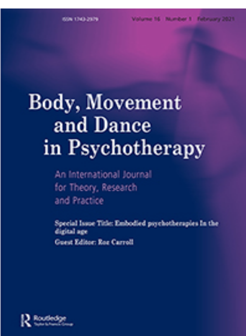

Body, Movement and Dance in Psychotherapy

An International Journal for Theory, Research and Practice

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/tbmd20

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To cite this article: Einat Shuper Engelhard & Avital Yael Furlager (2021) Remaining held: dance/movement therapy with children during lockdown, Body, Movement and Dance in Psychotherapy, 16:1, 73-86, DOI: 10.1080/17432979.2020.1850525

To link to this article: https://doi.org/10.1080/17432979.2020.1850525

Published online: 22 Nov 2020.

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BODY, MOVEMENT AND DANCE IN PSYCHOTHERAPY
2021, VOL. 16, NO. 1, 74–87
https://doi.org/10.1080/17432979.2020.1850525

Remaining held: dance/movement therapy with children during lockdown

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ABSTRACT
In this article, we will try to creatively expand the boundaries of our imagination, in an attempt to recognise the potential transitional space in remote dance/movement therapy (DMT) work with children that occurs from 'afar' in digital space due to the current global COVID19 pandemic. We propose that an observing arena via the digital screen offers a framework that acts as a playground, in which the client can hide, attack, get close, back off, and so on, despite the lack of an actual in-person meeting. Special emphasis will be placed on the kinaesthetic and sensory playfulness, which develops between therapist and client despite the physical distance, and on the understanding of the psychodynamic meanings within the therapy sessions. We will present two case studies that will demonstrate the scope of the psychodynamic work through the body, which is possible in remote dance/movement therapy.

ARTICLE HISTORY Received 20 July 2020; Accepted 3 November 2020

KEYWORDS Case study; COVID19; dance/movement therapy; remote therapy

During the recent lockdown period due to COVID-19, when physical distancing was required, we were exposed to case studies, both in therapy and supervision sessions, in which dance/movement therapists working with children were forced to find an alternative to in-person therapy sessions. Some therapy came to a halt, while other therapy sessions were transferred to digital space, maintaining the same time and therapeutic work as were present in the original holding aspects of the therapy setting. Potash et al. (2020) suggest that creative arts therapists can support recommended public health psychosocial guidelines by disseminating information, promoting

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expression and inspiration, challenging stigma, modulating media input, securing family connections, monitoring secondary traumatic stress, developing coping and resilience, maintaining relationships, and amplifying hope. In the field of dance/movement therapy (DMT) it is possible to find guidance on how to use central techniques of DMT in therapy happening remotely in digital space (Jenny, 2020).

An article which describes DMT by phone with psychiatric care clients, emphasises the difficulty in creating synchronised experiences and the continuous need to choose between seeing the client's facial expressions or full-body movement (Levy et al., 2018). Despite the clinical complexity, the authors point out that remote therapy creates a space for artistic expression within the client's home and makes it easier to share the therapeutic process with the family. Spooner et al. (2019) offer insights about remote creative arts therapy through case studies in a project at a medical centre in the United States. The case studies described reinforce the advantages of remote therapy as a way to strengthen the connections with the family and community, while also offering clients a sometimes first time exposure to digital media, which opens up the possibility and skill set for using different digital platforms to create other social connections.

In this article, we will try to trace the ways in which the presence of the therapist may help to transform the digital space to a safe playing ground where the client's psyche can continue to develop and grow in DMT, despite the limitations and restrictions experienced during crisis and specifically the COVID-19 pandemic.

Transitioning therapy to digital space via the computer screen, essentially returned the clinical setting to the home, and brought a new and challenging experience for both the therapist and client alike. From our DMT experience in the field both as therapists and as supervisors of dozens of therapists, we have learned that without the boundaries of the room which offer privacy and distancing from day to day life, the capacity to play is reduced; essentially the chance to arrive to the unique space created between the playfulness of the therapist and that of the client is lessened. The exposure to the home of the client and the therapist, with the accompanying noises and voices of the households, and the unexpected interruptions that can invade and disturb what is already limited and missing – the lack of the entire body being seen and the lack of the possibility to offer the client a sensory experience within the therapy room: to smell, to open or close a window, to get close, to distance – these missing possibilities are likely to shrink both the client and therapist alike.

