeutic message. Although many therapists are not aware of its implications, each therapeutic session ends with a therapeutic message. The message has a central role in creating the secure frame. In certain therapeutic approaches such as psychoanalysis, the therapeutic message is non-verbal.

The therapeutic message serves as a control mechanism by which therapists can ensure that they are tuned to their clients, thus preserving the secure frame as the core of the therapeutic relationship.

Since this category is not officially recognised in the context of ground rules, there are not many references to therapeutic messages in the therapeutic literature or in case studies.

a. Review. The therapeutic message enables therapists and clients to review the therapeutic process they have undergone in each session. The constant review of each session through the therapeutic message at the end of each session gives clients a sense of a secure frame and understanding.

b. Refreshing the therapeutic contract. The therapeutic message also estimates and re-defines the basic ground rules, thereby helping to explore and refresh the therapeutic contract.

c. Continuity. The therapeutic message links the actual session to the succession of encounters in the continuous therapeutic process. By doing

this, it integrates the whole therapeutic process and makes the secure frame visible and comprehensible.

The seven categories of ground rules serve as common denominators of various characteristics of ground rules that can be found in any therapeutic encounter. I defined these seven categories by presenting a phenomenological view of various characteristics of ground rules and searching for their common denominator. I presented a list of ten general characteristics of a "secure frame", and cossbreeded them with a list of the characteristics of three dimensions of the therapeutic interaction. This crossbred resulted in my definition of seven common categories.

According to my personal experience as a psychotherapist and my acquaintanceship with the therapeutic literature, I believe that my definition of the seven categories of ground rules may serve as a practical model for understanding the psychotherapeutic interaction, as well as a heuristic method for practice and research. These categories function as empty containers with different labels ('Emotions', "Language", "Therapeutic tools", " 'Contract", "Setting", "Time management" and "Therapeutic message"). The labels have no value in themselves since their content is different in each therapeutic encounter. These labeled containers or categories represent, by definition, the structure of any therapeutic interaction. This does not mean that therapists and clients are awere, for example, to the therapeutic contract in each session, but that the contract is an important component in any therapeutic encounter, even when a contract was not established.

Since the seven categories of ground rules reflect the general characteristics of the psychoterapeutic encounter, they may serve as a model which resembles the construct of the therapeutic interaction, according to Suzanne Langer's definition: 'A model always illustrates a principle of construction or operation' (Gedo and Goldberg, 1976: 4).

The seven categories of ground rules can serve as an explanatory agent. 'A model is an ad hoc construction designed to make easier the understanding of complex, abstract theoretical propositions through the use of more easily encompassable pictorial or verbal analogies' (ibid.: 3). Such a model can serve as a means of understanding and researching the role of ground rules in various approaches to psychotherapy. It can also help therapists to identify their own ground rules with each client, and to re-define them according to the actual situation.

McGin claims that a model is 'a *simulating engine* – a device that mimics, copies, replicates, duplicates, imitates, parallels reality' (Smith, 1991: 132). The seven categories, as a model, create a frame for such simulation, so they can function as a practical device in maintaining ground rules in the therapeutic encounter.

I defined the seven categories of ground rules by identifying their common structure in various therapeutic approaches, in order to bridge the gap between different theoretical approaches and a simple model. 'A model can be adequate for its theory only if it has an identical logical structure' (Macmillan, 1997: 195).

Practical implications of the common categories

The common categories of ground rules may seem abstract and "empty" as they are not conditioned to the contents of any kind of ground rules or any therapeutic principles. They are abstract and empty because they serve as a metaphorical container for defining specific sets of ground rules.

The common categories of ground rules serve as a map of the structure of psychotherapeutic relationship. As a map, they help therapists to be familiar with the structure of the relationship and to navigate through this complicated structure by defining their own appropriate ground rules. But like any other map, these categories do not show the right way or recommend appropriate transportation. Therapists must pave their own way and choose their own vehicle by defining and adjusting the best set of ground rules for each therapeutic goal and for each client. This map contains no inherent secure frame; this must be created by therapists' proper use of their own ground rules in "real life" therapeutic relationships.

The common categories of ground rules can serve as a practical therapeutic instrument in certain cases.

1. Research in the field of ground rules. Since the common categories of ground rules are not influenced or biased by any therapeutic pre-suppositions, they can function as practical criteria for comparative research of ground rules in various therapeutic approaches.

As I mentioned before, there are no concrete references to the concept of ground rules in most therapeutic approaches. The common categories can be a prism through which ground rules are identified and categorised. Such research may be based on an analysis of theoretical texts, which present the ideal practice and hypothesise the compatible ground rules. However, it might be more

accurate to identify the actual ground rules by analysing case studies. Such an effort can be demonstrated in analysing Freud's short case study of Katharina (Freud, 1895) through the prism of the common categories of ground rules.

a. Emotional interaction. Although Freud and Katharina met in a non-therapeutic context (on top of a mountain) and although Freud was not recognised by her as a psychotherapist, Katharina approached him as a doctor.

'Are you a doctor, sir?', (ibid.: 190) she asked, and immediately presented her emotional problem. 'My nerves are bad' (ibid.). This short exchange determined the ground rule of emotional interaction, and set the boundaries for the whole interaction.

This was validated by Freud's written reflections. 'So there I was with the neuroses once again – for nothing else could very well be the matter with this strong, well-built girl with her unhappy look' (ibid.). Now both "client" and doctor were made aware of the category of emotional interaction, and neither would talk about any other subject throughout the whole interaction.

b. The use of psychotherapeutic methods and tools. At the period when Freud took his first steps in psychoanalysis, he had no specific technique and continued to integrate medical methods and hypnosis. It is interesting to notice that he chose not to practise these methods with his casual "patient". 'Was I to make an attempt at an analysis? I could not venture to transplant hypnosis to these altitudes, but perhaps I might succeed with a simple talk' (ibid.: 192). Instead, he used the technique of interrogation and questioning, which, contrary to the official ground rules of psychoanalysis, was one of his professional trademarks.

Next Freud presented the technique of interpretation. '"I'll tell you how *I* think you got your attacks",' (ibid.). Katharina also co-operated with the use of this technique, and Freud decided to encourage her to utilise the ground rule of free association. 'But I told her to go on and tell me whatever occurred to her, in the confident expectation that she would think of precisely what I needed to explain the case' (ibid.: 195).

Although at first sight this case appears to present a non-therapeutic situation, Freud introduced Katharina to his technical ground rules, thereby gaining her co-operation.

c. The language. Katharina (Aurelia Kronich) was different from Freud's other women patients. She was not rich and educated, but a daughter of an innkeeper, who lived far from Vienna (Appignanesi & Forrester, 1993: 103).

In the case study, Freud described Katharina's unique dialect, and his attempts to create a common language by adapting to her simple speech. 'I report the conversation that followed between us just as it is impressed on my memory and I have not altered the patient's dialect' (Freud, 1895: 190). He gained her co-operation and introduced his therapeutic techniques without using any professional terminology. 'The words he used to communicate this hunch to the girl are interesting for what they tell us about Freud's sense of propriety' (Appignanesi & Forrester, 1993: 104).

Freud's special attempts to create a common language with this mountain girl created a secure frame on the top of a mountain. The strong bond that was created between Freud and Katharina, due to the creation of this common language lasted for many years and was even remembered by her children (Green, 2004a: 138).

This special common language affected Freud as well. 'I owed her a debt of gratitude for having made it so much easier for me to talk to her than to the prudish ladies of my city practice' (ibid.: 198).

d. The contract. It looks as if there was no contract between Freud and Katharina on the top of the mountain. But from her first question, 'Are you a doctor?' (Freud, 1895: 190) and his answer, 'Yes, I am a doctor' (ibid.) there was an agreement on the basis of a medical contract.

As holds true for any other contract, they both agreed upon the simple goal of their encounter: to remove Katharina's neurotic symptoms. They also agreed upon the therapeutic techniques that Freud suggested.

Katharina was also aware of the question of confidentiality, which she formulated in a very simple and unequivocal way. 'You can say *anything* to a doctor, I suppose, [so listen]' (ibid.: 193). (The additions in square brackets were translated directly from the German, since they were omitted from Strachey's translation.) Freud accepted this condition, and changed her personal details in the printed case study. But in 1924, almost thirty years later, he changed his mind and concluded that Katharina was sexually abused by her father. He claimed that 'Distortions like the one

which I introduced in the present instance should be altogether avoided in reporting a case history' (ibid.: 201). Thus, with Katharina's consent, he changed the ground rule of confidentiality.

e. The setting. The physical setting of the therapeutic encounter is essential in creating a secure frame. Obviously, there was no such setting on the top of the mountain where Freud accidentally met Katharina. But in a way, the special setting of their meeting has some characteristics of a secure frame.

Katharina met Freud at her mother's inn, where he was staying, but she chose to approach him in a neutral location, which was *her* secure frame, which for her was accessibile, convenient, private and confidential.

Freud was aware of Katharina's preference for that setting, so he had to define the physical setting and keep his authority as the creator of such a setting. In such a way he designed his own setting by asking her to sit in his "clinic". 'Sit down here' (ibid.: 191).

f. Time management. It was Katharina who determined the time for her encounter with Freud, in the same way as she determined the setting for their meeting. But it was again Freud who used his authority to create a secure time-frame for Katharina.

There is no indication of the length of this one-session therapy, but Freud chose other ways to manage the time boundaries. He did this by conducting the conversation at a very fast tempo, which was set by his questions.

He also decided to fulfil the girl's request during that same meeting, so he went on with his interrogation until he found the solution; he was the one to decide that the consultation had come to an end.

By taking her back and forth in time, Freud also managed the time frame of Katharina's memories until all parts of the puzzle were assembled.

g. The therapeutic message. It is hard to expect a therapeutic message in a coincidental encounter like this, since Freud didn't refer to it as an ordinary session and since in any case he never consciously reported his therapeutic messages to his patients.

In this case, the therapeutic interpretation, which was the goal of the meeting, was identical with the therapeutic message. During the meeting,

Freud demonstrated the logic of his interpretations: at the end of their meeting he summarised his technique and findings, knowing that Katharina could understand them at this stage of their relationship. 'I know now what it was you thought when you looked into the room. You thought: "now he's doing with her what he wanted to do with me that night and those other times." That was what you were disgusted at, because you remembered the feeling when you woke up in the night and felt his body' (ibid.: 197).

At the same time, this summary was a review of his technique and of their work together. This message was validated by Katharina, who internalised it and accepted it as their mutual achievement. 'Yes, I know now. The head is my uncle's head – I recognize it now – but not from *that* time' (ibid.: 198). With these words she not only accepted Freud's therapeutic thought and interpretation, but she also understood the multi-layered time structure of her memory.

2. Training and practising of ground rules. Although 'the relationship *is* the therapy' (Kahn 1991: xiii), there are no training courses for the therapeutic relationship or for practising ground rules.

The common categories of ground rules can be practised as a training programme for therapists. For the last five years (2000-2005) I ran such training programmes in the form of short seminars for family doctors and as part of a three-year programme in psychotherapy. There were no differences between the training programmes for family doctors and those for psychotherapists. Research has found that 50-75% of patients approach family doctors due to psycho-social difficulties and that a considerable part of their work can be considered psychotherapy (Melmed, 2001: 1).

a. Programme objectives. The main goal of the programme was to develop skills in creating a therapeutic relationship, or to learn how to create a secure frame.

- Effective management of the therapeutic encounter.
- Identifying the emotional and psycho-social background of clients/patients.
- Becoming acquainted with the ground rules of psychotherapy.
- Experiencing various aspects of ground rules.
- Acquiring skills for creating a therapeutic relationship and a secure

frame.

b. Programme structure. The programme is based on participants' knowledge, skills and experience and is aimed to help them realise these skills in creating a better therapeutic relationship.

The programme is designed for 10-15 participants. There are seven weekly for-hour sessions and each session is dedicated to one of the seven common categories of ground rules.

Each session included three parts: a short introduction and a presentation, a simulation and a discussion.

c. Training method. The programme utilizes no learning materials or methods; it is purely an experiential process.

The content of each session is based on participants' personalities, personal knowledge and life and work experiences.

The work is based on simulations of the therapeutic interaction. Participants simulate scenes from their own experience with the tutor or with other members of the group. Some simulations are presented to the group accompanied by other participants' remarks and reflections. Other simulations are created in pairs and then reported to the group by one or both participants. On other occasions simulations are done with an observer who reflects his impressions to the two participants and then reports to the group. Participants can re-experience the same simulation, while trying different modes of therapeutic interaction.

This work is integrated with dynamic group interaction, in which participants expose their emotional and personal lives. This constitutes a laboratory in which they actually examine their relational capacities in relation to the categories of ground rules.

d. Programme outcomes. Unfortunately, no funding was available to conduct scientific research concerning the existing data (detailed information saved on the doctor's computers regarding the therapeutic relationship before and after the training programme: the number of complaints by patients, the average number of medical consultations for each patient, the use of medicines, the direction of patients to examinations by experts, etc.). The subjective outcomes are promising.

During and after training, the participants reported better relationships with their patients and fewer complaints and medical consultations. They

also reported improved time management and a sense of relief from their usual work tensions. Some doctors joined the programme again for the following two years. They all became familiar with the special terminology of ground rules and increased their awareness of the therapeutic relationship.

Students of the three-year course in psychotherapy became much more skilled and aware of the role of ground rules in creating the psychotherapeutic relationship. They became fluent in applying the terminology of the common categories of ground rules, and used it when confronted by new therapeutic methods and approaches.

3. A therapeutic method of dealing with relationships. Since many clients turn to psychotherapy due to difficulties in personal relationship (with partners, family members, social contacts, etc.), the seven common categories of ground rules may serve as an experiential method of therapy.

This method can be practised as limited-time psychotherapy, or as part of open-ended therapy. It can be practised in the framework of individual therapy, couples therapy, family therapy or group therapy. The structure of the therapy consists of seven sessions of four hours each.

a. Individual therapy. David was 26 years old, an MA law student. His parents separated when he was twelve, and he still hated them for that. He had a paradoxical fear of marriage, since marriage may lead to separation. We agreed on open-ended one-hour weekly therapy.

Seven months after starting therapy his girlfriend moved into his flat. He loved and adored her, but this meaningful change in their relationship terrified him. They planned to marry the next year and he couldn't stop thinking about their expected separation. He was aware of the traumatic effects of his parents' separation, but this did not help. He wanted to separate from his girlfriend in order to remove this dread.

I told him about the method of the seven categories, and suggested that we devote some time to practising them. He agreed, but instead of seven sessions of four hours we kept to our usual schedule and decided to devote four sessions to each category.

I knew a lot about David's relationship with his girlfriend, their almost obsessive love, their sexual habits and his close relationship with her parents. When we started to practise the first category (the emotional

interaction), I realised that I had never really understood their relationship. By simulating their daily meeting each evening when she came home from work, and by playing her part in the encounter, I found out that he had never seen her as a separate individual. He couldn't hug her and ask about her day and her feelings, since he was so occupied with *his* feelings and fears.

This was not a real problem, since she, on the other hand, lost her baby sister when she was a child, and treated him as a helpless child.

It took more than four sessions to practice the first category and to train him to recognise other people's feelings. Two months later he asked me to terminate psychotherapy and instead to train both of them in the seven categories of ground rules of relationship.

b. Couples therapy. Jacob and Miri came to see me when they came back from their honeymoon. They were both in their thirties, successful hi-tech entrepreneurs who managed to sell their small company for such a large amount of money that they never had to work again.

They loved each other, and decided not to risk their happiness with a new enterprise. They wanted to have children and dedicate their whole time to building a family life, but they were not sure they knew how to do this. They came to me as a wedding gift they gave themselves, and they were very pleased when I suggested the seven categories' therapy.

They were very enthusiastic, and practised each category dedicatedly each week. There were no special difficulties in their relationship, since they were very experienced in working together under pressure day and night, but they were always glad to learn something new about their relationship, and were happy to practise and shape it.

This productive learning process came to an end when we practised the fifth category, the setting. Only than I did find out that they had never owned a house, since they spent most of their time travelling to other countries. Confronting their different views on their private images of a secure frame revealed conflicts and reminded them of a poor attempt a few years earlier to buy a house on a Greek island, which was a promising investment.

