The Care and Keeping of Therapeutic Connection in Telehealth: An Embodied Inquiry

Caitlyn Gilmore
cgilmor2@lesley.edu

Follow this and additional works at: https://digitalcommons.lesley.edu/expressive_theses

Part of the Social and Behavioral Sciences Commons

Recommended Citation
https://digitalcommons.lesley.edu/expressive_theses/469

This Thesis is brought to you for free and open access by the Graduate School of Arts and Social Sciences (GSASS) at DigitalCommons@Lesley. It has been accepted for inclusion in Expressive Therapies Capstone Theses by an authorized administrator of DigitalCommons@Lesley. For more information, please contact digitalcommons@lesley.edu, cvrattos@lesley.edu.
The Care and Keeping of Therapeutic Connection in Telehealth: An Embodied Inquiry

Caitlyn Gilmore

Capstone Thesis

Lesley University

05/05/2021

Caitlyn Gilmore

Dance and Movement Therapy

Carla Velázquez-García
Abstract

This qualitative embodied artistic inquiry self-study, developed through my perspective as an emerging dance and movement therapist, explored the effects of using telehealth for therapy due to the COVID-19 pandemic. The available literature discussed throughout this capstone thesis suggest that the adaptations made to therapy as a result of the pandemic affected the practices associated with dance and movement therapy’s theoretical principles of embodiment, attunement, and somatic countertransference. Because of the unknowns of COVID-19, research on mitigating the negative aspects of telehealth is still emerging, thus increasing my anxiety as an emerging professional. In order to address the anxiety and mitigate telehealth’s effects on embodiment, attunement, and somatic countertransference, I developed and followed a personal Authentic Movement practice. I followed this practice each day prior to all of my telehealth therapy sessions for a total of 18 Authentic Movement sessions. Analysis, which took the form of a writing synthesis in a journal immediately following each practice session, was a built-in part of the practice. Results included an increased ability to attune to my body, which correlated with feeling a stronger therapeutic relationship in sessions with participants and taking more therapeutic risks with them. Topics for further discussion and future research include how therapists can engage in regular self-care that incorporates their whole selves and the importance of future research on finding embodiment and relationship in telehealth.
Introduction

The year 2020 was an unprecedented one as the global COVID-19 pandemic thrust many people into uncertainty, hopelessness, and fear. One group of researchers found that about 40 percent of adults in the United States (US) aged 18-24 said that they have struggled with mental health or substance abuse in the 30 days prior to interview, and the same group found that there has been an increase in the demand for therapy in that same time period (Majlessi, 2020). Due to the pandemic, the therapeutic relationship is now largely confined to telehealth. Telehealth is defined as therapeutic care that takes place virtually either through video or phone call. Because I live in Washington state, this definition is adapted from the definition of telemedicine in the Washington State Legislature (WSHA, 2021). Practicing therapy via telehealth was until last year new for many therapists, notably for expressive and creative arts therapists and especially for dance and movement therapists. In view of that, in late March 2020, the American Dance Therapy Association (ADTA) provided a free hour-long webinar on how dance and movement therapists can become comfortable with using telehealth (ADTA, 2020). This webinar primarily focused on the technical aspects of telehealth and how to maintain confidentiality. Unfortunately, there has not been a subsequent webinar or discussion on how to adapt therapeutic practices to telehealth or how to cultivate and maintain relationships via telehealth as of this writing.

The effects of the pandemic are also personal. Beginning clinical work as an intern therapist practicing for the first time during this period has expectedly induced anxiety. That anxiety has been exacerbated by the following factors: being the only dance and movement therapist at the internship site, the uncertainties inherent in living through a pandemic, and the unknowns of using telehealth with children. Both staying stuck in that anxiety and trying to ignore it can take a toll on my well-being, which affects my capacity to show up for and be
present in sessions. Literature exploring the connections between dance and movement therapy (DMT), using telehealth, therapist presence and embodiment, and self-care is still an emerging area of research.

Drawing from self-study Authentic Movement practices, I designed a personal method for exploring my own embodied presence and how this practice may affect how present I am in telehealth sessions. After reviewing the available literature on the aforementioned connections that informed the development of this method, I will explore the implementation of this method on myself and what occurred in telehealth sessions during this process. Finally, I will discuss how this thesis will be a part of the foundation of the emerging body of research on telehealth in DMT by focusing on embodied presence in telehealth sessions and how being present in this way affects the quality of relationships with clients.

