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IS THE DIFFERENCE BETWEEN REMOTE PSYCHOTHERAPY AND PSYCHOTHERAPY WITH DIRECT CLIENT CONTACT RELEVANT?

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online therapy
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Summary

Objectives: During pandemic, what was offered to patients on a large scale was psychotherapy in the form of video interviews. The psychotherapeutic community, however, seems to be convinced of the inferiority of this form of work with patients. We undertook research to verify the rationality of this belief by asking whether the difference between remote psychotherapy and psychotherapy with direct client contact is relevant, i.e. whether it concerns the essence of what psychotherapy is.
Methods: In the research we used a phenomenological analysis of our own experiences of conducting psychotherapy in the form of video interviews and participating in psychotherapy training in the form of meetings using audio-visual channels. We explored in detail two phenomena that potentially distinguish these two forms of psychotherapy practice, namely the indirectness of person-to-person contact and long-distance communication.
Results: We conclude that the crucial difference between remote psychotherapy and psychotherapy with direct client contact is that in case of the former one, the patient's immersion in virtual reality, where the meeting with the therapist occurs, must be accompanied by an anchoring in a real-life space, where s/he is exposed to others. The fact that the therapist offers his/her office as a safe haven to the patient is, in principle, a way of creating better conditions for the healing process. Nevertheless, offering remote psychotherapy in a pandemic situation — with the therapist's office no longer a physically safe space – is in accordance with the essence of psychotherapy.
Conclusions: At a time of „high-risk office", the provision of opportunities for psychotherapy in the form of video interviews is an expression of concern for patient which, together with an attitude of openness and hospitality, constitutes the essence of psychotherapy, while the form of psychotherapy appears to be secondary importance in this respect.

1. Introduction

Since during the COVID-19 pandemic, it was necessary to temporarily close the offices and for many therapists, the decision to continue therapeutic work in the form of video calls meant leaving the comfort zone associated with the traditional office setting[1]. Each school of psychotherapy defined general their own recommendations for their members[2], however, as the regional pandemic spreading rate was changing, various specific problems needed to be resolved on an ongoing basis. One of them was whether, and if so, when patients, who during the lockdown period decided to continue psychotherapy in the form of video interviews, will be required to return to the office. Each decision, whether made as part of individual understanding or based on the position of authority, is based on some assumptions about the difference between psychotherapy conducted with office contact and conducted as online psychotherapy. Since returning to work with office contact was considered as real option (with the persistent risk of viral transmission), it means that this form of practice was implicitly evaluated as better than the online form. What does 'better' mean in this case? Who is it better for? In what respect is it better? Because it is longer known and therefore easier to carry out, because it is a prototype established by tradition, or maybe it is better, because it covers some important aspects that are absent online? Criteria for higher evaluation of practice in face-to-face contact need to be exposed, for example to make it clear whether the risk of returning to the offices is worth taking during the ongoing pandemic (after the hard lockdown has been loosened) or is an unjustified risk to patients' and therapists' health.

When we proceed to thinking about the title question, which is the main research problem, we are inclined to give up all expectations as to its result. As a result of this analysis, a statement can be made that the difference between psychotherapy in the form of in-office meetings and psychotherapy in the form of video calls is significant, or a statement that the difference is insignificant. In the latter case, of course, it is not a matter of denying all differences, but what matters is merely a statement that they do not involve the essence of what psychotherapy is. What exactly do we mean when we say, 'online psychotherapy is not the same as in-office psychotherapy'?

We raise the issue of how significant is the difference between psychotherapy provided in the office and psychotherapy in the form of video calls in the context of a real chance (risk?) for psychotherapy to become more popular through tools of remote communication with the audio and visual channel. It is actually possible in Poland only for several years, since – both in offices and in households – broadband Internet access has become

[1] In 2017, in the survey conducted by correspondence on a sample of 199 people (the questionnaire was sent back by 16% of the total number of 1,220 members of the Scientific Section of the Polish Psychiatric Association invited to participate in the study), it was found that 'only 12.2% of the therapists surveyed were ready to use online psychotherapy as the sole way to contact a patient. The most biggest group (59.8%) were people who considered online contact as a supplement to direct psychotherapy (complementary model). 24.9% of the respondents would not consider conducting online psychotherapy under any circumstances; 3.1% of respondents did not have an opinion in this subject' [1, p. 58].

[2] A quickly and precisely expressed position of the Polish Psychiatric Association [2] on working with children and adolescents and working with adult patients was an example that puts in order the work with minor patients in this chaotic time [3].

widely available that allows to hold undisturbed communication in the form of video calls. While fifteen years ago, considerations on making psychotherapy via the Internet more popular were a thought experiment, because only every tenth patient and probably not every therapist had a sufficiently efficient Internet connection, now 90% of people have the technical possibility to use this kind of help [4][3]. The fact that starting from 2020, benefits using video calls are funded by the National Health Fund, as well as announcements that telemedicine will remain in use on a larger scale than before, also after the pandemic ends (press release, PAP, 2020) [5] is an additional context for the discussion.

