

e-motion



Association for Dance Movement Therapy (ADMT) U.K.
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EDITORIAL

Whilst last season's issue had few articles submitted, this summer issue is flourishing with many interesting pieces of writing. It has been both enriching to read them all, and challenging to make decisions and prioritise for publication... I wonder whether the seasons have played a part in motivating and inspiring us to write?

In this issue the Council shares a lot of useful information on current developments in the profession and on the overall organisation of ADMT-UK.

Dawn Batcup shares the paper she submitted to upgrade her DMT registration to SRDMT: Dance Movement Therapy with Mothers and Babies. As far as I know, it is the first time emotion publishes this type document. In conversation with Dawn, she commented that in preparing her paper she had not had the opportunity to refer to an application for Senior Registered practitioner and did not know what was expected. We agreed that it could be useful for fellow Dance Movement Therapists to read her work. As editor, I would like to encourage other Senior Registered Dance movement therapists to submit similar papers for publication.

The next article written by Nina Papadopoulos: Disconnection and re-engagement: systemic reflections on Dance Movement Therapy and the therapeutic process in chronic schizophrenia – a

paper I was looking forward to reading and I hope others will find inspiring. It offers a new theoretical approach developed from the pioneering research work she undertook between 1999 and 2003 within an NHS Trust in East London.

The third article: Personal Text/ Public Body: introducing an integrative model is by Beatrice Allegranti. As she says herself, it "offers an overview of [her] practice-based doctoral research" around the themes of "gender and its huge impact on our lives and relationships".

Brief reports from the Field is rich with news on opportunities and development in the profession ... little news from the web this time ... an enthusiastic web-researcher would be welcome in the editorial team.

More therapists and supervisors have come forward with their details which illustrates how quickly the profession is developing. My apologies to those whose details had fallen off the list, I hope that information missing has now re-appeared.

This time I am really leaving my role of editor of emotion and have included the letter I wrote to council about it at the end of the News from ADMT-UK Council. Once again, I hope you enjoy the reading. Au revoir!
Céline

Contents

Editorial	2	Personal Text/Public body: Introducing an integrative model	
News from ADMT Council	3	by Beatrice Allegranti MA DMT SRDMT	19
News from the Web	3	Brief Reports from the Field	22
Dance Movement Therapy with mothers and babies		Listings	13
by Dawn Batcup RDMT (Laban) BSc.Hons., RGN, RMN	5	Workshops	24
Disconnection and re-engagement: systemic reflections on Dance Movement Therapy and the therapeutic process in chronic schizophrenia		Therapists and Supervisors	26
by Nina Papadopoulos SRDMT	13	News from the Web	27
		Membership and subscription	28



NEWS FROM ADMT-UK COUNCIL

Council meetings are public and you are welcome to attend a meeting which gives an insight into the structure and responsibilities of the Council

Job description and Agenda for Change (AfC)

Frequently asked questions at AfC meetings and training sessions concern job descriptions – whether they should be updated; whether they should follow the JE national profile or KSF format; whether there is a recommended format. Documents have circulated recently, which give misleading and unhelpful information, so it may be helpful to re-state the position.

The advice is, and always has been that:

- Having up-to-date, agreed job descriptions is good HR practice, their main purpose being to ensure that employees and their line managers have a common understanding of what is required of the jobholder; the required information is generally set out in the form of a list of job duties;
- Similarly, having person specifications available for all posts is good HR practice, as it facilitates the recruitment process;
- Up-to-date, agreed job descriptions and person specifications will facilitate matching and make it more accurate and efficient (EI experience confirms this);
- Job descriptions should not follow the national JE profile format, as profiles are not job descriptions and do not fulfil the main purpose of having job descriptions;
- Information required for matching, which is not usually included in job descriptions or person specifications (for example, in relation to the effort and environment factors) can be collected by other means, for instance, by short questionnaire (examples from EI sites can be found on the Modernisation Agency website) or through oral evidence.
- While it may suit the needs of the organisation to include in the job description information on competencies required for the job it should be noted that job descriptions, which are exclusively competence-based, are not helpful for matching purposes.
- There is no recommended format: the format and content of job descriptions are matters for individual organisations to agree in partnership and should be appropriate to the needs of the organisation.
- A KSF outline is for KSF use and not for job matching purposes. From www.amicushealth.org Besides, the www.doh.gov.uk site is easily

accessible and provides some useful information on the Agenda for Change process.

ADMT-UK 2004 Annual General Meeting, Annual Report and New representative onto the Board

Please note that the AGM date has changed. We will meet on **September 18th** in London. The reason for this change is so that we can have a whole day to discuss the many important issues that are current and will effect us as professionals.

You will be receiving the **Annual Report** and information as to time and venue during August. Council is keen to co-opt/adopt a **newly qualified DMT onto the Board** as we find that input from those who have just completed their training is invaluable. Céline has been this representative recently and we are expecting that she will now stand for a full place on Council. It is essential that we recruit new and younger blood onto Council as the ‘elders’ can run out of energy!!!

We are aware that some DMTs might not have realised that we have an administrator who is now the first point of contact with regard to all queries – this includes registration, re-registration, etc.

As a reminder, Andy's address is:

ADMT Administration

Mead Cottage, Torquay TQ1 2BW

All previous addresses are no longer active.

Council has also, for the first time, prepared a budget for this financial year (starting April 04) which means we are now much better informed on how we spent money and can prioritise expenditure. Having an administrator has shown to be a great asset and one of the most important changes we have made in the association. We are now able to reply to your request much faster and in the next few months the register will be fully up-to-date. If there are still delays then we apologise and hope to improve our services to all our members. With our current income from membership fees we can just cover our expenses.

Workshops/Seminars: In Autumn 04 and Spring 05 we are offering again a series of workshops to you – all for very attractive fees (please see ad in this issue). This time the focus will be on practitioners in the UK: eg Clinical work with particular client populations for new and more experienced DMTs; Dance Creation



and Improvisation with Video work. If you have any particular interest and would like a workshop/ seminar in your own field of interest please contact us with your request and council members will do their best. These workshops can count towards your CPD.

A small sub-group of the council will spend time and efforts to devise a checklist for CPD approved workshops, training, activities etc. So watch this space and the website for any updates.

ADMT-UK new patron

We are delighted to welcome Dr Frank Röhrich as a new patron. Dr Röhrich, Consultant Psychiatrist and integrative body psychotherapist, is clinical director for Adult Mental Health in Newham, East London and City Mental Health Trust. Dr Röhrich heads a large multi-disciplinary team within Newham and has, since his appointment introduced a number of dynamic and innovative changes to the Service. In addition to his clinical and managerial work he is also an internationally known researcher in the field of body image phenomenology in mental illness and has published widely on this subject. He has pioneered a number of important research studies within the NHS including a 5 year Randomised Controlled Trial comparing the effectiveness of body psychotherapy with supportive verbal counselling for people suffering from chronic schizophrenia. He is very supportive of the arts therapies, particularly dance movement therapy.

The Council is preparing small biographies for ADMT-UK's other two patrons: Professor Christopher Bannerman and Professor Andrew Samuels. We aim at publishing them in the next issue, in the autumn.

4th ADMT Conference

1 day: November 20, 2004, 10.00-5pm, Bristol call for presentations

'Transitions' - This year's conference is focusing on the changes and transitions Dance Movement Therapy will experience as a profession and Therapists in their professional roles with state registration and the implementation of 'Agenda for Change'. 'Transition' also invites presentations and workshops by professionals, who have experienced transitions in their working environment and clinical practice.

Your submissions need to be in by August 14, 2004.

Proposals should have the following information:

1. Title
2. Name
3. Job Title
4. Workplace

5. Mailing Address
6. Daytime Telephone Number
7. Fax Number/e-mail address
8. Overall Aim of Presentation
9. Intended learning outcomes
10. Type of presentation
11. Abstract of presentation (max 300 words; clear outline of the content)
12. Your professional biography (incl prev publications/ presentations)
13. Co-presenters (name, job title, workplace and mailing address)

Please submit your proposal to bobby64@gmx.net, specifying 'conference abstract' or send it (including disk) to Barbara Feldtkeller, ADMT Conference Organiser, Dance Voice, Wedmore Vale, Bristol BS3 5HX

ADMT-UK 2004 Annual General Meeting

e-motion

• **Stepping down:** Here is a letter that I want to share with all of you regarding my stepping down from my role as editor of e-motion:

'Dear Council

I am writing to inform you that I am stepping down from e-motion. As I have already mentioned, I cannot cope with organising that task on my own on a voluntary basis. I thought I could carry on until November and have now realised that my time and financial availabilities do not match with my enthusiasm at the moment. I will finish the work I have started for this issue and hope that Tracey French can organise the mailing out. I already know that I am working behind deadlines and feel the pressure it is creating for advertising of workshops, etc. On the one hand I feel that I am letting ADMT down and on the other hand I know that emotion is a shared responsibility for ADMT members that I am not prepared to hold any longer. Céline Butté'

• **Mailing out:** Please note that in order to save costs for ADMT-UK and time to the editorial team, it was agreed during Council Meeting that e-motion will be published on the web only. This will start with the next issue, in the autumn. We hope that everyone finds a way to adapt to this change. To access the newsletter, you will then need to go onto ADMT-UK website www.admt.org.uk, and click on e-motion newsletter, you can then download your copy of e-motion.

N.B: If you go on the web now you will note that the last few issues of emotion have not been put on the web. We are currently in discussion with the web master and publishers in order to get it all up and running.



Dance Movement Therapy with Mothers and Babies

Dawn Batcup RDMT (Laban). Bsc.Hons. RGN. RMN.

Introduction

When my close friend had a baby ten years ago, she confided in me that there were days when she felt like smashing its head up against the wall. I was shocked, horrified and confused. How could this otherwise competent woman want to kill her newborn baby? Secretly, I thought that having a child would be different for me and maybe she was mad. Since then I have had my own child, many years of psychoanalytic psychotherapy and trained as a Dance Movement Therapist. I was grateful for my friend's confession all those years ago as I struggled with my feelings about being bombarded by the anxiety and mental life of my newborn. I realized that she was not mad, just brave enough to think, feel and speak about that which was almost too difficult to bear. Through my therapy I recognized that by thinking, feeling and speaking about these almost unbearable feelings they were not split off and projected elsewhere in the family or indeed necessarily into the action of actually harming my baby. Consequently, the Dance Movement Therapy (DMT) with mothers and babies that I present here began in an exploration of myself as a mother three years before I had the opportunity to work with this group.

The following submission reviews a six-week trial of DMT with a small group of mothers and babies in an inpatient psychiatric unit alongside the relevant literature. The themes that emerged in the group presented here, in both movements and words, were 'holding', 'attachment and separation', 'support' and worries about being 'good enough mothers'. It is shown how, through using creativity and non-verbal expression in the context of a psychotherapeutic relationship, a whole range of emotions were explored in a way that facilitated the women sharing with each other, including the thoughts and feelings that were difficult to acknowledge.

