Dance Movement Therapy

Second edition

Theory, Research and Practice

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Koslowsky, J. (1953) *Children and Parents: Psychoanalytic Studies in Development.* New York: Jason Aronson.
Laban, R. (1975) *Modern Educational Dance.* London: MacDonald and Evans.
Levy, F. (1988) *Dance Movement Therapy: A Healing Art.* Reston: American Alliance for Health, Physical Education, Recreation and Dance.
Llewellin, S. (1994) Psychotherapy in the voluntary and independent sector, in P. Clarkson and M. Pokorny (eds) *The Handbook of Psychotherapy.* London: Routledge.
Meekums, B. (2002) *Dance Movement Therapy: A creative psychotherapeutic approach.* London: Sage.
National Institute for Clinical Excellence (NICE) (2002) *Schizophrenia: Core Interventions in the Treatment and Management of Primary and Secondary Care.* London: NICE. Online. Available HTTP:<http://www.nice.org.uk/pdf/CG1NICEguidelineoster.pdf.> (accessed 15 January 2005).
Payne, H. (1983) The development of the Association for Dance Movement Therapy, *New Dance,* winter, 27.
—— (1990) *Creative Movement and Dance in Groupwork.* Oxford: Winslow. Reprinted 2000.
—— (ed.) (1992) *Dance Movement Therapy: Theory and Practice.* London and New York: Tavistock/Routledge.
Quality Assurance Agency (QAA) (2004) *Benchmark Statement: Healthcare Programme – Arts Therapies.* Gloucester: QAA.
Regel, S. and Roberts, D. (2002) *Mental Health Liaison: A Handbook for Nurses and Health Professionals.* Edinburgh: Baillière Tindall Royal College of Nursing.
Ritter, M. and Low, K. (1996) Effects of dance/movement therapy: a meta-analysis, *The Arts in Psychotherapy* 23, 3, 249–260.
Royal College of Psychiatrists (2001) Press release: Changing Minds Anti-Stigma Campaign Film '1 in 4' Adopted by World Health Organisation's 'Stop Exclusion: Dare to Care' Campaign. Online. Available. HTTP: <http://www.rcpsych.ac.uk/press/preleases/pr/pr_191.htm> (accessed 27 December 2004).
Sandel, S. and Johnson, D. (1983) Structure and process of the nascent group: dance/movement therapy with chronic patients, *The Arts in Psychotherapy, 10,* 131–140.
Sherborne, V. (1990) *Developmental Movement for Children.* Cambridge: Cambridge University Press.
Siegel, E. V. (1984) *Dance Movement Therapy: Mirrors of Ourselves. The Psychoanalytic Approach.* New York: Human Sciences Press.
Stanton-Jones, K. (1992) *An Introduction to Dance Movement Therapy in Psychiatry.* London: Tavistock/Routledge.
Strauss, A. and Corbin, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* London: Sage.
Sullivan, H. S. (1955) *The Interpersonal Theory of Psychiatry.* New York: Norton.
Yalom, I. (1985) *The Theory and Practice of Group Psychotherapy,* 3rd edn. New York: Basic Books.
Yip, K. (2001) The community care movement in mental health services: implications for social work practice, *International Social Work* 43, 1, 33–48.

Chapter 4

Dancing with demons

Dance movement therapy and complex post-traumatic stress disorder

Jeanette MacDonald

We are bound to our bodies like an oyster is to its shell.

Plato

Introduction

A thin, wraith-like figure drifted into the therapy room, feet barely touching the ground. She reached out a bony hand, tentatively, towards me. 'I'm Alice,' she said. This was my first introduction to the person whose story we will hear in this chapter. Excavating my papers and notes whilst preparing to write this piece has been personally revelatory. It was very difficult to choose one small area of work to focus upon when I was invited to write this chapter. At the time of writing it is over 30 years since I began working with dance movement therapy (DMT) techniques in the UK National Health Service (NHS). Initially I worked with learning disabled clients (MacDonald 1992). During the last 20 years I have been privileged to broaden my practice, working privately whilst continuing to work within the NHS, developing mental health work, teaching students, supervising colleagues, teaching with and supporting European colleagues to develop training and professional regulatory bodies for DMT. Suffice here to set Alice's story in context.

Methodology

This study is a retrospective review of the DMT case notes of a client presenting with symptoms of complex post-traumatic stress disorder (PTSD). I chose to study this case in an attempt to make visible that which is invisible; the process in ameliorating her distressing symptoms through DMT interventions. When I contacted Alice to obtain permission to use her story she not only agreed but also gave me full access to her own journal[1] and a copy of an interview she had completed with her then care manager. I will therefore rely upon three data sources, the interview, Alice's journal and my own clinical case notes and reflections from supervision. The core data is my own clinical case notes and the peripheral data will come from the journal and the

interview. This process helps in the refinement of concepts so that 'the interconnected data within the core setting are strengthened through the triangulation with the periphery, but equally with interconnected data collected in the wider setting' (Holliday 2002: 43). Triangulation is normally thought of as increasing the validity of qualitative research by getting and comparing 'multiple perceptions' of the same phenomenon (Stake 1994: 241). Using grounded theory (Pidgeon and Henwood 1996) my aim is to find some consonance between theory and clinical practice. My principal research question is: Does DMT help to reintegrate the cognitive, emotional and physical disconnection, which is often a feature of PTSD? I finished working with Alice several years ago and she has now moved to another part of the country. Several identifying features have been changed and Alice is a pseudonym to protect her identity. Use of the first person throughout will provide continuity and flow of text. Holliday (2002) asserts that the use of the first person is a major device for separating the different voices in the text, thus increasing the transparency and accountability of the research.

This is a heuristic (Moustakas 1990) account of a traumatic childhood and its consequent embodied distress. Evaluation of treatment through single case study research both enhances clinical accountability and contributes to the existing clinical database (Acierno *et al.* 1996). I have reviewed all the data retrospectively and I shall use a constant comparative method of analysis (Snyder 1992) throughout the text.

