

Looking backward, dancing forward: A student's encounter with the practice of dance movement therapy

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Abstract

Early clinical placements in dance movement therapy are students' first encounters with the discipline as practiced. Clinical placement accentuates differences between class work, study and movement experientials (somatic learning) with other "normal urban neurotics," and the actual needs and expressions of clinical populations. A student's remembered perspective produces a less complicated view of the medical and ethical issues faced by a therapeutic team. The author frankly reflects on her student work – and emotional confrontation – with developmentally delayed children and their caregivers in a day programme. She explores the revelations and paradoxes of therapeutic provision, including counter-transference, family structures, and local regulations.

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Perspective

Fieldwork necessitates a substantial leap from acquaintance with literature to the expectations of practice. This article derives from notes made as a dance movement therapy (henceforth DMT) student in clinical placement, tempered by the reflective stance of a professional handling her own populations. The central issue is the DMT student's first encounter with the actual embodied contexts, prescriptions and problems of professional DMT practice, and the ongoing development required for the work. I have sought to retain the novice's original perspective on our discipline while infusing this article with the benefits of continuing engagement and experience. Although these observations occurred during my placement with Ms. Susan Maling, a very experienced RDMT based in Melbourne, the issues addressed remain my own. I am fortunate to have had the opportunity of a placement in a well-designed and expertly run program, and to have been nurtured through my first startling discoveries of DMT practice by so generous a practitioner: Maling's guidance continues to inflect my work.

Structure

"Noah's Ark" is a community facility that began as a toy library; 20 years later, the lending library is still in operation and a wealth of programmes for children take place in the two-storey Victorian residence. The programs are government-funded but run by a private organization, and the therapeutic team has the ability and autonomy to

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make decisions and policies centred on humanitarian and practical issues rather than the government's economical and political concerns. Like its sister programmes from the 1980s, Noah's Ark is a "family-based" operation that strives to support the unity of family. This may sometimes be at odds with the leanings of the therapists employed there. For instance, all the therapists with whom I worked on the Noah's Ark team were child-based: they placed the needs of children in our care before those of their parents or the family unit. This dichotomy in focus becomes critical when making treatment decisions or determining duty of care, as I will show.

Unlike my student peers in other programmes and facilities, I worked directly with children *and their caregivers* in weekly group-therapy sessions, and I was involved in the work of three distinct groups within the programme. The therapist (the DMT or an Occupational Therapist) would work directly with a child who was sitting either on the therapist's or mother's lap, while explaining to the entire group the somatic protocol she was following. In any single session there were 8–12 children accompanied by their caregivers, generally birth-mothers, as well as the 3–5 members of the therapeutic team. A group of 20 people was common. Some mothers had two or three children present, and children would be carefully distributed among the team members to provide optimum results both in terms of the current treatment and later follow-up. The most severely affected children were handled first by therapists modelling treatment, and then handed to their caregivers; the therapists would observe the caregivers' understanding and continuance of the movement. As I would discover, having caregivers present did not make the work easier. On the contrary, the caregivers had their own needs, which they also (perhaps unconsciously) sought to meet during the children's work. Sometimes the caregivers' own issues overshadowed those of the children.

Over an 8-week period of placement I observed and participated in three distinct groups made up from a population of developmentally delayed children, ranging in age from infant-in-arms to 4 years. Sessions are called "movement therapy," acknowledging DMT as an active and successful modality. As the DMT trainee I had the benefit of working with a therapeutic team made up of many modalities – occupational therapy, speech therapy, physiotherapy, dance therapy, and play therapy – all adhering to a humanistic psychotherapeutic approach of ample patient/client interaction, wellness, and transparent process. All participants – children, caregivers, and therapists – share a need for recognition, growth, and personal acceptance, and the circle is a meeting ground for all those present, showing that no one is more important than another. The circle also provides the basic structure for using the techniques of Dance Therapist Marian Chace, whose early work in circular patterns proved the simple effectiveness of this form for therapeutic work.

The "good enough" mother

The programme's tendency to reinforce mothers' desires (unless signalling a clear case of present harm) aligns with the notions of early developmental theorist Donald Winnicott that the "good enough" or "ordinary devoted" mother instinctively and compassionately knows what is best for her child (Winnicott, 1988: 3). Obviously Winnicott deals with special populations elsewhere; I wish here to identify "good enough" with "normalcy":

We often talk about difficult children, and we try to describe and classify their difficulties; we also talk of normality, or health, but it is much harder to describe a normal child. [. . .] But a child with a healthy body, and a normal or even supra-normal intellect, can still be very far from normal as a whole personality. [. . .] (Winnicott, 1964: 124).

In the combined population of my group's weekly session at Noah's Ark there were female caregivers with post-natal depression, chronic depression, failure to thrive, eating disorders, employment difficulties (such as lack of, desire to return to, problems with employment), genetic abnormalities, chronic illness, and marital problems, to name only a few of the issues. There were additionally problems with husbands or partners, families, and other children (outside the group) whom the team had not met (Kelly, 1992). The type and degree of principal caregivers' problems and issues can be problematic, requiring their own lengthy, detailed assessments, discussions, and resolutions. I found Winnicott's great body of knowledge, particularly his notion of the child/mother dyad, extremely helpful:

Winnicott (1965) believed that there was no such thing as an infant alone, but only an infant-mother unit. By this he meant that whatever the infant becomes as a social being is mutually created within the merged space molded by both the infant and its mother (Dosamantes, 1992, p. 261).

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