

**Making Telehealth a Relational Experience:**  
 Creating the Sense of Connection from a Distance

DMH  
 June 8, 2021  
 Janina Fisher, Ph.D.

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**We have been living in a traumatic environment. . .**

“Psychological trauma is **the unique individual experience of an event, a series of events, or a set of enduring conditions**, in which:

- The individual’s ability to tolerate or integrate the emotional and physical experience is overwhelmed (eg, s/he dissociates), **and/or**
- The individual experiences a sense of threat to life, bodily integrity, or sanity.’**

Saakvitne et al, 2000

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**Trauma’s Different Sources** Ogden 2002

Attack	Medical/surgical	Religious Trauma
Child Abuse	<b>Pandemic</b>	Ritual Abuse
Neglect	Natural Disaster	Terrorism
Torture, Captivity	<b>Racial Trauma</b>	Pre/Perinatal
Trans-generational	Loss/Death	Accidents
<b>Inside Threat</b>	War	Persecution
Vicarious Trauma		

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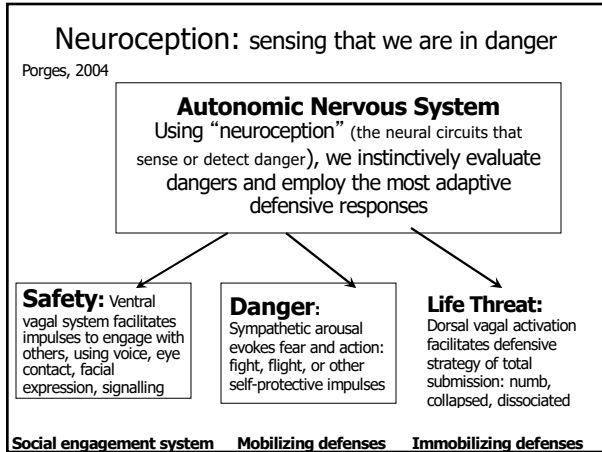
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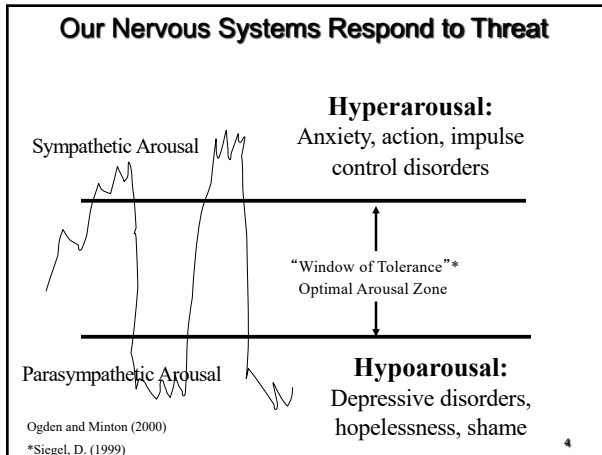
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**When we 'neurocept' COVID-19. .**

- **"Biased neuroception"** resulting from previous trauma may us feel in **more** or **less** danger than we really are
- **"When the going gets tough, the tough get going:"** sympathetic responses can drive action-taking. We shop, sanitize, research the virus online, and mask up
- **Collaboration and community:** social engagement responses can move some of us to connect **more** with others when we are anxious **or** to withdraw and isolate
- **We can choose to isolate as an empowered action, OR** we can feel forced to hide **OR** we may feel like we have been abandoned by the world

Fisher, 2021

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### Implicit memories are triggered, not recalled, cont.

