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I didn't think you were listening. Some Reflections on Online Setting and Patient Proxy in the Remote Clinical Relationship

Angelo Raffaele Pennella [1], *Giuditta Maria Bignami* [2, 3 *]

Abstract

Background: The limitations imposed by the SARS-CoV-2 pandemic on social relatedness (use of Personal Protective Equipment, interpersonal distancing, suspension of face-to-face activities, etc.) forced psychologists and psychotherapists to suspend face-to-face clinical activity for several months. The use of video calls (e.g., WhatsApp, Skype) and videoconferencing (e.g., Zoom, Meet) was the only way to avoid the interruption of psychotherapy and psychological counselling. However, the shift from offline to online psychotherapeutic settings has raised interesting theoretical and technical questions about how to consider the frame of clinical intervention. This article aims to contribute to the reflection on the characteristics of the online setting (videoconference) and its differences and specificities compared to the traditional setting.

Methods: The article proposes a clinical case treated in an online psychotherapeutic setting. The intervention was carried out in the context of a counseling and psychological support service of an Italian university.

Results: After a brief presentation of the case - a young adult with anxiety symptoms - the article describes a relational episode that occurred during a video-call interview (Skype). On the one hand, the episode highlights the characteristics of the patient and, on the other, how the online setting facilitated the expression of the patient's relational patterns.

Conclusions: The case refers to a young adult who seems to develop interpersonal relationships based on presence/absence. The others (parents, partners) are always described as lacking something and, therefore, in some way, "absent". The patient himself is described as lacking something (e.g. masculinity) and shows himself unable to be fully present in situations. However, the theme of presence/absence also characterizes the online psychotherapeutic setting: presence is disembodied, lacking physicality. On the one hand, the clinical case highlights the need to understand the characteristics of the online setting better, and on the other hand, the importance of always keeping frame and process connected. It is fundamental to remember that what happens in the setting and is always an integral part of the clinical intervention.

[1] Lecturer in Clinical Psychology at the Specializing School of Health Psychology at University of Rome "Sapienza", Rome, Italy

[2] Health Psychology specialist, Psychotherapist. Bologna, Italy

[3] Health Psychology specialization School, University of Rome "Sapienza", Rome, Italy

E-mail corresponding author: giuditta.bignami@gmail.com

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1. Introduction

1.1. Background

The SARS-CoV-2 pandemic has generated unprecedented health, economic, social and psychological emergency. The high risk of contagion, conveyed by droplets and physical touch, has made necessary personal protective equipment (PPE), interpersonal distancing, suspension of all social aggregation activities. Although essential to contain the spread of CoViD-19 and its impact on the National Health Service (Bartoszek et al., 2020; Luchetti et al., 2020; Rossi et al., 2020), all of this has affected people's quality of social engagement and their psychological well-being (Cao et al., 2020; Christakis, 2020; Di Giuseppe et al., 2020; Grover et al., 2020; Saltzman et al., 2020; Serafini et al., 2020).

Also, the psychologist's mode of work and the instruments usually used for clinical and psychotherapeutic intervention, primarily the clinical setting (McBeath et al., 2020; Poletti, 2020; Rochlen et al., 2004; Santhiveeran & Grant, 2006), had to adapt to the new "pandemic situation" (within this expression we include all the consequences of the health emergency). The most noticeable expression of this adaptation has been the shift from an in-person to a distant relationship, resulting in a transposition of the clinical setting from offline to online, thus conceiving the need to set a remote clinical relationship.

However, this massive migration has highlighted the limits of our models of framing the psychotherapy setting, and more generally, the clinical practice (Aafjes-van Doorn et al., 2020; Békés et al., 2020; Boldrini et al., 2020; Fasano & Mandolillo, 2020; Migone 2013), thus making it necessary to reflect on the "frame" of remote treatment. The boundaries of the online framework are, in fact, more fluid, and the device that mediates the interaction alters some of the fundamental characteristics of the offline setting (just think about the impoverishment of nonverbal communication).

