Chapter 4:

Sensorimotor Psychotherapy from a Distance: Engaging the Body, Creating Presence, and Building Relationship in Videoconferencing

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Sensorimotor Psychotherapy values body-related communications and the "somatic narrative:" the story told by posture, gesture, facial expressions, movement and eye gaze. In this approach, attention is given to how the body itself holds the legacy of trauma and attachment inadequacies, and to how this legacy can be changed through awareness of the body and its movement patterns. Because physical habits reflect and sustain implicit processes, some of which are shaped in the brain and body before the acquisition of language, the somatic narrative can reveal patterns that are not told with words. In Sensorimotor Psychotherapy, the correlations between the body, beliefs, and emotions are paramount. For example, a limiting belief such as, "I don't have any support," or an emotion such as disappointment, will correspond to patterns of physical sensation, posture, gesture, breath, gait, autonomic arousal, and movement. Clients become aware of these procedural habits, and eventually acquire skills to change the ones that reflect and sustain outdated working models that interfere with satisfaction and richness in current life.

To help clients discover and change the non-conscious habits that diminish well-being, Sensorimotor Psychotherapy prioritizes mindful awareness of the moment-by-moment *experience* of physical, emotional and cognitive patterns over engaging in conversation, or "talking about" (Kurtz, 1990; Ogden & Minton, 2000; Ogden, Minton & Pain, 2006; Ogden 2015). Mindfulness is often characterized as a non-verbal, internal endeavor, taught as a as a solitary, silent activity, even when practiced in group settings. In contrast, Sensorimotor Psychotherapy's "Embedded Relational Mindfulness:"

> "is integrated with and embedded within what transpires moment-to-moment between the therapist and client through the co-created relationship. Therapists encourage clients to observe internal experience in the present-moment, and verbally share what they observe as their experience is occurring" (Ogden & Goldstein, 2017, p 68).

Embedded relational mindfulness encompasses several critical elements: the therapist observes visible elements of clients' here and now experience, directs them to become aware of this experience (*Let's stay with that hollow feeling in your chest and the sadness that goes with it*) and asks mindfulness questions (*What do you notice in your body right now? Is that hollow feeling staying the same or changing?).* Through these interventions, clients become mindful of their internal organization of experience in the moment, and verbally report what they notice to the therapist.

Although this approach is traditionally an in-person treatment, it lends itself well to a videoconferencing format, where the client receives psychotherapy services at a different site from the therapist's location but where parties can see and hear one another in real time. Hilty,

Ferrer, Parish, Johnson, Callahan and Yellowlees (2013) concluded "Videoconferencing appears to be as effective as in-person care for most parameters, such as feasibility, outcomes, age, and satisfaction with a single assessment and consultation or follow up use" (p. 15). However, since working with the client's movement, gesture, posture as well as the body-to-body conversation between therapist and client are essential elements of the approach, Sensorimotor Psychotherapy via videoconferencing presents specific challenges. To elucidate these challenges and their possible solutions, we present a composite case study of a client -- "Lea" -- who suffers from a history of trauma (molestation by a friend of the family), attachment disturbances (divorce and abandonment), and the diagnosis of obsessive compulsive disorder (OCD).

Introduction to Lea

Lea, a 21-year-old college student, experienced uncontrollable worries and doubts that had become obsessions. When these emerged, she performed repetitive habits that decreased the anxiety caused by her obsessions. She complained that these time-consuming rituals caused her additional distress and interfered with her studies and relationships. Lea's symptoms included many of those typical of OCD: repeated hand washing, fear of touching "germy" objects, repeated checking (e.g. to see if doors are locked), needing things to be in a certain order, needing to do things "just right."

Lea's symptoms began prior to her parents' divorce when Lea was eight years old, leaving Lea, an only child, in the full-time care of her father. Her mother went on to remarry, move out of the country, and start a new family. Those who struggle with OCD are particularly

sensitive to stress, and tend to focus on negative thoughts, and Lea was no exception. She talked about the "rejection" and "abandonment" she felt, and wondered aloud what was wrong with her. Her feelings of inadequacy led to difficulty forming close bonds with others, and Lea tended to isolate herself from her peers. The rituals she compulsively performed exacerbated the self-criticism she felt about her OCD, creating a vicious cycle of behavior from which she could not easily escape, characteristic of those with an OCD diagnosis. Lea's feelings of abandonment, isolation, and low self-esteem were complicated by sexual harassment and molestation by a friend of her father's over a period of two years when in her early teens, a trauma that Lea did not reveal to anyone until she entered therapy.