Context

A short trial of DMT was possible for six weeks in a London Mother and Baby Unit (MBU). Most admissions to the MBU tended to be for around six weeks, which meant that people could access the DMT group for most if not all of their hospital stay. The MBU is a specialized inpatient psychiatric ward. It is equipped for four mothers and babies under eight months old. The MBU admits mothers with their babies

when the woman is acutely mentally ill and there are serious concerns about the welfare of the infant so all admissions are emergencies. From admission, the women are usually supervised constantly when attending to their babies. For most, it is unknown if they will be allowed to take their baby home with them when they are discharged.

Unusually for me, I wanted a nurse to participate in order to attend to the babies if necessary. I was clear in myself about not wanting to hold and be sentimental over the babies, which was partly because I wanted to avoid setting up an envious relationship between myself and mothers in the group. I wanted the group to be a safe place for them to explore their difficult to acknowledge feelings, which would already be tougher than usual due to their context and previous behaviour toward their babies. I communicated the DMT trial to MBU staff and clients by displaying posters and giving two presentations, which meant I met the clients and the nurses. I linked DMT, as one of the non-verbal psychotherapies, with the importance of exploring non-verbal communication between mothers and babies. I described the group's structure and the brief for the co-facilitating nurse. I said that my key aim was, as far as was possible, to work with the mothers together with their babies in order to *explore the whole range of emotions*. A nurse whose demeanor I was attracted to was so interested she requested to work with me in the group for the six weeks. Bearing in mind the complexities of co-facilitation (outlined by Bates, 1997) I was keen to develop a relationship with this one nurse rather than face the weekly uncertainty about who I would work with and how we would be together in a session.¹

DMT in Application to the Literature on Mothers and Babies in Psychiatry

Since DMT involves building relationships through using creativity and non-verbal expression in the context of a psychotherapeutic relationship, it is particularly suited to working with mothers and babies. The vital importance of non-verbal communication in this dyad has been well documented and researched (Winnicott, 1965; Bick, 1968 and 1987, Stern, 1985; Ostrov, 1981; and Kestenberg, 1999). Apart from the seminal work by Kestenberg, there is little evidence of DMT practice and research into working with groups of mothers and babies under eight months old in a



psychiatric context.¹

When observing the mother and baby interactions in sessions I endeavored to not be an expert but to be open, in a non-judgmental way, to what I saw and to my thoughts and feelings as in the infant observation literature (Magagna, 1987). However, there were times when I intervened using techniques associated more with therapeutic movement (Sherbourne, 1990) in order to keep the babies safe. For instance, in one session I was able to stop a baby from rolling onto the floor from a mother's lap by showing the mothers how to hold the baby there by making a nest shape with crossed legs. Laban's system of movement analysis (1960) came in and out of my focus as I got to know the group. I was mostly aware of the movement profiles of the women and was curious to work with the babies' developmental movement patterns. I sometimes used the babies movement to inspire the group, which is a technique adapted from infant psychotherapy, known as *infant initiated behavior* (developed by Mahrer, 1976 in Ostrov, *ibid.*) for therapeutic goals. This infant focus also informed much of the work by Kestenburg.

The Clinical Work: Structure and Philosophy of Sessions

The way I approached DMT with this group was to work with the mothers *together with* their babies in order to explore, better understand and develop this relationship. The sessions were for an hour a week with a structure that could be adapted in order to respond to what emerged whilst still being containing. This meant I slightly adapted how I would normally work with the Chacian model (in Chaiklin, 1975), configuring a beginning, middle and end, with talking at the start and verbal processing at the end of the movement experience.

The Beginning: 'Warm up'

The group started with brief verbal interactions, in which people talked about how they were and what was going on for them. I then led a 'warm up' for around fifteen minutes, which was the initial period of movement where I prepared people for finding ways into using movement in an exploratory way. This series of movement interventions were client led in the sense that I took elements of the clients' movements to inform my own in structuring the warm up. For example, at the start of the second session, the women were picking their fingers so I began by squeezing my fingers whilst asking the women to squeeze theirs, then their hands, wrists, elbows and so on, thus bringing their attention to their bodies, bony landmarks and the

connections in between. I was conscious of making connections with the body/self, the babies and with other women in the group.

Mothers usually carried the babies into the session for the start of the group either in their arms or in portable chairs. This defined how I would start the movement warm up. I was often amazed by how the babies joined in by copying the women's movements during the warm up when they were strapped into the portable chairs. The women generally noticed this and laughed. I sometimes used this as the transition into process. At other times, if it happened earlier in the warm up, I used the babies input to enable the women to make a transition from attending exclusively to themselves to focusing on their baby. This time for mothers to interact and give physical attention to their babies was purposefully different from the usual functional touch that generally characterizes this interaction (Ostrov, *ibid.*). Approximately seven minutes of warm up with the women was followed by the same amount of time for babies. This also enabled me to observe and gain some insight into the nature of their inter-relationship, which was also possible when the babies were in the mothers' arms for the warm up. On these occasions I was able to observe the inter-relationship through the shape effort and flow qualities (Laban).

The Middle: Process

This was the pivotal part of the session where I intervened less obviously and attempted to provide containment in the group for 'free association'/improvisation type movements and words. In this differently structured more process-orientated phase I found examples of movement interventions I could introduce if we got stuck. Themes were developed and explored mostly in movement, finding ways we could move together with the babies for around fifteen minutes. I will use an example from a group as a vignette to demonstrate a process period.

Vignette

A transition to process occurs through an attention shift to the babies after they begin waving a small scarf that they had been given. I then give a scarf to each mum and a game of peek-a-boo develops, which I make more obvious by naming it and talking of the importance of this game. That is, that the baby is having a playful experience of mum going away, which is their biggest worry, and then coming back, which is very reassuring. As the game continues I occasionally talk to facilitate the play by saying that playing with the experience of mother going and



returning helps the baby feel less worried about it. I also say that as mothers, the difficult emotional aspects that we have to manage ourselves are often the things we need to teach the babies about too. I suggest that being together and being apart may be the emotional things being practiced in the peek-a-boo game. This seemed to resonate with the women as they take it upon themselves to initiate play with their babies and move into process.

The process period emerges more fully when a mother holds and pushes on her baby's feet in response to his gleeful kicking and the other mothers follow. I say that it looks like they are helping the babies to explore their weight, a further thing babies cannot do by themselves. Another mother puts her baby's arms up and down and we copy. I add a side-to-side reaching thinking of making a connection between the women and this turns into reaching out to each other with one arm then the other. A mother puts her baby on the floor in front of her, propping him up in her open legs and the others do the same. This enables the babies to sit together in the middle of the group, close enough to look and touch each other. Mothers enjoy this and they are now able to both watch and hold the babies whilst interacting with each other.

The End: Verbal Processing

Special attention was paid to bringing the session to an end in a closure period in movement for five minutes and through verbally processing the movement for ten minutes when the women were encouraged to put some of their movement experiences into words. I worked with them to find psychological links and meaning in what happened and what was felt. Below is an example of verbal processing following a session as the group discussed 'rules'.

Mother, *"There's always a right way of doing things (on the MBU) not like in here (the DMT session) and we're always being watched."*

Therapist, aware of the client 'splitting' says, *"Whilst the DMT group is a space to explore, perhaps you're also saying you feel you're being watched in here?"*

Mother, *"No, no it's different, it's not criticizing."*

Therapist, *"Nurses rules are about safety and applying them is not a nice job, a bit like being a Mum. Not only do we have the fun and play time with baby, like the game we played earlier, but we also have to be the one who puts them to bed and gets them to eat vegetables and so on, the not so nice jobs."*

The women laugh and nod.

The Clinical Work: An Example of a Whole Session

What follows is the clinical work on the first week, as it happened, mistakes and all, which according to Casement (2002) may be poignant enactments by the therapist that can be useful when thoroughly reflected upon. Also, as most of the themes and issues that surfaced in the first group continued to emerge for exploration during the short time we worked together, it is worth presenting session one particularly in some detail. All names are changed to protect confidentiality.

The First Week

I do not sleep well the night before and I am anxious on my way to the MBU. Despite the preparation I think, *"How do I do DMT in this context?"* At the MBU my hands shake so much that I cannot unlock the door. A nurse lets me in. She is expecting me. The three mothers I talked to the previous week in my presentation are still in the Unit and they make various welcoming gestures. This is a good sign, I think, they have remembered. The nurse in charge gives me a brief verbal handover about how the mothers and babies are, which I struggle to keep in my thoughts amid my anxiety.

I summarize her handover in a rough and labeling way, which was all I could remember about each woman. There was one psychotic woman, Rae, with her first baby and episode of mental illness. The other two women had harmed their babies and had no mental illness diagnosis as yet. Both were waiting to be assessed by a forensic psychiatrist and neither had a previous criminal history. Sue with her first baby and Ella with her second. I could not remember the babies' names.

The nurse who wanted to work with me was waiting to help reorganize one of the sitting rooms we had chosen to use. She had Rae's baby with her in a portable chair, as Rae was asleep. The nurse and I exchange small talk as we shift furniture and Rae's baby watches us.

The First Session

Ella comes in first followed by Sue with their babies. They sit on the floor next to their babies who are strapped into portable chairs. The nurse and I sit on the floor too. We form a circle and everyone looks at me expectantly. I start by repeating in summary what I had said previously, focusing on what the group is not i.e. performance or aerobics and say something about it being a space to work together to explore feelings. I offer the women the chance to speak here but they



exchange glances and collectively decide they want to get on with moving. As I pull out my music selection I mention that it can be hard to know where to start. They want me to choose the music and I do, perhaps finding it hard to start myself so I went to what I knew, the music, structure and warm up.

The women look nervous (probably like me). Their eyes dart around the room in its new form. I start by asking them to focus on the space and suggest we look around the room. We all look around the space in an indirect way, the nurse joins in and the babies are quiet. I remind them that the room will be used for moving in and to notice where there may be things in the way and they start looking directly at furniture in room. I am thinking about them sensing the space and how to use it in terms of linking it to thinking and also as 'space effort', affined with feelings (Laban/Jung). I also need to ground myself in the new space.

I ask them to find something in the room that they do not like and pause. They do not say what this is and I do not ask them what is in their thoughts. Next I ask them to find something they do like as I think about conveying to them that the group can be about exploring the good and bad. Again, they are quiet. Following this, I ask them to notice the other people in the room and as we do this people start to smile at each other and become visibly less tense. Babies get noticed too, they notice that they are noticed and respond by smiling and wriggling. I ask the women to notice our self/our bodies and to wriggle our hands, mirroring the baby's effort qualities in a body part. I talk the women through working the wriggle through hands, wrists, elbows and shoulders and say that there is no right way of doing this and ask them to do it in a way that works for them.