Diagnostic features of PTSD

The American Psychological Association (1994) defines simple PTSD (DSM IV) as follows:

A. Exposure to life threatening experience
   Intense subjective distress upon exposure
B. Re-experiencing the trauma
   Recurrent intrusive recollections, or repetitive play
   Recurrent dreams
   Suddenly acting or feeling as if the traumatic event were recurring
   Intense distress upon re-exposure to events reminiscent of trauma
   Physiological reactivity upon re-exposure
C. Persistent avoidance or numbing of general responsiveness
   Efforts to avoid thoughts or feelings associated with trauma
   Efforts to avoid activities
   Psychogenic amnesia
   Diminished interest in significant activities
   Feelings of detachment of estrangement
   Sense of foreshortened future

D. Persistent symptoms of increased arousal
   Difficulty falling or staying asleep
   Irritability or outbursts of anger
   Difficulty concentrating
   Hypervigilance
   Exaggerated startle

In addition:

- Drug and/or alcohol abuse are commonly associated with this condition.
- Significant functional impairment.

There is growing recognition that PTSD can result from an accumulation of shocking events both life threatening and non-life threatening and the resultant PTSD is referred to as complex PTSD (Kinchin 2001). Complex PTSD is defined by the following factors:

I. Alteration in Regulation of Affect and Impulses
Affect Regulation
Modulation of Anger
Self-Destructive
Suicidal Preoccupation
Difficulty Modulating Sexual involvement
Excessive Risk taking

II. Alterations in Attention or Consciousness
Amnesia
Transient Dissociative Episodes and Depersonalisation

III. Somatization
Digestive System
Chronic Pain
Cardiopulmonary Symptoms
Conversion Symptoms
Sexual Symptoms

IV. Alterations in Self-Perception
Ineffectiveness
Permanent Damage
Guilt and Responsibility
Shame
Nobody Can Understand
Minimising

V. Alterations in Perception of the Perpetrator
Adopting Distorted Beliefs
Idealisation of the Perpetrator
Preoccupation with Hurting Perpetrator

VI. Alterations in Relations with Others
Inability to Trust
Re-victimisation
Victimising Others
VII. Alterations in Systems of Meaning
Despair and Hopelessness
Loss of Previously Sustaining Beliefs

Literature review

A comprehensive search of Amed, Medline, PsychLIT and PsychINFO for the keywords dance movement therapy and post-traumatic stress disorder revealed references for general DMT research articles but a review of these offered nothing relating specifically to DMT and complex PTSD. The range of problems arising from PTSD is very wide and there is a correspondingly wide range of PTSD research literature, which it is beyond the scope of this chapter to review. Surprisingly, there is relatively little emphasis upon the mind–body, body–mind continuum. Callaghan (1993) underlines the centrality of this continuum in her work with victims of torture, as does Rothschild (2000). Van der Kolk (1994), an eminent and controversial PTSD researcher, has written extensively on the psychobiology of PTSD. The very early work of Marian Chace (Chaiklin *et al.* 1993) in the USA, was essentially with the effects of PTSD as she danced on the back wards with men suffering from the traumatic effects of war. According to Peterson *et al.* (1992) there is increasing evidence that avoidance of painful material is a central mechanism in PTSD. I wish to question whether creative and transformational DMT interventions can help to access and integrate this painful material effectively.

Foa *et al.* (2000) present a range of current evidence-based treatments for PTSD which include the creative arts therapies, that is, dance movement therapy, music therapy, dramatherapy and art therapy as the major modalities. David Read Johnson states:

> The mean effect size of dance movement therapy for core psychiatric symptoms, based on meta-analyses, has been estimated as 0.37 (range = 0.15 to 0.54; Cruz and Sabers, 1998). However, no estimates are available with specifically PTSD populations.
>
> (Read Johnson cited in Foa *et al.* 2000: 308)

He proceeds to recommend the design of arts therapy treatments specific to PTSD.

The story

Alice was referred to me at the Creative Therapy Service – a unique, community-based NHS resource offering the four arts therapies, dance, art, music and drama. It is housed in a large country house in beautiful grounds surrounded by trees and shrubs. It is within the city boundary and accessible by public transport. Alice had recently completed a ten-session group for 'survivors of sexual abuse' facilitated by a community psychiatric nurse. This experience had re-opened many psychological wounds for her, wounds and memories which she had tried to avoid throughout her life. She was starting to write about this traumatic material in a journal when her care manager referred her to me to help her work through the emergent stories. From our very first meeting it was clear that Alice was 'disembodied'. Here is an observation from her care manager: 'When I first met Alice she was physically thin almost ethereal and gave the impression of being almost all spiritual rather than physical presence.'

Alice had a long history of terrible physical, emotional and sexual abuse, both at the hands of her own parents and subsequently from her foster parents. She told me that she had stopped developing around the age of 13 and that her physique had changed little since then apart from having grown taller. Here is a short extract from her journal:

> My brother tells of this incident. Apparently I wouldn't use the pot, so my father picked me up by my legs and repeatedly banged my head against the cooker. I must have passed out. I remember them wrapping towels and scarves around my head, there was blood everywhere. My father took me to the hospital; I was walking off the edge of the pavement. I reached out my hand for him to hold and he pushed me away. Blank until I came to in hospital. I had been unconscious for three days. Fractured skull. My mother and father told them I'd fallen down the stairs and banged my head of each step. The Dr. didn't believe them. They tried to make me a ward of court but it didn't go through, my mother told me. Next I remember going home in an ambulance. I had been given a rag doll. My brother and some of my sisters remember the next bit; as soon as I got in the house I had started screaming again and the rag doll was taken away from me. I was put in the cellar again . . . I remember a huge rolling pin, my sister being battered with it, she screaming and I was too. Sister was in hospital for weeks. Both of us taken away from them . . . I remember the sexual abuse that my real father did to me also.

Alice's journal is very shocking and painful to read and relates to a catalogue of violation and torment, which we confronted in our DMT sessions over a period of two years. She began her journal towards the end of the previous survivors' group and continued following our individual DMT sessions. I was not aware of, nor had access to, her journal until I began this review process.