Beginning Videoconferencing: The Physical Setting and Preparation

In videoconferencing, the therapeutic alliance can become unfocused and weakened, especially when casual formats, such as face time, are used. Creating a physical setting for videoconferencing that mirrors in-person therapy and using that setting consistently, can strengthen the therapeutic container. The work environment should be quite and support a focused intention. At their first meeting, Lea and her therapist each designated a room for their videoconferencing sessions, which helped to establish a sense of continuity and predictability. They also discussed disabling their phones and any distractions on the computer, such as the feed of email, text messages or alerts, to reduce the tendency to multitask or become sidetracked by these temptations.

Since Sensorimotor Psychotherapy depends upon mindfulness, allowing the time to shift gears and quiet the mind prior to the session is helpful. If the therapist arrives at a videoconferencing session in a speedy "action" or "to-do mode", the client might respond in kind. Mindfulness is facilitated when the client can also quiet the mind and be aware of internal experience rather that "do." Quieting the mind was challenging for Lea, and she and her therapist decided to start each videoconferencing session with a few moments of a quiet body scan to help shift gears to a more mindful "being" mode.

Lea's therapist initial goal was to build rapport with Lea in order to form a strong, collaborative therapeutic alliance with her. Sensorimotor Psychotherapy is an attachment-focused approach that emphasizes the role of the therapeutic relationship to foster safety and heal the aftermath of adverse experience. In contrast, although remote Cognitive Behavioral Therapy (CBT) has been found to be an effective modality for OCD (Aly, 2017), CBT relies on self-help protocols, with minimal client-therapist interactions (Rees, Anderson, Kane, & Finlay-Jones, 2017). Of note is that the therapeutic alliance is established not only with words, but through implicit body-to-body affective communication. As Bowlby asserted decades ago, "With attachment theory in mind, a therapist will convey, *largely by non-verbal means*, his respect and sympathy for his patient's desires for love and care from her relatives, her anxiety, anger and perhaps despair at her wishes having been frustrated and/or denigrated" (1980, p. 180, emphasis added). Similarly, Schore (2009) writes: "At the most fundamental level, the work of psychotherapy is not defined by what the therapist explicitly, objectively does for the patient, or says to the patient. Rather the key mechanism is how to implicitly and subjectively be with the patient" (p. 41). Essential to the therapeutic relationship is state-sharing, a reciprocal embodied

consciousness conveyed and experienced through body to body affective communication. Clearly, this presents challenges in online videoconferencing.

State sharing in videoconferencing required that the therapist be able to meet the client in resonant emotional territory in the absence of physical proximity. Because it is non-verbal and implicit, state sharing may be more difficult to attain during videoconferencing, especially when using a small screen. Lea and her therapist decided to use their large screen computers, rather than laptop or cell phone to allow for non-verbal details such as body posture and facial expression to be more easily noticed and felt by each party.

State sharing also requires that therapists are aware of how they use their voices to connect with clients. In the therapeutic relationship, "right-brain to right-brain prosodic communications . . . act as an essential vehicle of implicit communications…The right hemisphere is important in the processing of the 'music' behind our words" (Schore & Schore, 2008, p. 14.) Vital to establishing the relational safety and state sharing in videoconferencing is the therapist's ability to match client's prosody—timbre, volume, pace of their words—as well as their eye contact, facial expression and physical movements (leaning towards, taking a deep breath, tilting the head and so forth) to appropriately to join with the client. Thus, therapists need to be in touch with themselves, their bodies, and their own state, including countertransference, defenses, enactments, and so on.

In Sensorimotor Psychotherapy, tracking the body's posture, expression and movement is essential. During the first session, Lea and her therapist talked about the importance of

addressing the body and the challenges this presents in videoconferencing as compared to in-person therapy. For example, tracking the body is limited when only the client's face, rather than the whole body is visible on the screen. Moving chairs further from the camera allows more of the body to become visible, however doing so renders it difficult to track the subtleties of facial expression. Together Lea and her therapist established some guidelines to work with these challenges.