- The COVID-19 situation is especially difficult because **there IS a real and present threat, AND that threat is also a trigger** for trauma-related feeling and body memories
- The combination represents a ‘double whammy’ for traumatized individuals.** Experts are clear that isolation is an act of self-protection from the coronavirus, but isolation may be too triggering to **feel** self-protective for many
- Another challenge for the therapist is how to name the role of triggering** in the client’s state of distress without empathically failing the client at an objectively difficult time

Fisher, 2021

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### Challenges of Working Remotely

- **Technical issues:** over-coming techno-phobia, problems with connectivity (freezing, loss of signal, fragmenting images)
- **Lack of privacy for therapist and/or client:** children, pets, and other adults are also working from home!
- **Two-dimensional space** is different from three-dimensional space: we can’t ‘read’ clients as easily
- **The threat of COVID** is distracting, anxiety-provoking, and time-consuming for the therapist, too
- **Beliefs** shared by client and/or therapist **about the need for physical proximity** to feel emotionally close

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### Addressing these challenges virtually

- As if the coronavirus crisis were not enough stress, **therapists have to manage their own anxiety AND try to ‘be there’ for their clients**—in a new complicated way without the benefit of ‘being with’ the individuals
- Many therapists have been stressed by the challenges of learning how to manage the technical details of telehealth platforms **AND** managing aspects of practice like client crises from a distance
- **For many of us, ethical questions arise:** can we offer “good enough” therapy from a distance? What do I do if the client is suicidal or abusing substances?

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### Addressing these challenges virtually, cont.

- For most therapists, **the biggest challenge is the lack of proximity**: the transition from three-dimensional space to two-dimensional, from ‘felt’ contact to visual
- **Clients, too, are often triggered by the loss of close proximity**, especially those who are already isolated or who have few safe, supportive people in their lives. Also, **clients who have struggled with proximity issues prior to the crisis**, who are rejection-sensitive or easily feel abandoned, **may react strongly to the virtual space**
- For some clients, **the crisis may be less frightening than their triggered ‘feeling memories’ of aloneness**,

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### Longing for Proximity

- As another complication, **the longing for proximity and physical presence can be a feeling memory**. Feeling abandoned, unwanted, painfully alone, and at risk may have been a daily experience in childhood for many clients
- It is the implicit memories of longing for connection that used to make it difficult for certain clients to tolerate the days and hours between sessions **before** the crisis
- These feeling and somatic memories will naturally be re-triggered by telehealth because, **in a virtual session, the therapist is ‘there’ but not there**. AND, if the therapist is also triggered, it will be even harder for the client!

Fisher, 2020 10

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### Longing for Proximity, cont.

- **The belief that emotional closeness is only possible with physical proximity** is a natural one for clients who have never experienced safe connection, but it can be dangerous when shared by the therapist
- **Fact = secure attachment is built on the experience of learning to internalize the presence of a safe parent**. This crisis may be an opportunity to expand clients’ capacity to feel close and connected at a greater distance. **The belief that we are no longer close when in a virtual space is an example of a failure of object constancy**
- “Object constancy” develops in childhood by age 5-6, allowing children to separate and go to school Fisher, 2020 11

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### Longing for Proximity, p. 3

- **‘Object permanence’** (the ability to perceive objects or people as still existing even if they cannot be seen) is acquired generally by age 3. **‘Object constancy’** (the ability to perceive others as consistent and connected) develops next. When clients insist that they cannot feel our warmth and caring, that is a failure of object constancy
- **For telehealth to be successful, it is important that we offer something different and important rather than something that is less than “real” therapy**
- We can do that by using this opportunity **to challenge clients to feel our presence more AND increase our ability to communicate that we are present** Fisher, 2020

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### Cultivating Object Constancy

- **“Challenging”** the belief that we are **not** connected is important to avoid clients’ misperceiving real contact
  - **Challenge #1:** “Pause for a moment, and notice that, right here, right now, I **am** here with you. And you are here with me. . . Just notice that. . .”
  - **Challenge #2:** [Always said with warmth and lightness] “Wait a minute—I’m here, and you can’t feel me?? I can feel you, but you can’t feel me?”
- It is likely that clients missed the smile or laugh because **beliefs operate like a set of blinders**, preventing them from seeing the signs that we **are** connected. Fisher, 2021

