

TELEANALYTIC THERAPY IN THE ERA OF COVID-19: DISSOCIATION IN THE COUNTERTRANSFERENCE

While we and our patients have many transferences to the modality of video or telephone therapy, these meanings are ultimately not intrinsic to the medium itself. Rather, they are symbolic meanings we make of the modality. This paper discusses the symbolic meanings that we attribute to teletherapy and the ways we may use these attributed meanings to dissociate the trauma of Covid-19. It also explores the clinical opportunities in identifying these dissociated countertransferential experiences and embodying them in our own and our patients' experiences.

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As I enter the fourth week of social distancing, I notice a kind of exhaustion at the end of work days that is both new and yet also familiar. I am strangely reminded of my early days practicing therapy for the first time. I believe this familiarity is threefold: I am adjusting to holding and containing a new level of trauma in my patients, I am doing so while processing some of the same trauma in myself, and I am adjusting to a new framework for containing this trauma. The psychic information I am holding is received and processed by me in ways that are different both in form and in the symbolic meaning my patients and I attribute to them. It is not, I believe, that there is intrinsically less or more of a given part of the analytic experience, as I will detail below, but that the ways in which my patients and I *receive* these experiences are different, and we must figure out together how to create those experiences. We

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may be startled, even overwhelmed, by the new places from which a particular part of the therapy comes, or we might struggle to identify where that place is, in part because of the powerful meanings we have given to this new frame. We are often overwhelmed by the ways in which the medium magnifies the dynamics between us and forces us to confront painful experiences, long dissociated or newly so, and serves as a microcosm of the acute trauma now unfolding around and in both patient and therapist.

A common fear about conducting teleanalysis is that use of the medium will allow the patient (or the patient and therapist together) to descend the slippery slope into an enactment: a need for control over the terms of the session and the desire not to come in (Mirkin 2011), a fear of closeness, a patient's fear of putting effort into relationships. But, as both Mirkin (2011) and Ehrlich (2019) describe in detail, it appears that this is a problem not so much of medium as of technique: as in any treatment, if therapists can help patients explore the experience of what is happening, and their response to it, they are more likely to find what is happening helpful (Mirkin 2011).

Russell (2015) suggests that therapists conducting teleanalysis tend to avoid considering the meanings of technological events such as disconnections or a grainy image, or other frame issues that occur in teletherapy, due to the "two-dimensionality" of the medium. However, in her critique of Russell's analysis, Ehrlich (2019) suggests that Russell is interpreting therapists' reactions simply as reactions to the medium of teletherapy, rather than as *transferential/countertransferential* reactions to it. Zalusky (1978) describes a range of reactions, such as fear of colleagues' judgments, guilt about use of a nontraditional medium, and fear of providing substandard treatment; I believe therapists may also fear loss of control of the frame, have intense personal transferences to technology as a separate object, or fear personal constrictions on their bodies, as might occur sitting in front of a screen and needing to remain in view. Therapists thus might defensively respond to teletherapy by dismissing it, like Russell, as less substantial, more subject to analytic error, and more inherently problematic than in-person analysis, rather than examining the meaning of their responses to the medium, as well as their patients'.

Similarly, it is easy to dismiss working from home—a situation many therapists find themselves in during social distancing—as a kind of substitute for the "real thing." Working from home is fraught with emotional

vulnerability for both therapist and patient. Maroda (2007) suggests that therapists with a home office may find themselves having to restrict their family in various ways, and though she does not explore the emotional consequences of this for the therapist, she suggests it places a heavy burden on the family, and on the patient, who may experience guilt and confusion. Though therapists working from home electronically have somewhat more control over their environment, they may nonetheless be aware of a profound vulnerability and fear the patient will see into their living space, picking up information (as Maroda suggests) about their home life, hearing sounds from their families, and wanting to see even more.

I suggest, however, that this feeling of loss of control and breakdown of the frame provides useful countertransference material about the breakdown of the patient's usual ways of coping in the face of crisis and chaos in the external holding environment. It is easy for therapists to respond to their feeling of vulnerability as indicating a problem in the treatment or the frame—as something simply to be “gotten through” in a less-than-ideal treatment situation, a fill-in for the “real thing”—rather than understanding it as a reaction to something real happening in a genuine treatment. This vulnerability and disorientation in the therapist, this sense of existing in a temporary state, even a longing for it to be one, a holding place “in between” rather than being the treatment proper, can make the therapist want to break social distancing rules in order to see a particular patient who “needs” to be seen in person. All this reflects the therapist's agonizing state of mind.

