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The Regional Map: An Overview of this Book

This book introduces the reader to Dance Movement Therapy (DMT) as a form of psychotherapy. I do this within the metaphor of a journey. Before we embark on any journey we need maps. The first part of the book therefore maps our territory. This chapter maps the book as a whole, and sets the book in context by giving an overview of DMT theory and practice. Chapter 2 offers a more detailed map of DMT theory. Theory gives us a way of understanding what DMT is and how it works. My dissatisfaction with the 'pasting on' of theories from other disciplines (usually verbal psychotherapy) has led me to re-examine DMT. I propose a unified theory of DMT, emphasising the creative process and in particular the role of the 'movement metaphor'.

In the second part of this book, I describe my particular approach to DMT practice. I organise this part around the idea of DMT as a creative process, with its four aspects of preparation, incubation, illumination and evaluation. I make use of extensive reference to case study material in order to illustrate each stage of the process.

In Chapter 3 I propose a 'containment' approach to DMT, suitable for the early preparation or 'warm-up' phase of each session and of the therapy as a whole, and for clients struggling with overpowering experiences. I then examine in Chapter 4 the role of DMT in allowing the process to deepen and in developing insight. This is the stage of confrontation with dungeons and dragons, a letting-go into the darkness (incubation) before seeing a crack of light (illumination). I end in Chapter 5 with a consideration of the role of DMT in

processing and evaluating transitions, as we settle around the final campfire. At the end of the book are references and useful addresses, should you wish to explore further the topics raised in this book.

My case vignettes are all based on real experience, though some are presented as 'composite pictures' or with certain characteristics changed or disguised in order to protect confidentiality. Changes are only made where this does not affect the validity of the point being made. Pseudonyms are used throughout.

What is Dance Movement Therapy?

In Britain, DMT is defined as: 'the psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration' (ADMT UK, 1977).

What is interesting about this definition is that it places DMT firmly within the realms of psychotherapy. For many years, mainstream psychotherapy in the UK was envisaged solely as a talking therapy, and psychoanalytic or at least psychodynamic in its orientation. With the advent of psychotherapy registration via the United Kingdom Council for Psychotherapy (UKCP) it has been possible to embrace all three of the major schools of psychotherapeutic thought (psychodynamic, behavioural and humanistic) and more. Nevertheless, the arts therapies (dramatherapy, art therapy, music therapy and DMT) are generally not represented within UKCP and maintain their own systems of registration.

Dance Movement Therapy or Therapeutic Dance?

One of the confusions that abounds in many people's minds concerns the overlap between therapeutic dance and dance movement therapy. A lot of very valuable work goes on in the area of therapeutic dance, and both professions are required in order to meet the varied needs of our society. However, it is worth attempting to delineate the differences and similarities.

Therapeutic dance may be practised by talented and highly skilled dance teachers who are not trained as therapists but work within institutions such as schools, prisons and so on. There is considerable overlap between DMT and therapeutic dance, giving rise to some fruitful cross-fertilisation. One important figure in the

development of DMT in Britain has been the dance artist Wolfang Stange, who works with mixed groups of dancers including those with learning and physical disabilities. His goals are artistic; he runs a performance group, yet his methods look very similar to those used by dance movement therapists.

Both dance movement therapists and dancers working in therapeutic contexts are artists. Table 1.1 offers a comparison between the two disciplines. This is based both on my own practical experience and on the following sources: Boas (1943); Carnegie UK Trust (1985); Chace (1975); Claid (1977); Davidson (1979); Gill (1979); Hamilton (1989); Kestenberg and Sossin (1979); King (1983); Laban (1971); Leventhal (1986); Levy (1992); Malecka (1981); Meekums (1990); Meier (1997); Paludan (1977); Payne (1992); Prestidge (1982); Sherborne (c.1984); Solway (1988); Standing Committee of Arts Therapies Professions (1989); Stanton-Jones (1992); Steiner-Celebi (1996); Winnicott (1971). In reading my comparison, it is important to remember that this is an evolving field and that the parameters of each discipline are constantly changing. Table 1.1 should therefore be viewed as a snapshot in time.