**Literature Review**

**COVID-19 Pandemic, Telehealth, and DMT**

The COVID-19 pandemic caused a shift in mental health. The National Council for Behavioral Health conducted quantitative survey-based studies in April and October 2020, respectively. These studies revealed that 40 percent of adults aged 18-24, had struggled with mental health or substance abuse in the 30 days prior to interview, and they also showed that demand for therapy greatly increased. (Majlessi, 2020). These struggles are not limited to the general population; in fact, therapists have been and are “on the emotional frontlines” (Madani, 2020). In an online news article, Madani wrote about how the ongoing COVID-19 pandemic, which he refers to as a unifying and collective trauma, affected the personal and professional lives of three different mental health professionals. These mental health professionals mentioned
struggling with work boundaries due to “the pressure to take on more because they know the need for mental health care is more widespread than ever” in addition to “facing the same anxiety, uncertainty and financial stress that are troubling those who seek their services.” One of the therapists interviewed acknowledged that therapists have not “taken into account that we have our own fears and our own pressures and those sorts of things” while another mentioned having a diminished ability to “maintain that sense of self to remain attentive or as attentive for each person.” This article, written in June 2020, cited a US death toll of “just over 115,000” as part of the reason therapists have been experiencing pressure to provide services; in late April 2021 – more than a full year since the first COVID-related death in the US - that toll has exceeded 550,000 (New York Times, 2021, Fig. 1).

Several of the interviewed therapists took an ethics-based perspective to figure out how to best adapt their practice to telehealth, specifically because the continuity of services was a priority. Chenneville and Schwartz-Mtte of the American Psychological Association (APA) explored the ethical considerations for psychologists during the COVID-19 pandemic in a qualitative review. In this review, they cited concerns regarding “the ethical implications associated with transitioning from face-to-face to online or virtual formats as necessitated by stay-at-home orders designed to enforce the social distancing required to flatten the curve of new COVID-19 cases” (Chenneville and Schwartz-Mtte, 2020, p. 644). The writers cited multiple sections of the APA’s code of ethics, establishing the need for continuity of care for existing clients, not refusing services due to COVID-19 testing status, providing reasonable accommodations such as personal protective equipment (PPE) for in-person sessions, and providing ongoing informed consent to clients participating in telehealth services especially regarding privacy and confidentiality. In one provided “case vignette,” the writers shared the
experience of “Dr. Traditional,” a private practice psychologist worried about easing into telehealth (p. 651). This vignette explored the questions many therapists must have had in the beginning of the pandemic, particularly surrounding the issue of telehealth and technology access and using phone calls as “stop-gaps” between sessions. Dr. Traditional contemplated the risks of continuing in-person as well as the process of ongoing informed consent and ongoing telehealth-related trainings in the future. Dr. Traditional also weighed the option of referring out clients appropriately in the event they did not want to continue with telehealth. Notably, the writers mentioned that the current APA code was written in 2017 and its guidelines are “currently being revised,” implying that an updated code of ethics may include more explicit language regarding telehealth practices. Also, first published in May 2020, this article is likely steeped in the context of the uncertainty many mental health professionals found themselves – a very different experience from the date of this writing, April 2021. Since that time, widespread changes to the field have been made.

One of the biggest changes to the field of mental health was the availability of care via telehealth. A quantitative study assessing pandemic-based changes in the US mental health care system surveyed 2,619 licensed psychologists to assess the pandemic’s impact on their utilization of telehealth, one of “the first of its kind” (Pierce et al., 2021, p. 20). Their findings prompted the writers to include the following “public significance statement”:

The COVID-19 pandemic has led to a literal revolution in mental health care delivery, shifting the vast majority of psychological services to telepsychology. This study conducted a national survey of licensed psychologists and documented this seismic shift, finding that although 7.07% of psychologists’ clinical work was performed via telepsychology before the COVID-19 pandemic, this increased 12-
fold to 85.53% during the pandemic. Psychologists were optimistic that over one-third of their clinical work would still occur via telepsychology after the pandemic, suggesting the high likelihood of lasting changes in U.S. mental health care delivery. (p. 15)

The writers broke down the data even further. For instance, “45.70% of psychologists reported not using telepsychology at all before the pandemic, with 84.99% reporting using it for 0–10% of their clinical work.” Now, “96.45% of psychologists reported using telepsychology in their practice,” and “67.32% of psychologists reported going completely virtual” (Pierce et al., 2021, p. 20). These significant findings helped support one of the recommendations the writers made to develop increased telehealth trainings, as well as to incorporate telehealth-related care into training programs. The writers also mentioned several limitations, including an “11.8% completed response rate” on the survey, a “small representation” of practicing psychologists in community-based facilities, and a lack of variables “reflecting the limitations of telepsychology, rather than just its potential” (p. 20). However, a limitation not discussed is that this study focused on data from licensed psychologists; one can only infer the profound impact this “revolution” has had and will continue to have on others who work in the mental health profession, such as licensed masters-level therapists, students, and interns.