We had to go back to the fourth category and re-practise their contract, common goals and expectations.

Is this psychotherapy? I am not sure. It is training in life skills that can sometimes be part of the psychotherapeutic process.

4. Defining ground rules for new approaches. There are hundreds of therapeutic approaches and new approaches are still developing. Therapeutic relationships are like breathing, which means they are ignored as long as they cause no special difficulties.

Exploring new therapeutic approaches according to the common categories of ground rules may expose their weaknesses and advantages. While the common categories help to recognise and define the sets of ground rules in established approaches, they may point out the lack of ground rules in certain contexts or the contradiction between some aspects of ground rules and the unique setting of the said approach.

This may lead to the definition of new sets of ground rules, or to adjustment, replacement or development of certain aspects of the new therapeutic setting. In this way, the new setting of online psychotherapy can be developed or amended.

Conclusion

The term "ground rules" integrates many other terms that describe therapists' concepts concerning the therapeutic relationship: the therapeutic alliance, the therapeutic bonds, the therapeutic setting, the therapeutic contract, the secure frame, confidentiality, etc.

There are hundreds of therapeutic approaches, ewach based on different theories and beliefs but, one way or another, they all emphasise the central role of the therapeutic relationship in the psychotherapeutic process. There are many different ways to facilitate therapeutic relationships, but they are united by the same goal of creating a "secure frame".

Although there are no conventional ground rules for creating a secure frame, there are many sets of ground rules. Each set represents a certain therapeutic approach, special theoretical assumptions and therapists' personalities.

In addition to the common goal of creating a secure frame, the common denominator of all ground rules is an abstract structure of seven categories that represent the core characteristics of the therapeutic relationship. Each therapist makes his or her own ground rules and furnish these categories in his unique way according to his therapeutic approach, theoretical assumptions, beliefs and personality.

The seven common categories of ground rules have no absolute values or solid contents. They serve as a metaphoric structure for the generalisation, identification and adaptation of ground rules, according to the special needs of each therapist and each client. One can define six or eight categories, according to other points of view, or formulate similar categories with different headings that present the same characteristic of therapeutic relationships in different ways.

The common categories of ground rules may function as a practical method for comprehending and applying them. These categories can be used for researching the role of ground rules in various therapeutic approaches, training therapists in facilitating therapeutic relationships, developing new ground rules and adapting them to new therapeutic approaches, and even as a therapeutic method in itself.

In the following chapters, I will use the common categories of ground rules to identify and explore the adaptation of traditional ground rules in online psychotherapy and to refer to special alterations that are needed in order to create a secure frame in online therapy.

Chapter Three:

Ground Rules in Online Psychotherapy

When clients cannot see their therapists, and therapists cannot see their clients, this is necessarily a major deviation from the ideal ground rules, creating a different therapeutic relationship. If, as many therapists believe, body language and eye contact are necessary for any therapeutic process, this would be an inappropriate basis for psychotherapy. This would mean that blind clients or blind therapists are not suitable for psychotherapy.

In online therapy clients and therapists do not see each other (unless they use web cameras), but they can see a lot. They can see the therapeutic narrative and the therapeutic correspondence, and these data are accessible to both of them in a new way that has never been possible before.

When clients cannot hear their therapists, and therapists cannot hear their clients, there is also a major deviation from the ideal ground rules. Without talking and listening there is no 'talking cure', as psychotherapy has been called since its early days. This would mean that deaf clients or deaf therapists are hot suitable for psychotherapy.

In online psychotherapy clients and therapists do not hear each other (unless they also use online telephone systems), but they can hear a lot. They can hear the clicks of their keyboards, the sounds of new incoming messages, background music and vocal messages that they can send to one other.

The main criticism of online therapy refers to the physical aspects of the setting and the relationship. According to traditional psychotherapy, online psychotherapy is blind and deaf, but these characteristics may be viewed from other angles as an advanced means of seeing and listening. Actually, during online therapy clients and therapists can see and hear each other, but most of them choose not to do so, and they are satisfied with written communication. It will be interesting to explore this choice and its implications for the therapeutic relationship and the suitable accompanying ground rules.

Although the lack of physical interaction in online psychotherapy creates an obvious distinction between online and face-to-face psychotherapy, it may illuminate and refresh certain non-physical attributes of therapeutic interaction, which are sometimes underestimated in face-to-face psychotherapy. Several psychoanalytic authors have discussed such attributes regarding the question of ground rules, or the role of the analytic frame.

Bleger (1967) claims that there are two kinds of frames: 'one which is suggested and kept by the analyst, and consciously accepted by the patient, and the other, that of the "ghost world", on which the patient projects. One can take this argument one step further and present the "ghost world" of the therapist as well. This splitting of the frame diminishes the importance of the physical setting, which is only one component of the frame, and strengthens its mental qualities. This concept of the frame is well formulated by Young (1998), who claims that the analytic frame is more than a physical setting. 'It is a state of mind – a mental space' (ibid.). Young also separates the frame from the conservative ground rules of time, and claims that 'It is ideally tacitly in the minds of both therapist and patient all the time' (ibid.). Etchegoyen (1991) express a similar concept, claiming that 'the field fantasy is created *between* the two members of the analytic couple' (Ibid.: 501).

The metaphors of the analytic frame as a fantasy, a mental space or a ghost world are perfectly adequate to the non-physical qualities of online psychotherapy. If there is a frame in online psychotherapy, it probably is a "mental space". Any kind of online clinic, by its definition, is just a metaphor for a physical setting, and actually a "field fantasy". This kind of frame, which is 'in the minds of both therapist and patient all the time' (Young, 1998), is identical in online and in face-to-face psychotherapy. The lack of a physical setting even intensifies the qualities of this kind of therapeutic frame. This concept of the frame also exposes the illusionary aspects of the physical setting and eliminates some resistance to online psychotherapy.

Online psychotherapy is not a new approach to psychotherapy but a new setting. It is essentially different from the traditional setting and, like other changes, it evokes resistance and feelings of insecurity in both therapists and clients. The new kind of setting influences other aspects of the psychotherapeutic relationship and may affect the nature of certain ground rules.

1. The encounter. In online psychotherapy there is no clinic in the traditional sense of this term and, in most cases, there is no substitute for the sense of a clinic. This influences the therapeutic relationship and the ground rules.
2. The time. While time is synchronous in face-to-face psychotherapy, there are other options for non-synchronous communication in online therapy, requiring new ground rules regarding time management.
3. Technical dependency. Online psychotherapy is technically based, and both therapists and clients are dependent on their technical skills and on the availability

of online communication.

4. Confidentiality. Online communication is prone to exposure and disclosure by sophisticated hackers. This new kind of exposure may arouse distrust in clients and affect the therapeutic contract.
5. Body language. The lack of physical contact intensifies other aspects of the therapeutic relationship.
6. Listening. The lack of vocal exchange changes the art of listening and its influence on the therapeutic relationship.
7. The 'way to therapy'. In online therapy clients and therapists can correspond on personal computers at home. The journey to the therapist's venue is a meaningful process for clients and its absence changes basic aspects of the therapeutic process.
8. Privacy. In online psychotherapy the Internet and the technical devices serve as a 'third party' that participates in the therapeutic relationship.

In this chapter I will examine the adaptation of traditional ground rules during the short history of online psychotherapy and the formulation of new ground rules according to the seven common categories of ground rules.

Aristotle's rule of thumb

There are many ways of creating a secure frame in psychotherapy, and each therapist does this in his/her own way. The common categories of ground rules serve as a prism through which one can identify ground rules in various approaches or formulate guidelines for defining ground rules and creating a secure frame.

Aristotle's rule of thumb may suggest a simple method of identifying or creating a secure frame, since it represents the more complicated structure of the seven common categories of ground rules.

Aristotle, who wrote the first book about the human mind, or soul (Aristotle, ca 340 B.C.), also engaged in therapeutic thought. For him, the dramatic form of tragedy has therapeutic purposes. In *Poetics* (Aristotle, 330 B.C.) he claimed that

> A tragedy, then, is the imitation of an action that is serious and also, as having magnitude, complete in itself; in language with pleasurable accessories, each kind brought in separately in the parts of the work; in a dramatic, not in a narrative form; with incidents arousing pity and fear, wherewith to accomplish its catharsis of such emotions.
>
> (ibid.: 1460)

This means that the audience endures an emotional experience of pity and fear, which bring him relief from such emotions by a process of catharsis. This therapeutic process depends on a 'secure dramatic frame' which is known as the 'Three Unities' or 'dramatic unities': the unity of space, the unity of time and the unity of action (plot). These three unities originated in Aristotle's *Poetics* (Aristotle, 1941a) and were formulated as a 'rule of thumb' in French neo-classical drama in the 17th century.

The three unities encapsulate the seven common categories of ground rules in a clear and simple way. They present the main categories of **space** ('the setting') and **time** ('time management') and reduce 'emotional interaction', 'therapeutic tools', 'language', 'contract' and 'message' to **action** (or plot).

In Aristotelian terminology, 'unity' is the characteristic of a 'secure frame'. In psychotherapy one creates this unity by any sort of coherent set of ground rules. Any deviation from the sense of unity interferes with the sense of a secure frame.

Aristotle's three unities may serve as a rule of thumb, which represents the seven categories of ground rules, in exploring the ground rules in online psychotherapy, since the main characteristics of online therapy are manifested by the dimensions of space and time.

Sources for Ground Rules in Online Therapy

There is no literature on ground rules in online psychotherapy. Online therapy is not a therapeutic approach and each online therapist implements his or her own approach, theoretical assumptions, therapeutic techniques and ground rules in the new virtual setting.

However, by researching and analysing all sources of online therapy, one can try to identify these ground rules. Naturally, most of them are typical of certain traditional approaches that therapists apply to online therapy, while others are new ground rules that have been developed due to the special characteristics of online psychotherapy.

Since the question of ground rules concerning online psychotherapy has not yet been discussed, one can only search for partial results, based on casual sources and limited data. Nevertheless, there is no limit to any effort to define the new settings of online therapy or to identify their impact on implementing traditional ground rules or creating new ground rules in accordance with their special characteristics.

There are four sources that refer to ground rules in online psychotherapy.

A. Codes of ethics. There is a difference between ground rules and codes of

ethics, and modifications of codes of ethics can also teach us about certain aspects of ground rules. There are certain codes of ethics that have been formulated especially for online psychotherapy, and additional sections, which I will explore here, concerning online therapy in professional societies' codes of ethics.

1. Netiquette. Netiquett, or Net Etiquette, came into existence prior to the first online therapy code of ethics, and its purpose was to define the rules of conduct on the Internet. '"Netiquette" is network etiquette, the do's and don'ts of online communication. Netiquette covers both common courtesy online and the informal "rules of the road" of cyberspace' (Netiquette Home Page, 2004).

In her book, *Netiquette* (Shea, 1997), Virginia Shea created a unique combination of code of ethics and ground rules for online relationship, entitled 'Core Rules of Netiquett'.

- Rule 1: Remember the human.

This rule is parallel to the first category of psychotherapeutic ground rules, the category of emotional interaction. 'Never forget that the person reading your mail or posting is, indeed, a person, with feelings that can be hurt' (Shea, 1997: 32).

- Rule 2: Adhere to the same standards of behaviour online that you follow in real life.

This rule means that online code of ethics is no different from everyday code of ethics, or, in Shea's words: 'Be ethical' (Ibid.).

- Rule 3: Know where you are in cyberspace.

This rule is similar to the category of setting and it means that participants have to adapt themselves to the specific online setting in which they participate. It also means that the rules of online relationship are adjusted to certain settings and are not fixed, just as the ground rules of psychotherapy are adapted to certain therapeutic approaches and setting. 'Netiquette varies from domain to domain' (ibid.).

- Rule 4: Respect other people's time and bandwidth.

This rule is similar to the use of psychotherapeutic tools, especially those of listening and empathy. 'It's OK to think that what you're doing at the moment is the most important thing in the universe, but don't expect anyone else to agree with you' (ibid.).

- Rule 5: Make yourself look good online.

This rule is similar to the category of language. 'Check grammar and spelling before you post; know what you're talking about and make sense' (ibid.: 33).

- Rule 6: Share expert knowledge.

This is an ethical rule, which can be adapted to an online therapy code of ethics as well. 'Offer answers and help to people who ask questions on discussion groups' (ibid.).

- Rule 7: Help keep flame wars under control.

'"Flaming" is what people do when they express a strongly held opinion without holding back any emotion. It's the kind of message that makes people respond, "Oh come on, tell us how you really feel." Tact is not its objective' (ibid.: 43). This rule is similar to the category of the contract, or, more accurately, to part of it, i.e., the management of relationship according to participants' expectations.

- Rule 8: Respect other people's privacy.

This rule also corresponds to one aspect of the therapeutic category of 'contract', i.e., confidentiality and privacy.

- Rule 9: Don't abuse your power.

This rule also refers to the category of 'contract', which defines the boundaries of the relationship. 'The more power you have, the more important it is that you use it well' (ibid.).

- Rule 10: Be forgiving of other people's mistakes.

This rule resembles the category of therapeutic tools, such as empathy and positive regard.

Shea's core rules are relevant for online therapists and clients, although they are not mentioned in the limited literature concerning online therapy, except for Stofle's recommendation for online clients. 'The Internet has its own set of rules that participants are informally expected to follow' (Stofle, 2001: 81). Although these rules are almost obvious in face-to-face relationship, their adaptation to online relationship refers to the special setting of this new kind of communication.

The rules of behavior for face-to-face situations, from the board room to the church, are generally unwritten, but they are very extensive. Our lifetime of

> experience within our own cultures gives each of us ample time to build up knowledge about all these rules, and the physical presence of others is generally enough to ensure conformity when the rules seem to shift a bit or when we are in a strange situation and unsure of the rules. We willingly watch what others do, note what fork they use to pierce the shrimp, and face the rear of the elevator if we determine that rearward positioning is the social convention. The Internet, though, is a global environment with people from many cultures, and not many ways to convey social rules. Stronger measures are needed to get the job done, and the blunt sign on the door is one example.
>
> (Wallace, 1999: 66)

2. *ISMHO* code of ethics. The *International Society for Mental Health Online* is the only organisation for online psychotherapy, although it includes professional and non-professional members. The *ISMHO* code of ethics, or 'Suggested Principles' (*ISMHO*, 2000), therefore refers to both therapists and clients and is a recommendation that does not obligate online therapists.

The 'suggested principles' (ibid.) refer to ethical aspects of the unique characteristics of online psychotherapy. Although these do not refer to therapeutic technique or specific therapeutic relationships, some sections are relevant to the establishment of therapeutic ground rules of relationship.

Section 1-a(3), which introduces the 'suggested principles', presents the subject of 'possible misunderstanding' (ibid.). Although this section is not detailed, it is parallel to the category of 'common language', which is essential to any therapeutic relationship.

Section 1-a(2) resonates with the category of 'time management' and refers to the special characteristics of online time, including 'real time' (synchronised communication), asynchronous communication, time differences, etc.

Sections 2-e ('confidentiality of the client') and 2-f ('records') resonate with the category of 'contract' and refer to the special issues of confidentiality concerning online psychotherapy.

Suggested Principles for the Online Provision of Mental Health Services.

ISMHO has endorsed these principles, as per January 9, 2000. This is the only officially endorsed version.
Online mental health services often accompany traditional mental health services provided in person, but sometimes they are the only means of treatment. These suggestions are meant to address only those practice issues relating directly to

the online provision of mental health services. Questions of therapeutic technique are beyond the scope of this work.
The terms "services", "client", and "counselor" are used for the sake of inclusiveness and simplicity. No disrespect for the traditions or the unique aspects of any therapeutic discipline is intended.

1. Informed consent
   The client should be informed before he or she consents to receive online mental health services. In particular, the client should be informed about the process, the counselor, the potential risks and benefits of those services, safeguards against those risks, and alternatives to those services.

   a. Process
      1. Possible misunderstandings
         The client should be aware that misunderstandings are possible with text-based modalities such as email (since nonverbal cues are relatively lacking) and even with videoconferencing (since bandwidth is always limited).

