Case Study of a Five Year-Old Israeli Girl in Movement Therapy

Smadar Ben-Asher
Billie Koren

with Case Discussion

Elise Billock Tropea
Danielle Fraenkel

The authors describe the treatment of a five year-old Israeli girl by an Israeli movement therapist who was trained in the United States. The somatic transference and countertransference dynamics which inform the movement therapy process are discussed. Innovative concepts are employed to describe these dynamics in which sensations from the child's traumatic injury are transferred to the therapist's body. Two case discussions follow, written by two United States-trained dance/movement therapists experienced in child therapy. These case discussants highlight important dimensions of movement therapy with abused children specifically related to case conceptualization, movement assessment, treatment planning, collaboration, and some unique qualities of dance/movement therapy intervention in comparison to related forms of treatment. Questions emerge regarding possible cross-cultural differences in the context for dance/movement therapy, and for the treatment of sexual abuse.

KEY WORDS: sexual abuse; dance/movement therapy; transference; countertransference; case study.

Introduction

The development of dance/movement therapy as an expressive therapy modalilty over the past 30 years has been impressive. By its very nature, dance/movement therapy gives the highest priority to nonverbal language. It is difficult to translate nonverbal language into verbal language, and it is especially difficult to transform the 'therapeutic story' into professional language used by colleagues in other forms of therapy.

The case study that follows is an attempt to investigate the concepts of transference and countertransference, focusing on the unique forms that they take on within dance/movement therapy. We are proposing the use of a new concept that we have called 'the therapist's inner sonar.' This term emphasizes the role that the movement therapist's physical body plays as an important aspect of the therapeutic process. Through the use of this 'inner sonar', the therapist receives and locates the client's primary site of the injured memory cohesion (Shahar-Levy, 1994) by means of transference processes that take place within the therapeutic interaction.

Shahar-Levy (1994) hypothesizes that, beneath overt motor movement, primary memory cohesions are operating. They contain fixed combinations of perceptual sense impressions that have adhered to basic psychophysiological structures. These primary memory cohesions are preserved as body memories without cognitive awareness. Shahar-Levy distinguishes between two types of primary memory cohesions. The first type is flexible memory cohesion, in which motor paradigms undergo processes of breakdown that, over time, enable automatic reactions to enter areas of voluntary control. The second type is traumatic memory cohesion, which originates in early, traumatic experience. For example, the physiological anxiety reaction of the child preparing to receive a blow from the outside causes muscle contraction and constriction of movement. Locating these primary traumatic (or injured) memory cohesions by means of the processes of somatic transference and countertransference enables the therapist to diagnose the early sources of the client's distress, even without direct verbal statement of the experienced trauma.

The following case study is an example of movement therapy work in which the movement therapist's ability to perceive transference and countertransference processes through her body enabled her to locate the exact place of the client's injured primary memory cohesion. Location of the injured memory cohesion allowed the beginning of the process of healing and recovery from early trauma to take place.

Case Study

Background for Referral to Therapy

Nirit was referred to therapy at age five.[1] About the time that she entered kindergarten, her behavior changed dramatically and surprisingly, both in her behavior towards her peers and in response to other childrens' behavior towards her. She seemed to be 'drawing their fire' with antisocial behavior. This change very much surprised Nirit's parents, but was at first attributed to the crisis of adolescence that her older sister was going through at the time. The diagnostic interview with Nirit painted a very complex emotional situation. The adult world was perceived by the child as being extremely dangerous, with the adults experienced as passive and confused. Nirit felt unprotected. She lacked confidence, feared death, and experienced tremendous rage. The image of the child's inner world differed in the extreme from the impression formed by the educational staff regarding the devotion and energies invested by Nirit's father and mother in caring for her.

First Year of Therapy: Trust-Building

The child appeared small and slight for her age. She was introverted and hard to reach. Nirit did not make eye contact, nor did she relate directly to the therapist. Nirit seemed to have a great need to control the physical distance between herself and the therapist. During the sessions, only a small amount of imaginative play took place, with no spontaneous movement. Most of the time, Nirit moved about restlessly, with no calm moments. In the course of the sessions, she exhibited great ambivalence between her desire to approach the therapist and cooperate with her, and her distrust, which led her to avoid closeness with the therapist. On Nirit's initiative, they played tag and hide-and-seek, a game that illustrated her conflict about closeness. Her movement arose peripherally, and developed with very little connection to the center of her body. Her movements were sharp, broken, and stiff. However, over the first year, Nirit's eye contact improved, and she began to move closer to the therapist, penetrating her kinesphere (personal space) in a unilateral manner, and without any prior negotiations. The therapist experienced Nirit's drawing closer as being somewhat invasive.