To that end, some attempt has been made to guide mental health practitioners in what to expect in telehealth sessions and how they can adapt their practices to the medium. For example, a Psychology Today article included a general “therapist’s guide” to help therapists new to practicing via telehealth; this guide held reminders such as “get comfortable” and “have down time to ground yourself between sessions, as well as practice adaptations like choosing phone or audio-only sessions in place of video sessions (Huston, 2020, p. 56). While not explicitly stated
as such, the writer mentions some somatic-based practice recommendations, like increasing verbalization of what is experienced that cannot be seen via video or phone, “mirroring tone and energy level,” and making sure both therapist and client are in a proper space (p. 58). As a limitation of telehealth, though, a quoted therapist mentioned not being able to sense “breathing” or “shoulder-earing” – a physiological response where the client has their shoulders up to their ears from tension – over video (p. 58). Additionally, affiliates with the APA released “lessons from the field” in their work with children and families, which “provides guiding principles and strategies for engaging youth and families through TeleBehavioral health” (Jeffrey et al., 2020, p. S272). The writers recommended practices such as providing art materials or toys to clients practicing remotely to ensure they have access, but they also brought to light some somatic interventions as well. For example, in the event toys cannot be provided, the writers recommended giving “virtual high fives” and playing “emotion charades,” an embodied game; they also recommended either working in “wiggle breaks” or incorporating “movement-based interventions” to accommodate for children using telecommunication systems for school for many hours a day (p. S273).

As DMT professionals, we require more intervention adaptations as they pertain to accommodating telehealth in session. However, the aforementioned ADTA webinar about telehealth primarily focused on the technical aspects of telehealth and how to maintain confidentiality and did not mention practice-based interventions (ADTA, 2020). Before the pandemic, one research article outlined ways to adapt creative arts therapies (CATS) to telehealth settings and found some success with its population of rural veterans (Levy et al., 2018, p. 20). There were several limitations of this study. First, its interventions were primarily art therapy-based, and the study had a small niche population; additionally, the therapists were
located in facilities and not in their own homes (and therefore didn’t have the issues of having to be close to the computer for microphone or earbud purposes, to maintain confidentiality). There was a lack of DMT-focused work overall. Furthermore, this study occurred prior to the pandemic, and so perhaps the positive outcomes were in-part due to the newness of telehealth as a medium, particularly for veterans in rural areas; the therapists in this study were also not dealing with the collective trauma of the pandemic. That said, some efforts were made to include DMT work in the study, and the writers mentioned some drawbacks to using the modality. For instance, there were many “tradeoffs”: one had to choose to either view the whole body or feel “closeness,” and to either demonstrate a technique or observe and engage in movement analysis; they also had to rely on increased verbalization (p. 23-25).

As mentioned previously, there is little, if any, research on what is different in or missing from telehealth – the therapeutic relationship – and how DMT can adapt to fill that missing piece in an embodied way. That is why this thesis is a necessary part in an emerging body of research.

**Authentic Movement in DMT**

*Authentic Movement* is defined as “a discipline from [DMT] in which a person moves with their eyes closed following their own momentum in the presence of a witness” (García-Díaz, 2018). The mover and witness are often separate people; in a standard individual therapy session, for example, the mover is the client and the therapist the witness, and in group therapy, clients may take turns amongst each other being movers and witnesses. However, in self-practice, a mover can develop an internal witness in themselves where they act as both roles simultaneously, thereby expanding their attunement to the self. Authentic Movement is well-documented in its methods and effects as a practice.
In a study of the psycho-neurology of embodiment as it pertains to Authentic Movement, author Helen Payne connected the research in cognitive and neuroscientific domains with the theoretical and practical applications of DMT and embodied simulation. She made the case that “the era of the dominant cognitive paradigm…has passed,” which has ushered in a new era of psychology that explores the “role of the body in shaping the mind beyond the brain” (Payne, 2017, p. 165). The writer provided a biological framework and lens through which one can view Authentic Movement and DMT while also honoring the practice’s Jungian and psychodynamic roots – an important perspective for twenty-first century readers, scholars, and practitioners. Payne made a case for the importance of the body – of embodiment – in therapy, an aspect that may be missing when therapy moves into telehealth settings. Payne detailed types of research done in the context of embodied simulation before making connections to the use of Authentic Movement with clients and within DMT. This research was rooted in both quantitative and qualitative data and analysis, and Payne was clear about the need for further research to be completed in order to continue to connect embodied simulation research with DMT practices.

