Reflections, Thoughts, and Considerations on Regression Work in Group Using Online Video Platforms

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Abstract

One of the regrets frequently expressed by colleagues in these times of pandemic and restrictions on in-person, face-to-face meetings is that regression work is not possible due to the limitations inherent in videoconference sessions, and that we are forced to stick to cognitive work, or at best to emotional work, but only in the here and now. However, this should not be considered a hard and fast limit. In this article I give an example of group regression therapy via Zoom. I describe the conditions and possible limits to regression work when provided online.

Keywords: developmental model of the sense of self, attachment theories, integrative psychotherapy, relational trauma, implicit memories

Daniel Stern's Developmental Model

For Daniel Stern (2015), the sense of self is the way in which we experience ourselves in relation to others. It arises from preverbal and therefore non-conceptual elements, resulting from direct relational experiences which are the precursors of the later objectifiable, verbalizable, and reflective self. As the infant develops new skills, it forms new subjective organizing perspectives regarding its own self and those of others: the sense of self domains.

The development of the "sense of self" can be thought of as occurring in a series of age-related domains. With continuing internal coherence and relation building, each domain of the sense of self thus formed persists for life, with each new relational experience inducing a process of re-evocation and reinforcement or reorganization of all areas of the sense of self. The usually recognized domains and age ranges are: emergent (0–2 months), core (2–8 months), intersubjective (8–15months), verbal (15 months and up), and narrative (3 years and up) (Stern, 2015, pp. 43, 52–53).

It is a bit like a traveler who goes around the world, reorganizing his suitcase during his journey according to the climates encountered. When he gets home, it

is the same suitcase, containing the same fundamentals—e.g., jeans and sneakers—and yet, it is not quite the same since it has been embellished with a pretty loincloth, a fur shapka, a sari, and a gaucho hat.

Case History

I will explore the conditions for doing online regressive therapy using a case history. Sophie, a hospital supervisor, was put on sick leave by her doctor for two months for "burnout." She has felt badly treated during the pandemic by the paradoxical demands of her institution: availability of beds, reassignment of personnel, incessant reworking of schedules, and so on.

She has been in group therapy for many years, attending two sessions per month. Once she stopped working, she came to individual therapy sessions with me between the group sessions. Since the first pandemic lockdown (March 2020), all the sessions have been done via Zoom.

Her life process, because of an avoidant-anxious attachment pattern, urges her to be constantly alert and anticipating impending disaster in all aspects of her life. From the age of six she kept herself awake, making it her mission to watch over her father to be sure he would not die during the night, a behavior which did not seem to disturb her mother. She grew up in a dysfunctional family system impacted by her bipolar father's long depressive episodes and by an ambivalent mother who was both abandoning and rigid.

When Sophie was eight years old, she was given "a great present:" a little sister. Her father and, to a lesser extent, her mother were ecstatic. Sophie felt cheated and began struggling to outdo her sister in the eyes of her father and competing with her sister to please her mother.

The failure of the "be strong" message reactivated, in an individual session, an implicit archaic memory of her underlying experience of abandonment: as a baby she was placed in an incubator a few days after birth because she did not eat and was not gaining weight properly. Because her mother found it "too difficult" to see her bound up with all the incubator tubes and appendages, Sophie was effectively deprived of her mother's support.

In the following group session, Sophie shared her integration of the previous individual session with her peers, and to my great surprise, this triggered a panic attack. She once again described the frozen rigidity of her infant physiology, her

inability to breathe, her painful body. I invited her to welcome these sensations as "they have something important to say to you" (Erskine, 2019, p. 7). She made contact with the memory of the incubator experience again and realized that this tension was protecting her from her own temptation to let go of everything and die (Small, 2004, p. 10).

I sensed that a protocol experience of disorganized attachment was emerging. The avoidant-anxious attachment, with the decision to "be strong," had been put in place later in her growth to protect her from the risk of making contact with disorganization. The tension in her physiology protected her from a psychotic outburst and remained as a bodily inscription in the emergent sense of self.

For Stern (2015), throughout our lives, the bodily and sensory imprints of the relationships created in our first days continue to be elaborated and reshaped by necessity, because babies are born with the need and capacity to build attachment and create coherence. In the first two months of life, the infant internalizes the relational process and the result of this process; this is the beginning of one's internal organization (Stern, 2015, pp. 66–67).

