

Groupwork in Dance Movement Psychotherapy

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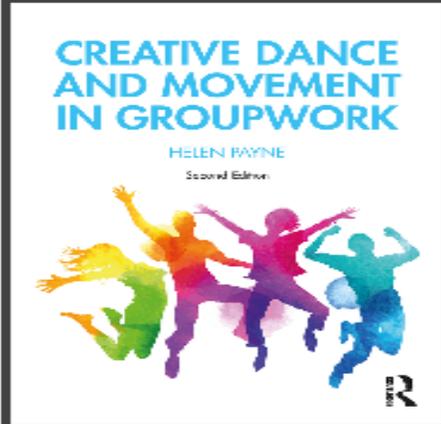
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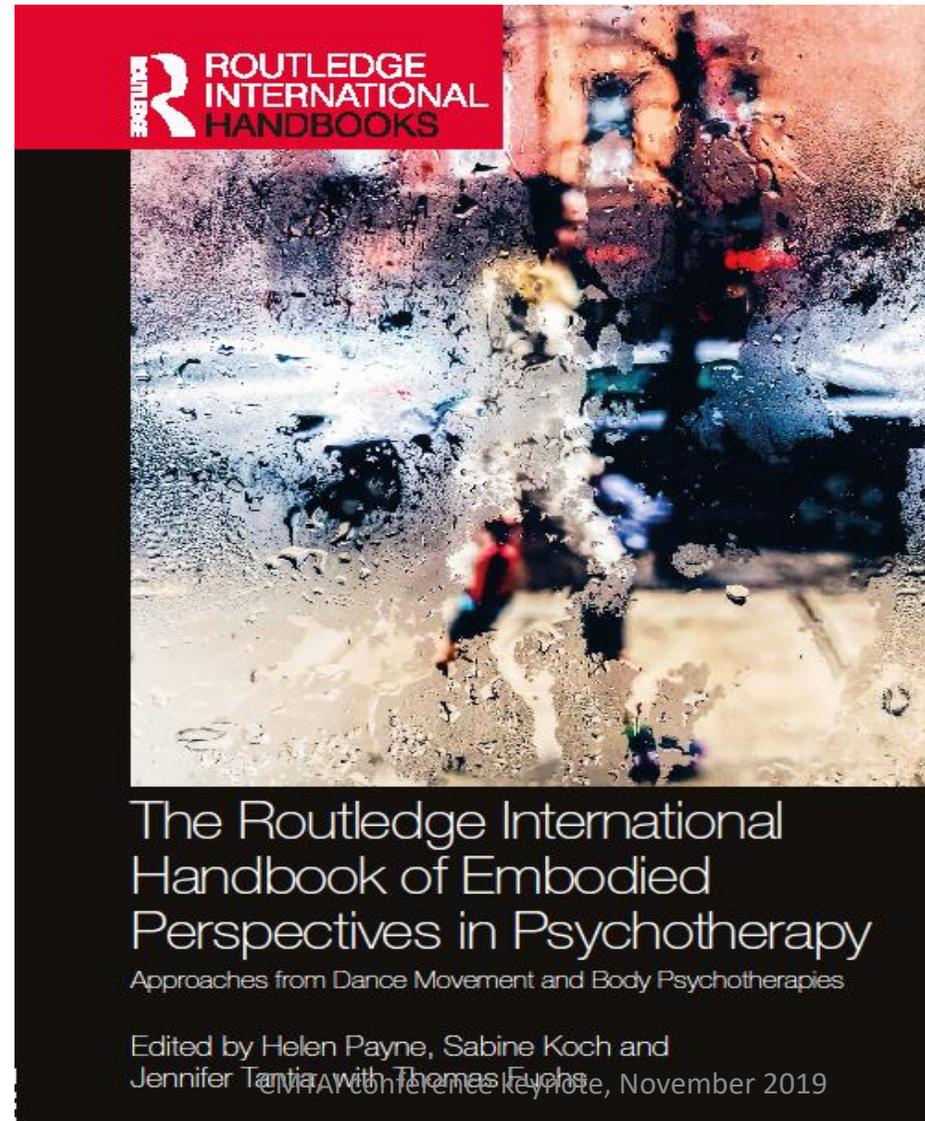
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Creative Dance and Movement in Groupwork

