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TELEANALYSIS: SLIPPERY SLOPE OR RICH OPPORTUNITY?

In certain cases, and under certain conditions, extremely useful analytic work can be done on the phone or through videoconferencing. Contrary to what some critics of teleanalysis maintain, with patients who are motivated and can make use of analysis, physical distance between analyst and patient and/or occasional technological difficulties do not limit or preclude successful analysis. Clinical material from three teleanalyses demonstrates various conditions that help make teleanalysis useful. Instead of being a disadvantage, the juxtaposition of the experience of the "tele" and the in-person settings (in occasional in-person sessions) provides increased and unique opportunities for analysis.

Keywords: countertransference, resistance, separation, transference, teleanalysis, videoconferencing, telephone analysis, Skype, analytic frame, reluctance

Anecdotal reports, surveys, and a growing number of publications devoted to the subject indicate that more and more often analysts are treating patients through teleanalysis—that is, analysis conducted over the telephone or via online videoconferencing platforms such as Skype or Zoom (Richards 2001). In addition, more candidates are being taught, treated, or supervised via online videoconferencing or the telephone than ever before (Manosevitz 2006; Fishkin et al. 2011; Spoto 2011; Scharff 2013a, 2015; Merchant 2016). While many analysts still question the

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practice of teleanalysis,[1] the rapidly expanding presence of technology in our everyday lives, and our growing reliance on it, suggests that the question for analysts should be how best to practice teleanalysis, not whether to. Anyone invested in the future of psychoanalysis, if not having done so already, must grapple with the practice of telephone or online analysis and its conceptual and technical underpinnings (Litowitz 2012).

When considering whether to practice teleanalysis, a newcomer faces many questions. Is psychoanalysis possible on the phone or through online videoconferencing? How does it compare to in-person analysis? What do we know about its usefulness, and what are the sources of our knowledge? What might be its limitations? Advantages? Who is it most useful for? When? Does online analysis provide an enlarged opportunity for analysts to practice analysis, or does it represent analysts' accommodation to patients and their own resistances to in-person treatment? As Tao (2015) asks, "How does technology affect the psychoanalytic situation in particular? Does a secure connection on the internet offer a 'good enough' setting for psychoanalysis, with enough oxygen in the atmosphere for the survival of the analytic couple and the analytic process? Or does it indulge an omnipotent fantasy of the analyst . . . ?" (p. 105).

The increasing body of literature addressing different aspects of teleanalysis is characterized by wide differences of opinion and controversy about its usefulness. At one end of a continuum are analysts who practice teleanalysis and have found it functionally equivalent to and at least as effective as in-person analysis (Spiro and Devenis 2000; Leffert 2003; Hanly 2007; Carlino 2011; Migone 2013). Less ardent proponents of teleanalysis maintain that teleanalysis is a valuable second choice to in-person analysis, a way of helping patients who otherwise could not be helped receive the intensive treatment they need (Lindon 1988; Zalusky 1998; Mirkin 2011; Scharff 2012). These analysts report that teleanalysis, when practiced with analytic thoughtfulness and skill, can produce good analytic results, comparable to those of successful in-person analyses. At the other end of the continuum, critics argue that teleanalysis, at its best, is less effective because its frame does not support a deep psychoanalytic process or its analysis (Bayles 2012; Essig 2015; Russell 2015; Turkle, Essig, and Russell 2017). Critics point to the limiting effects of

[1]To make the reading of this paper less laborious, I will be referring to both telephone sessions and online videoconferencing as *teleanalysis*.

technology on free association and on communication between analyst and analysand and therefore on the analytic process (Brainsky 2003). Some even suggest that teleanalysis undermines analytic practice and is a slippery slope leading to the extinction of any form of analysis (Essig and Russell 2017), or is such a diluted treatment that it does not merit the designation of psychoanalysis (Argentieri and Mehler 2003).

While the number of books and papers on teleanalysis increases, there is still a lack of objective research on the topic. In addition, only a relatively small number of publications provide clinical material to support these varying opinions. I will argue here, using detailed clinical material, that teleanalysis is not inherently "analysis-light" or resistance to analysis but can serve as another opportunity to help patients who need intensive work but cannot be present in the analyst's office.

I will begin with a selective review of the critics and skeptics of teleanalysis. Argentieri and Mehler (2003), arguing against telephone analysis, conclude that speaking with patients over the phone does not constitute analysis. Using as a springboard for discussion Zalusky's comprehensive report of analytic work with a patient who participated in an analysis conducted partly over the phone (1998), they suggest that in telephone analysis analysts accommodate, rather than help analyze, the anxieties inherent in separations and termination. They suggest further that practitioners of telephone analysis might be enacting omnipotent rescue fantasies and fostering omnipotent fantasies in their patients by denying the limitations of phone conversations. Argentieri and Mehler base their conclusions on their own telephone work with patients who were prevented from attending in-person because of illness, work obligations, or living in an area lacking access to analytic treatment.[2] Summarizing that work, they conclude that although "good work" took place in many of their cases, "nevertheless, there was a clear, explicit and mutual awareness of the fact that we were *not doing* or *continuing* to do analysis. We were *doing something else* like psychotherapy, post-analytic occasional follow-up, support therapy or simple human supporting contact. Undeniably, the telephone might

[2]"We, like most analysts, have come across situations that have prevented the regular analytic process from developing (or continuing) within 4–5 analytic sessions implying the couch and a regular frame, such as: a woman patient, aged over 65, travelling to Rome from an island and only able to have occasional vis-à-vis sessions; lengthy letters during a long absence due to work abroad; pilots or stewards who can only have extemporaneous sessions according to flight schedules; actors filming or on stage far from the analytical venue for long periods at a time; accidents requiring patients' long hospitalization" (Argentieri and Mehler 2003, p. 18).

occasionally be a useful therapeutic tool as well; but it simply is not compatible with a psychoanalytic process" (p. 18).

Argentieri's and Mehler's frequently referenced paper usefully calls our attention to the possibility that telephone analysis can be used as a resistance to analytic engagement. However, their conclusion that teleanalysis is not analysis is not based on analytic data. Although they use Zalusky's work as a starting point for their views on teleanalysis, they do not base their comments on the actual work of Zalusky, who offers detailed analytic process of a telephone analysis,[3] nor do they furnish their own analytic data to support their claims. By their own account, they never attempted to practice psychoanalysis when they met with patients on the phone. Their claim that telephone analysis is not analysis, therefore, rests primarily on their *beliefs* (even, perhaps, their biases) regarding telephone analysis.