Although Alice had begun the healing process by confronting her painful memories within the survivors' group, she was still far from any physical

remembering as evidenced by her arrested physical development, persistent shallow breathing, rigid posture and high chin. Stromstead (1994) talks about how, following trauma, the individual might engage in a 'spiritual bypass' of the body's experience. Here is another extract from her journal:

> As a child I developed an ability to separate myself as a physical being into a place of infinite light, warmth and loving understanding. Away from my inward fearful struggle to fight against my abusers aggression and darkness against me. I did not realise the full significance of this then. Now I identify this place as a higher spiritual dimension of great wisdom that kept my spirit if not my body safe and whole.

We can hear another account of this phenomenon in the interview with her care manager:

Care manager: What helped you to survive? How did you cope?
Alice: I can remember a number of occasions when I was being beaten just going right out of my body and sort of floating . . . that kept me going.
Care manager: Your spiritual self?
Alice: Yes.

Clearly, leaving her body was Alice's way of living through her appalling childhood. This characterological use of dissociation underlies the description offered by Allen and Coyne:

> Although initially they may have used dissociation to cope with traumatic events, they subsequently dissociate to defend against a broad range of daily stressors, including their own posttraumatic symptoms, pervasively undermining the continuity of their experience.
>
> (Allen and Coyne 1995: 620)

When she was 18, Alice reported going to live with a kind and gentle elderly lady whom she refers to in her journal as Aunt B. She describes this as her first experience of any sort of loving empathetic relationship. She trained as a nurse and went to work overseas for a short while before returning to the UK to continue nursing. Although she found it physically and emotionally stressful and difficult she enjoyed nursing and after a few years she gave birth to her daughter. She maintained no contact with the child's father. Alice concentrated her efforts in denying her own pain and creating a loving home for her daughter. She relates in her journal that being responsible for this small child saved her many times when, because of her emotional pain, she contemplated taking her life. The crisis came when one of her brothers took his life. This was the catalyst that compelled Alice to seek help.

The dance movement therapy sessions

As Alice had disconnected so completely from her body I felt that it was essential to approach this work very gently to avoid a complete flight from reality and to give context to her story text. When discussing her work with survivors of political torture and organised violence, Callaghan (1993) talks about how the process of reintegrating body and mind may be profoundly disturbing. I recalled a training intensive with Babette Rothschild, a body psychotherapist specialising in PTSD, where she stressed the importance of first creating a 'safe' physical place within the therapy space. The body is no longer a safe place for someone who has experienced physical shock or abusive physical treatment. I believe that because the body has experienced a normal shock reaction to an abnormal event, the neuorobiological effects may be compounded and held within the body structure. This body defence against feeling was described in the work of Reich (1945). In complex PTSD these abnormal events are repeated so the body's shock reaction is repeated. Almost like learning to dance, the repeated body actions and reactions become unconscious acts. These defence reactions are coping mechanisms for continuing to live in the world and therefore extreme caution is essential when attempting bodywork with a body holding and defending the psyche against overwhelming shock and disintegration.

For Alice, the safe place was a huge green floor cushion. A number of the early sessions were spent inhabiting the green cushion and as I sat beside her she reached out to hold my hand and, looking into my eyes, she told me her story. Stories are an important element of the therapeutic journey. Since the core problem in PTSD consists of a failure to integrate upsetting experiences into autobiographical memory, the goal of treatment is to find a way in which people can acknowledge the reality of what has happened, without having to re-experience the trauma all over again. For this to occur, merely uncovering memories is not enough: they need to be modified and transformed: placed in their proper context and reconstructed into neutral or meaningful narratives. Thus, in therapy, memory paradoxically becomes an act of creation, rather than the static recording of events which is characteristic of trauma-based memories.

In her novel *The Stone Diaries* Carol Shields (1995) talks about how we need important others to listen to our life stories: 'Life is an endless recruitment of witnesses' (Shields 1995: 36). This and other modern novels attest to the importance of having someone to listen to our experiences. This sort of relationship requires the development of an affective bond (Bowlby 1982). The most important new information is probably the fact that the patient is able to confront the traumatic memory with a trusted therapist in a safe environment (van der Hart and Spiegel 1993). In order to help the patient regulate emotional arousal, secure attachment may be even more important than evoking the traumatic memories. Therefore, it is important for the

patient to establish and maintain an emotional connection with the therapist. A rapidly expanding body of research (Schore 1994; Perry *et al.* 1995) has shown that disturbances of childhood attachment bonds can have long-term neurobiological consequences. In addition to the disturbances in affect regulation, van der Kolk (1995) identifies studies which show that childhood abuse, neglect and separation have far-reaching biopsychosocial effects, including lasting biological changes which affect the capacity to modulate emotions, difficulty in learning new coping skills, alterations in immune competency and impairment in the capacity to engage in meaningful social affiliation (van der Kolk 1995). Listening to the client's narrative whilst maintaining physical contact helps to develop a trusting therapeutic relationship. Any sort of physical contact with sufferers of PTSD must be approached with great care and sensitivity as the body is the container of so many of their painful and abusive past experiences. Working with survivors of torture (Callaghan 1993) describes the body as the physical and psychological site of destruction. This is illustrated in the following extract from my case notes:

> Today Alice explained that if she could just 'get it all out, without running away' it would be a first! When she related particularly distressing events her whole body tensed, her breathing became very shallow and the pitch of her voice became very high. She squeezed my hand with great intensity, hunched her shoulders and screwed her eyes tightly shut! When she had finished speaking she let out an enormous sigh, released her grip on my hand, opened her eyes and looked at me hard. 'What do you think about that?' she said. I told her that I felt very shocked and amazed that she had survived all her ordeals. She smiled ruefully; my response appeared to ease her tension. She continued her story and this 40-year-old woman reached out to hold my hand again.
>
> (Session 8 of 67)

We took short breaks from the narrative to focus on her body, naming and affirming body parts, discovering numb and frozen parts and breathing into every part of the body. When distressing or uncomfortable sensations emerged we would try to relate them to her story, to put them in their place, to reconnect with their source. Alice created metaphorical 'pockets' in the green cushion and when she was able to connect a physical sensation to her story she would put it into her pocket, 'For later,' she said. I kept details of her pockets and their contents in my clinical notes.