- explores links between movement and emotions
- 180 practical activities with a clear rationale for the use of creative dance and movement to enrich therapy or educational programmes
- features session plans divided into warm-ups, introductions/development of themes and warm-downs
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- updated content of the original edition, this timely sourcebook includes new material on creative dance and dance movement psychotherapy
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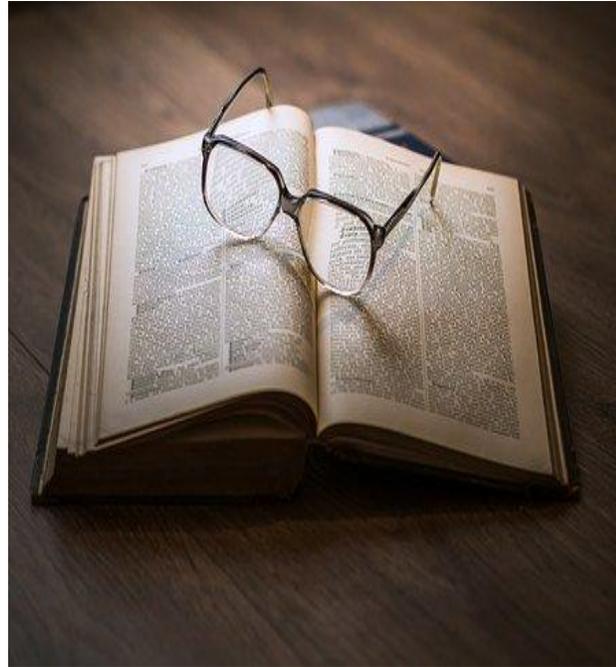




5 Overview

- Group therapy theory and practice
- Ins and outs of delivering DMT groups
- Two models of group work recognised in DMT/P
- Personal development groups in DMT/P training
- The BodyMind Approach
- Questions
- References

6 To deliver DMP groups we need knowledge and understanding of:



- the population
 - group process theory
 - the structure and dynamics of dance movement material
- A group is normally embedded in an institution/programme

7 Before Delivering a Group: Things to decide on:

- Open or closed, name
- Time, dates, venue, duration
- Ground rules and procedures
- Number of members
- Population needs
- Referral criteria, pre-group interview/assessment
- Information sheet for participants/referrers
- Schedule of sessions
- Music/props

8 More things to consider

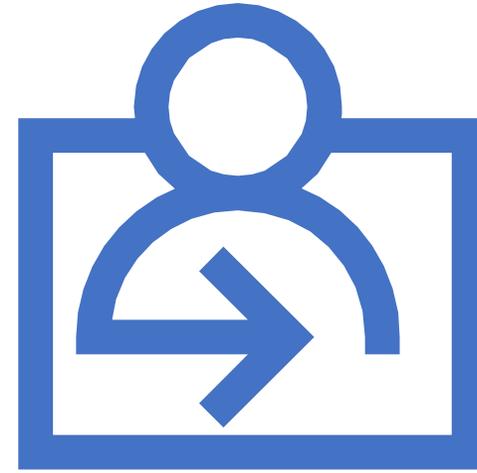
- Role of the therapist/ attitude/mind-set towards group
- The formal goals of the group
- Touch
- Degree of structure
- How to structure the movement process from start to finish..

9 Questions to answer



- How will you start the session?
- What will be the physical warm-up? Ritual each session?
- Will the structured movement work be guided by you or group members?
- Will the creative movement process guided by you?
- How will you end the movement work?
- How will you end the session?
- Where will the verbal processing come in?

10 Who will attend?



- Groups are a more complex than individual work
- People come into a group because they are referred
- A mix of those who are already interested in contact and communication, but also those who find it difficult to deal with others/ avoid direct contact.

11 Conducting a group

There are different ways to conduct groups:

- work **in** the group: attention to individuals - each is looked upon as a separate person, no attention to the interaction in the group i.e. individual therapy but in a group (Pesso, Mereno, Process-work)
- work **on** the group: attention to the group as a whole, little given to individual input; work is orientated on the transference themes between group and therapist (group analytic)
- work **through** the group: the group is the frame of reference; but also attention for how the individual group members participate in the group process (group psychotherapy)

12 The Group Process



- Participants have already experienced groups
- During the therapy process focus may switch from themes from the past, to here and now, to a future perspective
- Attending to how members respond can re-frame the embodied experience avoiding repeating former negative experiences

13 Content

Group aims might be to foster:

- personal movement experience
- verbal articulation of the dance movement
- contact in dance movement situations.