2. The Method

First author's experiences in psychotherapy in the psychodynamic approach under the NHF contract for adult and adolescent patients with various diagnoses in the pandemic period from its announcement to writing this article, and experiences in using training psychotherapy in the psychodynamic approach, as well as both authors' experience in using supervision and practical classes of comprehensive training in psychotherapy at the training centre recommended by the Polish Psychiatric Association are the material for the phenomenological analysis.

We use a phenomenological method that should not be considered identical to phenomenological doctrine, so in our analyses, we will not refer to any research results of phenomenology, its doctrinal assumptions or the views of individual representatives. The reason for this treatment of the phenomenological method is its own cross-border peculiarity[4], which allows it to be treated as one of the methods of modern thinking. With that, the phenomenological method not only can be positioned, as J.M. Bocheński does it [7], as one of methods that are used in non-philosophical sciences, but it can also be successfully used in these sciences [8]. For us, the phenomenological approach means, in particular, an attempt to describe the experience as unprejudiced as possible under the conditions of bracketing the beaten track knowledge and scientific theories.

The main research question is the title one, i.e.: is the difference between psychotherapy in the form of video calls and psychotherapy in the form of an in-office meetings significant, in the meaning: does it involve the essence of psychotherapy? When we attempt to answer, we accept a certain paradox. A strict phenomenological analysis of the essence of

3) Of course, this does not mean that 90% of patients can use online psychotherapy. Apart from an efficient connection, the use of psychotherapy in the form of video calls requires a certain minimum of technical conditions that let the patients to make the conversation confidential.

4) In a broader view, not limited only to the method, but also to the environment in which it was born, the spirit of philosophy is accurately conveyed in the words of J. Patočka: 'philosophy is nothing else than life (devoted to thinking) corresponding to the principle of total responsibility of thought. The responsible attitude is one where a view applies to the appearance of things, rather than the other way around. As we can see, the very responsible attitude lets you live in truth, makes possible the essence of philosophy and the whole science that has not lost ties with it. On the other hand, living in truth is rationality. Well, this life in truth as a particular kind of *bios* was the idea of the ancient Greeks. They have established it as a continuous tradition where the meaning can be rediscovered, renewed and enriched over and over again thanks to this very ability to find [6, 29].

psychotherapy would be a gigantic work that could result in a very extensive text, which, to our knowledge, has not yet been created. At its starting point, the research project is therefore doomed to a certain inaccuracy, because it is unable to refer to the explanation of the essence of psychotherapy, we are looking for landmarks for examining the differences between traditional and online practice by referring to what psychotherapy is. In order to be in line with the phenomenological tradition, we refer at the beginning of the research to a definition that – as we know – was formulated on the basis of the experience in practicing psychotherapy as a treatment method and which is consistent with our experience of providing and using psychotherapy. Jerzy Aleksandrowicz is its author[5]. We will reduce its definition in a way. This reduction consists in particular in disambiguating by referring to phenomenal intuition, the concept of 'psychosocial impact' of a mechanistic provenance, which seems to be the weak point of the definition. While doing the reduction, we temporarily assume that individual psychotherapy is a series of regular, approximately one-hour patient's meetings with a therapist that allow to establish of a meaningful interpersonal relationship within contractual boundaries where the therapist treats a patient's mental health disorders and intellectually and emotionally refers to the content contributed by a patient to their dialogue during the meetings.

This temporary attitude to thinking about the essence of psychotherapy allows us to ask two detailed questions that emerge within the area of possible differences between the office and the online form: (1) the question about the quality of communication (does the new form allow to 'refer intellectually and emotionally to what a patient contributes to the dialogue'?) and (2) the question about the quality of the relationship (can a meaningful relationship be established in the online form and can it have a similar meaning as in the traditional form?).

3. The Results

3.1. Is psychotherapy in the form of video calls different from psychotherapy carried out in office in terms of quality of communication between a patient and a therapist?

The main difference that is – so to say – immediately given to us when we juxtapose a meeting[6] in an office and an online meeting, comes down to the fact that we understand the

[5] According to the definition by Jerzy Aleksandrowicz: 'Psychotherapy is a form of psychosocial interactions that aims at the correction of disorders of experience and behaviour, and is intended to remove the symptoms and causes of the disease, including personality traits that cause disturbances in experiencing. While influencing the functional state of organs, experiencing and behaviour by changing patient's mental processes, these interactions are exerted within the interpersonal relationship between two people or in a group' [9, pp. 11–12]. In an important article that explains the difference between psychotherapy and psychological counselling, Czesław Czabała also refers to this definition [10].

