Absent Bodies: Psychotherapeutic Challenges during COVID-19

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\textbf{Keywords}
Intercorporeality · Online psychotherapy · Therapeutic meeting · Qualitative interview · Embodied trust

\textbf{Abstract}
\textbf{Introduction:} The paper's main aim is to analyze the theme of psychotherapy which, during the months of lockdown, has undergone a considerable transformation as it moved, in many cases, to the virtual modality. The scarce literature on this subject is divided between those who maintain that the screen establishes a relational distance between the patient and the therapist (disengagement theory) and those who instead consider it an element that stimulates and facilitates communication (stimulation theory). \textbf{Method:} Utilizing a qualitative and phenomenological interview, which allowed me to collect the testimonies of therapists and patients, I will try to understand if and how the fundamental components of psychotherapy and clinical encounter have changed. \textbf{Results:} I will describe how the lack of bodily resonance affects psychotherapy and emphasize the centrality of often-underestimated elements such as the atmosphere and setting. \textbf{Conclusion:} I will finally argue that what is missing is indeed an embodied trust which, in my view, is necessary for a successful therapeutic relationship.

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\begin{itemize}
\item Introduction

The Therapeutic Meeting as an Embodied Encounter

In a beautiful text, Minkowski describes the therapeutic encounter in these terms: “It was like two melodies being played simultaneously, although these two melodies are as dissonant as can be, a certain balance becomes established between the notes of one and the other and lets us penetrate a little further into our patient’s psyche” ([1], p. 182). The clinical meeting seems to be a matter of resonance – an encounter between living bodies that affect one another. We can claim that it is indeed this peculiar symphony that establishes the foundations for treatment. The mutuality of the therapeutic encounter has been largely described by psychoanalysis [2, 3], while the phenomenological account has emphasized how the subject is inextricably linked to her bodily dimension (being a \textit{Leib}, not a mere organic \textit{Koerper}). Accordingly, every encounter, including the clinical one, is a meeting between two corporeal and affective subjectivities that influence one another through their gestures and expressions (see [4] for the notions of intercorporeality and interaffectivity).

It is through the body that the patient expresses herself in an implicit manner, and the therapist can grasp important cues about the experiential dimension of the per-
son in front of her. Accordingly, the therapist herself is a living, corporeal subject with her own affective and bodily dimensions that characterize her in a specific manner and play a fundamental role in establishing the therapeutic relationship [5]. From this awareness, the therapist ought to begin creating a dialogue that gives voice to the patient’s painful disconnection from the lifeworld. The clinician should be “embodied aware” of herself (for the notion of “embodied awareness” in the clinical encounter, see [6]), focusing not only on the patient’s body or her own impressions but also on their encounter as embodied persons. In fact, “…as an embodied being, the psychiatrist always and already finds herself in an intercorporeal connection with the other person,” and she knows “…how to interpret the bodily presence of the other person and responds in the form of attunement or that of disengagement, for example, to the body of patient” ([6], p. E−92).

It is not the aim of this paper to go deeper and describe how psychotherapy works: my aim is to analyze how clinicians and patients have experienced online psychotherapy. I also do not want to reduce the entire psychotherapeutic process to a corporeal dimension, leaving aside the narrative and reflective moments of this experience. As I also argue elsewhere [5], we can understand the clinical meeting as an “expressive common environment” where the corporeal, prelinguistic components and the narrative, reflective ones work together. However, the formers are necessary for the arising of the latter. Furthermore, the clinical meeting is usually described as a “face-to-face relationship,” “a relationship in which the participants share time and space, perceiving one another” ([7], p. 223).

If the therapeutic meeting is a matter of embodied subjects1 resonating with one another, how can this kind of encounter change if it moves from offline to online life? And what happens if the participants do not share the same space in which the encounter takes place? Are therapy’s effects always the same even if the patient does not directly see or perceive the whole body of the therapist and vice versa but instead her facsimile?

