

# QUESTIONING THE COUCH: HISTORICAL AND CLINICAL PERSPECTIVES

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Since the beginning of the last century, when Freud introduced the couch in the psychoanalytic room, a number of “objects” have been removed or renovated, yet the couch has almost always remained in place, at least officially. This article has two distinct aims. The first is to offer a reconstruction of the psychoanalytic history of this element of the setting. The second is to rethink the couch, saving it from being reduced to a mere icon. Recent contributions coming from affective neurosciences, infant research, and psychotherapy research seem to question the utility of this element and the nature of the very mechanisms of its therapeutic action. The authors wonder whether the use of the couch is primarily protective for the therapist rather than necessarily helpful for all patients. Taking into account these observations implies bringing the couch out from a silent dimension and reflecting on its role in the conception of therapeutic action and mental functioning.

*Keywords:* couch, psychoanalysis, setting, therapeutic action, therapeutic relationship

In some 15 years of analytic relationship with DWW, I did succeed at three points or occasions to sink into my Self, be silent, present in my person or related to him. All these three occasions were physical or rather psychosomatic. He was in his chair seated and I had got off the couch and buried my head into the side of his coat. I can still hear his heart and watch beating. All else was still and sentiently neutral and I was at peace. And DWW never interpreted those three occasions. He had enabled me to reach to that point, allowed it to actualise, and let it pass—without comment. And these three occasions were my only experience of the Self in my analysis. (Masud Khan, *Work Books*, cited in Hopkins, 2006, p. 153)

In jokes and popular culture, the psychoanalyst is depicted as a silent figure who takes notes while the patient talks, lying on the couch, eyes lost in the void. James, the 18-year-old Salingeresque protagonist of *Someday This Pain Will Be Useful to You*

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(Cameron, 2007), recounts the beginning of his first session in this way: “Dr. Adler sat in her chair and indicated the other chair to me, which was a relief because I wasn’t about to lie on the couch. I’ve seen too many Woody Allen movies and New Yorker cartoons to do that” (pp. 84–85). For us practitioners, however (on, behind, or without the couch), reflections on this clinical object go far beyond simply recognizing its iconic role.

Since 1913, when Freud first discussed in detail the topic of the couch in psychoanalysis, a number of objects from the Freudian room have been removed or renovated and others have ended up in storage, yet the couch has almost always remained in place, at least officially. It emerged unscathed from the days of object relations, ego psychology, and psychology of the self, surviving even the major theoretical reevaluation associated with the relational turn and intersubjectivity. Indeed, more than any other setting element, the couch seems to be the lasting Freudian inheritance. The use of the couch (or lack thereof) is often taken for granted, as if it were a “mute” object in the consulting room. Instead we think, as Michael Fordham (1978, p. 65) put it, that “just as the analyst needs to be aware of his inner world, so does he need to be aware of parts of himself that are outside him in the room.”

This article has two distinct aims. The first is to offer a reconstruction of the psychoanalytic history of this element of the setting. Historically, psychoanalytic thought has been characterized by a tension between two opposing theoretical positions on what techniques actually bring about a change in the patient: One point of view stresses the effect of interpretation and insight in the therapeutic evolution, while the other stresses the role of the interpersonal interaction (Greenberg & Mitchell, 1983). In clinical practice, this difference in focus has led to further polarization between those who consider the space of the analytic treatment to be *within* the intrapsychic space (e.g., drives, defenses, and conflict) and those who identify it in the relation *between* the analyst and the analysand (e.g., clinical process and its vicissitudes). The current debate (see, e.g., Celenza, 2005; Olds, 2006; Gallese, Eagle, & Migone, 2007; Schachter & Kächele, 2010) on the usefulness (or not) of the face-to-face position, however, seems to underestimate the scope of this difference. Indeed, there are clearly assumptions underlying the choice of setting—*only* with face-to-face is it possible to focus attention on the clinical process and reciprocal patient-therapist adjustments, and *only* with the couch is it possible for the transference and its analysis to unfold properly. These assumptions, however, do not always take into account the various theories of therapeutic action that should support them.