      2. Turnaround time
         One issue specific to the provision of mental health services using asynchronous (not in "real time") communication is that of turnaround time. The client should be informed of how soon after sending an email, for example, he or she may expect a response.

      3. Privacy of the counselor
         Privacy is more of an issue online than in person. The counselor has a right to his or her privacy and may wish to restrict the use of any copies or recordings the client makes of their communications. See also the below on the confidentiality of the client.

   b. Counselor
      When the client and the counselor do not meet in person, the client may be less able to assess the counselor and to decide whether or not to enter into a treatment relationship with him or her.
      1. Name
         The client should be informed of the name of the counselor. The use of pseudonyms is common online, but the client should know the name of his or her counselor.
      2. Qualifications
         The client should be informed of the qualifications of the counselor. Examples of basic qualifications are degree, license, and certification. The counselor may also wish to provide supplemental information such as areas of special training or experience.
      3. How to confirm the above
         So that the client can confirm the counselor's qualifications, the counselor should provide the telephone numbers or web page URLs of the relevant institutions.

   c. Potential benefits
      The client should be informed of the potential benefits of receiving mental health services online. This includes both the circumstances in which the counselor considers online mental health services appropriate and the possible advantages of providing those services online. For example, the potential benefits of email may include: (1) being able to send and receive messages at any time of day or night; (2) never having to leave messages with intermediaries; (3) avoiding not only intermediaries, but also voice mail and "telephone tag"; (4) being able to take as long as one wants to compose, and

having the opportunity to reflect upon, one's messages; (5) automatically having a record of communications to refer to later; and (6) feeling less inhibited than in person.

d. Potential risks

The client should be informed of the potential risks of receiving mental health services online. For example, the potential risks of email may include (1) messages not being received and (2) confidentiality being breached. Emails could fail to be received if they are sent to the wrong address (which might also breach of confidentiality) or if they just are not noticed by the counselor. Confidentiality could be breached in transit by hackers or Internet service providers or at either end by others with access to the email account or the computer. Extra safeguards should be considered when the computer is shared by family members, students, library patrons, etc.

e. Safeguards

The client should be informed of safeguards that are taken by the counselor and could be taken by himself or herself against the potential risks. For example, (1) a "return receipt" can be requested whenever an email is sent and (2) a password can be required for access to the computer or, more secure, but also more difficult to set up, encryption can be used.

f. Alternatives

The client should be informed of the alternatives to receiving mental health services online. For example, other options might include (1) receiving mental health services in person; (2) talking to a friend or family member, (3) exercising or meditating, or (4) not doing anything at all.

g. Proxies

Some clients are not in a position to consent themselves to receive mental health services. In those cases, consent should be obtained from a parent, legal guardian, or other authorized party -- and the identity of that party should be verified.

2. Standard operating procedure

In general, the counselor should follow the same procedures when providing mental health services online as he or she would when providing them in person. In particular:

a. Boundaries of competence

The counselor should remain within his or her boundaries of competence and not attempt to address a problem online if he or she would not attempt to address the same problem in person.

b. Requirements to practice

The counselor should meet any necessary requirements (for example, be licensed) to provide mental health services where he or she is located. In fact, requirements where the client is located may also need to be met to make it legal to provide mental health services to that client. See also the above on qualifications.

c. Structure of the online services

The counselor and the client should agree on the frequency and mode of communication, the method for determining the fee, the estimated cost to the client, the method of payment, etc.

d. Evaluation

The counselor should adequately evaluate the client before providing any mental health services online. The client should understand that that evaluation could potentially be helped or hindered by communicating online.

e. Confidentiality of the client

The confidentiality of the client should be protected. Information about the client should be released only with his or her permission. The client should be informed of any exceptions to this general rule.

f. Records

The counselor should maintain records of the online mental heatlh services. If

those records include copies or recordings of communications with the client, the client should be informed.

i. Established guidelines

The counselor should of course follow the laws and other established guidelines (such as those of professional organizations) that apply to him or her.

3. Emergencies

a. Procedures

The procedures to follow in an emergency should be discussed. These procedures should address the possibility that the counselor might not immediately receive an online communication and might involve a local backup.

b. Local backup

Another issue specific to online mental health services is that the counselor can be a great distance from the client. This may limit the counselor's ability to respond to an emergency. The counselor should therefore in these cases obtain the name and telephone number of a qualified local (mental) health care provider (who preferably already knows the client, such as his or her primary care physician).

(ISMHO: 2000)

3. *HONcode*. The *HONcode* is a code of conduct for medical and health Web sites, defined by the *Health On the Net Foundation*. It 'defines a set of rules to: - hold Web site developers to basic ethical standards in the presentation of information. – help make sure readers always know the source and the purpose of the data they are reading' (HONcode, 1997). The eight principles are presented in thirty-one languages and serve as an ethical guideline for all the helping professions.

The *HONcode* relates to the category of 'contract' in section 3 ("confidentiality"), but most of its sections relate to the category of "setting". Since it was not defined specifically for online psychotherapy, *HONcode*'s suggestions are primarily applicable and useful for designing and maintaining therapeutic sites.

HON Code of Conduct (HONcode) for medical and health Web sites.

Principles

Authority

c. Any medical or health advice provided and hosted on this site will only be given by medically trained and qualified professionals unless a clear statement is made that a piece of advice offered is from a non-medically qualified individual or organisation.

Complementarity

d. The information provided on this site is designed to support, not replace, the relationship that exists between a patient/site visitor and his/her existing physician.

Confidentiality

e. Confidentiality of data relating to individual patients and visitors to a medical/health Web site, including their identity, is respected by this Web site. The Web site owners undertake to honour or exceed the legal requirements of

medical/health information privacy that apply in the country and state where the Web site and mirror sites are located.

Attribution

f. Where appropriate, information contained on this site will be supported by clear references to source data and, where possible, have specific HTML links to that data. The date when a clinical page was last modified will be clearly displayed (e.g., at the bottom of the page).

Justifiablility

g. Any claims relating to the benefits/performance of a specific treatment, commercial product or service will be supported by appropriate, balanced evidence in the manner outlined above in Principle 4.

Transparency of authorship

h. The designers of this Web site will seek to provide information in the clearest possible manner and provide contact addresses for visitors that seek further information or support. The Webmaster will display his/her E-mail address clearly throughout the Web site.

Transparency of sponsorship

i. Support for this Web site will be clearly identified, including the identities of commercial and non-commercial organisations that have contributed funding, services or material for the site.

Honesty in advertising & editorial policy

j. If advertising is a source of funding it will be clearly stated. A brief description of the advertising policy adopted by the Web site owners will be displayed on the site. Advertising and other promotional material will be presented to viewers in a manner and context that facilitates differentiation between it and the original material created by the institution operating the site.

(HONcode, 1997a)

4. *ACA* code of ethics. The *American Counseling Association* formulated an additional section concerning online psychotherapy and its code of ethics in1999 (ACA, 1999).

The code expands the definition of confidentiality (the category of 'contract'), due to certain characteristics of online therapy.

Professional counselors ensure that clients are provided sufficient information to adequately address and explain the limitations of (i) computer technology in the counseling process in general and (ii) the difficulties of ensuring complete client confidentiality of information transmitted through electronic communications over the Internet through on-line counseling.

(ibid.)

The code refers to identifying therapists and clients, which is not self-evident, as it is in face-to-face therapy. 'Professional counselors identify clients, verify identities of clients, and obtain alternative methods of contacting clients in emergency situations' (ibid.).

The code also refers to the category of 'time management' in online counseling relationships.

Professional counselors provide clients with a schedule of times during which the on-line counseling services will be available, including reasonable anticipated response times, and provide clients with an alternate means of contacting the professional counselor at other times, including in the event of emergencies. Professional counselors obtain from, and provide clients with, alternative means of communication, such as telephone numbers or pager numbers, for back-up purposes in the event the on-line counseling service is unavailable for any reason.

(ibid.)

5. APA code of ethics. The *American Psychological Association* formulated its supplement to the code of ethics in the *APA statement on services by telephone, teleconferencing and Internet* (APA, 1997). In this supplement there is no direct reference to online psychotherapy, since 'the Ethics Code is not specific with regard to telephone therapy or teleconferencing or any electronically provided services as such and has no rules prohibiting such services' (ibid.).
6. NBCC. The *National Board for Certified Counselors, Inc. and Center for Credentialing and Education* (nbcc, 2005) Formulated *Standards for the Ethical Practice of Internet Counseling.*

These standards refer to the therapeutic relationship in certain areas that are parallel to the common categories of ground rules.

In the section on the *Internet Counseling Relationship* there is a reference to the category of 'emotional interaction' and the identification of clients. 'In situations where it is difficult to verify the identity of the Internet client, steps are taken to address impostor concerns, such as by using code words or numbers' (ibid.: 1).

The standards refer to the category of 'language'. 'As part of the counseling orientation process, the Internet counselor explains to clients how to cope with potential misunderstandings when visual cues do not exist' (ibid.: 5). 'Internet counselors are aware that some clients may communicate in different languages, live in different time zones, and have unique cultural perspectives. Internet counselors are also aware that local conditions and events may impact the client' (ibid.: 9).

The section of *Confidentiality in Internet Counseling* refers to the common category of 'contract'.

10. The Internet counselor informs Internet clients of encryption methods being used to help insure the security of client/counselor/supervisor communications. Encryption methods should be used whenever possible. If encryption is not made available to clients, clients must be informed of the potential hazards of unsecured communication on the Internet. Hazards may include unauthorized monitoring of transmissions and/or records of Internet counseling sessions.
11. The Internet counselor informs Internet clients if, how, and how long session data are being preserved. Session data may include Internet counselor/Internet client e-mail, test results, audio/video session recordings, session notes, and counselor/supervisor communications. The likelihood of electronic sessions being preserved is greater because of the ease and decreased costs involved in recording. Thus, its potential use in supervision, research, and legal proceedings increases.
12. Internet counselors follow appropriate procedures regarding the release of information for sharing Internet client information with other electronic sources. Because of the relative ease with which e-mail messages can be forwarded to formal and casual referral sources, Internet counselors must work to insure the confidentiality of the Internet counseling relationship.

(ibid.)

7. Other codes of online ethics. There are other formulations for codes of ethics concerning medical and therapeutic online services. Most of them refer to health care sites and information and do not include guidance to therapeutic relationship, except for some aspects of the category of 'Contract'.

Such codes are the e-Health Code of Ethics (e-Health, 2000), AMHCA (American Mental Health Counselors Association) Code of Ethics (AMHCA, 2000), Guidelines for Mental Health and Healthcare Practice Online (Ethics Code, 1999), CSWF (Clinical Social Work Federation) Position Paper on Internet Text-Based Therapy (CSWF, 2001), eRisk Guidelines (ERISK, 2002), Ethical Principles For Offering Internet Health Services to Consumers

(Health Internet Ethics 2000), Guidelines for the Clinical Use of Electronic Mail with Patients. (JAMIA, 1998), Guidelines for the Use of Patient-Centered E-mail (MAHEALTH DATA, 1999), ATA (American Telemedicine Association) Adopts Telehomecare Clinical Guidelines (ATA, 2001), Guidelines for Physician-Patient Electronic Communications (AMA, 2004), Standards for Privacy of Individually Identifiable Health Information (Department of Health and Human Services, 2002).

B. Therapeutic contracts in online therapy. Since most therapists are not aware of the wide scope of ground rules of therapeutic relationship in their work, and since there are no references to the implications of online setting regarding the definitions of online ground rules, one can discover the underlying ground rules of online psychotherapy through suggested and latent therapeutic contracts. As is true of face-to-face psychotherapy, most online therapists are aware of the therapeutic contract and each of them formulates a contract according to his/her own approach and understanding.

Due to its nature, online psychotherapy is based on written communication. Written contracts are different from face-to-face verbal contracts and their nature influences the nature of online ground rules. There are a few kinds of online contracts:

1. Comprehensive therapeutic contracts. Few therapists formulate their therapeutic contracts and offer them to their clients. Such contracts give therapists the opportunity to present themselves and their therapeutic approach and techniques, introduce the terms and conditions for therapy and invite clients to state their expectations.

Dr Anna Williams suggests her private 'code of ethics' as a contract for her clients.

CODE OF ETHICS

I abide by Standards and Ethics stated by COSCA (Confederation of Scottish Counselling Agencies).I am subject to British Law.
As a counsellor I will always respect your autonomy.
Our contact will be based on TRUST, CONFIDENTIALITY and ACCEPTANCE.

All information given by you is STRICTLY CONFIDENTIAL. I am the ONLY person who will EVER have access to this information, including your identity, and any personal details. None of the information will be disclosed

without YOUR expressed written permission.

I will do nothing that is not in YOUR best interest. My main concern will be YOUR emotional well being. As a counsellor, I will always be there to guide and support you but all decisions will be YOURS alone.

My computer is protected by a variety of privacy control software including firewalls which prevents unauthorised access. Nobody but me will have access to your information. After every session, I will detete your email from my system in order to secure your confidentiality.

The notes from online, telephone and in person communications WILL NOT be kept on my computer (hard drive),but on a protected disc safely locked away.

In the rare event that information should be disclosed (without your written consent), it would be when others are at risk. This includes any risk posed to children by another party.

I will always SEEK to obtain your PERMISSION first, should the need for disclosure arise.

(Williams, 2005)

This contract is followed by other sections of Dr. William's site, which present her therapeutic approach, prices per appointment, methods of payment, counselling issues, FAQ, time zones and useful contacts. Clients do not have the option of making additions to the contract.

2. Latent contracts. Therapists' web sites offer clients much more information about their therapists than any face-to-face meeting. Clients can read about their therapists' education and experience, professional career, publications, therapeutic approaches, as well as detailed descriptions of their services.

Some online therapists present their views regarding online psychotherapy on their sites, while also presenting contractual information, including confidentiality, fees, time, etc. between the lines prospective clients can read the therapists' expectations concerning the therapeutic process and their relationships with their clients. Clients can also develop their own expectations regarding this kind of therapy. These unwritten expectations create a latent contract that might influence later therapeutic relationships and cause misunderstandings and disappointments.

On the web site of *MERZ Consulting* (Merz, 2005) clients are invited to create their own schedule for the therapeutic process and define their own therapeutic contract. Such an open-ended offer can be confusing, and does not supply the sense of a secure frame.

> Most people choose to schedule one session per week but you can choose the frequency according to your needs and schedule. If you would like, you can email me between sessions at dmerz@merzconsulting.com. you might want to send a weekly update prior to our next chat; or perhaps you would benefit from emailing daily. I will review your emails prior to the scheduled chat so that pertinent topics are covered during the session. Your between-session emails can also serve as a type of journaling process. Some people find this very helpful and there is no charge for utilizing between-session emails. The choice to email is yours. Use it if it works, rely strictly on chat if it does not.
>
> (ibid.)

This kind of latent contract has no time boundaries that can create the sense of a secure frame and it could be tempting for clients, since the therapist also offers free e-mail reading between scheduled sessions. This offer is parallel to traditional therapists' allowing their clients to send them letters or give them reading materials for no extra charge.

3. Terms and conditions. In most therapeutic web sites psychotherapists present their unilateral contract. This kind of contract can not represent any kind of therapeutic relationship, and it is actually a list of terms and conditions determined by therapists.

   In the web site of *Headworks* (Headworks, 2005) Richard Sansbury offers such an agreement. The title is: 'Email Service Agreement', and it starts with the words: **'You agree to the following:'** (ibid.). The 'agreement' is designed for the therapist's legal needs: '...You agree that our email exchange occurs in the state of Maryland, (USA) and is governed by the laws of that state. In a manner of speaking, you use the information super-highway to visit me in my Maryland office... where we meet to do our work' (ibid.). This condition subverts one of the main advantages of online therapy: the equal relationship between therapist and client, who meet in a virtual space, each from his own private space.

4. Web site structure. The design and structure of therapeutic web sites represent the first contact between therapists and clients, and serve as pre-contracts that affect the future of the therapeutic relationship.

   4eTherapy (4eTherapy, 2004) is one of the big online therapy clinics and its home page invites clients to try its services by assimilating some contractual details between the lines.