Next I work indirectly at drawing attention to the core of their bodies and ask them to reach up as I do it and then down, bringing their arms into their core. I take my arms out to the sides and ask them to do the same. I notice how they take more notice of each other and how, unprompted, they reach also to their babies. I bring my arms into my core and they follow with little verbal prompting. I reach out both arms into the middle of the group, the women follow and then we take our arms back to ourselves. This time I ask the women to wrap their arms around themselves and make a comment about holding it all in.

The babies are quietly watching us. I wonder aloud if we will be able to stand up and as we get onto our feet, Rae walks in and cuts across the room. She ignores the group, including her baby, who recognizes her. Her baby binds his flow and struggles against the

straps that hold him in the chair while he watches her disappear into the garden. Her baby cries. The other babies start to protest too and I think *oh no!* I say, *I guess they want their turn. How about we do what we did to ourselves to the babies? Perhaps Rae will join us soon.*

I had started the session with women focusing on attention to space, which I repeat for them to help their babies explore. The babies, not surprisingly, are not interested in space or space effort. I pull out some small chiffon scarves and suggest to the women that they might be more able to focus on the space in the room if we use them. The mother's take the scarves, kneel down and wave them in front of the babies' faces. The babies are momentarily interested but are far more interested in the person in the room closest to them. I say this and the women agree. Rae returns through a door behind me, the nurse asks her to stay. I explain that she has missed a bit of our warm up and verbalize what we are doing whilst carrying on doing it with the others. Rae starts to nervously and gradually take over with her baby from the nurse. The nurse manages the transition with grace. She stays close to Rae but now positions herself next to me.

I go through the upper body warm up in the same way I did with the women, using words like *massage*, *help them feel* whatever body part it is we work with on the babies. The babies love this attention from their mother and I talk about how we do lots of functional touching with baby but perhaps not enough touch for its own sake. The babies look into their mother's face and as they get wrapped up in each other, I feel I have a chance to observe them.

Rae's face is scrunched with anxiety and she struggles with being comfortable on the floor. She shakes, her legs twitch constantly and her upper body is bound and tense. Her movements seem to originate at the periphery of her body and it does not seem to link up. Her baby, whilst enjoying her attention, has a puzzled look on his face. Sue is so busy doing the task she focuses on it to the extent that she seems to see her baby as a series of body parts. The top of her head faces the baby's face so he cranes his neck sideways to look for her face. Ella places her hugely smiling face very close to her baby's face and gurgles at him whilst she touches him. Then suddenly, she sits back in a collapsing way and her facial expressions drop too. A few seconds later, she is back close to his face with the big smile. But the baby sees it all and corresponds bodily, collapsing and then binding his flow.

I am reiterating the movement interventions we had done earlier without much thought, as I am engrossed



in the snapshots of the mother baby dyads. I reach the point where I had asked the women to wrap their arms around themselves and so I repeat this for them to do with their babies. The mothers dutifully struggle to wrap their babies' short, fat arms around their babies' bodies, which does not work. In fact, they do not even go close to wrapping around. I think, *Argh! If someone looks in on this it might look like the mother was trying to strangle the baby with their own arms.* The nurse looks at me with a puzzled expression and I try to look like I know what I am doing and then a mother lets me off the hook and says, *It doesn't work.*

Process

I move on! I ask the group if we can try to find ways of moving together with the babies. All three women take their babies out of their chairs and lay them on the floor; they are too young to sit. The women sit looking at their babies.

Sue says *This is hard.* Ella shakes her head and Rae says, *I don't know.*

We stay with this for a little while whilst the women make postural shifts on the floor and occasionally reach to touch the baby, using spoke like shaping in the relating attempts. Then I say, *I have an idea* and suggest rocking each baby in turn in a Lycra cloth whilst we all hold it like a round hammock and watch what happens to the baby bodily. Ella goes first and puts her baby down in the cloth on the floor to face her. I say how we need to watch each other closely, so that we stand slowly and simultaneously together in a way that makes the baby feel safe. The women successfully manage the task with the nurse and myself and the baby obviously enjoys the experience and the attention. He coos appreciatively as the effect of his weight in the Lycra cloth takes him into shape flow.

I am surprised when Ella says, *He's worried.* I say *Worried?* She says, *I'm worried.* Ella smiles and her baby smiles. Ella takes her baby from the cloth and the nurse takes the baby from Ella so that she can join in with the other mothers in holding the cloth for the babies. Rae goes next and she puts baby down in the cloth to face me. He bends his knees up to his chest and quickly kicks his legs out repeatedly and whimpers. I say that in this strange, new situation maybe he needs to see his mother's face to check out her feelings about what is going on. Rae seems to take my words as criticism and she lifts her baby out of cloth and straps him back into the chair, declining the offer of putting him back in the cloth to face her. Sue is eager to go next and I lose a chance to somehow repair things or verbalize what may have happened with Rae. Sue puts her baby down to face her and they smile at each

other. We rock him in the cloth for at least as long as Rae's baby and although there is group synchrony and rhythm, I have a sense of Rae (or me?) feeling like the bad mother who got it wrong. I say that I think it is time to get the baby out of the cloth.

I get rid of the cloth and find myself wordless as Ella says, *I have an idea.* She shows us by rocking from side-to-side on her feet with her baby in her arms. We copy her and the mothers hold their babies whilst they do it. Sue says, *I've got one* and she lilts her baby up and down as she initiates walking in a clockwise direction around the room and we all follow. Rae twists her upper body away from the group and says that she cannot think of a movement. I say *You're doing one* and I enlarge the twist whilst the others copy. Rae smiles.

Closure

Sue says that her baby is getting heavy and I take this as a cue to bring closure to the movement period. I say that it is time to find a way of finishing the movement. The women sit on the floor, the nurse and I follow and Ella initiates again. She has her baby on her lap and she raises both arms up. The baby nearly rolls onto the floor. I suggest making more of a nest shape with our legs. I cross my legs to do this and make a bundle out of the discarded cloth we used earlier. Then I reach up with one arm whilst using the other to cradle the cloth in my lap. The women follow and we do it together whilst the nurse helps them to find a position for their baby in their laps. Sue's idea to finish is to lift her baby up above her head using both arms fully extended. We all copy then Rae brings her baby down cradles him in her arms and rocks him from side to side, which is how the group ends.

Verbal processing

I turn the music off and say that it is talking time. Rae puts her baby back into his chair and he farts and fills his nappy. Everyone laughs. I say, *Time for all the shitty stuff to come out.*

Sue starts by saying how the baby restricts her movements and the group discusses this whilst I try to say things that continue their exploration. They talk about how their arms ache.

Sue looks at me and says, *Babies can't hug themselves*

I say, *No they can't. We have to do that for them as well as hold ourselves together. They need a lot of holding (I wrap my arms around myself) – which not only makes our arms ache I guess its exhausting in other ways too.*

The women pick this up for discussion again and



Rae talks about how the baby pushes all her buttons. *Provocative?* I say.

The crying, Rae says, *I can't stand the crying.*

I ask, *What is it about the crying I wonder?*

Rae says, *That they need something, they always need something.*

The women discuss and agree on this. I ask about the needy part of us. There is a thoughtful silence, and I see the exhaustion on the women's face and remember it from that time in my life, *Remember sleep?* I say, *You know, that thing you used to do, when you were tired.*

The women laugh and Rae has tears in her eyes. I suggest that the group had echoed some aspects of what life is like with a tiny baby, *restricting*. I summarize the group's theme as *holding*.

Ella has the last word in asking if we can do more work on the floor because she found it most relaxing there. The group ends and the women stay in the room, talking. The nurse and I pack up the props. Sue says to me, *D'you know, this is the only thing we do on the ward together with our babies.* I nod and am relieved that they go back to talking to each other. As I leave the room Rae follows me to the door and asks, *Have you got children?* As we were out of the session proper, I respond directly and say that I did and that my daughter was three. Then I became unsure if I should have made such a disclosure. How to manage the 'in but not in' group time that occurs as part of ward work was a particular struggle for me in this context. I made a mental note to take this disclosure, along with other things I felt I could have done differently, to my clinical supervision.

Summary of Themes in Sessions Two to Six

In the second session, the mothers wanted to stay close to the floor with their babies also on the floor. Whilst it was appropriate for the babies I wondered if it represented regression for the women. In the session, we explored moving on different levels whilst being on the floor, sitting and standing. Later we talked about what this had brought up for the mothers. One woman became rigid and bound in her upper body as she talked about the importance of, *standing on her own two feet*. As she said it, I imagined that those words came critically out of her mother's mouth. As the movement themes that had emerged also seemed to concern weight and support, once clarified as such verbally, the women linked these concepts to the importance of how their own mothers, mothers in law or partners were or were not helpful. When the women reached sitting in the movement part of this group, I introduced side-to-side movements, thinking about the relational

aspects of the women to each other, rather than just mother and baby dyads, to convey the suggestion that mothers' can support each other.

In weeks three and four, making connections/relationships, inside/outside and themes of attachment and separation were key issues as the group dealt with the loss of a group member who was on leave in preparation for discharge. This began in movement when the women had initiated a side-to-side rocking in the process period of the group in the third week, which alternated between a soothing, oral sucking rhythm and a sway that was more twisted and strained with impulsive phrasing. They repeated this with the babies in their arms after one woman picked her baby up from the floor and the other followed. When I mentioned the missing group member later in the group during verbal processing, there was a silence. Then, a mother talked about finding it hard to put her baby down whilst at the same time struggling to hold the baby. The other mother said how she often held the baby for her own sake. A thoughtful discussion ensued concerning the difficulties and losses involved in making and remaking relationships to the baby after birth (and others in the family/group) as the baby developed and they themselves developed into 'mothers'. In the fourth week, similar themes were explored more deeply through returning to the movement intervention in the first session when we rocked the babies in a Lycra cloth. However, this time it was one of the women who suggested it and she noticed how the cloth bulged with the baby in it in a way that looked like a pregnant belly.

The 'Last' Session.

As often happens when working with inpatients, unknown to us all, week five turned out to be the last group with the women I had worked with so far. The movement part of this group had led to a playful changing of places between the women whilst they held their babies, with each other, the nurse and myself. This developed into occasionally giving their babies to each other, the nurse and myself as we changed places. During the verbal processing, it was clear that what was played out represented one of the most distressful aspect of their admission, namely that they might be discharged without their baby and give over their parental rights to Health and Social Service Authorities.