Allied Approaches to DMT

Other approaches to movement and dance that may be seen as allied to DMT include:

- Body Mind Centering™ (BMC) (Cohen 1980, 1984), a complex training based on both developmental movement and anatomy. BMC is used both to support performance and as a system of therapy. Several British dance movement therapists have trained in BMC, but by no means all BMC practitioners have registration as dance movement therapists.
- Gabrielle Roth's five rhythms (flowing, staccato, chaos, lyrical, stillness), which she views as a form of shamanism (1990). As the name suggests, the work centres around five rhythmic structures within which the dancer improvises.
- Circle dance, based on folk dances from around the world and often deemed to hold archetypal, healing significance. I discuss their usefulness with survivors of child sexual abuse in my book *Creative Group Therapy for Women Survivors of Child Sexual Abuse* (2000). I have also encouraged some groups to choreograph their own 'circle dance', based on a given theme

Table 1.1 *Comparison of DMT and Therapeutic Dance*

Field	DMT	Therapeutic Dance
Facilitator is an artist	Yes	Yes
Boundaries	Start and finish times, group rules, private space, confidentiality, limits to relationship (no socialisation).	Start and finish times and privacy of space may be more relaxed. Group rules may be relaxed or strict. Relationships may extend beyond the group.
Use of structure offered by leader	Probably, but in response to therapeutic goals and client's own contribution. Likely to be flexible.	Probably. Not necessarily responsive to the client's contribution. May be rigidly adhered to, or flexible.
Use of props	Probably. May be used as 'transitional objects' (Winnicott, 1971).	Probably. Used to stimulate creativity.
Performance to outside audience	Unlikely	Possibly
Performance to other members of group	Possibly	Probably
Use of choreographic structures	Possibly	Possibly
Use of improvisational structures	Definitely	Probably
Use of rhythm	Yes. To structure and contain. Also to develop certain psychological/ developmental states.	Yes. To structure and contain, and to develop skills.
Use of mirroring (rhythm, quality and shape of movement)	Yes. Conscious use to develop therapeutic relationship and group interrelationships.	Yes. May be used as a choreographic device or to develop group interrelationships.
Use of costume	Limited	Possibly
Use of theatre lighting	Unlikely	Possibly
Typical group size	1 to 8 or 10 individuals	4 to 30 or more individuals
Emphasis on aesthetic components	No	Possibly
Aims	Targeted to the therapeutic needs of the client group.	Broadly therapeutic and sometimes educational/ artistic.

Table 1.1 *continued*

Field	DMT	Therapeutic Dance
Theoretical underpinnings	Include psychological theories.	May or may not include psychological theories.
Client groups	Just about anybody, but may be subject to assessment.	Just about anybody, but may be targeted.
Competencies required	Experience in facilitation of groups and range of movement styles. Additional competencies including ability to work with distress.	Experience in facilitation of groups and in the movement form offered.
Own therapy required	Yes	No
Clinical supervision required	Yes	No
Level of academic training required	Post-graduate diploma minimum	No formal qualifications required
Work with group dynamics and interpersonal relationships	Definitely	Probably
Work with the internal imagery and symbolism of clients	Definitely	Probably
Integration of spiritual components	Possibly	Possibly
Distress versus fun	Actively work with distress, but fun is allowed and used to balance. 'Rescuing' by therapist avoided.	May avoid distress and emphasise fun. Alternatively, facilitator may act as shaman, 'rescuing' through the use of self.
Verbal evaluation of sessions	Usually	Not necessarily
Use of touch between therapist and clients	Rare	Occurs as part of normal interaction
Diagnostic or psychological formulation based on movement observation	Yes	Not necessarily

like 'empowerment'. These dances, performed at the end of each session, become a container for the session's material and reaffirm a sense of connectedness before leaving the session.