These questions do not sound odd nowadays: in the context of the COVID-19 pandemic, many psychotherapists have found themselves at a crossroads – substantially transitioning their normal practice online to continue providing therapy for most of their patients. This has required everyone, even the most skeptical, to adjust to using new technologies.

Online Interactions: Preliminary Observations

Given the extensive use of online communications prior to the pandemic, an open debate about the quality of these kinds of intersubjective exchanges existed already. Schematically, we can find two contrasting theories: disengagement theory states that online communication negatively impacts psychological well-being. The underlying assumption is that the Internet is a poor “virtual substitute” for face-to-face communication [10]. Stimulation theory holds, on the contrary, that online communication fosters the enrichment of the individual’s relational context and promotes opportunities for growth and adaptation [11].

It is not the aim of this paper to completely deny the value and the usefulness of online communications and of those devices (like WhatsApp, Skype, Zoom, etc.) which proved to be extremely helpful especially in the last 2 years, allowing many of us to cope with difficult situations (such as being abroad alone during one of the lockdowns, or with no possibility to physically attend seminars or other activities because of the quarantine). Furthermore, I acknowledge that, like Osler [12, 13] describes, despite the reduced perceptual richness and the different temporal structures, online interactions are indeed proper interactions: they represent a specific “subjective extendedness” [14] – a specific way we live spatiality, and they have a peculiar style and intensity. Osler argues that even the activity of texting (for instance, in WhatsApp chats) owns a communicative style, thanks to which we can perceive the conversation’s rhythm like in a face-to-face meeting. Furthermore, many researchers [15–17] support this kind of interaction: they claim that the Internet enables new styles of encounters that are characterized by more freedom and equality. Even though I recognize that online communication can represent a proper form of interaction and can even foster empathy, affective attunement, and collective awareness, I would like to make some general observations:

Despite the fact that I acknowledge online interactions are indeed possible and have some advantages (such as to reduce the distance, to allow for collective stances, to favor equality, etc.), I still agree with those researchers ([18–

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1 In the psychotherapeutic debate, a central element is represented by “epistemic trust”: “an individual’s willingness to consider new knowledge from another person as trustworthy, generalizable, and relevant to the self” ([8], p. 373). In my view, a central component of epistemic trust is indeed an “embodied trust”: before attributing mental states to others, we have to immediately perceive them in an intuitive and bodily manner as living bodies like us. Also Rocco [9] emphasized the role of embodied, co-present interactions in building trust.
To start with, the rhythm that is involved in our face-to-face conversations is undoubtedly different from the one we can perceive in text conversations: while in the first case we can rely on gestures, gazes, the tone of the voice, etc., in texting, we can only rely on what we see (if the other person is writing or rewriting a message, or if she is online but ignores us, if she uses emoticons). We can infer her emotions or mental states, maybe we can even grasp them, but we will need to rely more on our capacity to contextualize, on the narrative components (the words themselves), and also on luck. Maybe she is texting and re-texting because she has no connection, or she does not use emoticons because she personally does not like them, and not because the conversation is getting serious. However, in the offline encounter, it is certainly easier to immediately grasp these features and their shades. Without denying the fact that texting with another person (or group) indeed possesses a rhythm, I therefore would like to emphasize that online interactions own a peculiar kind of rhythm that is different from the one we can register in physical encounters.

The case of empathy can provide another example: even though we can indeed feel empathy without being physically present to one another, this feeling would lose its intensity. Not being physically present initiates a sort of “distancing effect”: we can find ourselves deeply sorry if we watch a video on Facebook representing the current situation in Afghanistan, but our feeling can be immediately changed into something else once we scroll down to another kind of video. Of course, I would easily feel empathy toward a dear friend of mine if I see her crying on Skype, but this is because I already have familiarity with her: I perfectly know how she expresses herself, and I can move my intercorporeal knowledge3 online.

