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A Dance Movement Therapy Warm Up Method in Bereavement Peer Support Groups for Children

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A Dance Movement Therapy Warm Up Method in Bereavement Peer Support Groups for

Children

Capstone Thesis

Lesley University

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Masters of Arts (MA) in Clinical Mental Health Counseling: Dance/movement Therapy

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Abstract

Every year in the United States, millions of children experience the death of a parent (Owens 2008; Stikkelbroek, Prinzie, de Graaf, ten Have, and Cuijpers 2012). Parental death in childhood can lead to severe impairments in physical and mental health, as well as overall life satisfaction, because of the potential traumatic nature of the event (Li, Vestergaard, Cnattingius, Gissler, Bech, Obel, & Olsen, 2014; Marks, Jun, & Song, 2007; Perkins & Harris 1990). Children have previously been neglected in regards to grief theory and the traumatic experience such loss impacts children. Recently, research has demonstrated that self-regulation is instrumental in the specific trauma work required for this population. Dance/movement therapy supports the development of self-regulation, especially with children, due to its non-verbal, body-based nature (Betty 2013; Philpott 2013; Seoane 2016). This study explored the impact of a movement based group warm-up utilizing self-applied touch and rhythm techniques in a bereavement peer support group with children ages 5-7. The study was limited in that it was used for two sessions, and in those two sessions, the movement warm-up was observed to succeed in its impact on establishing group cohesion and increasing self-regulation. Future research is recommended to explore the possibilities of this method.

Introduction

The death of a parent during childhood is a traumatic event in a child's life. It is estimated that one in every 20 children in the United States will experience the death of a parent before the age of 15, and 1.5 million children live in single-parent households because of the death of a parent (Owens 2008). Traumatic events, such as abuse, neglect, death, loss, and dysfunctional households are considered adverse childhood experiences. Adverse childhood experiences can negatively influence future physical, mental, and emotional health. There is a strong relationship between exposure to adverse childhood experiences and risk factors for conditions such as heart disease, chronic lung disease, cancer, and liver disease (Felitti et al., 1998). Felitti et al. (1998) states "because adverse childhood experiences are common and they have strong long-term associations with adult health risk behaviors, health status, and diseases, increased attention to...prevention strategies are needed. These strategies include... preventing the adoption of health risk behaviors as responses to adverse experiences during childhood and adolescence..." (p. 254).

When working with trauma, especially in children, cognitive interventions are not always effective due to the fact that trauma is typically stored in implicit memory rather than explicit memory. Explicit memory, also called declarative memory, has access to language to describe the event and therefore provide a way to process the experience. Implicit memory, however, does not have access to language, which makes processing trauma difficult (Shannon, C. 2018, personal correspondence). Van der Kolk (1996) used positron emission tomography (PET) scans to demonstrate that "when people with PTSD are exposed to stimuli reminiscent of their trauma, there is an increase in perfusion of the areas in the right hemisphere associated with emotional states and autonomic arousal. Moreover, there is a simultaneous decrease in oxygen utilization

in Broca's area-the region in the left inferior frontal cortex responsible for generating words to

attach to internal experience" (p. 193). Essentially, one's ability to put feelings or experiences

into words is inhibited but an extremely vivid memory is created. "These findings may account

for the observation that trauma may lead to 'speechless terror' which in some individuals

interferes with the ability to put feelings into words, leaving emotions to be mutely expressed by

dysfunction of the body" (Van der Kolk, 1996, p. 193). Van Dalen (2001) noted that individuals

tend to express themselves in action when they cannot transcribe their feelings into words.

All trauma involves loss, whether it be loss of safety or security, world-view, or the loss

of a person by death or other separation. Characteristics of grief tend to overlap with those of

trauma experience. As a clinician, assumptions can never be made about what is or is not

traumatic to someone. It is entirely dependent on the individuals experience. The uncertainty of a

person's trauma history necessitates the use of trauma informed practice. For the scope of this

paper, grief refers to the emotional process involved when an individual experiences the death of

someone significant. Since I did not have knowledge of my participants' trauma histories, I

consciously chose a trauma-informed approach which therefore necessitated an investigation of

the effects of trauma, trauma theory, and trauma-informed practice.

Dance/movement therapy interventions offer a unique opportunity to give individuals an

alternative method of expressing their emotions and processing their trauma. Trauma, in this case

grief, becomes manifested in the body due to the inability to verbalize the

experience. Dance/movement therapy can teach and support self-regulation of the bodily

experiences of grief. Philpott (2013) found that a participant in her study witnessed grieving

children finding "more embodiment, more control, and less anxiety" through dance/movement

therapy groups (p.164).

Dance/movement therapists have training in movement observation and the application of what is observed to clinical interventions. Furthermore, dance/movement therapists have an understanding for how a child's physical body and emotional expression may be impacted by grief. Philpott (2013) found that that the way dance/movement therapists work with the body through non-verbal communication can help to normalize the full expression of grief, supporting children to find connection with other peers without reactivating feelings of separateness. Additionally, movement groups add a dimension where children can feel normal, where it's okay to express their grief without fear of isolation, and where they can all for all the different stages and complexities of this emotion to surface (Philpott, 2013).