The second goal of this article is to save the couch from being reduced to a mere icon. The use of the couch as part of the psychoanalytic method is, by no means, a shibboleth. On the contrary, it involves fundamental, though no longer universally accepted, aspects of the very nature of the process, as well as technical responses to specific (and widely differing) patients who are unable, for various reasons, to accept the invitation to use the couch, or, when accepting, to tolerate it. This element of the setting raises significant issues, including whether the couch might impair the analyst’s receptivity to nonverbal communication and how to approach patients who experience the couch as intolerably depriving and possibly traumatic. Crucially, it also highlights the incompatible views within psychoanalysis concerning the nature of the analyst’s desirable or undesirable influence on the patient’s functioning. As Celenza wrote (2005, p. 1654, italics added),

The process of psychoanalysis entails an exploration of intrapsychic and intersubjective engagement as it is expressed (verbally and through enactments) in the potential space created. . . . The potential space can be symbolically demarcated and delimited by defensive retreats from intolerable aloneness (disconnection or annihilation) and overstimulating or engulfing

engagement. *The couch and the chair can come to represent endpoints for the axis around which these aspects revolve and are anchored.* It is not that the structural arrangement exclusively determines where this tension will be played out, but that, *in locating the endpoints of this axis for each particular analysis, the couch and chair may come to concretely represent disavowed aspects of the danger/safety dialectic attributed to either placement.*

We believe that recent discoveries in neuroscience (Gallese, 2003; Corrigan & Wilkinson, 2003) and in infant (Beebe, Knoublach, Rustin, & Sorter, 2005; Boston Change Process Study Group, 2005) and psychotherapy research (Barber & Sharpless, 2009; Jones, 2000) can provide a valuable contribution to new ways of thinking about this element of the setting in light of the particular theory of therapeutic action involved in each case.

### The Historical Couch

The traditional setting—patient lying on the couch and analyst sitting behind him—is described by Freud as the foundation of the journey into the dynamic unconscious, facilitating regression and the emergence of primary process material:

I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of his sight. This arrangement has a historical basis; it is the remnant of the hypnotic method out of which psycho-analysis was evolved. But it deserves to be maintained for many reasons. The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more). Since, while I am listening to the patient, I, too, give myself over to the current of my unconscious thoughts, I do not wish my expressions of face to give the patient the material for interpretations or to influence him in what he tells me. The patient usually regards being made to adopt this position as a hardship and rebels against it, especially if the insistence for looking (scopophilia) plays an important part in his neurosis. I insist on this procedure, however, for its purpose and result are to prevent the transference from mingling with the patient's associations imperceptibly, to isolate the transference and to allow it to come forward in due course sharply defined as a resistance. I know that many analysts work in a different way, but I do not know whether this deviation is due more to a craving for doing things differently or to some advantage which they find they gain by it. (Freud, 1913, pp. 133–134)

Although derived from the methods of hypnosis (Freud, 1925; Ellenberger, 1970), the couch has been maintained both as a *personal necessity* and as a *technical element* required for analytic work. In other words, Freud's aim is to give some *suggestions* to the doctor and analyst, making it clear that these suggestions arise from his own personal experience and are therefore liable to variation and not valid for everyone. However, the couch—an accommodation to the human need for a certain distance within so intimate a setting as that of psychoanalysis—became such a well-established rule that in the same article he refers to not adhering to it as a “deviation” (Freud, 1913, p. 134). As Etchegoyen (1986) pointed out, what “Freud introduces as a peculiarity of his own style” soon took on the value of a “universal technical rule” (p. 85), one which can be reflected upon but not modified, because “we can choose our own style, but technical rules are transmitted to us through an analytic community and they cannot be changed” (p. 86). Over time, other reasons have emerged for its use, including the need to inhibit mobility so as to minimize drive gratification and facilitate canalization of “psychic energy” into words; the

need to promote a more favorable, open disposition toward one's unconscious; and so forth.

Thirty years after Freud's "suggestions," Fenichel (1941) made his critical observations on the advantages and disadvantages of the couch. He notes how the "ceremony" of the beginning of the session—the patient enters the office and lies down—can produce a "magical" impression, which can create the effect that analysis and daily life are isolated from each other. This can lead the patient in two different directions: On the one hand, the patient might perceive a discontinuity between his life and what happens during the hour of analysis; on the other hand, the patient may not be able to "metabolize" the material that comes up in the analysis and, therefore, may refuse to transport what was learned into everyday life. Fenichel (1941) comes to the conclusion that the advantages of using the couch outweigh the disadvantages, but he emphasizes that technical rules should be applied flexibly.