Stromstead (1994) describes this descent back into the body as critical to the healing and transformative process. Movement was restricted to the green cushion until Alice felt secure in her body boundaries and ready to step into the larger space. This took the best part of a year. Alice wrote in her journal:

> In my childhood I came to know a different level of physical linear time, I give my heart's thanks to this higher dimension that has held me secure within its infinite love throughout my life.
>
> Now reflected within mother earth, her seas, sky, carpets of hills and valleys and all her profuse nature, is a gentle though awesome care and strength, that has drawn me ever close. Balancing and nurturing my physical senses within the depths of her living beauty and hope. I have been twice blessed.

I can see now from this entry in her journal that for Alice the big green cushion symbolised the earth and all its nurturing qualities. My notes speak of the physical softening and relaxation of Alice's body when she came to sit or lie on her cushion. My supervision notes speak of my own need to move quickly through some of the very heavy material we were processing. I began to set aside a 15-minute debriefing session for myself following our DMT sessions, so that I could 'dance out' the narrative that I had embodied in the transference:

> The goal of working with transference is the main goal of much of psychotherapy and body-psychotherapy: separating the past from the present so that the ghosts and imprints of the past no longer interfere with life in the present freeing the individual to develop new and more effective resources and tools to further his life.
>
> (Rothschild 1993)

The body of the therapist is an important tool, the most basic one. It is the therapist's body that will resonate to many of the subtle tensions and emotional states in the client. Reich (1945) called this process 'vegetative identification'. It means to feel in your own body a sense of the client's struggle, rhythm and quality of pulsation. Following our sessions Alice not only kept a journal but also began to paint and draw. She told me that she needed to record the physical experiences of our sessions. This raised the question for me of how the primacy of movement might act as a catalyst for further creative expression. Indeed, Sheets-Johnstone is eloquent in her argument:

> Behaviours evolve only because behaviours are essentially complex dynamic patternings of movement, and movement being the mother tongue of all animate forms, thinking in movement is both a primary fact and a perpetual possibility of animate life.
>
> (Sheets-Johnstone 2000: 11)

It may be argued that freeing Alice's body to move without fear and with emergent new patterns perhaps helped to create new multimodal pathways for expression of her internal state. Alice was beginning to make sense of her

experiences and to integrate them physically, mentally and emotionally. There is a need to address the effects of the trauma on people's perceptions of themselves and the world around them. People are meaning-making creatures. As we develop we organise our world according to a personal theory of reality, some of which may be conscious, but much of which is an unconscious integration of accumulated experience. These mental schemas organise psychological experience via the process of assimilation and accommodation and assure continuity of one's identity (Horowitz 1991). Although most people cannot clearly articulate the content of their mental schemes, they nonetheless determine what sensory input is selected for further coding and categorisation. Adaptive resolution to a stressful experience consists of the modification or accommodation of one's view of self, and others, which permits adaptive action and continued attention to the exigencies of daily life. In order to deal successfully with a distressing experience, it is necessary to refrain from generalising from that experience to the totality of existence, but to view it merely as one terrible event that has taken place at a particular place at a particular time (Epstein 1991). Here is another extract from Alice's journal:

Today I felt angry, sad, angry
And tired
Not a physical tiredness
Just an inner tiredness
Of living torn apart emotionally
Always trying to find a way
Of dealing with the effects of past memories
Still trying to heal the pain
That makes me feel so sad.

From this and the following extract from the interview it can be seen that she appears now to be able to differentiate her angry and sad feelings and that she was learning to recognise her physical responses to her memories.

Care manager: How do you manage to express your rage and anger without it spilling out and hurting others?

Alice: What I used to do when I was a child, I bit my finger. You can see the scars there. In temper.

Care manager: Did you bite it to the bone?

Alice: I bit it. Part of it was hanging and I had to have it stitched! I used to bite my arms a lot when I was a child. Not when I was growing up, because I didn't want to be angry – I recognised I had a lot of anger inside me that I needed to deal with. I started dealing with it when I was having individual DMT with J and I learned that I didn't have to keep it all inside. It does more damage to me so I've got an anger cushion[2] I really thrash hell out of. I don't think it's anger. I know there is still a lot of pain. It's sadness. I do cry now and I find I can cry more but it still gets stuck sometimes. If I'm really angry (it's wonderful because it makes a terrific amount of noise) I screw the *Radio Times* up and whack the table and just scream and shout but I don't do it very often.

It is interesting to note that I did not have access to either Alice's journal or the interview during the therapy period. The dates of these documents add weight to my decision that because Alice was beginning to recognise her physical responses and attribute them correctly to events in the past it was timely to move from the relative safety of the green cushion and into the larger therapy space. The larger therapy space seems to serve as a metaphor for the world. Bartenieff and Lewis (1980) speak of the immediate kinesphere the space around the body serving as an individual's bridge into the world. My notes from this first session away from the green cushion are an example of this.

> Alice stepped slowly and reluctantly into the far corner of the space and wrapped her arms tightly around her fragile body. 'I feel so cold and exposed,' she said. She described feeling the same as she had when anticipating a physical attack. I sank to the ground in front of her and slowly she followed me. Then she stretched out full length on her front and began to snake along the ground, tracing a diagonal path from the upper right corner towards the lower left corner of the space. As she approached the centre she curled into a tight ball. 'Help me, help me!' she said, not looking but stretching out her hand towards me. Keeping low on the ground I moved slowly towards her and took her hand. She related memories of being punished and physically beaten as a young child; she related feeling pain and soreness at the base of her spine.
>
> (Session 33 of 67)

I felt at the time that we were at a very critical stage in the therapy as Alice was re-experiencing her early distress both physically and emotionally. I can see now from her journal written after this session that it was, indeed, the case. It is so important in this work not to retraumatise the client and to keep all conscious physical activity firmly placed and attributed to the here and now or contained and identified as past events that have been survived and left behind. This is what she wrote at the time:

> I had done something wrong and the punishment you and my foster mother decided I should have was a smacked bottom for a week before I went to bed. It hurt daddy and what hurt more was the look of delight on

> your face as you made me strip, then put me over your knee. Whilst you and my foster mother laughed together. I had been a bad girl you said, though I still can't remember what I had done. Then I went to bed crying, thinking why do they hate me so.