Then, the quality of collective actions is different, and we cannot compare it to the offline ones. Let us take the example of a class action: it is true that online we can easily find more people with whom we can communicate and with whom we can feel similar and understood. We can create a Facebook page or a blog, where we post news, announcements, or whatever we find interesting for our cause: we can engage in deep discussions – we may find ourselves willing to defend our online peers if someone starts to be aggressive toward them. Then, we decide to meet offline in order to walk all together and defend our cause in an important city.

We will notice how this last action not only requires a more concrete and important engagement toward the cause but also owns features that are missing in the online space: atmosphere, embodiment, and coordination. The atmosphere I feel when I march for a cause with thousands of people who rhythmically coordinate their movements and loud slogans is completely different from the atmosphere I feel during a House Party or Zoom meeting, even though these options can also make me feel engaged with a group. In offline collective interactions, the intercorporeal attunement can allow us to spontaneously coordinate our movements, like during a strike or a concert. This is because in offline interactions the involvement of our bodies allows for a pre-reflective, spontaneous synchronization where we can register an emphasis on the protentional horizon (and improvised movements). Here, we usually spontaneously coordinate between individuals who have not necessarily planned to perform that action or movement together [22]. Differently, in online encounters, it is easier to find reflective and explicit synchronization, a cooperation that can be planned as voluntary but misses many pre-reflective components.

In other words, I believe it is easier to find actions that need “joint intentionality” online and actions requiring “we intentionality” offline. This could be why autistic subjects feel at ease in activities like playing online games: this does not require a spontaneous synchronization with others (which is the core problem of autism) but specific rules to follow and roles to attend. Nonetheless, when it comes to online psychotherapy, even autistic subjects register difficulties.

At a first glance, in fact, we can think that autistic subjects have finally found their dimension in online interactions, also in the case of online psychotherapeutic sessions. Even though this can be true for what concerns

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2 To compare online and offline communication, arguing for the priority of the latter over the former is not the scope of this paper (we would need another work entirely committed to this aim). My goal is to clarify how psychotherapeutic encounters suffer from the lack of the embodied meeting.

3 In other words, I already have an “embodied trust” toward her, and this facilitates the understanding of her emotions.

4 Nowadays, a concrete example is offered by the so-called No-vax movement: usually, these people meet online and share news (for the majority fake news) and opinions. We can also claim that they feel like a “we,” like a strong collective identity, and in fact, I am not denying that online we can build shared awareness and collective intentionality. Again, what I would like to emphasize is the fact that this kind of awareness is still different from the offline one, mainly in terms of intensity and engagement.

5 There are two forms of collective intentionality [23]: joint intentionality, which is distinctively goal-oriented and usually relies on explicitly formulated codes of conduct, and we intentionality, which is at stake when the individual perceives herself/himself as being part of a group and considers her/his mental states as contributions to that group, without a specific goal.
joint intentionality and those activities like games which involve clear rules and roles, and generally rely more on cognitive abilities and reflective stances than on pre-reflective spontaneous features, it seems this is not the case for psychotherapy or other activities where you have to “improviser.” Unfortunately, for the present study I did not have the chance to include autistic patients, but as a teacher and researcher in psychopathology (especially in autism studies) I had the chance to talk with many of them and their caregivers. They all agree that in online communication (for instance on Zoom or Skype) the self-image on the screen represents a huge problem, hindering to focus on the conversation; furthermore, the difficulties they have offline in terms of interpreting and grasping others’ gestures and expressions are even more dramatical when they are online and can rely on facial expressions only and on that visual gaze that they usually want to avoid.