Essig (2015) invited analysts to recognize biases for and against teleanalysis. Referring to relationships mediated by technology as "screen relations," he encourages clinicians to pay attention to both gains and losses involved in internet treatment. Essig calls clinicians' intense, visceral, a priori rejection of therapeutic experiences mediated by technology "simulation avoidance" (p. 687). He suggests that clinicians under the influence of simulation avoidance focus on the losses and cannot consider gains. Conversely, when clinicians suffer from what Essig calls "simulation entrapment" (p. 689), they are unable to register any differences in relating through technology and act as if the results of their actions within technologically mediated treatments are identical to those produced in the in-person setting.

Essig, in a later collaboration with Russell, is more critical of teleanalytic work and expresses concern about its deleterious effects on practitioners and the field more generally.

> Skype treatment really is paving the road for something like "Freud: The App." It's harsh to say, but those routinely treating at a distance via screen relations are unwittingly serving the needs of technology entrepreneurs who want to replace therapists with apps and programs. Such a practice does the work of what Turkle termed the robotic moment to turn us into creatures looking to machines rather than people for love and care [Essig and Russell 2017, p. 135].

[3]Zalusky (1998) demonstrated in her account that she paid careful attention to the setting, interpreted in the transference, and identified and analyzed her countertransferences and both hers and the patient's resistances to deepening the analysis.

Essig and Russell also predict that teleanalysis will disrupt the mental health market the way Amazon and Uber have disrupted the bookstore and taxi markets.

Turkle similarly suggests that teleanalysis moves away from the demands and difficulties inherent in psychoanalysis such as the anxieties of "embodied empathy, of being together in a messy way" (Turkle, Essig, and Russell 2017, p. 244). She observes that analysts often see teleanalysis as progress, a treatment that embraces the realities of contemporary culture and keeps psychoanalysis relevant, profitable, and more portable. Turkle argues that these positive views are rationalizations: analysts use them to justify practicing a treatment that avoids the difficult therapeutic conversations that promote vulnerability and full presence, elements essential to emotional healing.

Many reports of successful teleanalyses (e.g., Robertiello 1972; Lindon 1988; Zalusky 1998; Leffert 2003; Bassen 2007; Eckardt 2011; Mirkin 2011; Scharff 2010, 2012, 2013a,b; Hanly 2007; Essig 2015; Lemma 2015; Abbasi 2016; Merchant 2016; Wooldridge 2017) contradict Turkle's and Argentieri and Mehler's claims that teleanalysis is untenable. In my opinion, their claim that distance analysis is a priori defensive does not account for the fact that patients seek teleanalysis for a wide range of reasons, not purely defensive, and that defensive reasons if in fact present can be analyzed. As I intend to demonstrate in the case examples that follow, even if some patients might seek teleanalysis for primarily defensive reasons, such as a need for fierce distancing, teleanalysis provides the only setting flexible enough to contain them and allow for their eventual analysis. Also, although patients might be compelled to seek teleanalysis for external factors (e.g., issues of confidentiality, promoting one's career or following a spouse by relocating, scarcity of analysts or lack of the right therapeutic match in one's geographic location), which might contain some defensive elements, the overall opportunities for emotional growth and health are greater in teleanalysis than in choosing to forgo analysis altogether or continuing to meet in an in-person analysis and relinquishing other relationships or opportunities for growth.

Russell (2015) has written the most comprehensive critique of teleanalysis to date. In *Screen Relations: The Limits of Computer-Mediated Psychoanalysis and Psychotherapy,* she set out to explore the therapeutic effectiveness of teleanalysis after observing that her computer-mediated treatments were not functionally equivalent to treatments where she and the patient met in the same room. Adding to her own observations, Russell

interviewed many colleagues and patients who have had experience with teleanalysis and who contributed clinical vignettes and anecdotes to her book.

Borrowing Essig's term (2015), Russell concludes that screen relations[4] are not conducive to "an optimally effective therapeutic process" for three main reasons: first, the absence of physical co-presence; second, the incapacity to "kiss or kick"; and third, the supposed fact that the balance of communication between patient and therapist is tilted in favor of the explicitly verbal mode. Russell suggests that while computer-mediated treatments are "better than nothing" (p. 181), analysts must not present them to patients as being equivalent to in-person treatment.

Russell found that analysts practicing teleanalysis did not attend to the frame as diligently as they did in in-person treatments.

> It did not occur to most of the analysts I interviewed to discuss with their patients the issue of the safety of the environment and establish a working framework before embarking on computer-mediated treatment. This is despite the fact that all the analysts I have spoken to recognize the importance of this and are scrupulous in providing such a setting in their traditional, shared environment practices. . . . The mere act of establishing contact was their prime aim, whether the patient was in a sitting room, car seat, or a bed, and overshadowed the necessity to create some mutual form of a reliable and predictable setting [p. 11].

In addition, analysts tended to ignore, rather than consider for possible meaning, difficulties inherent in internet connection involving "poor sound, grainy visuals and frequent interruptions" (p. 3). Russell also reported that analysts observed in themselves and their patients a diminished capacity to concentrate, pay attention, engage with their own reverie, be silent, or feel intimate with each other:

> We had curious lapses. It was easy to forget treatment sessions and the times of our peer group meetings. We were likely to bring a cup of tea or glass of water to a session, something we did not do in co-present sessions. We did more talking with our patients about the comparative times and weather. We did more talking in general, as silences were not so easy. We felt less in touch, less intuitively connected [p. 3].

[4]Essig (2015) defines screen relation as "a technologically mediated simulation of a traditional physically co-present relationship experience" (p. 685).

Noting the lack of psychoanalytic research in this area, Russell turned to neuropsychological and memory research (Moser and Moser 2014; Buzsáki and Moser 2013; Clayton et al. 2007) to help explain clinicians' memory lapses and difficulty maintaining a therapeutic frame. She suggested that the two-dimensional nature of computer-mediated treatments affects memory, contributing to clinicians' difficulty in keeping the patient in mind as they would in an in-person treatment. Russell further asserts that the reason analysts do not attend to the therapeutic frame as diligently as they would in person is that patients are in a different location. Presence, she remarks, "requires the sense of bodies together. We know that it is dependent on recognizing the other as an intentional self, located in a shared physical space with the potential to interact with the other" (p. 179).

Referencing developmental research on communication (Boston Change Process Study Group 2008) and highlighting the importance of implicit communication in creating and maintaining intimacy, Russell also suggested that the nature of computer-mediated communication (with its narrow attentional focus, intrinsic two-dimensional nature, and limits of movement and action taking place within a common space) compromises communication and intimacy. Applying right brain research to teleanalysis (Shore 2005, 2011), she hypothesizes that use of the computer compromises right brain function in both clinician and patient by impeding the transmission of "finely nuanced, nonconscious information such as gestures, smells, and pheromones" (p. 97).