There was a lot done in the process period of this group because another 'game' emerged from the place changing. This happened when one of the women picked up a large prop, the circular elastic rope, and asked what it did when the babies were happily



strapped back into their chairs. I asked them to look at what the rope did and together with myself and the nurse, the women pulled and twisted it as hard as they could, wondering aloud whether it would break and how far it could stretch. My suggestion that what was happening seemed to be about trust facilitated more vigorous pulling which brought the group to its feet. I prompted the group to get inside the rope by stepping into it and placing it in the small of the back so that we could use our body weight to move with each other. I noticed how this assisted physical grounding and synchrony as we took turns to change the rhythms in the sway that had spontaneously developed through being connected to each other by the rope. When a baby began to protest, his mum clicked her fingers and turned to look at him outside the circle and clicked her fingers again after turning to look back at the women. We all joined in and created our own rhythm through the clicking to sway to. At the end of this session, one of the women said, *it seemed to bring us together*. Almost out of time I agreed and added, *it did seem that the group was exploring something about coming together, bonding*.

In week six, I ran the final DMT group on the MBU with the new admissions and work began again. The former participants had spoken to them about the group in a way that encouraged them to come and try it for the last week of the trial.

Discussion

It was clear from both the attendance levels and the way the DMT sessions were utilized that the women appreciated them. The theme of 'holding' emerging in session one suggests that the women might be exploring whether the sessions/therapist could 'hold' them alongside their explorations of whether they had the capacity to hold their babies. Other themes that emerged in the group, in both movement and words, were 'attachment and separation', 'support', and worries about being 'good enough mothers'.

The point of leading the mothers towards free association/improvisation in movement together with their babies was that this would probably be a struggle for some or all of the women. I felt that this in itself would be one of the key exploratory points of the work. The thoughts and feelings that emerged through the experience of moving with their babies in the sessions enabled the mothers to experience their relationship with their baby in a bodily, non-verbal way together. They were also able to verbalize the experiences encapsulated in the movement. Consequently they explored deep and probably difficult to acknowledge emotions, such as 'dependency' and 'neediness' and

made links with these feelings for themselves, with each other and with their babies.

As trust developed in the sessions, the women gained the confidence to explore feelings that nearly all-new mothers have. This was particularly difficult for women in the MBU who would probably have a psychiatric/forensic diagnosis due to acting out aspects of those thoughts and feelings on their baby. Similarly, this was difficult for MBU staff to manage, as they understandably had to minimize risk and keep the babies safe. Consequently, it felt appropriate that my thinking about and within the sessions could be slightly different, partly based on my experience of being a mother and informed by the work of psychoanalytic theories. For instance, Stern (1985) talked about the process of becoming a mother, which included the shock of realizing that you, as the mother, are expected to know what to do when the baby cries. He also described the difficulties associated with how the baby relationship with the mother takes center stage. According to Winnicott (1996) there are about fifteen legitimate reasons the healthy mother has for hating her baby, for taking just about everything really. He then applied this to the therapy relationship in discussing hate in the counter transference.

In terms of my counter transference I was surprised how initially, the babies had very little impact on me. I was more in touch with me as mother and providing 'holding' for the mothers or perhaps their baby/needy part. My other thoughts about this concerned the nature of the mother's own mothering and what their internalized, non-verbal experience of this may have been. Winnicott (1996) said that as most emotional learning is done by the time we are three months old, this is mostly non-verbal. Common themes did emerge in a number of sessions, which enabled me to express to the group that I was curious about their own mothering. Rather than analyze this directly in verbal processing, I used the insights they gave me to work with it in the non-verbal. In this respect my aim was to support and nurture the mother's learning about how to touch and play with their babies in a non-judgmental way. I took ideas into the session about movement interventions and structures I could use with the mothers that they could also use with their babies rather than staying with the uncertainty and awkwardness for too long.

I moved with the mother and baby dyads whilst being mindful of Stern's work on 'affect attunement', where he explained the importance of how the mother corresponds to the baby's feeling state, which is done mostly non-verbally and is more sophisticated than



mirroring. I did this in order to convey my intent to correspond and embodying the women's feeling states, to experience the counter transference feelings bodily, to avoid being perceived as a teacher and to model 'good mothering' towards the mothers.

Discussions in the group about the mother's own mothering were worked with in the transference and also linked in the movement with body boundaries and the skin as a container (Bick, 1968). For example, when the babies kicked their feet out and mother pushed on their feet and when the women pulled against each other in the rope. In Weldon's (1988) re-write of Freud's Oedipus complex, she applied it more meaningfully to mothers and babies, particularly daughters. She refers to the abuse in this dyad and said that it can occur partly because mothers perceive the baby as an extension of herself, onto which she can project, act out and ultimately harm. Assuming this may have been one of the reasons why these women harmed their babies, DMT was the ideal medium to work with the women to observe the clashing and attuning in the relationship, as described by Kestenburg, and also in discerning the end of one self and the start of another.

The above reflections form the basis of that which I would wish to study further with this client group, both in practice and theory. In this short pilot study, I learnt a great deal and I remain curious about the issues that emerged in the work. The complexities of working together with mothers and babies presented me with a challenge and an opportunity and I am grateful to all those who participated in making the trial a possibility. Perhaps most importantly, it was very well received by the mothers and the multi-disciplinary team and DMT is now a regular feature in the MBU.

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Notes

1. Lier-Schehl (2002) presented her doctoral thesis at the German Research Panel and Poster session of her DMT project in a mother-infant ward in the Psychiatric Hospital of Dortmund, Germany. 'Research in DMT' was held within the membership assembly of the BTG (Berufsverband der Tanztherapeutinnen Deutschlands) The German professional organization of DMT, on February 16th in Hanover. Results are in process.



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(Writing from the Body workshop title credited to Dr. Diana Theodores)

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Disconnection and re-engagement: systemic reflections on Dance Movement Therapy and the therapeutic process in chronic schizophrenia

Nina Papadopoulou SRDMT

Preamble

Between 1999 and 2003 pioneering research work took place within an NHS Trust in East London comparing the effectiveness of body psychotherapy, mainly dance movement therapy, with supportive verbal counselling for patients suffering from the negative symptoms of chronic schizophrenia. This research project was a Randomised Controlled Trial¹ and I contributed a paper based on this work to the first ADMT UK conference in Bristol in 2002, focusing mainly on the eclectic nature of the Dance Movement Therapy profession and DMT interventions. That paper was published in *Emotion* in the summer edition 2003 (Papadopoulou, 2003). The following paper which I presented at the Association of European Psychiatrists' conference in Heidelberg Germany in 2003 offers a new theoretical approach within which to conceptualise the psychotherapeutic interventions within the research study.

Introduction

According to the Diagnostic and Statistical Manual of the American Psychiatric Association, one of the main symptoms of schizophrenia is the expression of negative symptoms including affective flattening, alogia, avolition, anhedonia, anergia, and depression. Patients with these symptoms often do not recover fully despite the fact that they may overcome the acute stage of their illness (which include experiences of hallucinations, delusional systems, and disorganised behaviour). Traditional drug therapy and insight-oriented verbal interventions do not seem to have an impact on this negative symptomatology. Consequently, the quality of life of this group of people remains rather poor and their condition tends to become chronic. Circumstantial evidence suggests that reality oriented therapies such as body based therapy are more effective in bringing about change in these patients (Röhrlich, F. Priebe, S. 2000, Priebe, S. Röhrlich, F. 2001)

This paper will be devoted to three aspects of the research project that took place within an East London Trust. Firstly some basic theoretical reflections on the body in therapy will be offered, with special reference to schizophrenia. Secondly, the basic structure of this therapeutic intervention will be described and finally

the qualitative data that has emerged from this project with special reference to the therapeutic process will be discussed in the context of a case study.²

Theory

We do not need to go back to the ancient philosophers in order to accept the basic principle of 'A healthy mind in a healthy body' or as Juvenal put it: *mens sana in corpore sano*. The corollary of this, of course, is that an unhealthy body and unhealthy mind are also connected. Although nobody would suggest that there is a crude correlation between these two parts of our being, nevertheless, it is important not to forget its basic truth. We all know (either consciously or unconsciously) that the body contributes to our overall sense of well being. We all know this basic principle and yet we tend to take it for granted, not valuing it sufficiently. This principle is one of the basic tenets of DMT. And much of the work of the dance movement therapist is concerned with exploring the relationship between the body and our overall sense of well being. This principle of the interconnection between psyche and soma underlies the work in the research project, i.e. acknowledging the impact of the body on general psychological health, and developing specially designed programmes to utilise this fundamental resource.

From a human development stance, we can appreciate that most of our early connection with our mother, parents and the environment occurs via experiences through the body. We are held as babies and we explore the boundaries of our world directly via our body - grabbing, tasting, biting, feeding, crawling, being wet, being clean, etc. Early nurturing and psychological development occur in a locus where there is an intricate inter-linking between body and psyche and consequently with feeling, cognition, movement, expression and communication. (Gordon, R. 1985; Winnicott, D.W. 1974, 1984). Most psychological theorists from all traditions (and not only those in developmental psychology) have this undifferentiated phase of early human growth as the basis of their theorising; from evolutionary psychologists to psychoanalysts, cognitive therapists to family therapists, all seem to return to this early state on which to base their respective theories. In this



early developmental period it is difficult to distinguish the boundaries between the psychological, physical, emotional, social and cognitive realms.

Yet, as we know, development moves fast and very soon human functions begin to become increasingly more differentiated. Other priorities emerge and the importance of the physical level tends to be minimised. In Western society maturity is often measured in terms of the dominance of the intellectual over the emotional and physical, and it is here that the roots of many psychological difficulties begin. The separation and supremacy of the cognitive/verbal over the physical/non-verbal tend to create rifts and subdivisions within the unity of a person. These rifts can indeed become scars that result in the loss of communication between the various facets of our beings.

In schizophrenia, the negative symptoms such as anhedonia, anergia and depression can be considered as indicators of such rifts among these vital facets of human functions; admittedly, to a more substantial degree.

Most theories of schizophrenia are based on the assumption that certain kinds of rifts have taken place. In fact, the very word 'schizophrenia' implies this split and division. Schizophrenia, as a term was first introduced by Eugene Bleuler at the Burgholzli Mental Hospital in Zurich at the turn of the nineteenth century in order to emphasise the fact that in some psychotic disorders, people could have parts of their mental capacities completely intact whereas others were severely impaired (Eaton & Peterson 1969; Jung, 1911). The previous term used for schizophrenia was 'dementia praecox' which means premature deterioration; this term suggested that human beings deteriorate mentally as they get older, but in schizophrenics this deterioration came about at an earlier age. Bleuler's innovation was to emphasise that the deterioration was not global and not all facets of the personality are deteriorated. Therefore, the process that created a schizophrenic was this very schism or split within the personality resulting in some functions and processes being affected by the disorder and hence deteriorating, whereas other facets remain intact.