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### Challenge and Caring

- **We can be challenging and still caring with clients. Both are equally important ingredients in secure attachment.** The parent both regulates and contains, encourages spontaneity and creates structure
- **But challenging clients also requires lightness, warmth, humor, a tone of encouragement, and authenticity.** That is what distinguishes us from neglectful, abusive or shaming parent figures.
- **Transparency is also useful:** when the therapist says, “I feel close to you—but you can’t feel it?” we are being transparent as well as modeling object constancy Fisher, 2020

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### Increasing Curiosity

- Most therapists have been taught to first and foremost **express empathy as a way to help clients feel “felt”** and to increase their self-connection
- However, **curiosity is often an easier and more effective path** in telehealth to increase the client’s sense of a positive connection to us and to themselves.
- “Let’s be curious: when you see me on the screen, do I look like me?” “And what’s it like to see my familiar face?” **Before** the client is triggered and lost in the feeling memory of aloneness, asking the client to notice that **we are ‘here’** will help keep the client ‘here’ with us

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### Increasing Curiosity, cont.

- **Being curious is a non-shaming way** of interesting the client in triggered responses versus situational responses. E.g., being alone can feel protective but isolating, or just isolating and lonely, **or** as an ‘act of triumph’
- When the client says, “It’s just like my whole life—I never had anyone,” we can be curious: “Yes, there was never anyone there when you were little. But right here, right now, someone is here with you. Can you feel that?”
- It is helpful to clients when we point out that a situation is triggering as well as stressful. **When we name their struggle with both, clients never complain of empathic failure**

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### Increasing Curiosity, p. 3

- **The key to re-framing** a feeling as triggered or as a feeling memory **is the communication of empathy**: “It’s so hard to be in the midst of a real crisis AND to be triggered, too. . . It makes it all doubly hard.”
- **We can also empathize with the feelings of awkwardness or unfamiliarity**: “As if we didn’t have enough to deal with, we have this weird new way of meeting, too!”
- Bruce Ecker’s ‘memory reconsolidation’ approach emphasizes the provision of an experience that **directly contradicts** the client’s internalized models and beliefs, the ones biasing the client to feel abandoned or far away

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*“[E]motional learning usually consists of much more than stored memory of the ‘raw data’ of . . . what emotions one was experiencing during an original experience. Also [stored in implicit memory] is a constructed mental model of how the world functions, a template or schema that is the individual’s sense-making generalization of the raw data of perception and emotion. This model is created and stored with no memory of doing so. It does not exist in words. . . Emotional memory converts the past into an expectation of the future, without our awareness. . .”*

*Ecker et al, 2012, p. 6*

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### **Increasing Curiosity, p. 4**

- **When the therapist challenges the client’s perception that we are not ‘there’ and asks the client to notice the felt state of connection that is there in the moment, we are providing an alternative experience.**
- **It is not an alternative experience in words**—it is a palpably felt experience to which the words can be put after the old models have been contradicted
- To provide the alternative experience requires that the therapist ‘get’ that we can communicate our presence virtually AND that the client’s desperate need for contact is not manipulative or attention-seeking—it is a manifestation of trauma

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*“Long-lasting responses to trauma result not simply from the experience of fear and helplessness but from how our bodies interpret those experiences.”*

*Yehuda, 2004*

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## Sensorimotor Psychotherapy

Sensorimotor Psychotherapy is a body-oriented talking therapy developed in the 1980s by Pat Ogden, Ph.D. and enriched by contributions from the work of Alan Schore, Bessel van der Kolk, Daniel Siegel, and Steve Porges.