[1]Dance/movement with Nirit began in April, 1997 and ended in June, 1999. All sessions took place in a private clinic in a small town in Israel.

Internal Storm Approaching

After a month's break, Nirit arrived at the first session after the vacation as if there had been no separation at all from the therapist. However, by the second meeting, the signs of a what felt like a violent storm or a volcanic eruption began to bubble up (and spill over). Nirit began to fling objects around in the room, to curse, spit, and even to hit the therapist. She drew extremely close to and then was very distant from the therapist, alternately demonstrating brutal strength and absolute passivity. It seemed as if her body had broken into pieces accompanied by a complete breakdown of all of the rules and limits of therapy. Nirit came into the meeting room, went out, scattered things around and refused to pick them up. Her actions were accompanied by an extremely aggressive and unstoppable flow of words. The therapist's attempt to direct her aggressive outburst towards an inanimate object, and her emphasis on rules of behavior in the therapy room, were of no use. It was clear that the girl was quite familiar with the bounds and rules of the therapeutic space. Her behavior seemed to be a statement of some inner distress that was bursting out from deep within her, just at the time when she was promised an additional year of therapy.

Discovery of the Injured Memory Cohesion Located by the Therapist's Inner Sonar

During the course of the third session in which Nirit's 'great storm' took place, the therapist felt a physical sensation within her own body, a feeling of great confusion and internal nausea. The therapist tried to remain outwardly calm until the end of the session, but when she reached home, her headache symptoms increased, the pain sensations in her head became stronger, and she began to vomit. The therapist physically, through her 'inner sonar,' was reacting to the encounter with Nirit's injured memory cohesion. The insight that the therapist's painful physical reaction arose from the process of transference that had taken place within therapy enabled the therapist to consider her own physical reaction as the opportunity to decode the injured memory cohesion. This insight also enabled the therapist to contain Nirit's extreme reactions during the next sessions; her incessant physical activity, her desire to undress, to point out intimate body organs and her need to expose them, her strong state of arousal, and her lack of physical calm. Nirit brought into the treatment room bodily expressions of reckless endangerment, boldly risking herself through high jumps from the ladder, attempts at dangerous balancing feats intended to hurt her body, and to injure or to punish

herself. During this tempestuous time, the therapist was required to be alert at all times to prevent possible injury to Nirit. She padded the floor area with pillows and mattresses, provided support, and physically held Nirit while she fell and got up again in order to continue the repetitious and dizzying cycle from the beginning, again and again.

The therapist tried to send her the constant message that the therapy room had clear and protective boundaries. At the same time, the therapist attempted to divert the aggression directed towards herself onto dolls and other inanimate objects. It was clear that anger and anxiety together with feelings of defilement and filth had found expression in a process of internal and external cleansing, and that the therapist had to be there in order to enable this to happen.

Exposing the Secret of the Injured Memory Cohesion, and the Primacy of the Therapy Within the Traumatic Experience of Sexual Abuse

During the course of therapy, Nirit constructed secret hiding places for herself and for the therapist, thus expressing the need to safeguard her secret. She used a balloon as a screen, through which it was forbidden to see, and on it she drew a large black mouth with an object stuck in it, blocking the throat. The overall feeling was that 'something was sticking in her craw' and must be vomited out.

At this stage in the therapeutic process, it was clear the child's experience of early sexual abuse had surfaced. The process of cleansing, her need to undress and expose the body to dangers, and her extreme bodily arousal, were all typical reactions to such trauma. In a joint session with her parents in which the therapist raised the issue of possible sexual abuse to the child, Nirit's parents revealed the big family secret. Nirit's older sister had been sexually abused by their grandfather over an extended period of time. The sexual abuse of Nirit's sister had taken place as the girl entered adolescence. This revelation had a serious impact on the family network of relationships. During the entire time that her sister had been abused, their parents believed that the little sister, Nirit, had not been abused by the grandfather. However, during this joint session, for the very first time, the father expressed his grave concern that Nirit also had been abused by the grandfather. The mother preferred to believe that Nirit's reaction came only from what she saw or heard, without herself being victim to sexual injury.