Themes can develop from the different layers (Foulkes)

- Surface layer of actual experiences inside and outside the group.
- Latent layer (transference) in which participants may resonate with what is happening from another experience or feeling towards the movement action.
- Projective layer whereby primitive fantasies and objects relations manifest.
- Body layer with the physical expression referring to body image perhaps.
- Primordial layer of universal symbols manifested as archetypes (Jung)

14 Processing

- Verbal reflection on movement material
- Encourage less verbal clients to speak/ manage verbally effusive ones.
- Group dynamics present in verbal processing
- Focus on group themes where possible
- Confidentiality of members' history is essential.

15 Group cohesion

The development of a “we” feeling nurturing clarity in movement about “me”- “you – “we”.
through:

- body: actions, parts
- effort: qualities of movement
- space: personal kinesphere, levels, general space, group space
- rhythm: personal rhythm; group rhythm
- formation: moving alone, in dyads, triads, as a group-formation

16 Group cohesion

- Goes with attunement of personal movement towards group-movement - moving together as “one person”..
- Might find the focus of attention and intention of action are highly attuned.
- Body attitude and effort quality tend to develop towards close attunement.

17 Group DMP Models: The Chacian model

- Derived from DMT pioneer in USA Marion Chace
- Worked in psychiatry in the 1940s and 1950s
- Employs a circle of movers with a therapist
- Music normally included
- Used a strong and clear structure of form and pattern
- Can be for all or only one part of a session
- Movements from individuals develop group cohesion and a sense of belonging
- Therapists reflects back via mirroring individual movements to be mirrored by the whole group at the same time

18 Curative
factors DMP
groups: Early
Seminal Research

Schmais, C (1985) Healing processes in group dance therapy. *American J Dance Therapy*, 8, 1, 17–36.

Reviews literature on curative factors in verbal group therapy and develops a rationale for **eight healing processes** in group dance therapy (Chacian circles):

Synchrony

Expression

Rhythm

Education

Vitalization

Integration

Cohesion

Symbolism

19 Group DMP Models: Authentic Movement (AM)

- Begun by USA DMT Mary Whitehouse
- Uses a very open structure of following movement associations while witnessed by a group member
- Although often practiced in dyads the group model equally powerful
- Mover and witness, mover has eyes closed
- An amount of time is agreed for moving
- Movers move anywhere within the space including behind witness/therapist
- Each mover speaks of any significant moment/s and subsequently asks for witnessing from the therapist
- Can add a transition time

20 Group work in AM

1. **Breathing circle:**

- The amount of time and the number of movers is agreed for moving at the outset.
- Several witnesses and the therapist hold the circle in which an agreed number of movers move - the first breath.
- For the second breath the witnesses become movers and movers become witnesses in a silent changeover, followed by a transition.
- Therapist remains constant for both breaths.
- Verbal processing of first breath, then second.

2. **Long circle:**

- An overall duration is agreed beforehand.
- A circle of witnesses from which any one witness can become a mover at any time for any duration and for number of times.
- Transition and then verbal processing in chronological order of movers.

21 Research AM
Lucchi, B (2018) Authentic
Movement as a training
modality for private
practice clinicians.
*American J Dance
Therapy*, 40:300–317

What did clinicians learn which helped them?

- **Identification of experiential feeling states** which may have been repressed, denied or disassociated; of personal material in the witness which *may* originate in the mover from unconscious projections
- **Containment, mobilisation and the returning** of projections in ways which can be internalised without splitting or projective identification
- **Mastery of countertransference** reactions; **Differentiation** of personal material from others'
- **Unlocking of repressed affects** (which could impede the development of the relationship with the unconscious) to improve capacity for symbolisation
- **Symbolisation** which occurs when images and associated affects reunite in a differentiated form. **Linking** of images with associated affects for symbolisation
- **Processing, understanding and differentiation of bodily-felt experiences**
- **Disclosure of personal reactions in witness** which feeds mover to be more conscious and helps witness evaluate accuracy of her/his responses to their mover facilitating self/other differentiation
- **Witness function as the 'observing ego'** both of which need the internalisation of a positive object to be recognised for healthy functioning (could be group leader) in preparation for the witness role
- **Establishment of internal witness** helps movers to maintain conscious connection thread whilst in unconscious realm; **Internal** witness becoming a non-judgemental, non-intrusive observer of mover which can enable the mover to observe their feelings, thoughts, movements, sensations and images; **minimisation of** over-identification with symbols from unconscious if strong internal witness
- **Deepening the relationship to the unconscious; suspension of the super ego** so unconscious activity forced forward, conscious in background

