Time Out of Time: Dance/Movement Therapy on the Onco-hemotology Unit of a Pediatric Hospital

Marcia Plevin & Leonella Parteli

American Journal of Dance Therapy
Publication of the American Dance Therapy Association

ISSN 0146-3721

Am J Dance Ther
DOI 10.1007/s10465-014-9185-2

Springer

Am J Dance Ther
DOI 10.1007/s10465-014-9185-2

NARRATIVES

Time Out of Time: Dance/Movement Therapy on the Onco-hemotology Unit of a Pediatric Hospital

Marcia Plevin · Leonella Parteli

Abstract The suffering caused by a diagnosis of cancer with subsequent hospitalization is traumatic for children and their parents. Their lives change from one day to the next and time is no longer the same. Being hospitalized on the onco-hemotology unit of a pediatric hospital implies waiting for medical examinations and procedures to be completed with consequences of passivity or hyperactivity induced by long treatments lasting days, weeks, and even months with uncertain results. An underlying anxiety accompanies this waiting, which constantly pervades the atmosphere of the unit. It is a time out of time. This article illustrates, in the foreground, a clinical approach of dance/movement therapy (DMT) on the unit using movement analysis including Laban Movement Analysis (LMA) (Laban, 1980), fundamental body connections (Bartenieff & Lewis, 1980), and elements from the Kestenberg Movement Profile (KMP) (Kestenberg & Sossin, 1979). In the background influencing the understanding of movement analysis, theoretical concepts of authors such as Winnicott (1985), Bollas (2001), and Stern (2011), contribute to the interventions. The author's body as a *Corpo Ambiente* (body/mind environment) is the state of being that she brings with her from room to room, from

This is a revised publication from Marcia Plevin with a contribution of Leonella Parteli originally published in the volume *Lasciar parlare il corp* (Art Therapy Italiana, Istituto di Ortofonologia, editor Anna Di Quirico, Edition Magi, 2012, pp. 229–252) (Excerpted here with kind permission from *Edizioni Scientifiche Magi*).

M. Plevin (✉)
Via Raffaello Giovagnoli 25, Rome, Italy
e-mail: marcia.plevin@alice.it

M. Plevin · L. Parteli
Faculty Art Therapy Italiana, Institute of Expressive Arts Therapy, Bologna, Italy
e-mail: leonellaparteli@tiscali.it

M. Plevin
Institute of Creative Arts Therapy, Inspirees, Beijing, China

Published online: 13 November 2014

bed to bed, to activate and offer therapeutic relationships with three children through movement, dance, play, or simply assisting and staying with their emotional states. The child's age, particular medical treatment, temperament or personality, and resilience to change constitute the physical, emotional, mental, and spiritual nucleus within the hospital's structure, and are the center of this article.

Keywords Oncology · Life force · Dance/movement therapy · *Corpo Ambiente* · Body/mind environment · Creativity · Death

Introduction

An onco-hematology unit in a pediatric hospital is a place that induces waiting and passivity. It is a time out of time where both children and parents suffer in response to the diagnosis and see their lives change from 1 day to the next. Time is no longer the same. The familiarity of home, simple normal habits, and freedom for the body to go from here to there, are compromised. Along with medical care, the child's age, temperament, personality, and ability to find resilience or not to the changed situation, form the affective nucleus within this article.

After 8 years of practicing dance/movement therapy (DMT) on the onco-hematology unit of a children's hospital, I recognized the complex nature of DMT in this setting. Whereas an 8 year-old girl may tap out a beat with her hands on the bed moving her whole body in time to the rhythm, breaking out in a smile, an adolescent might refuse any kind of movement intervention because life is "out there" not "in here." He might wait until he is outside to live. Another adolescent might welcome with open arms a chance to stretch, move, stand up in a hospital room, dance to music, and talk about the difficulties of the confinement. This article is written with deep gratitude and affection for all the children I have worked with during these years. They are the motivation for me to share how communication and relationship through movement, dance, play, and simply being a presence next to or on the bed can be therapeutic factors, integrating "life time" with the medical oncology treatment.

As most know, the tradition in therapy is to have an enclosed private and protected space in order to practice. However, in this oncology unit, there was no closed or protected place. Even if a child was in a single room, there was a constant coming and going of parents, medical personnel, and cleaning staff. The dance/movement therapist is asked to bring a therapeutic presence into this setting. I have named this presence the *Corpo Ambiente* (body/mind-environment). This is a physical and mental state of being that encompasses a moving, dancing, playing, holding environment that is both created from and influenced by the particular atmosphere the therapists find when they enter a room (Winnicott, 1985). All incoming cues from verbal to non-verbal, any sounds, smells, the "feel" of seen objects, concrete physical contact with the different materials and fixtures in the room can become part of therapeutic interventions.

The therapist's internal dance meets, so to speak, the external environment that includes her naturalness of movement, kinesthetic and somatic empathy, a capacity

to create and improvise from thoughts and physical impulses both known (conscious) and unknown (unconscious) (Bollas, 2001). How a therapist responds to incoming stimuli is a deeply felt inner choreography, a "somatic countertransference," a term first coined by Bernstein (1984) who described it as an "inner pas de deux" (p. 321). Pallaro (2007) writes "…it is imperative for a therapist to be able to access one's own body memories, bodily affective states, and sensation in order to differentiate one's own material from that of the patient" (p. 184). This differentiation also comes from her being in touch with her internal perceptions, sensations, and emotional barometer. She checks the climate within her body and distinguishes parts of the inner pas de deux. What is hers? What belongs to the patient? Where is the ground of therapeutic responsiveness? The therapist might be perceiving the subtle body (Schwartz-Salant, 1982). The somatic impulses, movement or energetic impulses both within and without her body boundaries that indicate unconscious processes in the area between the patient and herself. *Corpo Ambiente* is a state of therapeutic presence that describes the therapist and the environment in constant flux and change. The sometimes rapid and unpredictable changes in the actual environment of the hospital room suggested spaciousness, to this author to which the words *Corpo Ambiente* are suitable. Importantly, the therapist must access and live in this spaciousness in order to register psychic/somatic and subtle body signals from the environment, resonate with the changes they may bring, and appropriately activate responses to the patient's needs.

