10 "Skyped, Zoomed and WhatsApped"
Practicing Psychotherapy in Pandemic Times

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Introduction

In this paper, I will reflect on my experiences as a practicing psychotherapist in Austria from an auto-ethnographic point of view. Having worked as a medical anthropologist in a medical school in the United Kingdom for nearly 17 years made me all too aware of the regulations of medical and allied health professional training. Being a student again at 40, when I started psychotherapy training, gave me another perspective together again. At 53 I was finally equipped to leave the academic world behind and start the adventure of opening my private practice, when all of a sudden, a pandemic was announced by the WHO. I was suddenly confronted with using Zoom, Skype, and the Smartphone as allies in the healing process. This brought more uncertainty and insecurities to my life as I was unsure how my professional life and practice would change.

In this chapter, I reflect on the changes in interactions and treatment in my psychotherapeutic practice from 2020 to 2023, when I suddenly had to switch from seeing clients in the privacy of the consulting room to seeing them as "talking heads" on Zoom. The COVID-19 pandemic was declared shortly after I had set up my private practice in Innsbruck, Austria, in January 2020. Apart from familiarizing myself with the complexity of diagnosing mental health disorders and finding dysfunctional patterns that caused my clients problems in everyday life, I had also finally mastered the problematic tasks of noticing, naming, and communicating what in psychotherapy is called "transference" and "countertransference" in the sessions in real-time. Transference occurs when a patient, based on their experiences and neurotic or dysfunctional interpretations of these experiences, casts other people as actors in their inner world and sees their actions and ways of being only through the lens of their dysfunction, leading most often to a repetition of the original trauma. In any therapeutic relationship, psychotherapists will also be given a role in this "play"; the therapist is more or less aware of the role they have been given in the client's world, and the reaction to this role is called countertransference, which any good

therapist will be able to recognize and use in the consultation room to make the implicit and unconscious "game" that the client is playing explicit. Learning to deal with this countertransference and its manifestations in the psyche and body of the therapist is one of the most challenging skills to master on the journey to practicing the "impossible profession." For this chapter, it is essential to conceptualize transference and countertransference because it helps us understand which challenges psychotherapy must face using video telephony.

Every school of psychotherapy has a model of transference and countertransference (Levy and Scala 2012). In my experience, I knew I had started to master this skill when I noticed that the sensation of my bodily affects had changed. Suddenly, I felt nervous on the way to my consulting room and didn't quite know why, or I made sure that I would wear more expensive items of clothing on a day I knew a specific client would be coming to see me or that I would worry about the quality and brand of the tea and water I would sometimes offer my clients. Reflecting on these "worries" in areas of my life in which I felt comfortable made me aware that a difficult client with severe narcissistic traits would wait for me, traits that I had not yet consciously made sense of in terms of diagnosis. Similarly, I started to notice very unusual exhaustion in the evenings on days in which depressed clients had come to see me, yet grieving clients did not have the same effect: I knew that despite the same symptoms they presented with as depressed clients, theirs was not a far less hopeless struggle. Likewise, I had started to use forms of somatic attention (see also Csordas 1993) with my clients: could they sense trust and certainty in their embodied feelings rather than in their thoughts? Could they move from cognitively analyzing whether they could trust someone, which often leads to obsessive thought patterns, to an intuitive sensation of trust in themselves, their partners, and their therapist? Could they distinguish a sensation of anxiety from the nervous tingling that hope engenders? Could they move from overthinking to focusing on these somatic modes of interpreting emotions and the world around them?

Just about when I noticed that I could use these newly honed skills of somatic attention to my feelings in the consulting room, everything changed: the pandemic COVID-19 hit us, and consultation in person was, in most cases, not possible anymore. I had to adapt to new versions of treatment quickly. While the professional body of psychotherapists in Austria, the Österreichischer Bundesverband für Psychotherapie (ÖBVP), viewed the delivery of mental health care via technology with a lot of scepticism because of a lack of evidence-based research (Finger-Ossinger 2021) my clients welcomed the integration of tools such as Skype, Zoom and WhatsApp in their search for an answer to their ailments.