Dance/movement therapy interventions provide methods of non-verbal processing of the trauma and self-regulation, which gives a feeling of safety when the words to talk about the trauma become accessible. Additionally, van der Kolk states "prone to action, and deficient in words, these patients can often express their internal states more articulately in physical movements or in pictures than in words" (1996, p. 195).

Children, in general, have difficulty with self-regulation and lack the language to accurately explain their emotions. Trauma exacerbates this. Movement provides a non-verbal avenue for self-regulation and emotional regulation to occur, which then provides space for verbal processing. As stated above, adverse childhood experiences, when left unprocessed, are correlated with poor health later in life.

I constructed a warm-up that target self-regulation, focus, and group cohesion to be used in the groups. Each warm-up lasted between three to five minutes. The warm-up was used in each session regardless of the planned activity, but was slightly altered each time to meet the needs of the individuals in the group. The planned activities were focused on grief and/or grief work, and

as such had the potential to create an emotional response. The anticipated outcome of my

capstone was that the movement warm-ups would increase verbal sharing, have a positive

effect on the group dynamics, and create a cohesive and productive peer support group. These

potential for these outcomes stemmed from the ability of the warm-up to help the children better

manage emotional responses, which provided the potential to connect and focus during group.

Literature Review

Theories of Grieving

For the scope and nature of this paper, it is important that the terms grief and bereavement are clarified. Grief and grieving used in this research refer specifically to "the process of experiencing the psychological, social, and physical reactions to your perception of loss" (Rando, 1988, p. 11). The term bereavement refers to the "state of having suffered a loss" (Rando, 1988, p. 12).

The history of grief work begins in 1917 with Freud's Mourning and Melancholia. He believed that healthy grieving required emotional detachment from the deceased (Simpkin & Myers, 2017). In order to have new relationships, all bonds with the deceased must be severed and any ongoing attachment was seen as pathological (Simpkin & Myers, 2017). This was the first theory to introduce the concept of grief work and 'normal mourning' verses 'pathological mourning.' Freud changed his mind about his theory after the death of his grandchild.

Freud's theory reigned until the late 1960's when stage/phase theories were introduced. Contemporaries of stage/phase theories were Kubler-Ross (1969), Bowlby (1970), and Rando (1988). Many are familiar with Kubler-Ross' 5 Stages of Death and Dying; denial, anger, depression, bargaining, and acceptance. While the original was based on the experience of those facing their own death, it has since been extrapolated to also encompass those grieving a death as well. The stages or phases of grief slightly differ depending on the theorist, but it was presumed that the stages/phases were linear and sequential. Once the stage/phase was completed, it was not revisited again.

Task theories of grieving were first introduced in 1985. Tasks can occur out of sequence or order and may be revisited over time. Major proponents of task theories were Worden, Parker

and Weiss, and Fox. While the actual names of each task differed by theorist, the overall themes were the same –accepting and understanding the loss, the emotional process of grieving, adaptation to life without deceased, and commemoration of the deceased. Task theories were first to introduce the concept of grieving as a life-long process.

Continuing bonds theory of grief hypothesizes that healthy grief requires maintaining a symbolic connection with the deceased. Researchers have found that retaining a bond to the deceased can be adaptive when adjusting to bereavement (Neimeyer, Baldwin, & Gillies, 2006; Root & Exline, 2014; Silverman, Nickman, & Worden, 1992; Stroebe, Schut, & Boerner, 2010; Wood, Byram, Gosling, & Stokes, 2012). This symbolic connection can take many forms and there is no 'right' way to maintain the connection. However, it is possible for an individual to place too much energy into the relationship with the deceased, preventing healthy relationships forming.

Post-traumatic growth, a theory coined by Tedeschi and Calhoun (1996). Tedeschi and Calhoun (1996) posited that growth arises out of the struggle with loss-the aftermath of it- rather than from the loss itself. Personal growth can occur within five domains: spiritual development, new paths [career or otherwise], stronger interpersonal relationship, appreciation for life, and sense of personal strength. A simplified explanation of this theory would be the example of anytime someone says, 'I never would have done (something) if (a loss) had not happened.' Opponents of this theory have argued that because the future is unknown, one cannot possibly know if they would or would not have done something, and therefore cannot say that the growth is because of the struggle with a loss.

The dual process model was developed by Stroebe and Schut in 1999. Essentially, the two processes involve loss oriented tasks and restoration oriented tasks. Loss oriented tasks include

grief work including remembering the deceased, intrusion of grief (ex. crying, missing, yearning), breaking bonds or ties, and denial or avoidance of restoration changes. Restoration tasks include attending to life changes, doing new things, distraction from grief, denial or avoidance of grief, and assuming new roles, identities, or relationships.

Ideally, an individual will oscillate between loss oriented and restoration oriented tasks. If an individual becomes stuck in one process or another, it can be potentially problematic.

Neimeyer (2001) provided one of the most recent grief theories- meaning making and constructivist theory. The focus of this theory is on constructing or reestablishing a coherent self-narrative that integrates the loss, while permitting one's life story to move forward along new lines (Shannon, 2017). Individuals constructs their loss narrative by assimilating the loss experience into their pre-loss belief system and self-concept. The individual's narrative and its meaning can take a variety of forms. The meaning created from a loss experience is not always positive.

Generally, most contemporary grief theories advocate for the integration of the individual, their feelings, their loss experiences, etc. as the main goal of grief work.

