Moods, Moves and Mudras: A bi-cultural approach to dance movement therapy

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SYNOPSIS

Combining academic research with experience in the field, *Moods, Moves and Mudras* will examine the implementation of models of dance movement therapy drawn from experiences in the UK and from using the Sampoornata model pioneered by Kolkata Sanved in India. It will reflect on efficacy, challenges and opportunities for future learning through the author's work with five participant groups in short-term group therapy. The paper will frame understanding through an exploration of the interface between theory and practice, the process of mapping participant growth, the implementation and communication of session theme and the impact of therapeutic relationships.

Key words:

movement across cultures, dance movement therapy models, Sampoornata, trauma

Background

I was inspired to train as a dance movement (DM) therapist after many years of working in the global south with survivors of trauma, disempowerment and poverty. Witnessing the impact of trauma, poverty and abuse upon communities, I became acutely aware of the need to enhance my existing skills as a community dance and social circus specialist with a greater focus on psychological wellbeing. I returned to the UK to train, working with notable refugee organizations, Helen Bamber (www.helenbamber.org) and Lewisham Refugee and Migrant Network, (www.lrmn.org) as well as in a school for children with emotional and behavioural difficulties/disorders (EBD) who have been excluded from mainstream education. Recognizing the limitations to the UK approach, particularly when working in culturally and linguistically diverse (CALD) environments, I moved to Kolkata, India, to study with Kolkata Sanved (http://kolkatasanved.org/).

There, I discovered the Sampoornata philosophy of dance movement therapy (DMT), which defines itself as a human rights based approach. Through my work with a number of client groups (see Tables 1 and 2, p.21 and 23), and my own therapeutic journey, I began my exploration into the two methodologies, reflecting on their similarities, their differences and their relative weakness and strengths. I began to meld the two, celebrating the intercultural process that pervades a shared creative space and my ongoing commitment to supporting the implementation of dance movement therapy globally.

Stylized into dance, movement is omnipresent across cultures: in entertainment, ritual, healing and celebration. It is non-verbal communication that allows us to recognize the joy or the sorrow behind a smile, the tension in a clenched fist, and the frustrated embarrassment in an out-of-practice run to a departing bus. Through the body we remember, relate and understand; a process which can be positive, such as a gentle touch, or a deeply distressing and disempowering violent rape. Our body is the place of memories. It is also the medium through which we are disempowered,

because of our gender, our appearance, our ability.

In these ways, our lives are defined by the body moving. DMT, a psychosocial movement- based creative therapy, works from the belief that the body and mind are inherently integrated. Meekums (2002) defines its key theoretical underpinnings as drawn from the following sources:

- 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 participant's movements (Chaiklin and Schmais, 1979, Stanton and Jones, 1992).
- Movement contains symbolic function and as such can be evidence of unconscious processes (Schmais, 1985, Stanton-Jones, 1992).
- Movement improvisation allows the participant 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).

(Meekums, 2002, p. 8.)

DMT is a process of working through the body, that which is done to, and experienced through, the body. Whether one moves through something as representative as a mudra or as metaphorical as a seed growing, one is communicating through movement. It is an active, empathetic form of therapy, which acknowledges the participant as their own healer. Gray (2011) quotes Whitehouse writing, "Movement, to be experienced, has to be found in the body, not put on like a dress coat. There is that in us which has moved from the very beginning: it is that which can liberate us" (Gray, p. 39).

A BI-CULTURAL FRAMEWORK

After working for many years as a community dance/social circus specialist in the global south, I returned to the UK to study DMT after recognizing the dire lack of mental health professionals in the communities in which I worked. Already, I was well aware of the transformative properties of dance, which provided a deeply empathetic, non-verbal form of communication, healing and understanding. It had allowed me to work with and connect to victims of domestic violence on remote Pacific Islands as readily as I did with child survivors of sex trafficking in Vietnam. Returning to the UK, I found in DMT a deeper capacity for psychosocial rehabilitation and change, grounded in psychodynamic theories, embodied in the self through the intrapersonal concept of therapeutic space. Working in this psychodynamic framework, I found new ways to understand my participants, to share this understanding through standardized demarcations, and I engaged in personal therapy to better understand myself.

Embodying and mirroring participants became an important part of my work. Moving from a 'facilitated' community dance background, to a participant-led process was an important growth; the journey of recognizing the participant as the agent of their own development, which neatly mirrored a global trend of 'community-led' development. A firm understanding of the theoretical backgrounds appealed to me as an academic, putting into context that which I had worked with instinctively for years.

Nevertheless, I felt a disconnect from the model, which relied heavily not merely upon first world luxuries, but upon a rapidly faltering National Health Service. The model felt like a house of cards, about to collapse in situ, never standing a chance in more challenging climes. Being part of a seven-person team supporting a single individual, I recognized that this model of DMT was designed to function in the supportive network of the National Health Service; a network I knew I would not find elsewhere.

I was very grateful to be offered work with the renowned Helen Bamber Foundation, working with survivors of torture and trafficking, but I still found myself in an environment of heat-controlled rooms, steady electricity, an abundance of props, and ample space to move. I knew this contrasted strongly with the single shared rooms the participants returned home to, and even more sharply with the homes from which they had fled. Even at an organization as prestigious as Helen Bamber, I worked with a far larger group than is typically 'allowed' for therapy, as resources, even in the UK, were limited. I knew from having worked with groups of up to sixty children that this was even worse elsewhere. I was fortunate that both Helen Bamber, and the organizations with which I did my internship, recognized the individual as existing in a failing system, and strove to work holistically to provide participants with everything from food to human rights awareness training.

