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# Embodied Narratives: The Influence of Dance/ Movement Therapy on the Mood of Hospitalized Children

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EMBODIED NARRATIVES: THE INFLUENCE OF DANCE/MOVEMENT THERAPY ON  
THE MOOD OF HOSPITALIZED CHILDREN

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Master of Arts

in

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## **Abstract**

The purpose of this qualitative collective case study was to understand how my Blanche Evan's based dance/movement therapy treatment influenced mood for children on my case load in an inpatient general medical pediatrics unit. Patients participated in a minimum of one dance/movement therapy (DMT) session based on: availability, schedule of the subjects' other medical treatments, and discharge date. Data collection methods included researcher journaling and audio recorded semi-structured interviews with participants and their caretakers following a one-hour dance/movement therapy session. Data was analyzed using thematic narrative analysis with a focus on the conversation between interview data and journal entries. Through these experiences, I gained a better understanding of what DMT was providing for them in their current reality and how it affected their mood. It revealed evidence of themes such as coping, mood, self-perception, socialization, stressors, and quality of life associated with the hospital setting. Each participant's narrative was written as a creative short story to illuminate the unique experiences and essence of each case while bringing understanding to the use of Evan's based dance/movement therapy for hospitalized children.

## **Acknowledgements**

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## **Chapter One: Introduction**

As an individual and clinician, I value the exploration of people's authentic narratives. I organically facilitate the nuances and intricacies of these stories on a daily basis. I am drawn to their fierce magic and energy. These act as invisible ingredients that are felt instead of seen that connect me to other beings. Within the fluctuation of giving and receiving through the facilitation of each story is where the profundities of healing lie. This exchange of energy represents my motivation for entering the dance/movement therapy (DMT) field. Movement facilitation happens at an energetic level. Movement guides an individual to trust their inner compass that connects them to their authenticity. This inner compass comprises of deeply embedded feelings, emotions, and memories. Instead of grasping onto thoughts and being primarily guided by the mind, DMT invites an individual to listen to their body inspired by their inner impulse to move.

Upon my acceptance into the DMT program at Columbia College Chicago, I was captivated by the work of Dr. Lori Baudino. Dr. Lori Baudino is a clinical psychologist and dance/movement therapist practicing in California. She specializes in working with pediatrics in the medical setting. Her work specifically serves pediatrics who suffer from cancer and chronic illness. Witnessing this woman's work inspired me to apply for an internship at a Chicagoland medical hospital with pediatrics. During my internship, I worked with many patients who suffered from chronic illness. I was exposed to the challenges children must face while being in the medical setting. Some of these challenges include being isolated, hooked up to an array of machines, getting poked and prodded by various strangers, and being immersed in a sterile and unfamiliar environment. I also noticed personal challenges I faced while working in this particular setting. Personal challenges included working around the plethora of machines each

patient was hooked to, restricted mobility and range of motion depending on each individual and limited space for the possibility of DMT. Some patients were frequently in and out of the hospital for immediate medical attention. It was easier to build a therapeutic alliance with the patients that I worked with more frequently, but I would often only have the opportunity to work with a patient one time. In addition, the unpredictable schedule of a patient during their medical stay presented as a barrier for my work to occur. On many occasions, in the midst of facilitating an individual session with a patient, a doctor would come in with a medical team in tow. Our DMT session would be forced to come to a halt, because medical needs were priority.

In between doctor's visits, care of the nursing staff, and scheduled procedures, tests, and surgeries, my DMT sessions were conducted. Many sessions were improvisational and were motivated by the journey that unfolded during our time together. I went into a hospital room only knowing what I read in each patient's medical chart. The patient's chart informed me of their medical history, current medical stressors, diagnosis, and family history. Therefore, I would create psychosocial goals and movement goals that coincided with the information provided. Movement goals were often created after my initial assessment with the patient that occurred during the first moments of walking into the hospital room. Movement goals can directly relate to biopsychosocial goals, but they can also be focused purely on shifting movement patterns or body habits. *Child life specialists* (see Appendix A) were of tremendous assistance throughout the entirety of my internship. They provided additional information that helped me prepare for interactions with each patient. Information they provided were present mood, coping strategies, and if a parent was present at bedside. All of which impacted the patient's overall quality of life in the hospital.

One of the greatest challenges I confronted during my internship was the ever present juxtaposition of hope and despair. Working with chronically ill patients sometimes meant working with terminally ill patients. Each day there was always the possibility of a patient dying. In fact, two of my patients with whom I had built a therapeutic alliance passed and died during my internship. I suddenly felt the great sadness and devastation that coexists with working in this setting. However, it also inspired me to delve into my soul and through the process of introspection, I rediscovered the light hidden beneath the darkness. I connected to each patient's story in the present moment during our DMT journey where joy and love came out to play. Joy and love became my coping strategies.