While technically not a theory, recent research and practice has found peer support to be helpful in an individual's grief process, particularly with children and adolescents. Despite the fact that parental death is increasingly common, many children and adolescents report that they did not know anyone else who had a parent die before joining a bereavement peer support group. Children and adolescents also report that their other peers and friends 'do get it' and have difficulty relating and maintaining friendships. Peer support also allows for relationships to develop in a space where having a parent die is the norm and does not necessarily have to be the focus.

Parental Death and Long Term Outcomes

    Effects on physical health

    Parental death and the period following bereavement has been regarded a traumatic life event that increases stress levels in children and raises their vulnerability to disease and illness (Marks, Jun, & Song, 2007; Perkins & Harris 1990).

    Parental death in childhood or adolescence is associated with increased all-cause mortality into early adulthood, which reflects both genetic susceptibility and long-term impacts of parental death on health and social well-being (Li, Vestergaard, Cnattingius, Gissler, Bech, Obel, & Olsen, 2014). Parental bereavement may also impact physical health later in life due to stress related illness (Agid et al., 1999; Krause, 1998).

    Experiencing parental death as a child is detrimental to the child's health for a myriad of reasons. Early parental death represents a number of potential influences including shared genetic risk that affects both the parent's and the adult child's health, loss of parental support (both emotional and financial), and the possibility that the larger environmental circumstances that led to the parents' death in the first place (including a shared event, such as a family accident) were likely encountered by the child (Smith, Hanson, Norton, Hollingshaus, & Mineau 2014). Loss of financial support has the potential to affect many other aspects of one's life, including health, lifestyle and location, which may impact a child's ability to maintain current friendships, if not sever those relationships completely. Additionally, with financial loss comes health deficits as the money required to buy nutritious food, receive adequate healthcare, and maintain an active lifestyle is no longer available.

    A multitude of research also highlights somatic symptoms as a part of the grieving process. Lieberman and Jacobs (1987) offer that 'normal' grief includes somatic symptoms, while

'pathological' grief can involve changes in immune functions as well as dysfunction within the autonomic nervous system (p. 23). Talbot (2001) affirms, "grief is a curiously somatic experience…the body can register sorrow as sensitively and as involuntarily as a seismograph, that sorrow can make you sick" (p. 62). Scharlach and Fredriksen (1993) as well as deVries, Davis, Wortman, and Lehman (1997) present research on grieving children who have lost their parents, as well as grieving parents who have lost their children. Both articles report that these populations suffered from 'somatic' effects and symptoms up to 5 years after the death of their loved ones (Betty 2013). Other studies suggest that somatic symptoms for grieving children may include headaches, stomachaches, difficulty sleeping or excessive sleeping, changes in appetite, agitation, rashes, and in extreme versions, higher cortisol (stress) levels, and dysregulation of the hypothalamic–pituitary–adrenal axis of the brain (Aldrich, 1995; Hagan, Luecken, Sandler, & Tein, 2010; Wolfelt, 1996). Thus, it seems evident that grief may have lasting impact on the physical body.

Smith, Hanson, Norton, Hollingshaus, and Mineau (2014) found that early stress has the potential to not only 'gets under the skin' but 'into the cell.' Previous work has shown how telomeres, the tips of chromosomes, experience a gradual loss of telomeric DNA as somatic cells divide and are now implicated in aging and apoptosis (Cawthon, Smith, O'Brien, Sivatchenko, & Kerber, 2003). This is relevant because a small but growing number of studies have shown how stress in childhood or younger adulthood contribute to telomere shortening and thus enhance aging in exposed individuals (Epel et al., 2004; Heidinger et al., 2012). Accelerated aging from telomere shortening may result in specific disease endpoints (cardiovascular disease for example) (Cawthon et al., 2003) but may also hasten the demise of an individual for reasons unassociated with a specific pathology (Smith, Hanson, Norton, Hollingshaus, & Mineau 2014).

Effects on mental health

Stikkelbroek, Prinzie, de Graaf, ten Have, and Cuijpers (2012) estimated that 1% to 5% of children in the USA experience the loss of a parent before they are 15 years old. The death of a parent is itself a tragic, disrupting and irreversible event which leaves the child in an ongoing, lifetime bereavement process. Most longitudinal research on the bereavement process is limited to duration of 2 years after the death of a parent (Balk and Corr, 2001). During these 2 years, the effects of bereavement are severe, and unresolved bereavement during this period has been linked to psychiatric problems (Cerel et al., 2006), depression, chronic illness and enduring and intense clinical reactions such as guilt (Carr, 2006). Additionally, significant disturbance in self-esteem, job and school performance and interpersonal relationships are reported as a result of parental death (Balk and Corr, 2001).

> Specific anxieties concerning separation and death of the surviving parent are common after parental bereavement (Silverman and Worden, 1992; Sanchez et al., 1994). Also fear of abandonment, children's beliefs that they cannot count on their caregiver to take care of them in the future (Schoenfelderet al., 2011), has a longitudinal pathway to higher levels of anxiety in romantic relations even after 6 years, in adolescence and young adulthood and mediates higher self - reported levels of depression (Schoenfelder et al., 2011). It can be hypothesized that panic disorders in adulthood are related to the fear of abandonment after the death of a parent before the age of 16 years (Stikkelbroek, Prinzie, de Graaf, ten Have, & Cuijpers 2012).

