Dance and Other Expressive Art Therapies

When Words are Not Enough

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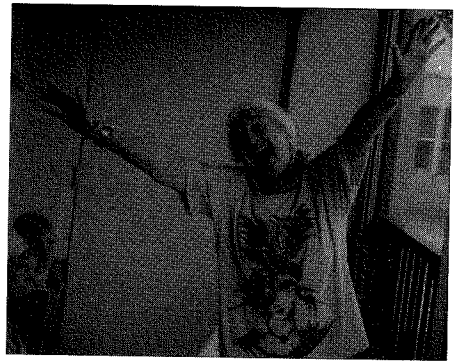

Dance/Movement Therapy with Aging Populations

Susan L. Sandel and Amy Scott Hollander

Movement is a meaningful part of many different treatment modalities for the aged. Although physical therapy, "fitness" programs, creative movement, and dance/movement therapy all use movement, each modality has its own goals.

Fitness programs offer exercises of varying levels of difficulty, depending on the stamina and overall health of the participants. The goals include increased mobility, improved circulation and breathing, relaxation, and release of tension. Emotional well-being, if it comes, is a by-product of better physical functioning. Although exercise programs take place in groups, the emphasis is on the individual's improvement.

Creative movement, which is widely used in nursing homes and senior centers, shares some of the goals that characterize fitness programs, but there are

additional aims. A variety of movement activities, often accompanied by music, are designed to encourage creativity, spontaneity, body awareness, increased self-esteem, and social interaction (Herman & Renzurri, 1978).

Of all the modalities, dance/movement therapy has the broadest goals, integrating physiology, psychology, and sociology. Dance/movement therapy gives meaning to movement through the development of images, encourages emotional responses and the processing of the responses both positive and negative, and it facilitates and supports social interaction. Movement activities are not the primary goal of the group experience, but rather the tool for creating a therapeutic environment. This approach distinguishes dance/movement therapy from the other activities and offers a comprehensive treatment method for the elderly (Sandel & Johnson, 1987).

Aging Populations Differ. When we refer to dance/movement therapy with "older adults" or "elderly people" it is necessary to define the targeted population. There are several subgroups and their needs and goals are different.

Well-Elderly. Chronological age has less impact on a person's abilities than the effects of illness, disease, or trauma. A person, whether 65 or 85, if healthy, active, and alert, may benefit from a dance/movement therapy experience that offers an opportunity to maintain physical wellness while providing an arena for expressing creativity and increasing social interaction. Normal developmental tasks often become the focus of sessions: the expected milestones of aging, the birth of grandchildren or great-grandchildren, the loss of a spouse and peers, retirement, and the needed, but often painful, redirection of life's interests and energies.

Physically Challenged. Many older people have disabling or chronic conditions, arthritis, or other degenerative illnesses. Physical limitations, however, need not prevent participation in dance/movement therapy. An accepting, nonjudgmental atmosphere in which people feel free to function within the limits of their own capabilities is essential. When the focus is on the psychosocial values of the group, rather than on the activity, even the most physically challenged can have something to offer. In such an environment, activities such as making sounds, singing, telling stories, or simply touching one another are especially meaningful. For example, a woman paralyzed on one side said, "We get together to be together. Then we do as much as we can do. It's okay."

A critical factor in creating an accepting atmosphere is the language that the therapist uses in guiding the group. If the therapist says, "Everyone lift your right arm; now your left arm; now both arms," there might be people who can not do any one of these activities. Feeling unable to participate, these individuals may drop out or otherwise resist. If directions are offered as suggestions, it is less likely that people will feel excluded. The therapist might say, "Can we lift one arm? How about the other arm? If you can lift one arm, that's okay. Can anyone lift both arms? If not, lift one arm as high as you can. If you can't lift your arms, how about your fingers?" This approach makes it possible for participants to say, "No, I can't do this, but I can do..." As group norms develop, the participants themselves come up with suggestions that include individuals with physical limitations.