[6] We use a fairly capacious term 'meeting' in the meaning that fits in the framework of the target detailing, which is a 'psychotherapeutic meeting' that has a more precise and specific purpose. Up to this point we can assume that the purpose of the meeting as such is, as defined by J Tischner, entering into the personal truth of a man we met [11]. At some level of understanding, moral or metaphysical, there is a strong conceptual

former as a direct meeting, we define it as a meeting: *face to face*, eye to eye. Meanwhile, a remote meeting is a distance meeting and requires something extra (a device) to take place.

If we consistently think about the directness of a meeting, which we intuitively evaluate positively (direct meeting seems to be better than the mediated one), it turns out to be relative. Indeed, what is crucial in presence that is characteristic for a meeting is 'some kind of, even if very limited, self-turning towards the other' [13, p. 29]), while this 'self-turning [...] is involved in corporeality' (ibid., p. 35). Hence, the so-called directness of the meeting is determined by the corporeal presence, the physical closeness of two people. However, not the whole body plays an equal role in a meeting. It is dominated by a face that focuses the expression of our peculiarity, our self. It is due to a face that we fully express our humanity,[7]our individuality, we manifest our experience, but also the content of our consciousness, originally – only directly accessible to us, in a verbal (speech/language) and non-verbal way[8]. Face refers to the inner world, i.e. to what is perhaps most important to us in meeting the Other; it transcends towards the interior, the depth; it makes that when we perceive the Other, we are not only a living body, a dynamic object, a thing; and due to the face of the Other, He/She is also something more to us, — Someone[9]. Our body, in particular our face, making it even more detailed – eyes and lips), all our physicality, to a different extent, performs the function of being a medium. We are not a body, but we have a body (which is also expressed in language – we use phrases like: my body, I have a body), which is for us, in a certain sense, a conscious, and in a sense, an unconscious tool to express the inner world. Therefore, our body is the primary mediation of communication in direct contact. It is not the only one, as W. Drath, Sz. Nęcki notice [1]: 'Perhaps online therapy does not so much make the communication with a patient indirect, as it adds another

association between *true* and *healthy*. For Plato, a healthy soul (psyche) is a soul that exercises truth (alethea) [12]. Additionally, the meeting may be one-off, incidental, but still important, meaningful. The series of meetings may, but does not have to, become the basis for the creation of a relationship or a deep bond.

7) It does not seem that it is possible to analyse this expression or this expression of humanity only on the basic physical level without reference to transcendence, without distinguishing what is presented to us – as it were – directly from what is hidden behind it. It is equally doubtful that all the qualities given to us are only the sum of the more basic qualities. On the contrary – it can be reasonably assumed that it is also necessary to take into account what R. Ingarden calls 'character qualities' [14], i.e. a specific facial expression or a characteristic gait. These assumptions are in part in line with the description of the phenomenon referred to as *uncanny valley*, and in part they provide an opportunity for new interpretations.

8) Of course, it is not impossible that getting to know each other, including the dimension of other people's mental states, may also be direct, in the impossible that it is not accompanied by verbalisation, and it is carried out with the use of a category developed by E. Stein, i.e. empathy (Einfühlung) [15], which should not be understood as identical with the concept of empathy (ἐμ-πάθεια – suffering; ἐμ-πάθής – touched, moved) or compassion based on imagining or recalling identical processes, and even less telepathy (see Aleksandrowicz 'The hypothesis of the influence of >psyche itself< would first require proving the existence of telepathy itself' [16, p. 22). It is a much simpler phenomenon, although its development is much more complex. Following Ingarden, it can be expressed very generally as a form of bridge a gap between subjects, however, it remains controversial whether some physical (non-verbal) carriers are the necessary condition for it, this position seems to be taken by Stein, or whether this necessity does not exist (Ingarden).

9) There is a fundamental difference between the I-You relation and the I-It relation, which is not based only on the change of the second element of this relation (It to You), while maintaining the invariability of the I, this I in both cases is basically different, so you can to say that everything is radically different here, both members of the relationship and the very relationship between them [cf. 17].

mediation, and, at the same time, it allows to make this indirectness visible. Contact with a patient is always mediated – through the language of words, gestures, intonation, and cultural forms' [1, p. 62]. In view of the above, it should be noted that in contact mediated by a computer network, the practice of psychotherapy in the form of video calls by pointing computer cameras to a patient's and the therapist's faces retains the essential values of a face-to-face meeting. Both a patient and the therapist can freely and clearly follow facial expressions [18, 19]. Any significant differences between the therapeutic contact in the form of in-office meetings and in the form of video calls should be looked for beyond the notion of directness or indirectness.

Now, the quality of mediation of the therapist's contact with a patient requires a more detailed study, as they use computers connected in the network in their mutual communication. How does exactly this mediation mediate? While being an intermediary, does it convey messages accurately in communication, doesn't it distort or even obscure something important?