However, in the face of changes to the external structural setting, it is not possible to ignore it by stressing the centrality of the internal mental setting only: the clinical relationship is not, in fact, just an encounter between disembodied minds, detached from external reality, but an encounter between people located in the same "world". Therefore, it is necessary to ponder how the remote clinical relationship intertwines the external setting (material dimension) with the mental dimension (mental dimension). With the support of a short clinical vignette, the present work tries to contribute the scientific reflections on the psychotherapeutic setting that have been developing throughout the past few months in psychotherapy literature.

1.2 Setting Functions

In brief, the clinical setting can be thought of as "a space-time area bound by rules that determine roles and functions in order to analyze the emotional meaning of the patient's experiences within a condition specifically constructed for this purpose" (Galimberti, 1999, p. 962). Therefore, this kind of setting is primarily identifiable in a place and a time called upon to welcome a psychological intervention. The development of a particular mental stance, an internal "space" that allows the mind of the other in the room to be recognized, is also facilitated when the material and procedural conditions of the frame are defined. It is, therefore, the synergy between factual conditions (external setting) and mental conditions (internal setting) that allows the development of the clinical and psychotherapeutic intervention (Bolko & Merini, 1989; Pennella, 2013a)

As we conceptualize it, this setting does not merely circumscribe and accommodate the process; it also promotes and supports it. Clinical psychology and psychotherapy blur the customary distinctions between picture and background, container and content, delimiting structure, and active component (Langs, 1998). The objects that make up the material setting - the same goes for the procedural components, however - are not there to just be used in their tangible features: "they will appear in ideas and dreams, and will then signify the analyst's body, his or her breasts, his or her arms, his or her hands by infinite variations. To the extent that the patient has regressed [...] the couch *is* the analyst, the pillows *are* the breasts, the analyst *is* the mother from a time in the distant past" (Winnicott, 1975, p. 343). For this reason, objects *must* be objects, that is, that they possess a solid, concrete element in order to possess an equally solid symbolic element to them: one cannot, for example, "symbolize a door using a curtain" (Semi, 1985, p. 18). However, often there is a tendency to separate the material dimension from the mental one and both from the clinical process (Bolko & Merini, 1989) as if we were not dealing with a complex and integrated system (Pennella, 2013b).

Therefore, the therapy setting performs several functions as an instrument. The first of these functions, as mentioned earlier, is to circumscribe and differentiate a portion of reality, recognizing it as a "space-time" in which the clinical intervention is embedded. Therefore, the setting establishes a boundary between the inside and outside that refers to what happens inside (mental dimension) as different and meaningful. The second function is to isolate and protect the space of relational interaction from the potential intrusion of elements of reality present outside of the setting (i.e., the entry of strangers during an interview) that could disrupt, in the broadest sense of the term, the clinical process. Finally, the third is to establish the conditions

necessary to facilitate the suspension of emotional enactment. The material and procedural components of the setting are thus structured to inhibit the emotional enactment and to facilitate the development of a more intense psychological outcome, a thought process upon the patient's enactment. In essence, the setting offers the psychologist and the patient the most favourable conditions for translating the non-symbolic into the symbolic.

In summary, the therapy setting allows people to experience the needed support, a feeling of trust, safety, good holding, assistance in getting in contact with reality, a container within which one can think upon emotions. All of this is now immersed within a new and atypical relationship, the remote clinical relationship.

1.3 Observations on the online nature of the therapy setting

As reported by some authors (Leffert, 2003; Migone, 2003, 2013; Richards, 2001; Vallario, 2020; Zarem, 2001), the use of technological tools in psychology is not new; think of the so-called "telepsychology" (Baer et al., 1995; Mitchell et al., 2008; Nelson & Bui, 2010; Nelson et al., 2011; Reed et al., 2000; Ruskin et al., 2004) or telephone-mediated psychotherapeutic experiences (Mermelstein & Holland, 1991; Mirkin, 2011; Saul, 1951; Scharff, 2012). The point is that these practices were confined to peculiar long-distance situations in which the remote relationship was the only option possible for clinical work to unfold (patient relocation, illness or disability, geographic constraints). However, in recent years, thanks to the use of the internet and modern digital technologies, resorting to videoconferencing in clinical psychology and psychotherapy has rapidly soared (Carlino, 2018; Fishkin & Fishkin, 2011; Fishkin et al., 2011; Saporta, 2008; Scharff, 2012, 2013), although it often remains a subordinate option to vis à vis interventions.