Because parental attachment is very strong during young age (Bowlby 1970), the death of a parent is especially disruptive and difficult among minor children. When deprived of a primary caregiver, a young child will have severe grief and stress reactions (if the child had a secure

attachment with the deceased). A child has a need for a secure relationship with adult caregivers, and, according to attachment theories, normal social and emotional development will not occur without it.

As previously stated, the loss of finical stability more or less directly impacts the social environment of the child, in addition to the loss of social and emotional support from the primary caregiver. The loss of social support that is associated with the loss of finical support can have devastating effects, especially as a child enters adolescence and early adulthood when social support relies heavily on non-familial relationships. For example, if the death of a parent requires a family to relocate, either because the surviving parent takes employment elsewhere or because the current housing is too expensive, often a child will have to transfer to a new school. It might also be more difficult for the child to engage in social relationships because of the new location (i.e. no transportation). The relocation itself is quite stressful on all parties involved, not to mention the anxiety and stress that comes with creating new relationships. Adverse health outcomes in this regard could also be due to a scarcity of educational guidance and material support, reduced surveillance of the child's health behaviors, and the loss of a role model (Maier & Lachman, 2000).

Developmental Perspective of Grief

Grief is a physical, emotional, behavioral, and cognitive response to loss (Worden, 2002). Each person's expression of grief is unique and is influenced by factors such as age, culture, and previous exposure to loss (D'Antonio 2011). "Depending on their age and development, children may react to grief through new behaviors, including confusion and defiance because they may not yet have the cognitive and verbal skills to process their emotions with another"

(Freeman, 2005; Sood, Razdan, Weller & Weller 2006). Because of this, it is vital to consider the developmental stage of the child as it relates to grief when planning interventions.

It is sometime during these years (5-11) that a child develops the ability to understand the irreversibility, nonfunctionality, and universality of death (Christ, 2000).

Children may also grieve intermittently because they "must be certain that their physical and emotional needs are going to be met before they can give into their grief" (Rando, 1988, p. 201). Studies show that children need to be given opportunities for play, where themes of their grieving process can emerge organically with non-verbal expression and the use of metaphor (Doka & Tucci, 2008; Freeman, 2005; Rando, 1988; Webb, 2003).

Theoretically, a school-aged child who has lost a parent or other close person has an advantage over younger children because of more advanced language skills. It is the one age group that is most able to speak openly about death and dying –younger children cannot and older children (adolescents) often will not (D'Antonio 2011).

A school-aged child will appropriately demonstrate sadness and anger over their loss and often experience physical symptoms such as stomachaches in response to their grief. Additionally, these children depend heavily on their surviving caregiver and resist separations from them, even for short periods (D'Antonio, 2011).

Wolchik, Ma, Tien, Sandler, and Ayers (2008) found fear of abandonment and coping efficacy to be factors that mediate the relationship of the bereaved child with his or her surviving caregiver and general grief reactions in this age group. Therefore, it is important to support children of this age in their desire to remain close to the surviving caregiver while enhancing independence as much as possible. Children who are offered bereavement support that includes ongoing informative discussion and conversation cope better (Fearnley, 2010).

Stress Response and Trauma

From a neurological perspective, the autonomic nervous system is extremely susceptible to repeated stress or trauma. Other body systems that respond to repeated stress or trauma are the sympathetic nervous system, the hypothalamic-pituitary- adrenal axis, the neuroendocrine systems, and the immune systems (Li, Precht, & Mortensen, 2003; McEwen, 1998).

The Window of Tolerance model proposes that there is an 'optimal arousal zone' in which individuals will tend to have gradual fluctuations in their arousal level, indicative of a regulated nervous system. However, repeated stress or trauma cause a dysregulated nervous system which results in maladaptive, unsustainable reactions. These maladaptive reactions are extreme fluctuations between the hyperarousal zone and the hypoarousal zone. The hyperarousal zone is a result of the overactivation of the sympathetic nervous system (flight or fight response). The hypoarousal zone is the opposite –an over-activation of the parasympathetic nervous system which often results in an 'immobilization' response. In the short term, this extreme oscillation causes maladaptive responses to everyday, commonplace experience and in the long term can cause further health issues, physical and/or psychological.

The body's natural response to trauma and repeated stress can be maladaptive, and therefore it is necessary to ensure any therapeutic practices are trauma-informed, in effort to prevent worsening trauma and to assist the creation of effective coping mechanisms and de-escalation of trauma.

According to Hodas (2006), trauma informed care focuses on safety (physical and emotional), containment, trustworthiness and transparency, choice, empowerment, validating strengths and accomplishments, and psychoeducation. As far as choice is concerned, simple, small choices are effective and containing (i.e. which color marker do you want?). Additionally,

inviting or offering type directives provide the client with choice regarding their participation in the intervention.

Based on Hodas' trauma informed care principles (2006), trauma based practices should establish safety, consistency, and predictability, include sensory interventions, give control and choice, and teach emotional regulation skills. The facilitator's own self-regulation is important to trauma based practice, as is their ability to set and maintain structure, rules, and boundaries. Reactions to stress and trauma often cause a bodily response, and sensory interventions can be useful in promoting self-regulation. This self-regulation (including emotional regulation) is essential to beginning grief or trauma work. When someone is having a visceral bodily reaction to something, the person's most urgent need to be safe, and they are unable to participate in therapeutic work, especially on a cognitive level (Seoane 2016; Cozolino 2002).