After initial confusion about data protection and "safe" delivery of the consultation online on Zoom video-telephony, my clients and I settled into the new routine of "being" with each on Zoom. Not only would we now see each other only as "talking heads," i.e., the face and upper torso rather than the whole body, but in addition, we

would also see our own faces talking in the more minor pop-up of the Zoom interface mirror. We would no longer share a bodily presence in the same room. How could we carry on working on embodied emotions? How could I use my skills of noticing transference and countertransference in the virtual world? These were the questions that I started to ask myself increasingly. Furthermore, I was concerned about my private space and the framework in which therapy should and could be delivered. The correct setting is a significant factor in psychotherapy. It is not an accident that we refer to therapy as "going to therapy" and "coming out of a depression". The consulting room provides the client with a setting and a framework for feeling safe and thus being able to trust. Words that cannot be spoken anywhere else can be uttered there and nobody would or should ever hear them again. Walking or driving back home gave the client with enough time to process what happened in the session so that everyday life could be lived without intruding on therapy. All this would change by using online tools to deliver therapy directly to the client's room and to their psyche.

It is also a truism that psychotherapy is an "impossible profession" because similar to social anthropology, it deals with a person's ideas of the past, the present and the future; sometimes it deals with waiting for the right moment to put into action what had been imagined and desired for a long time. One becomes all too aware of the passage of time when the past, present and future are condensed into a 50-minute session. The past and what we remember of it shape our present and influence what we fear or wish for the future.

Psychotherapy is an impossible profession because one can never know if the therapeutic relationship works, if there is an outcome and if there is an outcome, whether this outcome is what the client wanted or, rather, what he or she feared the most. Therapists work with aspects of the unconscious, with the numinous, with aspects of a person's life that are sometimes not known and sometimes not felt, yet these aspects are there and manifest in symptoms such as anxiety disorders or depression. If therapy is successful, these aspects of a client's personality are unearthed and made conscious. Happiness is not always achieved, but the client sometimes leads a more fulfilling life, and, in the best case, is equipped with the ability to make decisions when it is the right time or has the skills to wait until it is the right time. Holding the space of indecision is a critical element of good mental health. Hope is what brings people into therapy, a hope that the future will be less burdensome than the present, and fear or desire makes an uncertain future often hard to imagine. I was presented with these challenges at the beginning of my new career and had to navigate these by using newly developed technology such as Zoom and WhatsApp.

Having outlined all the above, let us now have a look at how health authorities in Austria dealt with these challenges. Then I will discuss the impact of using Zoom in my own private practice.

Regulating the impossible profession: Governance of online therapy in Austria

Practicing counseling and psychotherapy has changed over the last 30 years ever since the advent of personal computers and, more recently smartphones. Before 1991, practicing psychotherapy was not regulated by the Austrian government. The Psychotherapy Act (Psychotherapiegesetz), introduced in 1991, has provided a legislative framework for the profession. This framework governs training, practice, and the recommendations concerning professional development. Austria, the country where psychoanalysis and psychotherapy were developed at the beginning of the 20th century by Sigmund Freud and his circle, has chosen a unique path to train prospective psychotherapists: people of all professions can take up psychotherapy training. This means that anybody with an interest in psychotherapy who has a "sense of calling" can apply to a commission within the Ministry of Health to pursue professional training. This application must be argued for by the applicant and granted on a case-by-case decision. Once this has been granted, the applicant can go on to study the principles and basics of psychotherapy (Propädeutikum) at either a university or at a private institution with university status. The degree obtained falls short of one semester's duration and thus does not align with the Bologna legislation. Consequently, upon completion, graduates cannot carry any title such as Bachelor of Arts or Bachelor of Science but can only use this degree to gain access to one of the 40 training institutions in Austria. These institutions offer psychotherapy training in one of the 23 recognized psychotherapy forms, such as cognitive behavioral therapy, psychoanalysis, or humanistic psychotherapy. Teaching and training based on the Psychotherapy Act does not equip the student psychotherapist; however, with knowledge of the code of ethics surrounding online psychotherapy or data protection, two significant developments in social aspects of providing healthcare that have changed since 1991.