The benefits of the long-distance relationship are many: among others, it facilitates access to psychotherapy (e.g., for people who live in rural areas or where psychologists/psychotherapists are not available or for people with mobility impairments); it reduces the social stigma perceived by some people when they have to see a psychologist/psychotherapist; and it increases patients' feelings of self-efficacy (Sperandeo et al., 2020; Stoll et al., 2020).

Research has also shown no statistical difference between of online and face-to-face psychotherapy (Backhaus et al., 2012; Noorwood et al., 2018). In a recent review of 18 empirical studies, Poletti et al. (2020) demonstrated, for example, that online psychotherapy is substantially equivalent to face-to-face psychotherapy. Notably, data demonstrate the efficacy of telepsychotherapy in the treatment of anxiety (Berryhill et al., 2019; Catarino et al., 2020), depressive symptoms (Egede et al., 2015), and post-traumatic symptoms (Wierwille et al., 2016). Of course, there are still aspects to be understood, such as managing the therapeutic alliance

and its possible fractures (Cook & Doyle, 2002; Simpson et al., 2021) and the characteristics of empathy in an online setting (Sperandeo et al., 2021).

Online psychotherapy has always been met with doubt and perplexity (Russell, 2015). Many psychotherapists are convinced that it is less effective than face-to-face psychotherapy (Gordon et al., 2016) and, at least prior to the pandemic, had never used the long-distance relationship.

The SARS-CoV-2 pandemic drastically exaggerated this situation. What previously was an alternative and subordinate option has become, at least for most psychotherapists, the only viable solution to provide continuity of care. In this scenario, it is possible to think about the extent to which therapists found at the beginning of the pandemic that therapists found themselves managing an unfamiliar situation that needed time to be assimilated and fully understood (Békés et al., 2021; Cantone et al., 2021). Some qualities of the remote, online setting are pretty distant from those of a face-to-face relationship. For example, in an offline setting, the psychotherapist and the patient meet in a place "designed" by the therapist and for which the therapist is fully responsible. On the other hand, in an online setting, the two find themselves in two distinct and separate spaces, far from each other, and enter a "third place" (cyberspace) with its distinct qualities. In the remote relationship, the therapist delegates to the patient the responsibility of identifying and protecting his or hers external physical setting in which he or she dwells in at the time of the remote encounter.

In situations of a "double setting" (Pennella & Spaccarotella, 2020), the therapist may therefore be confronted with non-functional, "non-clinically appropriate", and "unusual" environments (cars, public parks, balconies, bathrooms) or witness the sudden entry of third parties (parents, partners, children, pets). The online setting may also be less effective in suspending emotional enactment. The patient may engage in similar activities (e.g., reading messages or emails) without being "caught" by the therapist or may "act out" behaviours that are experienced as "normal" (standing to open the door for a courier, moving from one chair to another) to the extent that they escape the clinically relevant process of "meaning attribution".

The pivoting towards remote relationships have also changed the pace and rhythm of the before and after time frame leading to and ending the therapeutic encounter. Accessing the meeting is quick, the "path from here to there" instantaneous, at the click of a mouse or the tap of a touchscreen. The time length approaching the clinical encounter, the clinical setting, is crunched, and this is a time where the patient may invest in reflecting upon the content to be offered to the therapist in their meeting, or in recovering memories of the previous meeting, or in simply mentally preparing for the upcoming clinical encounter. Similarly, we may speak of

the reflections, mental processing, allocated within the time frame following the therapy session. Once the clinical session is over, the patient finds him or herself, with a simple *click*, alone once again, without a "decompressing transition" between the reality of the clinical setting and the patient's reality. The therapist's office room, framed by the webcam, disappears instantaneously leaving no opportunity to anchor the lived experience to it (Russell, 2015).