Several key strategies taught me how to become a better clinician and therapist to each patient in this setting. I learned how to see the patient as a whole person, not just as an illness. I discovered how to work on being present in the moment despite the ever present feelings of despair or the possibility of death. This helped with my sensitivity to the somatic and emotional countertransference that I experienced. I became emotionally entangled with particular patient's that had a possibility of dying. I felt my heart embrace them as I formed an attachment to their narrative. Connecting to the present moment helped me surrender to the attachment. Tracking my bodily sensations during interactions also became a valuable tool to understanding my response to each patient. Other immeasurable lessons that these patient's taught me included how to believe in hope in the midst of illness and how to find power and inner strength while great pain is present. Each patient left me with a gift that I will keep treasured in my heart forever. These were all reasons that motivated me to complete my thesis with these patients.

**Motivation for the study.** Many factors influenced the motivation of this research study. Along with exposure to Dr. Lori Baudino's work and the patients at my internship site, my

interest within the medical field has been prominent since my Memaw was touched by illness and cancer at a young age. I was very close with my Memaw who transitioned too soon. I witnessed the discomfort and sadness that cancer had on her mind, body, and spirit. This was evidenced by her decline in affect, animation in her voice, and expression in her bodily movements. The hospital environment also added another layer of stress to her overall experience and emotional well-being. This personal testimony brought attention to how illness and hospitalization truly influenced her experience. Along with these personal motives, I have always felt connection and deep resonance with children and their free spirits. I feel my playful, whimsical personality fits together beautifully with children and is able to make a child feel seen. This is the very reason I wanted to work with this population.

During my internship voyage, my interest in conducting a research study at my site further intensified. During DMT sessions, I was drawn to each authentic narrative, and also to my curiosity in patients' moods and emotional shifts throughout the sessions. I noticed affect and body posture immediately upon meeting each patient. I wondered how mood could be influencing overall quality of life in hospitalized children. I then started thinking about how DMT could help improve a patient's mood. Finally, I started to envision how I could create a safe, contained space for these children to share and express their hospital experience in a more systematic way.

**Problem Statement.** "Being ill and hospitalized creates a dramatic change in a child's daily life" (Ekra & Gjengedal, 2012, p. 1). Some of the ways hospitalized children suffer while immersed in the medical setting includes feeling pain from physical illness or injury, discomfort due to immobility, an excess amount of stress and emotional pain, isolation from family and friends invasiveness of continued medical tests and procedures, and conscious and unconscious

fears related to being ill (Mendelsohn, 1999). These negative consequences illuminate potential needs related to quality of life for hospitalized children. Every day, children are hospitalized due to chronic conditions. Literature reviewing hospitalized children emphasizes their negative experiences and highlights the need for pediatric support, specifically further methods of coping with the environment. “While children make constant efforts to cope with disease and hospitalization, some occasionally have difficulty finding effective coping strategies to deal with the treatment and make it less traumatic” (Sposito et al Nascimento, 2015, p. 144). It is evident that pediatrics in a hospital setting experience unbearable emotions caused by many variables. However, difficulties arise in giving form to their feelings due to their particular stage of development.

Furthermore, a child’s mood is directly impacted if hospitalization occurs. By conducting this study, my intention was to answer the following primary research question: How does my Blanche Evan’s based dance/movement therapy influence mood in hospitalized children? Secondary questions include, how do mood, affect, and emotional state change and/or manifest within each narrative after dance/movement therapy? How does each narrative capture the essence of children’s authentic hospital experience?

**Purpose of the study.** My objective in conducting this research was to discover and understand how DMT influenced mood in hospitalized children. The subjective experience in hospitalized children were illuminated through their verbal and non-verbal communication in DMT sessions. I supported their stories and witnessed their feelings, emotions, and responses that were elicited by their hospital experience. I hope that the children’s stories will contribute to the growing field of DMT in medical settings. I also hope they inspire and encourage future research and increased utilization of DMT in all medical and health care settings. This study will

expand on utilizing dance/movement therapy as a general way of coping for pediatric patients in the hospital setting.

**Theoretical influences.** During my internship, I adopted a dance/movement therapy style similar to DMT field pioneer Blanche Evan. Evan's area of specialization was creative dance with children (Levy, 1992). "She was dedicated to helping children express a variety of thoughts and feelings through dance including those that were forbidden and frightening" (Levy, 1992, p. 33). Levy (1992) stated that Evan believed children express in movement and metaphor what they cannot express in words. Evan also utilized a plethora of props in her work with children. Similarly, I feel props can help support or externalize what a child is feeling. The prop can become a transitional object, or provide psychological comfort to a child during uncomfortable feelings or emotions. Evan believed that expression through movement allowed a child to feel a unity of mind and body. "When a child experiences the integration of mind and body, it permeates the action with their own affect" (Levy, 1992, p. 36). Movement has the potential to connect humans to their core essence while integrating all parts of the being: mind, body, spirit.

### **Contribution of the Study**

This research study builds on existing studies that look at the relationship between DMT and mood accompanied by emotional states within hospitalized children. This study will offer new findings or information related to DMT in the medical setting and related fields of general healthcare, psychology, and medical sciences. The following research will also offer new information to the extension of the mind/body approach to health and healing.

The next chapter will review the existing literature that discusses the impact hospitalization has on pediatrics, dance/movement therapy, and its overall influence on quality of life in hospitalized children.