A research article explored the connections between Authentic Movement and emotional state, specifically asking whether there are correlations between Authentic Movement and participants’ experiences of inhibited emotions (García-Díaz, 2018). The author separated participants into two groups: one that explored the practice of Authentic Movement and a control group that practiced voluntary movement, or “performing the movements that [participants] want” (p. 20). Then, the author provided surveys and mood scales to participants before and after their interventions to track their experiences over the course of group treatment. The author concluded that compared to voluntary movement participants, those who experienced Authentic Movement “experience more changes in their emotional state”; that those with previous
Authentic Movement experience “undergo more changes in their emotional state” as compared to those without prior experience; and that regardless of being assigned to the Authentic or voluntary movement group, participants with previous Authentic Movement experience will have more emotional state changes than those without prior experience with the practice (p. 23-24). This study was quantitative in nature. The study acknowledged the author having a small sample size of fewer than seventy-five participants as a limitation. Other possible limitations not mentioned include that this study was conducted in Spain and may have limited applicability outside of that culture, as well as the largely correlational nature of the study.

In research exploring the experiences of attunement and misattunement in DMT, the authors explored the connection between *attunement*, “the sense of being fully aware of the other person's sensations, needs, or feelings and the communication of that awareness to the other person,” and *misattunement*, “incorrectly” identifying another’s feeling or state or being unable to find it in oneself (Jerak et al, 2018, p. 55-56). The authors emphasized the importance of supporting attunement and of identifying how misattunement occurs. This article outlined both the existing subjective and empirical evidence in the field of DMT by tying in the empirical evidence that supports long-standing subjective theories in the field. It is important to note that the findings of this study on the importance of misattunement are mitigated by some evident factors; for instance, the group consisted of only four participants, all of whom were expressive therapies students, and the leader of that group was one of the researchers (p. 61). Their status as students implied that they were in a learning context and existed only within their limited knowledge on expression in therapy – the movement analysis results may have been ultimately incorrect because of their inexperience with the medium. Furthermore, because of their relative familiarity with this form, the study could not make any conclusions about the
efficacy of or relation between this work and clinical practice with clients. That said, the results do appear to support the weight of the importance of attunement and misattunement in relationship to others and to oneself.

**Personal Authentic Movement Practices as Support for Therapists**

Before the pandemic, whether a therapist should utilize Authentic Movement as a self-care practice was a personal choice; to recommend it now feels more like a necessity. In a time of widespread emotional turmoil and anxiety, where more than half a million people in the US have died and one in ten have had or currently have COVID-19 (New York Times, 2021, Fig. 1), finding self-care for oneself is paramount, especially for an essential worker “on the emotional frontlines” (Madani, 2021). For new therapists looking to find their footing in the mental health profession, self-care is especially important, as it can help find attunement with the self. Not attempting to find attunement to the self may be ethically questionable when in sessions with participants with whom we share collective traumatic experiences, as it can affect somatic countertransference, “the physical and emotional response elicited in the therapist in response to a client” (Rot, 2018, p. 48). However, the self-care therapists need – particularly student or intern therapists – can go beyond developing a personal practice.

One DMT group study documented a group of six post-graduate DMT students and emerging therapists over a period of two years in weekly group therapy-style meetings. At the time of publishing, the author had not found any studies “in either the arts therapies or psychotherapies [that] invite student perceptions of their personal development experiential group during or following their training. In…DMT in particular, no studies [had] been found on either client perceptions of therapy or on the training of therapists” (Payne, 2004, p. 512). This
group was held for one full day each week with the same leader in the same place at the same times and required 80 percent attendance. Participants made comments stated how the group encouraged them to find empathy with their clients but mostly, the participants noted how they became “aware of the counter-transferences in the role of therapist and were able to use the DMT group as a way to begin working through any personal issues emerging out of running their placement DMT group” (p. 520). Additionally, the participants noted how group participation affected their practice as therapists, not just in terms of self-awareness and “exploring their inner world” (p. 519) but also regarding “the importance of creating atmosphere, security, [and] safety” (p. 526). While this study had a small number of participants and was conducted nearly seventeen years ago, the evidence continues to be compelling in support of the need for emerging therapists’ self-care and attunement to self.