The enclave outside of normal life

The invitation to transfer the therapy to the home of the client intensifies themes connected to the space of the therapy room and the sensations that

are protected within that space. In response to the shift, clients share how much and in what way they need the therapy room as an enclave which exists 'outside' of actual life itself. For example, in what way the physical house in which they wrap themselves in during their daily lives is experienced as a safe and protective place, or on the other hand actually experienced as an unregulated space that drains them, lacks privacy and is subject to invasiveness and arbitrary attacks. In the later situations mentioned, the concrete room of the therapist, as well as the actual journey between the home and the therapy room, has a healing significance. From our clinical experience in these situations, the therapy room is used as a psychic sheath (further expansion on these ideas can be found in Anzieu & Turner, 1989) and when missing, work with the psyche is rendered impossible – without the room, anxiety will be too high and there will remain no space for movement of the psychic realms.

When several senses are diminished and physical stimulation is cancelled, the remote connection is likely to be experienced as more intimate, and at times too intimate. Elements in digital space such as: seeing or hearing the sounds of the personal home of client and therapist, intensification of the voice and intonation (uncovered even more when the conversation is without video), the closeup view of marks on the skin and complexion – all of these expose the therapist and client to a new type of intimacy. Especially exemplified is the complexity of holding the therapeutic connection in light of a client's request to be together in silence, when the capacity of the therapist to see the client and to maintain eye contact is compromised.

In this article, we will look at how actually through the body and movement, and by utilising the imaginary world of the therapist, it is possible to find an opening to playfulness, which allows for continued creation of the transitional space for psychic work, even within the new therapy setting manifest in digital therapy via a screen.

Creating a framework for emotional work with the psyche

Fonagy et al. (2020) emphasise that "in face-to face work, the therapist responds to both explicit and implicit communications by the child and makes sense of these by creating mental models of the intentional state of the client in a remarkably fluid way. Curiosity is an essential component of this process – we have termed this the not-knowing or inquisitive stance (Bateman & Fonagy, 2016). According to Bateman and Fonagy in remote working, the adoption of the mentalising stance of not knowing is even more critical as the therapist has less access to more implicit forms of communication.

In dance/movement therapists' clinical experience, the body of the therapist has a central role in the therapy session – even when the session is

happening remotely. We would like to propose that when faced with the not knowing of the therapy session in digital space, and in order to continue to sufficiently sustain the transitional space which acts as a substrate for therapy, we must view the therapy hour as a playing field for the psyche. In the process, the therapist must listen to the psychodynamic themes that are connected to all that is happening during the session in digital space; moments of disengagement on the part of the client, or disconnection due to internet issues, sound difficulties, other people entering the screen space, relating to the client's home and more.

Just as in the physical therapy room there may be noises or other distractions which can awaken transference material (Bleger, 2017), all the limitations imposed by the boundaries of the screen make up the substrate upon which the client is able to tell the story of his/her psyche. Every client will react differently to disruptive elements in the digital space such as what is seen behind the therapist, difficulties in hearing the therapist due to reception issues, knocks on the door during the session or 'invasion' into the session by someone entering the therapist's physical room during the session, and so on. The client's psyche is revealed all the time.

All that arises in the client's body and in his/her verbal references, provide a way for the therapist to get close to and to know the client. Essentially the psyche 'speaks' to no end in response to the therapy setting, whether the setting is a known and familiar room, or a digital space manifested on a screen. All of this requires that the therapist relate to the changes in the therapy setting, the new 'room' in which the therapy is taking place, the emotional expression upon meeting a new experience in the therapeutic connection, or as one 6-year-old-girl Michal states, 'It is very strange, it feels like a meeting in a new place.'

When there is no room to which the client arrives to, choosing the location of the session via the computer is also significant. Children 'tell' through their chosen location of the lack of boundaries in their home, or their wounded sense of privacy, and likewise of their level of capacity to guard their privacy. When Neta, a 9 year-old girl, yells at her brother who is trying to come into her room, 'Get out of here! Don't you see that you're bothering me!', she reveals to the therapist her power and strength in guarding her boundaries. That is, consciously or unconsciously, the client is choosing what to show and how much to show. The choice to show clean parts that are organised, good and delightful in his/her room, while guarding the dirty, messy, ugly and 'bad', tells about all that can and cannot be exposed in the session. We believe that through observation of all these elements, it is possible to engage the client, in order to continue the work of the psyche.