Key Principles Underpinning DMT

Dance movement therapy rests on certain theoretical principles. These are:

- Body and mind interact, so that a change in movement will affect total functioning (Berrol, 1992; Stanton-Jones, 1992)
- Movement reflects personality (North, 1972; Stanton-Jones, 1992).
- The therapeutic relationship is mediated at least to some extent non-verbally, for example through the therapist mirroring the client's movement (Chaiklin and Schmais, 1979; Stanton-Jones, 1992)
- Movement contains a symbolic function and as such can be evidence of unconscious processes (Schmais, 1985; Stanton-Jones, 1992).
- Movement improvisation allows the client to experiment with new ways of being (Stanton-Jones, 1992).
- DMT allows for the recapitulation of early object relationships by virtue of the largely non-verbal mediation of the latter (Meekums, 1990; Trevarthen, 2001).

The Evolution of Dance Movement Therapy

Dance Movement Therapy has had a separate development in the UK from the American experience. Whilst there have been American influences, it is true to say that some of the seeds of British DMT were being sewn before any significant input from American dance movement therapists began in the late 1970s and 1980s.

There are records of dance being used for therapeutic purposes in Britain during the nineteenth century (Browne, 1837). By the 1940s, a definite dance therapy movement had begun, paralleling that in the US. However, dance therapy at that time was seen as distinct from psychotherapy and it was not until the 1970s that a second wave of DMT pioneers began to experiment with the psychotherapeutic applications of dance and movement. This second wave eventually gave birth to DMT as we know it today in the UK, and is more akin to American practice.

Dance movement therapy in the twenty-first century is practised flexibly, either as a primary intervention and therefore as a form of focal psychotherapy, or as a supportive, adjunctive therapy. The more creative, supportive and adjunctive function of DMT overlaps in form and function with 'therapeutic dance'.

Training and Registration of Dance Movement Therapists

Training in the UK is at post-graduate level, for two or more years. Some courses offer a post-graduate diploma and others offer Masters level training. Courses are accredited via the professional association, the Association for Dance Movement Therapy UK (ADMT UK). During training, all DMT students must be in personal therapy. Theoretical training spans several academic disciplines including psychology, psychotherapy, anatomy and physiology, and of course dance movement therapy. Practical training includes weekly attendance at a DMT process group, 200 hours of client contact and 200 hours of non-contact related work activity (note-taking, staff meetings and other related activity). Practice is supervised both in a group setting and individually.

In Britain, there are three tiers of registration for dance movement therapists. The first of these, Basic Registration (BRDMT) is for those who have recently completed a post-graduate training in DMT. BRDMT is essentially a probationary qualification. Within two years, a BRDMT has to apply for Registered status (RDMT), having completed extra hours of supervised practice.

Senior Registered Dance Movement Therapists (SRDMT) have demonstrated extra supervised practice and personal therapy and submitted a paper of publishable standard. They qualify for private practice, teaching and supervision of others. SRDMTs have effectively been in training for approximately seven years (two years post-graduate training, two years as a BRDMT and a further three years as RDMT). RDMTs have been in training for up to four years. All fully registered British Dance Movement Therapists have thus had a similar length of training to that of any registered psychotherapist.

At present British dance movement therapists do not have registration with one of the formal psychotherapy bodies (for example, UKCP). It may be that the future of the profession lies in acknowledging that there are two ways of practising DMT: the more creative, supportive and adjunctive work on the one hand

(for BRDMTs) and the practice of DMT as a primary psychotherapeutic intervention on the other (for RDMTs and SRDMTs). The latter could conceivably negotiate status as psychotherapists via UKCP. The stumbling block to such registration has been to date that many, but not all, dance movement therapists would wish to be seen as psychodynamically orientated. However, they would be unlikely to be afforded equal status with their counterparts in verbal psychodynamic psychotherapy. The UKCP has no separate category for arts therapists, although one member organisation trains its students in an integrative arts therapies approach and registers under the humanistic and integrative section.