Authentic Movement is a path of consciousness based on the evolution of what is known as the inner witness. It is both a discipline and a practice regulated within specific parameters where to see, to be seen, and the relationship that develops from these two different states form the foundation of the work (Adler, 1999). The practice of Authentic Movement creates and refines the *Corpo Ambiente*. This practice deepens conscious embodied presence and readiness to witness and respond to subtle body/mind changes in oneself and in others. Adler writes, "Seeing oneself, seeing another, becomes synonymous with knowing oneself, knowing another. Direct experience creates intuitive knowing" (Adler, 2007, p. 262). As soon as the therapist steps into the hospital room, she is open to that intuition in service to what the environment requests. She renders herself part of that same environment, becoming a transformative object in a potential space (Winnicott, 1985).

Initial communication with patients is often non-verbal. The child's body language, more than words, speaks to a dance/movement therapist's organic approach to the relationship. Children in this hospital come from all over the world, which naturally translates into using body language, rather than words, to develop any kind of rapport. The affective nucleus of this article begins here—through a dance/movement therapist's use of non-verbal communication. Laban Movement Analysis (LMA) and the Kestenberg Movement Profile (KMP) are used in the foreground of this article for assessment and diagnosis. Underlying my responses to the patients and in the background, movement observation is understood together with psychodynamic theories rooted in the conceptual models of Bollas (2001), Stern (2011), and Winnicott (1985). The hospital setting will be described and illustrated through LMA's motion factors of tension flow, time, space, and weight (Bartenieff & Lewis, 1980; Laban, 1980). Although these particular factors are

understood theoretically as an individual's inner impulses for movement in relationship to space, they will be defined and integrated here within the experience of hospital life as they are "…a combination of kinesthetic and thought processes that appear to be almost simultaneous at different levels of consciousness" (Bartenieff & Lewis, 1980, p. 25). They belong to the child's concrete and symbolic experience of the inner world of feelings and emotions, which are affected by coping with the outer world requests of hospital life. Because LMA factors communicate conscious or unconscious inner impulses for movement, I use them to illustrate "time out of time" where inner impulses to act are, in the main, thwarted in order to conform to hospital regulations and required medical treatment procedures. Through this lens we will look at how the therapeutic relationship develops. Particular interventions are described to illustrate the responses of three children to dance/movement therapy. The second child's narrative includes observations from a Certified Movement Analyst, who analyzed the first author's interventions for 3 months. This analysis was part of the initial step toward a research project to measure the qualitative effect of DMT on the unit.

Hospital Life Through a Laban/Kestenberg Lens

The quality of tension-flow indicates the intensity with which energy moves through the muscles. The flow notes changes in muscle tension alternating between basic elements of movement from free to bound. Adjustments, abrupt or gradual changes in intensity, or the degree of animation in the flow can also indicate emotional or affect variance. (Kestenberg Amighi, Loman, Lewis, & Sossin, 1999). Tension flow is the initiator of all the efforts that follow and can determine at a certain level the affect or emotion underlying a body's posture, gesture, or movement. Both children and their parents are being asked to be in the flow of hospital time, whatever that entails, but mostly to wait. Natural daily rhythms are abated; movement and space become restricted for the family unit. This may result in a way of being that can be identified in the child as "neutral flow"—an un-animated way of being, the waiting or non-action of illness (Kestenberg Amighi et al., 1999). Within the spectrum of flow, there is a continuum from free and liberating, which is known as indulging muscular flow. For example, from freely swinging an arm while holding a scarf, to fighting muscular flow in a bound and contained way like pulling an elastic band tight around a box. Dance/movement therapy offers the child and, at times, the parent interventions that can alter and transform neutral flow through movement, dance, and play. This enables them to experience diverse intensity in flow through improvised and spontaneous rhythms. For example, using the bed or the child's body as a percussive instrument, stamping feet on the floor, swaying arms in the air in time to music, or simply playing ball.

There is a general sense of anxiety on the unit resulting from the uncertainty of treatment and the fear that death could be the final outcome. The impact of the medical diagnosis, the changing of it, or the effect of a different or new medical procedure can create an atmosphere of bound tension flow. A young girl's eyes dart quickly as the nurse walks into the room holding medicine to inject into the "tree,"

a vertically standing electric pump which administers medical treatments through a series of tubes directly into the child's body. The child's quick and sudden eye movement signals wariness and concern even if she is moving in free tension flow with a scarf in the bed. She illustrates a markedly mixed rhythm between bound and free tension flow, between low and high intensity (Kestenberg Amighi et al., 1999). The hope of life with the impending possibility of death is a constant presence on the unit. According to Kazak, Boeving, Alderfer, Hwag, & Reilly (2005),

> it is essential to view a child with cancer and his/her parents as a system unit. Not only does the child have cancer but the family as well. Parents of children with cancer commonly suffer symptoms of post traumatic stress both during the treatment and years after their children survive the disease (pp. 7405–7410).

Time can decelerate (with a felt sense of slowness) or contract (accelerate with a felt sense of velocity). Time is generally endured in a hospital. Even though this motion factor is not about the duration of time but rather one's relationship to it internally, the length of the hospital stay necessary to complete cycles of treatment affects the children and their parents. Deeply troubling questions lurk. How long will treatment last? Will this illness alter my child's life?

A child needs to be hospitalized in order to bring his life back, to get time back or, with the use of certain drugs or treatment, to "buy" time. There can be no urgency in the way treatment is given, but a palpable urgency exists in the hearts and minds of parents and children hoping to be cured. Hospital stays can be long, lasting months or even years.