Austria has stringent laws on confidentiality obligations (see Rechtsinformation des Bundes). It ensures that the relationship between therapist and client is legally regulated. Clients must feel safe, knowing and trusting that their secrets remain with the therapist. A usual setting is when a client visits a therapist's treatment room. The therapist must ensure that the room is soundproof. With the rise of online therapy, all these issues of assuring that trust can be maintained have been challenged because of the vulnerability to security breaches of electronic communication and the setting of the client's location at the time of consultation. Can clients arrange a space where they are free to talk without being listened to?

In Austria, psychotherapy is regulated alongside the medical ethics principles of the Hippocratic Oath which is based on confidentiality and non-maleficence. Furthermore, similar to other countries, the Declaration of Geneva, formulated by the World Medical Association in 1948, states that patients' rights need to be respected

regardless of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other faction to intervene between duty and patient. The duty of confidentiality is part of the respect that a medical professional has toward his patients. In the case of psychotherapy, it does not even end with death, but secrets told in the sessions must be maintained even if the patient dies. Confidentiality must also be maintained towards relatives, the police (with a few exceptions), other therapists, and medical doctors. Even the fact that someone is in treatment is a secret and must be treated as such. Information that can lead to a patient's change in economic or social standing must be treated as secret. There is, however, an exception, which is when the clients are planning to harm someone else or when they are planning to harm themselves and when children or adolescents are in danger of domestic violence.

As mentioned above, clients and therapists have requested videotelephony because of the ever-growing demand for psychological help in what is perceived as an era of increasing uncertainty. As such, online therapy can be placed under the umbrella of the newly emerging field of telemedicine (TM). In principle, telemedicine means that medicine is delivered and practiced from afar, using a digital device. In recent years, it has not only been used to diagnose conditions but also to instruct patients on how to treat themselves (Waller and Stotler 2018). Functionality, application, and technology have been defined as the taxonomy of TM (Bashshur 2011). These include consultation, diagnosis, monitoring, and mentoring (Waller and Stotler 2018). In terms of time, telemedicine can be asynchronous, which means that diagnostic images, exams, and other medical interventions could be delivered at different times, whereas a synchronous event is interactive and occurs at the same time (ibid.).Telemedicine can be delivered via mobile phones on apps, Zoom, or Skype. These applications proved to be increasingly difficult because they could no longer guarantee that meta-data would be protected from commercial interests. Zoom nevertheless became the market leader for the delivery of online therapy in Austria because the company behind Zoom could guarantee that meta-data were not shared with other cyber-companies. Yet it came with a caveat: after 40 Minutes, the free trial version of Zoom would cut conversations short, and one would have to restart the conversation. Therapy sessions usually last 50 Minutes. Normalization and professionalization thus meant purchasing the anual subscription to Zoom so that the 50-minute session could be guaranteed without interrution.

Ever since 2020, 30 percent of consultations in total are allowed using video-based consultations in Germany, but the first point of contact must be made in person. In Austria, a new legislation coming into force in 2024 will probably allow for video-based psychotherapy, especially ever since the COVID-19 pandemic in 2020 to 2021. This legislation will consider what has already happened, namely that "cybertherapy", or the "virtual couch", is here to stay. The new legislation will have to consider that therapists are aware of the pitfalls of data protection when they use on-

line tools such as Skype (which is not officially recommended) or Zoom. They must use a certified video service provider, guaranteeing that data is encrypted and no contact sharing happens. They also need to ensure that the client has privacy in their personal space to guarantee privacy. The therapist must be in his consultation room and not in his own home. Yet, WhatsApp—which clients frequently used to communicate with me, shares data with its mother company, Facebook or indeed Meta Platforms, Inc.

Zoom, Skype, and WhatsApp thus confronted me with several ethical questions: how would I respond if a client sent me a WhatsApp messages, which happened frequently? Should I buy a second phone and get a new phone number? Suddenly, patients appearing on my Facebook feed became a common occurrence. Would I also appear on their Facebook feed? Was it time to make my profile completely private? Would I be sued for being negligent? Could I be sued for breaching the confidentiality contract? These are issues that the incoming legislation will have to regulate.

Let us go back to the argument about the importance of somatic attention in psychotherapy that I mentioned above. Let us consider taking somatic modes of attention into account to understand why these changes need more debates rather than only legal regulation.