Implicit in a dance/movement therapy session with the physically challenged is the expectation that people will attempt to move and that movement stimulates their feelings about their bodies and their physical limitations. By creating an accepting atmosphere and not avoiding people's difficulties, the therapist models tolerant behavior that contributes to group members becoming more supportive of their peers.

Psychiatric Disorders. Significant differences exist between the elderly person who is clinically depressed due to the sudden onset of a traumatic illness or the loss of a spouse and the person with a long history of psychiatric disorders. For the depressed, the dance/movement therapy group can provide an opportunity to mobilize feelings of loss, anger, and frustration, express them through group activities, and gain support and validation by sharing the feelings with others.

People with chronic psychological problems, on the other hand, benefit from a dance/movement therapy program that emphasizes a consistent, orienting environment. These patients are often on antipsychotic or antidepressant medications and the medication, combined with the structured interpersonal milieu, helps such patients maintain adaptive functioning and prevents further social withdrawal and regression. Traditionally dance/movement therapy has proven to be effective for long-term psychiatric patients. It affords opportunities for simultaneous rhythmic movement, channeled expressions of emotions, and promotes socialization (Chaiklin & Schmais, 1979; Samuels, 1973).

Cognitively Impaired. People who suffer from memory loss, confusion, and other organic impairments, including Alzheimer's disease, benefit from dance/movement therapy that emphasizes consistency and predictability in

time, place, leadership, and activities. Reality-orientation techniques are incorporated into sessions, especially into opening and closing rituals. For example, beginning the group with a structured interaction, such as passing around a foam ball while participants say their names, is reassuring and serves to enhance orientation.

When participating in movements that recall past mastery experiences, confused people appear more alert. Reminiscing stimulates cognitive reorganization, even if only while the person is participating in the group. Physical actions that evoke images of concrete activities such as rowing a boat, washing clothes, or kneading dough can reawaken memories of the past and provide an excellent vehicle for discussion and sharing.

For example, in one group we began a rowing motion, moving our shoulders up and down, forward and back, in a circular fashion. We gripped our hands into fists and proceeded to "row." As we moved and talked, one of the participants began to sing, "Row, Row, Row Your Boat." The others all joined in. This became a ritual in the group. Those who found the movement difficult sang...others moved without singing and others could do both; all were included.

Direct physical contact also has a dramatic organizing effect on people who drift in and out of reality. Sometimes people who appear disoriented can carry on a conversation when holding hands with another. Movement experiences involving physical contact (holding hands and swaying, patting shoulders) are often effective in engaging even the most cognitively impaired.

Frail Elderly. This term is applied to older people who have physical or mental conditions that place them at risk if unaided or unsupervised for at least part of their day. Dance/movement therapy sessions that utilize gentle movements, music, props, with an emphasis on socialization, are most appropriate for this group (Needler & Baer, 1982). The therapist avoids any direct manipulation of people's limbs, as they may be fragile, and some people require assistance in ambulation or other tasks. Even though dance/movement therapy sessions may not be physically rigorous, any at-risk elderly population should have medical clearance to participate.

Dance/Movement Therapy Techniques

The following specific techniques have proven most useful in this author's dance/movement therapy work with the elderly.

Circle Formation. A circle formation, the primary spatial structure for session action, contributes to the feeling of group unity and increases the opportunity for eye contact. Because everyone is visible even those with hearing difficulties are able to participate by following others. People with visual impairments may be seated next to the therapist or someone in the group who can describe the activity to them. Although ambulatory participants may move into other spatial formations such as lines and spirals, or scatter around the room, the circle is desirable for beginning and ending groups. It is particularly important for physically disabled and disoriented people as it facilitates touch and communication.

Music. Music that taps into the natural inclination to respond to rhythm provides a useful stimulus for beginning a session. In fact, music with a clear rhythmic beat is the most consistently useful kind for dance/movement therapy. This should include music from the patients' pasts as well as more current music.