The first observation that cannot be escaped from when we compare the quality of contact in psychotherapy in the form of video calls and psychotherapy in the form of in-office meetings is that in the case of the former, the contact between the persons involved is limited to only two senses. Does this type of mediation of contact between the parties to the meeting make a significant difference between the two forms of psychotherapy analysed? Intuitively, we notice that two-sense contact with another person is impoverished. It is very well known by families separated by the necessity to undertake paid work abroad or other, even more acute necessities, such as separation by forced isolation that try to maintain contact with the use of video communicators. In everyday interactions with the loved ones, this form of contact is a significant limitation not only because the so-called sensual pleasure can be experienced only if the older senses in terms of evolution: smell, touch and taste are involved. Sensory stimuli that are necessarily based on another person's bodily closeness evoke some kind of bodily involvement. The smell turns out to be attractive or repulsive, while eating meals together or touching with tenderness allows us to directly experience another person's closeness and devotion, binding us to them. Signals from senses that are old in terms of phylogenetics, that are attractive, repulsive and bind us, in psychotherapeutic contact are, by definition, of marginal significance. Of course, a patients' intense smell that accompanies them as they enter the office may be a significant signal, but this signal is clearly of little importance for the therapeutic process. If neglected, it would rarely lead to malpractice. In psychotherapy, touch is limited to shaking hands at the beginning of the meeting, which can be easily skipped and it has been openly discussed whether it is right to do. As a rule, the sense of taste is not used. Treating a patient with a hot drink is one of the exceptions and it is largely justified only in special circumstances. It is certain that we participate in a therapeutic relationship with a limited involvement of sensory perception, but at the same time we maintain those senses that have always played the most important role in cognition. The sense of sight (vision), which focused thinking in ancient Greece, was considered the most important factor determining cognition as such; *eido* means, among others, 'seeing', 'watching', 'perceiving', 'experiencing', 'receiving' as well as 'being certain', 'being familiar with'. Hence, this is where the term 'essence', 'idea' (shape, form) comes from as what is seen with the eyes of the soul. On the other

hand, the sense of hearing dominated in medieval thought, e.g. ‘faith comes from hearing’, and ‘logos’ is read as ‘word’. The sense of hearing, as indicated by Gołaszewska [20], has a three-fold meaning for humans: it allows to receive speech, music and spatial orientation.

3.2. Is psychotherapy in the form of video calls different from psychotherapy carried out in office in terms of quality of the relationship between a patient and the therapist?

3.2.1. The importance of the meeting space between the therapist and a patient for the quality of their relationship

Psychotherapy provided in the office and psychotherapy in the form of video interviews are different in terms of the spatial dimension of the meetings. It can be assumed that the time factor does not change. In both cases, we meet in a specific real time, but in a real meeting we share a common space. One of the parties enters the space of the other, so from that moment we are together in ‘our’ common (equally available to us, similarly perceived) space (secondary territory) [cf. 18]. Sharing space unites us. In a meeting held in the form of a video call, the situation is different: in a sense, we meet in a common, but unreal (virtual) space, and at the same time each of us brings our own real space to the meeting[10]. The rule is that you can reliably meet another person when we precisely determine the time and place of the meeting. In the case of psychotherapy in the form of video calls, in order for the meeting to take place, it is necessary to establish the time and platform for communication. The name of the platform temporarily becomes a term for the place of the meeting (the psychotherapist may be met by a patient [when?] on Fridays at 4:00 p.m., [where?] on Skype. An interesting clue is revealed in everyday practice. When asked ‘where did you meet with X?’, we do not answer: ‘he was at his office, and I was at my home’; we only answer – ‘on Skype’. We say identically that training takes place at Zoom or at Teams. If we use the names of software for meetings to describe: ‘where the meeting takes place’, it is because their mediation in communication consists in taking the distances between real places in brackets. Thus, the communication platform becomes a kind of new place – virtual, composed of two distant real places. In fact, the software that enables communication is a bridge connecting two distant places (when organising professional remote audio-video communication, in Polish, the term ‘telemost’ [tele-bridge] is commonly used). The bridge metaphor accurately conveys the possibility to cover a certain distance in order to see and hear each other well, but it distorts the reality in so far as it makes it impossible to move to the other side. This bridge cannot be crossed. In fact, it is closed for people. It only allows to convey audio and visual messages between people very

[10] A patient also brings in his own space by choosing to use a virtual overlay that covers the background. Any decision taken in this area will be significant. A constant angle in presenting your room and your face is an additional message. The space shown to a therapist carries additional information. It can testify on the decision made. It becomes something similar to clothing for us; it gives a chance for an additional message to be made, a message about ‘us’. We can consciously choose a specific fragment of space that serves as a background (also semantic) for our statements. For example, in television interviews, the choice is often made, as a matter of fact not by accident, for a home library.

fast. Significantly, we say ‘on’ Skype, ‘on’ Teams. The use of this particular preposition to describe the ‘place’ of meetings in psychotherapy in the form of video calls suggests that this is a ‘two-dimension’ ‘place’, i.e. we meet on the promenade, on the sports ground, on the playground, on the beach, but we say in the parking lot, in the office, in the shopping mall, in the museum. Talking about a video calls software as a communication platform has a deeper meaning here, as if video communication software gave us a kind of ground under our feet, but no longer a roof over our heads. There can be no question of our own place or for leaving something within these four walls or outside the door[11].