Limits of the screen thus allow the client to tell through his/her behaviour what s/he wants to hide and what s/he want to show. The choice of which body parts are revealed on the screen, for example, signals the capacity to get

organised within a new reality, to take into account the other, and is likely to tell of experiences of body image and perception of body boundaries. Consciously or unconsciously, the body parts which appear on the screen tell what type of holding the client is requesting and re-enacting in the session. All that enters into the boundaries of the camera frame and all that lies beyond, are psychodynamic material.

The therapist is likely to suggest to the client to move his/her body within the camera frame, and to investigate possibilities while being mindful of the boundaries of the camera frame and the room itself, and each client with react in his/her own way to this suggestion. An invitation to come closer or move farther away from the screen will bring in endless new stories and new ways to be in connection. Relating to the physicality of the room the child is in (closeness to the wall, presence of space or lack of space, a bed, soft or hard objects, and so on) can invite more movement and with it other ways that the client can tell the story of his/her inner world.

Somatisation and symbolism in remote therapy

The sense of being seen in general and specifically in therapy with children is critical and can only be partially controlled in front of a screen. We find that in remote sessions clients are occupied with the question of whether or not we will be able to see them, to find them, to hear, to feel, to guard and protect them – perhaps even more so than when we are in the actual therapy room which is a protective and safe physical space.

In response to both the physical distance and the difficulty in symbolically holding the close, empathic and interested presence of the therapist from afar, remote psychotherapy with children often invites a sensory-somatic game. As described by Winnicott (1963), when a child has internalised an object (in this case the therapist), the child will have a sense of feeling guarded and protected by the object even when the object is not physically present or when the presence is not a full sensory experience (as is the case in remote therapy). When a child has ***not*** succeeded to internalise the therapist within him/herself – the therapist's eye contact, the experience of being with the therapist – the physical distance and limited sensory experience in remote therapy will cause a regression to primary stages of establishing a relationship.

Anzieu-Premmereur (2013) proposed that in variations of peek-a-boo games (in which one disappears and then reappears, while the tension levels rise and fall), the child practices the presence and then disappearance of the mother, and thus s/he can experience for the first time the sense of presence and absence, giving them validity and meaning and imbuing them with communicative potential. She emphasises that this is the only way to develop the possibility to bear the lack of presence which is inherent in absence, and with this to develop playfulness as well, which allows for symbolism.

In remote therapy with children situations are seen in which clients throw objects at the computer screen, press the buttons on the keyboard, come close and move away from the camera, turn the camera on and off, give a tour of the house without being in the camera frame themselves, show different parts of themselves, change location and positions, change the background on the screen (from a background of planets and stars all the way to a background of the sea or of the family), turn the microphone on and then whisper such that they cannot be heard, turn the microphone off and then roar loudly. In this way, the client controls the level of intimacy, closeness, and exposure, and plays with them. All of these, even when they do not tell of the symbolic experience, are ways for the therapist to invite the client to slide down the slide of transitional space.

For example, when six-year-old Yoni turned the telephone camera on and off over and over, the therapist related to this sequence moving between the appearance and disappearance of the child, and suggested a symbolic meaning for the sensory activity. She borrowed from her representational world and helped Yoni to find meaning in a game, that seemingly has a concrete and repetitive somatic quality. Thus, the story of inner realms which is portrayed implicitly on a sensory level becomes an explicit story.

In other cases, the physical distance actually encourages expansion of the use of symbolism and imagination. When the therapist focuses on the stories of the body (size, strength, speed of the movement), this is likely to create an expansion of the shared mutual symbolic experience. Without the concrete physical objects in the therapy room and without physical proximity, passing an imaginary ball between therapist and client, or pulling on an imaginary rope while paying attention to the intensity and speed happening on the other side of the screen, as well as 'offering hands' while nudging the back of the hands to the boundaries of the zoom frame, are all examples which invite exercises of make-believe experiences, into which the client pours the content of his/her inner world.

We will now describe work with these themes through case studies from two therapy sessions as they were presented in supervision sessions, which integrate psychotherapy and interventions from DMT. All of the names and identifying details have been changed to protect the privacy of the clients.