Online therapy or eTherapy is a new way to "see" a therapist. Use of the Internet allows us to make available therapists chosen from a large pool of expert licensed clinicians from various locations throughout the US.
Our size and reputation allow us to attract a more impressive panel of therapists than any hospital or clinic could possibly assemble under the roof.
ETherapy counseling means that someone is always there when you need to talk.
Select private, confidential online chat with a licensed therapist in "real time" or choose our email or phone option.
All of our therapists have passed our rigorous screening process, are licensed or certified in their states, and are carefully selected to be part of our network based on their demonstrated professional excellence.
We are committed to providing excellence in our clinical services and customer care.

(ibid.)

This introduction may be quite informative and contractual, but there are another nine sections on this site that give a comprehensive view of the service and create a sense of secure frame.

1. *Find a therapist.* Clients can see the photographs of 13 psychotherapists and view their personal profile, which includes personal and professional details, their diplomas, views regarding online therapy, therapeutic approach and areas of expertise.
2. *About eTherapy.* This section gives a detailed presentation of online chat options, email or phone sessions. There is more information about fees and payments.
3. *What Our Clients Say.* This section presents clients' recommendations of the service, and abstracts of its advantages: 'our online therapists', 'our values', 'our fees', 'our customer service' and 'our leadership'.
4. *Customer Service.* This section refers clients to business hours, a free telephone customer service and live online support, where they can chat with customer support personnel, online therapists or sales and advertising representatives.
5. *Arrange a Session.* This section guides new clients towards their first session with an online therapist. Clients can choose their preferred therapist, purchase any quantity of e-mail, chat or phone sessions, complete a pre-session form and schedule the appointment.

6. *Join our Network.* This section is addressed to professional therapists (therapists with Master's or Ph.D. degrees or psychiatrists), inviting them to join the service.
7. *Contact us.* This is a direct link for any written information by mail.
8. *About us.* This is a link to the main site of *Find-a-Therapist, Inc* (Find-a-Therapist, 2005), which is an international network of therapists, psychologists, psychiatrists, social workers, marriage and family therapists, counselors and other mental health professionals on the web. *Find-a-Therapist* is the owner of *4eTherapy.com.*
9. *In the News.* This section presents news reports on *4eTherapy* from 1997 onwards.

The design and information of this site give the sense of a detailed contract that creates a secure frame, although it does not present any therapeutic contract or any list of terms and conditions.

*C. **Professional literature.*** There are few books and many papers concerning online psychotherapy. Most writers refer to the ethical dilemmas of the new online psychotherapy setting. Although there are no references to ground rules in the professional literature on online psychotherapy, most writers refer to special kinds of relationships in 'the age of *text relationships*' (Suler, 2004: 19).

The main innovation of online psychotherapy is its unique setting, which is fundamentally different from face-to-face psychotherapy, nevertheless there is little reference to the role of online setting (the actual design and structure of web sites, e-mail software and chat rooms) in creating therapeutic relationships. Writers usually prefer to focus on the client's ability to be assisted by online therapy.

> Since the work is conducted through text alone, it is useful if the client is a proficient typist (although this could be more applicable to chat room work) and is comfortable communicating through text. The client should have a basic comfort level with technology and be reasonably knowledgeable about using his or her computer. Ideally he or she will have some tolerance for computer glitches and can endure periods of silence between communications. Although difficult to assess, the client should be emotionally strong enough and psychologically tough enough to be able to work through miscommunications and projections.

(Chechele & Stofle, 2003: 40)

If the setting is the most significant difference between online and face-to-face therapy, the question (or the ground rule) of time is also constitutes a meaningful difference. It looks as if online therapists are willing to forego the time-frame in favour of the benefits of e-mail therapy.

Face-to-face therapists typically attempt to accomplish this through weekly 50-minute sessions, while online therapists strive to achieve it through weekly email exchanges. With the former, clinician and client agree to a certain location and time of day when it fits within both their schedules. Email exchange communications occur at any time of day from any computer with an Internet connection. 'Asynchronous communication' is the term used to describe this type of alternating email exchange.

(ibid.: 41)

This concept manifests itself in the practice of online psychotherapy. In a survey that I will later present at length in which I analysed 236 online-therapy web sites, I found that only five therapists (2.11 %) referred to the element of frequency in e-mail therapy, and only two therapist (0.85%) actually defined fixed times for online psychotherapy.

There are certain sources for ground rules in the professional literature, although most of them are in the form of indirect references.

1. Ethical considerations. Although most books and papers ignore the question of ground rules, most of them devote a significant section to ethical discussion.

   In *e-Therapy* (Hsiung, 2002) three out of nine chapters deal with guidelines and the legal implications of E-Therapy. In *Online Counseling* (Kraus, Zack & Stricker, 2004) one chapter is dedicated to the 'ethical and legal considerations for providers of mental health services online', but ethical matters are also discussed in most of the other chapters. Gary Stofle, the author of *Choosing an Online Therapist* (Stofle, 2001), which includes the chapter 'Online Therapy Ethics', also published an online paper: 'Thoughts about online psychotherapy: ethical and practical considerations' (Stofle, 1997).
2. Segments of ground rules. As in any literature concerning therapeutic

relationship, the professional literature on online psychotherapy also relates to some characteristics of ground rules. Since the main difference between traditional and online psychotherapy is the setting and the question of time, one could assume that this literature would focus on these categories of ground rules. However, although most writers refer to the different types of setting and time in online psychotherapy they do not discuss the implications of these new characteristics or the definition of new ground rules that must be modified according to the new conditions.

The most popular category in ground rules that is discussed in the literature on online psychotherapy (or traditional psychotherapy) is the therapeutic contract and its components (fees, confidentiality, privacy, etc.).

> Contracting about the structure of treatment and the extent of counselor availability is a process that continues in the ongoing phase of treatment. Perhaps even more than f2f clients without prior therapy experience, online clients must be educated about the nature of the therapeutic relationship and the process of therapy.
>
> (Zelvin & Speyer, 2004a: 173)

Since online psychotherapy is textual, written contracts are more visible than in face-to-face psychotherapy and their role is more central. Many therapists are influenced by informed consent to the medical procedure, as one can find in the literature.

> The first and most important issue is informed consent. Many online clinicians have an informed consent/disclaimer form on their websites which the client must agree to before proceeding with treatment. There are many examples of informed consent issues that the client will need to know. These could be the differences between email therapy and fact-to-face therapy and mention of where the therapy is understood as being conducted.
>
> (Chechele & Stofle, 2003: 44)

Certain parts of the therapeutic contract that are also related to the code of ethics, namely the questions of confidentiality and privacy, are even more popular in online psychotherapy literature, as well as on many

therapeutic sites.

> For f2f practitioners this problem is familiar (if infrequent) and they have the training, skills, and the local knowledge to cope with the situation. The increased distance between therapist and client should potentially create great problems – whom would the therapist call? Moreover, there may well be different expectations with respect to confidentiality in different cultures.
>
> (Skinner & Latchford, 2004: 250)

Many writers emphasise the limits of confidentiality in online psychotherapy. 'Although experience shows that many clients do not worry much about confidentiality when using regular email, it is the responsibility of the clinician to explain the limits to privacy of such communications and offer alternatives' (Kraus, 2004: 134).

Writers also refer to the question of fees and the procedures of collecting payments from their clients. 'Stating clearly that a fee will be charged for counseling will discourage the frivolous or mischievous. The counselor, however, must still decide how he or she chooses to deal with requests from troubled individuals who were not expecting to pay and may not have the means to do so. Some therapists are willing to respond without charge to spontaneous queries, offering brief but substantial support and information' (Zelvin & Speyer, 2004a: 170).

3. The missing elements. It can be instructive to explore the absence of certain categories of ground rules in the professional literature. These can inform us about the present stage of online psychotherapy. Such matters include the significant characteristics of online therapy, namely the new definitions of time and space.

All writers are concerned with the two main modalities of online psychotherapy: e-mail therapy and chat room therapy. Writers describe the benefits and disadvantages of the two modalities, but do not refer to the ensuing lack of two basic ground rules or to options for creating new ground rules, rather ignoring the central role of these two categories of ground rules.

In his unique and comprehensive virtual book, *The Psychology of Cyberspace*, John Suler (Suler, 1996) explores the many aspects of online relationships and online psychotherapy. But although he coined the term

'psychological and social space', he ignores the role of time and setting in the therapeutic relationship.

The distinction between synchronised (chat room) and asynchronous (e-mail) types of psychotherapy and their advantages and disadvantages, has shifted writers' attention from the absence of unity of time and space concerning these two modalities.

The unity of time is related to the exact time of the therapeutic session (chat or e-mail), the length of the session (chat), the frequency of the therapeutic encounter and the length of therapy. The disregard for these ground rules of psychotherapy in the literature manifests itself also on the therapeutic sites and in online therapists' presentations of their work.

Unity of space relates to the characteristics of the virtual therapeutic setting, the therapeutic site or actual therapeutic encounter (the chat room or the e-mail software). The category of setting in online psychotherapy relates to the physical characteristics of the virtual space: design, content, type of information and technical devices. The professional literature of online psychotherapy does not refer to the role of consistent ground rules concerning setting.

D. Case studies. Direct evidence concerning online therapeutic relationships can be found in case studies and vignettes of therapeutic sessions. There are some case studies and therapeutic vignettes in the literature and in therapists' presentations of themselves on their therapeutic sites; these may indicate the nature of online therapeutic relationships.

There is a fundamental difference between traditional case studies reflecting the subjective view of each therapist, according to his/her own 'transparent model' of the therapeutic work (Green, 1998), and online case studies that are based on the actual data of the therapeutic encounter. Since the written interactions in online psychotherapy are entirely documented, these case studies and fragmented vignettes are the raw material for any research concerning online therapeutic relationship.

There are certain sources for online therapy case studies and vignettes:

1. Personal testimonies of therapists in books and papers. Some writers illustrate their articles or book chapters with original examples from their own work with their clients. Due to ethical obligations, some therapists

present fictional cases, such as Stofle's 'hypothetical chat conversation between a client and a therapist' (Stofle, 2001: 47), while other therapists share their experiences 'with examples taken from clients and practitioners who have experienced such relationships for themselves' (Goss & Anthony, 2003: 4).

These illustrations are based on transcripts from e-mail and chat room sessions and are presented 'as is'.

2. Reports about online case studies. As in traditional psychotherapy, some therapists introduce and analyse case studies from their own personal perspective, without quoting clients' exact texts.

Jeri Fink described such a case in his pioneering book (Fink, 1999), without exposing any identifying details about his clients. A substantial source for such reports can be found in 'The Online Clinical Case Study Group' (Ismho, 1999a) of the International Society for Mental Health Online. The members of this group published four papers concerning their discussions: 'A report from the Millennium group' (Suler, 2000), 'Assessing a person's suitability for online therapy' (ISMHO, 2001), 'Issues in online psychotherapy and clinical work' (Suler, 2000A) and 'Myths and realities of online clinical work' (Fenichel, 2002).

> The ISMHO Case Study Group confronted a number of situations that were thought to be impossible to address or manage online, given how difficult such clients and presenting problems can be f2f. In fact, what was discovered was that an online treatment frame sometimes worked exceptionally well.
>
> (Fenichel, 2004: 10)

3. The case of the therapist. A lot can be learned about psychotherapists, including their therapeutic approaches and personal views concerning online psychotherapy, by exploring their web sites.

Therapists' sites may serve as litmus paper for testing their personal and professional identity. The web site is more than a visiting card with which therapists present themselves to potential customers. It is a complicated structure that is meant to direct future clients to online therapy, while at the same time being a coded map of therapists' personalities and professional qualities.

While in traditional therapy psychotherapists are almost anonymous in

their communication with their clients, online therapy exposes them through their web sites. In Sean Harder's web site (Harder: WholeLifeGym) one can 'learn more about' (ibid) his personal life, his battle with depression, his professional experience and beliefs. One can also read his introduction to online counselling, its advantages and disadvantages and about confidentiality, fees, therapeutic terms and conditions, and the therapist's latest books.

The content and design of therapists' web sites actually present the therapist's case and serve as a rich source for learning about his/her unique way of working online and his/her personal style of creating online relationships.

5. Personal experience. I have practised online psychotherapy since 1999. I started with e-mail therapy, conducted (and continue until today to cunduct) groups for PTSD veterans and developed a forum that serves me as an online clinic for individual psychotherapy. I have no experience with chat room therapy, since I have found it to be inconsistent with my own perception of ground rules and secure frames.

Present Ground Rules in Online Therapy

In addition to asynchronous e-mail communication, contemporary online communication technology enables three kinds of synchronous interaction: chat-room communication, online-telephone and video-conferencing that is similar to face-to-face interaction.

But although telephone counselling preceded online psychotherapy by many years, and although videoconferencing has served as a successful substitute for face-to-face interaction in psychiatry for a long period, most online psychotherapists have chosen the options of chat room and e-mail therapy for their online practices. In my survey (from September 2005) of online psychotherapy sites I found that 215 out of 236 therapeutic sites (91.1%) offer chat and e-mail psychotherapy. These 215 sites include 18 sites (7.6%) that offer chat therapy only and 98 sites (41.5%) that offer e-mail therapy only.

This means that although online psychotherapists have the technical capability to imitate face-to-face interaction in online psychotherapy, they prefer textual

psychotherapeutic dialogue, with most of them selecting asynchronous therapeutic interaction. This finding is striking, since it indicates disappointment with traditional psychotherapy and a search for a new kind of therapy, even though this type of psychotherapy lacks certain characteristics inherent in the 'secure frame'.

This phenomenon (preference for textual interaction) is part of the communication revolution of the 21st century, where hundreds of millions of people devote a significant part of their free time to textual communication with other people through the Internet. Although telecommunication and video cellular phones are available all over the world, textual communication is even popular in telephone communication (sms). This phenomenon could be the topic for another comprehensive research study, and I hazard a guess that old-fashioned textual correspondence through the Internet constitutes a 'secure frame' and a response to the rapid development of communication technologies.

In this chapter I will explore the implications of chat and e-mail psychotherapy in the practice of traditional ground rules and the creation of a secure online therapeutic frame.

Although telephone counselling is also available on some therapeutic sites, I will not refer to this option, since this kind of therapy became common long before online psychotherapy (Sanders, 1996, Rosenfield, 1997). I will not explore the new setting of online video-conferencing, which is insignificant in online psychotherapy (only 5.9%); in addition this kind of therapy is similar to face-to-face psychotherapy.

I will explore the main differences between face-to-face and online psychotherapy by using the seven categories of ground rules as a means of observation. Then I will examine the two modalities of textual therapeutic relationship and the implications with regard to therapeutic ground rules. The categories of ground rules are not absolutes, and they only serve as a procedural instrument for identification and classification. I will explore the adaptation of ground rules to certain traditional therapeutic approaches and the new ground rules offered by online therapists. For the purpose of examining the therapeutic relationship in chat and e-mail psychotherapy, I will analyse samples of case studies and also translate a particular excerpt of Freud's 'Dora' case for both modalities.

A comparison of the ground rules for face-to-face and online therapy

Therapeutic relationships are different from any other kind of relationship. They eliminate most elements that are present in other sorts of relationship (mutuality, common interests, shared beliefs and activities, spontaneity, partnership, physical contact, etc.), and focus on a specific emotional process within a limited interaction (a limited succession of scheduled and relatively short interactions).

The ground rules for psychotherapy, as agreed between client and therapist, define this unique interaction and ensure that the unique characteristics of this interaction will be productive and not misused.

Despite the differences between the many approaches to the 'talking cure', a common denominator is the central role of clients' narratives concerning their emotional state. Since therapeutic relationships are the main instrument for coping with the therapeutic narrative, their presence plays a significant role in the psychotherapeutic process. The nature of the therapeutic relationship is influenced by the conditions in which they are practised as defined by the ground rules.

Face-to-face and online psychotherapy have the common goal of creating a secure frame for clients' narratives in order to facilitate a therapeutic process. From this point of view, the same ground rules may be adapted to both modes of psychotherapeutic interaction. At the same time, the unique characteristics of each mode, which are inseparable from the therapeutic process, involve different sets of ground rules. I will examine the potential ground rules in face-to-face and online psychotherapy, according to the seven categories of ground rules.