Suddenly, Sophie began hyperventilating. I started to breathe in rhythm with her and invited her to look into my eyes. (Technically, via Zoom, she could only look at an image of me looking at her image.) I guided her to gradually slow down her breathing in time with mine. I also instructed her to look at the other group members who had begun to breathe with us. Finally, the crisis calmed.

My attunement to the exaggerated rhythm of Sophie's breathing and to her developmental age and affect allowed me to guide her towards the integration of a rhythm that she could make her own. This would help her to gain security in relationship and therefore re-structure the developmental domain of the core sense of self (Erskine, 2019, p. 8).

In the domain of the core interpersonal connection, the baby resonates with the other and lives itself as part of a great whole, while at the same time the notion (without concept) emerges that "this is what it is to be me." In this domain the developmental baby's challenge is to integrate rhythms; to develop affectivity, the sense of continuity, and agency; and to begin managing oneself (Stern, 2015, pp. 98–99).

At this point, I thought I could stop the work, but I checked by asking her how she was and how the baby felt. She answered, "It's okay, but I am afraid that tonight the baby will start again." (Note: her companion was working that night.) The incongruence of the tone of her answer, without energy, and the generalization

“okay” plus her clinging tense appearance were significant. I became immediately alert and aware of the tension that I was feeling in my back. This was a warning signal for me not to be caught in what I identified as a parallel process of hypervigilance related to the little girl of six to eight years old who was made to carry responsibility too early. I took the initiative to tell Sophie, and I expect also the little girl inside her, that she could call me at any time during the night if she needed, and I promised I would answer.

I felt deeply connected with her trauma: the experience of abandonment as an infant in an incubator, reinforced by the experience of a little girl of eight who had to prevent her baby sister from crying and getting on Daddy’s nerves while Mum went out to play cards with friends. Obviously, this girl was too young to manage such a level of responsibility. By attuning myself to her trauma, my therapeutic intention was then to offer reliability and consistency to the ages that had lacked it.

The other members of the group expressed their concern for her, saying how they were touched by her work. They described the intense experience it had been for each of them to live, in a parallel process, the temptation of interrupting contact with the feeling of the risk of death (hers and possibly theirs), and to rely on my voice to allow themselves to risk living this oppression with her—without identifying with her. In the group process they expressed words of relief and hope for her after she accepted my offer. This was a reassuring indication of the effectiveness of emotional regressive work even at a distance.

Actually, Sophie did not call me despite waking up several times. She remembered our common breathing and my offer, and that was enough. The next morning, the other group members messaged her to check on her.

In an individual session, she came back to the paradox of feeling ambivalence. Her doctor, a man, had responded to her fear of having to return to work by extending her sick leave for two months. He also guaranteed her that he would extend the leave as long as she felt the need. She said she felt reassured. He verified that she was continuing her therapy and prescribed an antidepressant. Sophie again expressed her anxiety and her hesitation to accept this offer because it meant that “she was depressed and would never be as strong as she used to be.”

I understood the situation as a juxtaposition (Erskine, Morsund, & Trautmann, 2019, pp. 196–197); the symbolic parental couple, the female therapist and the male doctor, were really looking after her. Her fear was taken seriously by them.

She regressed to holding on to the paternal depression (like Father, I am depressed, but I don't want to be, so I fight my need to rest). In my understanding it was less painful to reconnect with Father's depression than with the mother's abandonment.

I normalized and summarized the current situation: we talked again about the need to relive the pain, just for a limited time. We discussed the depressed but resilient infant she was carrying inside. We clarified that feeling depressed was not the same thing as being depressive and that when she felt ready, we would organize with her doctor to discontinue the medication. She then accepted that.

In the second group session, still on video, Sophie talked again about her astonishment at having made contact with this infant part of herself who is tempted to let go of her body and die and her fear of this temptation. She indicated that, following the session, she felt the need to scream into a cushion. As she spoke, I again observed the tension in her neck and shoulders, the inward gaze, and the quickening of her breathing.

I thought back about the experience of the newborn baby in the incubator, whose whole being was mobilized to survive to the point of not having the strength to emit a sound.