Case study: being together in the bodily experience

Nadav, 7 years old, came to therapy with complaints from his mother about his difficulties with sleep, emotional self-regulation and verbal aggressivity. At age 3 his father died following a difficult illness. In movement, he is alternately slouched or rigid. At his first therapy sessions, he was drawn to activities which put him in danger, while later he learned to use the softness

of the room and began searching for activities which offered a sense of being cradled and protected.

Due to the COVID-19 pandemic, the therapy was transferred to remote video sessions. Nadav cooperated and at the same time expressed frustration at the lack of the regular sessions in the actual therapy room. The therapist described that in one of the sessions Nadav looked angry and sullen. After she related to this, he shared with her that his mother told him to stop playing because he needed to start the therapy session and this annoyed him. The therapist replied that indeed it is very annoying to stop doing something in the middle, especially something that you like to do, and it is annoying to part from something that you like. In response Nadav said sadly:

'Well, it's boring for me like this. When are we going to return to our room? It's only fun in the room . . . ' The therapist echoed repeating – that maybe he feels that it's difficult to meet via the computer screen,

> And that he misses their shared room,
> And how they were in the room together,
> One with the other,
> In the room.

Nadav started to focus the camera on specific parts of his face. Each time that he focused the camera on a different part – nose, eye, forehead, cheek, the therapist responded by verbally naming each part that he focused on. Later, he focused on a certain part and in response the therapist also focused her camera on the same part of her face. She shared: 'I felt that he was slowly connecting with me in such a primary and regressive way, like a baby who is exploring his body and the connection to the subject who is with him. In order to contain the session via the screen, this was the only way that was possible for him.'

Nadav started to make different facial expressions, and the therapist copied him or responded with expressions that reflected and corresponded to his expressions. With every expression, it was possible to see the different emotions bursting through. The faces he made showed anger, disappointment, happiness, and sadness. The therapist's verbal and movement reflections gave names to the varied emotions. Facial expressions developed into movement in other parts of the body – agitated hand and arm movements, head shakings at different tempos. The therapist joined his movements and reflected them back to him. She sensed the difficulty and frustration due to the longing for a face to face physical meeting, which gave rise to Nadav's need for a sense of being together and for a primary infant-like closeness, without words.

After the therapist joined Nadav's movement, he started to say her name and his name in different ways. In a whisper, shouting, in a silent shout, a huge shout with the microphone turned off. Nadav and the therapist continued in

what developed from a somatic experience to a playful experience, in which their names are said in different ways, at times being mixing up and at times differentiating between them. The therapist said to Nadav: 'We are saying our names and they are even getting mixed up and they are so together'.

At the end of the session, Nadav laid on his bed and lifted the computer screen over his face. The therapist said that she now sees him in a different way. She described the differences from the varied camera angles. Nadav checked out different angles in which his face and torso were viewed a little bit differently each time. The therapist related to the different ways which he chose to show himself and said: 'There are many different ways in which I can see you and many new ways for us to be together'.

Case study: building a shared room

Naama, a girl in the 5th grade, came to therapy with a diagnosis of separation anxiety. Her movement lies on a continuum between bounciness to holding and tensing her muscles. When she started therapy, she moved in between rejecting the therapist to showing concern towards her, but with time her behaviour calmed, and she utilised the therapist more.

Following the COVID-19 social distancing requirements, therapy with Naama was transferred to phone calls. In one of their phone conversations she said: 'I remember the first room that we were in, but the last room – I forgot it.' Naama asked the therapist to remind her how the room, which they had started using a few weeks before they stopped meeting face to face, looked. The therapist described the mattresses in the room which Naama liked to sit on, and Naama said: 'Right, I don't know how I forgot. I think I need another room'. The therapist suggested that they try to imagine that they are right now in another room. She proposed to Naama to sketch together, through walking, the size and shape of the room that she was in need of.

The therapist shared: 'We established that both of us are standing against the wall, our right hand touching the wall – and from there we will begin to walk. Naama counted the first steps, stopped and wanted to start again. I said to her that she wants the room to be exactly right, and that both of us will be in exactly the same room. Naama wanted big windows on the walls, and the ceiling to be the height of three columns standing one of top of the other.'