1. Emotional interaction. As in traditional psychotherapy, this category defines the therapeutic focus according to the therapist's theoretical approaches and beliefs. The first ground rule of most therapeutic approaches is 'say whatever comes to mind', which is parallel to the ground rule of free association. The online adaptation of this rule is similar: 'write whatever comes to mind'. It is not surprising to find that the origin of Freud's fundamental ground rule was the ground rule of creative writing, as formulated by Ludwig Börne in his short essay, 'The Art of Becoming an Original Writer in Three Days' (Freud, 1920: 265): 'Take a few sheets of paper and for three days on end write down, without fabrication or hypocrisy, everything that comes into your head' (ibid.).

   While engaged in face-to-face therapy clients can express their emotional state

by their vocal intonation or facial expression, whereas in online therapy they have to find their 'written voice' by using their writing skills. This means that the ground rules of emotional relationships are conditioned by clients and therapists' competence in formulating emotional situations in writing. This kind of expression is more conscious than vocal communication and at the same time less spontaneous.

The members of ISMHO's Clinical Case Study Group (Fenichel, 2002) wonder 'Why do people continue to argue that words alone cannot convey the breadth of human experience?' (ibid.). It is convenient to assume that advanced writing skills are needed for written emotional testimony, since most people cannot express themselves fluently in writing. This may be true, but one can also surmise that most people do not express their emotions fluently even through speech, and that face-to-face therapy may be appropriate even for self-conscious and educated people. People who seek traditional or online psychotherapy are able to express themselves in speech or in writing. Sometimes, written messages may be even more convenient for emotional expression.

> Our experience as online clinicians, as well as our personal experience with relationships on the Internet, demonstrated that some individuals are more honest, more uninhibited, and more expressive in writing than face-to-face. Certain literary forms, letters and journals in particular, have always been characterized by the skilled practitioner's ability to be just as authentic, as fully oneself, in text as in person.
>
> (ibid.)

As in face-to-face psychotherapy, online therapists can adapt the ground rule of emotional interaction to their theoretical approach and personal experience. They can focus on the 'here-and-now' of their clients' lives, their childhood memories or the therapeutic relationship. In online therapy other ground rules are needed to support clients in this delicate task. Since written emotional expressions are less spontaneous, and since they are documented and are conducive to second and third reflections, clients may need more courage to express themselves by the written word. The members of ISMHO's Clinical Case Study Group drew up a list of 'required emotional skills' for therapists (ibid.):

- Comfort describing own and other's feelings in text

- Comfort in a text-only environment
- Ability to make effective therapeutic interventions using only text
- Awareness of how client perceives therapist online
- Skill at clarifying accuracy of online communication
- Love of being online
- Experience with online relationships (synchronous and non-synchronous)
- Flexibility in approach and conceptualization of therapeutic relationships (e.g., believing it's possible to form therapeutic relationships without visual cues or employing traditional psychodynamic, frameworks, concepts, and techniques)
- Confidence with technology and role as online authority
- Tolerance for computer glitches
- Ability to move between modalities (virtual and f2f) in response to client need and circumstances
- Ability to handle acting-out behavior and intensity of emotion as expressed in client messages (ranging from frustration and anxiety to client projections, anger, boundary and abandonment issues, etc.)

(ibid.)

This list is followed by 'required client characteristics' (ibid.) for online psychotherapy.

- Comfort online
- Ability to contract and maintain a shared working relationship online
- Ability to clarify miscommunications, in both directions
- Motivated
- At least moderately fast typist (or has voice technology)
- Reasonably expressive writer, adequate reading/comprehension skills
- Credit card, willing to use it online

(ibid.)

The ground rules for emotional interaction in online psychotherapy are influenced by the special characteristics of written communication and its unique setting as reflected in clients' attitude to their own writing, clients' written relationships with others and clients' relationships with their therapists.

2. The use of psychotherapeutic methods and tools. The main ground rule for

psychotherapeutic method and tools, which is also common to many therapeutic approaches, complements the ground rule of emotional interaction: listening. Each therapeutic approach has its own ground rules for listening: silent listening, questioning, interpreting, reflecting, mirroring, challenging, etc.

There is a significant difference between face-to-face and online psychotherapy in terms of listening. In face-to-face interactions, therapists' senses are divided according to the various manifestations of clients' inner states. They listen to their vocal messages, while trying to understand them, decode them and connect them to previous narratives and contents, while simultaneously observing their body gestures and having a sense of their own bodies (whatever they do with their hands while listening. In online therapy, these three senses (seeing, hearing, touching) are focused on clients' words, i.e.,. observing the clients' on-screen texts. The visual appearance of clients' words helps them concentrate, so as not to miss a single word or idea. They hear the click of the keyboard and feel their fingers touching the keyboard. They can never miss a word, hear something incorrectly or be misled by their own associations, since the actual wording is documented on the screen. Their 'listening' is focused and conscious, and they can reread and digest clients' words as many times as necessary.

Listening in face-to-face psychotherapy also means creating a vocal space for the client, thereby creating a secure frame for the therapeutic process. The corresponding space in online psychotherapy means creating a space for the client's writing, but this option is inapplicable. While the passive action of 'listening' to the client's vocal expression is actually active avoidance, where the therapist's physical presence structures this avoidance, there is no corresponding alternative to a therapist's physical presence in online psychotherapy. Passive 'listening' (reading) in online interaction may be experienced by the client as the evanescence of the therapist, or as the opposite of therapeutic 'holding'.

A musical piece is a succession of single notes in a unique order of pitch and tempo but it is meaningless without the silent moments that shape its structure. One might say the same about the psychotherapeutic dialogue. It is impossible to imagine a psychoanalytic interaction without silence. 'Silence in the analytic situation is a recurrent and complex clinical phenomenon' (Khan, 1996: 168). The silence of clients and therapists plays a different role in various approaches to psychotherapy, but it is always a part of the therapeutic interaction.

> The first task of the therapeutic interaction is to allow clients to come out of their shell and venture into the in-between. After the psychotherapist has clearly defined the availability for this in-between space and has explained something about the way in which they will proceed together, it is crucial to leave the space open to the client. Welcoming silence will be one of the most significant interventions that the existential psychotherapist will use, both before dialogue becomes possible, and as essential breathing space within established dialogue.
>
> (van Deurzen-Smith, 1997: 226)

In online therapy, silence may be experienced as absence. There is no way to differentiate between active silence and technical problems. The sense of absence in online written psychotherapy affects the ground rule of listening and the therapeutic scene. Without the boundaries of silence a therapist's listening may be experienced by the client as overwhelming or as frame violation, or abandonment. Online therapists have to develop complementary ground rules that create the sense of 'being there' and reinforcing the secure frame.

The unique kind of listening necessary in online therapy also affects the accompanying listening tools, such as interventions, interpretations, questions, etc. All kind of written interventions should be adapted to the special qualities of written interaction.

As in face-to-face psychotherapy, online therapists can use manipulative therapeutic techniques, which are also modified to fit the new medium. Although online therapists cannot practice hypnosis and relaxation techniques by means of their own voice, they can utilise advanced technologies found on the Internet. They can also offer guided imagination, suggestion, reflection etc. in written format, while being aware of its advantages and disadvantages.

Above all, online therapists can use the unique advantages of written communication as tools for creating relationship and trust. These tools serve the ground rules of empathy by providing support, containing and love.

In order to operate the new therapeutic tools available to online psychotherapy, psychotherapists have to acquire knowledge and skill in this growing field. They also have to learn about the implications writing has for their clients and themselves.

> The process of writing may tap therapeutic cognitive processes and encourage an observing ego, insight, working through, and (especially in asynchronous text

> such as weblogs) the therapeutic construction of a personal narrative, as in journal writing and bibliotherapy. For some people, text communication will tap and strengthen cognitive processing, which could be an asset in cognitive therapies.
>
> (Suler, 1996A)

3. The language. In online therapy, as in face-to-face interaction, a common language is a pre-condition for creating a therapeutic relationship. One might say that creating a common language is the essence of the therapeutic process from beginning to end. Both client and therapist participate in the effort to build a therapeutic language in order to create a secure linguistic frame in which they can identify feelings and emotions and formulate goals for their joint venture. Awareness of the creation of the common language may serve as a powerful tool for introspection, learning about clients' psycho-social and cultural background and understanding the shared experience of both therapist and client during that process.

While creating a common language as a metaphor for an efficient therapeutic relationship, clients and therapists use their actual language (English, French, Hebrew, etc.). However, the use of the same language does not mean that they share a common language. People use different vocabulary, jargon, dialect and accents. They have different associations and connotations, different memories, beliefs and views. 'A critical point is that each of us *differs* in terms of our information and experience, and despite the ideal of having a "standard language" – even among people speaking the same dialect of the same language, or being truly "bilingual" – the fact is that each of us on this planet adds our own nuance to words, or phrases, or intonation, or some combination thereof' (Fenichel, 1997). Among other things, the psychotherapeutic process is an exploration of the components of clients' and therapists' languages in order to create a common language.

In face-to-face psychotherapy, language is communicated through vocal indicators, which are temporary and fleeting. Both parties remember only small portions of the actual wording, processing this portion by means of personal subjective interpretation.

In online psychotherapy language is communicated through visual signs which are relatively permanent, since the whole textual interaction is documented on a

web site or saved to the client's and the therapist's computers. Therefore, creating a common language is even more important in textual relationships: 'In text-based communication, perhaps more than in any other setting, there is a crucial relationship between what is said and how it is said' (Kraus, Zack & Stricker, 2004: 19).

The graphic representation of online messages plays a central role in online psychotherapy. On the one hand, there are techniques of abbreviation, which flatten the written style and create a low standard of common language, but on the other hand, there are technical means that enrich communication and create a multilevel structure of online messages including hypertexts and links. Each style has practical applications in the various types of online therapy, as I will argue later.

Most people are natural born speakers, but only few develop advanced writing skills: 'This is not speculation, but neurological fact. The portions of the brain used to process speech include entirely different sections of the brain than those used to read from written text. It is similarly a different process to speak, spontaneously, than to write' (Fenichel, 2003). Some writers believe that 'not everyone can write fluently or effectively communicate their ideas through typed or written text' (ibid.). But the new era of online psychotherapy is not limited to those few people who can express themselves through writing. Since 2000, I have run an online forum for PTSD veterans and most participants have difficulty writing and reading. They make spelling mistakes as if they were all dyslectic, and they cannot read long texts. Some of them are uneducated, but they have all participated in the forum for over five years and the forum contains more than 80,000 messages (some of the active members have written 1,000-5,000 messages each). I have found that the process of writing is therapeutic and useful to online clients or group members, whether they are fluent writers or almost illiterate. The claim that 'it may be unrealistic to expect that reading text on a screen or responding via a keyboard would be a meaningful or practical method for the great many people who, even while motivated by lack of access to other mental health services, are also lacking in written language skills, reading ability, or typing skill' (Fenichel, 2003) is therefore not valid. Even superficially surfing on one of the thousands of open forums for therapy questions will prove the contrary. At the same time, I have learned that there is a connection between people's writing skills and the media in which they are writing. While people who are poor writers prefer to write short

sentences in a chat room, writing in a forum demands better writing skills, while only a few choose to write e-mail letters.

While most people are trained from the day they are born to communicate through body language and decode physical gestures, even experienced and trained writers and readers may interpret the same textual message in different ways. This does not mean that online therapy is not effective. On the contrary, the members of ISMHO's Clinical Case Study Group claim that the myth that 'Text-only is inadequate to convey a richness of human experience' (Fenichel et al., 2002) is groundless.

Written communication has its advantages and disadvantages, but there is no debate about the unique characteristics of online psychotherapy, which are evidently different from those of face-to-face therapy. Written dialogues involve a higher degree of consciousness that may create a deeper level of common language concerning awareness of the psychosocial background, being acquainted with the theoretical assumptions and shared experience in the therapeutic process.

The process of creating a common language for online psychotherapy follows two paths. The first involves creating a therapeutic relationship and is the pre-condition for any therapeutic process. The second is an integral part of the therapeutic process itself. This process has the same importance as it has in face-to-face psychotherapy, but online therapy opens new fields of exploration. One can refer to this as a cognitive process, which is ingrained in the nature of online therapy. This process is made up of three stages:

a. The first stage in creating a common therapeutic language enables therapists to understand their clients' emotional language, personal terminology, psychosocial background and social networks. At the same time clients learn about their therapists, their personality, therapeutic approach and communication style. The therapeutic contract represents the level of common language or therapeutic language that has been achieved at this stage of the therapeutic process.

This natural process, which takes place at the beginning of any therapeutic relationship, has a different role in online psychotherapy, since both sides are aware of their printed messages and can re-read them again and again. Therapists can analyse the linguistic structure of their client's messages, search for key words and even count the frequency of certain recurring words in clients' messages. Although documented text enables such awareness and

research in all kinds of online therapy, such an activity is more effective in asynchronous therapy (e-mail therapy). Martha Ainsworth's e-mail to her therapist may exemplify this option:

> Have I scared you off yet?
> I find myself stranded and feeling extremely reluctant about entering into a therapy relationship. I am feeling timid about you. The thought of going through that is overwhelming right now. I am of uncertain hope about whether it can be helpful. And the recent feelings I have been having is stuff I never could talk about to anyone. I write better than I talk. The anonymity of online communication, etc., etc. You know all that. I do not talk well at all.
>
> (Ainsworth, 2002: 199)

In this short paragraph, Martha, the first famous e-mail client, uses the word 'feeling' three times, followed by 'stranded', 'extremely reluctant', 'timid', 'overwhelming', 'uncertain hope', 'stuff I never could talk about to anyone' (ibid.). The therapist could evaluate this word analysis according to the stage of therapy or the question of contract, for example, and compare it with other e-mails. He could share this finding with his client or refer to it in his preferred style of intervention (interpretation or support).

b. The second stage of 'processing the common language' involves a traumatic or destructive process of deconstruction. This is a process of constructive doubt in the Cartesian mode: 'never to accept anything as true that I did not know to be evidently so: that is to say, carefully to avoid precipitancy and prejudice, and to include in my judgements nothing more than what presented itself so clearly and so distinctly to my mind that I might have no occasion to place it in doubt' (Descartes,1976: 41). In this stage, when a relationship has been established and clients can trust the secure frame, therapists may challenge clients' values and beliefs by provoking and testing the deep meaning of the terms they use.

Online psychotherapy provides new paths to this important part of the therapeutic process, which is latent in most face-to-face interactive approaches. Therapists and clients can use this linguistic tool for a deeper exploration of the manifest therapeutic text. They can examine the linguistic structure of a certain message or explore the whole documented history of the therapeutic process.

For example, a therapist can search for all the contexts in which the word 'disappointed' appears, and find that this word is always adjacent to the words

'university', 'studying', 'BA' and 'examinations'. This finding may seem self-evident, since the main subject of the client's narrative is her difficulties in finishing her third year at the university. But after looking again, the therapist notices that in most cases, the word 'disappointed' is also followed by the word 'deeply', which did not appear as part of her usual vocabulary. In another search the therapist finds that the word 'deeply' appears only four times, outside the vicinity of terms connected with studying and always connected with discussions about psychotherapy. This finding may lead the therapist to explore the client's evident disappointment with him, discuss the therapeutic relationship and re-define the therapeutic process.

Although this hypothetical example may remind one of *The Psychopathology of Everyday Life* (Freud, 1901), this is quite a different matter, since online linguistic exploration is based on accurate documented data with no subjective associations and evaluations.

c. The third stage is the outcome of the psychotherapeutic process. The common language that is established between therapist and client indicates the development of the therapeutic relationship and the changes in client's emotional states within the therapeutic process.

