Finding the Best Psychodynamic Support for Dance Movement Therapy

Sandra Kay Lauffenburger

Abstract

Dance-movement therapy (DMT) focuses on the power of expressive movement. Nonetheless, many dance-movement therapists have found through personal, clinical and supervisory experience that movement must be supported with appropriate language in order to be therapeutically effective. Evolutionary theory also supports the need for movement and language. This paper suggests that a psychodynamic language is needed, but it must mirror and support the elements of and values within DMT. Although many psychoanalytic theories may contain some therapeutic concepts common to DMT, ad hoc theory picking is not good practice. A single theory, which can provide comprehensive theoretical support for DMT, is needed. Self-psychology is recommended as the psychodynamic language which holds the most parallels with DMT as well as applicability to a range of populations.

Keywords: Psychodynamic, dance movement therapy, self-psychology, affect, intersubjective.

The power of expressive movement is the core of dance movement therapy (DMT) philosophy. In my personal journey, movement 'kick started' access to my self. However, I found the 'talking' that occurred within a psychodynamically-oriented therapeutic relationship absolutely necessary to fully connect to my self. The same need is visible in my DMT students and supervisees. They ask for help with movement and words.

I present an argument for DMT training and practice to connect more completely with words, beyond the need to communicate with each other and with other professions, and beyond describing what we do with clients. We already have a theoretical language for movement observation, analysis and research: Laban Movement Analysis/Bartenieff Fundamentals.

However, we also need a theoretical language that informs us about the relational complexities and psychological processes and interactions with which we work, in particular, a focus on the healthy intersubjective self, rather than on pathology, conflict, or objectified relations.

I propose that DMT incorporate the psychodynamic theory of Self-psychology (SP) because of its parallel to DMT's empathically-attuned, experience-based work. SP can provide theory and guidelines to deepen our effectiveness in making connections that are meaningful to our clients.

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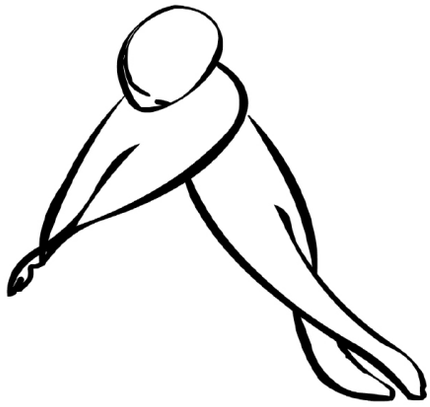
Examining our words

Conferences such as *Weaving the Threads*, held in November 2007, are wonderful examples of DM Therapists' ability to

use words. But the words we use seem to focus primarily on movement. The following statements, drawn from DMT's 'theory of therapeutic process' (Prochaska and Norcross, 2007. p. 36), or what DMT believes to underlie growth and change, show this bias.

- movement expression of the individual is reflective of their intra-psychic processes
- changes in movement expression will result in personality or behavioural change
- greater range of movement potential expressed translates into greater adaptability to cope with change.

Does our theory rely too heavily on movement alone to create change? This question comes from my clinical experience, as exemplified in the following example. My client Dan[i] started our sessions sitting in a three-dimensional diagonal posture, which I named for my own reference, the 'X' posture.



He would twist his torso and legs so that they extended along one line of the X and his head, eyes, and arms would follow down the other. He often rocked in a slow subtle rhythm reminiscent of a sucking rhythm (oral indulging, Kestenberg, 1999). This rhythm often occurred in his hands as he rubbed thumb and forefinger together. Sometimes the sucking rhythm shifted to a straining (anal sadistic, Kestenberg, 1999), visible in the opening and closing of his fists.

From this description it might be surmised that Dan was experiencing several affective states:

- attempts to self-sooth his anxiety (reflected in the slow rocking rhythms),
- feelings of anger and a wish for control (fist clenching) and
- shame/dislook (the affect that causes us to glance away) that may have been an attempt to shield the other feelings from view (the downward gaze and twist which hides the body/face in the X posture).

The therapeutic decision was where or how to intervene. Exploring ANY of these feelings or movements in the therapy led to an absolute 'NO GO Zone' and a halt to therapeutic interactions. Despite Dan's clear body level presentation, words saved the therapy. My psychodynamic understanding of the affect of shame, of attachment styles, and of relational (transferential) processes of an obsessional client guided me more effectively than movement theory alone.