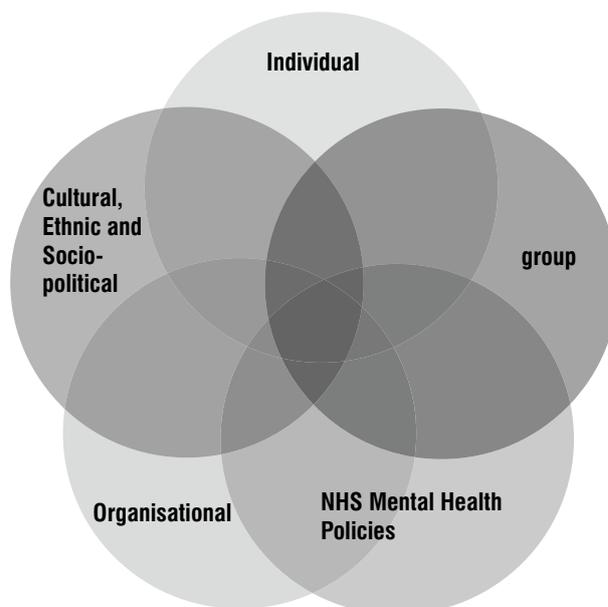
The idea of a split, rift or schism within a person seems to remain central in most theoretical approaches to schizophrenia. It is within this framework that the therapeutic interventions within this present project was conceived. The purpose therefore has been to develop a programme that addresses the splits experienced by people suffering from the negative symptoms of chronic schizophrenia.

The specific theoretical model that was found to be most useful here was a DMT based intervention plan

within the framework of a systemic perspective. The reason for opting for this perspective was that systemic approaches (cf. Bateson, 1972; Campbell, Draper, Huffington 1989, 2000; Lancs, 1992) enable one to include various different parts which can be interlinked together. More specifically, the model we developed here included a DMT group that adopts a wider perspective on the individual, focusing on conscious and unconscious dynamic factors (intrapsychic), interpersonal and organisational considerations, as well as broader socio-political dimensions.

Here, rather than assuming a reductive position in relation to the individual suffering from schizophrenia, the person is viewed more holistically in his cultural and social context. The focus is on examining the arrangement of and relationship between the vital facets or systems within the person's functioning that connect him/her with wider systems. Hence, more specifically, schizophrenia is viewed as a breakdown in the working relationships between these vital facets and, therefore, the thrust of the interventions from this perspective is to find ways to set up a new functional relationship among these vital facets or series of different systems.

There are five interacting systems that have been identified as significant in understanding the schizophrenic disorder that the patients involved in the study suffer from. They are:



1. Individual functions/ systems : physical, cognitive, emotional, social, imaginal
2. Therapy Group (including therapist) - psycho-dynamic dimensions e.g. transference
3. Organisational
4. Wider political Mental health policy
5. Wider cultural and socio-political systems



Therefore the key to the approach here is the establishment of a working connection among these five overlapping and interconnected systems. More specifically, it is important to be mindful of the individual with his or her subsystems / realms (e.g. the physical, intellectual, emotional, social, etc), then the group of individuals that comprise the group, then the system that encompasses the organisational facets of our services, then the therapeutic connection and relationship between the therapist and the group, as well as at least two other systems which refer to the wider socio-political issues as they inevitably impact on the group work and the specific therapeutic regime of the mental health services.

Dance movement therapy in a group setting within the NHS is unique in being able to offer a multi-system approach to therapy which simultaneously or sequentially can address these five systems. More specifically, the distinctiveness of the DMT approach is the inclusion of specific therapeutic work with the body. The body is recognised as one of the major sub-systems within the individual. Returning to the theme of development which was introduced above, it follows that as the body was central in the development and differentiation of these vital functions, it could similarly be central in facilitating a re-connection of these functions.

To summarise the above, DMT as an intervention is based on two principles:

- a) that in such states of fundamental disconnection (as in schizophrenia), the body can offer a point of entry with a view of establishing a working relationship between the various basic functions of the individual, and
- b) in order to establish such an intervention, it is best done in the context of a group setting so that individuals are also exposed to the realities of the other overlapping systems within which this group is located.

Essentially, this is, in short, the theoretical underpinning of this mode of intervention. By careful planning, sensitive implementation and rigorous monitoring, we were able to obtain positive results in our project.

Therapeutic Interventions

These theoretical principles were used as the backbone for this research study both in terms of understanding the patients that participated as well as the specific therapeutic interventions that were offered. It will now be useful to clarify in some detail how these patients are understood in the context of the therapy group within this systemic model.

Psychiatrically speaking these patients are diagnosed as suffering from the negative symptoms of schizophrenia. This condition includes specific body symptomatology such as de-somatisation, loss of body boundary and alteration of body schema (Priebe, Rohricht, 2000, 2001). So they do not have a normative coherent sense of their own bodies. And not unexpectedly, the disconnection with their body is mirrored by a disconnection in a wider sense: disconnection to themselves, to each other, to the therapist and to society. Therefore, in addition to the usual beginning problems that all therapeutic groups have, that individuals are disconnected from each other, feel anxious, suspicious, withdrawn, and fairly resistant to verbal interactions and communications, this group of patients also were particularly lifeless and cut-off even from themselves; in short they did not seem to inhabit their own bodies. They spoke monosyllabically, and tended to avoid eye contact. In terms of movement analysis, their movement did not include the use of the horizontal plane, which is referred to as the communication plane. In fact they hardly moved.

In order to address these difficulties, the sessions were structured as follows:

Patients in groups of up to six attended twenty one and half hour sessions over a ten week period. Every session was structured in the same way and included the following 5 distinct parts:

1. opening circle – check in
2. movement warm-up
3. structured movement activities – addressing the particular symptomatology of body boundary loss, de-somatisation and alteration of body schema using props such as balls, beanbags, ropes
4. creative movement including working with props, movement sculptures, parachute, buddy band, cloths
5. Closing circle – with reflections, self massage and relaxation

Some of the comments that patients made in the early stages of the treatment programme included the following: ‘my brain feels rotten and soft, my belly feels like sawdust, everything feels numb, my body feels empty inside, my body has no feeling, or even, my head is here, but my body is somewhere else and is disconnected’. As you can see, they had an unmistakable sense of disconnection with certain parts of their bodies and within themselves. Consequently, my own reactions as a therapist were particularly difficult as I experienced them as a closed



book and I did not feel that I would ever be able to connect with their distant worlds. There was minimal communication and virtually no verbal dialogue and exchange.

Therefore, the only point of entry into their world seemed to be through the body and the designed structure focused on engaging the body and directly addressing this symptomatology.

The purpose of each of the five parts of the session are as follows:

1. The *opening circle* offers non-threatening, activity-based tasks in which group members gather together in a group circle and the main focus is to provide simple 'ice-breaker' activities such as tossing or rolling a ball or bean bags to each other or verbally responding to a range of inanimate objects such as stones, feathers, shells, cuddly toys; the emphasis is on choosing activities and objects that are familiar to the patients to which they can relate to immediately.

2. In the *movement warm-up* patients are encouraged to focus as much as possible on their bodies, with special emphasis on their anatomical structure, their breathing and the movement potential in each of the major joints. This generally helps patients to begin to sense some basic connection with their bodies and thus makes them feel more grounded and more in control of themselves.

3. *Structured movement activities*

This focuses on specially designed structured tasks to address the specific body symptomatology of loss of body boundary, alteration of body schema and de-somatisation. etc. For instance to address the issue of alteration of body schema, each patient is given a 12 foot length of rope and asked to create the shape of their own body on the floor. When they have completed this task, they are asked to get into pairs and to use a rope to outline each other's shape so that they can see the difference between their own creation of themselves and the shape of themselves that their partner has created. These shapes are then reflected on together. Often the initial shape a patient creates is of a very distorted human figure, either completely amorphous in shape, or much larger than life. At times the shapes have been very evocative and one patient referred to his outline as looking like 'Frankenstein'. Once faced with these fairly concrete images of themselves patients tend to acknowledge the disproportion of their own representation, and over time re-create more realistic figures.

4. *Creative movement*

Here, more freedom is introduced so that patients can explore creative potentialities individually as well as interpersonally, thus entering into collaborative modes of movement. For example, they may be asked to mirror each others' movements in silence or to a range of different kinds of music, to embody animals that they feel they share characteristics with, create and enact stories or moving sculptures, jam together on percussion instruments, sing or engage with props such as balloons, balls, parachutes or buddy bands.

5. *Closing circle*

Finally, in this part of the session patients are prepared to disengage from the group process and each other and return to themselves. Usually specific body oriented exercises are suggested including self massage, deep breathing, polarity exercises, listening and feeling to one's own pulse etc. Before ending, they are encouraged to reflect on the session.

From the above it is clear that this structure is specifically designed to enable patients to connect with the various subsystems within themselves, between each other and with the therapist. Inevitably, as the group progresses, themes that emerge expand the therapeutic subsystem of the group and connect it with other wider systems i.e. the organisational, and socio-political realities.

Qualitative data (case study) and the therapeutic process

Now, to give you a picture of this experience, one member of a group will be followed through.

David³ was a middle aged white working class man who arrived at the first session and sat in a chair against the wall with his head down, gazing at the floor; occasionally he peered rather suspiciously around the room. Most of the time he was static and motionless and when he moved he did two different things: he shifted between being extremely passive with a sense of heaviness in his body, and moved around in his chair in a rather edgy, uncomfortable and uncoordinated manner. His posture and gait were asymmetrical and he walked with a slight limp in his big, heavy army boots. In the first few sessions he engaged rather half-heartedly in all aspects of the session, and I often had the feeling that I was 'dragging blood out of a stone'. Looking at my process notes, I wrote that I was anxious about David's lack of engagement and general discomfort. In addition, although a large and well built man, he was unable to harness any strength in



his movement, his body representations as well as his actual movement mirroring were extremely disjointed. Finally, I was acutely aware of his underlying frustration and anger.

Despite his discomfort and awkwardness, he committed himself to attending the group and kept participating in the sessions and gradually I noticed that by the 6th session he began to engage with more energy and intent. The first evident involvement he had was in thwacking the balloons and balls around the room to other group members. He did this with a clear sense of enjoyment. At the same time, I was aware that he was developing a strong positive transference to me, watching me and trying to please me.

However, this change in him was not unrelated to the overall changes in the quality of the group. Despite the difficulties group members had in relation to each other, a sense of trust and intimacy was beginning to develop. They would spontaneously chat to each other before and after the group session. By session 7, David challenged me, querying the function of the group and remarked that 'this is for children'. At the same time, he said that he felt uncomfortable because in some of the exercises, particularly those with mirroring, he felt he was losing his identity. The group responded positively to him, validating his concerns and his initiative to question things. Soon, David's risk taking contributed to a remarkably open and intimate exchange among all group members. They spoke about their feeling of being victimised by society because of their mental illness and some spoke most movingly about their cruel experiences. These included destructive experiences at school in which they were ridiculed, painful experiences within their families where they suffered abuse and neglect, and damaging experiences in their contemporary everyday lives where they were often frightened to defend themselves if attacked either verbally or physically because of their mental health label. They felt that the consequences of their actions in these more challenging situations would be far worse for them than for the 'normal' population. Consequently they often felt that their human rights were violated. As this discussion developed, strong political features emerged, such as the oppression they felt in the harsh reality of living in right-wing working class environments.

