THEMATIC UNFOLDING
Movement Therapy on a specialist self-harm unit

Gerry Harrison

"I began my career nursing - I was a ward sister in acute psychiatry and involved in Cognitve Behaviour Therapy. I studied Dance Movement Therapy at Roehampton University, in South West London, where amongst other lecturers who inspired me, Dr Marcia Leventhal's approach resonated with me the most. I graduated from there in 1991. My contact with her has been ongoing, and I am very influenced by her teachings.

Since graduating, I have worked extensively in psychiatry, both in in-patient and day facilities - often introducing DMT for the first time.

I have worked in acute and long-stay areas, and with the elderly and young people. Specialist populations include eating disorder and mother and baby units as well as working with those who self harm.

I also hold a visiting lecturer position at Roehampton University, where my teaching responsibilities include the psychopathology module.

In addition, I have created links in the dance performance world, and have worked as a creative consultant with, for example, the physical theatre company - DV8".

ORIENTATION

The Crisis Recovery Unit (CRU) is a national specialist unit working with a challenging client group - individuals who repeatedly harm themselves. Harming behaviours include laceration, overdosing, chemical burning and blood-letting, for example. Some of the people who come into the unit have been diagnosed with borderline personality disorder and, in addition, may have other problems such as depression and/or an eating disorder. These difficulties may have roots in early life trauma, including sexual abuse. It is not surprising, then, that these individuals also engage in harmful relationships. Crowe and Bunclark (2000), who were instrumental in setting up the unit, note how the degree of psychological and social handicap is very high with this population.

The CRU offers a six-month admission package. The unit has a specific approach towards self harm. During my former professional role as a psychiatric nurse, the conventional management of these individuals involved admission to an acute ward, restriction and close observation. Crowe and Bunclark (2000) state that it is almost 'impossible' to extinguish self-harm in this way (p.51). They explain how this approach leads to further difficulties including harming in secret, and/or continuing the self harm once restrictions are lifted, and the loss of therapeutic relationship. Interestingly, residents explain that in most cases, self harm is not about death, but a means of survival. The unit has adopted a more realistic aim of reducing the frequency and/or severity of self harm.

Safety planning is an important aspect of treatment, and the nursing staff play a key role in this. It involves the resident tolerating some time between impulse to harm, and injury. This allows thoughts and feelings to be recognised and tolerated, and for the individual to make a choice to harm or not. Residents are encouraged to find alternative, healthier ways of coping and communicating, and are involved in a mixture of individual work, and a diverse group program - including the use of art and creative writing. All aspects of the day are seen as 'work' and are geared towards self-understanding, reflection, growth and change (Crowe and Bunclark, 2000, p.51). Given that these individuals have difficulties tolerating feelings and with relationships, inter-personal dynamics between staff and other residents provide a major focus during their stay. The unit resembles a therapeutic community.

In the summer of 2005, I attended the CRU training day, open to clinicians countrywide, and this helped me to deepen my understanding of how the unit worked.

MY ROLE

I introduced DMT to the CRU in 1995. I have taken breaks in service, but my current contact covers the last two and a half years. During the life span of the group, I have experienced a rich variety of movement expression from residents attending the sessions. I can recall the whole group dancing with mock guitars to Pink Floyd, and a time when we walked around the room with books on our heads! I can also remember working with several women who danced with the natural, wild quality of a gypsy. There have even been periods when no one attended the session.

Residents are able to clearly articulate what they think about the group and state the activities they will/will not do! I have adapted my approach in response to this feedback. In the past, people have been put-off attending by the word 'DANCE', and prefer the session to be called 'MOVEMENT GROUP'. I have also learnt to be sensitive when using touch, which is a loaded issue for some residents. A ground-rule has developed whereby we do not share touch, unless it is planned and members have a choice about participation. This provides a starting point, and area for discussion. It seems crucial that residents can explore issues around consent while working with movement and their bodies.

The session is not a class or a performance. Movement improvisation is a key aspect of the group. When facilitating this process, I am influenced by 'The Five Part Session', pioneered by my teacher and mentor, Dr Marcia Leventhal (1987). The parts are: WARM UP, RELEASE, THEME, CENTERING and CLOSURE. This helps me organise the transition from a cognitive, verbal way of relating, to a bodily felt, expressive place, and back again. This model taps the organicity of dance movement and encourages the process to 'unfold' in a natural way. Leventhal explains that when the body is released, muscular tension and obsessive thoughts are eased and an energy flow occurs, allowing movement themes and a 'felt level' experience to emerge. The thematic stage of the session is where movement is least structured, more spontaneous and at a deep level. As well as this structure, I make use of two further concepts, which are central to my practice: beginning with the group wherever they are, and having a deep trust in the unfolding nature of the movement process.