On various occasions, Carl Gustav Jung discussed the couch "problem." Here he declares his position very clearly:

In psychotherapy . . . the very fact that the patient has emotion has an effect upon [the doctor]. And it is a great mistake if the doctor thinks he can lift himself out of it. He cannot do more than become conscious of the fact that he is affected. . . . It is even his duty to accept the emotions of the patient and mirror them. *That is the reason why I reject the idea of putting the patient upon a sofa and sitting behind him. I put my patients in front of me and I talk to them as a natural human being to another, and I expose myself completely and react with no restriction. . . . So, in order to be able to show my patients that their reactions have arrived in my system, I have to sit opposite them so that they can read the reactions in my face and can see that I am listening. If I sit behind them, then I can yawn, I can sleep, I can go off on my own thoughts, and I can do what I please. They never know what is happening to me, and then they remain in an auto-erotic and isolated condition.* (Jung, 1935/1976, pp. 139–140, italics added)

As we shall see, Jungian loathing for the couch anticipates two themes dear to contemporary psychoanalysis, especially to interpersonal-intersubjective psychoanalysis: the analyst as active participant of a bipersonal field (Renik, 1995) and the centrality of visual reflecting and nonverbal communication (Beebe & Lachmann, 2002). "The crucial point," Jung wrote in *Memories, Dreams, and Reflections*, "is that I confront the patient as one human being to another. Analysis is a dialogue demanding two partners. Analyst and patient sit facing one another, eye to eye; the doctor has something to say, but so has the patient" (Jung, 1961, p. 131). However, not all Jungian analysts have followed the sharp indications of the teacher from Zurich. According to Michael Fordham (1978), a London exponent of an analytical psychology sensitive to clinical theories of the Middle Group, Jung placed too much importance on physical position. Discussing the analytic setting in detail, Fordham explains why "having conducted the analysis with the patient sitting in an armchair in front of me, now I have changed system moving to the couch" (p. 95). Fordham (1978) thinks that the couch is not an obstacle for the establishment of a relationship with the patient; on the contrary, it has several advantages: (a) it facilitates regression; (b) it leads to a dreamlike state of consciousness, bringing the patient closer to his or her unconscious; (c) it facilitates the unfolding of the transference; (d) it allows greater contact with bodily sensations, and, finally, (e) it makes easier for the analyst to maintain the thread of his or her thoughts and bodily processes.

The coexistence of such dissimilar positions can partly explain the fact that use of the couch is not prescriptive in the Jungian setting; rather, it is optional, evaluated case by

case, and often connected to the therapist's personal choice, who may prefer the face-to-face position.

Subsequent to Fenichel's monograph (1941), direct references to the couch become less and less frequent. One of these is by Glover (1955), who calls for "reasonable elasticity" in organizing the setting and cites several situations in which patients might have trouble lying on the couch.

According to Fairbairn (1958), on the other hand, the argument for using the couch is actually a rationalization: Behind the need to leave the patient free from the analyst's influence hides the analyst's own need to protect himself from the patient's demands. The couch technique, according to Fairbairn (1958, p. 379), has the effect of

imposing quite arbitrarily upon the patient a positively traumatic situation calculated inevitably to reproduce such traumatic situations of childhood as that imposed upon the infant who is left to cry in his pram alone, or that imposed upon the child who finds himself isolated in his cot during the primal scene.

It is documented that Fairbairn used the couch with his analyzands—see, for example, Harry Guntrip's very telling personal account (Guntrip, 1975); but it is also clear that, after having developed his object-relations theory, he questioned the use of the couch:

Personally I have now abandoned the couch technique in the case of all comparatively recent patients—to great advantage in my opinion. This departure from the classic method on my part represents an attempt to put into practice the logical implications of the object-relations theory. It may be added, however, that I do not favor the technique of the face-to-face interview advocated by such psychotherapists as H. S. Sullivan. In actual practice I sit at a desk, and the patient sits in a comfortable chair placed to the side of the desk, almost parallel to mine, but slightly inclined toward me. In terms of this arrangement, patient and analyst are not ordinarily looking at one another; but either may look at the other, if he so wishes. (Fairbairn, 1958, p. 378)

Although the couch is left over from the hypnotic method, argues Brenner, it should not be considered an "atavistic anachronism" but should instead be seen as a necessary component of the analytic situation. He lists the ("real and concrete") advantages of the couch, including the reduction of interference from external stimuli, and sees the refusal of the couch as a "symptom" to be analyzed in the usual way. As long as this symptom has not been completely analyzed, the patient must maintain his or her face-to-face position, and if, in the end, the "symptom" will be not analyzed, one must conclude that the patient is not analyzable, "treatable maybe, but not analyzable" (Brenner, 1976, p. 155).