In other words, what is at stake in psychotherapy, as seen in the previous paragraph, is not a space of interaction regulated by specific rules and easy, practical aims to achieve. It is a matter of living, embodied, resonant, and often dissonant subjectivities that try to rely more on what has been untold, on gestures, and even silences. As many studies confirm (see in particular [24, 25]), there is widespread agreement that embodied features are crucial in the psychotherapeutic process. This is why focusing on online psychotherapy means to take into account a specific kind of interaction, not only because the implicit and nonverbal aspects play a substantial role, but also because in this kind of therapy, the involved characters are not provided with the abilities that each of us already has and can usually use in online communications. Psychopathologies, in fact, all involve a disruption in the social sphere: accordingly, we have to work with persons whose main problem is how to interact with others and learn how to restore familiarity with the social world.

Therefore, in the case of online psychotherapy, it seems even more difficult to choose if this kind of communication is effective or not. For these reasons, the main question that guides this paper is as follows: is online communication a form of disengagement, keeping a distance between patients and therapists, or a form of stimulation, connecting them more tightly, within psychotherapy?

6 For instance, a student of mine, diagnosed with high-functioning autism, explicitly told me that in case we will have to move our meetings online (because of the pandemic situation), he would prefer to write me long emails since he finds online interactions unbearable in terms of stress and comprehensibility.
I relied upon qualitative thematic analysis \[26, 27\] to analyze the collected data by grasping specific recurrent themes that, in my view, correspond to essential features of the therapy that registered a profound change. Thematic analysis is an easy and practical method for identifying, analyzing, and reporting patterns (themes) within data. By “theme,” I mean something that “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” \([27], p. 10\). Of course, to avoid being influenced by the questions that guided my work and given that the interviews were semi-structured, I discussed the themes with the interviewees and we have been actively engaged with one another. The conversations have been recorded to allow me to work on the collected information and engage in reflective interpretation.

I am aware that the number of the interviewees is relatively small and it is very difficult to generalize their reports. Nonetheless, I found significant the fact that they all agree (patients and clinicians) on the main points. Being a qualitative study, I also agree with Smith \[28\] who claims that “statistical types of generalizability that inform quantitative research are not applicable to judge the value of qualitative research or claim that it lacks generalizability” (p. 137). Instead of considering data saturation, qualitative research (in particular thematic analysis) relies on information power \[29\] which is mainly related to the quality of the dialogue and participants who own a higher specificity for the study. In the debate about qualitative analysis, it is commonly accepted that approximately 12 interviews are sufficient \[30\]. Following Braun and Clark \[31\], I believe that the point is still the quality of the information and how the researcher is able to interpret them. In particular, for the present study the sample size was dictated both by practical reasons and by the need to achieve a balance and an hermeneutic depth: the sample size needed to be small enough to allow each first-person account to be analyzed in full qualitative detail. Although the sample size of the present study limits definite conclusions regarding online psychotherapy and its techniques, it encourages to keep attention on how this kind of therapy is lived by patients and clinicians.

**Results**

The collected reports revealed 7 important themes. As far as the therapists are concerned, it is interesting to note that the answers were quite similar, regardless of their school of origin. The fundamental points that emerged support the thesis that the lack of intercorporeal exchange entails the danger of “ghosting” the other person, “disembodying” \[^7\] the encounter itself. These two aspects can be seen throughout all of the points that we will discuss below detailing the dominant changes in therapy which emerged during the transition from an intercorporeal encounter to a virtual one.

**New Patients: Diagnostic and Therapeutic Difficulties**

First, it is quite significant to notice that the majority of the therapists decided to continue the treatment with previous patients but not with new ones. Establishing a therapeutic arrangement with new patients seems to be more challenging because the online format presupposes a minor commitment from the patient’s side, who can decide more easily to leave the therapy or even the single session if she is not satisfied. Furthermore, the personal relationship built over time with existing patients seemingly allows an echo of the live encounter to remain online. In other words, long-term knowledge allows a sort of implicit reconstruction of the presence of the other. Another reason is the difficulty a therapist would experience in formulating a diagnosis. As one participant stated: “A lot of features related to somatic impressions, projections, etc. are muffled.” This is because “The diagnosis is made by the observation of many small details that go beyond what the person tells you or can prove to you. In the end the screen is focused on what you want: it is as if a part of the patient could remain more easily in the shadows. But the shadows are the main features of the therapy... Intersubjectivity is changed, it’s weird, and it’s difficult to sense and feel who is on the other side.”