It is little wonder that she felt such pain and soreness at the base of her spine! We identified Alice's diagonal pathway across the space as a timeline and she related particular traumatic events in her childhood to particular places along this physical and spatial diagonal. She started to choreograph her personal story with very clear symbolic movements along this line. I reflected these movements back to her and, when she chose, we would stop and talk about the experience. Emphasis was made upon the fact that although we were quite firmly here in the present, the dance that she was creating along the diagonal belonged to events that had happened in the past. She danced her diagonal dance many times, sometimes alone, a frail and poignant figure. Sometimes she asked me to join her and occasionally she stepped away asking to see, 'what it looked like'. I suggested that she could create another pathway in the space that might symbolise the present and future. From my case notes:

> Alice was very excited today about the prospect of creating another pathway in the space and I was surprised to witness her clarity of purpose in placing the large green cushion along the centre of the back wall and standing very firmly in its centre. She then proceeded to run, quite fast, very lightly on her feet, all around the edge of the room, right hand touching the wall. Avoiding the corners she made a complete circle, returning to the green cushion and throwing herself down upon it with a huge 'Haaaaa!', head thrown back, arms and legs outstretched with a smiling face. She related feeling a sense of freedom and release. I reflected back to her the run along her pathway. She observed that it looked as free as it had felt. We talked about the possibility of incorporating the two pathways, her past timeline with all of its symbolic, tortured and painful movements and this new circular pathway. Alice expressed some resistance to repeating or returning to the diagonal. We will have to approach this essential symbolic integration very gently and slowly. I believe that if she can physically integrate her past traumatic experiences into her present body – felt experience of freedom from pain and rigidity, she may move some way towards healing her pain.
>
> (Session 41 of 67)

At our next session Alice reports a reduction in her nightmares and flashbacks. She also relates to this in her interview:

Care manager: Have you had fewer dreams following therapy?
Alice: Oh I still dream, but not that kind of dream.

Care manager: When was the last one?
Alice: That was when I was seeing J because I remember telling her about it. Last time I saw her was a couple of months ago but previous to that I was actually seeing her every week so it could have been then.

Papadopoulos (2001) claims that dance, in a structured creative context, allows for dialogue between the conscious and unconscious and the possibility for interaction between the two. I would suggest that this interaction could facilitate the psyche-soma integration so necessary in healing past traumas. Rather than an expression of healing and freedom from pain (a facile interpretation), Alice's fast, free-flowing circular movement pathway could be regarded as a defence against addressing her painful feelings (Boas 1952) – a literal flight from pain. In her interview Alice speaks about a recurring dream:

> The dreams are not necessarily recurring dreams – I haven't had one of those for months and months, the one of my foster mother and would always be her and I would always be in either some corridors, running round corridors or in a maze. I don't get them any more.

It is for this reason that the therapist needs to approach this stage of the work with thought and caution. We are aware of the neurophysiological effect of movement upon the body, the release of endorphins producing the 'feel good factor' (Stephens 1988: 41–42). If this is contained in a purely body-felt experience we risk compounding the dissociation that the traumatised client has effected, further removing them from the source of their pain. It is only through confronting this pain that there can be a prospect of real, holistic healing. The client therefore needs to integrate all the movement experiences witnessed and expressed within the therapy space. We may need to revisit and refine certain movement sections before they may be woven into the finished piece. When working with symptoms of PTSD, the dance that our clients create needs to become a seamless piece of movement. It may express hidden and unconscious aspects of their lives, which have previously seeped out in nightmares, flashbacks, panic attacks and phobias and other physical, emotional and psychological symptoms. From my case notes:

> Alice was very resistant to revisiting her diagonal timeline today. She expressed the fear that she might get stuck there – be overwhelmed by painful memories – be unable to escape – to move! She repeated her circular, wall-touching run two or three times until she collapsed exhausted upon the green cushion. I did not press her to return to the diagonal but sat beside her whilst she told me some more of her painful memories. She said that she felt safe on the green cushion and that to her

it represented mother earth. I commented upon the fact that she had placed the green cushion at the starting point of her circular pathway and that it might help her to slow down her run and enjoy exploring this new pathway and its difference in relation to the old diagonal. I reminded her also of the symbolic pockets she had created in the cushion and how we might need to look at some of the things she had placed inside. I hoped that by making these tenuous links to persuade her to acknowledge the horrors of the diagonal and to begin to integrate the two pathways. Alice has brought me some wonderful, colourful drawings, which she has done following our sessions. They are stunning!

(Session 43 of 67)

The following extract from Alice's journal was written after this session:

> Last night before sleeping I asked for help in this work I am doing to release the fear, hurt and deep sadness I feel. Feeling a safe, slow, quiet, seeping energy through my body whilst lying there. Thinking to myself that I have always felt safer outside and this safety amongst nature has become very precious to me. For I am not a victim of mother earth, whatever my experiences from human kind have been. In nature I can be a whole like everyone, a part of her is for me also, and I am accepted on the earth for the me that is now.
>
> Having felt so very tired for so long, relaxed and was able to sleep. On waking up much later than usual I felt a light brightness.

This integration and healing is also reflected in this extract from the interview:

Care manager: You have remembered, worked through and owned your pain. Are you now able, like grief, to let it go?

Alice: That is how I feel now. Whereas as before I did all that work I was running away from it. I control it now. Sometimes things come up but I can honestly say that the last three or four months, it is almost as though my head has been freer.