According to the agreement at the close of the joint session, the parents agreed to tell Nirit explicitly that everything that the family had called "the sister's adolescent crisis" was actually the discovery of the

sexual misbehavior of the grandfather, whose victims were, first and foremost, his own granddaughters. At the same time, it was decided that the discovery process would continue within the therapy.

Within the therapy room, Nirit continued to construct secret caves into which she invited the therapist. From within these caves, Nirit gave still more details through the use of her body, by creating drawings on balloons, and through her play with dolls, providing evidence that a traumatic event had taken place, leaving her with feelings and memories that could not be approached directly. Following the festive ceremonial meal of the Passover seder, when the entire family stayed at the grandmother's house (the grandfather was banned from the house during the visit by court order), the dizzying reactions occurred again. Nirit again took physical risks, and tried to undress. She spoke of her longing for her grandfather, whom she believed to be ill from cancer. (This was how his absence was explained to her.) Nirit remembered her grandfather's house, where she had spent time when she was ages three and four. Then she began to tell the therapist that there was something that she did not want to talk about.

Suddenly, Nirit broke away from the therapist, ran into the trampoline in the center of the room, jumped on it intensively, with her body drawn and tense, while shouting out the nursery rhyme: "Fire, fire pants on fire . . . I see London, I see France, I see a girl's underpants."[2] Finally, she lay down on the trampoline, her strength gone. The therapist came closer to her, and said, gently, that she understood that something happened to Nirit that was unpleasant, and that burned like fire. Nirit wrapped herself up in a thin mattress and came over to the therapist, saying "A parcel has arrived for you. . . . "[3] Nirit was able to sit in the therapist's embrace, when it was clear that the secret was already shared and placed in the right hands, with someone who could help her, as they continued to work together.

Discussion and Case Analysis

In this case study, we have described the similarlity in the internal experiences of the movement therapist and child in the therapy room. These bodily experiences of transference and countertransference preceded cognitive awareness and insight for both the therapist and for the child.

As the therapist came closer to discovering Nirit's secret, she experi-

[2]"Esh, esh, medurah, tahtonim shel bahura." Literal translation: "Fire, fire, bonfire, a girls underpants."

[3]An Israeli children's game, "The parcel has arrived . . . ," in which a wrapped object stops at each person who then peels off a layer.

enced physiological arousal that is characteristic of anger, but which is experienced as an overflow of anxiety. The physical need of the therapist to vomit up something filthy that was stuck in her throat, and her understanding of the process of transference and countertransference that this expressed, constituted the beginning of the breakthrough process to the injured memory cohesion. In her paper on working with victims of sexual abuse, Siegel (1996) described her physical reactions of nausea to her clients' experiences of horror and anxiety revealed in their personal stories. Siegel has presented an original approach to the use of clinical countertransference that also includes the therapist's own physical reactions and how she relates to them, as a method of achieving a deeper clinical understanding of the client's unconscious processes.

In conclusion, it has been illustrated that the somatic transference and countertransference processes, unique to dance/movement therapy, make it a particularly effective method of treatment for children who are not able to verbalize their traumatic experience. These processes are experienced within the shared space of therapist and child. Understanding the charged reactions of the therapist and her ability to see them as the encounter of her inner sonar with the child's injured memory cohesion allowed for the discovery and treatment of the child's trauma.

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Discussion: Case Study of a Five Year-Old in Movement Therapy: One Clinician's Perspective

Elise Billock Tropea

Introduction

I would first like to acknowledge Billie Koren, the therapist for and the co-author of this case study, for her willingness to share her work in this forum. My intent in the following discussion is not to critically analyze the therapist's interventions, but rather to speak to three areas that I

believe are crucial to understanding the therapeutic nature of the author's work with the five year-old she presents. These three areas are: case conceptualization; the role of assessment in developing treatment goals and guiding therapeutic interventions; and collaborative team approach, both as a means for enhancing the treatment of children, and as a support to individual dance/movement therapists. My thoughts are influenced by my own experiences in the field over the last 30 years, by the dance/movement therapists who have contributed to my growth in work with children, and by the invaluable interdisciplinary efforts of my colleagues in related fields.