Self-regulation

One of the more widely used definitions of emotion regulation is Thompson's (1994): "Emotion regulation consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals" (p. 27). Emotion regulation is connected to attentional and stress response systems (Gross, 2007; Shields & Cicchetti, 1998) and the maturation of brain systems involved in emotion regulation is facilitated by the early affective communications of the attachment relationship (Schore, 2000, 2001). Early attachment history is extensively theorized to be significant in the development of self-regulating capabilities, and [interpersonal] touch may well be the most influential element in this process (Seoane 2016). Over time, the interactive, dyadic process of emotion regulation becomes increasingly internalized and autonomous (Calkins et al., 1998).

For the purposes of this paper, emotion regulation is used interchangeably with self-regulation.

An understanding of the self is incomplete without self-regulation –knowing how the self maintains control over itself and makes the adaptations necessary to feel harmony in its environment (McCabe, Cunningham & Brooks-Gunn 2004). "Self-regulation is powerful, and dysfunction in the ability to self-regulate is quite possibly among the more common reasons for seeking psychotherapy. Although fluctuations in regulation are inevitable on a moment-to-moment basis, the ability to re-stabilize in a healthy manner is central to a person's sense of responsive embodiment or integration" (Seoane 2016, p. 21). Self-regulation for integration is crucial for psychological well-being both in and outside of the therapeutic setting (Ogden, Minton, & Pain, 2006).

Touch is a key component to establishing self-regulation for integration in early attachment relationships and is associated with earned secure attachment later in life (White, 2004). Developmental psychology research shows that in early development of self-regulation begins in infancy by internalizing the stances of the primary caregiver (Seoane 2016), and "children continue to depend on caregivers for co-regulatory support, modeling, and behavioral contingencies for their emotional displays in order to learn how to regulate throughout childhood" (Betty 2013, p. 42).

Neuroplasticity research suggests that repairing one's attachment history and the resultant compromised ability to self-regulate is possible; thus, a new way of moving with oneself or 'parenting the self' during dysregulated states by using self-applied touch (SAT) may precipitate brain rewriting (Seoane 2016).

A person with an overactive sympathetic or parasympathetic nervous system in a situation that is not life--threatening may display dysfunctional self-regulation in a compensatory attempt to fix the imbalance. For example, a client with low capacity for self-regulation who recalls a fearful event may present in a reactive and hyper aroused state--with heart pounding, shallow breathing, intrusive imagery and thinking, muscle tension, and hypervigilance. Clients in such a state during a therapy session would be socially unavailable to the therapist because, from a psycho-neurobiological perspective they would remain oriented toward immediate survival rather than toward relational and cognitive understanding of their individual psychology or behavior (Cozolino, 2002). In life outside the therapy session, such persons may seek substance use or other self-destructive behaviors as a means to regulate intolerable arousal (Corrigan, Fisher & Nutt, 2011). Children who endure early adverse experiences often develop chronic emotional dysregulation and display off-putting behaviors in the face of stress; these strategies frequently alienate caregivers, making it even more difficult for children to receive the regulatory support they desperately need (Betty 2013). These tendencies are maladaptive because they may result in an ineffective and potentially harmful dysregulation of the nervous system.

Upon recalling a fearful event, a person who can effectively self-regulate, by contrast, may flexibly shift into optimal arousal, feeling both alert and relaxed, in a state in which thoughts and feelings are readily accessible (Ogden et. al, 2006).

Development of self-regulation is typical within psychotherapy interventions, but is also supportive of DMT's fundamental goal of facilitating a client's integration. "Integration is not possible when individuals find themselves in an arousal state that is beyond their Window of Tolerance, which underscores the importance of having the ability to modulate arousal with self-regulation." (Seoane 2016, p. 35).

Dance/Movement Therapy, Grief and Trauma

The American Dance/Movement Therapy Association (ADTA) has defined dance/movement therapy (D/MT) as "the psychotherapeutic use of movement to promote emotional, social, cognitive and physical integration of the individual" (2016). As previously discussed, when children grieve, they may not be able to verbalize their processes in ways that traditional talk therapies support. Creative arts therapies have been utilized successfully with this population. "The connection between body and emotion are integral to the work of dance/movement therapists, the direct relationship of these two entities being at the core of the therapeutic process" (Winters 2008, p. 97).

Philpott (2013) found that connection, presence, physical space/therapist's body as container, being witness/offering support, body regulation, and using structured rhythms were of greatest importance when working with grieving children.

 Each participant that Philpott (2013) interviewed described using the technique called the Chacian circle as a way to provide a physically safe space for children to work through their emotions in the grieving process. Creating a safe space can be done in several different ways such as designing and setting up the room so that it is containing and safe and positioning the group members in a circle so that each child is facing one another in the circle which help in finding a healthy balance between relating to oneself and others (Philpott 2013, Betty 2013).

D/MT groups create camaraderie and the community among group members, recognizing that children understand, not just cognitively but through a bodily experience, that they are not alone in the grieving process (Philpott 2013). Children have the opportunity to feel understood when their movements are mirrored or repeated back by other participants, and when they can see that other members are moving in ways that they can relate to (Chase 2013, Philpott 2013).