We have heard from her journal that Alice was symbolising and experiencing the green cushion as the earth. In fact, in the journal she talks about 'mother earth'. As she had been unable to internalise a 'good mother' in her development we were able to use the cushion as a 'holding place' and also a transitional object (Winnicott 1995). I suggested that she could take the green cushion with her to revisit the diagonal time line. It is important that avoidance patterns do not become embedded in the therapy space, so we needed to find a satisfactory way to overcome this fear whilst not overwhelming the ego with too much raw and primitive material. To embrace the necessity

of returning, as part of the process, to the very painful events that therapy is supposed to 'overcome' sounds manageable in the abstract, but is, of course, over and over again, deeply painful for both client and therapist in the intricate emotional detail which is their particular relationship. The client needs us to lose whatever we identify as our 'therapeutic position' sufficiently so that we are available for re-enactment. Only in externalising and re-experiencing in the therapeutic relationship what was unbearable in the past, and uncontainable by the client's ego in the present, is the full extent of the client's pain sufficiently accessible to transform itself. Here, the transformative character of dance acts as a container for feelings that might have been unmanageable in the past. Placing the disturbing feelings of anger, hostility, shame, disgust and so on within the dance form allows the psychic distance necessary to process these feelings and to give them a suitable place: a place not only within the narrative but within the therapeutic space which, through dance, comes to symbolise the life space and patterns. Here is another extract from Alice's journal:

> Somewhere along the way my emotions of heart and mind separated, travelling in different directions. Each along isolated lines, broken pieces drifted occasionally into the same route, surprising me with their rare clarity of view. More often shifting back to such heaviness of heart and confusion of mind.
>
> It happened a long time ago; my feeling became disconnected from the logic of my thinking.
>
> A warm stability of being in this world and trusting another soul, I couldn't know. Only what I saw 'to be' cruelty, harshness seemed 'all that was' a long time ago. When I learnt not everything was like the experiences I had, the routes my heart and mind were travelling realised with shattering hurt, pieces needed healing, a love to bring them back together along the same line.

It is interesting to hear the linear pattern created in the therapy space echoed in her narrative. We can see that Alice was beginning to locate her traumatic experiences in the past – 'a long time ago' – and to recognise the need to reintegrate thought and feeling – 'pieces needed healing'. I suggested some of her story connected to some classic fairy tales, and perhaps we could use the tales to weave a dance between her light-hearted circular pathway and the intensity of the diagonal. In his compelling work, Early (1993) examines the archetypal nature of psychological trauma, particularly as it applies to combat veterans. By examining the fairy tales, fables and folklore that have been handed down through the ages, this author is able to argue persuasively that much classic literature has elements of trauma survival woven through it, indicative of the timeless, collective struggle humankind has with trauma. Early finds elements of PTSD in fairy tales such as *Cinderella*, *Little Red*

Riding Hood, *Snow White*, *Blue Beard*, and *Beauty and the Beast*, as well as in modern-day fables such as *Superman* and *Batman*. The characters in these stories are often abused and abandoned and bent on avenging the evil forces that traumatise them. They dichotomise the world into good and evil and seek situations that replay the trauma experience. The author shows how these same feelings and behaviours are found in PTSD sufferers such as war veterans and rape victims. Early asserts that these tales are so popular across cultures precisely because they express fundamental human problems created by psychological trauma and provide an emotional outlet for people struggling with traumatic memories. Jungian psychologist Birgitte Brun (Brun *et al.* 1993) advocates the power of fairy tales to offer rich symbolism and therapeutic distance to difficult themes. Our discussion around themes from fairy tales appeared to touch Alice profoundly and she rose from the ground and walked to the corner of the room with clear firm steps, head bowed in thought. Here are some notes from this session:

> Today Alice dragged the green cushion over to the far corner of her diagonal. She reached into the metaphorical pockets in the cushion, drew out some of her symbolic experiences – those that were 'for later'. A ritual emerged where she lay each 'traumatic experience' along her diagonal and addressed each one with a movement piece, eventually she symbolically stamped two or three flat into the ground, others she symbolically tore into tiny pieces and tossed the pieces all around the space, moving gently but firmly between her diagonal and circular pathways. Her movements were clear and deliberate.
>
> (Session 47 of 67)

I made no attempt to interpret her dance but I did suggest that, providing she was satisfied with the result, she could repeat and rehearse it. Dance is the only time–space art form (De Mille 1963) and as such is a most valuable container for immediate experience. It is truly 'of the moment'. Following this session Alice wrote in her journal:

> I can only be responsible for the moment I am in.
> This moment is perfect, it is whole.
> I will be its completeness, not being a past or a future.
> For 'all' is contained within this moment's pure freedom.
> I will be its all.
> If only for a moment.

And an extract from the interview:

Care manager: What do you think has helped you to overcome your traumas?

Answer: Since a child, colour has been especially important to me but my heartfelt thanks really to my work with J who encouraged the development of my creative ability, the use of which helped me to heal the broken pieces within me.

The last extract is from Alice's care manager:

> Alice's healing journey and process is powerfully reflected in the complete contents of her journal and in her drawings. The work she did on reconnecting with her body shows in the change from clear, sharp, angular shapes and vivid colours using felt tips to the use of pastels and the introduction of more earth tones. Alice's journey is a testament to the indestructibility of the human spirit against all the odds and as such is a message of hope to others working in the field.

Alice produced over 50 stunning drawings, which she had completed outside of the therapeutic space but in parallel with the therapy sessions. Photographs of just two follow. The first was produced at the very beginning of our work together. The second was towards the end (see pages 66 and 67).

Discussion

A summary account of individual DMT work over a period of two years, one of weekly therapy and one of monthly sessions, underlines the need for careful and sensitive approaches to traumatic material. There is clear evidence from three separate sources that supports the hypothesis that dance movement interventions can help a traumatised individual to re-inhabit their body and to create new, healthy life meanings and pathways. It can be argued that the human condition is inherently one of embodiment and, whilst listening to the narrative is important, unless past experiences are consciously integrated on a body-felt level they remain poised to inhabit the body in unconscious and unhealthy ways. This is evidenced in the numerous somatic problems experienced by sufferers of PTSD. The creative quality of dance as an art form offers the opportunity to utilise physicality, symbolism, metaphor and story within a structured context; one in which the body is the principal tool of expression. Weaving together past and present pathways appeared to be instrumental in affording the possibility to confront painful memories and consequently to dissolve or transform them. It was of paramount importance to create a safe, holding environment and from this to rebuild the capacity to form a trusting relationship. The nature of the trauma might inform the basis of the therapeutic relationship. A female having experienced rape, sexual abuse and or physical and emotional violence from a male perpetrator might have difficulty forming a sound therapeutic relationship with a male therapist and vice versa. As I reviewed my notes I recognised the difficulties that we