Vocalization. Whenever possible, participants should make sounds while moving, as even a "hum" or an "ah" stimulates breathing, circulation, and central body involvement. Any sound that a person offers can be incorporated in the group experience. As people become more comfortable with vocalization, the therapist can encourage sounds that are expressive of particular feelings. "What kind of sounds do we make when we're happy? Sad? Angry?" In combination with movements, the sounds can increase the range of expression and communication.

A vocal ritual is routinely used to end a movement group that takes place in a day-treatment program. We raise our arms to the ceiling as our voices get louder and louder. As our arms come down our voices get softer and softer. Often participants forget the softer and softer but give out a good strong yell. Larry, a man with advanced Alzheimer's disease, is particularly loud. He holds the yell for a good 30 seconds, and ends with a smile on his face, feeling his power. Most participants love to yell and end the group smiling and laughing.

Props. Certain props are particularly useful for stimulating activity and encouraging interaction among the elderly. Some favorites are foam "Nerf"™ balls, colored scarves, and various lengths of stretch material (Caplow-Lindner, Harpaz, & Samberg, 1979). These objects may be used to motivate movements such as squeezing, punching, tugging, and throwing, and to develop participatory games. Any of the props may provide increased sensory stimulation and serve to link group members together to increase interpersonal awareness.

In groups with disoriented or confused patients, props may be the external focus or support that keeps the group together. In sessions with more alert people, props may serve as the initial stimuli for interaction but may not be necessary later on as group members begin to interact freely with one another.

Empathic Movement. One of the major characteristics that distinguishes dance/movement therapy from other body disciplines is the therapist's reliance on empathic movement as the basis for group interaction. Developed by pioneer dance therapist Marian Chace, empathic movement is a technique in which the therapist guides and develops group interaction as it unfolds during the session. Therapists do not come to a session with a preconceived plan of activities but rely on verbal and nonverbal cues from the participants for the contents of the session. Suggestions, rather than commands, characterize this approach, so that the therapist serves as catalyst, not teacher.

The therapist first creates an atmosphere that encourages self-expression through movement. Then the therapist responds to the feelings and thoughts being expressed, but does not impose specific muscle movements to condition postural changes or evoke certain emotions. This technique challenges the therapist's skills in dealing with both spontaneous movement expressions and group process (Sandel, 1993a).

Imagery. The development of group images is another distinguishing technique of dance/movement therapy. The use of imagery shifts the experience from simple action to a symbolic, shared act. A basic guideline for this technique is to begin with the movement and allow the image to develop out of the action. For example, if the group movement involves stamping feet, the therapist might ask, "What can we stamp on?" or "Have you ever stamped on something?" The questions encourage participants to express ideas and associations without binding the group to the therapist's imagination. Imagery is also useful in identifying feelings, relating movements to real situations, and facilitating reminiscence. Thus, the development of images gives significant meaning to the movements (Sandel, 1993b). For example, in a group with confused participants, the therapist danced with a woman in the center of the circle. As they danced, they talked playfully about what they would wear to the "ball." The woman, who had dementia and rarely recounted events from her past, described in detail a blue satin gown she had once worn.

Reminiscing. As in the example above, dance/movement therapy provides an opportunity for reminiscing in a social context. Reminiscing can be an adaptive behavior and should be encouraged (Butler, 1963; Fallot, 1976; McMahon & Rhudick, 1967). Reminiscing also aids in developing interaction among the participants. For example, rhythmic actions done in unison uncover forgotten memories and feelings, memories that may be pleasant or painful or of past experiences of mastery.

The principal that applies to imagery applies here: Always begin with the movement and allow the reminiscence to develop from the action. Progression from the sensory experience of movement to the symbolic image or association emerges from the spontaneous unfolding of material. For example, in a group of frail elderly who were seated in chairs, marching in place elicited a tremendous response. To the music of "Here we go, into the wild blue yonder..." foot stomping intensified. Ralph, who could not walk due to a stroke, stamped his feet rhythmically. Gertrude moved her feet despite a fractured hip. The energy level increased in the room and everyone "marched."