In addition to affecting memory, communication, and intimacy, Russell suggests, the screen in teleanalysis prevents the patient from experiencing the full potential for destructiveness in the analytic relationship, such as the potential for "kissing or kicking" the analyst. Using Winnicott's idea of object usage (1969), Russell argues that in teleanalysis use of the screen and awareness of simulation limit patients' imagination and thereby their chance of acting out their omnipotence and test analysts' capacity to maintain their separateness: "In 'screen relations,' the patient can never truly test the analyst's capacity to survive. The extent to which the patient can 'imagine' the destruction of the analyst (by zealous love or hate) is bounded by the barrier of the screen. . . . Therefore, the use of the object is foreclosed by the limitations of the medium" (p. 35).

Russell offers the account of Patrick, an Australian analyst, as an example of an analysis where meeting on Skype foreclosed the patient's

use of the analyst. After relocating and beginning to meet online, Patrick reports, the patient would blow up and express contempt and rage toward him and had difficulty calming down and reflecting on his experience. Patrick referred the patient to another analyst for in-person treatment, and he is quoted by Russell as concluding "it felt like there was something about being on Skype that made it just not possible" (p. 38).

Russell presents a wealth of clinical examples to support her thesis. In my opinion, however, her examples for the most part present problematic executions of teleanalysis, such as not being able to create an analytic frame that can contain the anxieties of patient and analyst sufficiently that they can be examined analytically. A second problem is that she bases her discussions on brief examples that lack detail and specificity. As a result, when she discusses these clinical examples using a psychoanalytic lens, the lack of process, context, and historical background does not allow the psychoanalytic reader a complex analytic consideration of the data to determine the veracity of her assertions and conclusions.

A third problem arises when she attempts to understand analysts' difficulties by importing findings from other fields without accounting for psychoanalytic findings. For instance, she uses a neuropsychological/cognitive focus and ignores the role of unconscious motivation. Thus, Russell explains analysts' and patients' symptomatic behaviors as reactions to the actual setting, rather than considering them as reactions associated to the *meaning* of the teleanalytic setting. For example, when analysts report that they tend to speak to patients on Skype more than usual, she explains their behavior as reactions to meeting on Skype, rather than behavior with deeper personal meaning—a manifestation of anxiety about the meaning of meeting on Skype[5] that needs to be thought about and understood in the context of the analyst's history and countertransferences, rather than as simply reactive to the medium. Similarly, Russell attributes forgetting "technologically mediated" sessions to the two-dimensional experience of screen relations and does not consider

[5]Scharff (2012) also observes the analyst's anxiety in teleanalysis: "Therapeutic regression occurs in analysis by telephone and on the Internet as it does in traditional analysis. However, it must be admitted that this is more anxiety-provoking for the analyst who may experience increased anxiety about doing harm and being censured" (p. 84).

forgetting to be a highly motivated symptom that reflects an attempt to manage and disguise consciously unacceptable difficult feelings. Consequently, although her collection of problematic behaviors and lapses usefully alerts analysts to possible enactments and countertransferential challenges associated with teleanalysis, I consider her attempts to illuminate these observations psychoanalytically disappointing and her conclusions unconvincing.

Fourth, in her effort to explain the difficulties she and other analysts have faced while practicing teleanalysis, Russell creates a straw man. She juxtaposes teleanalysis with what many analysts would recognize as a utopian version of in-person treatments. In this idealized version, analysts are assumed to be consistently and effectively attending to all therapeutic variables that render analysis optimally effective: the physical body and its role in the analytic process are attended to and understood[6]; free association and reverie are facilitated; challenges to the internal or external therapeutic frame by patient or analyst are considered diligently as evidence of the patient's or analyst's reluctance to understand or to engage in analytic intimacy; and patients' explicit or implicit modes of communication are recognized and used productively.

Some of Russell's criticisms about teleanalysis point to areas of difficulty in any analysis—for instance, the tendency to drift away from what is difficult emotionally and take refuge in external distractions. (Are analysts prone to look or wish to look at their Smartphone only when meeting with the patient on the internet? Are analysts inclined only when they meet online not to question when the patient participates in ways not conducive to analysis?)

Russell's account of Patrick typifies her clinical examples. By not providing more analytic data, she can easily frame his dilemmas as a teleanalysis problem rather than a countertransference problem of the sort analysts might struggle with in any analysis. She leaves unanswered many questions: How did Patrick feel about the patient's move away from

[6]On the contrary, the literature suggests that historically analysts have neglected to examine how the patient's and analyst's bodies affect analytic process. In recent years, from different theoretical traditions and with different emphases, Balsam (2011, 2013, 2015), Balsam and Harris (2012), Lemma (2014a,b,c; Lemma and Caparrotta 2014), and Sletvold (2011, 2012, 2014, 2016) have highlighted the clinical usefulness of focusing on the patient's and/or the analyst's body and have called for analysts to attend to and make use of bodily experiences and representations.

him and about their new videoconferencing frame? What was the transferential source of the patient's rage and contempt? How did the patient's rage and contempt connect to relocating away from his analyst and meeting teleanalytically? Without a closer look at the analytic process, it is impossible to ascertain whether this impasse is an example of possible limitations in the teleanalytic frame generally or an example of the analyst's incapacity to survive the patient's rage—an enactment of unrecognized and unaddressed feelings about the change in frame and its meaning for patient and analyst.

A fifth flaw in Russell's argument pertains to her assertion that teleanalysis limits the full expression of the patient's destructive and loving feelings and the analyst's capacity to survive them. Clinical experience refutes this assertion. The analyst's capacity to survive is not foreclosed by the screen but rests on the analyst's mind, her capacity not to withdraw or retaliate emotionally in the face of the patient's hatred, defiance, disappointments, and challenges.

As evidenced precisely in Russell's example of Patrick, patients *can* "kick" or even "kill" the analyst when they meet online. The telephone and Skype screen do not limit the enactment of unconscious fantasy or the patient's expression of unformulated experience, any more than using the couch and not seeing the analyst does. Unconscious fantasies of seducing or destroying the analyst are integral to every analysis, products of the patient's (and analyst's) mind regardless of the analytic setting. Whether in person, on the telephone, or through videoconferencing, analysts are "kicked and kissed" daily by their patients' evocative words, tones of voice, silences, detailed pornographic or gruesome accounts, and much more.[7] If simulation precluded imagination and the manifestation of unconscious fantasy, then analysis, itself a simulation, would not be useful in any setting, not just teleanalytically.