**The Prevalence of the Narrative Dimension over the Experiential One**

We can record the prevalence of the so-called “extended empathy” \[18\], which is primarily based on the imaginative representation of the other and does not rely upon the (inter)corporeal dimension: “You have to trust the story, the content and not the form. It is difficult to di-

[^7]: The paper “The Virtual Other. Empathy in the Age of Virtuality” written by Prof. Dr. Dr. Thomas Fuchs in 2014 has been fundamental for the development of my own reflections. In particular, the notions of (a) “phantomization” and (b) “disembodying” are introduced in that article, and they, respectively, signify (a) the process through which in online reality, the body, deprived of its organic needs and multimodal sensations, becomes a purely functional one which works according to the online media and situation; (b) the change that happens in online communication: in the virtual realm, “Instead of interacting with embodied persons, we interact more and more with pictures and symbols” (18], p. 167).
rectly experience what is happening, you have to interpret”; “It’s like living a scene rather than an experience.” Here, the gap between a primary kind of empathy, conceived of as an immediate, corporeal, and implicit understanding, and an intersubjective comprehension based on an “as if” mechanism is evident: the imaginative components and the explicit comprehension capacities prevail above all because, precisely, it is not possible to enjoy an immediate corporeal resonance and an automatic interaffective exchange. Instead, it is as if they had to be artificially constructed, starting from verbal and narrative elements. There is a kind of ideo-affective dissociation, a gap between what is heard and what is the emotional and affective resonance that the narrated experiences have on the patient. While in the face-to-face encounter it is easier to dissolve these tensions and grasp the correspondences and implicit resonances between the narration and the inner experience, there is an accentuated opacity in the online interview.

In fact, the expressiveness itself changes. It is difficult to understand the other intuitively – to discern between affective, incidental gestures and to attribute meanings to understand the other intuitively – to discern between emotions that usually enables the patient to become aware of it, whereas in online interaction, recognizing an emotion in the body that moves and expresses itself through its gestures, and more time is needed to connect and start the session. The decision of who starts the session times unchanged even though virtually the patients could have changed them.

Others try to adapt the setting in a way that enhances bodily communication:

“... As far as my position is concerned, I have dedicated a specific place in the house, always the same, and I have planned a shot that not only captures the face but allows me to be seen by the patients at least half-length. I am a person who gesturers a lot and my patients often point this out to me. I believe that my way of communicating, deprived of this dimension, could have resulted as deprived of a vital and less authentic component.”

However, the peculiarity of online therapy is that the patient suddenly becomes co-creator of the setting. In traditional therapy, the therapist manages the setting: the waiting room, one’s consultation room, the distances between the armchairs, the objects, the presence of plants, etc. The therapist welcomes the patient in a place that speaks for herself. In online therapy, these features are missing but several others emerge, for example, the place from where the patient and the therapist choose to connect and start the session. The decision of who starts the video session must also be agreed upon in advance. According to the Gestaltist, these features, although significant, do not change the theory of therapy. On the contrary, it is all new material to explore: “Does the patient always call her first or wait for me to call? In both cases it is therapeutic work material that becomes significant material because we have come out of the obvious ritual that makes me, for example, go to meet the patient in the waiting room. This allows us to come out of an acquired and taken for granted ritual and therefore reveals relational movements that would otherwise be covered by the ritual on which we normally rely.” Another feature I want to emphasize is that both the patient and the clinician can enter into one another’s intimate home space.