Marian Chase introduced the therapeutic concepts of mirroring and movement in a circle, creating "sensitive awareness of the symbolic movement expressions that were offered and to which there was validation and response" (Chaiklin, 2009, p. 7). The combination of these therapeutic concepts is commonly referred to as a Chacian circle within the dance/movement therapy profession. Wittig and Davis (2012) noted, "One way that we support a deeper entering and greater intimacy in the group is through the use of Chacian circles," and that the "use of mirroring as a way of making relationship in improvisational movement groups provides opportunities for individual group members to have a sense of belonging to the group" (p. 169).

Mirroring is a strong foundational technique in DMT that supports clients in feeling witnessed (Behrends et al., 2012). Mirroring may facilitate client comfort in terms of new forms of self-interaction, while nonverbally encouraging intermittent adaptation in the qualities and parameters of touch (Seoane 2016).

Dance/movement therapy often draws on attachment theory to guide the therapist-client relationship (e.g. Devereaux, 2008; Levy, 1988; Naess, 1982; Thom, 2010; Tortora, 2006), likely because of attachment theory's emphasis on preverbal and nonverbal processes derived from infant-caregiver dynamics. Just as the caregiver and others both model and shape a child's ability to self-regulate (Baumeister & Vohs, 2004; Siegel, 1999), the dance/movement therapist can help re-model and re-shape a client's ability to self-regulate if that function is missing (Berrol, 1992; Betty, 2013).

Physical body posturing is believed to be indicative of self-regulation abilities. Widening and narrowing the body stimulate regulated, stable, and balanced states. Bipolar expansion in the horizontal dimension, termed widening, can convey trustworthiness and an ability to support while simultaneously expressing comfort on the part of the giver (Betty 2013). It arises from and

creates positive feelings about oneself, such as generosity and openness. When combined with

free flow and flow adjustment, widening allows for accommodation and acceptance (Kestenberg,

1967; Kestenberg Amighi et al., 1999). Equally important, however, is the ability to use

narrowing when appropriate i.e. when the degree of contact offered by wide body shapes is

threatening to a child (Betty 2013). Widening and narrowing commonly occur in the rib cage,

shoulders, face, hands, feet, and pelvis.

    This 'body regulation' within themselves was also named as a modeling tool for how

children can learn to be with, and respond to, their own emotions throughout the grieving process

and hopefully within other areas of their lives (Philpott 2013).

    Simpkins-Meyer and Coffman (2017) noted that including body sensations could bring

deeper understanding in grief counseling, promoting body awareness could help to deepen self-

awareness, and fusing narrative and embodied approaches can provide a sense of control while

acknowledging emotions.

    Research on regulating self-touch in adults reveals the behavior to be integral in cognitive

processes related to body image and body schema (Kammers, de Vignemont, & Haggard, 2010;

Knoblich, 2002; van Stralen, van Zandvoort, & Dijkerman, 2011), as well as to mental

representations of the body with significance to arousal regulation. The more accurately and

coherently these representations map onto objective reality, the more likely the individual

involved will be able to self- regulate (Wallin, 2007).

    Documented ways self-touch may be effective include: to warm-up for a DMT group, to

establish body boundaries, to relieve physical tension, to increase the mind–body connection, to

increase awareness of sensations, and to offer an option of self-care (Seoane 2016). Aposhyan's

(2004) Body-Mind Psychotherapy approach indicates that self-touch can establish boundaries, self-soothe, and deepen the relationship with the body.

> For many years, psychotherapy and behavioral science privileged long-term behavioral changes through process work, and this is important work. However, this work lacks the power of DMT and its ability to promote immediate state-shifts, inside the body. These state-shifts, even if only momentary, can be metaphorically perceived as momentary "threads" that can weave a tapestry of restoration, healing, and reconnection. Music, movement, dance, and rhythm, are activities that provide an immediate resource to shift physiological states. Polyvagal-informed DMT also recognizes the safety-trust-relationship continuum as fundamental to humanity and to dignity. Trust is built on safety, and relationships are built on trust. Safety begins in the body (Gray 2017, p. 44).

Therapeutic self-touch can present in different ways. The use of self-applied touch (SAT) as a therapeutic intervention could be used in the following manner:

The observed client may begin with initial matching SAT of the hyper aroused state by using strong, direct, rhythmic patting (while avoiding pain and aggressiveness) and then using modulating transition SAT to gradually slow and soften the touch into the regulatory SAT of a circular and soothing rubbing motion. In instances of hypoarousal, the client may begin with light, relatively motionless touch that grows increasingly firm in pressure. The pressure can then turn into a rubbing motion until it becomes a stimulating patting motion. Guiding clients toward finding rhythm in their movement can be regulating to the nervous system. Additionally, if the therapist mirrors the client's rhythm, the interactive process can replicate the rhythmic stimulation that a caretaker often provides as external regulator (Behrends, Müller, & Dziobek, 2012; Koester et al., 1989). This concurrent self-regulation may stimulate mirror neurons,

allowing the client to feel an empathic resonance analogous to that of the caretaker-infant bond

(Beebe & Lachmann, 1998).