A sixth shortcoming involves Russell's equation of physical distance with emotional distance and lack of connection. This concrete

[7]Loewald (1975) speaks to language's capacity to serve as action: "Language is not merely a means of reporting action, it is itself action; narrative has a dramatic potential of its own. . . . One might express this by saying that we take the patient less and less as speaking merely *about* himself, about his experiences and memories, and more and more as symbolizing action in speech, as speaking from the depth of his memories, which regain life and poignancy by the impetus and urgency of re-experience in the present of the analytic situation" (pp. 293–294).

interpretation of physical distance does not comport with what we know about emotional communication and connection.[8]

As I have argued elsewhere (Ehrlich 2004, 2010, 2013), the analyst's resistance to analysis is vastly underestimated in in-person treatment. Russell's clinical examples confirm that this is true also for teleanalysis. Although the specific form resistance takes in any analysis is uniquely shaped by each analytic pair, I suggest that Russell's many anecdotes alert us to some of the common forms that resistance takes in online treatment. Difficulties in concentration, memory, attention, and sense of connection to the patient, reported by many of Russell's respondents, can be understood as manifestations of analysts' emotional distancing.

Russell's book helps analysts rethink therapeutic action in analysis in any setting by highlighting the need to bring analytic attention to the body and its meanings, the importance of the analyst's emotional presence, the necessity of attending to the frame, the need to take into account the explicit and verbal as well as the implicit and nonverbal aspects of the patient's communications and the vital role of containment and the analyst's capacity to survive. I believe it also underscores the need for the analyst's self-discipline and uncompromising commitment to self-assessment and consultation.

CASE EXAMPLES OF TELEANALYSIS

M.: When Open-Ended In-Person Analysis Is Not Possible

Several years ago I was presented with a clinical dilemma. A man in his early thirties, deep in despair and suffering from self-hatred and suicidal thoughts, came to see me for a consultation after breaking up with

[8]The Boston Change Process Study Group (2002) speak to this: "If two animals are put in the same space, a complicated process of regulating the physical distance, of moving towards and away from one another, will occur. . . . With humans, this process is largely mentalized, meaning that the exploration, regulation and establishing of proper contours, boundaries and temporal structures to the interaction will occur mainly in the intersubjective rather than in the physical space. But it occurs nonetheless. It is a process of trying to get closer, or further away, or to avoid something happening, or to get something to happen, or to increase or decrease the state of arousal, or to shift the affective state, in relation to the other. These might be called 'mentalized kinesics'. It is on the basis of such back and forth movement that we arrive at the feeling of being 'in sync' with another or are left with the feeling that the other is a million miles away. . . . This negotiation occurs in the implicit domain of interaction, even though in the analytic situation it would be mediated through verbal exchange" (p. 1053).

his fiancée. He told me he had been in intensive treatment twice before—for two and a half years each time—and that professional moves had led these treatments to end. He left each of these experiences feeling better about himself and thinking the treatment had been helpful. He recalled thinking, after each termination, that he had understood his difficulties with bouts of despair and sexual inhibition, and that his self-regard had improved lastingly. Subsequently, though, romantic disappointments led him to realize that his gains were temporary, and he felt he had no choice but to return for further treatment.

During our second consultation meeting, he told me he had definite plans to move to another state when in about two years he finished a project. He suggested that we meet weekly while he was in Michigan and that I provide a referral for an analyst in his new location when he moved. I wrestled with several considerations in my effort to determine how best to proceed. I contemplated his current painful state of mind and his account of his long-standing distress, which called for the intensive, long-term help that only psychoanalysis can provide. At the same time, I considered his history of previous treatments and noted his propensity to walk away before his treatment needs were met.

To further appreciate his fears and hopes in relationships, I took stock of how my encounters with M. affected me. I observed that during our first meeting when he appeared overwhelmed and desperate for relief, I had registered clearly his plea for urgent help and, simultaneously, a disconcerting feeling that I could not reach him. I felt surprised when he came to our second session visibly less distressed. Yet my sense that he could not be reached persisted throughout the second session. In reflecting on the discrepancy between my perception of his relief and my feeling that he could not be affected, I realized that M. felt some release in the process of unburdening himself by laying out his symptoms and feelings but not necessarily from any sense of emotional contact with me or hope that I could help him.

In the third meeting, after M. revealed more about his experiences and expectations of relationships, I further appreciated some of the meanings contained in my experience of him. He delineated his many efforts to find relief of his mood and physical symptoms by enlisting physical therapists, chiropractors, and yoga teachers, efforts that produced only temporary, limited results. M. clearly implied that he had low expectations for anything different happening in the future; though he was not explicit,

he conveyed the message that he viewed health care providers as capable of offering only temporary, impersonal relief and as interchangeable.

I recognized that M. saw me as one more anonymous, expendable helper whom he was seeing in order to vent or to straighten himself up, rather than someone he could rely on to help him in a substantive, deeply personal way. I became aware that M., though forthcoming with symptoms and facts, was cautious with his thoughts and feelings at a deeper level. I sensed that he profoundly doubted anyone's capacity to understand him or contain his feelings and questioned people's motives for offering to help. Instead, he expected others to buckle under the weight of his feelings or the power of his intellect and withdraw or retaliate for his view of them as inadequate or inferior. I thought that if he and I could find a way to understand these protective walls, perhaps our work together would allow him to feel more trustful of himself and others and therefore more likely to find and sustain intimacy.

Despite his vulnerabilities, M. had considerable strengths. Although in pain and unable to sustain intimate love relationships, he was a capable man who distinguished himself in most endeavors he engaged in. He was articulate, ambitious, determined, and extremely perceptive. His high standards, when not used self-punitively, led him to excel and to be a valuable partner in all he did. I thought M. had the raw material to be a great psychoanalytic partner and, if he could engage long enough, benefit from analysis.

It was clear M.'s difficulties had not been addressed sufficiently by earlier treatments. His subsequent efforts to find solutions, such as becoming entirely self-sufficient, moving frequently, focusing on career success, and having a big network of friends, had helped some. Underneath it all, however, he still struggled with emotional difficulties that prevented him from loving intimately and feeling worthy of love.

Given the nature and extent of his difficulties, M. needed immediate, frequent, reliable, and open-ended help. Yet, given that he was planning to leave, how could I help him get the treatment he needed? M. had an early history of losses and having had less help than he needed (parents who could not help him regulate his feelings, his mother's post-partum depression after the birth of his brother when he was a toddler, the death of his father when he was in elementary school, and a beloved aunt who lived with the family and left when M. still needed her). As an adult, he tried to protect himself from loss by remaining emotionally unattached.

Repeating his history, he repetitively left locations and therapists and fell in love with women he left or were emotionally unavailable.

What appeared to be an impossible external predicament mirrored one of M.'s central internal dilemmas: desperately needing help and simultaneously dreading it. During the consultation, I experienced first-hand M.'s ambivalent approach to relationships—at the receiving end of his great need for both relief and emotional distance. By announcing from the outset his intention to leave and find another analyst, M. attempted to proactively limit the duration and potential of our relationship. It was left to me to manage my feelings of disappointment, concern, apprehension, insecurity, frustration, and fear in order not to lose touch with his suffering, his need for intensive help, and my desire to provide it.