Before the audit period began, we had been using a typical group format, opening with each person saying how they are. Movement started with a ball-passing game, and then a movement prop and music were chosen by the residents. Props seemed an important part of the group. The closure stage of the session included an opportunity for people to verbally share their experience. The group lasts for one hour.

THE AUDIT PROCESS

Currently, I run four, weekly DMT sessions, all in acute inpatient settings within Mental Health facilities. It is my intention to be 'of service' in these specialist areas, both in terms of my collaboration with the multi-disciplinary team, and my therapeutic impact on clients. I had a sense that my work was valued by staff and residents on the CRU but I was curious as to how this could be explored further. As far as I was aware there was nothing written about using DMT with this client group, and further investigation of over a decade of journals yielded no further sources. This may reflect the lack of specialist units for this population. In an earlier paper about acute inpatient services I included a vignette of an individual cutting her arm, and how the therapy process helped to channel energy outwards in a safe way (see Harrison, 1994). The CRU has a tradition of research, especially in client-centred studies. I wanted DMT to be included within this portfolio.

Armed with embryonic ideas about examining a series of six sessions, and recording attendance figures, but with a main focus on exploring thematic material, I completed a proposal form, and forwarded it to the Clinical Governance Department of the Trust. I was delighted when they responded saying they would support the project. During fifteen years practice as a Dance Movement Therapist, I have noticed how service managers have used attendance figures as the main focus when evaluating the session. I have always supplemented this information with further detail about what happens in the group. I was interested then, in creating base-line standards when doing therapeutic movement work on a specialist self-harm unit.

I examined six consecutive Movement Therapy sessions during winter, 2005. I recorded group attendance and it was expressed as a fraction over the number of residents on the unit at the time of the session. Attendance in this group (and indeed all groups on the unit) is voluntary, and the unit has no more than six residents at any one time. The main focus of this project was to record thematic unfolding in each of the six sessions. I believed there would be a high resonance between the work in the Movement Therapy session and the therapeutic aims of the multi-disciplinary team. Following each session, I completed the 'Preliminary Observation/Discussion Grid' formulated by Leventhal (1982). This grid acts as a tool to record and reflect upon thematic material. It

draws upon Laban Movement Analysis, and the page is divided into three parts: BODY, SPACE, EFFORT. There are four columns headed 'First Impression', 'Associations', 'Interpretations' and 'Intervention'. See Grid below and refer to ***Note on p. 12:**

PRELIMINARY OBSERVATION/DISCUSSION GRID

P (PART)
O (OBS)

		Concrete Aware/ or 1st impression	Associations	Interpretations	Remedial or Intervention
	BODY				
BODY	Attitude				group activity
	Active, Inactive	arms/hands	handle	stay with	floor level
	Connections				scarves
	Integrated/Non				"
	Posture/Gestu	close upward	with	group intimacty	"
	Simul/Seq				"
	Sequences				"
	Initiation				"
	SPACE				
SPACE	Level	low/rising	release		"
	Plane	up/down			"
	Reach Space				"
	Directions				"
	Shape (Form)				"
	Paths				"
	EFFORT				
EFFORT	States				"
	Drives				"
	Indulging				"
	Fighting				"
	Phrasing	continuous	stay with		"
	Single standou	grow synchrony	release		"
	Range				"

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Role of LMA in Facilitation of Thematic Material in Dance Therapy Rye Hilton NY. 10/29/82 MBL

Prior to starting the study, I explained the process to staff and residents. Both parties were very supportive. I was impressed by the fact that the residents voiced their fears around losing the service, if not 'enough' people came. I stressed they should not feel under pressure to attend, and that the study would not result in the withdrawal of the group.