Practice Contexts for DMT

Dance movement therapists in Britain work with a wide range of client groups. Many work in the National Health Service (NHS), usually in adult mental health. Others work in child and/or family services, both statutory and voluntary agency based. Some dance movement therapists work in social services, for example with adults who have learning disabilities. Other locations and client groups include prisons, education (with children who have emotional and behavioural disturbance) and private practice.

The Importance of Research

There is a strong and growing trend in Britain towards evidence based practice (EBP) within the NHS. This has been driven by a series of government initiatives and is broadly welcomed by the profession. It is important that clients and referrers can make informed choices wherever possible concerning treatment options. Most importantly, clients should not be offered a form of treatment that is unlikely to benefit or may even damage them.

The 'gold standard' for research is taken as the Randomised Controlled Trial (RCT). In this form of research, adapted from the natural sciences (physics, chemistry and biology), DMT is offered to one group of individuals (the 'experimental' group), and the same number of individuals is offered 'treatment as usual' (the 'control' group). The allocation to each of these two groups is random in an attempt to minimise researcher bias. A series of valid and reliable measures relating to the research question is used with both the experimental and control groups, at similar intervals,

usually equating to before and after therapy. For example, if the research question is 'Does DMT reduce depression?' the measure will be a depression scale such as the Beck Depression Inventory (Beck, 1978). Statistical tests are then applied to the data to ascertain whether any difference in outcome between the two groups is deemed to be significant. A significant difference implies a causal relationship. For example, if the experimental group (those receiving DMT) show a statistically significant decrease in scores on the Beck Depression Inventory as compared to the control group (treatment as usual), it is considered likely that DMT has caused a reduction in depression in the experimental group.

Experimental research has demonstrated a role for DMT in reducing anxiety (Cruz and Sabers, 1998; Erwin-Grabner et al., 1999; Low and Ritter, 1998; Ritter and Low, 1996). As a form of gentle exercise, it is likely also that DMT has all of the positive health effects generally associated with this, including potentially the alleviation of depression (Ernst et al., 1998). However, there are fundamental problems with experimental methodology when applied to DMT research. It is often difficult to gather sufficient numbers to obtain a reliable result. The research is also limited by the measures available, so that it is difficult to investigate phenomena associated with complex symptom pictures or changes in beliefs, attitudes, feelings and relationships. Some research has focussed on the practice of developing DMT by participating with service users. This kind of research typically makes use of focus groups or conversational interviews and generates complex descriptive data rather than numerical data. Conclusions are likely to be similarly complex. For example, my own research (Meekums, 1998) showed that some women who had been sexually abused as children needed to use DMT in a very structured way in order to feel safe, while others benefited from the freedom of expression afforded through less structured, improvisatory forms. This difference seemed to be determined by the woman's degree of emotional and cognitive 'distance' from the abuse. Distance is a complex phenomenon that cannot be reduced to one single factor, for example length of time spent in treatment.

Navigating this Book

It is important not to skip the theory chapter of this book (Chapter 2), as this will help the reader to make sense of the practice of

DMT. My central thesis in this book is that DMT is a form of psychotherapy in its own right, mediated via the creative process and making unique use of the 'movement metaphor' in order to facilitate this process.

I hope that the reader will take from this book whatever is of use to them. However, I must emphasise that it is not advisable or ethical (and may soon be illegal in the UK) to practice dance movement therapy without full training. An experienced practitioner from an allied discipline (for example dramatherapy, psychodrama, therapeutic dance or perhaps occupational therapy) will know their own competencies and be able to select from the ideas I present here to inform their own practice. Expert clinical supervision is essential in order to examine the boundaries of one's own competence and comfort with the material. The student or qualified practitioner in dance movement therapy will be able to use this book to confirm or develop their own thinking and practice.