The following sessions were much more relaxed, and a sense of playfulness and fun emerged as the patients were able to voice how much they enjoyed coming to the group and being with each other. By session 9 David created an image of himself on the floor (with rope) which he thought looked

like Frankenstein. This realisation shocked him as well as connected him with his intense feelings of destructiveness. In subsequent sessions, he engaged in much more active stamping and punching, pulling and pushing movements and asked to work with the parachute which he shook violently, creating a storm. In the stories he created, there were also violent outbursts at football matches, in the pub, and in the park. Interestingly, the group were not shocked but seemed to accept his enacted violence and this had a containing effect on him.

His gait, co-ordination and energy level improved increasingly and his edginess began to decrease. By the time we got to session 17 he was able to talk openly about his appreciation of the group. The changes in him were especially apparent when it became clear to me that he was becoming less absorbed in himself and instead he was noticing others and their own difficulties; he even began offering his support to others, helping them with certain physical tasks and he began expressing his concern that the group would come to an end.

During the last session, he was able to offer a calm reflection on the positive benefits of the group process without idealising it but also adding appropriate criticisms. His movements were no longer disconnected but were fairly well co-ordinated and his anxiety was substantially reduced. His destructiveness was well contained and he moved about feeling safer in himself.

So, how do we understand the improvements David made while attending the group. I would tentatively like to suggest the following interpretation:

He came to the group in a very withdrawn, cut off state in which, systemically speaking, there was profound disengagement from his own totality and from the other interconnecting systems within which a human being is defined. The most tangible form of disconnection was from the other members of the group and from me. He kept to himself in an immobile position (literally and figuratively) and remained withdrawn for a long time. The diagnosis of 'Mental Illness' appeared to have created a further entrenched detachment between him and other people. His position in the mental health services was definitely one of a passive recipient who was well on his way to developing a chronic career of a person with a mental disorder. I have no doubt that in the old days, he would have been a person who would have stayed in a mental asylum for decades.

It seems to me that two things helped him initially to change his self-image and begin to acquire a new sense



of himself. The first was the overall central focus of the group on a dimension which he did not acknowledge much previously - the body. With regard to the body and the type of activities offered, he began to sense that he was not such a handicapped person and one could see how his self-respect was growing. The activities were introduced in a gradual, step by step way, starting from very basic ones which everybody could engage with. This approach not only raised his self-esteem but also enabled him to relate to others in ways that allowed him not to feel like a mental patient. His first remark to me (during the 7th session, complaining that the group was 'for children') reflected both a sense of confidence in himself and a determination not to lose his self-respect and be infantilised. The response he received both from the group and me was validating and must have strengthened further his new identity, thus enabling him to access a wider circle of systemic connections.

His concern about losing his identity in the mirroring exercise shows not only his trusting attitude to the group and me but also his own strength that he was now able to face some of his petrifying fears of disintegration. In the sanctioned space of the group, he was able to address these fears because he felt increasingly in his body a sense of connectedness, groundedness and non-disintegration. His open expression of these vulnerabilities helped the group locate these fears in their wider socio-political contexts and, therefore, it is not surprising that they began to talk about being victimised by societal oppression.

The emergence of fun is often a sign of the surfacing of more integrated parts of the personality which do not need to hold on to rigid structures to retain their sanity. Therefore, it is not surprising that the final crucial step in David's development - his ability to confront his own destructiveness, followed the phase of playfulness. Again, the combination of a focus on the body plus the group therapeutic factors, seem to have provided the containing context that enabled David to develop a more whole sense of himself.

In short, David gradually became a fully active and participating member of the therapy group and this extended to his relationship to the mental health services and his socio-political environment. He was no longer a passive and dependent recipient of therapeutic regimes. He took more control of himself, his own fate and his treatment in the group. This extended to his relationship with the other systems in which he functioned. He was able to make some changes in his own life and rather than spending most

of his time withdrawn and cut off from himself and the world around him, he was able to get involved in social activities and participate more fully in his own well being, as well as expressing concern about other's welfare.

In conclusion this multi-dimensional work with dance movement therapy as the main therapeutic intervention when applied sensitively to people suffering from chronic schizophrenia seems to facilitate significant, positive changes.

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Notes

- 1 Head of research : Dr. Frank Röhricht MD, MRCPsych Psychiatrist, Clinical Director for Adult Mental Health Newham
- 2 This research work was passed by the ethics committee of the NHS Trust and all patients involved in the study have signed consent forms giving permission for their clinical material to be published and used for scientific purposes, such as this chapter.
- 3 For reasons of confidentiality I have used a pseudonym



Personal Text/Public Body: Introducing an integrative model

Beatrice Allegranti MA DMT SRDMT

This article is adapted from my presentation at the first International Research Colloquium of the German Association for Dance Movement Therapy in Hannover, February 2004 and is offered here as an overview of my ongoing practice-based doctoral research.

As an arts and therapy professional I have worked in a variety of domains including clinical (primarily mental health), training (actors, dancers and therapists) and performance (theatre and film) and emerging from this diversity is the personal text/public body model. Within this model I have held a deep awareness of the dialectical nature of the body, it is *both* personal *and* public and rather than looking for it, I have simply noticed the presence of gender and its huge impact on our lives and relationships.

As a woman, a key feature within both my clinical and artistic practice is to encourage people to explore a multiplicity of gendered expressions in movement and words, rather than maintaining fixed or polarised notions of gender and thus unwittingly perpetuate power imbalances *between* and *amongst* women and men. This stance gives me the opportunity to develop an ethical conscience allowing me to transform hierarchical relationships into more egalitarian ones as well as recognising a deep interconnection between the 'internal' psychological world and the 'external' social world.

The theoretical underpinning for this model stems from my experience (both in training and supervisory contexts) of postmodern approaches in feminist psychotherapy and process oriented psychology (POP) linked with performance/choreography and clinical practice. In this paper, I aim to highlight how these interdisciplinary influences have informed my ongoing work as practitioner-researcher by focusing on the facilitation of a series of ongoing 'labs' attended by therapy and arts professionals and resulting in informal 'showings' entitled Personal Text/Public Body (1999-2003).

Embodying Theory

Influenced by feminist approaches to therapy I share a concern with understanding the impact of power and dominance and, of the social construction of gender, on both identity development and therapeutic practice. I am not only interested in exploring what theory can do for us in terms of practice (Wolff 1995), but in

exploring *how* practice may re-shape theory.

I am mindful of feminist psychodynamic theories like those of Nancy Chodrow (1989) and Orbach & Eichenbaum (1995) who provide a revised developmental theory and usefully raise the argument that the traditional developmental trajectory is inaccurate since it is a description of the male developmental trajectory in this culture. Chodorow provides a definition of female maturity based on attachment and not separation as well placing the individual within a social context and clearly suggesting that male and female infants follow different developmental paths according to their relationship with their mother.

Developmental revisionism is an important reconsideration, particularly since DMT draws (although not exclusively) from traditional psychodynamic principles. However, Chodrow et al have paradoxically, replaced androcentric (male biased) with gynocentric (female biased) arguments and thus continue to define gender identity as a fixed stable entity (Allegranti 1997, 1999). This is echoed in Feminist post-structuralist theorists such as discussed by Irigaray (1985) and Kristeva (1987) involved in deconstructing 'systems of binary oppositions' in texts. In this project, gender identity is viewed in terms of sexual 'differences' by emphasising a 'female signifier' as opposed to a 'male signifier' thus sustaining dichotomous thinking.

I prefer the notion of gender as a *practical* social construct (Lorber and Farrell, 1991, Allegranti 1997, 1999, 2002) and consequently, I suggest the development of an *embodied* language. For this I have turned to Chaplin's aptly named 'rhythm' model for feminist psychotherapy as it allows for an ever-changing space both *between* and *inclusive* of opposites (Chaplin, 1999-2003). This equalizing model shares postmodern notions of multiplicity since it allows for a "striving towards equality at all levels...[rather than] a new grand narrative [or] totalizing explanation" (2001). This postmodern stance allows for *both* psychodynamic *and* humanistic thinking to be placed within the wider social context, therefore allowing the theory to *move with the client*.

In terms of identity development the rhythm model is similar to the notion of "dynamic autonomy [where] increased complexity in relatedness replaces individuation and separation as the premise of



development” (Sheinberg, M. & Penn, P, 1991). This is a useful re-consideration of development as a process in the construction of gender and to develop this further, a focus in my practice is to facilitate alternating states of connection and differentiation as an experience through movement improvisation.

As a clinician and choreographer, this oscillational space of change and co-creation of meaning reflects my use of movement where gender identities and relationships are co-created and are in a constant state of flux. Specific techniques which allow me to *enter into* and *stay with* this murky ‘unknown’ process and find a language to address the depth and indeterminacy of this experience I find in POP (Mindell, 2000). It offers a new paradigm framework including Jungian psychology, bodywork, systems theory, eastern spiritual practices and quantum physics (I will explore this paradigm within a personal text/public body context in a forthcoming paper). Specifically helpful is the concept of the ‘dreaming body’ as a fluid experience which moves beyond the ‘every day’ identity or consensus reality (Mindell, 2000).

An example of how I explored moving beyond my every day identity was in the making of the film *aroundthebend* (Allegranti & Hagell 2001). The film unfolds the co-creation of identities between female choreographer/performer and male filmmaker with an exploration of the fe/male gaze. Within my teetering-toed and tutu-clad solo performance, my desire was to explore marginalised or ignored aspects of my feminine identity and sexuality. In addition to this my aim was to consciously acknowledge and *work with* my embodiment of what I consider to be the mutually influencing and constantly shifting roles of clinician and choreographer. This journey raised issues of how the therapist ‘holds’ the choreographer during the creative process and gives her permission to stay more comfortably with a ‘not-knowing’ approach to practice where she follows the tiniest seeds of experience into an unfolding story (Allegranti, 2002).

The Labs

...two men dancing together, they are recent first-time fathers. One is lying on his back, legs lifted, feet quivering. The other man is above him; arms out stretched echoing the quiver in his hands before he takes a spiral jump to the floor. Together they gurgle and squawk like infants, sliding along the floor on their stomachs...

The labs took place over the course of three days in arts venues, both nationally and internationally. They

were attended by a diverse group of performing artists (actors, dancers, visual artists), psychotherapists and arts therapists. My aim was to continue exploring a deep connection between DMT and choreography/performance and I considered these labs *both* a therapeutic *and* performance space.