This study falls within the remit of an audit, as it focuses on an established, on-going group on the unit. I wanted to be able to understand my research position, and reading Creswell (2003) helped me clarify that I was using a 'Mixed Methods Approach' involving both quantitative and qualitative data. A small aspect of the study was quantitative in nature, concerned with statistical data and attendance figures. However, the main focus was to track thematic material and involved a more qualitative, subjective approach. I was aware I had various roles within the group, a personal role, that of leader/therapist, and researcher/auditor. I moved with the residents, lead the group using my personal style of facilitation, and made my own reflections on the thematic material. Creswell (2003) validates using a 'personal, first-person subjective point of view', with myself 'in the narrative' (p75). He continues that qualitative procedures 'unfold', and so the research position reflects working practice (p179). Stanton-Jones (1992) in her introductory text

on DMT in Psychiatry, acknowledges the many styles of practice in this field, and says that to 'some degree, the therapy is the therapist' (p81).

I conducted this piece of work in a safe, ethical manner. Group attendance was voluntary at all times. The case notes were not used, and anonymity and boundaries around confidentiality were a priority, as well as my having a sense of equality and respect for each resident. These considerations are in accordance with my contractual arrangements with the Trust, and the Association for Dance Movement Therapy UK Code of Professional Conduct. I also attended regular clinical supervision. At a later stage, residents were asked to give consent to share the material with a wider audience, including publication in a professional journal.

RESULTS

Attendance

The attendance figures over the six-week period were good. Overall the modal average attendance was 80%. Of the six residents who attended over this time, two attended all six sessions. These two people said that they were aware that movement sessions were part of the CRU group program, and that this had had a positive influence on their decision to be admitted. One person came to five out of six sessions, and the other three people attended only one session. Two of these residents had just arrived on the unit, and new people are encouraged to attend all groups in their first week and then decide if they want to continue. A group member was unable to stay in the session and so left the room during week two, and then another member left in week four.

	Attendance Frequency	Attendance Percent rate
Week 1	4 out of 5	80
Week 2	4 out of 5	80
Week 3	2 out of 4	40
Week 4	3 out of 5	60
Week 5	3 out of 5	60
Week 6	4 out of 5	80
Modal Av.	4 out of 5	80

- 2 residents had 100% attendance
- 1 resident 83% attendance
- 3 residents had 16% attendance

Week One

An interesting development occurred in the first week of the study. In previous sessions we had been playing a ball game to warm up. This week a resident brought in three juggling balls and showed us a group juggling sequence. Everyone became involved in this, and were all more skilled than me! Once established, the effort synchrony between the members of the group was maintained for some time. This seemed to express an intention to be involved in the process and work (and play) as a group.

This week, the group chose to work with the Buddy Band. We got inside the band, and gentle music was chosen. We moved for about three minutes with no further direction from me. I noticed how the band continuously changed shape, like an amoeba, and, again, how we shared effort synchrony. The band was flexible, straining and releasing, causing us to come together and then apart.

After this experience, the group talked about relationship issues including balancing polarised feelings of co-operation and 'hate'.

Week Two

This week we worked in pairs while moving large scarves. The cloth was over two metres, setting a distance between us. One resident suggested we each took a turn to opt out of the activity to observe, and then come back in. Again, I can recall a strong effort-synchrony between the changing dyads, and indeed, the whole group. The cloth moved with a light, sustained floating quality. Then a surprise occurred, the movement expanded as couples shifted and the cloth passed over/under in a sudden, dextrous manoeuvre! We laughed, and it seemed like an exciting moment!

After this experience, a resident reflected on earlier discussions in the community meeting and 'walking on egg-shells'. It seemed that the group had released some tension, and could now move with more ease.

Week Three

Only two residents came to the session today, and we used a larger space, the hospital sports hall. At the beginning of the session one resident said they felt 'elated' while the other felt low in mood.

This was reflected when we moved across the space, and fighting and indulging qualities emerged. One person used jumping and stamping actions. We moved together at one point and I could feel the

force of my weight going into the floor. This resident liked the noise she made while moving, and said her name with assertion. The second resident moved with a light, floating quality, and raised her arms gracefully. She needed to take rests from time to time.

Something else happened in the session, and I was not able to fully appreciate how significant it was until later, when completing the Discussion Grid, and during further reflection in clinical supervision. Several times all three of us had been drawn to the big physio ball on the edge of the space. We formed a close circle, and beat out a rhythm on the ball using both strong and gentle weight through the hands and fingertips. We were absorbed with this for some time. I reflected how the experience seemed to provide the residents an opportunity to express their different feeling states, and then come together and share them.

Week Four

Two residents came to the session today. We moved on our own with scarves to classical music. One resident moved as if conducting the music. I noticed how this individual's body core was held, and their arms moved with speed and continuity. This resident had previously described difficulties in moving their arms while improvising. It was later helpful for me to recreate the same movement in supervision, and be aware of a need to release the breath.