Sohini Charkraborty, founder of the Kolkata based DMT organization Kolkata Sanved, developed the Sampoornata model which addresses many of these drawbacks. A rights-based approach, it lists its core values as: "redeeming the body through dance and DMT, passion for DMT and dance fulfilled, commitment to lifelong learning, freedom, empowerment" (Chakraborty, 2015, personal interview). Using a focused and structured form, the Sampoornata model reflects participants' needs but is not guided by the participants, instead it follows a pre-determined, yet flexible, curriculum. Unlike the UK approach to DMT, the Sampoornata model expressly states empowerment and creating 'agents of change' as intentions. It is adaptable to the diverse settings in which it is conducted, is appropriate for large groups and short-term therapy, and is not held by the strict boundaries that define a psychoanalytical approach.

The philosophies of practice of both the Sampoornata and the UK dance therapy models inform my approach which relies heavily on empathy, embodying and attuning, respecting the participant as an agent of change not only in their community, but also in their own lives. I work towards encouraging participants to discover their own definition of 'empowerment' and their own understanding of what is needed in themselves and in their communities to achieve that state. I believe in creating a safe space, in protecting boundaries as much as possible, in providing a space that is non-judgmental, nonthreatening and democratic. All movement is valid, whether it's the stylized mudra (symbolic or ritual hand gesture) or the rambunctious kick of a football. I believe in demonstrating my unconditional positive regard, and my unwavering commitment to provide participants with the care every human being inherently deserves.

THEORY AND PRACTICE: Interface and Interaction

Doctors, undertaking the Hippocratic oath, promise to, "First do no harm." It is a sentiment that remains a tenet of my work as a DM therapist. An ethical challenge raised in the student study of DMT and the formation of new pedagogy remains the impact of this learning period upon the participants themselves. Yet it is this committed study of theory surrounding DMT and participant groups, paired with an ongoing exploration of the self and effective use of supervision, which is imperative to not merely fulfilling one's duty of care, but actively fostering emotional, social, cognitive and physical integration within participants.

DMT theory can be examined through two lenses, the academic and the experiential. The academic ranges in influences from early psychotherapists to the latest in neuroscience breakthroughs. I found in working with the British psychodynamic approach to DMT that an understanding of psychodynamic concepts and phenomenon is crucial to an effective approach to therapy. A rich body of work, including that of Meekums (2002) and Eberhard-Kaechele (2009), has emerged connecting the spoken therapy of Jung (1875-1961) and Freud (1856- 1939) with the body-led work of Chace (1896-1970), and contemporary therapists Payne (2006) and Rothschild (2011). In comparison, there is little academic literature around the Sampoornata model.

When the scope for theory expands beyond DMT to include other body, play and creative therapies, one's understanding of the field becomes all the more broader and richer. My own work is very much led by Babette Rothschild's bodywork (2011) and the theories around play. I initially drew my understanding for working with people experiencing schizophrenia from Chace's work, recognizing that mirroring and attuning gives the grounded, held and shared experience often lacking from daily lives.

It is important to note that the term 'schizophrenic' is used by the Men's Home staff to broadly describe the participants, but it is the author's belief that this did not always fit the experience of the participants who may well have been diagnosed with a variety of other conditions, including physical disabilities, had they had access to better medical care.

DMT is frequently taught experientially, with learning and understanding gained through a felt experience. The process is itself therapeutic, and the practical and theoretical are melded as we move. Fischmann, paraphases Maturana (1984) writing that "DMT can be seen as an enactive approach..." and "we can only know by doing" (Fischmann, 2009, p. 34). This not only enhances a therapist's 'tool kit' through an expanded repertoire of therapeutic interventions but also becomes integrated in the therapist's own practice and therapeutic process.

The process of studying DMT is in itself a therapeutic process as practice begins with ourselves, and as long as we practice, so it continues. Embedding self-care into our daily lives, responding and understanding through movement, seeking the opportunity to dance, checking the impact of stimuli upon our mind and our bodies, all mark the behaviour of a safe, dedicated DMT. With a strong grounding in academic research and practical experience a good DMT can tailor effective therapeutic interventions to respond to individual participant needs.

The Sampoornata model, in its structure and method, addresses criticism of psychoanalytic methods that they "perpetuate the role of the unquestionable and sometimes unapproachable professional, and consequently disempower and marginalize women, ethnic minorities and other social oppressed groups including people with mental health issues" (Karkou, 1992, p. 36).

Under the Western model of DMT, practice is confined to the session, a rigidly boundaried space outside of which therapist and participant do not interact. With a more open structure as in the Sampoorna method the start of practice becomes less rigidly defined:

Is it our opening ritual of sharing names and clapping rhythms that opened the session, or is it the moment we opened the door? The process becomes part of the space, the interactions between therapist and client more organic and democratic, and the concept that therapeutic movement is somehow separate from daily life becomes eroded.