At that moment, so early in my relationship with him and not seeing a clear path forward, I contemplated all options. I considered going along with his stated wishes to be seen weekly and then facilitate a referral in his new location. However, this did not seem like a good option because he was in profound distress and needed more than weekly treatment immediately. Also, given his tendency to turn passive into active and leave before he was left, I thought chances were high he would not settle down in the next treatment either. I also presumed that if I agreed to his proposal to work together temporarily, I would be joining him in repeating his history of losses without the conditions necessary to help us understand it. Convinced that unless he was helped to understand this repetition sooner rather than later he would continue to enact it, I decided against going along with his proposed plan. Instead, I offered to be his analyst.

In my recommendation to him, I acknowledged his suffering and outlined what I perceived to be his difficulties, recognizing he had made many good efforts to address them. I also told him that he and I knew that there was work left to be done in addressing some very painful long-standing feelings that recede when times are good but persist raw and unintegrated inside of him. In times of stress, I said, these powerful feelings erupt and blindside him, knocking him off his feet.

M. agreed with my assessment and expressed chagrin that all his previous years of treatment had not cured him. I told him that based on his account I thought they had helped some. However, the problem seemed to be that the treatments ended because he moved, not because he was truly ready to stop. I let him know that I thought it was important to do it differently. I suggested we meet daily in an open-ended way and take as long

as needed to make sense of the profound pain he had struggled with for so long.

M. responded by saying he was still planning to leave and so did not see how we could meet in an open-ended way. Still, he agreed that, given his current distress, more than weekly sessions were needed. He proposed coming four times a week, the frequency of his previous analyses. I agreed to begin on these terms and said I hoped that he and I would continue to discuss frequency, as well as how to arrange to work in an open-ended way. Although I had a feeling that he considered these issues settled and was humoring me by agreeing to discuss them further, M. began analysis. Shortly after we began, after examining some of his fears of working teleanalytically, we agreed that we would work via videoconferencing once he moved.

Two years into the analysis and a couple of months before he planned to move, M. announced that, in anticipation of relocation expenses, he wanted to reduce his sessions from four to three times a week. At this point, having worked together productively and having evidence of the benefits of our work, I felt even more confident in my assessment that M. needed as intensive a treatment as possible. After exploring the timing of his request and discovering his expectation that his move would be the beginning of the end of my investment in him, I told him I thought cutting back was not the solution. Summoning my courage, I said that in fact I thought it would be best if we met five times weekly. The emotional storm that followed fleshed out more explicitly and vividly some of M.'s fears in relationships: being exploited and sexually misused, losing control and feeling uncontrollable voraciousness and rage, having a partner with very thin skin whom he could destroy with his honesty or successes, and losing his sense of himself and his ability to please and hold on to his partner. Realizing that similar concerns had gotten in the way of his relationships with his ex-fiancée and previous girlfriends, M. agreed to add a fifth session to better understand those concerns.

M.'s many resources, intellectual and financial, had allowed him to defend against fears of entrapment through frequent moves. In the beginning of our relationship, M. reminded me of Margaret Wise Brown's very young runaway bunny (1942), who left his mother prematurely. Teleanalysis allowed me to be the mother/analyst who could follow him long enough and persistently enough to help him recognize and begin to address the fears that motivated him to run self-defeatingly from himself

and from intimate relationships. Over the years of his long analysis we met teleanalytically for the most part; three times a year, he would come to Ann Arbor for several in-person sessions.

Teleanalysis allowed us to accommodate M.'s fears of entrapment and dependency and examine them long enough and intensively enough to slowly understand their many sources. Beginning teleanalysis with M. was not a defense against analysis but the only condition under which analysis could continue to take place. The determining factor for helping M. was not meeting exclusively in person. Rather, it was creating the conditions where we would have enough time and opportunity to identify the ongoing oscillations in his and my capacities to think, feel, and together make sense of M.'s unprocessed raw, intolerable states of mind and the symptomatic manifestations of his unconscious fantasies. Working together long enough and intensively enough provided him greater access to his mind and to ways of managing his feelings with increased tolerance. He became less self-attacking and dissociative and less phobic of emotional contact with others, beginning with me.

M. and I were able and willing to work well teleanalytically and achieved good therapeutic and analytic results. Would he have achieved greater gains if I had seen him in my office for the entire analysis? Although, of course, the question cannot be answered, I am doubtful. One of the many difficult realities that psychoanalytic practitioners must contend with is that analytic results cannot be compared. It is as impossible to know what he and I would have accomplished in my office together as it is to know what we would have accomplished at another period in his life.

Nevertheless, during the many years of our working together, as he felt "held" teleanalytically and during in-person sessions, we identified many fearful and shameful states of mind that contributed to his dread of connection and dependency and his efforts at omnipotent self-sufficiency. He gained better access to himself, felt more integrated, and eventually was able to allow others, including me, to know him and move closer to him. As he repeatedly encountered his difficulty sharing his achievements with me, M. became familiar with his unconscious guilt about his successes. Recognizing that he equated his successes with destructive triumph over less successful loved rivals, including his dead father, freed him from the need to deny them and to enjoy them more.

The juxtaposition of in-person and teleanalytic sessions gave us unique opportunities to understand his tendency to form long-distance

relationships that would eventually fizzle, as well as his avoidance of intimacy. A pattern of starting affairs just before he was scheduled to visit for in-person sessions, and ending them right after he left, led us to his shame and guilt over his passionate sexual feelings toward me. M. tried to create a buffer between us because the contact with me felt like a siren song: luring, overwhelmingly exciting, and very dangerous. We learned that his experience of the in-person sessions felt more real but intolerable, and his experience of the telesessions felt more tolerable but less real. Recognizing the extent to which he held back his *real* feelings in telesessions, especially negative feelings, allowed him to feel more real in the telesessions but also overwhelmed. We understood better that physical distance served as an emotional retreat. By unconsciously designating the telesessions as distant sessions, he tried to restore his sense of control and safety. Understanding the multiple functions of his need for distance and control in relationships allowed him to better engage with me and eventually find a physically, emotionally available partner.

My concern with M. was how to create external and internal frames that would allow him to get the help he needed. Having determined that he needed analysis, my consideration was not whether in-person is better than teleanalysis, but how to provide the frequency, continuity, and safety he needed to address his inability to feel safe enough within himself and with another.