Method

During the fall semester of my internship, I co-facilitated a group (Group I) with five 6- and 7-year-old males and females. In February (beginning session two), another child was added to the group (5.5-year-old female), bringing the group to six members total.

Group I had only completed one movement activity since beginning in October. To help the group feel more comfortable with the warm-up, I decided to implement the same movement warm-up for two sessions for this method. I then observed the group's reactions to the warm-up and its subsequent effects on the group.

To document the process, I logged experiences in the different sessions, noting observed experiences and my own felt sense. Additionally, I utilized my knowledge of Laban Movement Analysis to note any behavioral or movement changes within the group.

Procedure

All groups at my internship followed the same format: opening circle, activity, 'free-choice time', and closing circle. The format and content of the group is largely dictated by the internship site. My movement warm-up was placed between opening circle and the activity, in hopes of increasing focus and engagement with the activity.

When the group members entered the room, the three co-facilitators, already seated on pillows, greeted them. Each group member then took a seat on an empty pillow in the circle. In the center of the circle, was a Tibetan singing bowl, which was referred to as a 'bell', and a talking stick.

Opening

Opening circle was the same for each group. In opening circle, one group member rang the bell, and all listened to the ringing until it ended. The facilitators and group members then went

around and shared their name, name of the person who died, and answered a 'fun' question (e.g. 'what's your favorite animal?' or 'what do you like to do on a snow day?'). The 'fun' question functions as a tool to deescalate the individual after a potentially emotional question.

Warm-up

After opening circle, I initiated the movement warm-up, which I called 'Follow the rhythm.' 'Follow the rhythm' was a clapping and rhythm game in which the group members and co-facilitators would follow me as I changed the rhythm. The group started the warm-up in a seated, cross-legged position on the floor, patting both legs at same time. I would then look around and see how group members are naturally changing movement and incorporate that into my movement. For example, if one group member was patting their legs with light weight, bound flow, and hollowing in their torso (patting their legs softly and hunched over), I would copy that movement until most of the group was doing the same movement. I would then change the movement to be strong weight pats with an erect, upright posture. Based on how the group members reacted, each warm-up consisted of different movements. However, most warm-ups included smacking hands on the carpet (syncopated or asyncopated), gently tapping, rubbing, or running fingers through the carpet, stomping feet on the carpet, and lightly tapping feet on the carpet. All warm-ups ended with light pats on the top of the head, then shoulders, then arms (arms are crossed), and concluded with a self-hug and deep inhale and collapse to carpet with exhale. Posturing body so that head is below heart activates PNS, which calms the body and promotes sense of safety (Shannon, C., 2018, personal correspondence). During each warm-up, all group members participated in the movement and easily adapted to changes in movement.

Activity

After the movement warm-up, the co-facilitators led a group activity that varied from session to session in each group. All activities were grief-focused.

In Group I session one, the activity was 'the question ball.' The question ball is a medium sized ball with prompts written on it; some prompts being simpler, such as 'make a silly face' or 'what's your favorite movie?', while other prompts are more probing example. 'What did your person who died look like?' The activity worked by someone throwing the ball, and the person who caught it answering a question based on where their thumbs landed. Then, all group members were invited to answer the same question. We would occasionally ask follow-up questions to continue the conversation between ball passes.

In the second session, Group I created a group memory collage about the person in their life who died. Various collage images were spread out on the floor, and each group member was invited to find three images that reminded them of their person. After the collage was created, each group member was invited to share what they picked and why. The co-facilitators asked follow-up questions to individuals and to the group to extend the conversation.

Closing

In closing circle, the bell was rung again; all listened until it stopped ringing, and all participants went around and named their 'high' (favorite thing) and 'low' (least favorite thing) from the group. The group then played a game until it was time to leave. Games varied in each group, dependent on the amount of time left and the group's interest in a particular game.

Results

Group I: October-December

My initial observations of the presentation of Group I in the fall semester was a group that was not cohesive and resistant to sharing. There were five members in the group, half of them were very active, constantly moving around, (i.e. grabbing stuffed animals and playing with them during a group activity), while the others were very still and quiet. This group had frequent absences, and rarely had the same composition from session to session. The group typically was unwilling to share, even during opening circle, and took a long time to 'warm up' before they would share. Often, the children would share to one of the co-facilitators and not to the group. This was evidenced by eye contact only between child and co-facilitator, and by a child only sharing if they whispered into a co-facilitator's ear. The co-facilitator sometimes had permission to share what the child whispered to the group.

Group I: Session 1 Observations

My observations of Group I overall was that participants were excited and willing to share and engage in spontaneous, on-topic, conversation. During the warm-up method, all group members participated in the movement, perhaps somewhat hesitantly at first, but remained engaged throughout the warm-up's entirety. After the warm-up, all members remained seated during times they were supposed to be seated, while still having energy and continuing to move and fidget during the session. This movement did not escalate to the point of being disruptive and all group members were engaged with the group for the entirety of the activity. All five group members were present, arrived on time, and shared in the opening circle. For session 1, one co-facilitator was absent. Also beginning this session, a new male co-facilitator joined Group I who had the same first name as one of the children in the group. It was clear that this

child was very excited to share his name with the co-facilitator and in turn encouraged the child

to share more openly. Additionally, the stuffed animals, that typically sit against the wall, were

put away in the closet, in hopes of eliminating some distraction.