What is psychotherapy? A moment in time in which past, present, and future collide in sensations and interpretations?

The characteristic of psychotherapy is that a spoken word is a tool; that is why psychotherapy is also called a "talking cure." But the spoken word is not the only tool that therapists use. Increasingly, psychotherapists have become aware that body language and the transmission of affect in corporeal sessions are as influential as the spoken word in the session. When a problematic topic is discussed, the atmosphere in the room often says more about what is happening than the spoken word. Psychotherapy is much more than traditional medicine but also a corporal relationship; as such, it has much in common with the other allied health professions, such as physiotherapy or osteopathy, that treat the muscles and bones of a "touchable" body. In Austria, these somatic modes of experience can be studied as continuous professional development after therapy training. They are seen as an addition to the talking cures.

This paradigm shift to relational psychotherapy had already begun with the development of object relations theory in the 1950s, e.g., with Melanie Klein's discussion on object relations (see Mitchell 1987). This laid the ground for relational concepts, which focus on intersubjective views and embodied knowledge of both the client and the therapist. From this perspective, a therapist combining both the psychodynamic perspective and embodied, implicit, intuitive knowledge would

also consider the experience of the lived body of the client. The therapist would also be aware of their countertransference, manifested as lived-body sensation. Psychotherapists working from this perspective would be trained to notice any slight change in the atmosphere in a room which would indicate the mood surrounding the client. The client is "in a mood" to speak from a phenomenological perspective, and the psychotherapist also enters this mood.

Even more so, a therapist considering embodiment would notice how their body is tuned with the body of the client in countertransference, caused by affects that are primarily implicit in the body but cannot yet be voiced or made explicit in words and language; words which signify emotions but are not yet found. The German psychiatrist Thomas Fuchs, who also works from this interrelation embodied stance, distinguishes between "the phenomena of bodily expression, bodily presence, intercorporeal resonance and synchronicity as well as intercorporeal proximity" (Broschmann and Fuchs 2020: 460).

These new approaches in psychotherapy thus do not only deliver us a new perspective on the somatic expression of psychological pain, commonly referred to as psychosomatic medicine or psychotherapy, but they also allow us to understand bodily processes in the therapist during and after the consultation and thus to understand psychological phenomena such as grief, depression, and anxiety disorders from an entirely new perspective. A therapist trained in this tradition often experiences on a somatic level the pain which the client feels but cannot yet allow surfacing from their unconscious, due to the hypothesis that on a neurotic level, human beings all function similarly, otherwise the act of mentalisation (Fonagy 2008), i.e., implicitly and in anticipation knowing or feeling what another person is going through, which makes human interaction possible, could not take place. This phenomenon is increasingly incorporated into psychotherapeutic theory and practice, again basing this on what developmental psychologists call implicit relational knowing (Lyons-Ruth et al. 1999).

These developmental psychologists propose that in addition to being able to learn to verbalize knowledge as children, we human beings are already born with the knowledge of how to do things with intimate others, which they would refer to as "implicit relational knowing" of client and therapist that "intersect to create an intersubjective field that includes reasonably accurate sensing of each person's way of being with others, sensings we call the 'real relationship'" (Lyons-Ruth et al. 1999: 282).

A predecessor to these debates was the philosopher and psychotherapist Eugene Gendlin, who already in the 1960s, started to combine the philosophy of implicit experience with a new form of psychotherapy based on making the implicit explicit by guiding the client to feel what he referred to as the "felt sense." A felt sense is a bodily sensation that is an intuitive body feel for unresolved issues. This philosophy of the felt sense gave rise to the development of what is now referred to as "focusing," a psy-

chotherapeutic technique that allows the client to "focus" on this implicit bodily sensation to make it explicit cognitive knowledge (Gendlin 1996). Gendlin might be seen as a philosopher who anticipated more recent debates on the role of the microbiome of the gut in producing moods, which can then, in turn, lead to mood disorders such as major depressive disorder (Borkent et al. 2022). Suppose we take this type of research seriously: in that case, sensations and moods are "produced" or "created" in the abdomen before traveling upwards to the brain, where they are processed and turned into cognitive knowledge.