Table 1. Sampoornata (Fulfillment) Model

Elements	Concerns addressed	Concerns Raised
Opening ritual, warm up, process, free dance, relaxation, healing touch, feedback		
Session plan		Planning for session left practitioners less able to respond rapidly and intuitively to unique participant material
Less rigid boundaries – e.g. time, therapeutic relationships	Allows for cultural concepts of time, logistical challenges, cultural approaches to relationships, privacy, improves visibility and inclusion of therapy in the community	
Mandatory inclusion of participant feedback values participants as 'agents of change', capable of articulating and recognizing their own process	Addresses concerns of 'given therapy', varying understanding of 'self' /'body' in culturally diverse settings	Feedback was highly constrained by cultural/institutional practices, qualitative feedback remains undervalued outside the DMT community
Emphasis human rights, empowerment, democratic process	Addresses concerns of 'given' therapy, imperialist history, diminished access to and understanding of human rights within communities	Stressing a particular ideology left participants less able to choose their own path
Large group work	Allows for practice in low resource, high need communities	
Co-therapists		
Potential for ongoing involvement with Kolkata Sanved - dancer, DMT, office or training	Creates space for therapy to offer both psychological and financial support, improves visibility of therapy in communities	
Short term therapy	Responds to needs of transient population	
'Stand-alone' model	Recognizes lack of support structures within institutions (e.g. social workers, medical staff), and within families (e.g. trafficked children), emphasise a centralized model with regular supervision, stresses self-resilience and reflection	

Sampoornata- Exploring a Session

Sessions, traditionally, follow the pattern of opening ritual, warm up, process, a closing process and closing ritual, a meta-process reflecting the participant's overall therapeutic journey. The Sampoornata model adds the components of free dance (in lieu of a participant-led process), relaxation (in lieu of a closing process), healing touch, and feedback. Within the sessions themselves there are as many variations of forms, activities, and approaches as there are individuals. DMT is a constantly evolving discipline, drawing in aspects of creative arts therapies, psychotherapy and body therapy. It may be assumed that they use movement, dance, and creative expression as means of integrating, healing and empowering the self. Grounding the practice is the experience of being witnessed, held and valued. It is the experiencing, and expression of empathy,

> ….. the therapist's sensitive ability and willingness to understand the participant's thoughts, feelings, and struggles from the participant's point of view. [It is] this ability to see completely through the participant's eyes, to adopt his frame of reference) ... It means entering the private perceptual world of the other ... being sensitive, moment by moment, to the changing felt meanings which flow in this other person ... It means sensing meanings of which he or she is scarcely aware.
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> (Greenberg, Watson, Elliot, & Bohart, 2001, p. 486.)

Beyond this, it is the experience of participating in a democratic, self-initiated creative process and exploring the self through inter- and intrapersonal connections. Props, music and art enhance the session. Working within the UK psychodynamic form, sessions may appear more like play than dance, and follow the emergence of themes and the flow of the psychodynamic relationship. Therapists analyze participants' body movement, using movement to integrate body and mind, and work within the therapeutic relationship to illuminate a participant's psyche, and, with this understanding, work toward a process of healing and change. The Sampoornata model uses a predetermined curriculum following a needs assessment of the group. Employing former participants as DMT therapeutic practitioners the Sampoornata model adds an additional level of practice; it becomes a form of empowerment, independence and social change.

Table 2, (p.23) introduces the client groups worked with during my time with Kolkata Sanved in urban Kolkata and rural West Bengal.

Urban Kolkata

Rural West Bengal

Table 2. Client groups during time with Kolkata Sanved

Group	Night Shelter: Homeless women and girls/ insecure housing	Girls Short Stay: Survivors of trafficking, internal displacement, child marriage	Boys Short Stay: In insecure housing, runaways	Mens Shelter: Living with mental illness homeless, or in insecure housing	Girls: Living in rural villages
Age	10-50	8-18	7-12	18+	12-18
Gender	Female	Female	Male	Male	Female
Group Size	Average 15	Average 12	Average 10	Average 12	Average 6
Open	✓	✓	✓	✓	✓
Float-ing	✓	✓	✓	✓	
# Sessions	8	9	8	8	9
Notes	*Mixed age group (baby to geriatric), all present during session *Invited mothers to join *Street children with family- *mothers work and need safe place for children to stay *Children given food *Access to medical care *Access to extra activities	*Trafficking/child marriage/child labour/abuse PTSD/vulnerable *Additional mental health/learning disabilities *Art therapy/play therapy/psych-social rehab offered Hindi/Bengali *Four caregivers (not participating) *Try to rehouse if parents found. If not sent to longer term accommodation	*Runaways, child labour *Drop-in centre (some have parents at work) *Basic counseling and arts therapies offered *Try to rehouse if parents found - if not sent to longer term accommodation	*Homeless Depression /schizophrenia/ learning disabilities/phys-ical disabilities *Drop-in centre/day work *Attempt to reunite with family *Social work/ craft/physical exercise offered *Highly medicated No aggression Hindi/Bengal *Rotating caregivers *In additional DMT session *Small group participates, the rest watch	*In education *Rural village (risk of child marriage/ trafficking) *Enjoy art Bengali

CASE STUDY: RURAL GIRLS' GROUP

The Rural Girls' Group was the participant group in which I found the greatest participant growth. While happy to dance along to Bollywood numbers as a group, they struggled to use dance creatively, and were unable to initiate movement from an emotive, self-expressive point. Their movements, predominately, were characterized as bound, with an excessive lightness and aversion to sudden, direct movements. While they spoke loudly and expressively, their bodies seemed confined to the patriarchal expectations of discrete and ladylike. Their kinespheres blended into one another and they rarely moved independently. During the initial sessions, they would follow my movements exactly; even during partner mirroring exercises they would invariably return to copying my movements if numbers meant I needed to participate. During the sessions I used a number of adapted children's games to encourage a diverse range of movements; such as, dancing musical chairs, that encouraged the sudden and direct movements that they lacked in daily life. To explore the idea that movement can be expressive, we used everything from charades to flash cards. Challenging the idea that women are weak, we used exercises that involved taking and giving weight, which escalated from a giggling shy refusal to the girls successfully lifting each other, and me, off the floor. Embedding the opportunity for 'free dance' within activities encouraged creative movements, a 'laser maze' of ropes intended to encourage greater use of the space and levels became a series of individual stages for spontaneous performances. The girls loved drawing, and lengthy drawing relaxations to music helped them explore themselves creatively, and find an opportunity for praise, pride, support and sharing.