The suspended duration of time along with restricted physical activity can affect children differently and can change during different phases of treatment. A young child may become hyper-reactive to DMT interventions, which calls on me to introduce modulating movements. Given the chance to move, a child may escalate quickly into a frenetic release of energy, a vehement use of weight and accelerated time, which can be noted in the language of Laban (1980) and Kestenberg Amighi et al. (1999) as attributes and/or pre-efforts. According to Kestenberg Amighi et al. (1999), "Attributes are internally felt rhythms which indicate primitive patterns of tension flow associated with temperament: from neutral to low to high intensity, from gradual to brusque or an adjusting flow" (p. 15). Pre-efforts illustrate, "defensive behavior that acts as a bridge to the more mature effort actions in space such as gentle or vehement use of weight, hesitant or sudden use of time to a flexible or channelled use of space" (Kestenberg Amighi et al., 1999, p. 327). Although physical release is desired and needed for a young child, a modulated rhythm of exertion and recuperation (Bartenieff & Lewis, 1980) becomes central to the choreography of movement interventions. The choreography will look like a fluctuating exchange in movement between energy and repose. On the other hand, for a number of adolescents there is no "life" in the hospital. They wait for the time to be "out there." That is where life is. Yet they will move a hand-held video game with intense rapidity mirroring an internal need for focus, speed, and excitement that they consciously or unconsciously lack.

The duration of a therapeutic intervention is never fixed; it depends on the child's medical condition, the administration of medical procedures that go on continuously throughout the day, and whether or not the child is in the mood. Walking into the room to establish contact and attune my *Corpo Ambiente* to match the child's timing gives rise to the rhythm needed for establishing a relationship. Once a relationship is established, particularly with very young children two to five years old, issues of attachment and separation can present themselves even within the brief time of 20 minutes. For many, an object, such as a feather or a ball, has been left with a child to placate the loss of a found relationship or the need to hold onto something, to possess something, in an environment where so much is taken away.

The motion factor of space, an inner impulse for focused/direct or diffuse/indirect attention can be seen on the unit on different levels: the infant or toddler focused on the presence or absence of the mother can become immediately anxious if she goes to the bathroom or walks out of the room for a moment. The brief disappearance of the mother can leave the child bereft. Older children from four years to adolescence can be pointedly focused on the medical procedures or measurements of bodily functions to the extent that they literally cannot take their eyes away from the nurse or doctor. Older children in particular may want and need to be distracted to alleviate the pressure and stress of the illness. If the child or parent is not sleeping when I enter a room, they usually are reading, watching television, playing a video game, surfing the computer, or playing with toys in bed. A child's focus may change to interest and surprise, two positive life forces (Stewart as cited in Chodorow, 1991), when I step into the room to offer my presence and suggest possibilities of movement. My attention and body shifts to whatever is holding theirs in order to establish contact. Laban Movement Analysis refers to this as elements of Space Harmony (Bartenieff & Lewis, 1980). My body's ability to mold, shape, and carve space in different dimensions is a challenge in a small hospital room. The shape of my body mirrors the shape of the child in a restricted space. Children's psycho/physical development is dependent on their body's use of space (Kestenberg & Sossin, 1979). The space of the room, the bed, its confines, the tree pump administering treatments, and the length of the infusion tube are all factors which limit the child's use of space or intention to use space. Opening her arms wide, throwing a scarf from one end of the room to the other, stretching a long elastic band from her hand to mine while I stand in the corridor outside the room serves to extend the child's "kinesphere" or "reach space" (Bartenieff & Lewis, 1980) and allows her to cross through different spatial planes. Most importantly, it sparks muscle memory of being able to move, play, and dance.

During chemotherapy cycles, patients sometimes walk with the tree in the corridors. The pole can be moved to accompany the child's need to improvise dances or play movement games. An improvisation or choreography may evolve, dependent upon the space we have to move in, the length of the IV tube, and the probabilities of what body part may be available to move that day. Having adequate space to offer movement interventions is elusive at best. Yet one can do much in the space of a postage stamp. Limitations compel creativity.

Wanting to make and establish focused attention with the patient vies with the needs and the protocol of the hospital, calling on the therapist to be a multi-focused

juggler attending to the child's parents, the doctors, nurses, and other figures who constantly move in and out of the hospital room. At times these figures remain in the background, at others they may enter the setting to become an integral part of the DMT intervention at hand.

Seen on a continuum from passive to light/active or strong/active use of weight, the weight quality is concerned with one's relationship to gravity; how one's inner impulse translates into moving with intention and impact or with a light, airy touch. Passivity and inertia also belong to this quality. I may enter a room where all the family members are passively watching the television monitor. I register heaviness or a limp numbness in my body with underlying feelings of worry and fear. The weight drops in the room in a collective family act of passing the time. On the other hand, lightness and delicacy in the care and cure of their children is present in the parent's handling the child's hygiene and medication. Nurses in particular, must be direct and focused, quick and light in their touch, in order to manage a number of intravenous and other medical procedures.

It is an arduous and confusing time when the child and parents have to wait for directives from the nurses and doctors rather than act on their own; this time is one of patience and waiting. The wait for the patient is lived generally on the horizontal plane where perception of weight and strength can slowly ebb after many weeks in bed. A combination of dimensions, planes, and spatial pulls are at work on the children even while they are lying in bed. Basic body positions are found first in dimensions that can be seen in a vertical position-up/down, sagittal- forward/back, and horizontal-left/right or sideways/across dimensions. The planes invest in two spatial pulls at the same time. The horizontal plane combines right/left with forward/back spatial dimensions (Hackney, 1998). The child lying in bed is in the horizontal plane. A DMT intervention can transform the child's use of weight from a passive state in neutral tension flow to an active strong or light use of the body. This weight transformation can change a relationship of the body to space. Children naturally do not want to be passive. When they feel comfortable in an established and trusting relationship they are curious and generally want to move. A hospital bed can become a corral for horses, the cage of a ferocious animal, a performance stage, a place to hide under a tent and whisper secrets, a grass rug on which to eat a picnic…another place. Children can change their use of weight through different interventions without leaving the bed. When children physically can or want to change levels from the horizontal to the vertical plane, to put weight on their feet–to move, dance, play in the sagittal plane perhaps even rotating the pelvis using spirals and diagonals—they are reconnecting to their vital force, intention, and freedom to move.