Case Conceptualization

The first section of this case study includes background information and reasons for referral. My questions begin at this point. I want to know who made the referral, e.g., parents, school staff, physician, or therapist. What was the nature of the diagnostic interview, what tests were administered, and by whom? Was there a movement assessment conducted? If so, what parameters were considered and what information was gleaned? Conceptualization of a case, from the referral process to assessment, and finally to delivery of service, allows for clear treatment goals and effective means of intervention.

The Importance of Assessment

In addition to clear reporting of the referral process, accurate assessment is vital in identifying a child's present level of functioning, developing suitable treatment goals and objectives, and measuring change throughout the course of treatment. Dr. Judith Kestenberg, author of the Kestenberg Movement Profile (KMP), influenced the work of many therapists, and provided the profession with an instrument that could be used in a variety of ways to enhance treatment of children. In the early 1970s, Penny Lewis, a student of Kestenberg, began teaching Kestenberg's material in graduate programs in the United States. Others, such as Susan Loman and Hillary Merman, have moved the KMP into this millennium, sharing its efficacy internationally. At the same time, dance/movement therapist Beth Kalish-Weiss, also influenced by Kestenberg while working at a psychoanalytically-based treatment center for autistic children, developed a behavior-rating instrument, originally known as the Body Movement Scale, one of the scales in *Behavior Rating Instrument for Autistic and Atypical Children* (BRIAAC). This instrument was used to chart the progress of autistic children as they moved through treatment.

Of equal importance, the Body Movement Scale helped dance/movement therapists and others to develop clear treatment goals and objectives for autistic and other atypical children, based on an integration of developmental movement and interactional dynamics.

In 1978, dance/movement therapist William Freeman began working in Kansas, Missouri, and Nebraska public and private schools with children diagnosed with a range of disabilities. In the early 1980s, Freeman's vision prompted him to develop a professional development program through the Kansas State Department of Education. Eight years later, he founded Accessible Arts, Inc., an organization that promoted the collaborative team approach to training educational and clinical staff in the efficacy of the creative arts. Freeman also wrote and received a grant from the Kansas State Department of Education. In collaboration with Dulicai and Billock Tropea, he developed Best Practices for Implementation of a Movement Therapy Assessment with Special Education Students, a protocol providing referral criteria for movement therapy services. The Developmental Movement Assessment (DMA), (Billock Tropea, Dulicai & Freeman, 1990), combined social, emotional, interpersonal, and cognitive skills assessment, and was pilot-tested with children with disabilities in a Kansas public school.

While it is beyond the scope of this paper to provide an exhaustive review of the assessments developed by dance/movement therapists over the last 40 years, my intent is to point out that there is a wealth of information that does exist at present in our profession, providing therapists with assessment tools that will further enhance their work.

Toward a Collaborative Team Approach

As I read this case study, I wondered about the level of support to which the therapist had access in this complex and difficult case. I was reminded of many discussions with dance/movement therapists in the 1980s who felt they were functioning in isolation in their work places. In those discussions, we discovered that many of us were practicing dance / movement therapy in a variety of clinical settings, although we were often hired under different job titles, such as recreation therapist or counselor. Also, many therapists reported that they were hired to fulfill multiple duties outside of the realm of therapy. What also was true then was that the majority of dance/movement therapists were unable to find work in the public schools in the United States. Of those therapists who were fortunate enough to work in public education, many were not considered an integral part of the treatment team. Today, federal regulations from the United States Department of Education require that all members of the treatment team, including the dance/movement thera-

pist, meet to collaborate on a child's Individualized Educational Plan (IEP).