Societal holding structures are crumbling, and our patients' normal schedules have been profoundly and, depending on the nature of their work and their ability to maintain structure at home, at times catastrophically disrupted. Patients are isolated at varying levels, depending on their work and ability to connect via technology. And at varying levels they feel that something destructive and vast is making all of this happen and that no one is stopping it or protecting them from it. To make this all the more frightening, there is no clear timeline for when things will return to normal. Especially for those most severely traumatized, this will be terrifying, as they struggle with the feeling of timelessness and a return to primitive agonies. For these patients the catastrophe will never end: it is here forever. But, as I have suggested, it is not only our patients who experience unbearable states of mind. In doing work in times of national or global catastrophe, we therapists process the same trauma our patients

do, and it can be nearly unbearable to hold the patient's pain when it is our own pain that we must hold within the same frame.

No wonder we find ourselves wishing to disown this work as not "real," to *make* it temporary, to distance ourselves from the falling forever of the patient's experience! We are attempting to undo the trauma of the separation and catastrophic break in going on being by dissociating it from the "treatment proper." In this separate space it is controllable, because chopped out, something with a visible beginning and end, something that can be held as "not mine" and therefore less felt, and it can be manipulated as if a separate reality, to bring the therapist a comforting sense of control. We think, "If I want, I can return temporarily to the 'treatment proper' for a session, because the patient 'needs' it, and everything will be better, and then I will return to this 'as if' treatment, until such time as I decide to go back to 'treatment proper.'"

There can be a tendency for us to distance ourselves from what is happening by treating the trauma not as a *trauma*, but as a *trigger*, in ourselves and in our patients. We and our patients are struggling both with acute trauma and with unresolved traumas that the acute wound has stirred up. Just as when we acknowledge that this *is* the treatment, when we acknowledge that this *is* the trauma and it interacts with old traumas, it becomes harder to dissociate the overwhelming reality of the experience, and we must grapple with the fact that we are traumatized together with our patients, not merely stressed or "triggered."

What does it mean for us if we are traumatized and practicing therapy? Not only does acknowledging the trauma open the door to the overwhelming feelings of the trauma, but we then have to struggle with what it means to us that we are practicing traumatized. We may be afraid we are too broken to help our patients, fear falling apart in session; we might fear that our patients will see our vulnerability and exploit it, or be unable to trust and rely on us; might fear the judgment of our colleagues for practicing in a compromised state, and so on.

What happens, though, if we acknowledge the impact of the trauma? Our patients, of course, know that we, too, are traumatized, and this will have a range of effects on them. Frawley-O'Dea (2003) writes about the impact of the blurring of boundaries (at times uncontrollable) that occurred in the aftermath of 9/11, with therapists expressing their own response to the attacks, sharing whether friends and family members were safe, canceling sessions and/or not charging for canceled sessions, and

allowing patients to use their phones. Patients' responses, of course, weren't uniform or clear-cut, with many treatments opening up, patients describing a sense of increased trust and a feeling of their therapists as more human, and others feeling impinged on by a premature intrusion of the therapist's subjectivity. In the era of Covid-19, such intrusions are both more and less extreme. The event itself is less sudden, and therapists are less likely to break down or cancel sessions; we are less likely to have conversations with patients about who is safe, who has survived. But, on the other hand, we have entered into our patients' homes and they into ours, we have asked them to change their fundamental way of communicating with us, sometimes downloading technologies they are unfamiliar, even uncomfortable with, and many have waived cancellation fees for patients ill with the virus. There is a blurring of boundaries.

But perhaps the most important blurring of boundaries that occurs is psychic: each patient confronts us with a new fragment of our trauma, some more painful than others. Frawley-O'Dea (2003) suggests that we might feel envy toward patients farther along in processing their trauma, or hostility toward narcissistic patients who remain largely unaffected. I would add that these and other patients directly raise the specter of our own unbearable dissociated experience and, by our patients' very need, force us to be with these affects, to experience what has been dissociated. That is, if we can allow ourselves to meet our patients' need and be with them in these experiences. This is a huge if. Can I be with and effectively respond to the anger and resentment of the patient whose blatant disregard for social distancing rules is putting his family in danger, and who complains that loneliness will kill him? Can I do that when, when I am with him, I feel the helpless rage I feel when I watch our ineffective leaders failing to act, when I hear numbers of dead I feel powerless to affect, and hear unemployment numbers climbing catastrophically? How could I not feel a temptation to dissociate his experience, and mine?

The acute trauma also affects our experience of distance in the teleanalytic medium. Ehrlich (2019) suggests that telanalytic treatments do not inherently create distance, but rather unearth deep emotional wounds around distance in both therapist and patient; this situation may be compounded by the profound isolation many patients experience during social distancing. In particular, severely traumatized patients are likely reexperiencing early catastrophic disconnections and may be terrified that this change in their lives and this shift in medium signify the impending loss

of, even rejection by, their therapist. I also believe that the trauma we are experiencing and wish to dissociate may create complex experiences in the therapist around distance. We may successfully dissociate the patient's trauma (and our own) and experience the teleanalytic medium as the thing that creates distance; conversely, we may experience the patient's trauma as overwhelmingly intrusive and attribute the experience to the intrusiveness of working from home or the constriction of needing to stay within view of the screen. The patient, too, will have intense experiences associated with trauma that is more or less successfully dissociated.