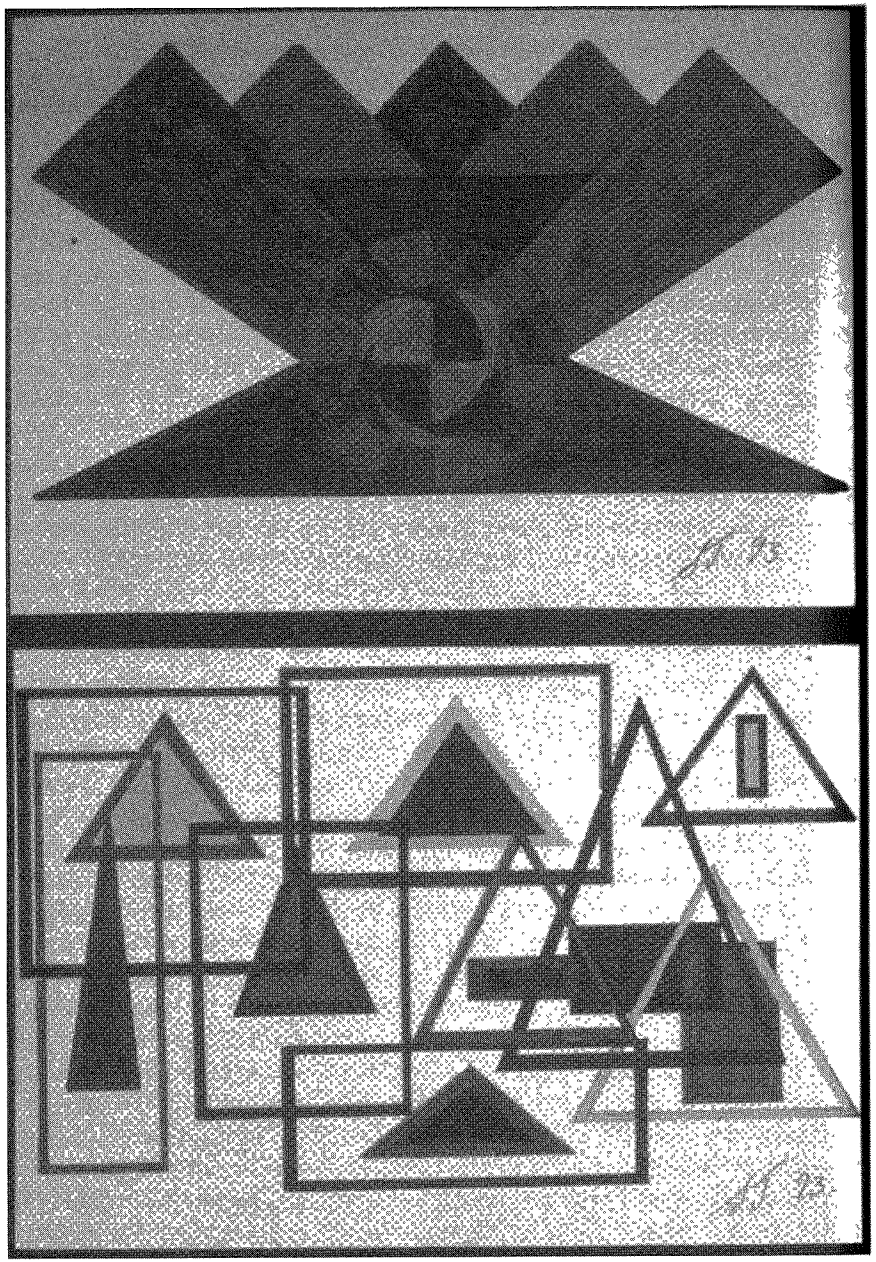

Figure 4.1 Alice's picture made at the start of DMT

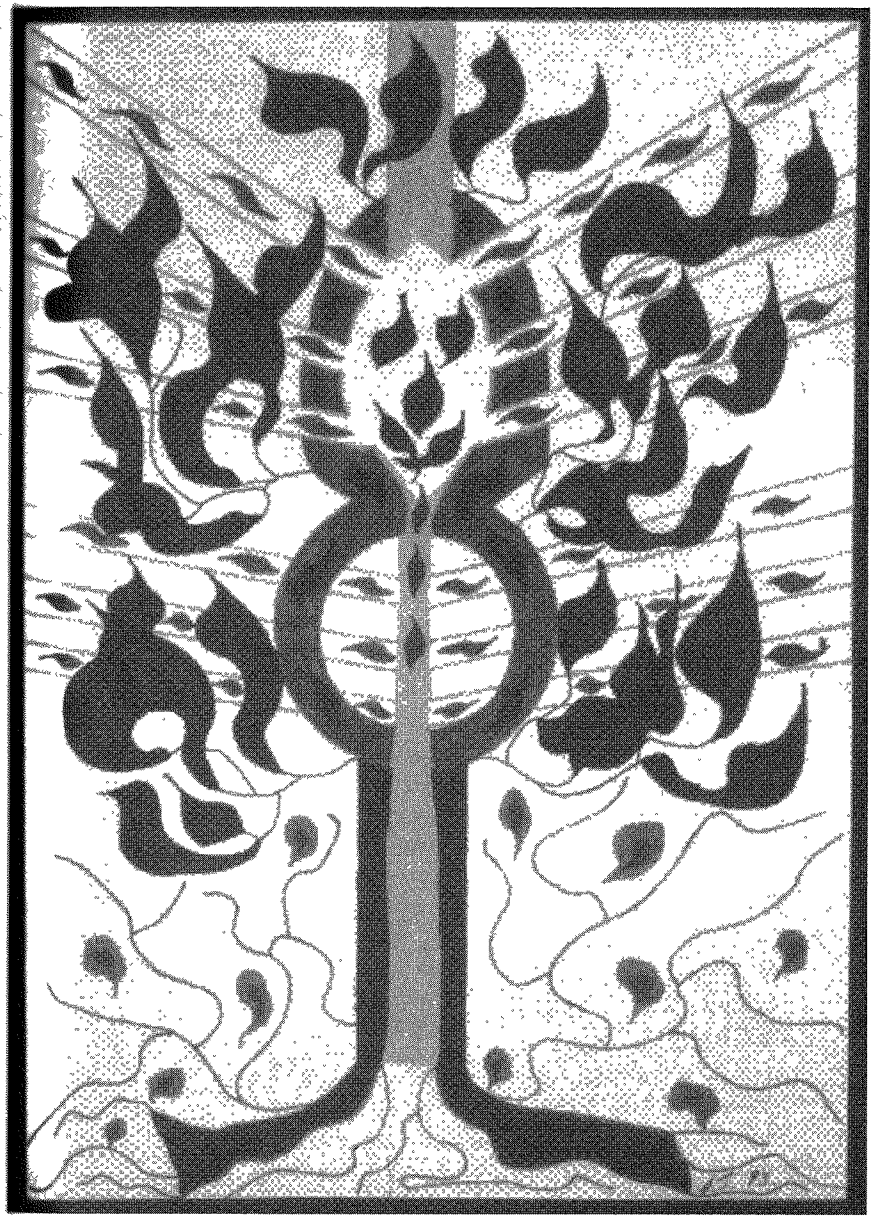

Figure 4.2 Alice's picture made at the end of DMT

encountered in the transference as Alice recalled terrible abuse at the hands of her father and foster mother and father. It was an intensely emotional experience forcing me to explore the darkest corners of the mind. Arbitrary convenience ruled the choice of participant for this study and such a small sample does not allow for generalised reporting in the traditional sense. The findings do, however, appear to provide a legitimate link to theory and a stepping stone to further research. The usefulness of this study will be considered by those who read it through their personal interpretation of the findings of Coffey and Atkinson:

> Establishing the trustworthiness of the insights generated through exploratory research is the job of those who are consumers of the research not the job of social science researchers.
>
> (Coffey and Atkinson 1996: 163)

Conclusion

Individual DMT is a powerful tool in reintegrating a fragmented self suffering from complex PTSD, particularly focusing upon the quality of the relationship. More research is needed into the place of DMT as an effective treatment modality for sufferers of complex PTSD. The traditional verbal psychotherapies do not pay enough attention to helping people recognise and understand bodily sensations (van der Kolk 1994). Choreography (creating dances), the essence of the art form, is central to my DMT practice with this population. This fundamental approach requires a therapist to have a broad and extensive range of dance skills underpinned by sound psychological theory. Whilst physical relaxation exercises are helpful and play a part in body awareness, the body is designed to move and it is through movement that real integration takes place. Movement with dance at its heart, the art form that encompasses all the senses, creates meaning from movement and the possibility for renewal and transformation. It is an honest reflection of the mover. In Alice's own words:

> Let us dream awhile
> And go to a wide space
> Where we can be a light
> Airy and free
> From our sad lonely pain of hearts darkness
> And fear.
> This space within our mind's soul
> Is real, full and makes us feel a
> Completeness
> Dancing a freedom of joy slipped past the heaviness of suffering.

Notes

1 Alice issued a caveat with her journal in that any material used was not to be edited.