Brenner's conclusions are part of the age-old debate about what psychoanalysis actually is as compared to other psychological methods. It is within this debate (especially beginning in the early 1950s) that the argument for the couch is presented as an element that can distinguish between psychoanalysis and the many other dynamic psychotherapies. This comparison with other psychotherapies was particularly awkward as regards the so-called psychoanalytic psychotherapy, which did not seem very different from psychoanalysis, except for its absence of the couch and less frequent sessions. However, psychoanalysis was facing other problems at the time as well, especially its internal fragmentation into different theoretical schools, which was threatening the very identity of psychoanalysis. If there were so many different theories, how could there be a single technique?

This state of events moved Merton Gill (1954) to propose a distinction between *extrinsic criteria*, which refers to a technique (frequent sessions, use of the couch, etc.)

and *intrinsic criteria*, which refers to the theory behind the technique (interpretation of transference, analyst neutrality, etc.). This is a distinction that Gill used many times, until, in 1994, he broadened the criteria to make psychoanalysis applicable to different situations (public service, short therapies, etc.) and to a wider spectrum of patients.

According to Kernberg (1999; see also 2004, pp. 105–132), on the other hand, what differentiates psychoanalytic from psychotherapeutic practice is not so much the setting elements (such as the use of the couch) as the quantitative difference. Seeing a patient four times a week allows the development of “changes” that are not possible with a single session a week. Migone (2000; see also Galatariotou, 2000, pp. 392–398; Kernberg, 2004, pp. 127–128) criticizes the reasoning underlying Kernberg’s idea of psychoanalysis: According to him, it is not its frequency or intensity that identifies a treatment as psychoanalysis but, if anything, the attention given to the transference. Whether one sees the patient two, four, or five times a week, on a couch or face-to-face, according to Migone, psychoanalysis can be defined mainly by the relevance given to the analysis of transference. The real problem for Migone is why an analyst should choose certain elements of the setting (such as the couch) a priori, without considering the patient’s reaction to this setting (for an in-depth examination, see Migone, 2000, 2007). Furthermore, the analyst’s preference for the couch may be a manifestation of a defensive attitude, aimed at hiding his own behavioral or emotional reactions, or his own countertransference. In other words, to free ourselves from the exclusive “either/or” position in the psychotherapy-versus-psychoanalysis debate, the later Gill and Migone seem to propose consideration of the use of the couch as a basis for a wider reflection on the relationship between theory and technique in psychoanalysis.

For many years, the issue of the couch has taken this form in the psychoanalytic debate. Only in 1995 did *Psychoanalytic Inquiry* publish an issue devoted to analysts’ personal experiences “on, behind, and without the couch” (Lichtenberg, 1995). Their reports confirm the existence of implicit technical, theoretical, and personal motivations in the choice of whether or not to use the couch. All of the authors described the need to analyze whether the patient could have any resistance to the couch, but, independently from whether the authors value its use in clinical practice, the Freudian position remains the baseline from which other considerations depart. Some authors advocate identifying counterindications for its use and possibilities for partial use (Gedo, 1995), and some point out that it is always necessary to think about its pros and cons (Grotstein, 1995; Wolf, 1995). In general, the contributions to this issue of *Psychoanalytic Inquiry* are heterogeneous and, thus, hard to summarize in one common line of thought. Despite efforts to shift the debate about the couch into a broader reflection on clinical techniques, the couch is still the object chosen to defend the psychoanalytic method.

To sum up, it seems that consideration of this element of the setting tends to be monopolized by the issue of the larger debate between psychoanalysis and psychotherapy, wherein the couch defines the border between the two. This, however, has contributed to thwarting the possibility of (and masking the need for) more clinical, less “ideological” reflection on its importance as an element in treatment.

### The Couch as a Potential Space

Ogden’s important 1996 work is dedicated to three aspects of analytic technique: the “fundamental rule,” the analysis of dreams, and the use of the couch. Rethinking in light of his concept of the “analytic third,” Ogden considers the couch an essential component



of the support structure of psychoanalysis, providing the conditions of privacy necessary for the analyst to enter a state of *reverie* and give himself up to the flow of thoughts:

Presenting the use of the couch in a manner that emphasizes my own need as well as that of the analysand for an area of privacy, a psychological space (in both a literal and metaphorical sense) in which to think and generate experience, represents an important statement to the patient of my conception of the analytic method and of course of our overlapping roles in it. (Ogden, 1996, p. 886)

Ogden, and British psychoanalysts in general, use the “private space,” with the couch as a symbolic space. However, while Ogden calls it the “analytic third,” other authors, such as Winnicott (1954b) and Balint (1959), interpret this space symbolically, using the metaphor of the mother-child relationship. This metaphor allows them to speak of analysis as a “new beginning.” “The child,” wrote Balint (1959), “begins his life as our patients, lying on his back. . . . When we start the treatment, we offer them a setting that, in most cases, causes them to adopt a child posture” (p. 95). “In so far as the patient is regressed (for a moment or for an hour or over a long period of time),” wrote Winnicott (1954b), “the couch is the analyst, the pillows are breasts, the analyst is the mother at a certain past era” (p. 288).