I hypothesized that the expression of the infant's distress, since it was now externalized, was to be welcomed as the manifestation of an integration. I regretted, at the same time, the reiteration of the trauma, as this externalization happened in solitude, even though there was a reliable, stable and consistent other (me) available for her, but at a distance.

The issue is still the integration of the self in the domain of the core sense of self, where the intuitive notion of an "other," who is potentially there in a predictable and reliable way and who meets needs as they emerge, is integrated (Small, 2012–2015).

Nevertheless, I chose not to invite Sophie to feel neither the baby's distress, nor, as I suspected, the little girl's anger. My concern was that by inviting my client to relive this distress, there was a risk of regression to a protocol (first interaction) level that would be difficult to physically contain using our remote online platform. I chose to stabilize and anchor a minimum of basic stability in the emerging and core senses of self, knowing we would have to deal with the archaic need for security in relationship, through bodywork, when sanitary conditions would allow this again.

I hypothesized that restoring this basic stability would then allow the expression, in relationship, of the little girl's anger. My preoccupation at that moment was to prepare the medium-term moment of the end of the medication: we had a contract about this with Sophie's Adult ego state, but more importantly, my immediate aim through this "medication topic" was to create a structure for her experience: with a beginning, an unfolding, and an end. By doing so, I hoped to address all of the domains of the development of the sense of self and all the ages where the difficulty of one moment was experienced as being there forever (Small, 2012–2015).

I therefore normalized her astonishment at breaking through the "be strong" system and making contact with the baby's temptation to let go and die. I affirmed that it was smart for both the baby to resist through body tension and the little girl to decide to always be strong. I validated that for the baby, the little girl, and the grown-up, holding herself frozen and uptight was the baby's way to stay alive and keep her emerging sense of self aggregated and functioning. I explained that for her to be alive meant being in her frozen body. Sophie nodded and relaxed.

I considered stopping the work here, but she tensed up again and held her stomach. I asked her to tell what was going on. She said, "The baby is a pain in the ass, we will have to take care of her again. She is all tight inside and prevents me from breathing." What had clearly emerged in the relational setting offered by the group was a little girl of six to eight years old—a little girl that had to act as a parent much too young, and to whom it was necessary to offer an interposition.

I addressed the little girl to tell her that "little girls like to learn how to take care of babies, Sophie, and I am going to teach you." We were going to do it together, and then she could go to sleep peacefully because "little girls also need to learn that it is the grown-ups who take care of troubled babies." She agreed.

I invited Sophie to put her hand on that place that was all tight, to feel the frozen baby, and to notice her sensations. The baby felt held, tightly, under her buttocks and lower back. I invited her to visualize her insides and very slowly widen that space a little bit, and to nod when she had done so. I then suggested that maybe the baby is relaxing a little bit, first a leg, then a shoulder or an arm and so on, with each nod from her we widened a bit more. Meanwhile the little girl watched and told us that "the baby still has pain in her leg or her neck" while the whole group began to breathe in rhythm with us. I checked on the level of pain from time to time as it lessened progressively.

I invited Sophie to tell the baby inside that she will always be there for her. I also invited her to tell the little girl that “they can do this together for the baby, but she doesn’t have to, she has her own eight-year-old things to take care of with Sophie.” I told the eight-year-old girl that she would sleep well tonight. She now knew how to cope with babies, but it was Sophie who would take care of the baby if needed. I finished by giving Sophie the instruction to repeat the experience of welcoming the baby with the little girl, to feel full internal contact at least once a day, and she agreed.

During this work, everyone in the group openly offered their empathy to Sophie. Empathy is one of the achievements of the structuring of the intersubjective domain, made possible by the activation of the mirror neurons which are operational from the first days of life in the brain’s physiology (Guarella, 2017). This potential aptitude of the infant to meet the other’s emotions is enabled through his early relationships during the process of structuring the emergent and core domains.

According to Stern (2015), this ability develops in the emotional system of the baby and allows the structuring of the baby’s sense of self in the intersubjective domain. The baby has the sense that his perceptions, sensations, and emotions belong to him. He begins to have the intuition that the other also has an internal world and discovers and verifies whether, with whom, and to what extent the subjective experience can be shared. The baby hopes for an other “who feels as I do and to whom I can respond emotionally, in an experience of full contact. But in this development phase the baby will also experience dissonance” (Stern, 2015, pp. 164–166).