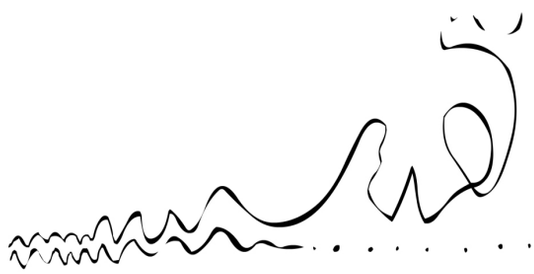
Bloom discusses the problem of change resulting from corrective emotional experiences or catharsis:

> *An underlying assumption occasionally associated with DMT is the suggestion that, through a cathartic experience in a movement session, a patient can regain a fundamental sense of wholeness and that through*

> *this experience something can be irrevocably changed. This idea of sudden transformation, which may or may not have any verbal insight connected with it, is probably misleading in terms of the way therapy of any kind actually works, and the time it takes to effect lasting change* (2006, p. 36).

Bloom makes two important points. First, cathartic or emotional release may give temporary relief to the client but it is not long lasting. Second, true change, in other words long lasting change, requires both affective expression and verbal insight. My clinical experience agrees with these conclusions. For Dan, affective expression emerged only after many months of regular sessions where I was simply talking 'with' him. Psychodynamic, attachment, and affect theories informed me how to 'be with' him. Thus, theory, before expressivity, led us toward a more satisfactory therapeutic outcome.

In contemplating the place of movement, expressivity and psychodynamic theory, another long term client comes to mind. Hanna came from a dance background, having trained in her youth at a performing arts school in Europe and, as an adult, had pursued a range of dance styles and somatic movement therapies. In an early session Hanna showed me pictures from her dance career. Photos of her performing at age four showed an expressive child. A video of her dancing as an adult demonstrated she was capable of multiple bodily rhythms as well as complex carving and shaping.



In an early session, I invited Hanna to move. Together we started from a simple mutual rhythm. Then Hanna's dance progressed from simple short phrases with repetitive rhythms and diminished efforts to extensive and complex phrases with variable crescendos and emphases, as well as high intensity efforts. She sustained this evocative dance for many minutes. Then she spontaneously stopped, looked me in the eye and said accusatively, 'Did it all wrong, didn't I?'

Hanna's dance showed a desire to break free, do it her own way, in her own time. In addition, it showed a difficulty with regulating the intensity of her feelings. Hanna suffered unrelenting chronic pain from the tension of muscles held tightly in ongoing vigilance and fear. Hanna had acquired a pathological accommodation in order to survive a perilous childhood and young adulthood. She had learned that her creative impulses were 'wrong'; that she must do it 'right' (in the eyes of the other) in order to ensure receiving needed support. Psychodynamic, attachment, and affect theories again informed me where we were developmentally and therapeutically. These theories also alerted me to the effects of the depressed and shaming milieu Hanna's early caretakers provided.

Although Hanna's dance showed me the essence of her therapeutic needs, her words suggested that no matter how often I might find delight in her dance, we would stay trapped in the transference/ countertransference of pathological accommodation. Hanna needed a vocabulary to connect her to her pain and the associated compliance. I needed theoretical support to guide me through the complex issues without retraumatizing her through shame or remaining stuck in intersubjective accommodation. Hanna could do the dance of change, but could

NOT change until we connected the verbal dots. Without words, Hanna's movement expression and the problems in her life remained unconnected.

These two cases demonstrate the ongoing dilemma inherent in working as a DM Therapist. Understanding psychodynamic relationships, theories of infant development, attachment, affect, trauma theory, and neuroscience as well as movement is absolutely necessary. Training in these theories is equally necessary for work with most DMT populations. For example, understanding the meaning and use of transitional objects aided one of my supervisees to work more effectively with an older male with intellectual disabilities.