Collaborative Team planning is not a new concept. In fact, I was first exposed to such a model in 1971, during my placement at the Developmental Center for Autistic Center in Philadelphia. Director, psychiatrist Bertram Ruttenberg, organized daily clinical staff meetings with the express purpose of integrating all modalities into the treatment of the child. Dance/movement therapy was respected, largely due to Beth Kalish-Weiss' astute and thorough explanations of the treatment modality, and also because of the observable positive results our work yielded. As reported earlier, consultation projects in Kansas with Freeman always promised opportunity for collaboration. While thankful for such an early introduction to the power of collaboration, I found it difficult to adjust to less in other treatment settings. It was not until I reached my present job as clinical dance/movement therapist at the Renfrew Center, Philadelphia, a facility for women suffering with eating disorders and other mental health issues, that I would learn the meaning of true collaboration. I cite Renfrew here because I have come to understand the need for such support from clinical staff, especially in treating individuals who have suffered the effects of sexual trauma. While the author has not described her milieu in this case study, it is my hope that she, too, is surrounded by a team that can both support her work and learn from our unique skills as dance/movement therapists.

In closing, many questions remain, particularly concerning possible cultural differences between Israel and the United States. How might cultural differences shape the ways in which dance/movement therapy education and training are integrated and applied in the practice of dance/movement therapy in Israel? What is the state of dance/movement therapy in Israel as compared to the United States, in terms of its acceptance, and its inclusion in educational and treatment settings? Is dance/movement therapy respected as an effective clinical discipline, and are dance/movement therapy positions granted appropriate compensation, professional status, and clear role definition in Israeli educational and treatment settings?

Also, how might cultural attitudes towards the treatment of child sexual abuse be similar or different in these two countries, particularly concerning the involvement of legal and other relevant authorities, rights to privacy, and other ethical issues? Although it is important to be aware of and responsive to cultural differences, what may be universal is that, as dance/movement therapists, we must be mindful and especially well-informed regarding issues of abuse because often this material is first manifested in nonverbal, bodily responses, identifiable as such by well-seasoned observer.

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Moving Dance/Movement Therapy from Isolation to Integration
Danielle L. Fraenkel

Introduction

This case study concerns a movement therapist's uncovering of five year-old Nirit's history of sexual abuse. The authors, Smadar Ben Asher and Billy Koren, identify the movement therapist's severe physical reactions during and after a session in which Nirit exploded, as the defining indicators in the child's treatment. In the authors' words, "The therapist's body, through her inner sonar was reacting to the encounter with Nirit's injured memory cohesion." As a result, the therapist's intense headache and nausea cast a new light on the child's treatment, signaling that the therapist had contacted the unconscious forces that had precipitated Nirit's disturbing behaviors. Armed with a clearer sense of the child's internal world, the therapist interacted with Nirit in new ways-setting boundaries, providing support and physical holding, while Nirit attempted daring feats that could have resulted in injury. The therapist also attempted to divert Nirit's self-destructive behaviors onto dolls and inanimate objects, supplying a container for Nirit's unleashed terror and isolating shame.

This critical incident and the ensuing process occurred more than a year into Nirit's treatment. While the first year had focused on building trust, the following year(s) attended more directly to Nirit's secret. That it took so long for the therapist to identify the underlying cause of Nirit's sudden behavioral changes is disturbing.

Intuition grounded in the somatic is crucial to dance/movement therapy. However, cognition and the ability to integrate information from a

variety of sources are also critical. A movement therapist's observations and the reports of others are certainly as important as a therapist's internal sensations. Both movement observations and reports were available early in Nirit's treatment. The authors present intake information and the therapist's movement observations and analysis, yet they do not consider that this constellation of data alone could have led to uncovering the family secret much earlier in treatment. As such, it raises questions about the role of dance/movement therapy in assessment and the importance of addressing systemic or ecological elements when working with children. It also points to the importance of understanding the differences and similarities among dance/movement therapy, movement therapy, and play therapy, and the ways in which these differences and similarities affect treatment planning.

Assessment

Assessment is vital in today's evidence-based approach to care. Although a number of dance/movement therapists have developed schema relating specific movement phenomena to stages of development (Fischer & Chaiklin, 1993; Siegel, 1984), and others have published movement inventories (Espenak, 1981), the Kestenberg Movement Profile (KMP) is the only diagnostic measure that has been extensively applied to a variety of populations (Amighi et al., 1999; Loman & Sossin, 1992). By linking measurable movement patterns and their psychological and behavioral correlates, the KMP provides a much needed platform for treatment planning. Yet, for most dance/movement therapists, assessment and treatment remain blurred, with observations and insights emerging through process. This lack of distinction, or what could be viewed as avoiding the difficult task of writing assessments, is not surprising. Integrating observed patterns of movement, psychological phenomena, and affective themes is a challenge. The KMP is a great asset for clinicians interested in movement observation and analysis, but it takes intensive training to master. Moreover, training is not easily accessible and it takes time to apply and score the KMP correctly.