It can be said that due to a camera and a microphone placed in a patient’s room and transmitting the image and sound, a therapist is bi-sensuously-present in a patient’s room. Apart from a therapist, due to a camera and a microphone, a patient is also bi-sensuously present in his office. A patient can intercept and make insights into the office. Interception and insights into the office, as well as interception and insights into a patient’s room can occur synchronously, so that the interactions between the parties to the meeting are kind of natural as if they were close to each other. If there are no accidental technical difficulties, the conversation interlocks exactly as in a face-to-face meeting. What is virtual here is the physical proximity between a patient and the therapist that is underpinned by a specific virtual space[12]. On the basis of this virtual physical closeness, real closeness can be experienced that can be understood as the readiness to turn to the other person as he or she is [13, p. 67].

The boundaries of the virtual meeting space, as defined by the needs and abilities of the sense of hearing, are less defined than the one defined by the range of sight. This fact has its consequences. Here, the scene of audible sounds is also what is on the side of the office and what is on the side of the room from which a patient establishes connection. It seems that on the therapist’s side this modification to the situation, which distinguishes psychotherapy in the form of video calls from psychotherapy provided in an office, does not matter (as long as a therapist can use his office and instead of connecting with a patient at home). Whereas, on a patient’s side, there is an important difference: in order for a patient to be heard by the therapist, he must speak out loud at his home. The sound coming from a patient’s vibrating vocal cords must spread in many directions in a specific environment in order to be able to target a microphone diaphragm. The presence of household members, and the fact that a patient may be unintentionally heard not only by the therapist, may significantly restrict the spontaneity of his statements. For people who live together with others, the principle of confidentiality of the content of psychotherapy sessions in the form of video calls may be significantly violated. When a patient’s place of residence has to accommodate the content of his experience, difficulties arise in using psychotherapy. And the problem is not the virtual contact with the therapist, but its physical reverse. A patient immersed in a virtual space where he finds a therapist, may be at the same time ‘at risk’ of being injured in the physical space where his voice must be heard

11) Due to the constant communication with a therapist (also) on the virtual platform, it happens that a patient finds his ‘own place’ in the therapist’s mind. This thread will be developed further.

12) It can be said that a bi-sensually accessible virtual room (with a shape similar to a horizontally located hourglass) – consists of parts of two real rooms (patient’s room and therapist’s room).

before it reaches the therapist's ear using a microphone placed in the room from which a patient establishes connection. This type of difference does not disqualify online support, it is important. When the therapist cannot host a patient in his office and provide him with a space that will not be accessible to other people, when a patient's confidentiality cannot be ensured, then in a way a patient becomes a patient in distress, a patient that expresses himself so that he is acceptable for household members. Of course, this circumstance is complemented by a patient's option to use therapeutic dialogue in shaping relations with household members. This must also be taken into account, for example when formulating a contract. It seems that for many patients involved in system relationships with family members who live together, the need to demarcate a home space sufficient for a session is out of reach. For patients who live together with other people, psychotherapy in the office and in the form of video calls will be significantly different. For patients who live alone, there is potentially no such difference.

You can get the impression that organising the conditions to keep a patient's conversations with the therapist confidential remains only a technical problem that can potentially be eliminated in various ways. And yet – since in this case a patient has to overcome additional technical difficulties, it is somehow different in terms of how the relationship between the therapist and a patient develops. Its significance may ultimately indicate how significant the difference between psychotherapy in the form of video calls and psychotherapy in the office is. In order to use therapy in the form of an in-office meeting, a patient has to make time that he/she would otherwise share with his relatives. When deciding to work in the form of video calls, he/she must also make a place for it from his family life. This may make psychotherapy in the form of video calls more difficult for some patients than in-office psychotherapy – even though it apparently appears to be more accessible ('you don't have to leave your home'). In each of these two forms of using psychotherapy, patients devote some of their free time to psychotherapy, which at the same time cannot be shared with their relatives, they have less time for their relatives, which does not escape their attention. The right to devote a part of free time to psychotherapy often requires a patient to defend himself, which is not always within his interpersonal competences. In the case of using psychotherapy in the form of video calls, if a patient temporarily needs to use exclusively the place that he usually shares with others, then it is a challenge that makes his/her position in the family system more complicated, which is anyway difficult. During the pandemic, many patients who spontaneously looked for a suitable place to talk to therapists in a way unhampered by the presence of others, used their own cars, which, despite the obvious inconvenience, gave them the opportunity to be alone with the therapist.