The online clinical setting also entails an impoverishment of non-verbal communication. In a video conferencing meeting, the visual and auditory channels predominate, while the nuances of technology-mediated communication take a toll. Just think of eye contact. In remote therapy, mediated by a telehealth device (notebook, tablet, smartphone), it becomes impossible to "reciprocate" eye contact. Our eyes do not land on those of the other person we are talking to, but simply on the screen or on the webcam. The clues that we usually pick up on to assess the psychological state of the other we converse with (Whittaker, 2003) are impoverished or non-directly accessible to the therapist's observation. Maclaren (2008) asserts that eye-contact between mother and child expresses humanity and intentionality, and actively seeking it is an attempt to establish a relationship with the other. Baron-Cohen (2011) emphasizes the importance of eye contact in assessing emotions and the psychological state of others, but what are the chances of this unfolding in front of an often unclear and grainy image? One may then have the impression of looking into the other's eyes to establish relational contact, but ultimately, this ends up being just a simulation of contact (Russell, 2015).

However, it is essential to note that the current pandemic has also changed the offline setting. In this period, the use of EPPs hinders verbal and nonverbal communication: among other things, there is more difficulty in listening and it is difficult to capture emotions expressed with facial expressions. In addition, some patients experience EPPs as alienating and threatening, thinking of the depressed or paranoid (Pal et al., 2020). Thus, EPPs can hinder both the psychologist/psychotherapist's assessment and interaction with the patient (Mehta et al., 2020).

On the other hand, the presence of the third party - the technological medium - which we often tend to place in the background of our attention to the point of losing awareness of it is far from irrelevant. The speed and stability of the internet connection, the video and audio quality of the devices used, the contingent problems of apps and platforms are issues that can "break into" the relationship reminding us that there is always someone else in between us.

In essence, the structure of the online setting is quite different from that of the offline setting, but this does not necessarily imply its "inferiority". Online psychotherapy is not only practical but is also liked by the majority of patients (Cioffi et al., 2020), who often perceive the therapist

as "closer" and empathetic (Sperandeo et al., 2021). The need to use online psychotherapy during and after lockdown has also generally reduced the perplexities of many psychotherapists (Bèkès et al., 2021) bringing them closer to a setting that will be increasingly used in clinical practice.

2. Method

The clinical material used for the reflections proposed in this article is taken from the reports of online psychotherapy initiated during the national lockdown (Decree of the President of the Council of Ministers - March 9, 2020).

The psychotherapy was carried out within the framework of the psychological support service of an Italian university. The service offers free counselling and psychotherapy to university students and young adults. To have access to the service, it is necessary to fill in a questionnaire and an informed consent form. The service includes four exploratory interviews aimed at understanding the request. In the end, based on the assessment made, it is possible to benefit from further interviews weekly and for a fixed period in an individual or group setting. Following the SARS-CoV-2 pandemic, all in-person activities have been replaced with interviews conducted on Skype.

2.1 M's online psychotherapy

The declared reason that prompted M., a 25-year-old off-site university student, to seek psychological help was his increasing difficulty using public transportation. After getting on the bus, M. begins to feel mounting anxiety that disappears as soon as he steps off the bus. He finds himself forced to walk long distances, often arriving late for appointments. When he travels by train on his commute to home, he tends to sit near the doors, repeating to himself that he will quickly leave the train car once at the station. M.'s concern is to "feel bad and show ill" in front of strangers; he is embarrassed by his discomfort but also fears that no one will help him if he needs support.