At the same time, as an integrative psychotherapy therapist, I committed myself, *with my client*, to the realistic and life-giving hope that she would emerge from her suffering regardless of her developmental age (Cadot, 2011; Erskine, 2020). In this work of repairing the traumatic relational experience with the client, I remained attentive to stimulating Sophie to mobilize her own resources. In order not to offer hope as a panacea, I was careful to propose attuned options that were in harmony with the rhythm, emotions, and type of trauma and to verify her commitment to herself.

In this work, simultaneously and implicitly, both the group members and the therapist formed an internal image of a family, with the therapist as the head who guarantees the safety of all, and with everyone cooperating to take care of the baby’s and the little girl’s welfare. Each family member expressed their own experience and their experience of the baby. Each member put their energy into

serving the baby and co-creating a safe relational space, where the baby has nothing to do for the family, where the baby has only to deal with being herself, with her internal experiences, and with the manifestations of these.

The group was a determining factor in the impact of the therapy on Sophie's progress. The group offered a stable and consistent process through lockdowns, deconfinements, fear of contamination for oneself or one's relatives, and experiences of loneliness and sometimes isolation during the COVID-19 crisis. All of this reactivated everyone's archaic systems of protection. Every group member had the opportunity to (re)experience the lack of the "other," was encouraged to express it, and was welcomed in this expression. They assumed the responsibility of being present for their peers as themselves, with their own authenticity, awkwardness, and relevance.

Both the little girl and the grownup Sophie benefited from this peer group where their emotions could be expressed, where they were welcomed and understood, where experiences and practical options were shared, and where solidarity was expressed and acted upon—even outside the group's scheduled working times. The group became a relational cradle that offered a reliable and stable holding, providing a shield for the baby's and the child's over-excitement. Particularly for this type of work and under these conditions, the group was both process and matter, the relationship that heals.

Therefore, everyone, including Sophie, revisited and rearranged *by and for* the group all the domains of the sense of self in a strong process of coalescence. Each of the group members, and the group as a whole, were offered permission, protection, and power and experienced the process of integration of the self.

Regression Work via Videoconference

From the above case history, we can see how group regression work in videoconferencing, despite the distance, can provide a process of developing one's own and the group's sense of self.

When we talk about regression work, the question we are often asked is to define whether we are dealing with spontaneous regression or induced regression. In my opinion this is almost a false debate. The only truly spontaneous regressions that I have encountered in twenty years of practice were the results of a massive traumatic shock: a sudden death, violent crime, the suicide of a loved one, incest or sexual abuse, etc. The type of support offered in such cases fundamentally

depends on the therapist's attunement to the degree of alliance established with the client and with the therapy group. In the case I've described, it should be obvious that the group and therapist already had a long-shared history.

Most of the time what we call spontaneous regression is a regression induced by the reaction to a rubber band situation. A stressing situation in the here and now invites the client to remobilize memories of an original trauma, to contact her belief system and relaunch, in relationship, the emotional and behavioral survival decisions based on a long-established script dynamic. In more favorable situations, regression is not induced by the therapist who merely guides and accompanies it, but by the therapeutic work that continues within the client, on their own (like Sophie screaming into her cushion), in between sessions.

Bodywork and Work with the Body at a Distance

Another question often raised about regressive work concerns the difference between *bodywork* and *work with the body.*

Bodywork is a specific therapeutic intervention to facilitate the client's contact with the impact of a massive traumatic shock or with distress that was physiologically inscribed at a preverbal age. The objective is to allow the client to come out of the process having lived a restorative experience in a healthy physical proximity that is emotionally protective and relational. This will then generate in the brain new neuronal and synaptic connections and a new gestalt of a soothing and safe encounter with the other.

In my practice, I use the mediation of bodywork only for the treatment of the first unattuned protocol interactions, when their impact was damaging for the structuring of the sense of self of my clients. I also use bodywork for treatment when there is in my clients' history the awareness of serious traumatic events that hinder their ability to hold onto their sense of self in stable personal psychic boundaries.