While this in-person group formatting with fellow therapists would be ideal for helping therapists feel supported, the pandemic has made holding such a group unsafe. An alternative for finding support as a therapist is developing a self-care Authentic Movement practice. Morrissey wrote an article on Authentic Movement and embodied consciousness that sought to validate the practice of Authentic Movement as a method for introspective evaluation of the movers’ and witnesses’ “conditioned hierarchical attitudes” (Morrissey, 2006, p. 28). Obvious limitations of this article included its age – nearly fifteen years at the time of this writing – as well as how Morrissey used only herself as an example of using Authentic Movement for this kind of introspection (an extremely limited sample size). That said, the article successfully argued how important it is as a dance and movement therapist to find attunement to the self via a practice such as Authentic Movement, as it encouraged conscious awareness affected by the movement practice.
Related to self-study, one graduate more recently explored their experiences of change related to “embodied power.” Rot inquired into her embodied experience of Whiteness, sharing experiences of “shame” and “apprehension” as she recalled moving through or anticipating privilege walks (Rot, 2018, p. 46). Operating within a relational-cultural theory framework, the author engaged in an Authentic Movement practice with a “trained professional” to explore her racial identity and how it related to her work within the field of DMT. As she wrote in the beginning of the Methods section, “engaging in this study was a use of power in and of itself, as safely examining one’s embodied power is not a universal opportunity” (p. 51), a statement that I find personally applicable - it is a privilege to be able to make space for self-care and for attuning to oneself, especially in a pandemic. Through this process, Rot concluded and recommended the following:

I came to recognize my body as a place of home and could approach the feelings of shame and guilt with compassion…. One must be open to engaging in ongoing, introspective exploration of their own power and privilege to understand how these elements may be utilized ethically and intentionally. (p. 59)

The author noted that her exploration has several limitations, namely that it is a “one-sided conversation” with only one participant, but she nonetheless made the case for the crucial nature of self-exploration as a therapist, especially an emerging one. This self-exploration was rooted in an Authentic Movement practice that encouraged embodiment, attunement to the self, and an understanding of the presence of somatic countertransference.

**Methods**
Developing and practicing this method for personal embodied inquiry began in February 2021 and continued for six weeks through mid-March 2021 when I returned to working in person. I began a regular 15-minute Authentic Movement practice each day prior to all of my telehealth therapy sessions for a total of 18 Authentic Movement sessions over the course of six weeks. The practice served the following purposes: to help me attune to myself and increase awareness of somatic countertransference, to allow me to engage in movement and creative self-care, and to increase my competence in following therapeutic instincts as they related to the therapeutic relationships between myself and my internship site’s participants. I followed each of the 18 daily practices with a written synthesis for 10 minutes to help me condense and verbalize what came up during each practice. Then, after each telehealth session each day, I dedicated 1-5 minutes to *ground*, or to connect with the present moment. This time also allowed me to check in with my body and to write about what happened within me during the session in the form of free verse creative writing. The purposes of these creative reflections were to track my embodied attunement to myself and to the participant in the session, to reflect on any somatic countertransference that emerged, and to document what it was that I did in sessions, be it conscious choice or therapeutic instinct. All of the above writings were kept in a journal with no participant identifying information. Before beginning this practice, I hoped to be more able to identify and separate my experiences of somatic countertransference so that I could be more present in telehealth sessions and be more engaged in the therapeutic relationship between the participants and myself. I also believed that the practice would serve a self-care purpose, restoring balance via regular movement into my days of sitting at a desk and staring at a computer screen.
Support for working with this method came in two parts. The first part consisted of continued weekly site supervisor meetings as I continued to explore the qualities of relationships that I developed with site participants, to pose clinical questions as they pertained to the site and its population, and to address population-specific concerns as they arose. The second part consisted of weekly DMT supervision meetings for exploring more embodied qualities of relationships with site participants, to obtain more insight into my DMT technical practice, and to receive Authentic Movement practice support and guidance. Both parts offered opportunities to explore any somatic countertransference or other issues that revealed themselves that may have influenced embodiment or attunement.