Case Examples

The following is taken from a therapy session with five women, ages 78 to 92, all nursing-home residents. Four of the five were confused, and three had diagnoses of organic brain syndrome. All of the women experienced extensive periods of disorientation, and several did not know where they were until they entered the therapy room. Three of them participated minimally in verbal conversations, whereas one had lengthy spells of total muteness. All had been attending the movement-therapy group weekly for at least 6 months.

We began by lifting our arms up and down slowly as part of our warm-up. I added a suggestion that we raise our arms as if we were lifting something very heavy and then proposed that we pass the heavy object around the circle from one person to the next. When I asked, "What can we pass?" Ms. D. said, "A sack of potatoes." As we continued, Ms. D., who had grown up on a farm in Ireland, told the group about potato farming. She described the process of planting, digging, and storing the potatoes in the barn covered with hay. When she finished I asked the group, "What else can we do with the potatoes?" Ms. S. started throwing imaginary potatoes across the circle, an action that was picked up by the rest of the group and caused much laughter, even from Ms. K., who had been mute.

When I asked if we could do anything else with the potatoes, someone suggested mashing, and everyone proceeded to "mash" the potatoes, with several offering ingredients such as butter and salt, and giving directions concerning

proper preparation! When I asked what we could do next, Ms. S. said gleefully, "Eat them!" and the women began "feeding" the mashed potatoes to one another.

Discussion followed:

Ms. K: I'm a good cook. I can make soup.
Ms. S: I used to like to cook.
Therapist: Did anyone else like to cook?
Ms. C: I was a good cook once.
Ms. S: (Turning to Ms. C., her roommate) M., you never told me you cook! (She looked respectfully at Ms. C.)
Ms. D: I did a lot of cooking. You know I have nine children. I used to like to feed them spinach in the winter; it was good for them.
Therapist: What else did you feed them?
Ms. D: I baked pies. Apple pies, with potato in the crust.

The conversation then shifted to a current concern—the food in the nursing home.

Ms. S: They gave us apples today—apples in a dish. It's not real apple pie (she paused, looked around, and made a face). I ate it anyway! (Big smile.)

The group responded with giggles and nods.

Of significance is that these five women, supported by the structure of the movements and periodic interventions by the therapist, were able to sustain a logical sequence of cognitive and motor activity that lasted for 20 minutes. Even the less verbal people contributed to a conversation organized around the memory of past competencies. Ms. S.'s regard for her roommate clearly increased when she learned that Ms. C. had been a good cook. Repeatedly, in such situations, residents learn about each other's accomplishments for the first time. The resulting interaction can be a first step toward socialization for people who have been socially isolated (Sandel, 1978).

Reminiscing, of course, is not always linked to positive experiences; it can also evoke painful memories. In many institutions there are few opportunities for aged residents to express negative affect in a constructive way. Because angry outbursts and abusive language are abhorred by most residents and staff alike, many patients fear that they would be viewed as "impolite" or "ungrateful" if they openly expressed negative feelings or critical attitudes. The intimacy that evolves in small groups through sharing memories creates an atmosphere in which upsetting feelings and complaints may be aired.

In a more alert group of seven residents, male and female, who ranged in age from 77 to 95, the first expression of negative affect occurred after the group had been meeting weekly for many months. The following took place during the 14th month.

Each person took turns leading warm-up exercises, which included a variety of movements such as talking to others with our hands. While we did this, there was talk of the many residents who had the flu. The talk developed into symbolic action of throwing and pushing the sickness away from the members of the group.

Mr. J: Push it away; pull it back.
Mr. L: Why the hell do you want to pull it back?
Mr. J: Okay, push it away and leave it there!