P.: When Career Opportunity Calls

P., a middle-aged university professor, had been in analysis with me for five years when he was invited to join the faculty of a renowned university overseas. The invitation included funds and resources unavailable in his current position. P. felt torn. He wanted to accept the invitation, not only because it was an honor but because the university overseas had a department known for innovative work in his area of expertise and for supporting creative original research. At the same time, he still suffered from sexual and writing inhibitions, social anxiety, and occasional panic attacks. Having gained some relief from our work but still suffering, P. did not want to end analysis.

P. had had a helpful first analysis when in his twenties. However, because he had had an unproductive experience with phone sessions during that analysis, he felt that working teleanalytically might compromise our work. In exploring his earlier telephone experience, we found that

when P. left town for a sabbatical semester, he and his analyst reduced their sessions from four to one a week. P. hated the phone sessions and described feeling panicked in anticipation of each session and distant from his analyst when they spoke. P. initiated the reduction in sessions because he had privately thought that speaking on the phone would be difficult. He interpreted his analyst's unquestioning agreement as confirmation that he, too, did not like meeting by phone. After recognizing that his negative reaction to speaking by phone was partly a response to having spoken less often and having felt rejected by his analyst, P. was more optimistic about using phone sessions to speak to me productively. He briefly considered videoconferencing but decided he preferred speaking by phone because in his mind it replicated most closely his experience of using the couch, which he found helpful. At that point, ten months before he would have needed to move, he decided to accept the job and, after moving, continue to meet teleanalytically five times weekly.

The months preceding the move proved to be very productive for our work. Initially, after making his decision, he spoke with dread about the logistics of the move and anticipated many difficulties when he arrived, including problems adjusting to his new environment, being disappointed by his future colleagues, and not being able to work creatively enough. Noting that he was focused on the destination and not the departure, I suggested that he might be having difficulty thinking about what it would be like leaving his home in Ann Arbor and our way of working together in-person. Initially he dismissed my suggestion and maintained that, since we would be continuing phone sessions at the same frequency, he did not anticipate any changes. However, after repeated allusions to professional collaborations in Michigan falling apart following his move, he reluctantly recognized that, despite our plan to continue, at some level he expected our relationship to end. Once identified, P.'s fear of losing me transformed into a haunting certainty. He experienced waves of panic states and an inability to sleep, work, and even think. At times he appeared robotic and distant or hypervigilant. Recognizing that he was lost in states of mind he could not verbalize, let alone explain, I reached into my own mind to find any thoughts, sensations, or feelings that might help us understand him. At moments I felt lost myself and wondered privately whether he could manage the move psychically and doubted the wisdom of arranging to meet by phone.

As we looked for meaning within these disturbing feelings, slowly we began to make out different facets of P.'s emotional experiences. Although

we had previously identified the traumatic impact of a surgery and hospitalization when he was a toddler, at this juncture we understood their emotional effect with unprecedented immediacy and resonance. As the months passed and the date of the move approached, we came to experience between us the separation-individuation struggles that P. described having had with his parents, especially his mother. At moments, he experienced his decision to leave as if *I* were leaving him. He imagined I was eager not to have him around and to be free from what he thought I experienced as his demanding presence. "Why did you not stop me from committing to go? If you cared, why would you agree to continue remotely and no longer see me in person?" he asked. At other moments, he reversed himself and felt suspicious of my interest in his feelings about leaving. He feared I was encouraging him to share his feelings to create a need in him and manipulate him to want to stay. He further imagined that I wanted to hold him back, to feel wanted and needed. When he thought of me as unable to release him because of my own needs, he worried that when he left I would retaliate and disengage from him, and he would have to manage without my attention, care, or help.

P.'s growing ability to share his negative views of me, including fears of my fragility and likelihood of retaliation if he disclosed these "horrible" views of me, contributed to a growing sense of trust between us. At the same time, our joint efforts to tolerate his states of mind, find words to speak about them, and understand what they represented gave me hope that we could carry these gains into our telesessions. Yet, with the move in sight, questions remained: Could he feel his sense of abandonment and loss without devaluing, as he characteristically stopped himself from experiencing loss in the past? Would he be able to bear feelings of deprivation without falling into a paranoid state and experiencing me as a frightening stranger?

P. had always felt that his sense of freedom and independence and the security of relationships were mutually exclusive. Now, as the time to leave approached, he felt pleased he could envision something different and would be pursuing his interests while continuing to have my help and support. Although regretful for having made similar arrangements in his first analysis, he felt grateful we could do so now.

During our first calls after the move, P. commented with relief that having talked about the way he disengaged and withdrew paid off and he retained his sense of my presence and investment in him. P.'s characteristic mode of defending was, of course, available to him, and he had deployed it regularly since the beginning of the analysis. However, it became more

prominent after his decision to move. His move gave us a chance to identify his emotional withdrawal more clearly, understand the suffering that catalyzed it, and be better able to help him with it. He became more capable with me and in other relationships of monitoring himself for emotional distance and becoming more present. Regular in-person visits helped us identify elements he defended against in telephone sessions, such as longings to be physically close and the presence of a suspicious, persecutory way of looking at himself that close physical presence could activate.

Of the many difficulties we worked on, one stands out because it highlights an advantage of working teleanalytically. A news story involving a priest accused of molesting children brought up his own molestation by a beloved priest, which he had mentioned in an in-person session. In the past, during in-person sessions, he had been seized with panic when he thought of the event and had been unable to share details. Now, as he spoke of details of the news story, he slowly recalled the specifics of his abuse with fear, shame, and eventually fury. He volunteered that speaking on the phone felt safer. He recognized that at some level he worried that I, too, would be a predator and overstimulate him or traumatize him.[9]

S.: When Issues of Confidentiality Preclude In-Person Analysis

S., a professional woman from another city, contacted me for a consultation after a period of depressive symptoms that interfered with her capacity to work. S. had heard about me from her husband, a mental health professional who had attended a workshop where I presented on the analyst's reluctance to deepen analysis. Her hopelessness had begun a few months earlier, after her daughter was diagnosed with a major mental illness. S. had been in analysis previously, but her analyst had since died. For reasons of confidentiality—her husband was well known in the mental health community—she did not want to be seen locally. After a brief consultation, we decided that her symptoms had been persistent and debilitating enough to require intensive help. Blaming herself for her daughter's illness but determined not to burden her with her own distress, S. was strongly motivated to reenter analysis. We agreed to meet for a five-times-a-week analysis over the phone.

S.'s first analysis had helped her identify that her mother's suicide when she was four years old, her parents' sadomasochistic relating while

[9]Scharff (2012) also reports on how the teleanalytic frame affected the emergence and working through of sexual trauma.

her mother was alive, the birth of her two younger siblings, and the elaboration of these realities and experiences in her own mind had contributed to her painful emotional states and a pervasive sense of insecurity about her worth and lovability. Because of the help that she received, S. had lived with less discontent after ending her analysis fifteen years earlier and until her daughter's diagnosis.