In this case, when rubber balls were used in the DMT session, the client would become possessive of the balls, and enraged if another person kicked the ball or hit it too forcefully. The institute staff had decided that the client didn't know how to share and was too aggressive. However, using a Self-psychological psychodynamic case formulation, this therapist and I were able to understand that the client needed to protect his 'ball family'. His rage was not aggression, but the protective instincts of a 'good father'. Understanding the client in this way, using Self-psychological theory, altered the therapist's interventions. Her client's behaviour changed almost immediately, and he began to meet behavioural goals, and display improved relational interactions.

The neuroscientific origins of words and movement

In my own DMT training, I was given the impression that we dance movement therapists do not always need to use words with our clients; movement is all that is needed. This implies that healing is a one way process where changes in movement lead to changes in mind. Evolutionary evidence shows that this is not the case. Llinas, a Nobel Prize winner in Medicine and Physiology, researched the development of the nervous system and brain. He showed that 'motoricity' is the evolutionary motivation behind this development (2001). Movement is the reason we have a brain and nerves, but movement is only the beginning.

Llinas' thesis is that motoricity developed when plants and animals diverged evolutionarily. Both survived, but each evolved a different strategy to do so. Plants became sessile or fixed in one place, whereas animals developed a strategy of movement. This complex activity of 'motoricity' required a nervous system. The Ascidiacea or sea squirt exemplifies the point of evolutionary divergence. This organism has a larval form that swims freely, albeit for only a day. During that time, it has a neural ganglia notochord (or primitive spinal chord) of 300 cells that sense its surrounding via an organ of balance (ear) and light-sensitive patch of skin (eye). When the larva finds a suitable location, it attaches itself and adopts a sessile strategy for survival, becoming a filtering device. Once stationary it absorbs its primitive nervous system into its digestive system (Lee, Rountree, and McMahon, 2008). Thus the evolutionary development of a nervous system seems to be an exclusive property of actively moving creatures (Llinas, 2001, p. 17).

The evolutionary advantage of movement and brain/nervous system is not only the ability to escape but the facility for anticipation, prediction, and planning. An organism has a distinct advantage if it can understand, learn, and remember the behavioural patterns of its environment, particularly of its food sources and

predators. However, the organism must be able to communicate this understanding and information to other members of the species. Movement must be paired with memory and communication tools. The therapeutic implication is twofold: movement does form the essence of our self and without a way to perceive, encode, understand and communicate patterns of movement we work with only half of the self.

What words does DMT need?

We have many choices for 'words', but need a way to organise and choose how to use the evocative metaphors and the Laban/Bartenieff language. Movement must be placed in the full context of human expressive capacities. Greenspan (1997), a paediatrician specializing in developmentally-delayed children, emphasizes that assisting **affective communication** is the essence of therapy. Humans actually express affect continually, but are not always understood by colleagues, caretakers or therapists because of the form and intensity in which expression occurs. Greenspan identified a developmental spectrum of affect representation which includes somatic expression, expressive motoric action, symbolism/imagery, as well as verbal/abstract representation (Table One).

Greenspan (1997) suggests that therapy's aim is an integration of thoughts and feelings. He argues that, neuroscientifically, this requires the integration of the neocortex and limbic system, which paves the way for structuralization of new behaviours (1997). This table is not to be understood as a linear hierarchy that moves from body to mind. Rather, it is simply a representation of the spectrum of expressivity available to human beings.

Table One – Adapted from Greenspan's Levels of Affective Communication
(Greenspan, 1997, p.229)

Levels of representation of Affect	Description
Somatic/ Prebehavioural	*Regulation and interest in the world* *Manner of engagement* *Physiological response*
Behavioural/Motoric	*Simple/complex gestural communication* *Direct discharge of behaviour*
Symbolic	*Pretend play sequences* *Visual imagery* *Dreams* *Free associations* *Spatial communications*
Abstract/Verbal	*Verbalization of affective states which include both affective and cognitive meaning and refer to specific differentiated feeling states*

It reminds us of what we DM Therapists know: that we are always working toward a full range of expressivity. We must be able to feel and understand body-based signals and behaviourally engage with our feelings. We need symbolic representation to creatively communicate our feelings. We need abstract verbalness because we are a verbal species. DMT excels particularly at the somatic, motoric, and symbolic levels of representation. In adding abstract words and supportive theories, our effectiveness can but increase. Nonetheless, we seem uncomfortable in this realm.