Results

After each daily incorporation of this personal practice, I engaged in a written synthesis in a journal to help condense and verbalize my experience. From the 18 daily Authentic Movement practices’ writings, two recurring themes emerged: a developing embodied attunement to myself and a comfort yielding into self-care.

Developing Embodied Attunement

Prior to starting this Authentic Movement practice, I felt overwhelmed by somatic stimuli, by pandemic-related anxiety, by holding space for both myself and site participants in sessions, and by trying to find a livable work-life balance. I struggled to connect with my body in a meaningful way, meaning that I still danced for personal enjoyment but felt unable to attune to my body or feel embodied. My mind-body connection felt weak. As a result of this strained
connection, I found myself struggling to engage in sessions in a way that fostered an authentic therapeutic relationship.

The first sensations I noticed as I began this practice were heaviness and deceleration. I wrote on February 2nd that I was “called to the floor, needing its support.” I rejected this need in the beginning, and I noticed that I could not distinguish whether I was cognitively choosing to move or “following impulse.” I could sense vibrations in my body after moving that first day, but I could not tell whether my body had found those vibrations pleasant. I felt myself in my head more than in my body, meaning that I was more cognitively fixated on doing the practice “right” than I was attuned to my body.

As I let go of the cognitive fixation, needs began to surface. I wrote on February 3rd that “I need support for expansion and release.” Several days after making this statement in my writings, I connected with sensations of “energy and warmth and cognitive pre-occupation” on February 16th. On that same date, I wrote that I could “feel the energy shift and disperse” throughout my body while I was lying on the ground. As I continued to attune to and sense my body, I found that what I needed was stillness and to give into gravity. I wrote that I felt like I was “drowning.”

I explored this sensation in a virtual meeting with my DMT supervisor. I told her that I was feeling ungrounded as we spoke, and I recounted the sensation of “drowning” to her as well. My supervisor called this feeling “collapse”, and my body responded with tears of relief. I wrote on February 18th acknowledging and accepting the weight behind what it meant to be in collapse. At the same time, I also noticed that I was pulling away from the screen, hollowing out to the back space of my body. Together, we made the cognitive connection that I was self-conscious of feeling collapse. While naming the sensations of collapse and self-consciousness did not fully
alleviate these feelings, it did allow me the space to begin to embrace the self-care aspect of this practice.

**Yielding into Self-Care**

I started writing about *yielding*, or gradually easing into gravity. On February 23rd, I wrote that as I tried “to breathe and yield into the floor, my body initially felt very tense” but “eventually became less so as I noticed my weight sinking into the ground.” Yielding somatically allowed the figurative weight of my anxieties to flow and be renegotiated in my body. It felt as if each ounce of weight I allowed the floor to support was accompanied by a thought demanding my attention. Before this practice, these recurring thoughts would have been overwhelming. During the practice, I felt I could regulate myself through them, name them, and give them space. By somatically engaging with the sensation of yielding, not only was I practicing embodied attunement, but I was also preparing myself to identify somatic countertransference. By giving myself permission to yield, I was also giving myself permission to engage in self-care.

**Finding Therapeutic Relationship**

It was when I began to embrace the self-care aspect of the practice that I found that I was able to engage more fully with in telehealth sessions. I noticed that as I found more space for myself, I had more space for site participants and for somatic countertransference. I felt more connected to them, despite not being in the same room with them or even laying eyes on them. I wrote that I felt “tender and warm” after a phone session on February 11th, and I also named that there was a sense of “searching, feeling lost – weightless.” Following a different session on
March 3rd, I felt energy and anxiety “lodge in my chest,” and attuning to that energy in my body connected the thought of “I am afraid, too” in my mind. Having clearly defined what sensations and feelings were mine prior to engaging in sessions, I found that I could stay grounded and engaged, deepening my connections to site participants.