From my point of view, the offer of regression bodywork, probably and to a certain extent, leads the client's Child ego state to confluence with the therapist, who is fantasized as a good Parent. Therefore, such work requires the express and Adult consent of the clients who do understand the possible impacts of these traumatic memories on their lives and who choose to go through them again in order to emerge lighter, joyful, and free to make their own life choices.

Indeed, in this project *with the true self of the grown-up client* (Cadot, 2011), I need to observe their whole physiology in order to verify they don't over-adapt with the bodywork proposal from a terrified and confused child ego state, especially in the presence of trauma resulting from physical or sexual abuse. Confluence is an intrinsic component of this type of trauma, in which the person is confronted with such a psychic implosion that the only reference point that emerges afterwards and remains is a kind of loyalty to the aggressor. This reaction is an attempt to give meaning and predictability to such an experience, even at the cost of dissociation, and to remain in agreement and attachment with the total or partial denial practiced by the family system.

From another perspective, my own personal experience of bodywork as a client in a therapy group brought undeniable resolution for me, but left me with few conscious or constructed memories. This seems logical since this type of work touches on a preverbal trauma and repairs at an age when the child cannot think about or express their experience. As a therapist, I therefore know that the clients may emerge from this work with few organized memories of their experience. There may be a feeling of physical and emotional fatigue, followed, later on, by an Adult awareness of the liberating impact of this specific therapy work on the rest of their life.

To do this work in group is of primary importance; the group members' trusting and attuned presence offers holding, providing implicit and explicit psychic regulation that the clients lack from birth or from the onset of a traumatic experience, whether acute or cumulative. What's more, the group's holding implicitly validates and normalizes the therapist's intervention. Insofar, as affect confusion or even affect disorder (understanding: emotion, sensation, and behavior) is an intrinsic part of a traumatic experience, the physical holding and containing presence of the group brings back, in the work setting, a dimension of shared reality that contributes to a sense of protection for the clients against possible fantasies of traumatic reiteration.

I only consider bodywork with clients who demonstrate a good enough plasticity of their ego state boundaries and can return easily to their Adult ego state (which excludes people with an underlying psychotic core), and only when they have already built up enough security in their daily lives and relationships and enough re-appropriation and understanding of their history. This means that these clients already have a usual experience of working *with the body.*

This is my choice: according to me, the treatment of protocol inscriptions or spontaneous regression through bodywork requires physical presence and the

presence of the group. However, as soon as my clients have gained confidence in our therapeutic relationship, I feel free to routinely work with the body, in both individual and group settings. In this respect, working via videoconference didn't require any change in my way of supporting my clients.

I practice in the French Alps, and quite often, in winter, clients have trouble reaching my office to attend their session because the roads are too snowy. In this pandemic, I found myself greatly trained by my first ten years of work as a therapist, when neither WhatsApp, Skype, nor Zoom were available. We had to manage by phone. I learned, in such situations, to close my eyes, imagine a bubble around me, and concentrate on the voice and breath of my clients.

I keep in mind that there is a difference between presence, meaning the geographical context of the session, and presence, meaning the availability to unconditionally and empathetically welcome, on a psychic level, the vulnerability of the other. Fortunately, the second type of presence does not always require the first.

There are however exceptions: during the recent lockdown, I found it necessary to have two face-to-face sessions with another client to address an archaic issue of abandonment while responding to the here and now need for mutuality. Despite the lockdown, I decided it was therapeutically justified for my patient to attend. This client, with a borderline structure and a strong propensity for denial and insensitivity, was plunged into an intense panic on seeing the frozen faces of her group on the screen. This was caused by a technical failure of internet and she regressed to a too-young age to be soothed by the SMS support we had established.

I knew this client would benefit from a bodywork session, and I was aware that her reaction was related to the therapy contract she had elaborated (telling her mother about her anger). My choice was, at this point in her ongoing therapy, to make an exception for her. I offered physical proximity to make my being present for her affect and need more tangible for her. My objective was to validate her need for self-definition in the relationship, her need to be acknowledged, even distinguished, which her mother had never satisfied. We were then able to work with her body so that she could recommit to her ability to remain physically and mentally consistent by learning to moderate her comfort distance with me.

Protection for the Therapist

Working at a distance (via Zoom) when accompanying and treating regression *with the body* nevertheless requires setting up additional and particular protections.