Group I: Session 2 Observations

In the second session, the group engaged excitedly in the warm-up method. I could sense that

the group members were becoming more comfortable and playful with the movement than they

had been the previous session. One group member came into session about halfway through the

warm-up. I sustained the same rhythm until she was seated and mirrored the rhythm. She

seemed to be embarrassed by her lateness and her discomfort was felt by the entire group. She

also took a while before verbally sharing during the activity. This child had been more resistant

to sharing since groups began in October. In the session 1, the warm-up appeared to engage her

and promoted safety and comfort within the group. I believe that if she had been able to

participate from the beginning of the warm-up, she would have presented differently for the rest

of the group.

Consequently, the group seemed to be less engaged with each other during the activity. The

group members still participated in the creation of the memory collage and shared what images

they selected and why, however, the conversations typically occurred between child and a co-

facilitator, as opposed to the entire group. All members appeared to be more still and less

rambunctious than the previous session.

In total, there were four children and three co-facilitators present in this session and all the

stuffed animals were hidden away in the closet. Two group members were absent for this

session, and a new child joined Group I. This child had previously been a part of a younger

group, so she was familiar with the routine and rituals of the program.

Discussion

The intention of examining the warm up method was to learn more about how it impacted the process of the group. By doing so with two groups, I was able to glean new insights into the practical and clinical benefits of grief-oriented warm up techniques.

The following themes and techniques showed promising implications for developing a grief-oriented approach further. While the intention was originally to examine more groups over a longer amount of time, the results of this clinical method exploration provide a foundation for future research in this area of practice.

Strengths of my warm-up were the ability to engage all group members non-verbally, that each group member participated in warm-up and were not distracted by other stimuli, group cohesion (for at least the warm-up), and that the warm-up allowed for high and low energy to be accepted and validated.

A theme that emerged during the sessions was an oscillation and modulation. The group members often had different energies when coming into group, and after the warm-up, their energies balanced out a bit. The warm-up utilized oscillation between quick and sustained time, strong weight and light weight, and bound and free flow to encourage the group members to try out effort qualities that they may not normally engage in and the capacity to move in and out of a certain quality as needed.

Within these themes, there were certain techniques that worked well. The concepts of SAT (Seoane 2016), mirroring (Philpott 2013; Betty 2013), Chacian circle (Chase 1993, Philpott 2013), and body shaping (Betty 2013) self-regulation heavily influenced the design of my warm-up. For example, the use of mirroring within the groups allowed for me as the clinician to facilitate processes that supported validation of each child's connection to the group. This was

especially poignant when I mirrored a child's specific movement and that child could see not only a group leader, a grown-up, doing their movement, but also their peers' movements. This experience supports the literature on mirroring and connection from the work of Philpott (2013), Winters (2008), Betty (2013), and Chase (1993). The use of SAT through rhythms allowed for connection within the entire group as they moved together and could not only see, but also hear their connection.

Additionally, when this process was happening, I also noticed that abilities to attend to tasks and focused work in the group increased. According to Hodas (2005), when children feel contained, safe, and focused, they are better able to attend to their emotions and needs. This concept was present during both sessions.

The application of the technique of self-applied touch provided the containment and safety that supported gaining knowledge about the body's physical boundaries and location within a space. This experience also reflected the literature of Philpott (2013), Seoane (2016), and Betty (2013).

Future Considerations

Ritual and routine are extremely important in grief work. Rituals provide people a sense of predictability and control over what is happening around them (Hodas 2005). When grieving, everything can feel out of control and unpredictable, which is a frightening feeling, even on the best of days. Unfortunately, due to time constraints, the warm-up method was not routine for the group. It would have been extremely valuable to have more sessions in which I implemented the same warm-up so the warm-up could have become part of the ritual of our group format.

If I had been able to implement this method in more than two groups, I would have considered adding vocalizations with the movement, so that the vocalizations would have added

another element to engage the group. Additionally, incorporating breath throughout the warm-up, perhaps via vocalizations, can provide another regulatory tool for the group. As an added challenge, it would be interesting to explore slowing down the movement and the rhythms, again to stimulate self-regulation in a slow, calm manner.

For future use in grief and trauma work, this warm-up would be best implemented as soon as possible to allow the individual or group to become comfortable with movement and to create a ritual. The specific movements would have to be adapted to fit the needs of each group, and with minor adaptations could be applied to any age. After the warm-up has become a routine, a more integrated incorporation of breath would be beneficial (Betty 2013; Hodas 2005).

I am unsure how adaptable this warm-up is for individuals of differing physical abilities, specifically those with limited to no use of the upper extremities, including those without upper extremities. Additionally, there are cultural differences regarding the use of self-touch which would have to be taken into consideration when adapting this warm-up for a specific group.

The ethnicity and SES of group members was unknown, however, it appeared as if the majority of group members in both groups were Caucasian and with a wide range of SES.

Of greatest importance, every group creates its own unique microcosm. The needs and goals of the group are the most important consideration when creating a warm-up.

My goal of this project was to create a warm-up which could easily be replicated and adapted for use within other bereavement groups or any therapeutic group setting. I believe that I have done that, and therefore feel confident in continuing this warm-up with my groups that extend past the scope of this paper and recommending and teaching this method to other professionals working in the mental health field.

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