Revealing personal space can have positive effects: “I have seen that my patients are less defended as if they felt

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8 Opacity is a term that Husserl, the father of phenomenology, uses to describe the fundamental element of the intersubjective relation: the experiences of others will always remain inaccessible to me, opaque, because I will never be able to live them directly, just as I will never be able to perceive directly the motivations for the behavior of others. For this reason, he stresses the importance of the interpretation of movements, which is much more useful than a simple observation. It is therefore clear that, if we also lack intercorporeality, opacity becomes a radicalized element in online interaction, to the point that not only will I never be able to live the experience of others because we are two unique and unrepeatable individuals, but I will not even be able to fully understand the other – something that both Fuchs and Illouz warn against. The result is often that people try to do this by projecting their own emotions and experiences onto the other.
less threatened and therefore some have opened up more.” Nonetheless, as a patient said:

“The context makes the difference more than anything else: at home I don’t have that feeling of real detachment that comes to me in my therapist’s room. When I usually enter there, it is a place where everything can be said, and when I leave, it stays there, as in a safe place. Doing therapy from my home creates much more promiscuity of environments. When I have finished I often continue to brood or cry for a long time. As if the switch wouldn’t go off and all the pain would come out”.

Nonetheless, it is interesting to observe both what changes in the patient and what changes in clinicians. One participant disclosed that she feels a little more vulnerable being at home; she feels a little less protected by her professional role, as the patient somehow enters her intimate places (an element we can describe as the therapist’s and patient’s vulnerability). This opens up the field for another crucial issue: the fact that both therapist and patient are living bodies. The patient has to deal with the fact that beyond the screen there is another human person, with her own vulnerability and subjective experiences. Moved outside of the professional environment, the therapist can be perceived in another shape, in a decontextualized space where it is even more difficult to establish a safe relationship.

The Embodiment of the Therapist

We should not forget that the therapist herself is a living body, an active part of the mutual resonance established in the therapeutic encounter. So, how does the online meeting affect the therapist’s living body?

“During the session, there was a tendency to bring attention to the higher part of my body because, probably, there is a mirroring of the body part I see of my patient, and therefore there is a risk that I lose a more global body sensitivity.” There is a loss of spontaneity in the kinesthetic bodily exchange:

“I’m learning to intentionally focus body sensitivity when I work through the screen. These are processes that must come into play in a more intentional way, I have to remember more to feel what I feel at the level of my legs, of my belly; the risk is to go a little more on sensory aspects that are visual and less kinesthetic.” In contrast, body memory also seems to need time to adapt to the new situation:

“Sometimes, after a session, I instinctively wash my hands (as I did after my face-to-face meetings, between one patient and another) and this makes me reflect on how in some way my mind has recorded the physical presence of the patient.” So, we have a sort of “desynchronized embodied memory.”

Furthermore, the therapist experiences an effort in focusing on her own body to confirm her attention: it is as if she were trying to amplify her proprioception to control her movements given possible reactions of the patient. In this way, intercorporeality and the spontaneous and circular arising of affective actions and reactions could be further compromised. In this regard, one therapist claims to have started to pay attention to avoid going out of frame, explaining every single movement to the patient (for example, if she has to bend down to pick up a pen on the floor). In general, it seems that it is necessary not to appear distracted, although the new setting and the mediation of the screen make this task somewhat difficult.

Interpersonal Atmosphere

When referring specifically to clinical meetings, Costa writes:

Atmospheres are bodily resonant qualities of the lived space, manifest as affordances that build on the multimodal sensorial continuum of experience and guide our intuitive grasping of reality…clinicians rely mainly on the pre-reflective experiential realms, such as lived body and space, through which the expressive qualities in atmospheric perception, could for instance be described as expanding, retracting, being light or heavy, empty or full, floating, undulating or flat, etc. ([36], p. 7).

Usually, the atmosphere of the session is something within which communication takes place. It is a horizon that is drawn immediately in which and from which meanings emerge. One therapist stated: “If I meet a patient who has a depressive experience there is a depressive field between us in which, for example, there is an implicit spatial force that pulls down, there is an implicit
temporal force that slows down time and in which the horizon shrinks; this is how I can perceive a depressive field: through an atmosphere that deforms the space-time in which the air is heavy and dark.”