They chose rooms that were large enough to move their chairs closer and more distant from their computers, and they each utilized rolling chairs. They explored each moving closer to the camera and further away, checking Lea's reaction to each position. With her therapist's prompting, Lea decided that the "default" view that was most comfortable for her was to be able to see the therapist's head and shoulders. This became the therapist's normal position in videoconferencing with Lea, but was adjusted according to their guidelines throughout each session. They also agreed to move their chairs further from the camera when exploring posture and movement to make the body more visible, and move closer to the camera at other times, especially when Lea felt emotionally vulnerable and needed to clearly sense her therapist's resonant empathy that shows most in facial expression and eye contact.

The therapist also asked Lea to pay special attention to her body, and be sure to report any physical changes she experienced, since these might not be visible to the therapist. Providing a menu of what might be important—such as "tell me when someplace in your body becomes tight, or you feel a tingling sensation, or a little movement, like a lifting of your fingers

or a pressing down with your feet…" helped Lea understand what her therapist was asking of her.

Lea's therapist also requested permission to frequently ask Lea questions about her body to compensate for the limitations in tracking the body in videoconferencing, and also asked Lea to tell her if any of these questions felt uncomfortable. For instance, questions such "When you bring up the molestation, what do you notice in your body? Can you sense any movement, maybe in your legs or somewhere else?" are asked when Sensorimotor Psychotherapy is conducted in-person, but become even more frequent and critical during via videoconferencing to continually call upon the body's movement, posture and sensation to address the client's concerns.

Additionally, they discussed that the therapist would also pay attention to her own body and share her somatic response to something Lea might say, for example, "I feel like my stomach is tightening and I'm pulling back as you mention your aloneness – I wonder if that corresponds to what you're feeling in your body?" The therapist may also contact what transpires between therapist and client, emotionally and physically such as by saying, "There's a real shift in the emotion between us," or "It seems like you move back in your chair as I lean forward."

Once these initial guidelines were established, Lea and her therapist were prepared to commence Sensorimotor Psychotherapy via video conferencing. Lea's primary initial goal was to modulate anxiety and hyperarousal and reduce the OCD behaviors she found so challenging, so therapy began with developing somatic resources--physical actions that would ease Lea's

anxiety "just a little." The goal was not to eliminate her anxiety altogether, but rather discover a variety of gestures or movements that would help her quiet it slightly.

Somatic Resource: Hand on Heart

Lea had a great fear of illness from the germs she might contact, a fear she admitted was irrational. Her stated goal was to refrain from washing her hands after contact with objects, particularly when she was in public. However, when she tried to refrain, her anxiety escalated causing her heart rate to increase. The somatic resource Lea discovered was to place her hand on her heart, which helped her to soothe the anxiety and gain a sense of self-regulation. Lea and her therapist both moved their chairs so that each of their torsos, rather than just the face, was visible. Slowly, and mindfully, the therapist suggested that they bring their hands gently to their hearts, and to notice the effect. The therapist and Lea's executing this somatic resource together strengthened their attunement and allowed the therapist to model a gentle, nourishing self-touch action. As she repeated this somatic resource over and over, she began to recognize that nothing bad happened when she refrained from washing. With this new awareness, Lea built her confidence in drawing upon her own body to manage her anxiety.

In Sensorimotor Psychotherapy clients and therapists collaborate to discover somatic resources. This is especially important for these with OCD because reassurance seeking (i.e., from parents, teachers, and therapists) is a predominant response when anxiety or obsessive thoughts are experienced as unmanageable. However, looking for reassurance from a therapist or caretaker can foster an endless cycle, with clients fearing they will not be able to tolerate the

uncertainties that arise if they do not get the reassurance they seek. Lea's discovery of a somatic resource was a tangible tool that she could use independently rather than seek reassurance from others, which she found empowering.

Somatic Resource: Posture

Lea's anxiety about eating at restaurants began after her parents divorced, and became so profound that she obsessed about avoiding any food she considered "unhealthy." She became unable or unwilling to go to a restaurant without prior reassurance that the venue would accommodate her ever-growing concerns. During videoconferencing, Lea was in the throes of anxiety as she spoke of this issue. Her therapist noticed that Lea's whole body tightened and her posture became both tense and droopy. This tight, slumped posture further diminished her sense of confidence and control, leading her even more anxious.