Self-referential language of the witness aims to:

- Keep focus of exchange on the experience of the mover; own projections and interpretation; enable movers to take or leave information; minimise defensiveness; provide for an open dialogue to find meaning in symbolic expression; gain insight into self and other relationships; stay close to feelings to enhance emotional repertoire and capacity to contain issue

22 DMP as
personal
development
groups: Early
research

- All masters programmes in the UK and some countries contain a PD group
- 1.5 hours weekly over two years
- Facilitated by an experienced DMP uninvolved in assessment/teaching
- External supervision is usually provided for the facilitator
- All material arising in the group is confidential
- Viewed as an 'as if' therapy group

23 PD groups in DMT
post graduate training
- a research study
(Payne, 1996, 1999,
2001a/b, 2002, 2004,
2008)



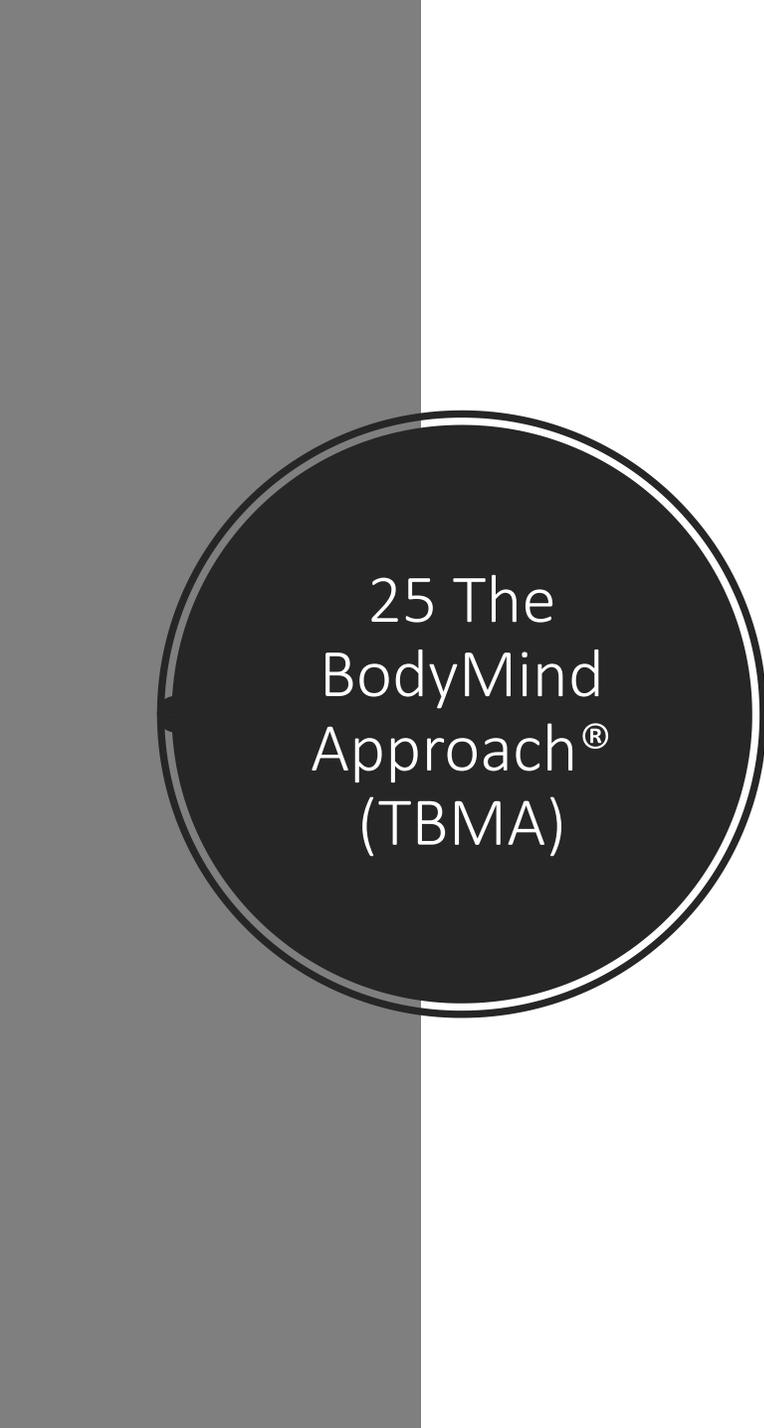
Qualitative - thematic analysis,
years 1, 2 and follow up year 3
post training, N=7, 36 semi
structured interviews