In a highly controversial clinical case, Casement (1982) presents the story of a woman, Mrs. B., who had suffered severe burns at the age of 11 months and later had to endure long surgical procedures. Mrs. B. remembered her mother holding her hand during one of these operations and, later, “her terror upon finding her mother’s hands slipping out of hers as she fainted and disappeared” (p. 280). At that moment, the patient “felt that she was left alone with no one to protect her from the surgeon who seemed to be about to kill her with his knife” (p. 280). During another session, Mrs. B. recalled a dream (in which she tries to feed a desperate child) that made Casement think that the patient had constructed an idealized vision of her childhood prior to the accident. However, when he tried to tell her that everything may not have gone as happily as she always needed to believe, she reacted by raising her arm as if to stop his words. After a period of silence, Casement took the opportunity to interpret her fear of finding any negative element in the period before the accident:

The next day Mrs B. came to her session with a look of terror on her face. For this session and the five sessions following, *she could not lie on the couch*. She explained that when I had gone on talking, after she had signaled me to stop, *the couch had “become” the operating table with me as the surgeon*, who had gone on operating regardless, after her mother had fainted. She now couldn’t lie down ‘because the experience will go on’ . . . At the start of the operation her mother had been holding her hands in hers, and Mrs B. remember her terror upon finding her mother’s hands slipping out of hers as she fainted and disappeared . . . She now thought she had been trying to refind her mother’s hands ever since, and she began to stress the importance of physical contact for her. (Casement, 1982, p. 280, italics added)

In this context, we can see the couch taking on a more specific meaning tied to both the patient’s history and the content of the sessions.

In a recent article, Tyminski (2006), a Jungian author strongly influenced by the British school of object relations, describes three patient reactions to a change in the analytic setting—in this case, the introduction of the couch: the *embracing* response (excitement and curiosity), the *ambivalent* response (startle and surprise), and the *rejecting* response (anger and fear). Tyminski (2006) interprets these responses as transference reactions, confirming the “symbolic territory” of the couch. “Each of these affects,” he

concludes, “gave a different meaning to the couch, which as a true symbol could not have a single, fixed signification” (p. 649).

Seen in this way, the couch can be a crib (Waugaman, 1987, 1995; Winnicott, 1954a) or a coffin (Frank, 1992; Guntrip, 1961; Winnicott, 1954b); it can evoke experiences of abandonment, fear of dirtying the couch (Frank, 1995), and fear of being attacked (Chessick, 1971). The couch, as well as the setting in general, can also become a battlefield for control, where there is an imposition that can be accepted or rebelled against (Ferro, 1996; Meissner, 2005). It can be the measure of rivalry with other patients associated with the desire to own the analyst exclusively, taking the couch as a symbol of the analyst (Waugaman, 1995, 2003); it can be the object of sexualized or incestuous desires, such as lying in the bed of the analyst-mother (Ogden, 1996).

According to these authors, the couch takes on the role of a “potential space” (Ogden, 1996), capable of activating transference and countertransference dynamics in which patient fantasies merge on a symbolic level with the relationship with the analyst. Thus, rather than bringing out the dynamics of patient drives, the space between patient and analyst created by the couch serves to facilitate regressive, fantasy, and symbolic elements activated by the transference. Moreover, Grotstein (1995) advocates the use of the couch, adding that “lying down facilitates the attainment of that brain state known electroencephalographically as theta rhythm, which corresponds to what Bion (1962) termed *reverie*—the state that characterizes the receptivity of a nursing mother and the receptive state of her infant during the nursing” (p. 398). In this way, the analyst receives the patient’s dreamlike associations in a dreamlike state and then processes them cognitively.

However, making the point that the use of the couch reflects the analyst’s own needs, Ogden (1996) leads us to believe that the couch continues to be used primarily because it serves to “protect” the analyst and his or her privacy. Behind the couch, the analyst is not seen by the many eyes that would otherwise be continually questioning and probing him or her. There is no doubt that, in many cases, this “protection” is useful for the analyst, but we may question whether it is also useful for the patient.