**Sensorimotor work combines psychodynamic techniques with body-centered interventions that can address the implicit learning of trauma.** By using “just enough” narrative to evoke the implicit experience, **we attend first to how the body holds and keeps alive old trauma and attachment failure and later to cognitive and emotional meaning-making**

Sensorimotor Psychotherapy Institute Ogden, 2002; Fisher, 2006

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## Noticing rather than narrating, playing rather than ‘working’

*In collaboration, therapist and client “study what is going on [for the client], not as disease or something to be rid of, but in an effort to help the client become conscious of how experience is managed and how the capacity for experience can be expanded. **The whole endeavor is more fun and play rather than work and is motivated by curiosity, rather than fear.**”*

Sensorimotor Psychotherapy Institute Kurtz, 1990, p. 11

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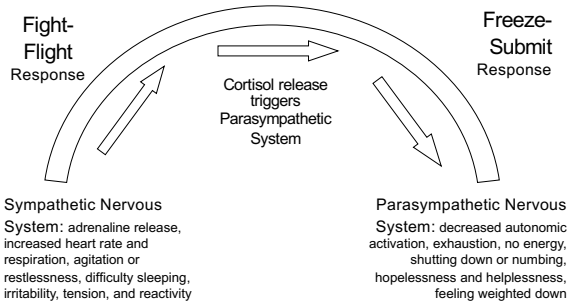
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## In an unsafe world, the human body has two choices for defending itself



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**Traumatized people tend to exhibit either hyperactive or passive defensive responses or an alternation between the two.**

**Hyperactive defensive responses:** defensiveness, anger, irritability, aggression against self or others, hyper-alertness, hyper-vigilance, excessive motor activity, overly rigid boundaries, uncontrollable bouts of rage.

**Habitual passive defensive responses:** chronic patterns of helplessness and hopelessness, inability to set boundaries, feelings of inadequacy, and repetition of the victim role. **The person may appear lifeless, non-expressive, and may fail to defend against or orient toward danger**

Ogden, 2002

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**Defensive responses can be unsafe or disabled during COVID**

- **Flight responses are ineffective right now:** if we are self-quarantining, there is nowhere to run
- **Fight responses are even more ineffective:** if we rebel against restrictions, we endanger ourselves and others
- **Freezing and isolating** turn social distancing into hiding out and waiting for the war to be over
- **The challenge for some clients is that their bodies have learned to shut down or dissociate under stress, leading them to feel depressed, despite the reality that passive defenses (willingness to stay inside) are more protective right now**

Fisher, 2020

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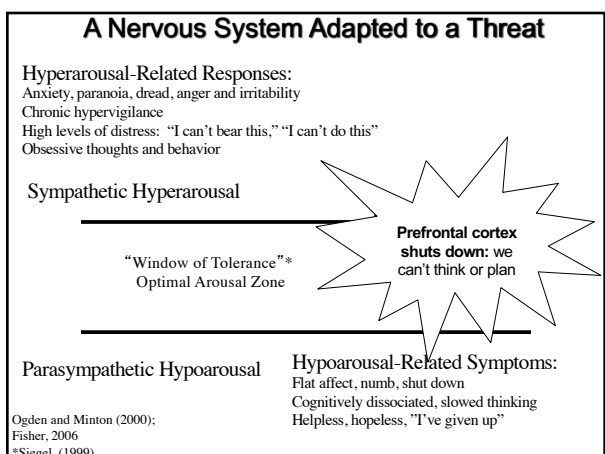
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**What we are likely to see. . .**

**Hyperarousal-Related Responses:**  
Alcohol and marijuana down-regulate hyperarousal  
Self-injury is also a down-regulator as is restricting food intake or bingeing/purging or overeating

Sympathetic Hyperarousal

"Window of Tolerance"\*  
Optimal Arousal Zone

Poor choices caused by the prefrontal cortex shutting down

Parasympathetic Hypoarousal

**Hypoarousal-Related Symptoms:**  
Alcohol is a stimulant in small doses  
Marijuana maintains hypoarousal, zoning out  
Belief that one is depressed feels confirmed

Ogden and Minton (2000);  
Fisher, 2006  
\*Siegel (1999)

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**Focus on Cultivating Mindfulness**

- **Instead of trying to continue with the work of therapy as it unfolded pre-COVID-19, try to use this uninvited opportunity to help build the client’s resilience and creativity**—both essential ingredients in coping right now
- **Mindfulness changes our bodily state:** “When we say, ‘I’m scared,’ notice that the heart rate goes up—there is a more intense feeling of anxiety.” When we ask, “How is your body telling you you’re scared? What sensations do you notice?” there is a feeling of interest or curiosity.
- **The bodily state of being mindful is calmer, more open, less tense,** all of which are immune system-supporting responses.