Loss, anger, physical contact,
sexuality, experiencing the
DMT method, safety, becoming
a client and practitioner.

24 Groupwork for
people with
medically
unexplained
symptoms (MUS)

Characteristics of people suffering MUS:

- 50% more consultations and healthcare costs
- 33% more hospitalisations
- Uncertainty /Unnecessary procedures
- ACEs, tendency towards insecure attachment
- 70% depression (Malhi 2013)
- Health anxiety/anxiety
- Social isolation

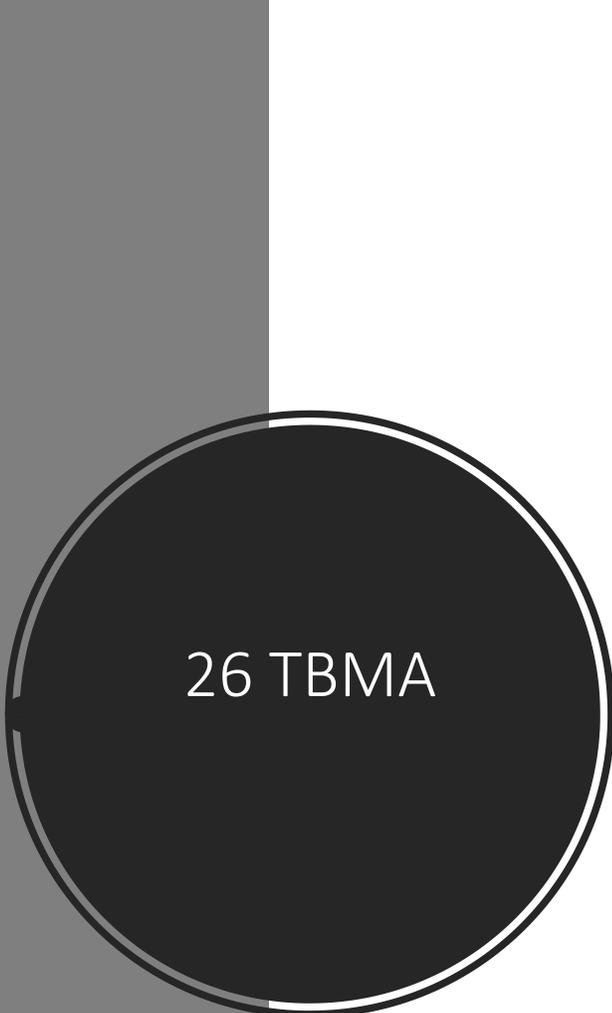


25 The
BodyMind
Approach[®]
(TBMA)

Derived from DMP adapted for people with chronic bodily symptoms for which no medical explanation (MUS)

Tested in NHS, evidence-based, research-informed (Payne, & Stott, 2010; Payne, 2012; Payne & Brooks, 2015, 2016, 2017, 2018, 2019)

It aims to shift experience of symptom/s, changing the relationship, perception and mind-set to cultivate the **self management** symptoms to unlock wellbeing to live well



26 TBMA

Informed by research in attachment, mindfulness, self-management, group psychotherapy TBMA is a facilitated group process emphasising lived experience of symptom as an avenue for transformation (Payne et al. 2019)

Framed as experiential group learning

Transforms seeing symptoms 'enemy' to embracing them as 'ally'

Caring for the self is initially modelled by the facilitator

Practices compare symptom sensations with other areas of the body as functioning and positive to create a balance

27 Safety and MUS

In Maslow's (1943) hierarchy of needs for self-actualisation the first is physiological then comes safety needs followed by a sense of belonging.

Insecure attachment often found in people suffering MUS means a sense of belonging is missing, maybe because social engagement is too difficult.