As Alessandra Lemma (2010, pp. 8–9) points out,

the use of the couch with patients whose anxieties are concretely experienced in the body . . . requires careful consideration. In my experience, for some of these patients, the use of the couch is unhelpful . . . not because it provokes a malignant regression . . . but primarily because it bypasses the visual field and the conflicts that are encapsulated through the meeting of two gazes. The invitation to lie on the couch may indeed be welcomed by some of these patient because they want to avert the mutual gaze of therapist and patient, out of fear of what it might do to them (e.g., they may feel shamed as the therapist looks at them), or out of fear of what their gaze might expose to the therapist (, e.g., it may reveal their hatred). Conversely, some patients seek out the visual relationship to intimidate or humiliate the therapist. But here, too, I have wondered whether the use of the couch is primarily protective for the therapist rather than necessarily helpful for this kind of patient.

### The Relational Couch

The foundations of classic analytic technique, which defined the therapeutic relationship in terms of neutrality, abstinence, and anonymity, have given way to other metaphors to



describe the analytic process<sup>1</sup>. If in the classical view the couch had a specific technical function, what will be its place in this new model of the therapeutic relationship? Stephen Mitchell (1997) relates an initial session with a woman coming from a 6-year analysis with an analyst she recalls as cold and distant:

This woman told me that she had become very focused on her analyst's squeaky chair, which, she decided, betrayed discomfort on the analyst's part. The patient used the squeaks to guide her productions (either associations or silences), sometimes changing what she was doing when a squeak occurred or, alternatively, defiantly continuing. (Mitchell, 1997, p. 13)

In the classical model, the couch was seen as allied with the analyst in the attempt to eliminate from the setting his or her personal characteristics, subjectivity, and idiosyncrasies. All this did, according to Mitchell (1997), was to assure that "the history of psychoanalysis has been laced through with squeaks" (p. 13). After recognizing the inevitability of the analyst's participation in the relationship, the couch was still not eliminated but, as opposed to earlier interpretations, "those squeaks are now being heard and deciphered" (p. 13). In this sense, Gill asks, "Is the couch really necessary?" (1994, p. 70)

Aron (1996) explains that he prefers to use it because

it is easier for me to listen to [the patient] and to let myself relax and try to tune into what [the patient] is saying when I don't have the pressure of being looked at. In not being observed, I can be less self-conscious. I can join [the patient] in a state of mind in which we both may hear and see things differently than we usually do. (Aron, 1996, p. 142)

In any case, the couch *remains* a valid analytic tool, more and more integrated into a subjective approach to the setting. The patient's uncomfortable feeling or his refusal to lie down is no longer seen as "a symptom of his mental conflict" (Brenner, 1976, p. 154) or as the result of the neurotic character's need to look (to control; Freud, 1913, p. 715).

On this subject, Aron says that

There have been times when patients have told me how isolated they have felt on the couch, and I told them that I found the couch to be a deprivation as well, since I missed not seeing them in the usual manner and have given up a more social position in relation to them. Patients have been quite surprised to learn not only that I might miss them but that I have mixed reactions to the couch (Aron, 1996, p. 142).

As anticipated, in his work, "Vis-à-vis the Couch: Where is Psychoanalysis?" Celenza (2005) reflects on the ways in which the couch and the armchair can be used in analysis to preserve a sense of safety and to defend against fear. Celenza shows how (a) the themes of danger and safety imply a continuous dialectic tension within the dimensions of involvement/privacy, interiority/exteriority, and subject/object, (b) the different positions of the setting imply a vision of the analyst as an objectified other, a partial and subjective object, or a subject with his own internal world, and (c) therapeutic action associated with the patient lying versus sitting has been underestimated in clinical theory (see Meissner, 2007).

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<sup>1</sup> The references to these "new orientations" are growing in number and are part of a literature that is now very vast. Of the many, we will limit ourselves to mention Aron (1996), Aron & Harris (2005), Mitchell and Aron (1999), Beebe & Lachmann (2002), Mitchell (2000), Sander (2007), Stern et al. (1998), and Suchet, Harris, and Aron (2007).

The premises change, as does the couch's use and significance, but not the tool itself. As we know, in the relational perspective, every aspect of the behavior of both patient and analyst is seen within a continuous *negotiation* of the analyst's needs and the needs of the patient, and it is within this framework of meanings that the significance of the couch, as a *symbolic* and *concrete* object, is to be understood.

In brief, relational authors, along with the British authors, consider the couch as a physical object that organizes the personal and interpersonal space, the subjective and intersubjective space. It is seen as an object that "organizes" the distance between patient and therapist, a distance that is monitored (negotiated), given its impact on the therapeutic relationship and the clinical process.