The above-mentioned motion factors are generally found in combination with one another. They offer an integrated grid of qualities to evaluate the psycho/physical aspects of the child. However, here they were separated to illustrate the hospital experience and their relationship to the children's response and, to a lesser degree, the parents' response.

Children's body language—the way they are lying in bed or up and about, their eyes and facial expressions, their being attached to the "tree," indicates how I need to transform my *Corpo Ambiente,* body-environment, in order to enter into a

therapeutic relationship. The unique contribution of DMT lies in its emphasis on the meaningful nuances and subtleties of body movement (Cohen & Walco, 1999). Sensitive attunement to gestures, movement, and voice creates a non-verbal bridge which can bring the child and myself into contact. As I come into contact with the child, I ask:

- On the functional level: what is physically possible for the child?
- On the developmental level: what type of sensory or cognitive intervention may be age appropriate?
- On the psychological level: what message is the child sending about herself and the stage of her illness through movement? Is this a first cycle of treatment or perhaps the last? Is the child in the hospital because of fever, a surgical procedure, other? What are the emotional consequences that are both visible and invisible?
- How is the child reacting to my presence in the room—with curiosity, interest, acceptance, refusal, or indifference?

The patients (their names have been changed) in this article are middle school aged children. They are seen moving, playing, dancing, laughing, and sometimes immobilized displaying silence, fear and anxiety. The central part of a DMT intervention is to first establish a relationship with the child, then to contact the internal resources of the patient, to sense where he or she is in the "here and now," and to be intuitively sensitive to what a child needs on both conscious and unconscious levels.

Case Examples

Play Hidden in the Curves of the Body: David

When I entered nine-year old David's room for the first visit, I sensed palpable anxiety and fear. He was sitting in bed with his knees tucked under his chin, his back curved and chest sunken in. His wide blue eyes darted quickly to his parents, who were standing near the bed. He seemed to be mirroring the anxiety and tension that I felt emanating from his parents. After I introduced myself as a psychologist and a dance/movement therapist, we talked about where they come from, what grade David was in school, and he told me that he was on a soccer team. Because I speak with an accent in Italian, the conversation turned to where I came from (USA) and how long I had lived in Rome. I already knew from the medical charts I consulted with before visiting the children, that David recently had a tumor removed from his right foot.

I began to sense the situation and assess if and how an intervention might be initiated. Although David was hugging his knees and sunken in his chest, his eyes and face were alive with interest and curiosity. I felt in my own *Corpo Ambiente*, a lack of breath. I could not sense any "shape flow" in his body. Shape flow indicates how the body grows or shrinks in relationship to breathing. Enlarging the breath can create open space with the accompanying sensation of ease while diminishing the

breath may create a closed form associated with ill ease (Kestenberg Amighi et al., 1999). By offering him a small "bean bag" to throw back and forth between his hands, I was interested to see if David could open his chest and use his arms. As he began throwing the bag, his knees dropped down to the bed, his chest widened causing his breath to become deeper, and he begans challenging himself by throwing it higher in the air. Although his parents hovered nearby, David's focus left his parents' gaze as he concentrated fully on the movement. Soon after, I offered a small ball to throw that turned into a game of catch. David begans throwing the ball to me with more force. His torso and arms spiralled out into space to reach me as I moved further away to different parts of the room. His range of movement grew as he engaged his pelvis. This added more thrust to his arms. Next he used transversal movement on all three planes: horizontal, vertical, and sagittal in ample spiral forms (Hackney, 1998). He was laughing and challenging me when an important action occurred. He suddenly threw the ball to his father who joined in. What ensued was a three way game of catch with changing levels of intensity, different ways of throwing, and unpredictable moves by David who wanted to trick both his father and me. A non-verbal relationship was set up by David's throw to his father that seemed to reassure his parents. As Mendelsohn (1999) described, "…children are put in a situation where they feel they must take care of the very people from whom they should be receiving emotional and physical support" (p. 67).

The initial anxiety I felt when entering the room dissipated into an atmosphere of play and liveliness. David's narrow and restricted upper body had opened and widened into space; his posture was re-shaped and his movement quality had changed which allowed for a visibly different self-concept.

The body memory of playing ball accompanied by laughter started the motor of David's inner resources and engaged his own and his father's life force. Through movement, both parent and child were able to modulate the affect of anxiety. This assisted them in coping and adapting to the demands of the situation.

Sara's Landscapes

Walking in the corridor, I saw 7 year-old Sara for the fifth time in about 3 months. I made two observations: first, she was physically attached by a tube to the 'tree.' Body movement would necessarily be limited to the extension of the tube. The second observation came as a pleasant surprise—Sara's eyes lit up when she saw me. When I arrived at the hospital, I do not know what children will still be on the unit from 1 week to the next. I have learned that the continuity of a therapeutic relationship is not necessarily in seeing a patient every week. A child remembers and continues our relationship even though we may not see each other for weeks or even months. Sara's eyes widening was, I believe, because she also saw the wagon that I wheel with me on my visits from room to room, from bed to bed. In our previous sessions, Sara chose some objects from the wagon to dance and play with, but she never looked into the wagon. These initial sessions stimulated her to experiment and familiarize herself with some of the wagon's contents, a precursor of what was to come. The wagon was home to a portable CD player, colored

scarves, balls, puppets, tubes that light up, large colored elastic material, etc. It was a container holding objects that can open potential space in where a child might discover her own vital force and energy. It contained the fertile earth of the child's and my own creative potential.