In Nirit's case, the lack of any clear-cut movement assessment may have inadvertently helped to conceal the family's secret. Although the presenting symptoms do not include references to specific nonverbal behaviors, descriptive language in the background statement made it clear that Nirit's "anti-social behavior" came on rather suddenly. The change was dramatic, surprising, and self-destructive, "drawing . . . [the] fire" of other children. These sudden alterations in Nirit's behavior, along with her view of adults as "passive and confused," and the educational staff's contrasting view of the parents as devoted, presented disturbing data—

warnings that needed immediate attention. In addition, younger siblings do not typically respond so violently to an older sibling's "crisis of adolescence." The phrase in itself was also a distress signal, a euphemism, a suggestion that there was more to the story. A movement assessment and analysis of its relationship to the warnings presented in the background referral might have created an alternate narrative, one which portrayed Nirit as the messenger and the family as the identified patient.

The discussion of Nirit's first year of therapy includes movement observations that could probably have been accrued during an assigned period of assessment. Imagine a four-week period or four hours across two weeks to observe eye contact, interactive distance, level of imagination, spontaneity, movement qualities, and movement themes. Results of this assessment might have highlighted Nirit's defensive behaviors, not just the obvious indicators such as lack of eye contact and her need to control the physical distance between herself and the therapist, but the more subtle ones that communicated Nirit's internal chaos and fear of expression. The movement therapist made a good start in this direction. She identified a constellation of movement phenomena: the lack of "connection to the center of her body," "sharp, broken, and stiff" limb movements, lack of spontaneous movement, and restlessness.

This constellation of observations, along with the sudden emergence of Nirit's anti-social behaviors, the results of the diagnostic interview, and the contrast between the child's perceptions of her parents and the educational staff's description of her parents constitute a powerful picture. Unfortunately, the therapist did not organize the information she gleaned into a coherent movement assessment. Her observations of Nirit's nonverbal behavior might have shed light on the conflicting information others had gathered. At the least, the therapist's observations could have reinforced the diagnostic interviewer's assessment or, at most, unearthed new information, hitherto unavailable to the team. Had the movement therapist been trained in the KMP, for example, she probably would have recognized that Nirit had been traumatized at ages three and four. However, one does not need the KMP to understand that Nirit's sudden acting out was related to facts and feelings she was unable to express in any other way.

Intervention

The authors make it clear that building trust was difficult, yet they do not mention movement empathy, the kinesthetic technique and resonant state that relates directly to rapport and the therapeutic alliance. Nor do they address nonverbal phenomena linked to movement empathy

such as synchrony, echoing, and shared effort and spatial qualities (Fraenkel, 1983; Schmais & Felber, 1977; Schmais & Salazar, 1998). A treatment plan based on the therapist's assessment of Nirit's movement repertoire could have actively involved the nonverbal indicators of rapport, and, more likely than not, shortened the lengthy trust-building phase. Similarly, analyses of the relationships between Nirit's movement repertoire and the warnings mentioned above might have resulted in a call for systemic interventions much earlier in the process. Adding family dance/movement therapy to Nirit's treatment plan is but one example.

While all dance/movement therapists must meet the challenges associated with documentation, and the goal of providing information from nonverbal channels to which other clinicians do not attend, dance/movement therapists who work with children have additional tasks. They must be able to explain how their work differs from play therapy, recreation therapy, and even movement therapy. In practice, dance/movement therapy treatment means integrating a child's preference or familiarity with play, the developmental aspects of movement, and the healing factors inherent to the art of dance. In Nirit's case, the therapist attends to nonverbal phenomena that a play therapist or others might not see. She is aware of Nirit's lack of "connection to the center of her body," "sharp, broken, and stiff" limb movements, lack of spontaneous movement, and restlessness. She also incorporates games that children at Nirit's developmental stage often play. The games free Nirit to embody her feelings within the structure of familiar modes of interaction. However, the therapist does not report working with elements of dance such as rhythm, flow, or the quality of movement, to name a few. Nor does she incorporate methods derived from dance such as improvisation, creative movement, or skill-building.