The online meeting is deprived of the presence of the living body as a whole and is mediated by the screen. This mediation hinders the creation of a meaningful, pregnant atmosphere. A therapist strictly linked to phenomenology says “The screen is something more. A superstructure, which requires additional work and that I should put into brackets. The problem is: How much can we make it invisible-and let it not hinder our attempt to meet”? Another one said:

“Normally for me the phase of the patient’s entry into the studio has particular relevance in determining the (initial) climate of the session. When the patient rings the intercom, I also open the studio door so that I am already at the door when she arrives. This allows me a very brief observation of her arrival, and very often I find myself thinking “it will be a difficult session” or “today she is in a good mood,” or maybe “she seems like another person,” etc. Often this first climatic impression is useful in the course of the session. In the online work the patient is just there, and this “climatic preliminary” is missing. Besides this, if I think about it, I am a therapist who often during the sessions thinks inside herself about the emotional climate (“today we are far away,” “we are in perfect harmony,” “there is electricity in the air,” etc.), lately, I make fewer observations of this kind, and I am more inclined to keep analytical attention on the contents proposed by the patient.”

Relying only on what they see through the screen, it seems impossible for the agents involved in the online encounter to perceive and feel an inter-bodily atmosphere. Contrariwise, the screen itself is perceived as a structure, adding more “layers” to the masks that patients can normally assume. The lack of an atmospheric foothold, of an intuitive feeling that usually succeeds in grasping even fundamental elements (for example, the “prae-cox feeling” for schizophrenia [40]), makes the encounter with the patient much more challenging and artificial.

**The Therapeutic Relationship (and the Quality of the Therapy)**

All of the therapists registered a worsening of the therapeutic relationship. Basically, this is because “We have to do with an image, and not with another ‘other’”; “I struggle with the absence of a possibility of understanding which, in my case, relies a lot to the presence and observation of the body in action in the room”; “The absence of the bodies of analyst and patient does not allow to appreciate those phenomena which arise from resonance; they are difficult to evaluate even with patients in vis-à-vis because, in my opinion, the intermediation of the screen has a negative effect in this sense.”

Also, the increased intimacy emerging from the altered setting alters the relationship, and from the patients’ side, we can register different reactions: for some patients, being suddenly allowed to enter the therapist’s house and vice versa elicits the perception of the therapist “as more human” and facilitates the exchange of information. For others, this exchange is uncomfortable and intrusive12. Other participants talk about online therapy as something that has “distancing effects” between themselves and the therapist. This perception can have negative consequences on the quality of the therapy: from a phenomenological perspective, the therapeutic relationship is a dialogical, intercorporeal space, whose primary components are pre-reflective, interaffective elements that converge into a participatory “we-subject.” The clinician and the patient aim to find shared meanings and build a path together that can allow the patient to readjust her field of possibilities. In online therapy, the limits of the living body, which suffers from the mediation of the screen and also from the fact that it can only be seen, and not touched, smelled, or holistically and atmospherically felt in its kinesthetic and affective dimensions, make difficult the therapeutic process and all of those mechanisms linked to it.

**Embodied Trust**

The major issue that emerged from the interviews is what I call “embodied trust.” This element represents an essential aspect of the living space between therapist and patient and also helps establish that attention and awareness to vulnerability which calls to those who deal with psychopathology (but not only).

In fact, both clinicians and patients complain about losing or weakening a good therapeutic alliance. The mediation of the screen, the impossibility of a holistic perception of the other, the different settings, the feeling of intrusiveness, the intentional attempts from the part of the therapist to be perceived as always focused, and the consequent loss of spontaneity, all make very difficult to trust in the other and in the therapy itself. As argued by Dolezal ([41], p. 23), “Even the most sophisticated technological interface cannot compensate for the lack of em-

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12 In their paper, Garcia et al. [35] call this feature “horizontality”: “a more symmetrical interaction where the separation between roles becomes less sharp” ([35], p. 12).
bodied proximity that comes from face-to-face contact with another.”