I suggested that we extend the movement so that we were rocking forward and back in our chairs. One woman mentioned that it was an awful feeling to fall, and recounted an incident in which she had fallen badly. I asked if anyone else remembered a fall. Mr. J. remembered going iceskating and falling backward on the ice. Ms. K. and Mr. L. both shared their memories of breaking an arm in a fall.

Ms. B: I don't remember falling. I was always very careful.
Mr. J: (In a joking tone) You're a fallen woman!
Ms. B: I should hope not (laughing). That would be something, wouldn't it!
(Everyone laughed, conversed, with neighbors.)

What is important here is not only the specific content of what was discussed, but also the fact that people were able to share unpleasant memories while maintaining a sense of humor in a spontaneous and largely unselfconscious manner. The reminiscences developed from the sensorimotor experiences and provided a focus around which the interaction occurred.

In another group of confused patients, we were exercising our legs by lifting one foot after the other.

Mr. H: This reminds me of marching.
Ms. G: Aren't we too old to march anymore?
Ms. F: No.
Therapist: Did anyone ever march in a parade or a procession?
Mr. H: In the army. (He sings. "When the Caissons Go Marching Along," and several people join him.)
Therapist: (The group continued stamping their feet.) Anyone else ever march in a procession?

Ms. M: I know I have, but I can't remember. Maybe in school, yes school.
Therapist: Perhaps in a graduation procession?
Ms. M: Yes, that's it.
Ms. V: There were processions in Italy when Hitler came to power. All the soldiers marched down the streets. And processions for Mussolini.
Therapist: Can we march like soldiers? (The group responded with louder, more militant stamping.)
Ms. V: And then there were processions in Israel for the Jews who were killed by Hitler. (She started to cry.) Many of my people were killed there, in Europe.
(A co-therapist and patient on either side of her extended their hands to her, as the rest of the group stopped stamping.)
Co-therapist: It's understandable that you feel sad about that.
Ms. V: I'm sorry to trouble you with my problems. They say I talk too much.
Co-therapist: Who says that?
Ms. V: They all do.
Ms. S: We like hearing your stories.
Therapist: It's okay to tell us.
Ms. V: Thank you.

Although the reminiscence was not fully explored at that time, the value that painful memories can be shared and that group members are willing to listen was supported by the group. Despite the impact of Ms. V.'s associations, the group did not fall apart, and Ms. V. seemed much relieved when her pain was openly acknowledged (Sandel, 1978).

The reminiscing that develops from movement also leads to discussion about current issues in the participant's lives. The activity itself and the memories it stimulates can be used by the therapist to facilitate here-and-now interactions.

Joe, a 79-year-old man with a primary diagnosis of Alzheimer's disease, began attending a dance/movement therapy group in a specialized day program. He was tall and slim and, despite his dementia, was physically fit. He had owned a company and had been clever and well-liked by his employees. Because Joe was deaf in one ear he had difficulty following oral instructions but followed the movements when he could see the therapist. When he moved he often smiled and sometimes sang or told a story. Over and over he told about "during the war" when he was involved in intrigue and was sometimes in danger. (The information was confirmed by his family.) Joe's story of his

exciting past stimulated the admiration of others. As his self-confidence was bolstered by their admiration, Joe began to get up on his feet and dance with the therapist and with any able group members. He began to initiate movements and exert leadership. Others respected him and asked his opinion about things that concerned them.

Although Joe declined physically over the next 4 years, he continued participating in the daily group. The structure and routine, as well as his role in the group, helped him to maintain his self-esteem. A few months ago, Joe suffered a stroke that partially paralyzed his left side. With encouragement from the group, he used his right arm to raise his left arm and assist in lifting his left foot. This effort contributed to his rehabilitation and further enhanced the admiration and respect of his peers.

Conclusions

All elderly people, even those limited by physical, cognitive, or mental disabilities, can function in a dance/movement therapy session. The human response to rhythm, music, and touch is enduring and transcends the effects of aging.