To stay on the virtual communication platform, a patient must be anchored in real space and also feel safe in it. In this respect, the therapist does not provide him/her with a safe base [21]. Any disruption of security in real space affects the quality of communication that takes place in the virtual space. To some extent, psychotherapy sessions lose the value of an intermediary space – you cannot rest here, as you can in an office, from the constant 'study of the relationship between internal reality and external reality' in the meaning that D.W. Winnicott gave to this experience [22, p. 37]. The experience of participation in psychotherapy is more distant form 'a playing small child lost in it' [cf. ibid.]. A patient can be disturbed in this state over and over by the pressure of reality (e.g. sounds reminding

of the presence of household members) that increases the state of self-control, preventing free experiments with thinking about oneself and others and preventing acquiring new interpersonal experiences in the relationship with the therapist.

Of course, the concepts of a safe haven, which the therapist is (Bowlby) [23], or the space between a therapist and a patient (Winnicott) [22], or the therapist's mind accommodating function towards a patient's mental life (Bion) [24] are metaphors. Despite the fact that to illustrate important aspects of the psychotherapy process these metaphors make use of words related to place, they actually mean something non-spatial. It is the therapist's way of behaving towards a patient, attitude towards him/her, responding to what he contributes to the meeting, creating a certain 'space' for a patient to experience and think in a different way than before. All this can potentially take place in therapy in the form of video calls. However, in order for the relationship between the therapist and a patient to fulfil these metaphorically spatial functions, that means: in order for the therapist (his mind) to be a place made available to a patient, this relationship must actually be really protected, separated from other relationships. The office is that kind of place, physically closed to others. It is thanks to this therapist's and patient's being physical locked in the office that unrestricted imaginative activity can take place, which opens up a patient to relationships, among other things. However, when experiments take place, a patient must be safe, he/she must have a guarantee that the situation will not require interpersonal responses from him at the moment, he may remain in a state of being unprepared and vulnerable.

When collecting these thoughts, it can be concluded that psychotherapy in the formula of video calls differs from psychotherapy in the office-based formula in terms of the mutual location, or a patient's and the therapist's location. The responsibility for making a place appropriate for the meeting is shared between a therapist and a patient. First, a patient's investment in each session is greater and possibly limited by his resources; it may make him/her feel he is getting less from a therapist than he/she could get in the conditions of office setting. Last but not least, the roles are becoming equal here: in the virtual room both – a patient and a therapist – are the hosts, or perhaps it would be appropriate to say: no one is the host. No doubt, these are the circumstances that may affect the quality of the relationship that is being established in the therapeutic process, however, it always is the conditions that is the key factor as to a suggestion of what form of contact will be expressed.

3.2.2. How Important Therapist's Ability to See a Patient Is for the Quality of their Relationship?

When pursuing our reflections on the space where psychotherapy takes place, it should be noted that if we give up using an office as a meeting place, then a patient is unable to see his therapist. We say and think: at the doctor's, at the dentist's, but also perhaps more primarily at friends, and in particular at his/her mom's (thinking about a child held in her arms, on her lap)[13]. The observation here is that the use of someone's hospitality presupposes

[13] Polish language is sensitive to express a special dimesion of 'seeing a doctor' connected with care and protection.

the experience of being accepted by someone[14], and in the context of psychotherapy and treatment, this seems to be a desirable experience. Does the fact that a patient participates in psychotherapy sessions, but does not visit the therapist, have therapeutic or anti-therapeutic effects for him? The key factor is whether, without being in the therapist's office, a patient is admitted by the therapist anyway, because there is no psychotherapy without it[15]. There is no psychotherapy when a patient experiences rejection by the therapist. Although to elaborate this thread would go far beyond the research area adopted here, it requires noticing that the therapist's hospitality remains an obligation that is not limited to opening or closing an office to patients. You can remain inhospitable, which means – outside of psychotherapy – in an open office. Hospitality in a radical (full?) sense is being ready to feel at home as a 'foreigner', to accept the anxiety that is introduced by a guest with his otherness and origin. In the essay dedicated to the memory of Cezary Wodziński, the above thought of the author contained in the texts *Saint Idiot* and *Odysseus* is interpreted by D. Kot [25] as follows: 'And perhaps some important feature of foreignness is revealed here. For why <<the arrival of a foreigner reveals the foreignness of being in the world>> [26, p. 205]. Apparently, a foreigner is only slightly different: he speaks a different language, has a different skin tone, believes in other gods and condemns acts others than we do. However, such otherness can be reduced to regular diversity and to a difference that is not of fundamental importance. We encounter such others every day and they do not destroy our well-being, i.e. the feeling of being at home. However, a foreigner brings in something more: his whole world, arranged disturbingly similar to ours, although it is completely different. A foreigner prevents us from believing that our worlds, our indigenousness, are universal in character. By his appearance, a foreigner takes away our peace' [25, p. 72][16]. In view of these reflections, a thought arises that perhaps only when the host of the office starts feeling that (he also) is not at home. It is possible to fully share time with a patient. It seems that outside the office – when a patient and a therapist meet in a video conversa-

14) The word 'admission' is strongly preserved in the language that describes treatment, such as: 'admission point'.