M. is a sensitive, thoughtful person with a sharp sense of humor. He is curious and eager for self-improvement. However, especially in the first interviews, he speaks about himself with uneasiness; sometimes, he gets intimidated by a possible judgment the psychologist may make. Originally from a small town in central Italy, his family consists of his parents and a sister. His father, described as terribly busy working, appears to be a relatively marginal figure, while his mother, who works at home as a hairdresser, is described as very present. M. says that he grew up surrounded by family's women whom he considers his role models. His mother has always

been concerned about the judgment of others and has therefore carefully managed the way the family should come across to others. Attentive to order and cleanliness, she raised M. and her sister to take care of household chores early in childhood.

M. reports that his fear of others' judgment has always held him back, especially his homosexuality for example, he says that he would have liked to dye his hair blond when he was a teenager, but his mother forbade it because it would have been too conspicuous, and "others would have talked". M. has also felt inhibited in his clothing: he has always wanted to wear colorful and flashy clothes, but the fear of judgment and rejection has pushed him to prefer rather large and bland pants and sweatshirts.

M. believes to be "inadequate" as a man, not just because of a feminine demeanor but also because he lacks an athletic body type.

M. has been living in Bologna for three years and over the past few months he has been living with P., his current partner, who is a few years older than him. M. describes him as a tall and muscular man with interests and activities much more "masculine" than his (among other things, P. plays rugby). Before P., M. had another relationship with D., a refined and cultured young man with sophisticated intellectual interests. On the one hand, the relationship with D. was characterized by the feeling of a strong connection; on the other, by M's numerous betrayals, the last of which with P.

Recently, P. has decided to buy a small flat in residential building which M. does not enjoy. M. would not even have wanted to buy this house because he still feels too young for this kind of commitment; however, he did not express his opinion; on the contrary, he offered to participate in the purchase.

3. Results: a relational episode

In the first two meetings, M. initiates the Skype connection as if he had just woken up, appearing sleepy, in a still dark room. He tends to remain silent, struggles to tell his story and often limits himself to answering questions. From the third meeting on, he begins to be more active, to describe his difficulties with more detail and involvement.

In one of the first interviews after the exploratory phase, M. shares of having called on the phone his ex-boyfriend on the occasion of his birthday. Recalling their relationship, he adds that he used to get along well with him; he had an attractive way of speaking, a polished language that M. has always tried to emulate. There was a solid intellectual affinity between them that was missing in his current relationship with P.

Presumably from the next room, P.'s voice breaks in, engaged in a telephone conversation. M. continues in his story as if he did not hear the loud voice of his partner. He then adds that he has not shared anything with P. about his phone call with his ex-boyfriend, but M. does not feel guilty; he finds nothing wrong with this omission.

Meanwhile, the tone of P.'s voice has become more excited, the volume louder. Nevertheless, M. continues to speak as if nothing had happened, almost as if his partner's voice - which is rather annoying and disturbing to the psychologist - did not exist. At this point, the psychologist intervenes, pointing out to M. P's loud presence. To the observation, M. answers with surprise: "I didn't think you were listening".

4. Discussion

As mentioned above, we intend to propose some reflections on the online setting by taking as a pretext the case of M. In this regard, it is helpful to note that M. describes his romantic relationships as lacking something. D. is intellectually lively but lacks athleticism; P. is physically fit but lacks cultural interests. One could therefore hypothesize that in both relationships, the "presence" of the other is incomplete, as well as M.'s "presence" to his relationships. The betrayals acted towards D. or the omissions made towards P. express, in fact, the limits of his ability to be present to them. On the other hand, the fear of judgment and rejection has pushed him to hide aspects of himself and not declare them to the other person in his relationships.

The presence/absence dichotomy is recognizable in many elements of M.'s story: think about the parental couple (mother present and father-absent) or about the anxiety on buses (he cannot be "present" to the end of the bus ride, so much so that he needs to get off the bus early) or even about the financial support provided to P. without sharing his emotional struggles. The presence/absence dichotomy also seems to characterize M.'s relationship with the psychologist. As we might remember, the consultation starts with a sleepy patient - therefore not fully present to himself - and not very willing to share his story. On the other hand, the online setting also seems to lack something: bodily presence or, to be more exact, intracorporeal (García et al., 2021).