I believe the success lay in three aspects. With a small group of, at most, twelve participants, I could offer participant-led sessions, a change which had the greatest impact. While each session had a 'Plan B' of set activities, I would encourage the girls to direct the sessions, offering them the opportunity to be their own leaders and agents of their own process. Creating the sessions this way, there was a natural emergence, flow and adhesion to a theme. In the beginning, I relied heavily on the planned activities that incorporated mirroring and sharing the girls' movement. I soon found that they took great pride in this. Too shy to share them with the group themselves, holding me as a conduit was an initial step. Being 'noticed' was an important part of the process, as was being valued as a creative being. By the middle of the process, the girls were initiating activities themselves, using aspects from previous warm-ups, such as 'meeting' each others' hands in the centre of a Chacian circle, to develop new activities; meeting hands then turned to meeting each others' feet through comically acrobatic yoga moves. Cross-modal mirroring allowed me to counter light movements with strong ones, silence with sound. Demonstrating how a game could be adapted to use more of the body encouraged them to try their own adaptations, and to creatively explore to the fullest extent any presented activities. By the end of the session, the girls initiated and led an activity in which a series of 'dares' were written on small chits of paper. The girls who had once hidden behind their hands as they did a 'shaking warm-up', too shy to do anything but copy my moves, were independently performing songs and dances for their peers to thunderous applause.

Secondly, I work best independently and was able to use my strength as DM therapist to respond intuitively and effectively. As I work heavily through embodiment, mirroring and attunement, working independently allowed me to focus on the deep insight those tools provide through the use of my own body and self. In reducing the number of relationships in the room, it allowed more energy to be invested in each, and I became happier and more confident in myself.

Thirdly, as previously mentioned, working without a translator encouraged us to work through a body-based mode of communication, and any verbal communication was achieved through dedicated and consistent effort on behalf of both the participants and myself. This communication was duly celebrated, and whenever a girl took on the role of translating movement to words, it was clear it was a source of great pride to be in the role of facilitator.

These were sessions that came to be defined by laughter, first nervous giggles behind coyly raised dupptas, and then, gradually, day by day, to laughter so overwhelmingly glorious, we could do nothing but roll on the floor, wiping the tears of joy from our eyes. Bodies were bound not by society's expectations of how a woman should sit, but because of stomachs held as distinctly unladylike snorts of laughter echoed about the room. When the final feedback of 'kuhbalo achai' came, it was with arms upstretched to the ceiling, smiles wide, and another wave of laughter sweeping over us.

MAPPING PARTICIPANT GROWTH: Understanding the impact upon physical, emotional, cognitive and social development, and empowerment

The British Association of Dance Movement Psychotherapy (ADMP) defines DMT as, "a relational process in which participant/s and therapist engage creatively using body movement and dance to assist integration of emotional, cognitive, physical, social and spiritual aspects of self." (http://admp.org.uk/). The Sampoornata Model, a rights-based approach to DMT, includes 'empowerment' and 'agent of change' in its aims. This creates a more community based approach; participants move forward not just for self, but for others, integrating psychosocial support into communities in a way Western therapy cannot. The ability and approach to mapping participant growth has posed a challenge to the acceptance of DMT in therapeutic settings and academic communities. Movement diagnostic tools, such as Laban Movement Analysis (LMA) or Kestenberg Movement Profile (KMP), while revealing and, to a degree, standardizing, rely on the therapist's capacity for accurate observation, and the ability of others to 'read' these analyses. While LMA is elitist in that it requires specialist training, it has the potential to be highly accessible. Created as choreography denotation, it requires neither a shared language nor literacy to be understood. While I draw on my LMA background to analyse and record participant movement, working within the local context there is little value to it as a tool for sharing data. Global development has increasingly moved from charity to capacity building, yet therapy often remains mired in the attitude it is 'given', a sense reflected in these exclusive monitoring methods. Sampoornata seeks to address this power balance through a more democratic process of self-reporting, a practice of reflection that is not a required element of Western therapeutic support. This, paired with therapist observation and organization report, form the basis for mapping the change and growth of participants. A therapist's observation is subjective, and must be checked through self-reflection, supervision, and discussion with any co-therapists. Working psychodynamically or with a heavy focus on attunement and embodying, the therapist must have a strong understanding of their own self and the impact of participant movement and behaviour upon them. Using embodying and attuning techniques with three of the participants at the Girls' Short Stay, I was nearly overwhelmed by the weight of their sorrow, the dual forces of isolation and connection, and the need for this to be an acknowledged, witnessed emotion. Remaining with this feeling allowed me to have a better understanding of my participants. When a participant self-reports change, they too must reflect, "Do I see therapy as a thing that is given, that I must feel gratitude for? Can I say, "This isn't good" to a therapist? Can I accept that I didn't change or does that feel like a failure?" We frequently met with the response of "kubahlo (good)" even from those participants who had elected not to participate. It was observed during our time in the settings that the participants knew what to say to visitors, what was expected of them by the organization, and by the group. Cultural practices, such as respecting guests and elders, further hampered the ability to receive accurate feedback. It is likely that feedback from organizations was similarly nuanced. Yet, despite these drawbacks, we rely on the tools we have while continuing to explore and experiment with more accurate means of mapping change. Accurate reflective notes, good use of supervision, and a commitment to understanding the process enable us to utilize these tools as efficiently as possible.