Lea and her therapist collaborated to find ways to relax the tension and shift her posture. They both moved their chairs back from their computers far enough so that they could see each other's posture. This presented an opportunity for the therapist to model different postures—both a slumped and an upright, aligned posture—and describe the difference she experienced with each of these two stances, sparking Lea to experiment as well. Lea compared each posture and her therapist asked her to notice the different emotions, thoughts, and degrees of self-esteem. Lea had recently seen the Broadway production of *The Lion King* and was reminded of when the young Simba gained confidence. She described that his whole body shifted as he held his head high and his posture became tall and powerful. Lea's therapist observed and named similar

shifts in Lea's body as she spoke, encouraging her to exaggerate this posture to attain a taller, more powerful stance.

Since both Lea's and her therapist's rooms were large, they could easily move far enough away from the camera to allow a view of their full bodies when standing. Doing so, they explored contrasting Simba's aligned stance with a collapsed one, and Lea immediately noticed that she felt more fearful, anxious and less willing to notice her surroundings when her posture was collapsed. She recognized that an upright posture decreased her fear. Her therapist suggested that they practice this upright posture while walking. They each took a few minutes to walk around their rooms, noticing how it felt to walk with a tall, upright posture. When they came back face-to-face in front of the computer, Lea reported that she felt more engaged with her environment in an upright posture, and imagined walking into a restaurant in this posture, which then became her homework. Lea found that she felt stronger, more powerful, and more confident and could explore eating in a restaurant when she maintained an aligned, tall posture.

Somatic Resource: Boundaries

Lea had difficulty setting boundaries with others who came "too close" to her personal space, or asked her to do something she did not want to do. Drawing upon a Sensorimotor Psychotherapy boundary exercise, traditionally used to establish a felt sense of physical safety, Lea's therapist suggested they explore saying "no" with their bodies, rather than with words. Pushing their chairs away from the camera for more visibility, they tried out different ways of physically saying "no:" tensing their bodies, using facial expressions, narrowing their eyes and putting their

hands up with palms facing outward. It should be noted that such a pushing action by the therapist can appear distorted if the outward facing palms fill up the screen of the client. The therapist must be aware of how their actions come across on the client's screen. Lea's therapist kept one eye on the window that reflected her own body to assure that her demonstration of actions the pushing motion appeared as intended to Lea, and did not appear warped.

Lea liked the boundary exercises. She said she felt a strong "no" inside and she would like to stomp her feet. Her therapist suggested, "Perhaps you would like to stand and stomp your feet to say 'No." Lea hesitated, saying she would be embarrassed for anyone to see her stomping. Her therapist suggested she might mute the sound on her computer and try the stomping out of view of the camera. With the ability to control her environment and exclude the therapist, Lea felt safer and more comfortable. After she tried the exercise, came back to the camera, and turned on the sound, her face glowed and she reported a felt sense of freedom. Giggling, she said she stomped on the floor so fiercely that she worried her roommate, who came running from the other room.

This foundational boundary work was then applied to real-life situations when Lea's anxiety and her OCD symptoms encroached on her well-being. For example, she said "no" when her concerns about germs arose. She envisioned Simba and his powerful stance, and laughed as she described Simba trying to find his roar; when he tried, only the tiniest of roars was vocalized at first, yet he persisted. Lea imagined herself roaring "no" in a restaurant, and even laughed aloud as she described all the diners roaring back in her imagined scenario. Her therapist suggested that maybe they could both roar "no", in a message of solidarity with Lea in

her newfound assertion and joy. Face-to-face at their computer screens, the therapist counted to three, and then both roared, much to Lea's delight.

This joyful collaborative experience was enhanced by the videoconferencing format, as Lea could control the volume on her computer, move out of view of the therapist, and silence her therapist or herself when she felt the need by putting her sound on mute. In this way, she could assert her sense of control over her environment and give herself safety as she tried new actions. This mitigated the sense of awkwardness or even shame that might inhibit exploring new actions. In this respect, videoconferencing offers more options than does in-person work.

Somatic Resource: Breath

Lea compulsively used social media, which had turned into an overarching obsession. Only a generation ago, social exchanges were limited to family members and select friends, and people carefully selected who was privy to their personal thoughts and actions. Now, however, young and old alike post on Facebook, Instagram, and Snapchat; write personal blogs; and send tweets, often fueling an escalating need to let others know of one's actions and thoughts at any given moment throughout the day. This culture in which it is so easy to document our lives can foster addictive behavior, although clear diagnostic criteria remain to be defined (van Rooii, Ferguson, Van de Mheen, 2017).