Often words, particularly psychological theories feel 'distant' from actual experience. Many theories, such as Freudian psychoanalysis or Klein's or Mahler's ideas, are difficult to 'see' or 'feel' in the movement processes with which we work. For example, many DMTs quote the famous Freudian statement that 'the first ego is a body ego'. But what does 'ego' look like in DMT? How or where can we use such an idea in our interventions? Any theory (or words) that DMT embraces must add meaning to our work.

Psychodynamic theory

Psychodynamic therapy focuses on unconscious processes as they are

manifested in an individual's current behaviour. The goals of psychodynamic therapy include the development of client self-awareness and an understanding of the influence the past has on current behaviour. Importantly, it relies on the interpersonal relationship between client and therapist. The theory supporting psychodynamic therapy originated in, and is informed by, psychoanalytic theory. Currently there are four major schools of theory which have influenced psychodynamic therapy: Freudian, Ego Psychology, Object Relations and Self Psychology. Each of the four schools presents discrete theories of personality formation, psychopathology formation and change, and techniques by which to conduct therapy.

Because we can already use words that metaphorically, evocatively, graphically, and/or narratively describe our client's movement, the words we particularly require are ones that aid us to understand the transferential and intersubjective relationships that we experience in therapy. Siegel (1984) notes the potential damage of not having the theory to guide us in understanding relationships.

> *Movement is an aspect of human experience that bears the imprint of past life but is subject to influence in the present. By focusing primarily on movement in its expressive aspects, DM Therapists unwittingly propagate the splits that verbal therapies also foster. By ignoring or downplaying the intellectual and cognitive functions of their clients, they shift the emphasis from one aspect of human behaviour to another. Thus, the split between body and mind frequently remains, to the detriment of the client's further evolution* (p. 3).

Additionally, DMT needs theoretical understanding of the client's coping mechanism (or defences), understanding of the process of change and of maintenance of change. These deficiencies can be resolved by incorporating psychodynamic theory.

A truly supportive psychodynamic theory could reduce the therapist's anxiety. Therapist anxiety often bubbles beneath the surface and manifests as the inability to stand in the chaos of the therapy or as feelings of inadequacy. Anxiety can occur because the therapist is 'lost', in other words, does not know where she and the client are in the therapeutic process of change. A conceptual framework for relationship/transference and change allows the therapist to remain engaged and empathic with the client, connected to the therapeutic process and not distracted by anxiety.

Anxieties permeated my clinical experience prior to psychodynamic training. Now as a DMT supervisor, I also encounter the anxiety of supervisees. A supervisee, Sue, is a talented and experienced DMT. However, she found herself ready to give up on a traumatized and abused client. Sue told me she felt lost, frightened, and drained. She knew her client's experiences were resonating with her own past history, but felt lost in the patterns of relationship that were unwittingly playing out with her client. Empathizing with her feelings, I hypothesized the psychodynamic processes that she and her client were repeating. Translating these theoretical ideas into movement and verbal interventions, Sue recovered her own self, reduced her anxiety, stayed engaged with her client and found a way forward for the therapy. The psychodynamic framework provided the grounding for Sue.

However, understanding transference is only part of what a useful psychodynamic

theory offers. Theory must also mirror and support DMT's values and philosophy of intervention. DMT values

- empathy – via attunement and mirroring in both verbal and non-verbal realms,
- affective expression,
- the subjective experience of the client,
- the dyadic process occurring between client and therapist,
- belief in the integrative process of expressive movement,
- play, creativity, and positive affect as a developmentally-appropriate, growth experience.

It is important that the psychodynamic theory we choose embraces and expands these ideas.

Which psychodynamic theory?

Three major components underpin therapeutic change and growth: understanding, meaning, and relationship. **Understanding** requires attunement to one's own and the client's body and verbal processes. **Meaning** involves the historical and present day stories that unfold in the therapy and how they link to each other. **Relationship** is the intersubjective process in which both the client and therapist contribute to meaning, difficulties, and pathology as well as to healthy growth.

Although as DMTs we work with relationship, we do not have a sufficient framework for understanding what is occurring within that relationship. Bloom (2006) suggests that psychoanalytic[ii] thought is needed if DMT is going to have the words to understand these relationships, particularly the relationships between therapist and client, and the client and their self.