> Concrete, emotional, and abstract expression; complexity of vocabulary and sentence structure; the organization and flow of thought -- all reflect one's cognitive/personality style and influence how the other reacts. People who are compulsive may strive for well-organized, logically constructed, intellectualized messages with sparse emotion and few, if any, spelling or grammatical errors. Those with a histrionic flair may offer a more dramatic presentation, where neatness plays a back seat to the expressive use of spacing, caps, unique keyboard characters, and colorful language. Narcissistic people may write extremely long, rambling blocks of paragraphs. People with schizoid tendencies may be pithy, whereas those who are more impulsive may dash off a disorganized, spelling-challenged message with emotional phrases highlighted in shouted caps. Different writing/personality styles may be compatible, or complementary to other styles.
>
> (Suler, 2004: 21)

Since there is no reference in the professional literature regarding online psychotherapy to the practical use of linguistic therapeutic techniques, and since

there are no references to such use of linguistic tools in case studies and field experiments, this could be a fertile field for further exploration and research.

One of the advantages of online psychotherapy is its multicultural characteristics. This kind of psychotherapy, which enables long-distance communication, brings together clients and therapists from different cultures and languages; however, the result of this could be difficulties in communication. On the other hand, online therapy enables clients to find therapists that share common culture and language. Most of my online clients, for example, are Israelis who live abroad. 'The use of the Internet for counseling has, therefore, both potential advantages and disadvantages from a multicultural perspective. The absence of visual and auditory cues might imply that both parties are less likely to be swayed in their judgements by cultural factors' (Skinner & Latchford, 2004: 244).

Since online psychotherapy provides an option for therapeutic linguistic techniques, the 'disadvantages' of online multicultural therapy may appear as advantages. The sense of textual misunderstanding may serve as an accelerator for such therapeutic processes. Through my experience as a therapist in England I learned that being a foreigner could help my clients to express themselves in a detailed and clear style that in itself constituted a therapeutic process of introspection.

4. The contract. As in face-to-face psychotherapy, the contract in online therapy is a fundamental platform for creating a therapeutic relationship and a secure frame and contains the formulated components, which are literally agreed upon by both client and therapist.

   There are two kinds of therapeutic contracts. The first is the agreed-upon contract referring to expectations, goals, fees, time and confidentiality, which is openly discussed between therapist and client in the first sessions. The second is the latent contract that shapes the structure of each session, whereby both sides test each other again and again and challenge the agreed contract. This fluctuating contract defines the renewed alliance and temporary plan for each session.

Regarding face-to-face psychotherapy, most contracts are oral whereas in the case of online therapy the contract, like any other communication, is written and documented. In order to create a secure frame, most online therapists present part of the contract on their web sites, so that prospective clients are able to read and digest it as their first contact with the therapist. Usually this written generic contract presents the terms and conditions of the proposed therapeutic relationship

and a brief introduction to the therapeutic approach and technique. Such an agreement is suggested in 'Life Issues Counseling' (Smith, 2005).

Client/Counselor Agreement

You agree that you have read the separate section here on confidentiality and agree with the terms set out in that section.

You agree that our email exchanges occur in the state of Pennsylvania (USA) and are governed by the laws of this state and country.
You agree that you are at least 18 years old.
You agree that you are not currently under the influence of drugs or alcohol.

While I am hopeful that our online sessions will be very helpful to you, there is no way that I could possibly guarantee a positive outcome. In addition, you agree that because online counseling has only been in existence for several years, we have only preliminary evidence indicating that it is helpful to most of those who have tried it with the help of a well-trained, experienced therapist. Thus, you must understand that working with me online is, in many ways, an experimental activity.

I reserve the right to choose whether to work with you or not once you've contacted me. I will work with you only if I feel that you are a suitable candidate and that I can be helpful to you. If I do NOT feel that I can be helpful to you, I will suggest alternatives.

As I've noted, online counseling and face-to-face psychotherapy or counseling are not the same and online counseling is NOT a substitute for traditional face-to-face psychotherapy treatment.

Our work together should be construed as an educational process designed to assist you in dealing with emotional difficulties, rather than as formal diagnosis and treatment of psychological disorders. As such, I cannot and will not make any formal diagnoses nor carry out traditional psychotherapy online. Therefore, it remains your right and responsibility to seek face-to-face psychotherapeutic assistance whenever necessary.

Like any other therapeutic modality, the effectiveness of online counseling depends greatly on how much of an investment of time and energy you are willing to make. Generally speaking, the more you invest in it, the more you will get out of it.

You agree that I cannot be held responsible for providing services to you in the event of a crisis or emergency situation. While online counseling may be very effective for helping people with mild-to-moderate difficulties, it is likely to be much less effective for people with moderate-to-severe difficulties.

You agree that if you are currently seeing a therapist on a regular basis, it is your responsibility to discuss with that therapist the advisability of working with me before doing so.

The goal of our exchanges is to help you. If either of us feels, at any time, that working together is not helpful enough to you, either of us is free to terminate our relationship at any time.
There are no other explicit or implicit commitments in our online relationship.

Paradoxically, the general contract is impersonal and, although it may create a sense of security, it is imposed by the therapist and is not a substitute for the mutual agreement necessary for a therapeutic alliance to be formed. Sometimes this kind of suggested contract emphasises the need for an additional personal

agreement within the consensual therapeutic setting.

In a survey of 236 therapeutic sites I found that 136 web sites (57.6%) present general contracts or semi-contractual forms, in order to create a sense of 'secure frame'. Seventy-to of these sites (30.5%) use the terms 'contract' or 'terms and conditions', while 64 sites (27.1%) are substitutes for a real contract: 'disclaimer', 'informed consent', 'intake form', 'questionnaire', 'evaluation form', 'statement of understanding', 'registration form', 'guidelines' and 'application form'. One hundred web sites (42.4%) ignore the question of contract. Only seven web sites (2.9%) offer a real contract to prospective clients:

a. Gill Jones. 'Agreement: All my counselling is based on an agreement to work together. When you contact me asking for some online counselling I send you my basis for an agreement and ask you to read it through carefully and to ask me any questions before the work begins. The agreement looks at how frequently we expect to have contact and how you will pay for your counselling' (Jones, 2005).
b. Counselling Skyways. 'Your sessions with a counsellor whether face to face or online are subject to an agreement between you (the client) and the counsellor' (Counselling Skyways, 2001).
c. Cocoon, Counselling connections online. 'Once you and the counsellor of your choice decide to work together, you will be sent a Contract or Agreement. The aim of the Contract is for you and your counsellor to agree the basis of your work together. Please note: the Contract can be revised at any time' (Cocoon, 2004).
d. Couples Counselling Network. 'Once you and the counsellor of your choice decide to work together, you will be sent a Contract or Agreement. The aim of the Contract is for you and your counsellor to agree the basis of your work together. The contract may need to be revised at times, but this would be discussed with you'. (Couples Counselling Network, 2004).
e. HelpUCounselling. 'A written agreement will be made between your e-counselor and yourself before counseling is undertaken. The agreement will be tailored to the client's specific requirements. The content of the agreement, as with all other communications will be treated confidentially' (HelpUCounselling, 2003).
f. Brian Turner. 'If we are working on-line I will send you a contract by e-mail early in our exchanges' (Turner, 2005).

These findings indicate that although online therapy provides new therapeutic tools for creating a secure frame, most therapists practice online therapy as they used to practice face-to-face psychotherapy, informally discussing the contract during the early sessions. At the same time, most of them compel their clients to sign a formal prepared agreements to cover legal obligations and protect themselves from future law suits. 'The first and most important issue is informed consent. Many online clinicians have an informed consent/disclaimer form on their websites to which the client must agree before proceeding with treatment' (Chechele and Stofle, 2003: 44). While informed consent is 'the first and most important issue' (ibid.) for therapists, the therapeutic contract is an essential condition for creating a secure frame for the therapeutic relationship. Although online therapy actually provides better conditions for documenting and revision of such contracts than does face-to-face therapy, the lack of such contracts in online therapy is one of the disadvantages of contemporary online psychotherapy.

5. The setting. The setting is the main difference between online and face-to-face psychotherapy. There is no common setting for both therapist and client in online therapy, with each participant communicating from his own room and computer.

The physical setting of face-to-face therapy plays an important role in creating a 'secure frame' for therapeutic relationship. But the secure therapeutic frame is not meant to secure the physical presence of therapists and clients. It is meant to secure the psychotherapeutic narrative, which is inevitably accompanied by physical presence. It is also meant to manifest a metaphoric sense of a secure frame for emotional interaction. As such, a secure frame can be formed without the physical participation of clients and therapists, as long as another manifestation of the secure frame exists.

The ground rules of a face-to-face setting are adapted to the physical presence of the therapeutic narrative: the audio-vocal characteristics of the interaction (participants' voices and other noises) and the physical nature of the clinic. The corresponding characteristics of online therapy constitute the 'body' of the printed text and the unique modes of online communication (chat room, e-mail, etc.).

'Setting' in online therapy is on a metaphoric plane and its physical representations are different from those of face-to-face psychotherapy. These representations include the hardware (computer, screen, keyboard, etc.) and software involved, the communication providers (telephone lines, cable communication, satellite communication, etc.), the visual message (the text or the

video-conferencing), the audio message (recorded messages or music) and the personal space of both therapist and client.

All these characteristics of the metaphoric setting of online psychotherapy are manifested in three kinds of settings.

a. The client's physical setting. The traditional therapeutic setting creates a unique therapeutic space, which is artificial in order to separate therapist and client from their everyday surroundings and clear the space for the therapeutic process. Prima facie, one might claim that there is no such common space in online psychotherapy. While by leaving their natural setting and going to the therapist's clinic clients prepare themselves to engage in an unique process, in online therapy they stay at home. It is more convenient for clients to communicate with their therapists from their own homes, where they may feel more secure. However, they are not secure in the therapeutic scene, and therapists can not provide them with privacy, which is one of the main ground rules of the setting. 'For example, one therapist belatedly discovered that a client was allowing family members to read the therapist's emails. Their comments and reactions were reflected in the client's changing attitudes toward therapy and the therapist' (Zelvin & Speyer, 2004a: 173).

Does that mean that the ground rules of privacy and exclusivity can not be implemented in online psychotherapy? Not necessarily. It means that the responsibility for some ground rules shifts from the therapist to the client, causing the online therapeutic relationship to differ from the face-to-face therapeutic relationship. Online relationships are more equal or 'democratic':

> In text communication we don't see the trappings of status and power – the fancy office, expensive clothes, diplomas on the walls and books on the shelves. In addition, a long-standing attitude on the Internet is that everyone should be equal, everyone should share, everyone should have equivalent access and influence.
>
> (Suler, 2004: 31)

b. Therapist's physical setting. While clients may wrongly confuse convenience and security when engaging in therapy from their own homes and private rooms, working from home may cause therapists to feel insecure and threatened. The flexible nature of online therapy, which constitutes a

frame deviation in therapeutic terms, provokes profound reflection concerning the boundaries of the new therapeutic frame.

Many therapists, even those who are not psychoanalysts who frequently work from home, do not keep their computers in their clinics, but rather share them with other family members. There are still no full time online therapists who keep a private clinic or a special room for online therapy only. This could explain why most therapists choose not to use web-cams and engage in video-conferencing psychotherapy. This can also explain why more than half the online therapists (53.8%) do not believe that online psychotherapy is equal to face-to-face psychotherapy.

My private clinic is in my home, but separated from the rest of the house and having a separate entrance. When I have an online session I change my clothes and prepare my clinic and myself the same as I do when meeting my face-to-face clients. This ritual helps me enter the therapeutic setting and differentiate between my everyday life and my work.

c. The virtual therapeutic setting. Immediate communication through the Internet spans long distances between clients and psychotherapists and creates a sense of a virtual setting:

> A much more subjective, psychological sense of space replaces the physical or geographical sense of space. As I mentioned earlier, people may experience text relationships as an intermediate zone between self and other, an interpersonal space that is part self, part other. Sitting down at one's computer and opening up the communication software activates the feeling that one is entering that space.
>
> (Suler, 2004: 31)

By defining particular ground rules for online psychotherapy, one can recruit this sense of a setting and turn the virtual therapeutic setting into a secure frame for the therapeutic relationship. This is not a simple task, since each mode of online psychotherapy provokes a different sense of setting and imparts different characteristics to the shared space.

The ground rules of the setting are intended to create a unifying metaphor that will produce a sense of a common secure space that is defined by clear boundaries. Since each mode of online psychotherapy is associated with a different kind of setting, there is more than one setting for online therapy and each setting provides a different security level.

> Most contemporary modes of online psychotherapy enable only partial substantiation of a secure frame, which can explain the suspicious attitude towards online psychotherapy held by many professionals, as thought it were a 'second-best' psychotherapy.

While referring to the setting in online psychotherapy as a secure frame and examining the ground rules of the virtual setting, one should calculate the new factors that influence this new setting: the different modes of online settings and the different physical settings of clients and therapists.

6. Time management. While face-to-face psychotherapy is exclusively based on synchronous interaction, online psychotherapy enables synchronous dialogue, asynchronous interaction or any combination of these two options. This may change the whole perception of time and the corresponding ground rules in online psychotherapy.

The ground rules of psychotherapy are based on fixed categories that create a sense of continuity and security. Modifications or flexible definitions of ground rules may be experienced by clients as frame deviations and evoke anxiety and insecurity. The new options of online psychotherapy might tempt therapists and clients to choose flexible ground rules that are manifestly more convenient, free or 'democratic', but which at the same time evoke unconscious anxieties and prevent the creation of trust. In many cases, therapists engaging in online psychotherapy fail to comply with their own ground rules by deviating from them regarding the time frame.

The new options may cause therapists to deviate from the traditional time frame even in cases where they can adhere to their ground rules, by choosing to extend their boundaries. For example, many therapists offer chat room session of sixty minutes. Since the a public is accustomed to a 'fifty minute hour', these extra ten minutes may be interpreted by clients as a seduction or a sort of compensation for the lower status of online psychotherapy, or any other deviation from the ground rule of abstinence. Another deviation from the ground rule of 'fixed time' can be demonstrated in the web sites of 'Helping Hand Counselling' (Herzog, 2004).

> A session is set for one hour but can run longer with no extra fees incurred. I find that sometimes an hour is just not long enough to get through a session that leaves you feeling more relaxed and positive about continuing on with your

counselling by booking an appointment for another session.'

(ibid.)

This option of extra time with 'no extra fees' may be interpreted as generous in everyday life, but as a frame deviation in a therapeutic situation. While therapists seldom offer such generous terms in face-to-face psychotherapy, this kind of frame deviation is common to online psychotherapy. It may be an indication of therapists' insecurity and lack of self-control when engaging in online psychotherapy.

As in face-to-face psychotherapy, online therapeutic relationships also depend on therapists' ability to create and maintain the boundaries of time. Exploring online therapists' references to certain aspects of time management may reflect their competence in creating a secure frame for the therapeutic process.

a. Scheduling. A psychotherapeutic process is a succession of scheduled sessions. Theoretically, therapists and clients may agree on the exact time of each session and its exact length without considering the duration of the whole process. Practically, therapists define their ground rules concerning time in order to allow them create a sense of time boundaries in order to provide a secure time frame.

Online psychotherapy provides more options for scheduling therapeutic sessions since asynchronous communication brings its own definitions of time. Many online therapists refer to synchronous communication (e.g., chat rooms) as though this sort of communication also changes the definition of time. This is not self-explanatory, since all alterations of time management in online psychotherapy can also be practised in face-to-face psychotherapy. One should wonder why traditional therapists do not offer their clients portions of twenty or thirty minutes, as many chat room therapists do, or why they do not regularly agree to 'on demand' session.

While contemporary f2f treatment models have diverse treatment lengths (from one-session crisis intervention to traditional long-term psychoanalysis), online therapy offers a fresh perspective on the duration of treatment. Mental health treatment online is a relative latecomer to an Internet culture inhabited by young people who are computer-savvy, but not necessarily knowledgeable about therapy. The expectations of online clientele may be different than those seeking traditional therapy. Online practitioners need to examine their preconceived ideas regarding treatment structure, duration, and methods.

(Zelvin & Speyer, 2004a: 167)

There are new definitions of time in online psychotherapy and some of them do not stem from the new characteristics of online therapy, but from a natural response to the sense of innovation and freedom that are associated with the Internet.