Working in open groups and with floating populations the ability to chart participant growth becomes even more of a challenge. When the group changes weekly, the expected patterns of "formation, cohesion, break, reformation, ending" or of "form, storm, norm, perform" can exist only in microcosm or, at times, not at all. The benefits of that process, negotiation, trust, conflict resolution, capacity to bear endings and beginnings, are simultaneously weakened by their absence over an extended time period, and, for those participants' whose families could not be traced, unequally reinforced by the repetition of certain stages. The benefit of a single session is likely to be within the realm of therapeutic dance, rather than a deeper catalyst for lasting change. Without seeing a participant again, ascertaining this is impossible. Nevertheless, change is possible within a session:

> *A young child bride attended a single session at the Girls' Short Stay, with the sindor still in her hair and the bridal mendhi still fading on her hands, she sat silent, her body bound, hands holding herself in, physically and symbolically holding herself together. She said nothing, would not participate. Then, responding to a frequent theme of needing to escape, I introduced the game of "lock and key." The tagger had 'locked' nearly all the participants and it seemed the game was lost. Suddenly, she sprang up from the corner in*

which she had crouched and ran about the room freeing all the participants. As she set people free, a smile broke out, and gradually, laughter. Perhaps this is not a lasting change, but it was a moment of being the one who saved, of stepping out of the role of victim, of finding laughter and joy.

While we offered between six to nine two-hour sessions per participant group, the reality is that fewer sessions were able to progress to full process work due to my internship with the Rural Girls' Group or disruptions, such as building work, in the settings themselves. This further limited our ability to witness a marked change in participants' growth. The efficacy of short-term therapy has been debated since Freud's day. Mander (2007), puts the aim of time-limited therapy as "the modest claim of 'making a difference" or, in the words of Gregory Bateson, of 'making the difference that makes the difference' " (Mander, p.12). Anecdotally, it was possible to see moments of change, such as when a disparate group came together over a stretch cloth, working together to gently rock a participant; was the first time the Boys Short Stay remained with a process for an entire session. At the Men's Shelter during an independently led session, I was free to work through a more UK-based framework. Rather than preparing an activity, I engaged the participants to initiate and move the session. I sat with the feelings of stifling air and dragging weight, with the tick of the clock and the feeling of waiting. Then, gradually, movements started; a hand clapped, a finger drummed, a newspaper was rolled and torn until it shook like a maraca. I picked up and followed movements, gradually expanding them to open up bound bodies. I cross-mirrored them, bringing hand movements into feet so other body parts were engaged. And for the first time, we were dancing a dance that the participants had initiated, with movements drawn from their own experiences. Was this from the experience of a session that held them as autonomous individuals, capable and respected for holding their own healing process? How many two-hour sessions of respect, of being witnessed and heard would be needed to counter a lifetime of the opposite? Were these smiles the result of being heard and respected? This session's effectiveness is supported by Sullivan, a psychiatrist and Chace's predecessor, who pioneered

> … a therapeutic methodology with schizophrenics that focused on an accepting them at their own developmental level and interacting with them at this level. Most of all he accepted them as equal human beings who could benefit from genuine communication with others. (Levy, 1988, p. 21**)**

We live in societies that marginalize people because of their gender, age, sexuality, appearance, religion, ability and more. Working with girls it became clear that they had absorbed the messages which subjugate females: marriage is the ultimate goal, education serves no function beyond a certain age, and girls must be neither seen nor heard. Not only surviving this but also challenging it and inspiring others to change are integral to the Kolkata Sanved approach. Working with the young girls at the Girls' Short Stay, Night Shelter, and Rural Girls' Group it was apparent they had the capacity to dream, to see a future where they were engineers, doctors, teachers, and social workers. Yet further discussion demonstrated their awareness and acceptance of the more socially normative cessation of education and early marriage. The gap between dream, reality and attainment seems insurmountable. While with such short-term therapy it is unlikely that a permanent change was made, perhaps some seeds were sown. Importantly, working with a model that promotes social change, the experience needs to be felt not only in those struggling but those in power. Without jobs available for women, without equal wage, without societal acceptance of a loud, expansive, expressive female body, without a global understanding of the value of education (whatever form that takes), empowerment exists only in the individual. Were longer-term therapy possible, I would like to extend the opportunity to those in power, be it fathers or policy makers.

The process also revealed the universal depth of prejudice regarding a participant's initial stage. We all have the capacity for growth, for a greater understanding of ourselves. With poverty comes oppression, loss, isolation, fear... with poverty comes sorrow. Yet the participants came to the session with a phenomenal well of strength, with an unbridled capacity for joy, for support and for creativity. Far from the meek, oppressed stereotype, these were young women who could ask a caregiver to be quiet during relaxation with calm insistence, men who danced despite the ravages of mental illness and the stigma of gender prejudices, young boys who could turn a single, locked room from a train station into a cricket stadium. Therapy will always have value as a tool for self-betterment and social integration, but poverty is not similarly synonymous with needing external aid to actively participate in one's own growth.