> *Psychoanalytic thinking, by informing the intersubjective relationship between therapist and patient provides a window through which insight into the transference and counter-transference processes in DMT can be made more conscious and available for thought. In addition, the psychoanalytic perspective, by providing words to mediate between physical sensation and turbulent feelings, makes it more possible to tolerate and reflect on experience* (p. 205).

DMT's unique offering is the ability to enter the subjective, feeling world of our clients through the use of the embodied self. This experience-near, bodily form of empathy is central to DMT; thus it must also hold the central place in the psychodynamic theory we choose. Unfortunately, many psychodynamic frameworks use experience-distant ideas which ignore the physical immediacy of our work. Psychodynamically, DMT requires a theory that

- holds empathy/attunement as central,
- provides experience-near ideas for the relationships and interactions we encounter,
- guides the process of internalization of growth and change,
- embraces play, creativity, and expression of feeling, and
- ideally provides a non-shaming theory of defense/coping mechanisms, personality and pathology.

A number of psychoanalytic/psychodynamic theories exist to choose from. Many contain specific elements common to those important in DMT theory. Post-Freudian psychodynamic theory has benefited from a number of theorists and theories, including Horney (1950), Winnicott (1970), and Stern (1985) who have provided developmental perspectives; Schore (1994) who highlighted the importance of affect

regulation; Meltzer and Williams (1988), who focussed on aesthetics within the therapeutic process.

The argument offered in this paper is that DM Therapists already undergo significant amounts of training in DMT theory, thus being fully versatile in a variety of psychodynamic theories is daunting and more importantly unfeasible. Ideally, we need a psychodynamic theory that contains more than a useful element or two; we need a useful theory that closely parallels the theory and practice of DMT and provides the most support.

The Psychology of the Self (SP), developed in the 1970s by Heinz Kohut, meets these criteria. Five basic postulates define this psychodynamic theory; the most central of which focuses on empathy (Lee, Rountree and McMahon, 2008). SP, like DMT, recognises that the most important therapeutic 'data' is the client's subjective, feeling state. SP obtains this non-objective data using empathy, which Kohut defined as 'vicarious introspection' or thinking, feeling, and sensing our way into another's world as if it were our own, but without losing our self (Kohut, 1972).

SP sees empathy as being a data-gathering tool, not an intuitive trait of the therapist. In practice, empathy has both a direct and an inferential component. Direct perception occurs primarily at an affective level where the therapist reads the face (and body posture) of the client and receives information on their state of mind. The theory of direct perception is supported by research in affect theory (Tomkins, 1962, 1963), facial recognition and communication (Ekman, Levenson, Frieson, 1983), infant facial mirroring (Beebe and Lachmann, 2002), and mirror neuron discoveries (Gallese, et al, 2007; Ramachandran, 2006; Wolf, Gales, Shane and Shane, 2001). The inferential component is a relatively cognitive process occurring in the therapist's mind and is based on their experience with the client as well as their experience as a therapist. Both of these aspects are employed to understand the client's emotional and mental state.

Most critically, SP postulates that empathy is the experience of the client. Contrary to most psychotherapy training, empathy is NOT seen as an action or skilful behaviour of the therapist. Of course the therapist does his/her best to attune to and understand the client. This is similar to 'good enough mothering' (Winnicott, 1974) where the mother continually does her best, recognizing that 'getting it wrong some of the time' is inevitable. In that mother-infant dyad, it is not the mother who determines the empathy, but rather, the baby lets the mother know if she/mother has correctly understood the need for food, nappy change, or a burp. Self Psychology's client-focussed theory of empathy parallels the attunement process of DMT better than any other psychodynamic/psychoanalytic theory. It also prevents the sort of trivialized acts of reflecting or parroting words (or movement) back to the client, a process which ultimately led Carl Rogers (another key figure associated with empathy) to frustration and disappointment (Vincent, 2005, p. 33).

The other four postulates[iii] of SP are

- A theory of the dyadic process between client and therapist, termed the 'self-object experience'. This concept provides useful theory regarding both classical (historical) transferences and growth transferences (self object functions). The self-object concept draws on infant research, attachment theory and Intersubjectivity theory.

This concept aids the DM Therapist to understand and recognise the multiple relational processes occurring in the therapy and provides language to discuss this complexity and develop effective interventions.