It is imperative for the therapist who is willing to accompany her clients through regressions to revisit, if necessary in therapy, her own experiences of previous unchosen separations (because this is what lockdown is). This is needed to be able to conduct a therapy process that is not contaminated by a transferential dimension, and thus to avoid unconsciously imposing one's own project of personal reparation on the client (Cadot, 2011). It is also important to remember that even chosen separations are not free of grief or nostalgia and to acknowledge this and normalize it for ourselves and our clients.

Working with regression therapy from a distance requires the therapist, who now cannot work with physical proximity or touch, to be more open to her own vulnerability in order to keep a close focus on the client's vulnerability, to be attuned to voice inflections, choices of vocabulary, the rhythm of "phrases," silences, breath, feedbacks, and so on. The loss of the face-to-face meeting deprives the therapist of the possibility "to live her bodily involvement as an encounter with the other. It makes it difficult to be fully attentive to her bodily counter-transferential experience and feelings in her function as therapeutic mirror, and to her capacity to modulate her bodily tone in relation to the other" (Gourbin, 2017, p. 16).

The therapist must therefore accept in advance the possibility of being surprised, and she must be prepared to make contact with her own personal feeling of fear or powerlessness. A therapist's insecurity while accompanying her client in regressive therapy may be amplified in the context of distance work and could be linked to the (momentary) loss of a resource inscribed in each of us from the first spark of physis: the memory, even if only cellular, of the desire for contact and for the physical presence of the other. Our clients may also experience this loss, effectively without any filter, since one of the first effects of isolation is to question their relational systems of protection and adaptation. The therapeutic work thus demands more energy, as the need for holding and bounding is stronger.

It is then of vital interest for the therapist to systematize personal physiological, emotional, and relational resourcing modes for herself, in real life—for example, by recalling memories of strong satisfying physical and emotional contacts (the anchor model of Neuro Linguistic Programming).

Protections for the Group

The possibility of a loss of the internet connection during a session is certainly the first risk. What can be done in the event of a sudden loss of contact should be discussed in advance, and explored with each member of the group. The discussion should include how such a situation might be experienced both internally and in relationship with the others.

Like the virus, the loss of the network can happen without warning, and this may undermine our all-mighty phantasmatic childhood illusions of guarantee that "as far as my environment and my relationships are concerned, everything is under control, nothing changes everything remains as it is forever."

It is therefore necessary to set up a ritualized process of pre-contact and re-contact within the group, with the aim of providing each person with a sense of security and continuity, of leaving no one in isolation, in order to cope with a possible feeling of loss of the relation.

We therefore set up a "watch" by text message, defining in advance who maintains contact with whom, during the time it takes to recover the network. Moreover, each member of the group identified and specified what they would need to hear from their partner while maintaining contact by text message, which turned out to be their antidote to self-generated criticism or personal survival decisions.

In addition, the group expressed its need to be updated on the ongoing therapy of those members who would ask for individual sessions between two group sessions. The decision was, in such a situation, after two days for private integration, to send written keynotes to all by mail.

It is also necessary to take into account the fact that each member of the group participates in the session from his or her private geographical space, which is not insignificant. This is a big change from the usual functioning of a therapy group where the common space is provided by the therapist.

According to me, an essential protection during the first remote group session consists of offering a psychic space for the exploration of each person's experience due to the change of the usual session setting. There could be the loss of the group's geographical "between us self," the fear of being interrupted or listened to by a family member, the reinforcement of a feeling of separateness or isolation. Careful and caring discussion in this area and respectful historical enquiry may allow members to renew emotional connections despite the physical separation.

Painful memories may then emerge in the clients' consciousness. These might include never having been able, as a child or adolescent, to invite friends home. These memories might be associated with the feeling of shame of having to hide something intimate about the family (extreme poverty, family violence, parental addictions, or educational neglect), or of not having been able, despite the enjoyment of a room of one's own, to be protected from repeated incestuous abuses. On the other hand, some may recall memories of a sense of relief in a depressive family environment due to the arrival of benevolent bearers of joy and openness.

Additional Dynamics

Taking into consideration the above, working via videoconference could be considered as a helpful factor in the integration of the self rather than as an obstacle to the therapy. Once the experience of intrusion/invitation into the private and intimate space has been elaborated, this way of working favors both mutuality and self-definition in the relationship. And this internal positioning of each member of the group within their own boundaries helps to protect each of them from possible identifying or projective reactions from their peers.