Technique, much decried by dance/movement therapists because it is an essential and sometimes stifling component of dance instruction, brings a vital aspect of dance to the therapeutic movement dialogue. If we accept that art is an interaction between form (technique) and content (expression), and that dance/movement therapists aim to expand their clients' movement repertoires, then technique ought to be presented as intrinsic to the dance/movement therapy process. The pioneers of dance/movement therapy included technique in their methods of intervention. Most obvious are Evan's Functional Technique (Rifkin-Gainer et al., 1984), and Espenak's Restructuring (1981). Functional Technique involved non-stylized rehabilitative and re-educative dance techniques such as postural work, coordination, placement of body parts, and rhythmicity (Evan, 1960, 1978a, 1978b, 1979). Restructuring addressed posture and movement capabilities such as coordination, strength, awareness, and relaxation.

Schoop took an overtly educational approach and worked, for example, with alignment exercises and mime to explore posture. She also choreographed therapeutic movement formulations to capture the essence of a client's experience. (Schoop & Mitchell, 1974). Even Chace taught basics such as posture and "body control as . . . taught in dance sessions in schools anywhere." (Chaiklin, 1975, p. 60) Siegel (1984), a psychoanlytically-oriented dance/movement therapist, introduced her patients to ballet. *LivingDance*™, a more recent approach to dance/movement therapy, calls for the therapist to function as a teacher/director who instructs clients in a technique grounded in natural movement, but a technique, neverthless. Mastering the *LivingDance*™ technique expands the clients' movement repertoire incrementally. This allows them to discover, in their own time, new ways express themselves and to access their innate capacities to heal. (Fraenkel, Franks, & Jacoby, 1997)

Nirit may have been too disorganized to respond to instruction, but a treatment plan that called for a movement ritual that included attending to boundaries, for example, could have incorporated other elements of dance—giving her a sense of place while creatively embodying the reality of beginnings and endings. Ritual is inherent to dances of healing in most, if not all cultures (El Guindy & Schmais, 1994). Acknowledging ritual and other aspects of dance such as synchronous and echoed movement, posture sharing, shared shared rhythms, efforts, and spatial designs, improvisation, choreography, and even costuming, hold the keys to unlocking the healing factors inherent to dance/movement therapy. (Benov, 1991; Duggan, 1995; El Guindy & Schmais, 1994; Espenak, 1981; Fraenkel, 1983; Navarre, 1982; Schmais, 1988)

Movement and dance/movement therapists work with nonverbal information as discrete events that can be viewed as kinesthetic messages (e.g., running to and from the therapist), but the dance in dance/movement therapy frees the clinician to go beyond the functional and the representational, to the abstract. Dances in the abstract, whether spontaneous or planned, can be understood best as a whole. They involve the neurophysiological changes that accompany physical exercise (Berrol, 1992), and the connections between motion and emotion (Berrol, 1992; van der Kolk, 1994), but they also involve the "spirit of dance" (Bruno, 1980) and its aesthetic elements.

Schmais (1988) made a brilliant start at identifying the healing processes that are unique to dance/movement therapy groups, but the conversation seems to have become lost in the need to justify dance/movement therapy in relation to psychology or "New Age" views on healing. Current body-based approaches to treatment may share our basic assumptions, but they do not focus on the healing inherent in the art of dance.

Summary

This case study serves as an excellent point of departure for examining what is unique in dance/movement therapy—whether it is specialized information that the dance/movement therapist can provide during the assessment phase, a treatment plan grounded in the language of movement, or healing processes that are inherent to the art of dance. It also points to the importance of taking a systems approach to working with children and to recognizing that individual dance/movement therapy, though primary, is still a sub-system within a much larger system. Dance/movement therapy affects the child, but it can also have a powerful effect on the system. Similarly, dance/movement therapy as a field is part of a much larger system—a system that will grow to respect dance/movement therapy—not in spite of, but because of, its unique contributions to the therapeutic process.

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