Fisher, 2020

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**Focus on Mindfulness, cont.**

- **In a pandemic, we need ‘signal anxiety,’** enough anxiety to drive us to take the precautions recommended, but not so much anxiety that we become chronically stressed
- **Mindfulness does not judge—it just notices:** “Interesting—I have wiped down my entire kitchen and bathroom again today even though no one has come in. And what do I notice? Less anxiety or more?”
- **In Buddhism, mindfulness requires “interest” in whatever comes up “without attachment or aversion.”** Meaning that we do not agree with any thought or feeling and we don’t reject any thought, feeling or sensation. In a pandemic, it is easy to get ‘attached’ to fear

Fisher, 2020

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### Neurobiological Effects of Mindfulness

- **Mindful concentration has been correlated with** increased activity in the medial prefrontal cortex and **decreased activity in the amygdala**, the brain's fire alarm and smoke detector, which down-regulates fear
- **Mindful noticing inhibits impulsive behavior:** the more mindful detachment from emotions, the less overwhelming the feelings are and the less likely we are to act out
- **Mindfulness discourages negative self-talk** and cognitive distortions that exacerbate symptoms. Clients may be used to their critical, shaming thoughts, and the current crisis gives them "ammunition" to use against themselves

Fisher, 2012

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*"Although mindfulness is often seen as a form of attentional skill that focuses your mind on the present, [we can also see] mindfulness as a form of healthy relationship with oneself. **That is, mindful awareness is a form of intra-personal attunement. Being mindful is a way of becoming your own best friend.**"*

*Dan Siegel*

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*"[The restoration of] competence is the single biggest issue in trauma treatment"*

*Bessel van der Kolk, 2009*

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### Sensorimotor Interventions [Ogden, 1999]

If the issue in the COVID-19 crisis is anxiety and isolation, the remedy should be action and and self-support

- *“Notice what happens if you lengthen your spine just a little bit . . .”* The action of lengthening the spine increases energy and feelings of solidity. If the client feels hopeless, lengthening the spine helps support hope
- *“See what happens if you orient to the room by turning your head and neck and slowly looking all around. What do you notice?”* The actions of orienting and scanning increase perceptual contact with the environment and accurate assessment of threat

Fisher, 2020

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### More Sensorimotor Interventions

- *“Let’s notice what happens if you assume that your fear is trying to help you?”* Techniques in which the symptom is studied as survival response support curiosity and interest
- ‘Experiments’ facilitate changes in emotions, body, and negative cognitions. Notice that these experiments interrupt automatic responses of either anxiety or self-flagellation
- *“Let’s study what happens to the hopelessness when you repeat those words, ‘There is no hope for the future.’ Does it feel better or worse?”* “
- *“Notice what happens when you say the words, ‘I’m doing the best I can. . .’?”*

Fisher, 2010 34

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### Increasing the Client’s Window of Tolerance

- **Expanding the Window of Tolerance is always an end goal of body-informed trauma treatment,** and increasing the capacity to tolerate how we feel is crucial for processing the pandemic experience
- **How can clients expand the Window of Tolerance?**
- **First, we can help them learn to use their existing resources to regulate fear and loneliness.** Clients often forget there are things that help them feel better or they forget to use them when stressed or triggered
- **And we can teach them simple somatic resources**

Ogden, 2000; Fisher, 2005

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**Increasing the Client's Window of Tolerance, p. 2**

<b>Trauma responses:</b>	<b>Resources:</b>
Fear, tension	Deep breath or sigh
Frozen—can't move	Movement, standing up
Slowed thinking, no energy	Grounding
Collapsed, helpless	Lengthening the spine
Feeling overwhelmed	Rolling the shoulders back
Hopelessness and other trauma-related beliefs	Lifting the chin
	Hand on the heart