We know reliable safety is crucial to allow social engagement to occur.

When safety and wellbeing is threatened, as in MUS, there is a greater need for safety to reduce the activation of the stress adaption response of mobility (Porges, 2018).

In people with both MUS and insecure attachment the need for safety is even more critical (Payne & Brooks, 2019).

Hence the group needs to be a safe place, non-threatening and social to give a sense of belonging .

No one need disclose their symptom/s which helps enable experimentation and exploration of symptoms.



28 Safety
needs met in
TBMA

The TBMA group gives permission to share intimate personal stories.

Participants share & discover common experiences, feel less isolated, make friends, often meet up following the group in line with group identification and group attachment.

Smith et al., (1999) explain subsystems and functions regulating one-to-one attachment

Including seeking support, responsiveness and emotional disclosure

Thus careful preparation to beginning/ending of sessions/ programme

Individual pre-group consultations with the facilitator, an action plan post group and non-face-to-face contact every 6 weeks for 6 months.

The group's capacity to act as an attachment object and provider of security can affect neural integration down-regulating participants' emotions by being a regular, steady influence in their lives.

Porges' Polyvagal Theory concludes that human social interaction combined with taking the psychological mind-set into account in interventions turns off the sympathetic fight/ flight response.

The calming of the sympathetic nervous system and feeling listened to enables safety to engage in the play, self-reflection, self-regulation and self-management (Porges, 2003).

- For people with MUS insecurely attached the group can act as a support towards learning to make healthy attachments in a safe setting.
- The TBMA group acts as a source of peer support rather than support from one health professional
- Friendships test out and strengthen the ability to form more secure attachments.
- Group solidarity and approval develop, encouraging each other towards improvement.
- The group shares goals .
- These shared goals/beliefs help form group identity, rationale for the sense of belonging, the protection offered, and the group's continuous existence through the bond created (Bar-Tal, 2000).
- For the MUS population which often experienced isolation group can be a 'comfort blanket' bridging them into a different world of experimentation and exploration.
- Groups may be self-selecting since people who avoid attachment or anxiously attached may filter themselves out before committing.

29 Attachment and MUS (Payne & Brooker, 2019)

30 RESEARCH AND PRACTICE- BASED EVIDENCE

Based on research study of TBMA (Payne & Stott 2010) (N=21)

Accounting for conversion and dissociation (Lin & Payne 2014)

Women with/without depression (Lin, 2016) (N=24)

Practice-based evidence (QIPP project) (N=16) (Payne 2015; Payne & Brooks 2016)

Practice-based evidence (N=30) Payne & Brooks (2017)

Practice-based evidence (N=18) Payne (2018); Payne & Brooks (2019) in review

RCT pilot in the corporate world (N=6) showed similar outcomes

Over 90 patients mirror research outcomes

31 Outcomes reliable change study (Payne & Brooks 2017)

73% of people who engaged reported **lower levels of symptom distress, anxiety and depression, higher levels of wellbeing, overall functioning and activity**

95% of people **completed** the clinic groups

97% of people **would recommend the clinic to friends and family** without hesitation



32 Shim et al. (2017) A model of dance/movement therapy for people living with chronic pain. *European Journal of Integrative Medicine*, 9, 1, 27-40.

A mixed methods study to test and refine a preliminary model towards building a composite model of DMT for pain resilience (N=22). 10-week group DMT intervention.

Quantitative assessments of resilience, kinesiophobia (fear of movement), body awareness, pain, mood, stress, relaxation
Qualitative data were collected and analysed according to grounded theory method and compared with the quantitative findings.

Results- statistically significant improvements in resilience ($p < 0.001$), kinesiophobia ($p = 0.03$), body awareness ($p = 0.02$), and pain intensity ($p = 0.03$) over time.

68% of people felt 'moderately to a great deal better' post intervention. Significant within-session changes in mood, stress, relaxation, and pain.

Key mechanisms - activating self-agency, connecting to self, connecting to others, enhancing emotional intelligence, and reframing,.

Conclusions - Group DMT is a promising treatment for chronic pain through dynamic mind-body pathways. The quantitative findings should be interpreted with caution due to the small sample size and the lack of control group. More substantive and methodological work is required such as utilization of a large scale randomized controlled trial and mediation analysis is needed to further refine the model (Shim et al., 2017)

Questions

- ?



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