The other resident moved using a variety of actions. She made a full slashing action with the scarf and made a sound. She wore the scarf around her like a cloak, and raised her arms upwards lifting the cloth and walked in a light, sustained way. She was tearful after this experience, and shared verbally, and later, in narrative about her dance in three parts. She was interested in exploring 'less destructive' ways of expressing 'intense' emotion, and found the group an 'effective outlet'. Her anger was 'diffused' using props, including using the scarf as a 'whip' and making a 'cracking' sound. Wrapping the scarf around her gave her a sense of 'security'. The scarf, 'nymph-like' above her head was like 'the ripple of breeze flowing through the woodland' and 'freedom'.

Week Five

This week, the staff said that the residents were having difficulty staying with feelings.
One resident did not like the music we played and the person who had chosen the piece became tearful, and believed she was at fault. We sat close together on the floor with scarves in the centre. I put on a piece of gentle music. One resident began lifting the scarves up into the air. We all became involved and used our hands to keep the scarves in their upward, growing motion, and maintained this for some time. I felt part of the group effort involved in this.

Afterwards, I acknowledged how people had stayed in the session. Later, I reflected on how the group had been able to find a creative way of 'handling' difficult feelings together.

Week Six

A member of ward staff came into the session today, the last session in this study. It is usual for new staff to visit the group as part of their induction process.

We played the juggling game again, and managed to keep four balls in play! We went on to use the stretch cloth, and moved to a piece of music brought in by a resident.

After this, another resident voiced her curiosity about what it would be like to be held in the cloth, and so I suggested we test it out. I was first to lie on the cloth, and with one person near my head, and two people each side of me, I was rocked from side to side. I could feel the tentative quality of the movement, and I asked if it could be done more slowly, and they responded sensitively to this. Two residents took a turn to be rocked and lie in a tucked, foetal position, and were able to yield and experience their weight being held. Everyone assisted with the cradling, and I noticed how the core of their bodies were involved in the rocking rhythm. I was very moved when several residents sang a soft lullaby as we did this, and one person sang descant harmony.

After this experience, the group talked about a variety of issues, including trust, gentleness and strength. Self-nurturing and comfort were also discussed.

CONCLUSION

This audit project represents a first stage or pilot study. It examines the attendance and thematic unfolding of six sessions of Movement Therapy on a specialist self harm unit. The attendance in the group was good over this period. Interpersonal relationships was the central theme explored during the study. The optimum environment for these themes to unfold were afforded by the containing structure of 'The Five Part Session' (Leventhal 1987). Stanton-Jones (1992) cites Hawkins who says that such experiences heighten awareness,

making interaction occur 'at a felt level' and is 'honest, authentic' (p.44). I am also aware of the importance of the use of movement props in the session. The movement event allowed this group to play, create, and experience at a felt level. This illuminates for me the profundity of using this medium. Working with relationships is resonant with the therapeutic aims of the unit, especially given that it is run along the lines of a therapeutic community.

The 'Preliminary Observation Discussion Grid' (Leventhal, 1982) served as a valuable tool when recording and processing the thematic content of each session. It helped me make valuable connections that I had not made in the session. It also acted as an excellent preparation for clinical supervision. I can see that video recording would be useful in future projects. However, I am also aware the camera would be an intrusion into the group space.

The biggest challenge I encountered during this study, was working on the text within my working hours. I am contracted to work seven hours a week for the Trust, and in this time, provide a weekly session for one other unit as well as CRU. I wanted to complete the project within six months, but resisted doing a large amount of the work at home. It was important to protect myself from burn-out, or my own 'self harm'. I realise I have a learning need, and in the future, I would like to further develop movement observation skills, especially in group settings.

I welcomed the opportunity to define my role, and doing the study did seem to have a positive effect on my relationship with residents and colleagues. I am planning to employ the Thematic Unfolding Evaluation Model in other clinical areas in the Trust. I will seek opportunities to present this work to staff within the hospital, or to a wider audience, especially with my DMT peers. I now feel more prepared and experienced to take on further research-related challenges, and would be interested in collaborating with a co-worker.

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***Note:** The Preliminary/Observation Discussion Grid is the work of Dr Marcia B. Leventhal and printed with her kind permission. Anyone wanting to use it for validation or as a research tool must have consent from Dr Leventhal and may require training prior to its use.