Ogden, 2000; Fisher, 2005

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**Cultivating "10% Solutions" to Overwhelming Feelings**

- Sighing, breathing in calm and breathing out fear, lengthening exhale
- Taking walks, stretching, yoga, tai chi, doing chores
- Watching calming TV shows, avoiding the news
- Engaging in any safe activity that calms the body (taking a bath, making cookies, ironing, knitting, drawing, playing with a pet)
- Engaging in activities that require concentration but not much thinking (tanagrams, jigsaw puzzles, computer games, solitaire)
- Working with the hands (gardening, cooking, needlework, painting)
- Prayer and meditation, listening to guided visualizations, podcasts
- Inspiration: finding one thing that makes you smile
- Using mantras or sayings: "This too shall pass," "One day at a time"

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**The Challenge of Making Virtual Space Feel Relational**

- **What complicates** implementing all of these ideas and interventions **is most often the conflict between our wish to work on issues and the client's wish for contact or their distress about the lack of contact**
- **When isolation is triggering, clients can feel overwhelmed** by feeling memories of loneliness
- Rather than trying to work **around** the client's distress over the distance, **therapists can make virtual psychotherapy a more relational space.** It 'just' requires a change in how we 'are' in the therapeutic encounter

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### Make Use of the Social Engagement System [Porges, 2005]

- The ‘social engagement system’ regulates movements of the eyelids, facial muscles, middle ear muscles, larynx, and head tilting and turning movements
- The development of an infant’s social engagement system is dependent upon the caregiver’s ability to stimulate and interactively regulate social interaction
- When clients have had abusive and neglectful parents, social engagement was usually absent, and they come to therapy with an inhibited or shutdown social engagement system and dorsal vagal dominance

Ogden, 2006; Fisher, 2007

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### Increasing your level of social engagement in tele-therapy combats the perception of distance

- Make use of your own social engagement muscles, being sure to utilize facial and eye expression, your head movements, intonation, and synchrony so that you evoke the client’s social engagement system.
- The social engagement system is body-oriented: it relies upon the “muscles that give expression to our faces, allow us to gesture with our heads, put intonation into our voices, direct our gaze, and permit us to distinguish human voices from background sounds.” (Porges, 2004, p. 21)
- Because social engagement is associated with safety, it decreases fear and overwhelm

Ogden, 2004; Fisher, 2007

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### Be “louder” relationally

- In the physical presence of the client, our energy and the sense of our listening and positive regard can be felt. **In virtual space, our ability to listen and resonate cannot be felt**—unless the client has secure attachment
- **To compensate, the therapist has to become a bigger presence:** more vivid, more socially engaged, more reactive, more “there,” more
- Think of an actor trying to communicate a character’s presence to an audience of hundreds: **it takes the ability to exaggerate just enough to communicate that individual and not so much that it feels ‘fake’**

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### Be “louder” relationally, cont.

- **Make your gestures bigger, your facial reactions more dramatic**—don’t be afraid to be a ‘drama queen’ or king
- **Use the social engagement system to its capacity:** use facial expression to support the words you say, soften or put a sparkle in your eyes, tilt your head as you listen so the client can see you listening
- **Laugh and smile more!** Remember that **laughing is associated with increased immune function** as well as with regulating sympathetic arousal states. We can laugh **WITH** and **FOR** our clients so that the laughter feels like a shared experience

Fisher, 2020

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### Be “louder” relationally, p. 3

- **The stress of navigating telehealth technology can take its toll on the therapist** as well as the client. We may be more stressed and more frozen, less relaxed
- **Try to relax your shoulders, lengthen your spine, and stay in contact with the floor.** The more grounded you are, the more likely the client can feel you there
- **Be more of neighbor than a therapist:** we are all literally in this together, and there is no usefulness to being a blank screen right now. We can have boundaries and be somewhat more transparent at the same time
- **Be practical:** this is survival time, not processing time!