Naama continued to describe the room and all that was inside of it, and when she stopped the therapist asked: 'Are we already in the room or do we need to enter?' Naama said that they need to enter, and that the way in is by crawling through a tunnel. She asked the therapist to bend down and crawl, and the therapist can hear Naama's effort as she crawls on the floor, and she herself also crawls on the floor in her own house with Naama. Naama explained that they need to turn right and then left, go straight until they

see the door and then they can enter. Only then can they stand up. The therapist said:

> We had to work hard to enter the room,
> So that we can each be in our full body,
> Fully comfortable,
> One with the other,
> Without a need to contract or hide different parts of ourselves.

The therapist asked: ‘How does the room that we made feel? And how does it feel to be inside the room?’ Naama answered: ‘It’s almost exactly right and yet it bothers me a bit … it’s off … it’s not real.’ The therapist echoed in return: ‘We are pretending we are there and it’s almost exactly right, but also not quite.’ Naama’s tone changed and she said: ‘But why can’t we meet?’ And the therapist replied:

> I know that our meetings are missing for you,
> And that our phone conversations are already not enough,
> That they don’t feel the same.

Naama was silent and asked if they could rest a little bit together, ‘Let’s imagine that we are resting on huge beanbag chairs’, she invited the therapist to participate in the experience with her. The therapist checked to see if they are still in the room they created, and Naama said yes, and asked that they be together in silence, ‘Like we sometimes do in the room’. The therapist said that she feels that today the room is really missing for Naama and asked: ‘Are the lights on or off?’. ‘Off’, said Naama. ‘But there’s light from the window’. And the therapist replied, ‘Dark, but we can still see each other’. For several minutes they were silent together. Every once in a while Naama checked to see if the therapist was still there on the other end of the line, and the therapist immediately responded and emphasised: ‘I’m here, with you’. And the silence continued.

Before the end of the meeting, Naama asked that each of them propose a movement, as they usually do to end the session in the therapy room. Naama described her movement – the therapist joined her movement. While the two of them are still lying down, Naama requests that they raise their arms up and shake them out together, and the therapist continues her movement, suggesting that they each hug their legs. In response, Naama suggests stretching out their arms and legs to the sides. In the last movement the therapist proposes that they roll to one side, stand up slowly and breath three breaths together. ‘I’m now opening the door slowly’, said the therapist, and Naama describes how she leaves the room, goes to her parents and waves to the therapist bye from the hallway.

Discussion

The first case study that was presented demonstrates how the lack of a physical meeting with the therapist lays the groundwork for regression around early primitive areas. In the case of Nadav, the video sessions invited somatic infant-like regressive themes. The communication is primarily through facial expressions, making faces and focusing the camera on different body parts. It is significant that Nadav requests a new self-discovery in the relationship. Initially, there is a connection through body parts (nose, mouth, eyes), and when the therapist joins and gives meaning to the sensory experience, the communication expands to sharing emotions that are seen in his facial expressions.

The therapist reflects to the child his/her own feelings through the use of the therapist's own body. As Winnicott (1971, p. 112) suggested: The mother reflects back to the infant him/herself through mirroring the baby's emotional experience with her body, with the goal of helping the infant so that s/he 'will find his or her own self, and will be able to exist and to feel real' (p. 118) (The mirroring is a central technique in DMT, see: McGarry & Russo, 2011; Sandel et al., 1993).

When the therapist reflects back to the child his/her movement, the movement expands into other body parts, connecting different body parts and transforming the parts into a whole complete body. These moments allow for the peek-a-boo game to develop by the therapist and client calling each other's names. Calling out each other's names is like creating Nadav and the therapist, and in turn they also disappear when the names being called out are changed, mixed together or played within different tones. Nadav looks for different ways to get close, and goes through a journey of development, from a meeting of body parts, to a meeting of his name and his identity with those of the therapist. And thus, he practices alternative ways which provide a symbolic answer for his need to merge with the therapist.

In the case of Naama, the space which the therapist offers in movement helps her to hold the closeness and togetherness within the imaginary make-believe experience. In imagination and in the body, Naama and the therapist create together a shared room, which unifies their presence into an optimal third space. There are moments when the space collapses, when the pain and the distance surge, the concrete takes over, and the need for actual closeness is spoken about and processed, while touching upon the pain of the missed opportunities. With the help of the therapist, she returns and creates a space that requires of her a joint experience.