Mental health in modern times

Feeling uncertain about where things are going in your life, fearing the worst, feeling depressed, unhappiness, impatience, just wanting to cry, to run away, wishing you were someone else, in some other place, or in with someone else, losing all hope that your life and your work in this world make any sense at all—these are all states of being that every human is familiar with. When these states of being become permanent and won't dissolve, when we cannot control them any longer by sheer willpower, when we have lost hope that things will change, we speak of poor mental health. We find ways of naming these states which then manifest in diagnosis so that we can treat these manifestations.

We create metaphors to speak about these manifestations (see Kirmayer 2004) and we nominate and train people to treat these manifestations. In some cultures, these people are called shamans; in Western societies, caring for ailments of the soul has been institutionalized as counseling and psychotherapy (Kirmayer 2004). The healer restores the faith of the afflicted in the world and makes sure that the uncertainty of living and being is transformed into trust and the capability to rely on oneself and on others. In the best case, a sense of awe and beauty of life itself and the world around us is restored. In the best-case scenario, a sense of self and belonging in the bigger scheme of life is found (Frankl 2006[1959]). The person is capable again of leaving his or her inner shell and going out into the world to transcend himself and contribute to what anthropologists refer to as "dwelling" (Ingold 2011).

A healthy person can resonate within any given lifeworld (Rosa 2019) so that inner and outer needs are found and fulfilled. As such, everyone contributes to the best of all worlds. This is how sociality functions in the best of cases. Of course, this best-case-scenario is most of the time only held together by the worst-case scenario: people increasingly live on their own and only communicate via premeditated technology, which does not allow them to create inner spaces of being with their own self, what psychoanalysts call the "inner garden" (Kristeva 1982). Climate change and new global-scale diseases remind us every day that certainty in necessary security to lead our lives is only a dream, a long-lost hallucination. Beauty is increasingly only

found in protected areas of the world where human beings are not allowed to dwell as they like. Increasingly, people lead lives online rather than in the real world. Sociologist Christopher Lasch (1991) has already 1991 pointed out that narcissistic traits such as taking the self as a reference point rather than adhering to the values of a wider community have become mainstream in the contemporary USA. The need for permanent self-improvement and the need to compare oneself to others in a competitive spirit fosters depression and anxiety and a sense of weariness, as described by sociologist Alain Ehrenberg (2010). This is not the place to discuss the complexities of the contemporary state of mind, so to speak, but the cultural diagnosis of these two sociologists should remind us of the tasks of contemporary psychotherapy as a type of social work. The need for constant self-improvement, alienation, and isolation all contribute to a diminished sense of social coherence and social resonance, as described by Hartmut Rosa (2019). Would telemedicine and cyber-psychotherapy contribute to this trend of increasing isolation and alienation?

Let us have a look at how I experienced the change from delivering health care in the consultation room to having to use digital media.

Auto-ethnographic observations: The transfiguration of the therapeutic relationship

As I have already mentioned above, virtual communication tools such as Skype, Zoom, and WhatsApp replaced face-to-face meetings and the intimacy of the space in the consulting room. When I first started using these tools, the clients seemed to adapt to these new technologies much better than I did: they cherished the convenience that they no longer had to leave the house for an appointment. They could see me, come rain or sunshine, early in the morning or late at night. They often needed to find a space in their home where they felt safe and protected to speak to me and tell me about their lives, but once they had arranged this, they were fine. With some of them, the change to using Skype or Zoom—we had moved to Zoom after initially using Skype but stopped it because it did not provide the safe digital space that I was required to use—even provided them with a much more intimate space than the consulting room.

I noticed that they started to talk about issues that had been difficult to talk about in my consultation room; once they had gotten over the uncanny feeling of seeing themselves and me on the same screen, they started talking about topics that in other settings are much more difficult to talk about, such as e.g., body dysmorphia, issues with substance misuse, and difficulties with their partners. Sometimes they stepped away from their screens, seeking retreat in the areas of their rooms that I could not see. This seemed to give them more freedom to control their own space, especially their own private space. It felt as if they were more in charge of

regulating their free associations, a technique pioneered by Sigmund Freud. Freud asked his patients to lie on the sofa and he would sit behind them so that the patients could just say what came to their minds rather than having to have a conversation with the therapist. They could freely speak without censoring what they would say to me so that they would not have to feel a sense of shame. Sometimes they sat at their desks, having become part of the home office movement, and showed me their favorite books; sometimes, they would arrange their books so that I could appreciate their intellectual curiosity. My younger patients were already equipped with the professional tools of the YouTuber generation and were proud to show me their equipment such as vintage-style microphones.