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### Be “louder” relationally, p. 4

- **Don’t just rely on your facial expression: use your whole body.** You may need to sit back a little from the screen, but the result will be worth it
- **Remember the theory of ‘mirror neurons:’** the client’s ability to be present will increase the more you are present
- Use gesture, shrugging, tilting or turning the head, and **make sure to demonstrate skills like lengthening the spine so the client can imitate your movements**
- **Be more spontaneous, silly, ‘real,’ and unexpected.** The expected in virtual space may be disappointing or evoke feelings of deprivation. A slightly different you is novelty

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### Experiment with the impact of different styles of communicating

- **Vary your voice tone and pace of speech:** soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone
- **Experiment with facial expression:** does the client respond differently to calm vs. warm, expressive, or playful expressions?
- **Change energy level:** very “there,” energetic vs. quiet, calm
- **Notice: does the client respond better to empathy or to challenge?** Better to playfulness or to seriousness?
- **Amount of information provided:** does the client benefit from psychoeducation? Or does it evoke more feelings of distance?
- **Experiment with posture:** different postures communicate different messages about ourselves and the client

Fisher, 2015

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### Maximizing positive states, not just repairing negative ones

- Attachment theory says that secure attachment is equally the result of caregivers **amplifying opportunities for positive affect** (Schore, 2001), e.g., in play states.
- Even though “good enough caregivers are inevitably somewhat inconsistent in their attunement with their children, they promote **recovery from breaches of attunement by providing interactive repair**. . . .”
- “**This transitioning between negative and positive affect helps the infant to develop resiliency** and, later, flexible adaptive capabilities.” (Tronick, 1989)

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### Maximizing positive states, not just repairing negative ones

- To the extent that therapists have been taught primarily to empathize with states of distress, we are not using the lessons of the attachment research demonstrating that secure attachment develops as a result of caregivers **amplifying opportunities for positive affect** (Schore, 2001)
- **Clients may experience telehealth as a failure of empathy** rather than seeing it as a resource. It is our job to empathize while also helping them to laugh, smile, and enjoy the encounter with us. **We are not minimizing their feelings—we are regulating them**, just as we do with children

Fisher, 2021

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**“Dyadic dancing” with clients**

- **Rather than a therapeutic style of listening** to all that the client has to say before responding, **the therapist engages in a “duet” with the client.**
- The client says something, then the therapist responds by echoing the words or making a clarification in them; the client reacts to that, and the therapist echoes again or re-directs the client to be curious or . . .
- **When clients use “self-defeating” interpretations, the therapist interrupts:** *“Isn’t it interesting? The thought comes up that it’s your fault. Wow. . . That’s right where your mind went, huh?”*

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**“Dancing” with clients, cont.**

- But therapists have a ‘phobia’ of interrupting! **We believe we fail them empathically if we interrupt.** But if we do **not** interrupt, the client will be dancing alone to a very old negative song—and encoding it more deeply.
- The key to ensuring that clients feel no loss of empathy when they are interrupted is the therapist’s tone of voice. **When we are excited, awed, fascinated, touched, or amused by their words, clients will feel “met” by our interruptions, rather than cut off.**
- The success of a therapeutic “dancing style” rests on it feeling like we are “with” the patient, not just trying to evoke the emotional pain or move stuckness Fisher, 2019

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**“Dancing” with clients, p. 3**

- In good attachment, **each maternal response soothes or builds excitement.** The attuned caregiver makes sure to track the baby’s signals to ensure that she or he is enjoying the exchange and not getting over-stimulated.
- Similarly, **the attuned therapist observes what elicits the patient’s curiosity and interest,** what is irritating, reassuring, what helps them come more present, what is soothing and what is not soothing
- **Like a ‘good enough’ mother, the therapist repeats what maintains the patient’s positive state** and refrains from repeating words, tone, and body language that dysregulate the patient Fisher, 2019

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“The primary therapeutic attitude [that needs to be] demonstrated [by the therapist] throughout a session is one of :

**P** = playfulness

**A** = acceptance

**C** = curiosity

**E** = empathy

Hughes, 2006

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