Mirkin (2011), unlike Ehrlich, suggests that it is precisely the distance created in teletherapy that is the advantage and opportunity of this medium. However, in speaking of distance, Mirkin describes not emotional distance per se, but rather the safety of *physical* distance, which for the severely traumatized patient creates a sense of increased safety in the emotional intensity. I take a position somewhat between Mirkin and Ehrlich. I believe that in the virtual space, while there is not an *intrinsic* distance created, there is a symbolic *experience* of distance for some patients that can be meaningful. The key, I think, is that the therapist needs to make therapeutic use of this symbolic difference. Zalusky (1998) describes how, when reading the transcript of a session, one typically cannot tell whether it was conducted by telephone or in person. Mirkin (2011) describes a similar experience regarding session-to-session minutiae, but finds a long-term arc in which an overall difference emerges. And this is where I think the symbolic difference comes out: Mirkin's Mr. A has a *transferential* response to the telephone sessions, and she makes symbolic, analytic use of them, which has a meaningful and positive impact on the treatment.

Physical distance is not an experience *inherent* in teleanalytic therapy, but it is a *potential* experience of the medium. Particularly for patients who have experienced severe physical or sexual abuse there can be a literal quality to this sense of increased safety: to some parts of the severely traumatized patient, there can be a felt experience of increased physical safety—a knowledge that the therapist is *there*, not *here*, and cannot hurt me. But this can cut both ways, particularly with the use of video therapy, as mentioned above, when there can be a feeling that the therapist is “in” my home.

Just as Mirkin's Mr. A found her presence less overwhelming by telephone—no longer painfully aware of the scent of her perfume and the

sound of her sighs, he had greater access to his thoughts—so my more traumatized adult patients have commented on the experience of finding me less overwhelming by virtue of their having less physical information about me. In short, I am less impinging. One highly interactive child patient commented on my decreased intrusiveness and the increased space for his fantasies by pausing to put on a puppet show for me between games; another showed me artwork he had been longing to share for several sessions but had been too anxious to show me.

But what about the patients for whom the experience of video therapy is, at least for parts of them, *more* intrusive? What about the experience of the therapist as *in* the patient's home? Child patients may want to literally show therapists their rooms, their belongings, or even their entire home, while adults are more likely to experience this longing only in fantasy. Some patients are terrified of the therapist's seeing their spaces, or feel deep shame. Many will feel both terror and a longing to "show." This will be especially true in severely traumatized patients, who may be dissociatively organized and have disorganized attachment, and who will have multiple conflicting models of the therapist. In a therapeutic context that is unfamiliar, in which the patient may feel either more in control, less, or both, these models of the therapist might feel more extreme, conflicting, and pronounced than usual. We become the longed-for good parent and the intrusive abuser; to manage this, the "showing" might become an opportunity to omnipotently control us by "moving" us about the patient's space—and so on.

Physical distance also raises the question of physical *presence*. Many therapists fear that teletherapy removes the body from the work. As at any other time, the frame is ultimately located inside the therapist, and our difficulty in locating it comes down in no small part to our trauma-shattered sense of self and newly disorganized ways of relating to the other. When we find ourselves searching for bodily experience in the therapy, we might conclude that it is missing from the therapy when in fact we are having trouble locating it inside ourselves; or perhaps we do not want to locate our bodies, which are, after all, carrying our trauma. When we then struggle to help our patients find their own resonant bodily experience, we become more certain that it is absent from the medium itself, when in fact there are still two bodies responding to powerful internal and relational experiences. We miss the ways in which, as in many traumatic experiences, our relationship to our bodies has been

disrupted, and the transition to the new medium becomes a way for us to dissociate from the full disruption we are experiencing: it is not *I* who am disrupted; it is the therapy. Thus we create an experience that can be felt as finite, controllable, and “not me.”

There is much here that has potential meaning, but I must repeat that I do not believe that *any* of these experiences are inherent in the medium of teletherapy. They are potential symbolic experiences that it behooves us to attend to and make use of in the oversaturated space in which we currently find ourselves working. Indeed, as with any other aspect of treatment, the meaning of each element may be utterly transformed by changes *within* the therapist or patient. What I think is more universal is the experience with which I began this paper: the unbearable overstimulation of finding ourselves processing information through an entirely new frame, indeed, of actively relocating the frame in ourselves and in the emotional space; of understanding and making meaning of our own and our patients’ intense transferences to this new frame; and of holding an ongoing, acute trauma, in our patients and in ourselves; and the intense need to dissociate what is unbearable. There is, in this, an opportunity, if we can bear it, to understand our own and our patients’ trauma.

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