COMMUNICATION, UNDERSTANDING AND THEORETICAL GROUNDING:
Exploring a session's theme

Therapy is, foremost, the protection of time and space: the delineation of a few hours to understand, heal, nurture and empower the self in a safe environment. It is a democratic space, dictated by the needs of the participant(s). Reflecting this, the inclusion of a verbal, cognitive reflection of an activity and of a session's themes is at the discretion of the participant. While I have previously worked with participants for whom this was an important part of their ability to engage with the process, this was not something sought by the participants with whom I worked during the Sanved internship. This may have been because of the participants' lack of vocabulary to describe such sessions, as the children were as young as four years old and the men at the Men's Shelter suffered from a variety of learning disabilities. Working without a translator in the Rural Girls' Group, all of our experience was non-verbal. It may also have been the process of taking something felt into something described, from the act of doing to the act of cognitive thinking. Fischmann (2009) explores this difference with the suggestion

> ….. that besides verbalization and recovery of memories to bring the unconscious to consciousness, it pays attention to affective-perceptive and spatial-temporal experiences.... This does not deny the value of words and narration of lived experiences. It maintains that they are two parallel and interlinked ways of operating, one verbal and the other one pre-verbal and untranslatable one into the other (Lyons, R. K, 1999, quoted in Fischmann, 2009, p. 39).

As a therapist, I believe something is lost when the 'purpose' of an activity is actively communicated. DMT draws its strength from the concept of, "what is too fine, too deep for words," and to rely too heavily on verbalization negates this power (St. Denis, in Cattanach, 1999, p.157). Something felt, something experienced, can be held as deeply personal and to bring this into the realm of theory can challenge the sensation of 'this is my learning. This is unique and special to me, a creative, wise individual'. While we can hypothesis the impact of an activity and make conscious choices to use an activity for its intended outcomes, we cannot predict, nor fully understand, its impact on the individual moving. For a participant suffering from anxiety, the implication that they did not 'succeed' at the intended goal could be devastating. Seizing the opportunity to have an independent session at the Boys Group, I brought a bundle of newspapers, intending to encourage their capacity for creative play. It soon emerged as a tool for working though their anger issues, turning a child from one choking another child at the start of the session, to one excitedly holding both my hands bouncing, "So happy! So happy, happy, happy! So happy now." Had I insisted on the purpose of the activity, this would have diminished the very real, very different impact on the child in front of me.

Children learn through play, where:

> ... not only are children developing the neurological foundations that will enable problem solving, language and creativity, they are also learning while they are playing. They are learning how to relate to others, how to calibrate their muscles and bodies and how to think in abstract terms. Through their play children learn how to learn. What is acquired through play is not specific information but a general mind set towards solving problems that includes both abstraction and combinatorial flexibility where children string bits of behaviour together to form novel solutions to problems requiring the restructuring of thought or action. (Sutton-Smith, 1997, quoted in Goldstein, 2012, p.5)

Providing the space for play can provide retrograde development opportunities or can return a participant to a younger, simpler time. There is a universality to play, certain games across cultures, make-believe is an inherent part of childhood. Play teaches and nurtures non-didactically, and therein lays its efficiency: Whereas therapy carries the stigma of implied madness and interrogation, we want to play. This desire is so ingrained within us that, "the opposite of play is not work, but depression." (Sutton-Smith, 1997, quoted in Goldstein, p.5) Using play in DMT helped participants to explore concepts, to experience transformation opportunities without the sense that this is 'therapy'. It works with the natural impulses of the participant and allows them to feel their suggestions are being listened to and respected. Taking a well-loved game, such as football, and adapting it, asking players to remain in a crouched 'crab' position as they play, encourages them to experience a new movement quality, bound and low instead of the usual free and high, whilst instantly engaging

them. Working with floating populations, a participant may have only one exposure to DMT. Even those participants who remain in longer-term therapy do so for only a couple of hours a week. Using games that they will initiate and enjoy outside of settings encourages them to integrate DMT into their daily lives. Using art as relaxation at Rural Girls' Group soon created an 'after-group' who stayed on, of their own volition, to work creatively.

Working from both the Sampoornata and the UK psychodynamic framework, the idea that one provides an activity, rather than encouraging participants to initiate the session from their own movements, has been a balancing of two very different theoretical approaches. Responding to participant-initiated material, a therapist typically does not explain the activity, but may offer an interpretation and modification of the participant's actions. To take the example of a participant at the Men's Shelter, I might, under the UK-model, have verbally reflected on his behavior saying, "I notice you breath heavily, mime and fidget when activities invoking actions associated with smoking occur. Perhaps you could carry those actions through to the extinguishing of the cigarette, physically and symbolically ending the smoking session." In India, without a shared language, I used mime to encourage him to join me in stubbing out his imaginary cigarette in an ashtray. Working without a shared language constantly challenged and strengthened my capacity to communicate in these non-verbal modes.

Whether planned or spontaneous, therapists must hold in themselves the understanding of each activity, must see its potential for healing and harm, its relevance and accessibility to the participant. It is important that the participant perceives this ability, this capacity for care and this willingness to invest thought both in and out of the session. To achieve this in a spontaneous session requires not only a rich and ready arsenal of therapeutic interventions, but also an instinctual ability to apply them and the capacity to attune with and understand the participant in the moment. While in certain themes, certain activities re-emerge across participant groups and sessions, the participants themselves develop others within sessions, that take on new, and unexpected forms. At the Night Shelter, I used the stretch cloth to create a modeling catwalk, hoping to encourage support and self-confidence. The girls began impersonating, with great compassion and to the applause of their peers, individuals with disabilities and illnesses. While I understood the activity, had used it previously, and had experienced it as a participant during my training, I could not have anticipated the extent of its impact.