Presence/absence, then, as a possible key for interpretation.

Going back to the relational episode, faced with P.'s voice interfering in the therapy setting, M. "pretends nothing happened". He could have asked P. to lower his voice, invited him to close the door of the room he was in, or told him to go somewhere else. Why not do so? Perhaps, we think, because he would have had to declare himself. Asking for something might imply

displaying oneself to the other, facing the risk of censorship and rejection (think of the request he made to the mother about dyeing his hair). Therefore, "pretending nothing happened" is a way "to be there" and at the same time "not to be there", to be present as well as absent, to talk to the psychologist without declaring it (to the partner) and at the same time not being fully present to her.

The "pretending nothing happened" stance appears to be a way to avoid confrontation with the cumbersome presence of the other person. A way of "being with the other" that M. also offers the psychologist in their relationships. Although implicitly, M. asks her to "pretend nothing happened", to not listen to P.'s voice. The psychologist, however, raises the question, she signals P.'s intrusion in the therapy setting and refuses, in fact, the collusive request (Carli & Paniccia, 2003) of the patient by declaring her own, and others', presence. M. responds with amazement: "I didn't think you were listening". An expression with a suggestive polysemy: on the one hand, it can be understood as "I didn't think she was listening (to him)", on the other hand, "I didn't think she was listening (to me)", in that she was "present" at the moment.

Incidentally, we might mention that not saying anything to P. about the phone call with D. is analogous to not saying anything to the psychologist about P.'s voice suddenly barging into the online therapy setting. In both situations, the "third party" appears as an element of potential conflict and rupture, to be ignored and kept in the background (the marginality of M's father in his background narrative becomes interesting here). In any case, if we consider this episode as a re-enactment of a relational pattern of the patient, what could it say about the therapy setting?

From this perspective, we could say that the online therapy setting is more permeable than the offline one: undoubtedly, if the clinical session had taken place offline, in the therapist's office, the event in question would not have happened (Drum & Littleton, 2014; Markowitz et al., 2020; Palma, 2020). In all fairness, intrusions can occur even in the therapist's office: a ringing cell phone, construction work just outside the building, a discussion between office neighbors in the hallway. Nevertheless, we believe that a crucial point here should not be found in the greater or lesser degree of efficacy that the online nature of the therapy setting has in isolating the therapeutic relationship - think of what often happens in public mental health services, for example - but in the shared responsibility that this kind of therapy setting entails.

The online therapy setting in remote clinical sessions produces both a split in the physical environment frame and a necessary revision of the clinical relationship contract (a procedural component of the therapy setting) that impacts the role and functions of both the patient and the therapist (Pennella & Spaccarotella, 2020). In our case, for example, the fact that the

psychologist is unable to protect the therapeutic relationship from P.'s intrusions risks to assign her a role similar to that of M.: in front of the other who "speaks" one cannot but be inhibited in one's own freedom of expression. Therefore, the psychologist's intervention is not only limited to highlighting P.'s intrusion in the psychotherapeutic setting but also intervenes upon the same setting by questioning a role that M. takes for granted. When considering the shared responsibility, delegating part of the external structural features of the therapy setting to the patient has at least two implications. The first implication is that the patient's cognitive and emotional skills to differentiate a portion of space-time and use it as a container for the therapeutic relationship are granted. Suppose this cognitive process is accessible and expected from some psychotherapy patients, for others. In that case, it might be frankly challenging to perform, as for those who are characterized by a chaotic internal world, by poor integration of the Self and by the instability of interpersonal relationships. This leads to thinking carefully about the clinical profiles of patients who can benefit from remote types of psychotherapy settings. However, this delegation of responsibility to the patient also highlights a necessary compromise made a change in the therapist's role. The therapist no longer offers the patient a safe environment; the patient must provide it for him or herself. Although some patients show up to therapy already possessing this capacity, others ask for psychological services precisely because they are compelled, since early childhood, to "contain on their own". Winnicott's theory (1975) come to mind. When the caregiver does not adequately support the child, one of different possible outcomes is the development of a defensive "self-holding": namely, the formation of a False Self, compliant with environmental demands. Therefore, one might suggest that sharing responsibility to different aspects of the external setting with the patient might reinforce this mental formation and facilitate the development of an "interminable analysis", perhaps accompanied by an illusion of change (Russell, 2015).