Several factors lay the groundwork for this phenomenon. Posts on social media often leave out the more challenging moments in life, including self-reflective posts that process one's

hurts, frustrations, sadness, and anxieties. Instead, a deliberate attempt is made to portray a persona that conveys the message "all is great." This false self, in turn, generates a sense of longing, envy, feelings of being left out in others, and unrealistic expectations about how their lives should be.

Lea aspired to be an "influencer" on social media by generating followers and obtaining sponsors to pay her for product placement. Lea experienced an addictive, obsessive, never-ending pressure to post, tweet, and so forth, similar to phenomenon that occur in the addictive cycle of any substance (Borba, 2017, Pantic, 2014). Concomitantly, she experienced anxiety about the negative feedback she received online and lived in constant fear of online haters. She also felt painfully excluded whenever she discovered she had not been invited to an event or party others she knew were attending. She acknowledged that she tended to withdraw, avoid, and shut down when feeling wounded. She described an entire summer during which she saw no one in-person, and remained solitary in her room, connecting solely through social media. As her social withdrawal escalated, she became more isolated in all aspects of her life.

Feeling under pressure to create new and ever-more witty, beautiful, or dramatic online content, Lea found herself spiraling downward. She described a rapid escalation of overwhelming feelings as she waited for acknowledgment and responses to her posts. Her self-destructive thoughts increased, her already low self-esteem plummeted, and she became ensnared in depression. Her anxiety further escalated after a brief dating relationship when her former partner began posting photos to show that he had moved on. Lea felt humiliated, especially in contrast with others' supposedly perfect relationship status updates. Her addiction

to social media grew unbearable, leaving her feeling abandoned, left out, with the sense that the world was going on without her, stimulating the attachment wound of losing her mother.

Videoconferencing offers a powerful forum to address anxieties and addictions related to social media. The therapeutic setup can be compared to one in which the therapist is trying to work with an alcoholic client while alcohol is present, tempting and preoccupying the client. The agreed upon guideline that Lea would refrain from using social media during sessions proved difficult for Lea to achieve. Posts showed up on her computer or phone during videoconferencing, and rather than disabling this feature, Lea tried to conceal her use of social media from her therapist. Eventually she confessed that she was "cheating" by checking her social media during sessions, and exclaimed, "Do they have a rehab for this?" Indeed, her therapist had noticed her hunched shoulders and anxious expression as Lea attempted to maintain dual attention—both on the session and on the feed from her social media. As they discussed this issue, Lea said she felt simultaneously empty and filled with anxiety (i.e., tremors or shaking).

Lea's therapist encouraged her to look at social media during the session, and pay attention to how she held her body, particularly her shoulders. Lea discovered that she hunched her shoulders, became very still and held her breath for extended moments when she gazed at social media. Her therapist suggested they explore shifting these physical reactions. She pushed her chair further away from the screen to model opening and relaxing her shoulders and gently expanding her chest by bending her elbows and moving her arms and shoulders backwards, suggesting that Lea also explore this movement and notice what changed, if anytihng, in her

body. Lea reported that pushing her shoulders back allowed her spine to lengthen, and she could breathe more deeply, smoothly and easily. Homework between sessions included Lea watching how she held her body, and how that posture linked to her breath throughout her day-to-day use of social media. She realized that hunching her shoulders and holding her breath deepened her anxiety and panic and the contrast of doing the breath work exercise helped her recognize the adverse impact this holding of breath had on her whole body.

Encouraging Lea to journal her thoughts and feelings as they arose, and coupling this with newfound awareness of her breath and body lay the foundation for even deeper work as videoconferencing sessions continued, and exercises and handouts from *Sensorimotor Psychotherapy, Interventions for Trauma and Attachment* (Ogden & Fisher, 2015, p. 389, pp. 697-719) were integrated into the session and practiced as homework. Her obsession lessened as she continued to integrate the breath work exercise when she engaged social media.

Somatic Resources: Reaching Out

Proximity seeking actions, like reaching out, secure the nearness of attachment figures (Bowlby (1969/1982) and are "based on that person's forecasts of how accessible and responsive his attachment figures are likely to be should he turn to them for support" (Bowlby, 1973 p. 203). Thus, proximity seeking actions are adjusted depending on the response of attachment figures. Ogden (2012/2015 states that reaching out with the arm(s) "can be executed in a variety of styles that reflect and sustain unsymbolized meaning: palm up, palm down, full arm extension or with bent elbow held close to the body, relaxed or rigid musculature, shoulders

curved in or pulled back" (pp. XX). Lea was fearful of social interactions and tended to isolate herself rather than pursue relationships. She was reluctant to reach out to others, stating that "no one would be there."