Kulmartuli Market, Kolkata

RELATING WITHIN THE SPACE:
The Importance of Participant/Therapist Relationship

Within the therapeutic space, there exist five relationships: the participant's relationship with themselves, the participant/therapist relationship, the participant/participant relationship in group settings, between therapists in a co-facilitated session, and the therapist's relationship with themselves. It can be assumed that the participant's relationship to themselves is, in some way, impaired, and that improving, exploring and understanding this relationship is a vital part of the therapeutic process.

Within a psychodynamic approach the participant /therapist relationship forms the basis of a therapist's understanding. This is even more profoundly felt in body psychotherapies, when it is not just the intangible 'relating state' but an actual physical sensation felt in the therapists' body. The giggly effervescence of the Rural Girls' Group or the trancelike sinking in the Men's Shelter is keenly felt. Projecting, counter-transference, and transference, which are all integral to analyses and change. The relationship between therapist and participant exists as a mirror to the therapeutic process: brief, empathetic, violent, gentle, condescending, respectful. Working psychodynamically, allows for a deep, empathetic understanding of another individual, yet the scope for this long-term, small group or individual therapy is a luxury. The Sampoornata model accommodates an Indian context: larger open groups, non-confidential spaces, floating populations, etc. This reflects Gray's assertion that, "the adaptability of DMT to multiple and low resource, insecure settings is a worthwhile consideration in relation to its application to survivors of trauma and torture." (Gray, 2011, p.43) While the capacity to build a deep relationship within a couple of hours is limited, this does not prevent the emergence of the six conditions Rogers (1957) deems necessary for an effective therapeutic process:

1. Two persons are in psychological contact.
2. The first, whom we shall term the participant, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the participant.
5. The therapist experiences an empathic understanding of the participant's internal frame of reference and endeavors to communicate this experience to the participant.
6. The communication to the participant of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

(p.221)

Nurtured within this empathetic, resilient relationship, bolstered by unconditional positive regard, participants can begin to integrate themselves, bodily, mentally, socially, and emotionally.

Just as rhythm and movement are integral to life, they are central to forming our relationship with those around us. Formalized in dance, they define and bridge cultures. Dance and movement allowed me to amalgamate two approaches to DMT and it similarly allowed me to reach across a multitude of cultural and social divides. Walking fingers into a wiggling pile in the centre of a circle, the girls at the Rural Girls group brought ourselves closer together, leaning back to back, we supported one another, collapsing into boisterous laugher, we needed no common spoken language. Empathy, respect and commitment form the cornerstones of my practice, bolstered by a capacity to listen, to hold and to play. This nurtures relationships readily. I hold the trust my participants have in me in the highest regard. The Sampoornata model holds DMTs as a member of a community, an ethos that allows for a deep, more human connection. Staying in the village, the girls were soon showing up as much as forty-five minutes before the start of a session to sit, draw and try communicating together.

Psychotherapy holds that the capacity for secure attachment comes from a process of rupture and repair. It was at the end of a particularly challenging session at the Boys Group, that I began to sing, swaying gently to the rhythm as I did so. Transfixed, they gathered round, slowly matching their helter-skelter freewheeling bodies to my sway, erasing body boundaries as they melted against one another. In the midst of chaos, we had found one another.

Working through a translator introduces another variant to the therapist/participant relationship. While working with the Rural Girls Group and during those sessions a co-therapist was absent, I was able to work non-verbally, which I find can be a deeper connection. This belief is supported by Eberhard-Kaechele's (2009) research:

> Implicit or nonverbal communication is an imperative part of establishing trust and implementing psychotherapeutic intervention, considering that verbal expression impacts communication to a much lesser degree than nonverbal expression (Grawe 2004). Schore (2003) claims verbal therapies alone are insufficient for the treatment of affect dysregulation, and suggests instead that the co-creation of a new socio-affective reality should be central to the therapeutic relationship. (Eberhard-Kaechele, 2009, p.2).

Working through a translator raises questions as to direct or transliterated translation, whether it is the choice of words or the sentiment behind them that best convey the sentiment. Working through a translator, one verbally relates through a third-party. My initial concerns that, as the 'non-verbal' communicator, I would be seen as an appendage to the process proved unfounded. Instead, there came the concern that my co-therapist was being seen as merely a mouthpiece. With so much material to be translated, it was unsurprising that things were left unshared. What, and who, was worthy of translation was left to the discretion of a co-therapist and so my verbal understanding of a participant's material was filtered through someone else's judgment. Frequent sentences such as, "Oh she's just homesick", "He's just talking about his family", implied that certain individuals or certain sentiments were not valid or were less valid than others. This brought a hierarchy of understanding and communication into the process that otherwise would not have existed, and doubtless impacted the relationships of all involved.

As all the groups were floating populations/open groups, the group dynamics changed weekly. As mentioned above, it was apparent this would impact the flow of therapeutic relationships. The makeup of a group impacted their response to activities, as even relatively simple things like average age or common language changed weekly. At the Girls' Short Stay and the Boys' Groups what repeatedly struck me was the speed with which the children formed such close, supportive bonds. It stung as a mixed blessing, the support kept them together, but this ready trust had also perhaps led some of them to their trafficking. Again, the question of raising this in short-term therapy was problematic, and so we focused on the more universally positive elements of trust and support by celebrating the ability to give as well as receive. For those cast as victims, this was a vital opportunity to reimage themselves as strong, necessary people. As participants were either reunited with their families or moved on to longer-term accommodation, the theme of 'being left' emerged for those girls who stayed. In a longer-term setting, I would have liked to have created another set of sessions for those who experienced this recurrent process of 'goodbye', for this undoubtedly impacted the ability to form relationships within a group. The Night Shelter had the most stable group. Comprised of large family groups, there was the additional dynamic of family life. This meant the therapy group was not a contained space but a fluctuating one that existed daily, with all the slights, joys and inconveniences of family life. While they presented a cohesive unit, any activity with the potential for competition and blame could quickly ignite what simmered below the surface. As a therapist working in short-term therapy, it raised the question as to how deeply to tap into this discontent, when creating this rupture potentially did not come with adequate time for repair. While initially asked to work with only the girls, we asked their mothers to join us. This brought in the dynamic of an older individual, but also changed the group into the full model of a matriarchal family. Ultimately, the brief relationships formed by offering short-term open-group therapy with a floating population, mirrored the instability of, and unfulfilled potential of, the participants' lives.