During the termination phase of our work six years later, as we reflected on what we had accomplished, S. suggested that she and I had not discovered much that was new to her in terms of historical events in her early life. Yet she observed that our collaboration had afforded her a deeper, fuller emotional appreciation of how her mother's suicide disrupted her sense of herself as safe, stable, and good and profoundly affected her development and relationships thereafter. Despite the physical distance, by attending to what emerged in her mind and our interactions within each session, we were able to move emotionally close to the origins and meanings of her deep feelings of guilt and self-recriminations, her fear of her hostility and her love, her pervasive but unconscious sense of omnipotence and grandiosity, and her shame for her vulnerability, longings, and suffering.

In time, we understood that her daughter's illness had reawakened the loss of her mother, activating a depth of anguish S. did not know existed within her and leading her to call me. At that time, I had some psychotherapy experience working teleanalytically but had never begun an analysis remotely. Yet, given her concerns about confidentiality, referring her for in-person psychoanalysis was not an option. Responding to her desolation and my own undefined but distinct sense that working together could help her, I offered her analysis. Although, of course, it not possible to know what she and I could have accomplished if we had met in-person, her resulting relief from depression, increased capacity to self-regulate and self-analyze, and expanded ability to be present to herself and relate to others led us to conclude that this had been an effort worth undertaking.

DISCUSSION

I came of age analytically when in-person analysis and supervision were the norm. I remember driving an hour each way once a week to meet with one of my supervisors, and forty-five minutes each way a different day to see a second supervisor. I imagined but never seriously considered speaking on the phone for supervision. It was just not done. At present,

analyzing, supervising, and consulting teleanalytically with occasional in-person meetings are regular facets of my practice.

I approached teleanalysis with some apprehension,[10] rooted in part in the presumption that what teleanalysis offered was inevitably second best. In retrospect, I think this belief rested partly on my underappreciating the importance of the analyst's emotional engagement and overestimating the importance of physical presence.[11] I was confusing distance analysis with distant analysis. I think my apprehension was also related to insecurity stemming from my lack of training and experience doing teleanalysis. I will address these issues briefly later.

What I have learned from working teleanalytically has surprised me and has led me to revise earlier preconceptions. My work with M., P., and S. has contributed to my understanding that, in certain circumstances, teleanalysis is not just the only opportunity for analysis—and not offering it is a resistance to engaging intensively with a patient—but can offer results indistinguishable from those of in-person analysis.

Over the years, I have presented process material from teleanalytic sessions to study groups of senior analysts and to senior consultants. Time and again I was surprised to find that the "telematerial" was indistinguishable from in-person process to my colleagues[12] unless I specifically told them, or it was explicitly contained in the process—when, for example, the patient and I were addressing the teleanalytic frame. I am not suggesting that there are no differences. There are. However, if one uses an analytic lens to consider reactions to the frame, the differences provide not liabilities but rich sources of meaning that can add to the understanding of the patient's psychology. For example, as seen with M., physical distance

[10]Lindon (1998) finds that "the analyst initially seems more ill at ease than the patient" (p. 526). He further reports that the anxiety related to telephone analysis dissipates with more experience and over time. I agree with the many authors who suggest that the analyst's comfort with the medium determines in part the ease with which she can listen and intervene. Beginning on the internet for an analyst is anxiety-producing in the same way as being behind the couch for the first time, whether she knows it consciously or not.

[11]Lemma and Caparrotta (2014) agree that although Skype and telephone analysis affect each member of the analytic couple and bring "an additional dimension to the therapeutic relationship that requires analysis, the analyst doing teleanalysis is no different from an analyst who works with his patient in the actual consulting room" (p. 14).

[12]Lindon (1988) reports that he, his patient, and his study group could not distinguish between in-person and telephone sessions in terms of the quality of the therapeutic rapport or the dyad's ability to do analytic work. Similarly, Neumann (2013) suggests that process from telesessions and in-person sessions could not be distinguished by reviewers.

and physical presence were used both defensively and adaptively. He defensively and unconsciously designated the in-person sessions as the "close" and scary sessions and the teleanalytic sessions as the safer retreats. Identifying and speaking to the defensive uses of these designations—that is, not taking them at face value—allowed for their analytic consideration. The analyst's and patient's attention to the *meanings* of the setting constitute an analysis, not the setting itself.

My experience with P. provides further confirmation. In anticipating a move and major separation while knowing we would still be working together, P. felt contained enough and at the same time activated enough that he experienced unprocessed early separation trauma with unprecedented intensity. Only then did we have the chance to appreciate in an experience-near way the full force of his trauma. Although his decision to move contained elements of resistance to deepening the analysis, it also contained his attempt to rework his earlier trauma. Our consistent, close attention to his thoughts and feelings about the move and about working teleanalytically, before and after he moved, allowed us to analyze the passive-into-active enactment of his early separations and resulted in a deepening of the analysis.[13]

In teleanalysis I stay as close to an analytic frame as possible. I recommend that patients attend five times weekly, use a couch, and speak as freely as they can. When videoconferencing, I greet and say good-bye to patients face to face. After greeting me, patients lie on their couch with the computer placed in the position I would assume if I were in the room with them and in a way that I can see their whole body and they can turn around and see me if they wish. Patients begin and end sessions by initiating and ending calls, similar to their entering and leaving my office. I expect payment at the same time and charge for missed sessions in the same way as with the in-person setting. I ask that patients tell me in advance if they plan to meet with me in a location other than what is usual for us. Similarly, when on a few occasions I have needed to meet with a patient from my home office, I informed her and attended to her conscious and unconscious reactions to my announcement of this change of

[13]I agree with Migone (2013), who thinks that what is most important in deciding whether to begin an analysis in any setting, including online, are the patient's treatment needs, his or her ego function, and the transferential and countertransferential meaning of the setting for patient and analyst. He offers the useful reminder that to achieve a "truly psychoanalytic way of thinking," an analyst must strive to hold in mind the meaning of the choice of setting, not only at the beginning but throughout the analysis, so that it can remain available for ongoing understanding (p. 293).

location. I do not accept meeting arrangements that are distracting to me and interfere with my ability to analyze, such as the patient's driving or being at a noisy place where we cannot hear each other clearly.

Since my analytic training did not include instruction or supervision in teleanalysis, and certainly not a training teleanalysis, I found it very useful to consult with and read the work of analysts who practice teleanalysis. Reading the literature has sensitized me to ways I have normalized technological difficulties and avoided acknowledging them. Essig's and Russell's writings alerted me to analysts' tendency to deny the differences, difficulties, and losses that inhere in meeting online and try to ignore, compensate for, or accommodate them. In retrospect, these attempts to protect myself and my patients from difficult feelings created an atmosphere of distance and falseness. Addressing with patients the painful realities of teleanalytic interruptions and malfunctions, or their frustrated yearnings to smell me or lie on my couch, resulted in a stronger sense of emotional connection. As I have felt more confident in the usefulness of teleanalysis and my capacity to practice it, I have become better able to acknowledge and speak to patients' perceptions of differences and limitations in telesessions and their meanings.