Lea's therapist implemented creative ways of mirroring one another as playfully explored proximity seeking, such as moving closer to the computer camera and then apart, leaning towards the screen, and reaching towards one another with their eyes and eventually with arms, with Lea reporting the changes she noticed with each. Sensorimotor Psychotherapy capitalizes on mirror neurons by therapists' modeling certain actions to primes the client to execute the same. As Lea observed her therapist demonstrating the movement of reaching out, motor neurons in her brain fired as if she were executing the same action, essentially 'rehearsing' the action herself (Rizzolatti & Craighero, 2004; Rizzolatti, Fadiga, Gallese, & Fogassi, 1996). Lea was then more willing to then explore reaching out with her hands toward the screen, mirroring her therapist's gesture. The therapist made sure so have her chair far enough back from the camera that the reaching action was not distorted on Lea's computer screen. In this supportive, playful manner, Lea could try out new proximity seeking actions by mimicking her therapist's modeling of them and together they explored the meaning of Lea's actions. For example, as Lea reached out as if to touch her therapist's hand through the computer screen, the words that accompanied the reaching were: "I have help and I'm going to get through this," referring to her struggles with OCD. Lea began to consider that she was not alone, that she did have help, and that maybe she could reach out to others.

In addition, the therapist suggested that they each select a small object that represented support. Lea had a collection of crystals on her desk and she selected a large polished amethyst. Her therapist had a basket of polished stones in her office, and selected one of them. Together, they practiced reaching out at the same time to grasp the object that symbolized support. As they explored the meaning therein, Lea said she felt supported by the amethyst because of its dense weight, smooth texture, and familiarity. Keeping the amethyst with her in her purse or pocket represented deserving support and taking a bit of nourishment. This exercise too helped her combat feelings of isolation, and allowed her to begin to let others in from a position of more internal strength.

Traumatic Memory: Restoring Empowering Action

All the somatic resources described above helped Lea develop self-regulatory capacities, paving the way for more complex processing of painful memories. As she practiced these resources in her daily life, her confidence in herself increased, and eventually she felt ready to directly address the molestation by her father's friend, someone she had trusted, when she was a young teen. She expressed shame and self-critical thoughts like, "Why did I let that happen? I didn't even try to stop him," not realizing that during the actual event she instinctively froze and became unable to take action to defend herself.

Sensorimotor Psychotherapy work with traumatic memory addresses the instinctual protective physical defenses that emerge automatically during threat. These defenses fall into two general types: *mobilizing* defenses, such as calling for help, fighting, and fleeing, and

immobilizing defenses such as freezing and feigning death or shutdown (Ogden, Minton & Pain 2006). Discovering and physically executing instinctive mobilizing actions when immobilizing ones have become default defenses helps diminish feelings of being out of control or helpless, replacing them with the experience of empowerment and control.

As Lea talked about the molestation, she reported that her body felt "shut down," and "mostly numb," indicative of immobilizing defenses. Her therapist asked her if there was any part of her body that was less numb, a question intended to prompt an impulse to take defensive action. Lea reported slight tension in her arms and hands. Since tension is often a precursor to action, the therapist directed Lea's mindful attention to the tension and asked what her body "wanted" to do. Lea said she felt an impulse to push. In the prior section on boundary work, the boundary actions were practiced devoid of memory content, whereas in this case, these actions emerged from her awareness of her body during traumatic memory processing. The defensive impulse to push away that could not be executed at the time of the molestation appeared spontaneously as Lea directed mindful attention toward the tension in her hands as she remembered the incident.

In person-to-person therapy, this pushing action could be executed against a pillow held by the therapist, which would allow a client to sense the physical capacity to defend in the here and now. Since this is not possible in videoconferencing, Lea's therapist suggested that she might push use the large exercise ball that Lea had in her room to push against the wall instead. She instructed Lea to place this ball against the wall, which provided some give-and-take as Lea pushed against it, simulating the effect of pushing against a pillow held by the therapist. Lea felt

a surge of energy as she pushed hard against the ball. She reported that the movement felt "really, really good" and that she felt angry that the molestation had happened to her. Anger serves to support instinctually driven defenses (Frijda, 1986; Hobson, 1994; Rivers, 1920), and as Lea's anger energized the pushing action, she experienced a physical sense of empowerment and strength. Lea had felt disempowered and helpless to defend herself until she was able to experience the gratification of physically executing a defensive action fully and with vigor. Afterwards, she reported a newfound confidence in interactions with others and less isolation. Her "freezing" in the face of presumed threat that she implicitly experienced when she was with others was replaced with a bodily sense of confidence in their ability to protect and defend herself.