2 The cushion she speaks of here was not our large green cushion but another small cushion that she kept at home.

References

Acierno, R., Hersen, M. and Van Hasselt, V.B. (1996) *Accountability in Psychological Treatment*. New York/London: Plenum Press.

Allen, J.G. and Coyne, L. (1995) Dissociation and vulnerability to psychotic experience. The Dissociative Experiences Scale and the MMPI-2, *Journal of Nervous and Mental Disease* 183, 615–622.

American Psychiatric Association (1994) *The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. Washington, DC, American Psychiatric Association.

Bartenieff, I. and Lewis, D. (1980) *Body Movement: Coping with the Environment*. London: Gordon and Breach.

Boas, F. (1952) Creative dance, in L. Bender (ed.) *Child Psychiatric Techniques*. Illinois: C.C. Thomas.

Bowlby, J. (1982) *Attachment and Loss, vol. 1, Attachment*, 2nd edn. New York, Basic Books.

Brun, B., Pedersen, E.W. and Runberg, M. (1993) *Symbols of the Soul: Therapy and Guidance through Fairy Tales*. London: Jessica Kingsley.

Callaghan, K. (1993) Movement psychotherapy with adult survivors of political torture and organised violence, *The Arts in Psychotherapy* 20, 411–421.

Chaiklen, S., Lohn, A. and Sandel, S. (1993) *Foundations of Dance/Movement Therapy: The Life and Work of Marian Chace*. Columbia, MD: Marian Chace Memorial Fund of the American Dance Therapy Association.

Coffey, A. and Atkinson, P. (1996) *Making Sense of Qualitative Data*. Thousand Oaks, CA: Sage.

De Mille, A. (1963) *The Book of the Dance*. London: Paul Hamlyn.

Early, E. (1993) *The Raven's Return: The Influence of Psychological Trauma on Individuals and Culture*. New York: Chiron.

Epstein, S. (1991) The self-concept, the traumatic neurosis, and the structure of personality. In D. Ozer, J.M. Healy, Jr and A.J. Stewart (eds) *Perspectives in Personality, vol. 3*. London: Jessica Kingsley, pp. 63–98.

Foa, E.B., Friedman, M.J. and Keane, T.M. (eds) (2000) *Effective Treatments for PTSD*. New York: Guilford Press.

Holliday, A. (2002) *Doing and Writing Qualitative Research*. London: Sage.

Horowitz, M.J. (1991) *Person Schemas and Maladaptive Interpersonal Patterns*. Chicago: University of Chicago Press.

Kinchin, D. (2001) *Post Traumatic Stress Disorder: The Invisible Injury*. Didcot: Success Unlimited Publications.

MacDonald, J. (1992) Dance movement therapy for people with learning difficulties, in H. Payne (ed.) *Dance Movement Therapy: Theory and Practice*. London: Tavistock/Routledge.