My previous DMT experience has been entirely as a solo therapist. I recognized from the start of sessions that adding another DM therapist to the session would impact the process. An additional therapist offered the scope for a different set of eyes in the room, but also for the emergence of another relationship. Unlike the therapist client relationship, these may exist outside of the therapeutic space, offering for a multifaceted understanding of both parties. Working in a bi-cultural relationship presents additional challenges and rewards. Things held as absolutes in Western approaches to DMT, such attitudes to punctuality, respect towards classes, ages, or abilities, or corporal punishment, were not so rigidly understood by local practitioners, despite remaining as concrete in Sampoornata theory. Learning to better reflect on my partner's movements, as well as my participants, helped form an understanding which came with a heightened empathy. Recognizing both that positive and supportive professional relationships have the potential to enhance the session and that my personal strength lies in working individually has strengthened my resolve to complement individually-led sessions with strong supportive ties to organizations and individuals who

champion a holistic approach to psychosocial care.

A fifth relationship then emerges; a therapist's relationship with themselves:

> The therapist should be, within the confines of this relationship, a congruent, genuine, integrated person... he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly ... he is accurately himself in this hour of this relationship, that in this basic sense he is what he actually is, in this moment of time. It should be clear that this includes being himself even in ways which are not regarded as ideal for psychotherapy. His experience may be "I am afraid of this participant" or "My attention is so focused on my own problems that I can scarcely listen to him." If the therapist is not denying these feelings to awareness, but is able freely to be them (as well as being his other feelings), then the condition we have stated is me." (Rogers, 1957, p.96).

Working in the UK, I had attended weekly private therapy, as well using dance as a tool for self-reflection. Working in Kolkata, where I no longer had that opportunity, the need to continue this exploration of myself became increasingly evident. It was vital for understanding my relationship with my co-therapist and my clients. When an act of threatened violence occurred in a session, and "the power that is inherent in the creative process indicates discretion and careful consideration in how and when these modalities are used, by whom and with whom," (Gray, 2011, p.46) was abused, I felt it keenly. Why could I not separate myself from participants as 'work,' as distinct individuals, and instead internalize it as a hand raised against my own child? A co-therapist's 'flexibility with the truth' went directly against my very identity, even my name comes from the Latin *veritas*, 'truth', and against an ethic I had been raised to hold in the highest esteem. Dishonesty felt an insurmountable barrier to an open, honest therapeutic relationship. I had once been asked to dance our names, Verity/veritas, and the identity we formed with them. Confronted with 'flexibility with the truth' I again found myself exploring the impact that identity had on my inter- and intra- personal relationships. Exploring this later with dance, I played with the concepts of rigidity and flexibility, with myself and with the absence of myself. Yet why did all of this impact me so deeply? Without exploring my relationship to myself, answering this question would have been impossible. I had begun exploring these questions in personal therapy, as part of my UK training, and it remains an ongoing process, one bolstered by a support network of peers, friends and family. It impressed on me the need to nurture an adaptable practice of self-reflection, exploration and care, one that could be carried within myself.

CONCLUSION

Recognizing the UK approach was not entirely suited to the communities in which I work internationally, I wanted to explore ways of applying DMT to a global setting. Drawing upon my previous professional experience as a community dance and social circus specialist, I had formulated a number of hypotheses and raised a number of concerns regarding how to safely and efficiently implement DMT in these settings. The Sampoornata model, which has been specifically developed to work within the Indian sub-continent, has, for many years, successfully implemented approaches I had previously explored only as theories. It feels a testimony to the universality of dance that, from such separate cultures and experiences, a common belief in the potential of DMT in such settings could arise.

It was a great joy to work within a model holding ethics so aligned with mine and answered many questions raised in my prior training. Through practical application, academic research and movement, I was fortunate to be able draw upon the best of both models, and upon those skills which have been honed within my own practice to develop my own approach; a melding of embodiment, attunement and an understanding of psychodynamic and body trauma therapy concepts with a strengthened adaptability to diverse settings, large groups, floating populations and short-term work. I value all movement and creative expression, whether it comes as play, dance, music or art, both in and out of a therapeutic space. I focus on respect, empathy and a held space in which the participant is not only an agent of change but also an autonomous being capable of understanding their own body and devising their own process of healing.

All therapeutic relationships must come to an end. Reflecting on endings, Mander (2000) quotes the Roman philosopher Seneca, "as it is with a play so it is with life. What matters is not how long it lasts, but how good it is. Make sure you round it off with a good ending." (p. 10). Working with

floating populations, our therapeutic process was one of goodbyes from the beginning, rehearsals for the final cessation of the therapeutic space. Neither of the DMT approaches studied views the therapeutic process as a linear one. Instead, both celebrate a process that expands, stalls, dips, regresses, builds, flees, and advances. A process that greets and says goodbye, weeps and laughs, holds and touches, witnesses and respects. It is, in short, a process symbolized, and then embodied, by the body moving.

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