In this particular framework and with the limits it imposes, it is especially necessary that the therapist thinks of the group as a therapeutic "entity" or even "person," of which she is a part, with a specific responsibility: offering everyone a foundation of reliability and consistency for their different developmental needs. The therapist is the guarantor of everyone's intimate boundaries, facilitating, when necessary, the verbalization of "what is theirs, what is yours" and of the boundaries of the group as a whole ("what is ours"). She also monitors and manages, as necessary, the energy put into participation and on which the therapist and the group rely.

From this perspective, the therapist, as "shepherd of the client's hope," engages her own hopeful function. She carries within her the *hope for the client* that, through re-experiencing trauma in an involved and attuned relationship with the group, the client will come to reach the best of their potential (Cadot, 2011). And the therapist commits herself with the same *hope for the group* because the latter, through its accompaniment, holding, and bounding, also grows and is transformed in its specific "relational color."

In addition, even if the members of the group do not cognitively analyze the therapist's intervention options, they actively participate in them, with equal involvement for themselves and for the others and with equal attunement. Each member of the group participates from both their own experience of the trauma, thus mainly from the intuition of what they lacked at that moment, or from the internalization of a previous and personal repairing experience.

Conclusions

The debate between *bodywork, work with the body,* and *regression support*, whether in a face-to-face or remote setting, is first and foremost a matter of therapeutic indication: of the personality's diagnosis, i.e. the degree of solidity in the structuring in the domains of development of sense of self; of the understanding and taking into account the person's script dynamics; of the progression in the treatment plan; of the nature of the trauma; and of the client's membership in a sufficiently mature group.

From this point of view, the pandemic or similarly isolating circumstances does impose a different or additional set of working conditions on us. But these conditions have not fundamentally changed my practice or my orientations in terms of choice of therapeutic intervention options, insofar as I reserve bodywork for regression to the face-to-face and in- group setting.

However, whatever the context of the session, but even more so when conducted at distance, the therapist will have to be extremely careful to verify the security of the framework that she proposes. She should not be reluctant to question it, for herself internally but also for the group, and to share this questioning in the group. In doing so, she will reinforce her functions as the moderating influence of over-excitement and as the guarantor of a stable and coherent reliable structure.

The members of the group, and the group as a whole, by experiencing this process, will be able to internalize it. Moreover, it is interesting to note that therapy groups where regression support through work with the body is the least demanding and the most powerful, are those whose members have developed, over time, their own processes of mutual questioning, sharing (difficulties as well as successes), and support *outside* of the actual session times—when the therapist is not directly involved.

The therapist will need to internalize the group as a therapeutic ally, to whom each person contributes in their own personal and responsible way, but all with equal involvement and attunement. The result is like a dance, where one of the partners assumes the lead role in the tempo of the music and the other partner offers their grace and lightness; the couple then lives the happiness of a shared movement.

The demand for online therapy is becoming more common and will probably increase due to the continuing risks of new pandemics or other catastrophic events, or simply because of the need to limit our carbon footprint. We need to remember that the framework of the therapy that we have integrated was designed years ago, in and for rather secure and predictable living contexts where face-to-face work was not a problem. In light of this new situation, we now need to re-elaborate the contractual framework of therapy's work setting, most of all regarding the protections and boundaries of the therapeutic transferential space for our clients.

On an additional note, we can hypothesize that the digitalization of our intra-family and societal relational space may promote, more and more, the emergence of highly disorganized personality structures. The freedom and anonymity of the internet allows people to externalize and enact the affects of an extremely disturbed Child ego state without having to directly confront relationships. With such clients, in-person face-to-face encounters, combined with attuned involvement, allowed us to offer acceptance of pain while invoking principles of reality. We were then able to define both limits and boundaries for these clients' injured sense of self.

But as we now integrate into our practice this new challenge of conducting therapy without in-person presence, it is necessary, beyond the few options offered here, to carry on elaborating the structure, boundaries, and containment we need to build and make available to our clients. From this perspective the therapy group, in its process and "countenance," will constitute one essential key to the success of this development.

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