For me, it was a much more difficult move. I often found that having to keep up with the rapid changes in how to use online video telephony is stressful. At first, I was also concerned about seeing myself in the little pop-up window that comes up when the Zoom sessions start. Was this what I looked like? Was this the expression I unconsciously made when someone told me about stressful events or difficult emotions? I wanted to minimize this pop-up window even more, but I soon learned to cherish it: at least I could now study myself and observe my own unconscious reactions and mimics.

I could learn from this, knowing that patients very much try to "read" the facial expressions of their therapists. Already established trust can be ruined within one mini-second of a therapist's raised eyebrow. Seeing and being seen becomes part of the therapeutic process. I needed to learn to own my face and my expressions. I needed to learn to take care of my expressions. Mental health and psychological well-being are tied to seeing and being seen. The image I want to present to others, the (imagined) need to invent a respectable persona that hides my true inner self, the fear I have of being judged on my looks, the terror of seeing myself reflected in the mirror after a sleepless night: who is not familiar with these feelings?

Eating disorders and body dysmorphia are some of the most common psychological disorders that people present in the consulting room and that are a direct result of not being seen from a kind and favorable perspective. Thus, suddenly, here we were, having to look each other in the eye on Skype or Zoom, but not only that, but we also had to face our own faces, so to speak. Suddenly, I saw my own twitches of the eyelid in close-up, and I became aware of the micro-expressions of my own mimic. I became painfully aware of how often I waved my hands around while speaking, trying to emphasize my point. Had I always been like that? How could I look others in the eye while trying frantically to ignore my own reflection in the Zoom mirror? I suddenly not only had to be aware of and process the micro-expressions of my clients, but also those of myself. Did the horror of seeing myself reflected whilst thinking and speaking signal that I was suffering from body dysmorphia myself or was that just a normal reaction to a new phenomenon? Was this even a phenomenon I could use and discuss with my patients, thus sharing the common expe-

rience? Suddenly, we no longer had to painfully go through the exercises of getting to know—and hopefully like—our own reflections in the mirror, which is a much-used tool in the treatment of body dysmorphia. Suddenly, I and the client had both arrived in the desert of the real, to quote Slavoj Žižek (2002).

Yes, that was us, talking to each other as we really were, not our imagined persona. As Freud observed, when two people make love, there are always at least three people present because one of the parties involved in physical contact would dream of an imagined perfect erotic partner whilst pretending to be in touch with the present partner. Current relational psychoanalysis knows that this is true: when we communicate, we always communicate with an imagined other who then, in turn, communicates with us as the imagined other. What we refer to as our "real selves" is often painful and shameful to experienc, and often, we do our utmost to hide it and invent personas. Yet, in the Zoom meeting, even though it was a virtual space, it was a space that was more "real" than the real space. Yes, this was us: unkempt, crying, in need of coffee, in pajamas, and without make-up. With a twitching eye (my own neurobiology of stress expressed itself) and red cheeks (the neurobiology of the client's shame). One more phenomenon often jokingly referred to as the "séance-quality" of online meetings had to be dealt with. "Are you there?", "I cannot hear you," "Are you still with me?", "I can only see your frozen image, but I hear your voice!", became standard sentences in the Zoom consulting room. How would these disturbances interfere with the intense process of the emotions that we were just discussing and trying to understand? And strangely enough, yes, we could. Sometimes, these disturbances even became jokes, which lightened up an already emotionally laden session.