I was happy to see Sara also. My internal climate was positive, my breathing easy; using LMA terminology, I opened into more of a communicative horizontal plane. Concentrating on observing my *Corpo Ambiente*, my internal climate, I sensed attention to the space was both direct and multi-focused. The sensorial signals from Sara created an attentive and fluctuating state between us that functioned to synchronize our therapeutic relationship.

Below is a LMA/KMP analysis by Leonella Parteli of a session with Sara based on the session in the following week.

When the therapist arrived (in the room), she found Sara, a seven-year-old child, lying on the bed. The extreme thinness of her suffering body was suffused with a constant low intensity flow of muscular tension with no animation. This spoke to the seriousness of the disease that had reached a terminal stage. According to Kestenberg and Sossin (1979), flow of muscle tension with a "neutral" attribute—particularly when it is so deep and in combination with a "low-intensity" attribute—contributes to silencing feelings and thought. We often find this in existential situations such as nervous breakdown, depression, disease and trauma. While it anesthetizes and stupefies the body, emotions and thought, "neutral" flow also carries out protective functions such as defense and/or adaptation to the anguish of existential situations perceived as overpowering.

The therapist introduced a colored ostrich-feather with a pliable central stem and soft filaments along its sides. These filaments hovered and floated lightly in the air with a wave-like motion. The spiral waving movement of my wrist released a lightness and flow. The feather brought a smile to the child's face that broadened gradually and gently becames more radiantly intense and full. The broadening smile radiated through Sara's whole body and her muscles seemed to regain tone and plasticity. It was now evident that a transference of qualities in their essence had been made and a delicate animated flow appeared in Sara's body. She was so involved in this movement that her inner worries seemed to have gone away. The feather became a medium for relationship/curiosity: was this an object that could attract interest somehow? How could it be used? It was an "evocative object" (Bollas, 2001) that could be invested with subjectivity and could activate, motivate, or surprise.

Sometimes the young patient herself invested objects with expressive movement-actions. Other times it is the therapist who introduced actions that encouraged the patient to say "yes" (a curious response towards the object, receptive openness to know and interact with this object better, verbal or even non-verbal answers given through widening eyes, the body moving forward, a smile softening and relaxing the facial features…) and as the session goes on, the therapist introduced other actions. "How" the object was presented, explored, used and discovered was a continual dialogue between what the therapist perceived and registered within the patient during the movement process.

Little by little the feather assumed the "colors" of Sara—objective material permeated with subjectivity. A rhythmic phrase began to appear with a dynamic quality that announced a combination of motor actions that later on became more incisive in the session. Lightness flowed freely (in the wrists of the patient and therapist) designing flexible and animated trajectories in the space that brought a joyful and playful atmosphere to the session. Within the space there was a fluctuating sensation when her movements changed the tempo of the phrase. This happened when time accelerated, and movements suddenly became transfigured into their opposite quality of active and direct force. A fighting quality predominated in the actions that brought Sara to a loose spatial attention and she entered a disoriented state.

The therapist introduced a type of bean bag—a cloth sack with a filling inside that makes sound, that Sara accepted with the questions: "What is it?" "What produces this sound?" "What's inside?" Perhaps this simply reflected a state of curiosity and a need of knowing/defining what was not known. Perhaps it was a reflection or need for Sara to understand it by herself. The cloth sack made the child stand up. Fighting qualities—structured in directional forms and related to the environment with intention—were now in her feet and hit the sack. In this case, Sara's attention to the space and her relationship to the environment disappeared. This loss was preceded by micro-pauses in the actions.

I introduced some fabrics, materials resembling the feather for its characteristic qualitative combinations of dynamics and form that are potentially intrinsic to the object. Sara was standing in her extreme thinness, but stable and light. The soft fabric allowed her to recover more indulgent qualities by coming into contact and touching it. After this sensory contact, Sara started to throw the material in the air. She loved to throw things especially when her own kinesphere got larger by degrees reaching beyond it towards the other. Sara was surprised by her ability to catch and throw the material and this was accompanied by laughter and amusement.

Throwing the material brought back the rhythmic phrase containing motor actions that changed from a predominantly indulgent and expansive quality, to dynamics of rapid acceleration in time and a fighting quality with sudden decelerations. As was seen first with the cloth sack, a certain model of action returned which brought a quick change from a more indulgent quality to one that was predominately fighting which led Sara to again lose relationship with her surroundings.

Concentration of vital energy in order for Sara to express her needs came up against her physiological and emotional state which risked to disorganize her inner being. After initially enjoying the activity with accelerated rhythms there seemed to have appeared movement containing inevitable anger and desperation.

It was crucial for the therapist to practice the skill of modulating her intervention to the children's responses, acknowledging the non-verbal signals within their movements. These signs revealed that the patient was going beyond what her physical and emotional capacity could sustain. Evaluating the risk of hyperactivity with sensitivity and anticipating the risk of exhaustion was a fundamental role and skill to constantly refine. There are many signals from patients when it is too much for them to self-regulate including: initial unexpected micro-pauses, the decreased

muscular tension flow from a slightly animated state to inanimate, a body shape that suddenly falls into itself and wilts with a sigh. Often if the child deactivated, she would reactivate again carrying on the wings of pleasure and interest and living moments where she was not identified by the disease. But these were very delicate moments and signals that needed to be considered carefully- the energies needed to be recovered.

The therapist accompanied the child to recover a more tranquil rhythm and invited her tired body to rest and sit down. Sara, however, needed to do something else. She eyed the colored wagon, stood up, went close to it and pulled some of the objects out and began to create a landscape on the floor. From the resolute way she moved, it seemed that she was guided by a very clear inner vision or image. A brook was the starting point of her image. She laid a rag doll down in the brook with its' face turned to the water. The brook flowed like a meridian line with mountains and fields emerging around it. Movement qualities in Sara appeared that seemed to want to reveal herself to herself giving expression to an emotional world and guiding her actions efficiently in the space. There was an inner objective a goal to reach that was structured in directional forms.