### New Directions: Psychotherapy Research, Infant Research, and Neuroscience

In recent years, great interest has been shown in the construction of the therapeutic alliance, which has, in turn, redirected the interest of researchers toward multiple aspects of the therapeutic relationship. Transference and countertransference (Betan, Heim, Conklin, & Westen, 2005; Bradley, Heim, & Westen, 2005) and the dynamics of attachment (Diamond, Clarkin, et al. 2003; Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Obegi & Berant, 2009), for example, have been studied in terms that are increasingly interactive and concerned with microprocesses (Barber & Sharpless, 2009; Lingiard & De Bei, 2005; Colli & Lingiard, 2009).

Interest in the relationship and the individual characteristics of patient and therapist, along with the study of rupture and repair and concurrent negotiation processes, are all aspects that have resonated within contemporary relational psychoanalysis, contributing not only to fill the gap between researchers and clinicians but also to build a common field of dialogue between research and clinical psychoanalysis (Safran & Muran, 2006; Westen, 1998).

Similarly emerging from a fertile clinical exchange are the data and studies coming from infant research. In this case, *rhythm* and *attunement* are the recurring terms. Child and caregiver interact in search of a "specific correspondence" (Sander, 2007); preverbal children and their mothers are involved in a dialogue that is a precursor to later relational ability and style (Jaffe, Beebe, Feldstein, Crown, & Jasnow, 2001), and the child is predisposed from birth to use other people to regulate his or her behaviors and emotional states (Gergely & Watson, 1996; Watson, 1994). These regulatory exchanges are precursors to the subsequent development of self/other regulation skills, which eventually inform the adult relational style and are inevitably represented in the therapeutic relationship (Beebe & Lachmann, 2002; Schore, 2000, 2007).

Recognition of the importance of the nonverbal seems to offer a new dimension to the usefulness of the couch as an instrument of treatment. For Lachmann (2005, personal communication), for example, nonverbal signals represent a channel of communication that is fundamental for therapeutic work, especially with "difficult patients," but the use of the couch deprives the treatment of this communication. Naturally, vocal rhythm and intonation would still be available, but Lachmann asks, "Why restrict the nonverbal to this level?"<sup>2</sup>

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<sup>2</sup> It is interesting to remember that Freud himself (Breuer and Freud, 1895/1955, p. 280) had been the first to suggest to the clinician to observe attentively the expression of the patient's face in order to discover, through the presence of tension and facial expression, the memory of what he was trying to deny.

As is well known, studies on procedural memory, which led to a reconceptualization of the repressed unconscious in terms of procedural unconscious (see, e.g., Lyons-Ruth, 1999; Stern et al., 1998; Stern, 2004), initiated a dialogue between psychoanalysis and neurosciences that has made it possible to construct shared concepts of mental development (Mayes, Fonagy, & Target, 2007; Siegel, 1999) and of the functioning of the emotions (Schore, 1994, 1997), in which the theme of the relationship is central. On the other hand, they have also inspired a redefinition of the mechanisms of therapeutic action. Psychotherapy is conceived as an “enriched environment” in which, thanks to the plasticity of the brain, new interactions and experiences add stimuli capable of acting on the conscious and unconscious associative networks underlying affective states and pathological or dysfunctional behaviors. Outcome studies on psychotherapies that use brain imaging in an attempt to identify neuronal correlates of change (see also Mundo, 2006) are still few but are cited more and more frequently. Indeed, Gabbard and Westen (2003, p. 59, italics added) went so far as to state, in a rather lapidary manner, that “psychoanalytic theory will rapidly become an anachronism if theorists imagine that *reclining on a couch* generates useful data but *reclining on a table during neuroimaging procedures* does not.”

It is difficult to approach discoveries such as those of mirror neurons and their implications for fundamental themes of psychoanalysis, such as intentionality, empathy, linguistic understanding, identification and projective identification, transference, and countertransference, without reflecting, as some authors are beginning to do (Celenza, 2005; Olds, 2006), on the various intersubjective implications of the use of the couch and the face-to-face position.

According to this point of view, if the analyst’s observation of the patient’s actions and emotional expression activates the same neural pattern in him or her that is activated in the patient, thus triggering an automatic simulation process in the analyst, then it is plausible to hypothesize that the analyst’s sensitivity to, and awareness of, his or her own spontaneous thoughts and feelings when interacting with the patient may constitute an important source of information on what is going on in the patient’s mind. Similar reasoning also holds for the conceptualization of the patient’s transference reactions: As the analytic situation become more interactional, the patient’s observation of the analyst’s behavior and emotional expressions activates in the patient the same neural patterns activated in the analyst, triggering an automatic simulation process in the patient.