As I already discussed above, recent developments in psychotherapy made us aware that bodily presence is as significant in the consulting room as the narrative that is being constructed in mutual talking engagements. Co-regulation of breathing is as important a factor in establishing a trusting relationship as is nodding and making reassuring sounds and noises. The sense of sharing a bodily space of being together, of sharing a place and feeling safe, is as important in counseling as is the clever interpretation of a dream and the wise insights of shared experiences. Was this possible on Zoom? Was it possible to feel connected and yet be in two different rooms? A strange phenomenon occurred: yes, it was possible. Sometimes the shared virtual space was even more intimate than the shared physical space could ever be. Suddenly some strange form of democracy started to take shape: the client no longer came to my room only. I no longer had the privilege of "being at home" while the clients had to create a place for themselves in my space.

Suddenly, we both shared only the online space. Often, this led to some interesting exchange: Me: "What lovely curtains you have, and I really like your sofa!" or "I had not realized you were on a beach in Brazil?", until I noticed that one could "fake" the environment on Zoom. Interestingly, after approximately 5 minutes these envi-

ronments were forgotten: oftentimes, a much more intense space between the client and me developed in these virtual spaces. Yet, the need for "faking" the background of the Zoom meeting also allowed me to understand more aspects of client's needs: the need to conceal parts of the self and the home environment often disclosed more about them than they wanted to let on. And yet, the phenomenon remained that there was a felt-sense of greater shared space on Zoom. This continued to amaze me when, after we were allowed again to meet in person and my clients returned to my consulting room, there was a strangeness in the air, as if we had come too close online and now had to re-establish corporeal boundaries.

The last aspect of telemedicine I wanted to discuss is the impact of mobile phones on the communication between therapists and clients. As I mentioned above, WhatsApp also became a lifeline for some of my clients. In some treatment contracts, I allow suicidal clients to add me to their list of people to be contacted if a crisis occurs, and for some of them, this became a lifeline. We later also switched to SMS or iPhone messenger again because of data protection and WhatsApp becoming part of the Meta-group to which Facebook also belongs. One of the aspects that WhatsApp also "allowed" or indeed "afforded" me to do was to notice when clients were last online, which sometimes meant that they were online all night when they could not sleep. Despite warning them about this feature, some clients found it comforting that I would know that they were still alive. This feature entered my everyday life. I could hear the "ping" when a new message arrived. I also wondered what it would mean when they switched off the function that I could see when they had read my message. What did it mean when I noticed that someone had sent me a message but then deleted it again? These functions of technology and the mobile phone became part of the consultation outside of the consultation room. Going back to where I started this discussion, I had to learn not to always be in "somatic modes of attention" and to consciously switch off the hard-learned bodily sensation of transference and countertransference. For my clients, mobile phones and messenger services such as WhatsApp became a lifeline in their search for hope and certainty.

Conclusion

I have described above how cultural commentators such as Julia Kristeva, Christopher Lasch and Alain Ehrenberg have tried to construe the contemporary self. They diagnose a lack of inner mental space, increased traits of narcissism, and, following on from that, weariness. Hartmut Rosa reminds us to resonate with our environment to stay sane. At the same time, communication between human beings, which helps to regulate emotions, fosters empathy, connections, is increasingly aided by technological devices. This is also the case in psychotherapy. My question thus was

whether the use of telecommunication tools in psychotherapy would contribute to the trend of alienation and isolation.

The usage of Zoom, Skype, and WhatsApp has entered the therapeutic space between psychotherapists and clients and, in all likelihood, is here to stay. Even though clients are again allowed to leave their houses and see the therapist in private practice in their consulting rooms, the Austrian government has not yet decided to regulate the usage of the communication tools as was the case before the pandemic. We can thus assume that they will become part of the therapeutic alliance between clients and therapists. The fact that these technologies allow us to create a different, sometimes more intimate, relationship with the clients should let us embrace these technologies rather than legislate against their use. Cyber-psychotherapy will become part of telemedicine in the near future, and this will be a good thing because it allows clients to stay in their own familiar environment, in case they cannot reach a psychotherapist. Legislation will come in that will regulate the governance and ethics aspect of this kind of telemedicine, such as which software is safe to use and how often therapists and clients will have to meet up in person. However, some other aspects of the therapeutic alliance will have to be redefined if we take video telephony as a unique tool seriously.