This first phase was followed by another one with Sara coming and going to the wagon, progressively pulling out all the objects inside. Gradually, their placement became more casual and disordered as if an impasse or a disorientated phase was setting in. Suddenly, a transformation appeared in her tension flow that went from animated to de-animated and vehement gestures caused her to become lost in space. Uncertain, uncaring, and without intention to where she placed the objects, a visible movement began pervaded by anxiety. Her absent minded throwing gestures in the environment seemed to directly announce and express her inner state, which was evolving and changing. At this point, the therapist intervened and supported the narrative that had begun: "What is this? And that?" Sara talked about holidays and of a girl on holiday swimming in the brook. Then the wind came and she said, "it throws everything to the ground, throws everything in the air." Sara gesticulated with her hands while speaking, representing a living wind which made the girl who was serenely swimming brutally roll around. Then, the wind demolished every other element in the landscape. Next, Sara wanted to cut the doll's braids. It appeared as if she was lost. She brusquely collected everything in a rush, like in a whirlwind, and threw it all into the wagon. I watch at the end and wondered if the way Sara had concluded her actions reflected her discomfort and inner disorder. What was happening to her seemed overwhelming. Perhaps there was no form to express her new sensations.

Seeing what was happening, I offered a way to end the session by gently inviting and supporting her to put the objects in the wagon back in order. Then, I offered Sara a way to face what she had felt that caused her disorganization. The objects in her disturbed emotional landscape re-found their order again while contained in my wagon. Sara's relief was evident as if a veil of protection to her inner chaos had been provided. What contributed to the solidity, stability and firm calm was, at the same time, the warm and lively voice of the therapist.

Sara's landscape, an experience, a need, a memory of the time when vacations existed came out during the pre-Christmas period and at the peak of her terminal

illness. Only with humility, commotion and respect, tiptoeing in silence, I bowed to the mystery and could only touch and share some considerations that accompanied this epiphany.

Meeting Sara's landscape evoked the experience of a clear impression and certainty that Sara's deep unconscious organism knew that the time of her death was approaching. Within the nucleus of this premonition and deep truth, imagination guided her visual representation. At the same time this visual manifestation seemed to narrate the experience of happy memories in the past that occurred before the onset of her disease. Then a wind came which disrupted everything and Sara did not know how to go on with the story. The cataclysm arrived. It seemed that Sara's vital energy expressed perhaps also rage, confusion, and bewilderment for what had happened. Often when people are close to death, with the weakening of vital energy and ego strength, they recall happy memories, warmth, contact and ask, "Where have I been? What have I done?" Objects from childhood can re-emerge and immediate needs can be put aside. Death has no age. It passes through all ages and with it brings accompanying phenomena, which turn out to be universal events. Archetypal elements can return included in the stories of many myths, religions, ancient philosophies, science that speak to the creation of the world and cosmogony. Wind, ruah, pneuma, soul, and breath instill animated life in a human being. Wind, in an Indian myth of creation, rises from water immersed in the primordial darkness. Quiet silence contains and returns to itself, in strength, the infinite kaleidoscopic sparks in the manifestation and disappearance of life forms.

I looked at this event and the developing movement process, which the session has finished with, and it seemed to be a dance, "What does the dancer create? What does she express? What does she feel? A dance, like every kind of artwork, is a perceptible form expressing the nature of human feelings. Rhythms, bonds, crisis, rifts, complexity and richness of what we can call the intimate human life, flow of direct experience and life as a human being perceives it" (Langer, 1962, p. 19).

Three weeks later Sara created her third landscape on the floor. I was invited into the scene for the first time to dance, sing, and play ball—to act and respond not only with Sara but also with the patient sharing her room invited into play with her the landscape. Our previous sessions had developed trust and comfort, allowing for others to enter Sara's space.

A type of complicity emerged between us to protect her environment from the various disturbances that continually invaded the landscape. One of Sara's oncologists tried to enter the room and exclaimed, "What is this, an 'art attack'?" The doctor had to truly see the space that Sara had created and to take into consideration that the environment was transformed. The oncologist had to move her body in a different way in order to enter the room. Sara had made an impact on her environment using creative intention and determination.

I will briefly mention the phenomenon of regression during hospitalization—the impact of illness on age-appropriate development (Langford, 1948). The sessions with Sara became a time and space where she had access to an activity and could practice an age-appropriate separation from her mother. Hospital protocol calls for a parent to remain with the child 24/7; however the child's need for holding and comfort to abate fear and pain can create a regressive direction in both the child and

in the mother's handling of the child. The limits of this article cannot focus on the hospitalized parent–child relationship, but what I understood from our sessions was that I became a buffer, a "transformational object" that mediated between 7-year-old Sara and her mother. Even though Sara's mother stayed in the room during our sessions, it became clear that they had an agreement that her mother would not enter Sara's created landscapes. This was a separate time and physical space only for Sara and myself.

How a patient touches the walls and floor, how she moves or doesn't move in a setting of DMT, is generally a reflection of the therapist/patient relationship. Symbolically these movements contain pre-conscious and unconscious communications of the patient. Sara's use of objects and where she placed them on the walls, the floor, in the closet became a symbolic way to use the objects from the wagon. The objects can be seen as an extension of my body, the setting I bring with me, in order to create the environment and a self-identity that she needed. She brought nature into the hospital room including the sun, mountains, an owl, cats swimming in a stream, a pillow bed for a dog, making music, playing ball and choosing relationships.

Then, inevitably, as in any therapeutic setting, the time comes for separation.

Separation in a session is a delicate moment. The child may accept the ending of our session and know that I see other children on the unit or she may try to prolong the session, demonstrating different emotional responses such as anger, sadness, or procrastination. They may, like Sara did, throw the objects in the wagon, begin to ignore me as I put things back, or want to keep objects with them.