Attachment-Related Memory and Strong Emotion:

Bowlby (1980) states that "many of the most intense emotions arise during the formation, the maintenance, the disruption, and the renewal of attachment relationships" (p. 40). Lea had always done her best to minimize the intensely painful emotions related to her mother's leaving. Until she had developed the resources to regulate her anxiety and arousal, her window of tolerance (a term coined by Dan Siegel, 1999) was not wide enough to tolerate emotional intensity. Lea and her therapist felt that her tolerance for emotions had increased sufficiently so that she was now prepared to address the powerful emotions pertaining to the abandonment she had experienced as a child.

Addressing strong emotions presents challenges in videoconferencing because clients need a compassionate other – the therapist – to attune to, accept, and "hold" the vulnerability of emotions, as well as help regulate their intensity if needed. It is imperative that clients can sense and receive empathic support from the therapist, which was typically absent during the original event(s). A crucial element is the therapist's own tolerance for emotions, which will determine the kinds, strength, and variety of emotions that are expressed or denied by the client (Schore, 2003). In videoconferencing, therapists need to assess their own affect tolerance and pay attention to their own verbal and non-verbal communications to assure that their ability to welcome emotions can be clearly seen and felt by the client.

Lea's therapist noticed that when she spoke of her mother, her spine slumped slightly. Whereas previously Lea had developed an aligned posture as a resource for her anxiety, at this point in therapy, the therapist asked Lea to exaggerate the slumped posture instead. Studies show that when subjects embody a certain posture they are likely to recall memories and emotions in which that posture had been operational (Dykstra, Kaschak, and Zwann 2006). Indeed, as Lea allowed her posture to slump a little more, she said she felt terrible about herself, and a vivid memory from her past came to her mind; an image of watching her mother walk away from their home, get into the car and drive away. Realizing the importance of experiencing and expressing the pain of this memory in her presence, Lea's therapist encouraged her to focus on the image as she allowed her spine to slump, which escalated Lea's emotions of sadness and grief.

Making sure to convey her emotional resonance over the distance, yhe therapist made comforting, encouraging, nonverbal sounds as Lea cried. She wanted to communicate without words that she was present with Lea in this heart-wrenching moment even at thousands of miles away, so that Lea could sense that someone who was able to share the intensity of her feelings accompanied her as she revisited this old wound. Such non-verbal sounds, uttered in a manner so that the client knows that the therapist "gets it," can convey a degree of empathy that often eludes words.

Emotions are reflected prominently in facial expression, which are registered implicitly by others, who "make inferences about intention, personality, and social relationship…" (Ekman, 2004, p. 412). Lea's therapist made sure to lean toward the camera, so that her facial expressions of empathy and compassion and the softness of her eyes were clearly visible to Lea. Leaning towards also communicates a desire for proximity, which is usually needed by clients when they are in pain. The non-verbal sounds, facial expression, eye-gaze, and seeking proximity all convey to Lea that her therapist resonates with her internal emotional state, and fosters her ability to feel and express deep emotions in a safe attuned relationship.

As Lea's sobs subsided, the therapist used short, simple sentences of empathy, understanding, and encouragement, which prompted Lea to continue to experience her emotions. These statements, said tenderly with resonant prosody, included, "Oh, there's so much pain…how hurtful for such a little girl… this image has haunted you all your life…you never really got over it, huh" and so forth. Statements like, "the pain makes you just want to curl up, huh" also include the body, and upon hearing this, Lea curled up more, which in turn deepened

her emotions further. It was important for the therapist to track Lea's reaction to each statement, most of which resonated but some of which did not. One statement that Lea did not resonate with was, "You must have wished she wouldn't leave." The therapist noticed the knitting of Lea's brow, knew her statement did not resonate, and immediately recovered, saying, "That's not quite it, is it---maybe it would have been worse if she stayed…" Lea nodded as her tears spilled over, saying, "All they ever did was fight!" The therapist's ability to track and recover from a statement that did not resonate helped Lea feel understood and again deepened her emotions.