Working collaboratively, I illicited material from the lab participants and let them ‘free associate’ notions around the concept of ‘personal text/public body’. I held the awareness that as humans we have the potential to embody the paradox of personal *and* public, from minimal gesture to universal theme. Therefore, my guiding hypothesis was based on the notion of the labs as a microcosm of our gendered ‘performances’ and interactions in everyday life

...a man, gaze fixed, creeps stealthily towards his destination - a woman - and suddenly shape-shifts back into human form, positions himself in front of the woman as she begins to coiffeur his curls...

Consequently, my evolving intention within the labs was for individuals to experiment in movement and words with personal and public gender identities. Specifically, I invited them to address marginalized issues of sexuality and power within their gendered bodies, in other words, to pay attention to what they had placed on the ‘margins’ of their focus. I became intensely curious about individuals examining these ‘uninvited’ aspects of gender identities and wondered how they were held in their ‘dreaming bodies’ and movement interactions. How could getting to know the ‘uninvited guest’ assist in addressing their own social gender assumptions and prejudices?

...a woman precariously walks a tightrope, arms flailing, bound torso, carefully placing one foot after the other, she runs the last few inches and announces herself as “the wonderful performing woman..!”

Part of my facilitation in the labs was to provide questions as a stimulus and structure for example; what is it like to perform for yourself? What is your usual gender mantra? How can you *interrupt* it? These questions were born out of the initial group discussions. Participants were then invited to improvise verbally and non-verbally with their relationship to ‘performing, observing and playing’ within gender/sexual identities and relationships. At the end of each lab participants were not only invited to verbalise their individual experiences (as coherent with a DMT session) but to ‘perform’ their story or ‘personal text’.



...a woman begins to develop a movement and verbal rhythm, "I...I...I..." as she balances precariously on one leg, the other out stretched behind her, she falls, exclaiming "I...I...I... w... w... w..." as the pattern repeats she becomes more determined, falling less, yet not quite managing to find the point of balance "I...I...I... w. wa ...wan... t...t...f...fl..." increasing in speed she suddenly resumes her everyday posture, walks away saying "I want to fly" and finds a resolution within a light hand gesture leading her body upwards...

The result was a series of juxtaposed 'personal texts' performed in front of a small invited audience, an invitation to be *seen*. By doing this, I suggest the presentation of the work through an artefact (film and live performance) allows it to come full circle; from public perceptions through individual processes and mirrored back into the public domain.

...aping 1950's Monroe-esque posturing, a woman performs for an imaginary audience. In lotus position a man sits to her side, back turned throughout, suddenly he springs up and turns around applauding profusely, but the space is now empty...

Layered into the group's unfolding over the three days was the use of film recording as 'reflexive witness'. I consider filming forms an integral part of the personal text unfolding since film images can be used reflexively by participants. Individuals performed for themselves, filmed/witnessed by another and in doing so experienced the reciprocal role shifting of 'performer' and 'audience'. Viewing the video became a cyclical process where individuals watched and re-worked captured and re-curing themes through the process of amplification and repetition. I have also noticed that for myself and for clients, the very act of examining the *distinctions between*, and *process of* 'performing' gender identity for oneself and for a (social) audience provides clarity. It also has the potential to create perceptual shifts.

Methodological Coherence and Conclusions

Within my ongoing research I have experienced a postmodern shift which has allowed my practice to evolve in an improvisational and egalitarian manner (Allegranti 1997, 1999). Significantly, I have also experienced a theoretical shift where I am guided by a qualitative research paradigm (Kvale, 2003) which considers the position of 'knowing' as perspectival

since it is a necessarily partial account of the truth rather than an independent reality.

The methods I use resonate with the arts based inquiry of McNiff (1999) and Wordsworth-Hervey (2004). My methods are also participatory (Reason, P. 1998), because the collected "data" for this research is not only embodied *within* the participants but exists in the *co-creation of meaning* between participants and myself as practitioner-researcher.

I consider *how* I inquire is important because I do not wish to reinforce power relations in the research context by looking at participants 'objectively', neither do I wish to maintain inequality by privileging a subjective position over an objective one. Consequently, on a *methodological* level my aims within my ongoing research are to dissolve a hierarchical approach to inquiry and on an *epistemological* level to co-construct meaning in the context of participant's experiences.

Further epistemological questions arise because of my position as both practitioner and researcher. However, I consider this positioning to be coherent with a postmodern feminist ethical stance which privileges pluralistic enquiry (Akman, et al, 2001) and also connects with the way I practice as a clinician/artist since I am actively involved in moving with the group or individuals (Allegranti 1999). Therefore in the labs and according to the demands of the group at different points in time, I shift positions between clinician - choreographer and researcher, reflecting my choice to shift between directive and no-directive positions as clinician (Allegranti 1997). Consequently, I consider value in this positioning being dialectical or reciprocal; as practitioner researcher and as a personal/public gendered body.

Although not self consciously postmodern, I believe the practice of DMT specifically using in-depth improvisation demonstrates the effectiveness of using postmodern principles and provides a context for fluidity regarding gender meanings. My next step is to introduce a second phase of labs with members of multidisciplinary teams in psychiatry and/or general medicine in order to highlight practitioners' capacity to work across diverse paradigmatic frames. The aim will be to examine the impact of personal/public gender expressions within healthcare and to explore how a 'gender sensitive' approach can positively influence the emotional, physical and spiritual health of clients and clinicians alike.

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Brief Reports from the Field

Dance Movement Therapy and Dementia Research

"A descriptive evaluation of the patterns of practice of arts therapists working with older people who have a DSM IV diagnosis of dementia in the UK"

- Are you a dance movement therapist working with older people with dementia?
- Would you be interested in sharing your experiences of working with older people with dementia?
- Would you be willing to be interviewed at your place of work?
- If yes to the above, would you be willing to participate (confidentially) in dance movement therapy and dementia research?

I am a qualified art therapist currently in the process of undertaking my PhD at Queen Margaret University College in Edinburgh. I am looking for practising arts therapists from the fields of art, music, dance

movement and dramatherapy who would be willing to participate in my research. If you would be interested in learning more about this research then please contact me at the address below.

Jane Burns, Research Student – S09, Queen Margaret University College, Duke Street, Leith Campus, Edinburgh, EH6 8HF

Tel. 0131 317 3665

Email: Jburns@qmuc.ac.uk

Body, Movement and Dance in Psychotherapy Journal – forthcoming in 2005 – Aims and scope

Body, Movement and Dance in Psychotherapy is a new international, peer-review journal focusing on the significance and possibilities of the body and movement in the therapeutic setting. It is the only scholarly journal with an international reach wholly dedicated to the growing fields of body psychotherapy



and dance movement therapy. The journal encourages broad and in-depth discussion of issues relating to research activities, theory, clinical practice, and professional development.

Research contributions include reports from research studies using qualitative and quantitative methods and discussions of research methodologies. The theoretical section provides a space for new insights into the development of the knowledge-base and theory of body/movement therapies as well as systematic and critical overviews of previous studies and/or relevant literature. The clinical practice section publishes descriptions and evaluations of practice with an innovative character, discussions of ethical issues and short reports from user groups. Contributions about professional issues include those addressing matters like state registration, training and professional development.

“chatter box or serious talk”

Hi there!

Anyone out there who is working with Learning Disabled Clients (all age groups) and uses attachment theory as her/his theoretical underpinning for interventions – I WOULD LIKE TO TALK TO YOU AND SHARE INFORMATION, VIEWS, EXPERIENCES. I am also looking for literature on [attachmenttheory&artstherapies&learningdisability](#) and haven't been very successful. So if you would like to contact me - that's the way: bobby64@gmx.net

Proposal of Professional Skill Sharing Between Dance Movement Therapists

Tracey French RDMT

I am writing briefly, with the purpose of possibly finding new ways to develop networking amongst the dance movement therapist's of the UK, and open up the very real need for more collaborative sharing in our profession.

Since my very short four years in the professional world of dance movement therapy, I have met a number of therapists who have moved from working with a particular client group to a completely different group of clients, with very different needs. This, I would suggest has something to do with our need to discover our full potential as dmt's and explore and be curious about other client groups. I also feel strongly that at any time in our own personal and professional

development, that perhaps we all need a change, and sometimes this is guided by our personal and spiritual growth, and sometimes by an urge to take a 'leap' into something unknown and new!

I propose that one way we could tackle 'leaping into the unknown' is by collaborating, and offering each other advice and voluntary time on our projects to gain a grounding and skill base in a range and variety of client groups, if that is an interest any one of us has. My own time as a dmt has been spent closely working with families and young people at the adolescent stage of life. I have thoroughly enjoyed spending time with the young people who are indeed our future, and the spirit of adolescence being so excitingly powerful, and I have also enjoyed getting to a stage in my work where I feel at ease and comfortable with any challenge that a young person may bring.

However, I am on a journey of my own, and would be very interested to see the other sides of dmt in all its colourful varieties. I would be very interested in co-working/volunteering/or 'lending a helping hand' as a dmt to anyone working with refugees, the elderly or mother's and baby groups. It would be an honour to join another dmt in their work with any of the above clients, and I would be grateful if I can work alongside someone in the near future.

How: Once a week preferably.

Where: I can reach most parts of London, I live in Hampshire on the Surrey border, so anywhere within these areas would be of benefit to me.

Objective: Skill Sharing from one dance therapist to another.

Contact Details: E-mail: tracestar100@yahoo.com

Write: T. French

Carrick Lodge, Carrick Lane, Yateley

Hampshire GU46 6XN

Note: If this article has touched the leaping urge in anyone else, I would be interested to hear from you, as I would consider organising a list of contacts sharing projects and names of people interested in offering places to collaborate, and people interested in taking part in other projects as an ongoing regular Skills Sharing project.

Doctorat

Dr Jill Hayes contacted ADMT to give everyone the good news that her doctorat in DMT entitled 'The Experience of student dancers in higher education in a dance movement therapy group, with reference to choreography and performance' has been awarded by the University of Herfordshire.



Workshops, courses and conferences

Authentic Movement Ongoing Group

If you have some experience of Authentic Movement and are familiar with the discipline of witnessing, you are invited to join an ongoing group which will meet monthly on Sunday afternoons in the Bethnal Green area, London: September 2004 - May 2005. It will be led by Linda Hartley.

For details telephone 01799 502143 or e-mail: linda.hartley@ntlworld.com

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Authentic Movement and Therapeutic Presence

With Fran Lavendel in Edinburgh

Introductory Day: September 11, 2004

Four weekends: October 2004-March 2005

The study of the discipline of Authentic Movement and how it can bring greater clarity to our work with others. An opportunity for professional development for practitioners and trainees in therapeutic and bodywork practices, education, the caring professions and the community.