Sara's response, I believe in the analysis of the session above, was bewilderment stemming from confusion brought on by months of treatment with no end, anger at being abandoned, not only by my leaving the room that particular day, but by her known life being lost to her. Her actions destroyed in a haphazard manner what she took time to create. That destruction (the wind) left us both feeling fragmented. I invited Sara to separate out the different objects she had shoved into the wagon. This served to organize and structure both her and myself, a necessary step before I was able to leave the setting. The second and third sessions when she created her landscape, she developed a ritual of putting the objects back. She first balanced each of the objects in the crook of her elbow and then let them slide in. She needed to mark and ritualize an ending time that symbolically spoke to her own "ending time," which was approaching. Mendelshon (1999) writes "Kübler-Ross focused on the emotional states of children who suffer from serious illness and on how they perceive the threat of death" (p. 67). Quoting Kübler-Ross, "All children know when they have a terminal illness…they all know when they are dying… they do not know it cognitively-and therefore cannot talk about it- but they know it intuitively" (Mendelsohn, 1999, p. 147).

I Want to Dance: Gemma

As I opened the door to eight-year-old Gemma's room I immediately sensed an unusual atmosphere of calm and tranquillity. Her mother was lying down next to her in bed, and they were whispering softly to one another. Gemma shyly smiled at her mother when I introduced myself and explained who I was and what I did. As we

made small talk, I observed that she kept her voice very low, and turned her body to create a private space between her and the other child's bed in the room. She was visibly embarrassed, but her eyes lit up when she saw the CD player.

Questions I reflected on before considering an intervention were: Was she functionally able to move, the whole body or body parts? Did the tumor in any part of the body restrict movement? Was she under treatment that required being attached to the portable IV tree? Was there a chronic or temporary paralysis due to a specific illness? Did the surgically implanted catheter impede movement on one side of the body? Gemma had just completed a cycle of treatment and was not hampered by being attached to the tree

I asked Gemma if she would like to listen to music and simply see where that took us. She agreed. She sat up in bed expectantly as her mother moved to a chair nearby. I chose music that was quiet and harmonious. We began placing our hands on the bed and made small movements with our fingers, hands, and wrists to the music. She began to mirror my movements. As I raised my arms in the air, I mirrored her movements that were quick, unpredictable, sharp accents to the music's slow rhythm. Her arms were held lightly as if she had a small fluttering bird in each hand. At this point, I stopped moving as she continued on her own. She "slipped" into a dimension of creative self- absorption, what was known as "being moved." According to Mendelsohn (1999), "As defenses relax a shift can be noticed in a child's level of consciousness and qualities of movement, when the child passes from "moving" to "being moved" by inner impulses" (p. 74). Gemma's embarrassment and shyness had vanished. She called me into join her after a few minutes, and we created a movement story about the coming of rain, the growth of flowers and the rising of the sun. The illness was present but she became *other* than the illness as she mirrored back to me healthy and creative body movements.

A few weeks later, she was undergoing treatment and attached to the tree but wanted to get out of bed and dance standing up. She seemed very tired and fatigued but she chose lively folk music. Again, she stood with her back to the other children in the room. We moved in a very small space between the bed and the wall, but the position of her body space held the privacy she needed. We began again by mirroring our hands and arms, this time, in the air. As her arms rose above her head, she began swaying her hips in time to the music. I offered a red scarf, and she began alternately to wind it around her body and then throw it into the air. It was then that she asked to throw a ball. She had seen me playing with it the week before with another child in her room. Initially, as in our first meeting, Gemma spoke in a low whisper, with body movement qualities of fluidity and lightness together with the need for closed private space. This quality changed abruptly as she began to throw the ball with surprising precision and force. We had to open up the distance between ourselves and move out into the room throwing the ball in time to the music. She was particularly energized when I suggested she throw the ball as hard as she could on the floor, which she did with as much force as she could muster. She laughed to see how high the ball could go using her force.

Gemma began the session with fatigue and tired eyes, but when I left her that day she appeared brighter as she had released powerful energy which changed her

spatial relationship to myself and to the room bringing animation and vitality to her body (Stern, 2011). Her body language let us both know that she wanted and needed to assert herself—to use her own physically strong body resources. According to Goodill (2005), "In DMT children with cancer communicate their awareness and fear through symbolic activity" (p. 142). Gemma's unusual show of strength and changing spatial needs may have been her response to angry feelings and the resulting fatigue of her long hospital stay.

The following week Gemma was immobile, very tired and restricted to staying in bed because of an infection in her chest, a complication of the chemotherapy treatment, but she still wanted to dance. Carefully assessing her situation, I suggested a contained small rhythmic game of clapping our hands on the bed and with each other. Her face and eyes began to open as we increased speed, force, and timing of the game. After this initial play, she took all the scarves that I had with me and began tying them end-to-end until they formed a large colorful circle around her bed. On a symbolic plane, I sense that Gemma communicated her relationship with our work together by tying the scarves together to form a circle. Her care and delicacy in doing this was beautiful to witness. We had created a relationship together. We then shifted the scarves around to music with our hands, putting our heads into and out of the circle. This was the dance. I intuited on a preconscious level that we both knew that she was in the circle and I was out of it and that the knots that held the scarves together would be untied and we would separate. The separation that day in fact would be permanent. Gemma's immobility in bed became a place for communication and relationship. All the efforts of time, space, weight, and flow were used to create vitality in a non-verbal language giving significance to the time we had spent together.

Conclusion

Each of the efforts described in the beginning of this article is woven into a tapestry of life in the hospital from the setting itself, to the patient, the parents, and staff. Living time when it is out of kilter through disease is nevertheless living life. Children can dance and play and make sense of life through verbal and non-verbal action and interactions. The eye and body/mind of the therapist calibrates how and in what way these efforts are being used or not by the child, in the way muscular flow, use of time, weight and space are combined. Movement interventions may be proposed to liberate the child's focus on the illness and therefore augment a sense of well-being. Interventions may contain, hold, or organize in an appropriate way a child's fear, confusion, or sadness by simply being present with these emotions or interventions can aid in comprehending and accepting a new reality.