- A theory of healthy and dysfunctional Self. Unlike traditional psychoanalysis which sees the basic cause of pathology as an intrapsychic conflict, SP recognises that the self is strengthened or weakened as a result of the experiences occurring in relationship. For SP, the goal of therapy is strengthening the nuclear (or core self) so it can function cohesively in the external (peripheral) world. SP recognises that strengthening of the nuclear self must occur in relation and actively focuses on the core invariants of self-agency, affectivity, cohesion, continuity and vitality. This postulate aids the DM Therapist in better defining and measuring the goals of the therapy, as well as recognizing where they are within the therapeutic process.

- A theory of feelings and affectivity. SP recognises that affectivity enlivens the self, and unlike the currently popular CBT (cognitive-behavioural therapy), sees affect as the essence of therapy. Cognitive-behaviour therapy (CBT) is a form of psychotherapy that focuses on changing unhelpful or unhealthy thinking habits, feelings and behaviours. CBT involves the use of practical self-help strategies, which are designed to bring about positive and immediate changes in the person's quality of life. CBT was primarily developed through a merging of psychological behaviour theory with cognitive therapy. While rooted in rather different theories, these two traditions found common ground in focusing on the "here and now" and symptom removal. Some CBT therapies are more oriented towards predominately cognitive interventions while some are more behaviourally oriented.

Theory for this postulate comes from the work of Tomkins (1962, 1963), who drew on the observations of human expression and emotion made by Darwin (1872), to build a theory of affect. It also draws from infant research, recognizing that affect regulation and modulation take place within dyadic experiences (Stern, 1985; Schore, 1994). In Affect theory, affects are understood as the biological portion of emotion, or hard-wired, preprogrammed, genetically transmitted mechanisms that exist in each of us. When triggered, this mechanism precipitates a known pattern of biological events. However, it is also acknowledged that the affective experience is a result of both the innate mechanism and learned responses that are a result of environmental modelling.

This postulate informs DM Therapists' appropriate responses to the nine 'hard-wired' affects (Tomkins, 1962, 1963). Each affect has a preferred responsiveness style which supports the client's development of affect regulation and modulation. And because SP values the affects of joy and interest, it is able to support play and creativity which are key to healthy growth and development.

- A theory of internalization and structuralization by which permanent changes in behaviour, thought, and feeling can be understood. If a psychotherapist ignores this component, it can leave the client dependent on on-going therapy because appropriate learning has not yet taken place. DMT is a subjective process which is not easily quantified. With the current

focus on 'evidence-based practice', DMT can struggle to sell itself as a viable model. The value of this postulate for DM Therapists is the ability to define and document change, as well as ensure maintenance of change.

Conclusion

It is beyond the scope of this paper to explicate the entire theory of SP, or to completely compare and contrast SP with other psychodynamic theories in relation to DMT. Obviously, well-documented applications of SP to a range of DMT populations are also needed. Examples have been offered of 'normal neurotics' and 'special needs' clients who benefited from the application of SP. The intent of this has been to offer a preview of the possibilities and not to restrict the use of psychodynamic theory to clients who choose a verbal (rather than movement) modality. As there are parallels between the values and approaches of Self Psychology and DMT, this discussion has hopefully provoked the reader to explore Self Psychology's theory within their DMT practice, most ideally through supervision[iv].

Illustrations: Lisa Roberts

Footnotes

i. Case examples used in this paper are used with permission. Names and details have been altered as appropriate to prevent identification.

ii. Bloom (2006) uses the term 'psychoanalytic', which the author reports faithfully. However, it must be noted that this author prefers the term 'psychodynamic' because historically post-Freudian or neo-Freudian theories are more commonly referred to as 'psychodynamic' (Prochaska and Norcross, 2007, p. 62). Heinz Kohut's Self Psychology is a post-Freudian psychoanalytic theory.

iii. **Postulate** is used consciously as it is the term that Self-Psychologists have given to the five core tenets of Self Psychology. This terminology is used in the Lakatosian manner (Lakatos, 1970).

iv. This author recognizes that the range of application of Self psychology to DMT is currently undocumented. However, it is hoped that several case examples will be written up in the next year or two. This author is highly interested in exploring this theoretical marriage and can be contacted for phone or face to face supervision.

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