The therapist opens for her the possibility of creating a womb for herself that meets her needs. The room is good enough for her. While crawling on the floor at the entrance to the imaginary room, Naama is metaphorically passing through the birth canal, and with the guidance of the therapist to create a space which is exactly what she needs, she practices in the session

the possibility of sensing the closeness of the therapist even when they are far apart from each other.

When the therapist invites Naama to imagine the room she needs, she gives her the permission to find the space in which she can rest and calm herself in the presence of another. "Are you here?, she asks the therapist and requests to hear her voice, in between the moments of continued silence. Towards the end of the session, she moves her body, and tells the therapist how she is moving. While it is not possible to see the whole body and the movement, the client, perhaps for the first time, can verbally share about the internalisation of the eyes of the therapist who sees her, and describes to the therapist the way her body is moving.

This capacity was internalised in the actual face-to-face sessions, in which the therapist tracked her body and movement. Naama moves while speaking aloud how she is moving and thus, in service of the connection with the therapist, she develops her inner witness and she learns to mentalise herself. Initially her somatic and kinaesthetic experience, and later her emotional and psychic experience.

As described, accordingly, remote therapy with children in digital space, with the distance and physical limitations, often invites primitive sensory expressions by the children. These expressions re-enact primary regressive experiences in relationship. The transition between sensory-somatic play to symbolic play is connected to primary developmental processes between the mother and the child. The lack of symbolic play is likely to be connected to a lack of sufficient trust in another, and/or lack of sufficient stability in the reality of the child (Alvarez, 1988).

In normal development, by holding emotional attunement in space and time to the body of the infant, the mother regulates the sensory arousal in the body of the infant and gives meaning to the sensory experiences (Bion, 1962; Winnicott, 1945, 1956). The mother's level of intonation reflects the level of excitement of the infant, length and the magnitude of the touch correspond to the muscular tension in the baby's body, and the length the mother holds her gaze on the baby and the physical distance from him/her allows for calming through the pace of the breath and the mutual communication. The listening mother who is attuned through her senses to her infant's body, creates in the baby's body and psyche a continuum of pleasurable and continuous sensory experiences of 'being together with the mother', which become symbolic representation in the body-psyche of the infant and continue to accompany him/her even when the mother is absent (Anzieu-Premmereur, 2013).

These experiences are the foundation from which the baby can pour meanings of soothing and comforting into concrete sensory experiences. That is, with internalisation of the pleasurable experiences with the mother, her absence (appropriate in length of time, neither continuous nor extended) is

filled with emotional activity that is imbued with meaning and creativity. This is the beginning of symbolism which is needed to create transitional space for playing, in which a child gives an object distinct new qualities beyond the actual qualities it has. In the cases presented, the sensitivity and attunement to the body, even when the therapy is via a computer screen, opened a portal, granting symbolic meaning to the relationship, to the playing, to the emotional dialogue. Thus, the computer screen becomes the framework for DMT in situations where meeting in an actual room is not possible.

Main conclusion, and implications

DMT during the COVID-19 pandemic often requires a transition to remote therapy. In such situations, the remote therapy via a screen reminds clients of the presence of the pandemic, even if unconsciously, and they respond to this through bodily activity. The current article emphasises the central function of the dance/movement therapist in being curious about the bodily narratives and allowing meaning-making to happen both physically and verbally. In remote DMT attention should be placed on the following points:

- A set space which is private and has familiar objects from the original therapy room and which is big enough to allow for movement will support the remote DMT work. On the other hand, flexibility and creativity in all the situations when the aforementioned are not possible, are key to success of continued DMT during a complex time when the client is obliged to stay in his/her home.
- Differentiating between somatic and kinaesthetic delight in a client's movement, versus movement which is symbolic expression can support the therapist in tailoring movement interventions according to the client's needs.
- Body awareness and intentionality, synchronisation, and mirroring of movement, constitute a central way to create a sense of closeness in remote therapy as well.

Acknowledgments

Special thanks to Shiel Avidan and Zohar Regev who granted permission to share parts of their clinical work, as they were discussed in supervision sessions. Their sensitivity to the place of the body within the analytical relationship, describes the uniqueness of their clinical work.

Disclosure statement

No potential conflict of interest was reported by the authors.

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