Laban used the metaphor of electrical current to describe effort, "Out of the storeroom of life energy, which is continuously replenished from birth to death, a spark is detached and used to ignite, as it were, the flow of the mechanism from which the mental-bodily deed results" (Laban, 1980, p. 169). As we have seen in the examples above, the child's body language calls forth a spark and a response in the dance/movement therapist's body, her *Corpo Ambiente*, which is felt on a sensory-

perceptive- somatic level. I experience this "call" as a matching silent current of energy that moves me to aid the child in accessing her vital force. The dance/movement therapist's *Corpo Ambiente*, her internal weather vane, barometer, and mental and somatic inner climate, resonates with the child and hospital environment in order to flow from room to room with a therapeutic presence, even in the midst of space and time restraints with multiple distracting stimuli within the hospital setting.

Paradoxically, it is not the act of knowing or bringing more into a setting, but instead is the emptying of oneself (Adler, 2002; Bion, 1973) with which one becomes a source that can nourish the child through a particular intervention. The therapist's state of openness giving space to unpredictability and surprise, ready to use what is presented is a mainstay. Imagine standing on firm ground yet feeling one's legs and feet on a floating board in the middle of a lake, listening, feeling the currents of the water and the air, having trust in one's internal paddle to hold, move, or be moved onto the right course.

Acknowledgments Judith Mendelshon, for sensitivity and care in helping me learn how to be. Leonella Parteli, friend co-author and collegue, who witnessed.

References

Adler, J. (1999). Who is the witness? A description of authentic movement. In P. Pallaro (Ed.), *Authentic movement: Essays by Mary Starks Whitehouse, Janet Adler and Joan Chodorow* (pp. 141–159). London: Jessica Kingsley.

Adler, J. (2002). *Offerings from the conscious body: The discipline of authentic movement*. Rochester, VT: Inner Traditions.

Adler, J. (2007). From seeing to knowing. In P. Pallaro (Ed.), *Authentic movement, moving the body, moving the self, being moved: A collection of essays* (Vol. 2, pp. 260–269). London: Jessica Kingsley.

Bartenieff, I., & Lewis, D. (1980). *Body movement: Coping with the environment*. New York: Gordon and Breach.

Bernstein, P. L. (1984). The somatic countertransference: The inner pas de deux. In P. L. Bernstein (Ed.), *Theoretical approaches in dance movement therapy* (Vol. 2, pp. 321–342). Dubuque, IA: Kendall/Hunt.

Bion, W. R. (1973). *Attenzione e interpretazione: Una prospettiva scientifica sulla psicoanalisi e sui gruppi [Attention and interpretation. A scientific approach to insight in psycho-analysis and groups]*. Rome: Armando.

Bollas, C. (2001). *Il mondo dell'oggetto evocativo [The shadow of the object: Psychoanalysis of the unknown thought known]*. Roma: Astrolabio Ubaldini.

Chodorow, J. (1991). *Dance therapy and depth psychology*. New York: Routledge.

Cohen, S. O., & Walco, G. A. (1999). Dance/movement therapy for children and adolescents with cancer. *Cancer Practice, 7*(1), 34–41.

Goodill, S. (2005). *An introduction to medical dance/movement therapy: Health care in motion*. Philadelphia, PA: Jessica Kingsley.

Hackney, P. (1998). *Making connections: Total body integration through Bartenieff fundamentals*. New York: Routledge.

Kazak, A. E., Boeving, C. A., Alderfer, M. A., Hwang, W. T., & Reilly, A. (2005). Posttraumatic stress symptoms during treatment in parents of children with cancer. *Journal of Clinical Oncology, 23*(30), 7405–7410.

Kestenberg, J., & Sossin, K. M. (1979). *The role of movement patterns in development* (Vol. 2). New York: Dance Notation Bureau.

Kestenberg Amighi, J., Loman, S., Lewis, P., & Sossin, K. M. (1999). *The meaning of movement: developmental and clinical perspectives of the Kestenberg movement profile*. New York: Brunner-Routledge.

Laban, R. (1980). *The mastery of movement*. London: Macdonald and Evans.

Langer, S. K. (1962). *Problemi dell'arte [Problems of art]*. Il Saggiatore: Milano.

Langford, W. (1948). Physical illness and convalescence: Their meaning to the child. *Journal of Pediatrics, 33*(2), 242–250.

Mendelsohn, J. (1999). Dance/movement therapy with hospitalized children. *American Journal of Dance Therapy, 21*(2), 65–80.

Pallaro, P. (2007). Somatic countertransference: The therapist in relationship. *Authentic movement: Moving the body, moving the self, being moved: a collection of essays* (Vol. 2, pp. 176–189). London: Jessica Kingsley.

Schwartz-Salant, N. (1982). *Narcissism and character transformation*. Toronto: Inner City Books.

Stern, D. (2011). *Le Forme Vitali: L'esperienza dinamica in psicologia, nell'arte, in psicoterapia e nello sviluppo [Forms of vitality: Exploring dynamic experience in psychology, the arts, psychotherapy and development]*. Milano: Raffaello Cortina.

Winnicott, D. W. (1985). *Playing and reality*. London: Penguin Books.

Marcia Plevin
former dancer awarded two National Endowment Choreographer fellowships, presently dance movement therapist BC-DMT, art psychotherapist, psychologist, teacher/supervisor for the Institute of Expressive Arts Therapies, Art Therapy Italiana, Bologna, Inspirees Institute of Creative Education, Beijing, China, co-professor for the Creative Movement-Dance Therapy certificate program, Bilgi University, Istanbul, Turkey, co-founder of the Association of Creative Movement-method Garcia-levin, Rome, Italy. She has begun and guided Authentic Movement groups in Italy, Finland, Spain and Turkey.

Leonella Parteli
Supervisor Art Therapy Italiana, Italian National DMT Association APID, Certified Movement analyst (L.I.M.S-NY) training in Authentic Movement with Janet Adler.