15) During the lockdown, many patients manifested anger and frustration because of medical consultations made by phone only. They perceived doctors refusing to meet in the office as protecting doctors' own health at the expense of neglecting their right to treatment. It is not certain whether under this aggressive demand from doctors to take heroic risks, there was a much more fragile longing for an authentic 'admission' by a doctor that could be possible both in direct and online contact, which would accommodate the drama of the inability to use help in a time when the health service came under pressure of next waves of the pandemic.

16) The ability to understand the tension between admitting a patient and attachment to the existing ways of thinking cannot be overestimated for good practice. These ways of thinking are the subject of teaching (necessary because of other reasons) in psychotherapy schools. This is what M. Opoczyńska writes about hospitality, which in practice is a difficult task: 'I now recall moments from the time of psychotherapy when, unable to bear the burden of meeting the Other, I was hiding behind words. The man I'm talking to wants to share his pain with me. He wants and does not want to, because he knows that the pain cannot be shared. I want and do not want to share his pain, because I would have to remain silent and 'suffer-together completely' [27, p. 63]. I don't want to witness his pain and that's why I run away to words to hide. Because I fear a mother who lost her child, I fear a girl who is killed by cancer, I fear a man who plans to die with watchmaker's precision. I fear their complaint that I accept as an accusation. Why not me? Where was I then? What is all the knowledge for? So I grab the words to save myself. Not to feel guilty that their world is dying. In order not to be a witness, which then means 'to suffer-together' [28, p. 220].

tion, this type of patient admission by the therapist is also possible, or at least there is no reason to believe that in this context he is more at risk than in a traditional context. It can be concluded here that the modification of the mutual position of a patient and a therapist encountered in the formula of video calls where a therapist no more acts as a host (especially in terms of providing something; here – a meeting place) not only does not contradict the essence of psychotherapy, but it may be one of the ways this essence is enlightened to us.

4. Conclusions

As it can be seen based on these investigations, the mere mediation of conscious and unconscious communication between a patient and a therapist via a computer network and devices that allow to transmit video and sound images does not significantly affect this communication. The possibility to transmit synchronic image and sound between the room in which a therapist is located and the room in which a patient is located allows us to conclude that with the current state of technology, the therapist and a patient conversation-related aspects of psychotherapy conducted in in the form of video call psychotherapy are preserved. Moreover, communication in the form of video calls lets the therapist mindfully understand not only what a patient says, but also to what he/she does. In this form of work, like in psychotherapy, in an office, patient's behaviour can be assumed as significant. Traces of patient's experience acquired in previous relationships are recorded in it. Patient's behaviour must also be perceived by a therapist. In psychotherapy, first of all, patient's behaviour, which is available to the therapist thanks to the senses of sight and hearing, is interpreted and used for the healing process. Unconscious communication also takes place through these two channels and there is no reason to believe that limitations related to, for example, a specific angle of view of the inside of patient's room by the therapist or limitations related to the inability (unlike in the office) to see the entire patient's figure will not be unconsciously taken into account by him/her in how he/she expresses himself.

However, there is a significant difference between psychotherapy provided in an office and psychotherapy in the form of video calls in terms of the quality of the relationship between a patient and a therapist, yet, the specific nature of virtual space is not a point here. The point is the fact that while staying in the virtual space, a patient is simultaneously in the real space of his apartment and brings in its quality to the therapist meeting situation. The most obvious consequence of this state of affairs is that the confidentiality of psychotherapy may be compromised, because at the present stage of technology patient's thoughts must be spoken aloud amplified so that they can be electronically transmitted to a therapist's office, so they can be heard by other people[17]. However, unlike in the tradi-

[17] It is rare to have such a level of interiors sound insulation so that the household members cannot hear the content of the conversation with a therapist. Appropriate soundproofing rooms are sometimes used in large offices. Perhaps in the time of the pandemic, they will become more popular in private apartments, but now they are certainly not standard equipment. At present, in practice, it is necessary to bear in mind whether the patient who undertakes therapy in the form of video calls has sufficient conditions for this, i.e. whether he has a large enough apartment so that the presence of household members does not interfere with communication with a therapist, and if not, whether the time of the session can be adjusted so that the patient is alone at home.