In addition to strong motivation and commitment from analyst and patient, I can identify a few other elements that were consequential in teleanalytic work with M., P., and S.: establishing and holding an internal and external analytic frame rigorously; periodic in-person visits; recognizing my patients' and my thoughts and feelings about the teleanalytic and in-person settings and seeking to understand their meanings as well as their use as resistance[14]; and the energetic analytic exploration of resistance and transference-countertransference enactments and fantasies. I have found that frequency, continuity, and safety, and a focus on explicating transferential and countertransferential experiences and enactments, determine the usefulness of a treatment, whether it takes place in the office or teleanalytically.

Most analysts would agree that establishing and maintaining an analytic frame requires ongoing emotional effort and resolve. In my work and in supervising others, I have found that analysts, including myself,

[14]For example, when a patient has consciously or unconsciously decided that the telesessions are the "safe" sessions while the in-person sessions can be dangerous, or that the in-person sessions are real while the telesessions are the pretend sessions.

can countertransferentially slide into underappreciating the role that the analytic frame of mind and setting plays in supporting a lively, effective analytic engagement and process (Ehrlich 2010). As important as paying analytic attention to the frame is in in-person analysis, I have found it to be even more so in teleanalysis. As we saw in Russell's examples, the inherent flexibility of the teleanalytic setting provides fertile ground for unexamined enactments that undermine analytic work.

Is the heightened anxiety reported by analysts about maintaining the connection with their patients catalyzed by physical distance in teleanalysis, or is it just more obvious? My experience leads me to conclude that the physical distance inherent in teleanalysis poignantly evokes patients' and analysts' painful early experiences of emotional distance, separations, and losses and therefore strong resistances.[15] In working teleanalytically, establishing an explicitly stated, dependable frame, and regarding variations in the frame as meaningful, helped contain my patients' and my own anxieties about distance, loss, and separation enough for us to understand their meanings. I believe it also conveyed the seriousness of my commitment to them and my confidence in the value of our analytic collaboration, which in turn helped them prioritize it.

How do analysts' identity and conviction affect their capacity to do teleanalysis? As with in-person analysis, I have found that analysts' confidence in the teleanalysis is a function of many variables, including the analyst's confidence in analysis in general, prior experiences with teleanalysis, facility with technology, and a capacity to address difficult frame issues. Given that an analyst's confidence depends in large measure on having benefited from personal analysis, does the fact that most analysts have not benefited from teleanalysis as patients preclude their having the same level of conviction about its therapeutic value as they have regarding in-person analysis? Although analysts' confidence in their capacity to be helpful can transfer to teleanalysis, I have found that having had a helpful teleanalytic experience as a patient or supervisee adds considerably to their conviction about its usefulness and feasibility. Even though I practiced teleanalysis before having my own analytic

[15]Lindon (1998) reports feeling deprived by the patient's physical absence. I, too, have found that separation and physical distance evoke poignant memories and experiences like those evoked by the analyst's vacations or other analytic separations or disruptions.

experience with teleanalysis, since then I have a more visceral conviction regarding its value and helpfulness.

CONCLUSION

Asking whether teleanalysis is useful is not the most pertinent question. More germane is the question: Are analyst and patient able and willing to do the emotional work necessary to create a good-enough analytic frame and work analytically while meeting teleanalytically? I have argued here that teleanalysis, if practiced with an analytic frame of mind and setting, does not constitute a move away from analysis, as some maintain. Instead it can offer additional rich opportunities for patients to receive analytic help and for analysts to practice analysis. Teleanalysis will not destroy analysis if analysts practice *analysis* within the teleanalytic setting.[16]

In contrast to critics of teleanalysis, I have found that the physical distance and occasional technological difficulties do not limit or preclude useful analysis as long as analysts pay disciplined, thoughtful attention to establishing and maintaining an external and internal analytic setting conducive to analysis; identify, contain, and analyze their and their patients' responses to the setting, including anxieties about meeting at a distance and experiencing technological disruption; arrange to meet with patients periodically in person; and want to practice teleanalysis.

Comparing analytic process from in-person and teleanalysis, I have found that analysts' emotional engagement and working affectively close to patients is more consequential than physical distance. Recognizing how analyst and patient use physical distance to create emotional distance provides valuable analytic information. When considered analytically, the feelings and thoughts distance evokes are not insurmountable obstacles. On the contrary, they help deepen an analysis. In addition, the juxtaposition of the experiences of the in-person and the "tele" settings provide increased, unique opportunities for analysis because they activate different transference-countertransference wishes, fears, and states of mind.

[16]I concur with Migone (2013), who contends that neither in-person nor virtual presence is analytically inferior or superior to the other. He suggests that they constitute two different kinds of experience and that each experience, when explored analytically, yields valuable information with meanings specific to each individual patient.

In earlier work (Ehrlich 2004, 2010) I identified different manifestations of the analyst's reluctance to engage in analysis, including taking at face value patients' scheduling conflicts and their apparent lack of interest in analysis. Adding to the list, I believe that focusing on physical distance or potential technical difficulties when teleanalysis is the only way a patient can have or continue to have an analytic experience can be another manifestation of the analyst's reluctance to engage in analysis. In my direct and supervisory experience with teleanalysis, I have found that not offering teleanalysis, or practicing it sloppily by not adhering to a consistent and reliable internal and external analytic frame, often reflects manifestations of additional, more contemporary versions of the analyst's reluctance.

I do not believe that any patient/analyst pair can or should engage in teleanalysis. When proposed by patient or analyst primarily as a matter of convenience, I would suggest it constitutes a move away from inconvenient emotional truths that need to be identified and understood. Also, some patients and analysts, for various internal or external reasons, cannot work well within the teleanalytic setting.[17] For example, analysts who do not believe the teleanalytic setting is effective will not engage in it with the same determination and conviction they would in the in-person setting and consequently will not get good results.

Analysts who practice teleanalysis would benefit from clinical accounts addressing a number of questions: Under what conditions is teleanalysis most effective? When should distance analysis be offered? What should the training for it be? What are some technical considerations specific to distance analysis? When is accepting the patient's request to meet remotely a rationalized resistance on the analyst's part, and when is it a necessary adaptation that allows patients to receive the intensive help they need and otherwise would not receive?

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[17]For indications and counterindications, see discussions provided by Zalusky (2005), Eckardt (2011), and Scharff (2012)

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