My research sample has only been I, so it is hardly representative, but I would like to propose a few aspects that might shape future discussions. First, I think that the online relationship does not impact transference and countertransference. We human beings seem to be able to relate on a somatic level, even mediated by a computer or by a mobile phone. Discussions on the alienating characteristics of these technologies will have to be reimagined because, from my limited experience, these technologies sometimes even allow us to build deeper connections and relationships. Thus, rather than contributing to more alienation, they allow us to relate on different levels of intimacy and privacy. Some aspects of our somatic experience will have to be adapted, e.g., the phenomenon that for some clients, corporeality in the consulting room can be intimidating and hindering their willingness to discuss certain aspectst of their lives, e.g., shame and guilt. The notion of being able to control the environment, crucial for patients with anxiety disorders, might be helpful for them. In conclusion, I would like to suggest that a lot of research is needed to understand the impact of these new technologies on the therapeutic relationship so that they can be used to their full potential.

References

Bashshur Rashid, Elizabeth Krupinski, and Jim Grigsby. 2011. The Taxonomy of Telemedicine. Telemedicine and e-Health 17(6): 484–494.

Borkent, Jenny, Magdalini Ioannou, Jon D. Laman, et al. 2022. Role of the Gut Microbiome in Three Major Psychiatric Disorders. Psychological Medicine 52(7): 1222–1242.

Broschmann, Daniel, and Thomas Fuchs. 2020. Zwischenleiblichkeit in der psychodynamischen Psychotherapie: Ansatz zu einem verkörperten Verständnis von Intersubjektivität. Forum Psychoanalyse 36: 459–475.

Csordas, Thomas. 1993. Somatic Modes of Attention. Cultural Anthropology 8(2): 135–156.

Ehrenberg, Alain. 2010. The Weariness of the Self: Diagnosing the History or Depression in the Contemporary Age. Montreal: McGill University Press.

Finger-Ossinger, Margarete. 2021. Internetberatung und Psychotherapie: Reflektierte Erfahrungen von Psychotherapeuten_innen und Klient_innen. Psychotherapeutisches Forum 25(3-4): 115–123.

Fonagy, Peter. 2008. The Mentalization-Focused Approach to Social Development. London: Routledge.

Frankl, Viktor. 2006 [1959]. Man's Search for Meaning. Boston: Beacon Press.

Gendlin, Eugene. 1996. Focusing-Oriented Psychotherapy. A Manual of the Experiential Method. New York: The Guildford Press.

Ingold, Tim. 2011. Being Alive: Essays on Movement, Knowledge and Description. London: Routledge.

Kirmayer, Laurence. J. 2004. The Cultural Diversity of Healing: Meaning, Metaphor and Mechanism. British Medical Bulletin 69: 33–48.

Kristeva, Julia. 1982. Powers of Horror: An Essay on Abjection. New York: Columbia University Press.

Lasch, Christopher. 1991. The Culture of Narcissism: American Life in an Era of Diminishing Expectations. New York: W.W. Norton and Company.

Levy, Kenneth, and Wesley J. Scala. 2012. Transference, Transference Interpretations, and Transference-Focused Psychotherapies. Psychotherapy 49(3): 391–403.

Lyons-Ruth, Karlen, Nadia Bruschweiler-Stern, Alexandra M. Harrison, et al. 1999. Implicit Relational Knowing: Its Role in Development and Psychoanalytic Treatment. Infant Mental Health Journal 19(3): 282–289.

Mitchell, Juliet, ed. 1987. The Selected Melanie Klein. New York: Free Press.

Rosa, Hartmut. 2019. Resonanz: Eine Soziologie der Weltbeziehung. Frankfurt/Main: Suhrkamp.

Rechtsinformation des Bundes. 2023. Bundesrecht Konsolidiert: Gesamte Rechtsvorschrift für Psychotherapiegesetz. Fassung vom 22.11.2023. https://www.ris.bka.gv.at. Accessed on 22.11.2023.

Waller, Morgan, and Chad Stotler. 2018. Telemedicine: A Primer. Current Allergy and Asthma Reports 18(54): https://doi.org/10.1007/s11882-018-0808-4.

Žižek, Slavoj. 2002. Welcome to the Desert of the Real. London: Verso.