In this context, Gallese, Eagle, and Migone (2007, p. 163, italics added) write,

To the extent that the analyst “hides” behind the couch, the initial condition of mutual empathic resonance is tilted in favor of the analyst. That is, the patient has fewer cues to observe and simulate than the analyst. . . . When the analyst is “hidden” [behind the couch] what appears to be lost are reduced opportunities for the patient to examine and reflect on transference reactions in the light of cues emitted by the analyst . . . and to understand and internalize various aspects of the analyst’s reactions and the effects these reactions have on him or her. If *one considers such interactions an important aspect of the therapeutic process*, then indeed a good deal may be lost by use of the couch.

The result of this is that the analytic method is beginning to be criticized from the point of view of the couch as a “depriving” factor (Olds, 2006, p. 39), which risks weakening the therapeutic process. Those who begin to see psychotherapy as an intra- and inter-cerebral communication know that a large part of this communication takes place on the visual and nonverbal level. Hence, we can ask along with Olds (2006, p. 39), “Why then give up one of our major assets?”

## Conclusions

What is the place of the couch in a method of treatment that is increasingly in dialogue with the mechanisms being described by these new disciplines? Does it still have a place? Or have these discoveries inevitably transformed it into an anachronistic, if not outright “depriving,” tool? Surely the contributions coming from intersubjectivity theory and affective neurosciences, attachment theory, and research in psychotherapy all raise even more central questions that concern the nature and the very mechanisms of therapeutic action.

As we tried to demonstrate in the first section, the various psychoanalytic models use and legitimate the couch within their vision of “what works to cure.” In this sense, we should not speak simply of a psychoanalytic couch but rather of an intrapsychic couch, an object couch and a relational couch.

In the classical model, the couch is conceived (and used) within a theory of treatment that focuses on insight; thus, the couch becomes an effort to help eliminate the analyst from the field, leaving him or her in the background in order to bring out the patient’s transference and defense configurations.

With the relational authors, attention on the transference-relational dimension combines with a clinical focus on the therapeutic *relationship*. In this model, the couch becomes the border, continually being negotiated, between *the professional* and *the personal* on which the analytic relationship is based (Bromberg, 1998).

Contributions from neuroscience and infant research suggest the importance of mutual regulation in attachment relationships and describe the mind as inherently diadic, social, and interactive (e.g., Siegel, 1999). Moreover, researchers have repeatedly stressed the role of “interactive regulation” (Beebe & Lachmann, 1998, 2002; Beebe et al., 2005) and “something more than interpretation” in psychotherapeutic change (Stern et al., 1998; Boston Change Process Study Group, 2010). In brief, these fields of research draw us to consider the *quality* of interactive processes in psychotherapy, in order to prevent the transformation of the analytic environment from therapeutic to depriving.

However, analytic practice has taught us not only the importance of paying attention to the *therapeutic relationship* and the subjectivity involved but also the healing power of the individual’s symbolic and private space (e.g., Winnicott, 1965; Khan, 1974; Modell, 1993). To use a more up-to-date terminology, we could call this the dialectic between self- and other-regulation (Beebe & Lachmann, 2002).

Taking into account the discoveries and observations from neuroscience, infant research, and attachment theory implies bringing the couch out from a silent dimension and reflecting on its role in the conception of therapeutic action and mental functioning. This would allow greater flexibility in its use, freeing the “couch versus face-to-face” question from the “psychoanalysis versus face-to-face” dichotomy. Personality traits, psychopathology, and the nature of the *relationship* can thus become the basis on which to determine whether or not the couch will serve in each case as a catalyst for the clinical process and the therapeutic relation. The fact remains that many clinicians no longer use the couch in their practice with severely anxious, paranoid, or personality disordered patients. This seems to confirm the recent statement in the *Psychodynamic Diagnostic Manual* (Psychodynamic Diagnostic Manual Task Force, 2006) that claimed that “borderline patients are helped by clear limits and structure, and *they usually need to look at and hear from the clinician* so that they can develop a sense of the therapist as a ‘real person’ (*hence, both the psychoanalytic couch and long silences are ordinarily contraindicated*)” (p. 28, italics added).

In this way, a reference framework is established in which the couch is an option that can be considered, and one that is capable of responding to the clinical reference model and the contributions coming from other disciplines.

Without reducing the value of the couch as an identitarian object (as Bollas, 1989, writes, especially in the beginning, we feel that we are truly analysts because we are behind a couch), we need to recognize that although the couch has graced our consulting rooms for more than a century, we must learn not to take it for granted.

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