We can therefore affirm that simply seeing and listening to the therapist cannot replace that physical proximity which, itself, helps generate trust. This is clear also in other studies [42] where the centrality of trust and its problematic role in the online relationship has been introduced: “To decide whether the therapist is trustworthy, whether the session is just a customized lesson in theory or whether it can be a life-changing opportunity, it is necessary to hear the tone of voice, see his or her expression up close, and perceive the full size of the therapist” ([42], p. 324). Physical presence is even more significant when treatment is aimed not only to reduce symptoms but also to address the underlying personality disorder. In this case, the therapeutic alliance is, per se, the most powerful therapeutic tool [43]. “Trust” is not an explicit attitude, but a kind of felt, bodily openness to the other person. This embodied, affective trust is a key element of the therapeutic meeting and has a dual nature: it influences and is influenced by the shared, resonant space (a space which is primarily bodily and not mediated).

**Conclusion**

In March 2020, the world came to a standstill: the intercorporeal meeting became something to be avoided, and most of our activities moved online, including psychotherapy. How can we deal with this kind of encounter? And, more specifically, how to deal with an encounter with people who are experiencing “a limit situation”? In this text, using a series of qualitative interviews, an attempt has been made to shed light on the lived experience of patients and therapists, and to find the main characters of this “encounter between images without bodies”13. The analysis highlighted fundamental structures (diagnosis, setting, atmosphere, embodied trust, therapeutic relationship, embodiment, narrative dimension), that seem to have been profoundly changed by this kind of meeting. The centrality of intercorporeality has indeed emerged, showing the limits of a communication deprived of that pathic dimension that usually pervades our existence.

In other words, we can conclude that psychotherapy is not an exchange of words; it is communication between bodies. The (partial) return to face-to-face therapy would seem to confirm these intuitions, given the enthusiasm expressed by patients and therapists. Therefore, it seems significant to conclude with their words, pronounced when one of them resumed the group analysis sessions in person (albeit at a safe distance and wearing masks):

> “Before I felt more our physical body (Koerper) as almost stuck, now I have a clear perception that our lived body (Leib), the body we are, suddenly escapes from the physical body, just like an evanescence, and mixes within the group space. It happens, like this, something paradoxical: that we, even though we can’t touch each other, actually touch each other. We touch each other without touching. We touch ourselves inside the living flesh, inside the naked structure of life” [44].

For sure, the future will see ourselves more and more immersed in a hybrid reality that reduces the space among us but still not the distances. In order to cope with these changes, especially when what is at stake is the psychotherapeutic meeting, we need to defend “the naked structure of life,” made up by ineffable atmospheres and permeated by an essential sense of embodied trust. While prioritizing face-to-face, offline interactions still remains central, we can also design more effective online spaces, for instance, by allowing to see each other’s bodies in their whole, or using virtual reality devices able to simulate a real encounter. In other words, our corporeal, kinesthetic self should be elicited as more as possible and with it the pathicity of our (offline) existence.

**Acknowledgments**

I would like to express my gratitude to all patients and therapists, who accepted to share their experiences with me, and to Professor Thomas Fuchs who kindly encouraged me to write this work. I am also very grateful toward the two anonymous reviewers who helped me a lot to develop and clarify my theses.

**Statement of Ethics**

Written informed consent to participate and use the collected data in an anonymous form for publication has been obtained by the interviewees. According to the national guidelines, this study was exempt from the need of ethical approval.

**Conflict of Interest Statement**

The author has no conflicts of interest to declare.
This work has been partially funded by the Fritz Thyssen Foundation (research project number Az. 40.18.0.033PH) and by the Research Foundation Flanders (FWO, project 3H200042). There has been no influence on preparation, conducting the study, and writing processes.

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