Co-occurring with these deepening connections was an increased capacity to take and own the risk of following therapeutic instinct. Risks were of varying sizes that I determined based on the time they would take in a session. For example, a small risk was asking a question, e.g. asking “What was it like to share that with me?” after a site participant’s self-disclosure. A big risk was suggesting an intervention, e.g. “It sounds like you have a lot of thoughts and feelings you’d like to get out, but you’re afraid of what the response would be. Maybe this won’t fit, but what would happen if you wrote these things in a letter you didn’t send?”. When I would take risks before, I would feel a cognitive anxiety and a somatic weightlessness. After an Authentic Movement practice, however, I felt confident when I took risks. The confidence manifested as a sense of grounded weight in my contacts to the floor or my seat. I let down the façade and made clear to site participants that we were experimenting together. If a risk did not result in a “reward” so to speak, I felt humbled and I accepted the “failure” with relative ease. More often than not, though, the risk of following therapeutic instinct would work out because I was successfully relating to and being present with the site participant. I wrote on February 24th about attuning to a participant, writing that I noticed in our “dancing and playing”, the participant was also “sharing and daring with me.”

A pleasant result of taking risks together with site participants was that I felt more competent and effective as a therapist, alleviating anxious cognitions. Once I noticed these growing feelings of competence, I began to share insights from the Authentic Movement practice
with my site supervisor in our meetings. I shared how attuning to my body before starting my
day opened up my ability to be with and attune to site participants, and I shared both pleasant
and unpleasant relational moments from sessions. This supervisor named what I had been
noticing, that engaging in this practice regularly was important. This practice was an act of
embodied self-care, a daily exercise in recognizing that before I could attune to anyone else, I
first had to attune to my body, my feelings – my whole self.

Discussion

The Authentic Movement practice developed here began as a way to explore how
therapists practicing DMT can address telehealth’s effects on embodiment, attunement, and
somatic countertransference and to explore how these effects may affect the therapeutic
relationship when that relationship is reduced to a telehealth setting. The practice was also
developed to help alleviate the anxieties of emerging clinicians starting in the field of DMT
during a time of unprecedented unknown. I had hoped to be more able to identify and separate
my experiences of somatic countertransference so that I could be more present in telehealth
sessions and be more engaged in the therapeutic relationship between the participants and
myself. I also hoped that the practice would serve a self-care purpose, restoring embodiment and
balance into days of relating through computer screens.

I found that engaging in this practice did positively affect my attuned embodied presence
in telehealth sessions by providing grounding for processing somatic countertransference. This
practice also helped alleviate some of my anxieties and allowed me to be vulnerable with my
supervisors. The method described here was not unlike the others referenced in this thesis. In
fact, it was similar, in that it encouraged a regular practice within a given framework, it had an
intended outcome, and it involved written reflection. Like Rot found in her thesis, the method developed here also had an outcome of “bringing [the] whole self into relationship with others” (Rot, 2018, p. 57).

At the time of writing, the world has begun to conceptualize and believe in “a new normal.” About 40 percent of Washington state’s population has received at least one dose of a COVID-19 vaccine, and about 30 percent have been fully vaccinated, myself included (Seattle Times, 2021, Fig. 2). However, the pandemic is not over, which means some of the uncertainty regarding the future remains. What does feel certain though, is that telehealth as an option for therapy will likely integrate itself alongside traditional in-person sessions. There will remain a need for therapists, especially those who practice DMT, to find ways to connect to participants virtually. There is an opportunity to shape the “new normal” by incorporating regular, embodied self-care into the daily lives of DMT therapists with a practice that could look like the one explored in this thesis.

This capstone thesis project is only one piece in the emerging body of research on telehealth in DMT. It has highlighted the need for self-care and the importance of providing space for the therapist to find embodied attunement to the self, prior to engaging in telehealth sessions. It has also demonstrated how embodied attunement can make the therapist aware of somatic countertransference and better engage in the therapeutic relationship. More research is required to know more about the connection between Authentic Movement-based personal self-care practices and therapeutic relationships via telehealth, particularly from the perspectives of session participants. More research about the effects of the pandemic is also required.
References


https://www.youtube.com/watch?v=16QBfWd6HT8


http://dx.doi.org/10.1037/amp0000661


Madani, N. (2020, June 14). *Therapists are under strain in COVID-19 era, counseling clients on
trauma they're also experiencing themselves. NBC News.


https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=1&sid=07346ccb-ac60-4811-aed0-031aa7caadf4%40sessionmgr103


https://doi.org/10.1007/s10465-018-9273-9


THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Dance/Movement Therapy, MA

Student's Name: Caitlyn Gilmore

Type of Project: Thesis

Title: The Care and Keeping of Therapeutic Connection in Telehealth: An Embodied Inquiry

Date of Graduation: 05/22/2021

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Carla Velázquez-Garcia