tional form, where a therapist is responsible for the comfort of his office, this difference does not only boil down to the fact that caring for the confidentiality of psychotherapeutic sessions is part of the online formula on the side of both a therapist and a patient. This difference goes deeper – in psychotherapy in the form of video calls, patients bring their own part of space to the meeting with all its qualities. The video and sound stage of a virtual office is created by a patient and a therapist equally. As for the place of meeting, a patient (bi-sensually) is equally 'at a therapist's' and a therapist is 'at a patient's'. Is it appropriate now to acknowledge that the effects of this significant modification of patient's and therapist's relationship to the course and success of the treatment process are unknown? Shouldn't it be stated that it is identically difficult to imagine, as a thought experiment this form of the model therapeutic setting? What far-reaching consequences would home sessions with a patient have for the development of psychotherapy at the end of the 19th century and at the beginning of the 20th century? No doubt, patient's need to develop a part of the virtual meeting space can be seen in the light of opportunities or threats. Since medical home visits, as well as contact with an environmental therapist are not always expected by patients because caused greater embarrassment as if a doctor was to some extent knowing not only a patient, but also his immediate surroundings. It is even ambiguous whether this necessity empowers a patient rather than makes him more distant from being a subject. From therapist's point of view, video call therapy is a factor that makes his work more complicated. At the beginning of the pandemic, many practitioners experienced feeling more active in online sessions as if they required more involvement. Perhaps it was so because it was new, but one can also put forward a working hypothesis that patients in the environment that they know are more resistant to the change they expected than in the new environment. What is different and arouses hope (therapist, session), closed within a web browser window, is suppressed among what is known, although sometimes it is uncomfortable (known surroundings, relationships with people behind the door), despite the ability to plunge into virtual space? Does a therapist have to strive to be more pronounced in order to start existing in a patient's mind? Does a therapist have to go beyond the place where he usually anticipates patient's experience in order to accommodate what patients bring in?

Current knowledge about the process of virus transmission in humans [29] requires the therapist to recognize that he cannot secure the patient's health and life when inviting him to an office for a psychotherapy session during a pandemic if he/she and a patient are not effectively vaccinated. There are no rational reasons to doubt that video call psychotherapy is a sensible, adequate and necessary solution at a time when face-to-face contact carries a foreseeable health risk for either party. There is no doubt that this type of work indeed generates new qualities in the therapist-patient relationship, in particular the fact that the patient brings in a significant part of the meeting space/scene. When a patient and a therapist experience switching to online contact and returning (or not) to traditional work, it can be profitable each time as a material for analysis in a specific psychotherapy process. This is a circumstance that mitigates the uncertainty of the effects of the change forced by this situation. Probably in each case this experience will mean something different, otherwise it will be part of the treatment process on the one hand, and it will be part of therapist's professional biography on the other.

Since there is a significant difference in the mutual position of a therapist and a patient in the online and office work that can affect the quality of their relationship, it should be noted that the real consequences for the development of the relationship between a patient and a therapist, and therefore – for the entire psychotherapy process, will depend each time on the reason why a therapist (or a patient) suggests working at a physical distance. This may have conscious and unconscious aspects. If a suggestion is made by a therapist and is related to his permanent or temporary attitude of carelessness, 'inhospitality' – it requires reflection and correction. Similarly, if a patient expresses a fear of closeness, dependency, it requires naming and reflection (perhaps a certain group of patients who would not be able to start working on themselves in an office will start the online psychotherapy). As we already know, an offer to work online, which is significantly different from the office formula, can undoubtedly still serve a patient, provided that its significance is considered. Offering psychotherapy in the form of video calls during the pandemic is an exceptional circumstance that carries special significance.

If the traditional significance of an office in the psychotherapy process was accurately conveyed in the metaphor of a haven or a marina where a patient is anchored for a fixed period of time, it should be noted that the pandemic changes this situation in terms of quality. It cannot be overlooked that switching to a video-call contact was forced precisely by the fact that an office was no longer a safe place. The pandemic has hit the haven, making all of us shipwrecked persons. A therapist has to face the fact that he can no longer serve a patient in an office as a safe haven. He also has to face the sadness associated with the fact that in this crisis situation, he requires more than usually from a patient, i.e. looking for a space to protect the course of therapy on his own. At the same time, the transition to online work on the part of a therapist is also preceded by the loss of the familiar surroundings and context of everyday work. So, is what he can offer a kind of drift in a lifeboat, which protects both himself and a patient, albeit in a different sense? For a patient, it is a chance to continue (albeit under suboptimal conditions) the treatment he needs, while in this pandemic crisis a therapist is given an opportunity to practice a profession that allows him to maintain a sense of meaning and a source of income in a crisis situation?

As we go down to a deeper level of thinking about the psychotherapy process, we can ask: how is the ability to share one's own mind as a space for a patient's difficult experiences affected by sharing with him/her the fate of a shipwrecked person? It seems that with this question we are getting closer to the essence of psychotherapy from the side that is still poorly recognised. Apart from monumental images of a haven and a ship, isn't psychotherapy actually an encounter of two persons where none of them is at home? Doesn't a mother soothing her crying infant appeal to a hope whose fulfilment is actually beyond her control? As a rule, the ability to heal is not determined by the therapist's existential advantage over a patient, no matter how confusing the poses we adopt may be. Therapist's condition as a comer, a foreigner reveals the perspective of a special (dramatic? tragic?) tenderness present in the treatment process that often escapes the story of psychotherapy as an intended procedure of using specific methods and interactions.

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