The presence/absence dichotomy described earlier does not just pertain to the patient in our clinical vignette but also underlies the remote nature of the therapy setting unfolding online. The remote relationship is built on just a partial presence of the person in which the missing, absent element is the body, namely its flesh. This distinction is not irrelevant: the flesh allows us to feel and to locate ourselves in the world surrounding us- it is, therefore, a subject that feels itself - while the body is the flesh made visible to others, turning it into a hetero-perceived object and, in essence, what makes us someone's object (Stanghellini, 2020).

By not allowing patients and therapists to "inhabit" the same physical space, that is to locate their flesh in the same place, the setting unfolding online does not allow bodies to communicate fully. It, therefore, deprives the relationship of those somatic and sensory archaic experiences –

learned but not mentally processed experiences (Bollas, 1987) - that can only be actualized and conveyed through the flesh. The absence of the flesh, along with the absence of touch, smell, make the encounter inevitably partial, incomplete, lacking those elements on which our "being with" the other is often based: a smell, a perfume, the warmth or firmness of a couch pillow. Vice versa, sight and hearing are saturated and limited by the camera angle or quality of the device's audio hardware or internet data bandwidth. Auditory and visual stimuli are salient. These stimuli risk acquiring intrinsic value. Faced with viewing objects, activities or listening to noises or voices that burst into and over crowd the online setting (as in P.'s phone call incident), one can be led to believe that the meaning of these perceptions is obvious, immediate: that P. is "clearly" and "inevitably" annoying and invasive. In other words, images and sounds risk being accepted in their most superficial and concrete meanings. With its exclusive reliance on images and sounds, the therapy setting in remote could facilitate the tendency to simplified attribution of meaning in which "things are just things", especially if one has them right in front of one's eyes.

From this perspective, it is, therefore, crucial to develop in psychotherapists the ability to be "present" in the online setting. This means, among other things, staying in touch with one's own body and emotions, using countertransference to understand the patient's emotional experience, grasping patients' micro-expressions (Geller, 2020). Despite the impoverishment of nonverbal communication, the long-distance relationship, in fact, retains important information through facial expressions, gestures, and prosody.

5. Conclusions

The increasingly widespread dissemination of Internet accessibility and the increasing performance quality of communication devices have made the use technological tools viable in clinical psychology and psychotherapy services. This favoured a tendency in the field to compare the "in presence" with the remote relationships, the offline therapy setting with the online therapy setting, often to assign dominance to one or the other. However, this is a misleading way of pondering the question, as it even recalls, to an extent, the historical contrast between the supine position of the patient on the psychoanalytic couch and the *vis à vis* position sitting in the armchair (Lingiardi & De Bei, 2008). Proving the efficacy of online psychotherapy is not of core relevance we believe, on which, however, interesting data are already available. The issue does not linger in whether a remote psychotherapy setting is better or worse than a traditional "in presence" one, but in being able to theoretically justify this technological solution in our clinical work (Migone, 2003). Even when a comparison between offline and online therapy

settings is made, the goal cannot be to identify a winner between the two but to favour a thought process upon the features and specificities of these instruments and how they support and guide the clinical practice. The psychotherapist-patient relationship is always influenced by the very nature of the therapy setting, whichever this may be. It is, therefore, necessary to reflect on the specifics of the remote therapy setting and on different ways in which this setting integrates with the therapeutic process. On the other hand, it is clear that offline and online settings may find different areas of use but may complement each other depending on the patient's needs and stage of therapy (Eichenberg, 2021). The relational episode highlights the importance of keeping the frame and the process connected, thus reminding that what happens *in* the therapy setting and *on* the therapy setting is always an integral part of the clinical intervention.

Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any potential conflict of interest.

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