In my survey of 236 therapeutic web sites, I found that only 36 sites (15.3%) created such a structure and framework for time boundaries and defined the exact time of the therapeutic sessions, the length of each session and the proposed duration of the therapeutic process. On 117 sites (49.5%) therapists offer partial information about the time-frame or flexible definitions of time. Eighty-three sites (35.2%) ignore the question of time, as if this is not a significant element in the therapeutic process.

b. Planning and managing the therapeutic session. The online setting affects therapists' ability to manage the time frame in online interaction. The different modes of interaction and the technical procedures influence the practise of time management in an online session.

Although synchronous communication may have the same time characteristics as face-to-face psychotherapy, some ground rules may be re-defined. For example, accuracy of starting and terminating sessions is not always possible due to technical difficulties in communication. The rhythm and pace of the online session is also dependent on both participants' reading and typing rate.

Asynchronous communication confronts therapists with a new dimension of time, to which they have to adapt appropriate new ground rules. In a way, this kind of therapeutic interaction is 'out of time', but in reality there are new concepts of time, to which therapists have to adapt. Therapists have to find a measure of time that is equivalent to the duration of a session, its structure, etc.

c. Concepts of time. Face-to-face psychotherapy is linear and simple, whereas in online psychotherapy new concepts of time are created. In a way, online communication is a type of time machine that enables therapists and clients to change the direction of time's arrow.

Both chat room and e-mail therapy are characterised by the documentation of the textual interaction. This is a unique characteristic that changes the function of time in online psychotherapy. While in the face-to-face session, the time's arrow is irreversible, in online therapy both

participants can go back in time and read previous messages. While this new time travelling may enhance the sense of secure frame for clients, therapists might experience it as a threatening frame violation, since it may undermine their theoretical basis and technical approach:

> It can come as a shock to online counselors when they realize that some clients not only save and regard their emails, but also may copy and paste in order to quote them verbatim in their replies. Sometimes the vulnerability counselors feel about their words being recorded without their control can be a trigger for countertransference.
>
> (Zelvin & Speyer, 2004a: 174)

In traditional psychotherapy, the perception of time is one of the main topics of the therapeutic interaction. The subjective perception of time is associated with death anxieties, the issue of termination in the therapeutic process, and the various personal concepts of time in relationships. Beyond technical aspects of time, online psychotherapy adds new dimensions to the notion of time.

a. Geographical time. Online psychotherapy brings together therapists and clients from different geographical locations. This means that there is no shared time frame and each participant actually experiences a different kind of time perception. While the therapist might communicate with his client in the middle of the night, it might be morning or afternoon for the client. While a client is writing about the damages of storms in a hard winter, the therapist may be suffering from an allergy to dust and sirocco. These differences affect the creation of a common language, possibly even empathic skills.
b. Cultural time. In different cultures, time plays a different role and has a different meaning. There are differences between the concept of time in Eastern and Western cultures. These differences refer to time in the sense of here-and-now and to concepts and values of past events, life and death.
c. Subjective time. Time perception is always subjective, but since clients and therapists do not share the same experience of time and space, the unique characteristics of online therapy may exaggerate the differences between the various perceptions. For example, the typing

skills of therapists and clients determine the rate of their responses in chat room communication. Differences between typing speeds create different time perceptions and may evoke tension and anxiety. To cope with this phenomenon, therapists must be aware and adjust their typing rate to that of the client.

The new dimensions of time in online psychotherapy influence therapists' imaginations, leading them to define new ground rules for the time frame. This may be expressed in an altered duration of chat sessions, where clients can choose a session that consists of twenty- or thirty-minute segments, or e-mail therapists who calculate their fees according to the time they devote to the writing of each e-mail. These new options may be implemented as new ground rules that serve the needs of online therapists and clients, but which sometimes contradict other ground rules.

7. The message. In face-to-face psychotherapy, the therapeutic message, which has a central role in the therapeutic relationship and in creating a secure frame, is instant and vanishes within seconds. Even in cases of very important and significant messages, clients hardly remember even a small part of them. In online psychotherapy, the situation is quite different. Since the whole interaction is documented, messages remain with clients and therapists as long as they wish and are always available for rereading.

The therapeutic message may be seen as a control mechanism that functions as an ongoing attempt to preserve the secure frame. It usually manifests itself at the end of each session as a review of the therapeutic process that re-establish the contract and creaties a sense of continuity. But even before the therapeutic process starts, there are many other manifestations of therapeutic messages within it. Such messages may manifest themselves in the first contact between client and therapist, the proposed therapeutic contract or some kinds of therapeutic intervention, for example, psychoanalytic interpretations.

If anything stays with clients after the therapeutic session, or at the end of the therapeutic process, it is the therapeutic message. In a way the message becomes the client's 'inner therapist'.

To write a therapeutic message, therapists need writing skills, awareness of clients' needs and sensitivities and accurate timing. The therapeutic message in online psychotherapy plays certain defined roles in the process of therapy:

a. Advanced message. Clients acquire their first impression of therapists while

reading the message on the first page of their web sites. Some therapists, like Kali Munro (Munro, 2006), present their personal message to their potential clients at the top of the first page.

> **We All Need Help Sometimes**
> When you need help, you want someone there who understands and who knows how to help. As a therapist online with a private practice in Toronto, I can help you with many problems. For online help, see online counseling and for Toronto therapy see my approach.
>
> (ibid.)

This short message, illustrated by an emotionally-charged photograph, gives the reader a sense of the therapist's personality ('someone there who understands') and professional skills ('and who *knows how to help*'), with actual information ('private practice in Toronto') and guidance to the site itself ('For online help, see...').

Such messages create a sense of trust and a secure frame before the first contact between client and therapist. This kind of message helps clients to consider the option of starting psychotherapy and gives them a general impression of certain therapists.

b. Organising message. Starting a therapeutic session can be confusing for many clients at the beginning of therapy and even later on. An organising message may help clients to arrange their thoughts, renew their intimate relationship with the therapists and refer to the therapeutic contract. In online psychotherapy, organising messages replace the procedural ceremony of the first interaction and mutual body language.

c. Messages within the session. Each therapist presents certain messages during the therapeutic session in accordance with his or her therapeutic approach and theory. This kind of message might relate to the client's narrative by interpreting a dream, re-framing a concept or defining a value system. It might also relate to the therapist's functioning in the therapeutic process by sharing personal experiences, feelings or thoughts. These messages shape the structure of the therapeutic session and may be a basis for the actual discussion.

d. Messages at the end of session. The final message in each session is the most significant or most remembered message. In this message therapists review the process of the session, examine expectations, test the therapeutic contract and set a goal for the next session.

This written message is important because it stays with the client until the next session, becoming part of the client's 'real life'. This message enables clients to practice the therapeutic work 'in action' and explore the implications of the therapeutic process.

e. Messages at the end of therapy. The message of the last therapeutic session stays with clients as summation of the whole therapeutic process. It gives the clients a retrospective view of their emotional state from start to finish and a deep understanding of the changes taking place during this process. It refers to the unique kind of relationship that has been established, the pain of separation, the mutual learning that has taken place and each participant's contribution to it. It also leaves an open door for clients who might feel the need for future consultation or help.

The final message is the therapist's gift to the client, a gift that is the documentation of effort and a relationship that could serve as a healing metaphor in the future.

While the message in face-to-face psychotherapy exists in both the client's and the therapist's memories, in online therapy, the message is present in 'real life' and documented, since it was printed by the therapist. This places a grave responsibility on therapists, which could also be threatening.

There are risks in writing online messages due to the impact of written words. Therapists must be aware of their messages and acquire experience in message writing in order to avoid such risks.

a. Avoidance of impulsive and spontaneous messages. Spontaneous messages may be sincere and genuine, but there is a risk of mistakes and misunderstandings that could damage the therapeutic relationship. This risk is even greater in chat room therapy. It is relatively easy to repair misunderstandings in face-to-face conversation, but it is impossible to erase the documented message.

b. The distinction between therapeutic message and empathy. Empathy is important for creating a therapeutic relationship, but it does not replace the therapeutic message. While empathy means 'to look through the client's

eyes', the message refers to the mutual relationship of client and therapist. An empathic message at the end of a session may ignore some important part of the process and betray the trust of the client.

c. Profound editing of messages. The significance of written messages in online psychotherapy forces therapists to be aware of the broad implications of their content. Since the whole therapeutic process is documented and available in any time, therapists should review the relevant files, check their phrasing and review their text before sharing it with their clients.

The therapeutic message is an important and central therapeutic tool in online psychotherapy and any negligence in using this tool may put the therapeutic process and relationship at risk.

The ground rules of chat room psychotherapy

Chat room psychotherapy is an imitation of face-to-face psychotherapy. It is a linear dialogue in 'real time', and it can be scheduled like face-to-face psychotherapy (e.g., for weekly sessions of 50 minutes). This means that the 'time' category is the same as that of face-to-face therapy.

The main distinction between chat room and traditional psychotherapy is the textual setting that reduces the interaction to synchronous verbal dialogue and totally lacking in physical cues and body language.

Most categories of ground rules in chat room therapy seem similar to those in face-to-face psychotherapy, but the new medium gives rise to some alterations and modifications.

1. Emotional interaction. As in face-to-face psychotherapy, clients are invited to share their feelings with their therapists in a chat room. Although in chat room therapy the text is documented, it moves so fast that it gives the sense of a dynamic face-to-face interaction. Client and therapist must read each other's messages and reply before another message is printed, so the whole process is spontaneous and fluent.

The unique dynamics of chat room psychotherapy affects clients' ability to express their feelings in writing, at times neutralising the advantages of written interaction.

Gary Stofle demonstrates a first interview with a new client in a chat room, in which he presents the main role of psychotherapy, namely, 'talking about feelings'

in ('we each need at least one person we can talk to on a feeling level'. Stofle, 2002: 105).

Stofle: *I don't know. Sometimes people divorce themselves from their feelings. It's a way of coping.*

Client: I just feel silly that it's affected me this way after so long. That it didn't bother me sooner instead of later.

Stofle: *feelings are real. and no one can tell you that you should or shouldn't feel a certain way.*

Client: even though everyone seems to think they can

Stofle: *right... they just don't understand how it works.*

Client: i guess not

Stofle: *so many people don't understand how to deal with their feelings. yet, it's so much a part of everyone's life. do you have friends?*

Client: that's true *because I don't know how to deal with the way i feel now either*

Stofle: right.

Client: not really. I have some friends but none that I feel comfortable talking to

Stofle: *we each need at least one person we can talk to on a feeling level.*

(ibid.)

In similar chat interactions, therapists can offer their clients different ways of expressing their feelings in writing, in accordance with their own ground rule of emotional interaction. They can focus on childhood memories or dreams, in accordance with the psychoanalytic point of view, or relate to the 'here and now' in accordance with existential views. Apparently, there is no difference between this kind of chat dialogue and face-to-face therapeutic session, but actually the unique characteristics of chat room therapy influence the emotional dialogue.

While in face-to-face therapy clients may express their emotional state by using vocal intonations or facial expressions, in chat room therapy they have to find their 'written voice' through writing skills. This means that the ground rules of emotional relationships are conditioned by clients' and therapists' competence in formulating emotional situations. This kind of expression is more conscious than vocal communication and at the same time less spontaneous. 'One of the reasons I like on-line counseling is that I feel I am able to express my feelings better in writing than in person. I'm finding that one of the down sides is that it's hard to maintain the normal ebb and flow of a conversation' (Chechele & Stofle, 2003: 41).

Paradoxically, chat room interaction is rapis and dynamic and sometimes clients prefer to describe their doings rather than their feelings.

Stofle: *that must be sad for you.*

Client: it is & very hard because I don't really have anyone to get out & do things with & then it's so hard for me to go out & meet new people.

(ibid.)

If this client had had the time to formulate her exact feelings, she could have written: 'Yes, it is sad. Sometimes I feel so lonely when it happens, but there is no one to share my feelings with. When it happens I always feel as if I was eight years old, when all the girls in my class stopped talking to me, and I feel so much pity about myself.'

2. The use of psychotherapeutic methods and tools. Although chat room psychotherapy is similar to face-to-face psychotherapy concerning time and synchronous dialogue, it involves a different kind of listening. Clients and therapists are more conscious and focused on the dialogue, but this awareness forces them to focus on the last sentence which they both can see on the screen, so that the dialogue naturally deals with the 'here and now' situation (even if they 'talk' about past memories). This kind of focused listening and the fast pace of the visual images on the screen make it difficult to explore the multilevel structures of clients' narratives, as the presence of the last sentence is too strong.

Theoretically, since chat room therapy has the same time structure as face-to-face therapy, there is an option for time intervals that provide a 'vocal space' for the client. Actually, the absence of any physical presence prevents this option, since passive reading or any delay in the therapist's response may be perceived by the client as desertion or frame violation.

This phenomenon has a significant impact on the nature of chat room therapy. The following example presents a typical chat room interaction:

Client: I'm okay.

Therapist: *did your week get any better after we last talked?*

Client: yeah... I guess so...

Therapist: *where should we start tonight?*

Client: I don't know... I don't think I feel much like talking.... I feel kind of like.

Client: like I'm tied up... on the inside.

Therapist: *well, there's quite a value in sticking with that and talking anyway.*

Client: why?

Therapist: *because it's a valuable skill to learn how to talk when you don't want to,*

Client: oh

Therapist: *because that's precisely the time you need to.*

Client: oh

Therapist: *talk about the tied up feeling.*

(pause for about two minutes – a long time in a chat session)

Therapist: *ok?*

Client: about what?

Therapist: *about what you are feeling inside.*

Client: I kind of feel like I have no control over anything right now.

(Stofle & Chechele, 2004: 184)

The authors presented this example of chat room session as a demonstration of 'sessional contracting skills' (ibid.), where 'the therapist has to motivate the client to work on issues in a session' (ibid.). But this example also demonstrates the therapist's fear of silence (a two-minute pause is 'a long time in a chat session.' ibid.) and his directive style, which almost castrates the client ('I kind of feel like I have no control over anything right now.' ibid.).

The absence of pauses in chat room therapy and the inability of therapists to present their passive presence in the therapeutic frame shape the nature of this kind of therapeutic encounter. On the one hand, chat room psychotherapy imitates the time frame of face-to-face psychotherapy, relating to the exact time and length of the session and to the frequency and succession of sessions. It provides a secure time frame for a dynamic dialogue in real time. But, on the other hand, the absence of textual pauses creates a stressful atmosphere that can undermine the whole process.

If listening is a condition for creating a secure frame for clients' narratives, there is no such secure frame in chat room therapy, where silence may be experienced as threatening.

While listening and silence are limited in chat room psychotherapy, other therapeutic tools are still available and may serve clients and therapists as a catalyst for the therapeutic interaction. The absence of silence reinforces manipulations, directive suggestions and even empathy and positive regard that

may all strengthen the therapeutic relationship.

Therefore, while chat psychotherapy lacks a necessary condition for the therapeutic interaction, it creates a solid, strong relationship between client and therapist.

3. Language. The advantages of written dialogue that are present in online therapy are limited in the case of chat room psychotherapy. The fast pace of chat dialogue blocks participants' conscious observation, forcing them to reply spontaneously. This, and the lack of physical cues, may cause misunderstandings, misspelling and faulty interpretation of certain words and notions.

Some therapists warn their potential clients of the risks of misunderstanding in written dialogues. 'The possibility of misunderstandings due to text-based communications...' (Benedict, 2005). 'The most significant drawback of online counseling is not being able to interpret body language, facial expression, tone of voice, and so forth' (Futton, 2002). On the other hand some writers suggested that this disadvantage could be turned into an advantage: 'Stuart Klein, 1997, has hypothesized that the lack of visual cues intensifies the need to listen and the ability to listen' (Grohol, 1997).

There is a special written language that was developed in the first days of online chat rooms and which has also affected the language of online psychotherapy. This language is based on abbreviations and simplification, which sometimes serve to flattens personal style and characteristics:

> The chat medium affects the register in several ways, pushing it toward a highly economical use of language in which we struggle hard to emulate a face-to-face conversation. Acronyms like lol (laughing out loud) and rofl (rolling on the floor laughing) abound, and anything that *can* be abbreviated *will* be. This includes common words like pls (please), cya (see you), u r (you are), and thx (thanks), as well as nicknames.
>
> (Wallace, 1999: 11)

Although chat room language is not sophisticated due to the rapid pace of communication, therapists must be aware of other kinds of emotional manifestations that may be represented by graphic expression.

a. Typography. One can choose the font type and the font size to express feelings and emotions. Any change in the typography, like changing the size of a word or a sentence, or choosing bold letters or italics, is meaningful.