Please contact Fran on 01968 676461 or lavendelmaclea@ednet.co.uk

Eastwest Somatics for Dance and Movement Therapy

announces its summer program to be held at Exeter University, Devon

Eastwest founder Sondra Fraleigh is an international leader in the emerging field of Somatic practices. The Workshops: July 21-25, 2004- 'Seven Core Lessons in Somatic Kinesiology, July 26-30 - 'Embodying Expression', workshops can be taken individually or consecutively. Eastwest practice includes gentle movement patterns and dance influences by somatic yoga, movement meditation, Feldenkrais and breathwork.

To register: send a brief, one page vita and one paragraph statement of your personal goals for the program of study to Ksifter@sbcglobal.net

Cost: each workshop £375.00, option to take the first

18 hours as an introduction - £188.00

Accommodation can also be arranged for participants on the St Luke's campus at Exeter University

For more information contact:

esatwest@frontiernet.net

THE SESAME INSTITUTE UK & INTERNATIONAL

The British Association of Art Therapists The British Association of Dramatherapists

Present a one day conference:

Crafting the Future The Power of Creative Arts Therapies in Education - Tools and Strategies for Inclusion

Date: FRIDAY 8th OCTOBER 2004

Venue: The Albany Douglas Way Deptford, London SE8

Cost: £95 (includes lunch & refreshments)

Conference will be of specific interest to all educational professionals: Headteachers, SENCOs, Teachers, Educational Psychologists & LEA support services For more information and a booking form contact: craftingthefuture@hotmail.com

The Conference provides an opportunity for all those working with children in schools including Headteachers, Special Needs Coordinators, Teachers, Educational Psychologists, Counsellors

- To attend presentations and workshops by leading professionals in the field of the Creative Arts Therapies (Music Therapy, Art Therapy, Dramatherapy, Dance Movement Therapy, Play Therapy) and education
- To hear about the way schools and education authorities work with Creative Arts Therapists to meet the needs of children and young people who are at risk of being excluded, experience emotional, social and behavioural difficulties because as the green paper says - "Every Child Matters"
- To talk to Creative Arts Therapists, Teachers and Headteachers about the practical details of providing Creative Arts Therapies within schools - primary, secondary, mainstream and special.

N.B: If you are interested to offer a workshop, put up a stall/stand on the day The Sesame institute would like to hear from you, please contact Tamara Collinson at Tamara_collinson@hotmail.com . The deadline for planning was May 5th but it might be possible to negotiate!



Therapists and Supervisors

- For the exhaustive listing see *ADMT Register of Professional Members*
- DMT Trainees will need to ensure that their choice of supervisor/therapist is **APPROVED** by their training institution.

Beatrice Allegranti, MA DMT, SRDMT

Offers individual supervision; feminist and gender sensitive approach as well as Laban Movement Studies and Improvisation. For more information or an appointment contact: beatriceallegranti@mac.com or Tel: 07714 196 810

Dawn Batcup, SRDMT

is available for supervision or DMT in South London. Tel. 020 8682 6236 or email: dawn.batcup@swlstg-tr.nhs.uk

Katya Bloom, SRDMT, CMA, MA

is available for individual movement therapy and supervision in North London. Tel: 020 8444 2071 or email: kbloom@talk21.com

Sue Curtis, SRDMT

is available in South East London for supervision, training or workshops. Sue specialises in all aspects of work with children and young people. Tel: 0208 244 0968
sue@dircon.co.uk

Yeva Feldman, SRDMT, Gestalt Psychotherapist in advanced training.

offering supervision and personal therapy. Specialising in area of eating disorders. Humanistic orientation.
yevafeldman@prevyet.freeserve.co.uk

Sarah Holden, BA Hons, SRDMT, Member IGA UKCP reg.,

offers individual movement psychotherapy, and supervision in South London. Tel: 020 8682 6246
sarah.holden@swlstg-tr.nhs.uk

Janet Kaylo, MA, RMT, SRDMT, CMA

offers supervision or personal therapy, including integrative, somatic movement work, and links to Movement Analysis in clinical and personal work. Tel: (southeast London) 020 7078 5012 or email: j.kaylo@gold.ac.uk

Fran Lavendel, MA, SRDMT, BMC practitioner offers individual sessions in movement psychotherapy, interweaving DMT, Authentic Movement and Body-Mind Centering. An on-going Authentic Movement Group that meets monthly in Penicuik or Edinburgh welcomes new members. Supervision for trainees or practitioners is also available.

Tel: 01968 676461

E-mail: lavendelmaclean@ednet.co.uk

Bonnie Meekums SRDMT, UKCP registered psychotherapist

is available for both private individual therapy and clinical supervision in the North and North West of England.

Bonnie Meekums, PhD, Lecturer in Counselling,

University of Leeds, Wakefield Campus, Barnsley Road, Wakefield WF1 5NS. Tel: 0113 343 9414 or e-mail b.meekums@leeds.ac.uk

Nina Papadopoulos, SRDMT

is available for individual DMT and supervision in East London. Tel 020 85563180 or email: ninadmt@yahoo.com

Dr Helen Payne, SRDMT, Fellow ADMT, UKCP

Registered Psychotherapist offers training and therapy, on-going supervision is available for qualified and trainee dance movement therapist. Dr Helen Payne is also trained in authentic movement and integrates this into her private practice.

Please contact Helen on 01707 285861 or

E-mail: H.L.Payne@herts.ac.uk

Helen Poynor SRDMT

is available for individual movement therapy and supervision in East Devon & Totnes. Tel: 01297 20624

Susannah Rosewater, SRDMT

is offering individual movement psychotherapy and supervision at low cost fee (£15@hour) in



private practice in Camden Town NW 1, based on Authentic Movement, Feldenkrais and Humanistic Psychotherapy. For more information call: 020 7485 3440 or email: sue.rosewater@virgin.net

Rosa Shreeves, dance artist and therapist, SRDMT, UKCP

offers individual movement therapy and supervision in West London and workshops in the UK and Spain; Humanistic psychotherapy and the creative arts. Tel: 0208 995 5904 or email: roger.north@btinternet.com

Marion Violets, SRDMT

The Willows, Rhydowen, Llandsul, Ceredigion SA44 4QD

Tel: 01545 590 315 or 07973415287

marionviolets@magic.freeserve.co.uk

News from the Web

European Conference for Professional Development of Dance Movement Therapy 18th - 19th of June 2004

Chair: Annelies Schrijen van Gastel

Please let us know whether you are coming or not. Mail to birgitta.harkonen@danshogskolan.se no later than 1st of June 2004. If you are attending, please let us know which hotel you are staying at and if you are a vegetarian or have any food allergies.

Here are suggestions for hotels that are situated nearby communications to the school. Please note that you have to make the booking arrangements by yourself, and you also have to make reservations quickly, because there are many conferences in Stockholm in June .

- Noréns Malmgård,
Skinnarviksringen,
14 A, 117 27 Stockholm
phone: + 46 - (0)8 - 66966490.
For prices see www.norens.com.

- Rica City Hotel, Slöjdgatan 7,
111, 56 Stockholm
phone: + 46 - (0)8 - 7237220.

For prices see www.rica.se.

- Columbus Hotel,
Tjärhovsgatan 11,
116 21 Stockholm.
Phone: +46 - (0) 8 - 503 112 00.
For prices see www.columbus.se.



The e - motion ADMT U.K. Quarterly is an official publication of the Association for Dance Movement Therapy. The quarterly Committee invites all members to contribute and reserves the right to edit all material. Views expressed by the contributors are the authors' and do not necessarily express the views of the Association. Similarly, any publication, advertisement or workshop not part of the Association's activities is not necessarily recommended or approved by the ADMT U.K. Copyright of articles remains with the author unless otherwise specified. When writing articles, please use the following editorial guidelines:

A maximum of 10 sides of A4 including references. Single line spacing. For text only, there is no need to do formatting. All references cited in the text must be listed in alphabetical order in a reference section at the end of the article. Only items cited in the article should be listed as references. Each one should include the following as a general guide:

Books:

Author/s surname/s followed by initials, year of publication (in brackets), title (underlined), place of publication, name of publisher, page numbers (if referring to an article within an edited book)
 Chodorow, J. (1991) Dance Therapy and Depth Psychology: The Moving Imagination. London & New York: Routledge

Journals:

Author/s Surname/s followed by initials, year of publication (in brackets), title of article (lower case), title of journal (uppercase and underlined), volume and issue number, page numbers of article.
 Karkou, V. (1999) Who? Where? What? A brief description of DMT: Results from a nationwide study in arts therapies, e-motion, ADMT UK Quarterly, XI, (2), 5-10.

Please carefully edit your work before submitting it, i.e. check spelling and grammar thoroughly.

Send material via e-mail as an attachment to: emotion@admt.org.uk e-mail us for SUBSCRIPTION to the journal, ADVERTISING and LISTINGS. Please note that receipt of contributions will not be acknowledged unless requested.

ADMT U.K. Membership & Subscription

Annual membership to ADMT U.K is available from: ADMT UK Administration 32 Meadfoot Lane Torquay, Devon TQ1 2BW	<table border="1"> <tr><td>Associate</td><td>£ 35.00</td></tr> <tr><td>Student / Unwaged</td><td>£ 20.00</td></tr> <tr><td>Institution</td><td>£ 60.00</td></tr> <tr><td>BRDMT Member</td><td>£ 60.00</td></tr> <tr><td>Full RDMT Member</td><td>£ 80.00</td></tr> <tr><td>SRDMT Member</td><td>£ 100.00</td></tr> <tr><td>Overseas Supplement</td><td>£ 10.00</td></tr> </table>	Associate	£ 35.00	Student / Unwaged	£ 20.00	Institution	£ 60.00	BRDMT Member	£ 60.00	Full RDMT Member	£ 80.00	SRDMT Member	£ 100.00	Overseas Supplement	£ 10.00	Annual Subscription to e - motion ADMT U.K. Quarterly for non-members costs: for Institutions £40, Individual £16 including p&p (overseas + £6.00)
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BRDMT Member	£ 60.00															
Full RDMT Member	£ 80.00															
SRDMT Member	£ 100.00															
Overseas Supplement	£ 10.00															

Advertising Policy

The **e - motion ADMT U.K. Quarterly** will publish listings in the columns provided as a free service to our members. Council reserves the right to limit listings to those which will be of interest to ADMT members. These listings may include the name of the event / service, the leader, the dates, the location, a brief description (one sentence) and contact information.

Paid advertisement space is available in **e - motion ADMT U.K. Quarterly**. Fees are:

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	height	width		
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Quarter Page	120	85	£25	£35
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Flyer			£80	£100

10% Discount available for yearly (x4) insertions, price of insertions at above rates.

**e - motion ADMT U.K. Quarterly DEADLINES:
 1 FEBRUARY, 1 MAY, 1 AUGUST, 1 NOVEMBER**

The editorial committee will undertake to mail the publication approximately six weeks after deadlines.

EDITORIAL COMMITTEE: Celine Butte, Tracey French.