The embodied presence and state sharing that Lea's therapist demonstrated during videoconferencing created the safety for Lea to fully feel and express the emotional pain of her past. After her sobs quieted, Lea could more easily recognize the inaccuracy of the meaning she had made from her mother's abandonment. The limiting beliefs of being unworthy and underserving of love were exchanged for the realization that the abandonment had nothing to do with her worthiness, and that she, like all of us, did deserve love. Lea's habitual collapsed posture, which had reflected her feeling unworthy, did not support this new realization. After this session, Lea and her therapist together embodied an aligned posture and full breath that expanded Lea's chest and uplifted her chin, all of which reflected and helped to sustain Lea's new belief, "I do deserve love."

Conclusion

At first glance, Sensorimotor Psychotherapy as a body oriented therapy may not seem to lend itself well to videoconferencing, because working with movement, posture, and gesture is

essential to this method. However, with the following adjustments, Sensorimotor Psychotherapy via videoconferencing can be an effective way to serve clients.

- Designate a physical workspace that mimics a therapy room and limits interference during sessions.
- Use a large enough room so that you can stand, and move away from the computer without adjusting the screen to make the entire body visible to track and model posture, stance, walking, and so forth.
- Use a large screen computer rather than a laptop or phone to broaden the visual field
- Use a rolling chair to easily adjust distance and proximity to the computer screen to more easily demonstrate posture, gesture, and other movements.
- Discuss the challenges of a body oriented approach with clients and ask them to stay aware of their movement, posture, and body sensation and report to you what they notice, especially the movements that are not visible on the screen.
- Collaborate with clients to establish a visual picture that will be your norm (face only, full body, or torso), noting also that Sensorimotor Psychotherapy's work with the body requires adjustments—moving back at times to see full body, closer for facial expression, etc.
- Encourage having props (e.g., therapy balls, pillows, and ropes for boundary work) available to both you and your client.
- Realize that arm gestures, such as reaching out or pushing away, can be distorted in videoconferencing, and make sure the distance from the computer allows for a normal-looking gesture on your client's screen.

- Pay extra attention to facial expression, eye contact, and prosody, and make sure that these are fully visible to the client when needed, because these are primary means to communicate empathy.
- Request clients' permission to ask numerous questions about the body, because it is invariably more difficult to track the body vis videoconferencing.
- Use menus related to the body (such as, "maybe you feel tight, or sense a movement in your body, or a sensation like tingling or buzzing, maybe your heart rate changes, and so forth) to prompt your clients' awareness of the body.
- Provide a menu that might indicate preparatory movements—such as "maybe someplace in your body becomes tight, or you feel a tingling sensation, or a little movement, like a lifting of your fingers or a pressing down with your feet…"
- Appropriately share your own experience of your body to model comfort with body awareness and encourage clients to do the same.
- Stay mindful of the moment-to-moment body-to-body interchange,
- Use a slow pace to encourage mindful awareness, giving clients plenty of time to sense the body.
- Support emotional state-sharing through awareness of what is happening in your own body, along with curiosity about what is happening in the client's body

Kocsis and Yellowlees (2017) conclude that online therapy offers novel ways to reach and form strong psychotherapeutic relationships with many different types of patients, and proposed that this may foster therapeutic intimacy in ways that in-person psychotherapy cannot. Sensorimotor Psychotherapy at a distance may be especially befitting for clients with

high degrees of shame, body or social phobia, or awkwardness or self-consciousness related to their body, those with a need for greater control or those who might feel safer and more comfortable engaging in body oriented therapy from the security of their own homes. The benefits of Sensorimotor Psychotherapy via videoconferencing also may enhance cost-effectiveness and continuity of care, by increasing accessibility and serving communities without access to local Sensorimotor Psychotherapy-trained therapists.

Implicit processes are not always accessible through words because they exist beneath cognitive awareness and verbal language. The efficacy of the therapeutic journey between therapist and client can be heightened by thoughtful attention not only to the verbal narrative, but also to the somatic narrative—the story told by posture, movement and expression. With creative adaptations explored in this chapter, videoconferencing can be effectively used to tap the wisdom of the body, offering clients a valuable avenue to heal the wounds of the past and develop new competencies.

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