Therapist: *I hope you remember that we will not meet next week.*

Client: yes, I remember. :(well, I'll be here, and I'll find an open chat so I wont stay alone.

Therapist: *I know that you need me, but I've told you about my vacation when we started. We know each other for more than three months, and I trust you and know that you'll be OK. I noticed that you changed your font, and it was like you're demonstrating the separation, and also that you can take care of yourself.*

Therapists may interpret this change of font in many other ways, and any kind of interpretation would serve the same purpose, namely: being aware of the 'body language' of text communication. Therapists' awareness of clients' typographical changes helps create a sense of a secure frame.

b. Volume. In 'online language' it is common to shout by using upper case letters. This is another attempt to imitate body language in online relationships. An amplification of text volume may look like this: 'Jim! help, Help, HELP!!' (Suler, 2004: 41).

c. Pauses. Although silence has no place in chat room interaction, one can demonstrate a pause by using trailers (series of dots). 'combined with such vocal expression as.... Uh.... Um.... Trailers can mimic the cadence of in-person speech, perhaps simulating hesitation or confusion' (ibid.: 39).

d. Emoticons. The simple use of keyboard characters may serve for expressing empathy. Instead of laughing with words (lol) one can just (-: or (-;. Instead of crying one can)-:, etc.

e. Colours. Colours are unconsciously associated with mood and emotions. One can change the colours of letters and the background of the text on one's own side of the chat room.

f. Links and hypertext. Although therapists and clients are not present in the same traditional therapeutic clinic, they are both part of the World Wide Web. By using links to other sites on the Web, or hypertexts, which are sophisticated links, they can enrich the segmented text of chat room.

This option, which represents one of the main advantages of online text, can risk the sense of secure frame and damage the therapeutic relationship. Links break the fragile boundaries of chat room therapy and serve as foreign agents or 'third parties'.

The basic ground rules of language in chat room therapy are imported from the common agreement about online behaviour, which are defined and gathered in 'Netiquette' (Netiquette, 2004).

4. The contract. In most therapeutic web sites (57.6%) clients have to sign a contract or disclaimer in a 'pre session form' before starting the therapeutic process. In some sites, clients can complete the form on the site itself, while others are required to submit their agreement forms via e-mail. A 'pre session contract' has usually been agreed upon before chat room therapy starts through other types of communication (on the site, by e-mail, telephone or fax).

Since chat room therapy resembles face-to-face psychotherapy, many therapists discuss the mutual therapeutic contract in the course of the first sessions. Chat room therapy is not the ideal setting for discussing a written contract, since it is rapid and fragmented. Usually, the limitations of chat room therapy lead the therapist to concentrate on certain segments of the contract or upon planning the actual session accordingly. Such a contractual discussion might go like this:

Therapist: *I thought we would work on some treatment planning tonight if that's ok with you.*

Client: thank you,... ok

Therapist: *so, let's start by naming the issues/problems that you want to work on.*

Therapist: *we've talked about you growing up in an alcoholic home.*

Therapist: *and being involved with people with alcohol problems.*

Therapist: *but what do you see as the specific problem?*

Client: if I think it will upset someone I won't do it

Client: It doesn't seem like I'm living my own life

Therapist: *talk some more about not being able to do what you want.*

Client: an example, this past weekend I went to meet someone for the first time

Client: everyone in my family was very upset with me for it, but I had fun until I got home

Client: I feel like I let them down. Don't know if I will do it again, but I do want to

Therapist: *you let them down because they were unhappy with you?*

Client: yes

Therapist: *can you give me more of the details about this? Was it like a date?*

(Stofle & Chechele, 2004: 185)

This dialogue started with a suggestion to define the treatment plann and its

central issue/problem and continued with a swift transition to the here-and-now of the client's life. In a way, this associative correspondence is similar to face-to-face psychotherapy, and it is the therapists' role to follow the thread and focus on the contract discussion. But while in face-to-face therapy therapists can interrupt their client's fluency with a question, a suggestion or a physical gesture, in chat room therapy clients are focused on their own writing process and therapists' messages affect them only when they have finished writing. Although it is sometimes only a matter of a few seconds difference between responses in chat room therapy and those in face-to-face therapy, this difference can be meaningful.

The 'pre session contract' that has been established for chat room therapy may cause therapists' to ignore their face-to-face practice of creating a 'real' therapeutic contract, since some type of a contract has already been established, and time is short. Some writers believe that the new culture of online chat communication and the shaky temperament of the Internet generation may force therapists to relinquish certain ground rules:

> Compared to the f2f process, some therapists may find it more difficult to keep online clients coming back while working through negative transference. Therefore, more supportive interventions may be called for online. Responsiveness on a nonclinical level can also help maintain engagement. For example, the therapist can reply briefly but supportively to between session emails and direct the client to adjunctive information and resources on the Internet.
>
> (Zelvin & Speyer, 2004a: 173)

The lack of traditional therapeutic contracts in chat room therapy calls for a new way of committing clients to an ongoing process. Online clients differ from traditional clients: 'The data seem to suggest that many of those who are drawn to contact a therapist on the Internet do so because, for them, traditional psychotherapy is not accessible' (Ainthworth, 2002: 208). On the one hand, these clients are new to psychotherapy but, on the other hand, they are exposed to enormous information resources concerning psychotherapy. Chat room therapy may integrate contract negotiations into the ongoing process of therapy.

> Contracting about the structure of treatment and the extent of counselor availability is a process that continues in the ongoing phase of treatment. Perhaps

> even more than f2f clients without prior therapy experience, online clients must be educated about the nature of the therapeutic relationship and the process of therapy.
>
> (Zelvin & Speyer, 2004a: 173)

5. The setting. The chat room interaction takes place in a common online setting, which consists of special software for instant messaging. There are various kinds of chat room software, each of which resembles a different kind of therapist's clinic in face-to-face psychotherapy. Each kind of software provides a different level of privacy and confidentiality and is designed in a different style.

The setting of chat room psychotherapy is influenced by its unique characteristics that shape its functioning and reflect the corresponding ground rules.

a. The location. The location of a chat room is important for creating a sense of privacy and exclusivity, which are essential for creating a secure frame. There are two basic, totally different kinds of chat room location.

There are many options for the private use of chat rooms on the Internet. Well-known chat room software packages include Windows Messenger, ICQ and Skype, and many others. Each enables online users to create a list of permitted contacts with whom they can exchange instant messages online. Each chat room software package is located on a different site, which is operated by a different provider. These are public services, so they are open to millions of surfers, while each has its own design and technical characteristics. Each participant can save the chat dialogue on his own computer or on the provider's site.

There are online therapists who offer chat room therapy based on this kind of shared software, which is similar to a therapeutic session taking place in a public venue (a public garden, restaurant, coffee shop, etc.). Obviously this kind of setting cannot provide a sense of privacy, intimacy, exclusivity and confidentiality.

The other type of chat room is located on the therapist's web site, and this in itself is meant to create the sense of a secure frame. All the sessions that take place in this kind of chat room therapy are located on the therapist's site so there is no danger of detection when the information is transferred on the

net.

b. Design. Most chat room software looks similar so the aesthetic aspects of the setting do not fulfil a functional role in creating a secure frame for the therapeutic process.

The architecture and design of the therapist's web site can compensate for the lack of control over the design of the chat room. Practitioners can locate their secure chat room within the boundaries of their web site, thus creating the sense of a familiar space. For example, in order to create a personal style and design, therapists may add links to clients' personal files or libraries at the top of the web page.

In most chat room software, both sides can influence some aspects of the design that are meaningful for the therapeutic interaction. They can change the font style, size and colour. They can also enrich the dialogue by using a built-in gallery of emoticons or by sending personal files, containing text, photographs, audio or video files or links through the chat programme. This option also equalises the relationship and gives both participants a sense of control that contributes to the sense of a secure setting.

c. Technical applications. There are three typical kinds of chat room programmes and each influences the nature of the communication and the therapeutic relationship. Actually, these technical applications function like the corresponding physical contact in face-to-face psychotherapy.

There are chat room programmes in which clicking the 'Enter' key sends the text to the common screen. This means that both client and therapist cannot write or send more than one paragraph at a time, and the dialogue is based on short messages at a fast pace. This technical limitation dictates a more spontaneous and swift dialogue, which demands a special kind of 'listening' from the therapist.

Other chat room programmes enable participants to write more than one paragraph and send the whole text by clicking with the mouse on the 'Send' button. This technical application changes the whole atmosphere, since it enables clients and therapists to develop their ideas and edit them before sending them. This kind of chat room dialogue is slower, and gives both sides time for thinking and introspection and even a sense of silence.

The third kind of programme for chat room therapy enables each side to view the other side's typing in progress, including mistakes and corrections.

This programme is closer to 'real' talking, and it creates a sense of a genuine conversation. On the other hand, this option cancels out one of the advantages of online written communication, the option to re-read and revise the message before sending.

The characteristics of chat room programmes influence the evolution of the therapeutic relationship, enabling therapists to identify the 'tone' of their clients' textual manifestations as if they were present in the same room:

> During a chat session, the therapist and the client each may feel as though the other is physically present. That feeling of presence is contributed to by all of the ways each person presents in that chat room at that moment in time. This includes screen name, font style, typing speed, interaction tempo, verbosity, use of colloquialisms and emoticons, and spelling and grammar. Another term for this might be *nontextuals*, that is, everything other than the words themselves. Although not all of these factors are specifically evaluated while online, many can be assessed through a review of the transcript, and they all add to the feeling of presence.
>
> (Stofle, 2002: 94)

Apparently, one may refer to the characteristics of the chat room programme as the equivalent of the face-to-face physical clinic, to which therapists should adapt their ground rules according to their theoretical assumptions. However, one also has to consider the influence of clients' and therapists' private settings. There is an unrelenting tension between these two kinds of setting and this tension threatens the sense of a secure frame.

To create a secure frame in this delicate situation, chat room therapy has to provide advantages that cannot be found in face-to-face psychotherapy. The creation of a secure frame in chat room therapy depends on the relation between these advantages and the inevitable silent presence of the parallel private settings.

The main advantage of the setting in chat room psychotherapy is the documentation of the text and the physical presence of the text, and this holds true for all kinds of online therapy. At the same time, the lack of technical means that enable therapists to control the architecture and atmosphere of the chat room prevents the immediate sense of a secure frame, or of 'containing'.

6. Time management. Although there is no reason why the same ground rules of time management should not be applied to both face-to-face psychotherapy and

chat room therapy, the differences between the two different time categories may influence therapists' perceptions and activities. Written communication is slower than talking and reading messages is slower than listening, causing the whole sense of time to be different.

As in face-to-face psychotherapy, therapists define the time boundaries in the therapeutic contract. 'As with any therapy, it is essential to develop with the client a contract for a number of sessions and then provide the client with a structure and framework for the chat sessions' (Chechele & Stofle, 2003: 49). In practice, things are different due to the new atmosphere of chat room therapy, although nothing prevents the setting of traditional ground rules in chat room therapy.

a. Scheduling and frequency. Online therapists can stick to the conventional fixed time, i.e., a weekly session on an agreed day and at the same hour (or six days a week for psychoanalytic therapy). But only 14.5% of online therapists (17 web sites out of 117 that offer chat room therapy) define such a ground rule in their proposed agreement.

   Many therapists adapt themselves to the unconventional Internet atmosphere. Eighty-five therapists (72.7%) disregard the role of fixed time in creating therapeutic relationship and choose to create a sense of a new kind of therapy without firm boundaries. Fifteen therapists (12.8%) offer 'on demand' chat room sessions.

b. The length of sessions. A 'fifty-minute hour' of psychotherapy is conventional, but chat room therapists choose to break this convention. Although 46 therapists (39.3%) define a fixed session length, only 12 therapists (10.2%) stick to the fifty-minute session. Chat room therapists are opening up a new concept of therapeutic time, offering their clients the option of various session lengths: 30 minutes (6%), 45 minutes (2.6%), 60 minutes (13.7 %) and other options (4.2 %)

   Other therapists (29.9%) suggest a modular time session that is a combination of time segments of 20, 25 or 30 minutes. Some therapists (5.1%) offer a flexible time frame for clients who prefer to pay by the minute, and some (25.7%) prefer not to mention the length of the sessions.

c. The duration of the treatment. Although short-term therapy is popular in face-to-face therapy, very few chat room therapists (5.1%) refer to the duration of the therapeutic process, while 111 (94.9%) ignore the subject or offer open-ended therapy:

> Long-term treatment can be a rich source of healing and growth for the client and satisfaction for the skilled and dedicated therapist, just as f2f therapy can. Assuming both therapist and client have the verbal and technical skills to handle text and synchronicity well, therapy in a chat room can be remarkably similar to psychotherapy in an office.
>
> (Zelvin & Speyer, 2004a: 169)

The sense of time in chat room psychotherapy is different from that in face-to-face psychotherapy, even if they both occur in the same structure of synchronous fifty-minute sessions. The process of writing and reading is slower and less spontaneous than talking, thus the sense of stress and hustle increases in inverse proportion to the slowness of this process.

This phenomenon may fail to create a secure frame and therapists have to address and neutralise this obstacle. To do this, therapists have to hold back; even if their typing skills are excellent, they should slow down and adjust themselves to their client's pace.

7. The therapeutic message. There is a contradiction between the immediate and spontaneous spirit of chat room psychotherapy and the stable and profound nature of the therapeutic message. The fast exchange of short and segmented messages is not the ideal condition for formulating a sound and solid therapeutic message.

The special qualities of chat room psychotherapy limit the therapeutic message to immediate reactions concerning the content of each therapeutic session.

   a. The opening message. This is the most significant therapeutic message in chat room psychotherapy, since the therapist can prepare it in advance, before each session. Therapists can read previously documented sessions and open the session with a welcoming message that bridges previous sessions and every subsequent one.
   b. Ongoing messages. All therapists intervene during each session and formulate therapeutic messages according to their therapeutic approaches. In face-to-face psychotherapy, therapists can formulate these messages while listening during silent moments or through a process of 'free floating attention'.

But there are almost no silent moments in chat room psychotherapy, so in such a situation a therapist may find it difficult to interpret or formulate sound therapeutic messages. This limitation might change the ground rules of

chat room psychotherapy and therapists may have to limit their messages unless they are able to prepare them in advance.

c. The ending message. The role of the ending message of each session, which is so significant in face-to-face therapy, is weakened in chat room psychotherapy. Since chat room communication focuses on the last few minutes, it is difficult to review the whole session, refer to previous sessions and the therapeutic contract and relate to future sessions.

Therapists have to be careful about mistakes and misunderstanding and focus on subjects that are not fallible.

Therapist: *so, do you want to summarize tonight, or should I?*
Client: ah, I don't know … why don't you do it? :o)
Therapist: *ok. ;0)*
Therapist: *here goes….*
Therapist: *you talked tonight about how upset you were at your boss…*
Therapist: *you said he doesn't consider you or your needs when making out the schedule for the week.*
Therapist: *you talked about feeling taken advantage of,*
Therapist: *and you said you didn't like that feeling and you feel it a lot.*
Therapist: *we talked about making your needs known to your boss in an appropriate manner.*
Therapist: *you said you are not quite there yet, but are making progress.*
Therapist: *(I agree that you are making progress! ;0)*
Therapist: *you told me you plan to continue with your feelings diary because*
Therapist: *you see it as helping you see the impact others have on you and*
Therapist: *your feelings….*
Therapist: *did I get it right?*
Client: yep … that's about it…. You must have paid attention. ;o)
Therapist: *yep.*

The limitations of chat room psychotherapy change the role of therapeutic messages, forcing therapists to be aware of the risks and invest their energy in definite available messages. The pressure of time forces therapists to focus on clients' last words in the present session, making it difficult to formulate a comprehensive message.

Chat room therapist may overcome these limitations by preparing their opening messages in advance and by avoiding unnecessary therapeutic messages when there is not enough time to formulate them.