## **Chapter Two: Literature Review**

### **Introduction**

Hart & Walton (2010) demonstrated the impact hospitalization has on pediatrics by illuminating that hospitalization could be extremely stressful for many children affecting both their physical health and emotional well-being. Hospitalized children report many significant stressors including doctors' exams, restricted activity, and separation from loved ones (Bossier, 1994). Other negative consequences of hospitalization include separation from families, and at times even loss of control over bodily functions, each of which can lead to responses of anxiety, fear, sadness, and anger (Rokach, 2013). Research illuminates that there are also the added stressors that come with hospitalization, such as pain, being away from their home environment and normal routines, as well as being subject to the way the hospital functions. "The negative emotions elicited by these stressors are detrimental to children's health and well-being, and therefore can greatly influence a child's prognosis" (Hendon & Bohon, 2007, p. 141). These negative consequences illuminate the needs of hospitalized children and the need for further examination of the hospital setting. The next sections will examine the overall quality of life in the pediatric hospital setting that include physical environment, impacts on socialization, self-perception, and mood.

### **Hospital Environments for Children**

In order to understand the quality of life in a hospital setting, one must have an idea about the physical and social environment itself. Most hospital wards for children were traditionally built and designed around adults' understanding of children's preferences and needs (Ekra & Gjengedal, 2012). "Children in the hospital setting yearn to find some type of connection to their home lives, whether it be through meals, games, and TV or videos" (p. 1). More recently,

hospital designers and decorators have considered and studied children's preferences in the design of a pediatric unit. Pediatric patients found preferences for a pale blue-green color with simplicity in design and preferred themes related to sea, water, and nature (Ekra & Gjengedal, 2012). Furthermore, a study that explored the children's view of the hospital environment found that they were concerned about noise, light in their bed area, and the age and gender-associated features of the environment.

Ekra & Gjengedal (2012) conducted a study at a Norwegian hospital, which highlighted the children's *lifeworld* (see Appendix A) within this environment as a subjective experience. The study was designed as a combination of close observation and in-depth interviews in order to gain insight into the children's lived experience. Ekra & Gjengedal (2012) discovered that being present in the hospital context with the children provided an opportunity to become familiar with them and observe events, interactions, and their relationships with their physical environment and other people. They also found that a well-adapted and child-friendly environment, as well as the presence of their parents, gave the children a somewhat comfortable feeling.

In conclusion, the external environment informs hospitalized children's physical and social experience. In addition, the external environment informs hospitalized children's internal world such as bodily movements and development of self through self-perception and mood. Therefore, such environments can profoundly affect a child or young person who spends periods of their life in a hospital setting. Spending periods of time in the hospital setting can also greatly influence a child's socialization and relation to others.

### **Hospitalized Children and Socialization**

Socialization is a crucial part of pediatric hospital care which is supported through child

life programs and therapy services. “Hospitals are places dedicated to curing; however, they are also where those admitted experience pain and suffering with different meanings. Therefore, hospitalization is a potentially traumatic situation because it separates children from their natural environment and social life and exposes them to unknown people, inflexible routines, medical equipment, and aggressive treatments (Sposito et al., 2015, p. 144). Children are prone to suffer the consequence of a decrease in socialization (Rokach, 2013). Hospitalization has caused distress in children’s lives because of severance with family routines and everyday activities (Coyne, 2006). “Sleep disturbances have been noted, as well as difficulties experienced by children and youths, who have an increased need of involvement with their peers, but cannot do so to any appreciable extent while hospitalized” (Gusella, Ward, & Butler, 1998; Rokach, 2013, p.70). Hospitalization also causes a child to be isolated. Isolation can take a toll on children in hospital settings.

Socialization promotes interpersonal relationships, which are essential for all human beings. According to Siegel (2002), a fundamental result of interpersonal relationships is to facilitate internal integration in a child. “Internal integration becomes a developmental capacity within the foundation of nurturing and reflective early relationships” (Siegel, 2002, p. 374). Relationships are comprised of various concepts such as perceptions, beliefs, feelings, and emotions (Siegel, 2002). According to Andersen & Chen (2002), relationships are valuable because of their ability to help individuals develop a sense of self. “The relational self is the part of an individual’s self-concept that consists of the feelings and beliefs that one develops based on interactions with others” (Andersen & Chen, 2002, p. 619). Lack of socialization and interpersonal interaction can affect a child differently depending on the child’s developmental stage. According to Piaget, cognitive development occurs differently during each stage

coinciding with age: Sensorimotor stage (newborn-2 years), preoperational stage (2-7 years), concrete operational stage (7-11 years), formal operational stage (11 and over) (McLeod, 2009). Therefore, a decrease in socialization and interpersonal interaction may affect the overarching quality of life and human development in pediatrics within a hospital setting depending on their developmental stage.

### **Hospitalized Children and Quality of Life**

In addition to services that ensure socialization, hospitals are prioritizing overall quality of life for their pediatric patients. Whitehouse & Slevin (1996) operationalized the term as “what makes life worth living” (Hall, 2011, p. 5). Others define quality of life as the general well-being of individuals and societies (Gregory, Johnston, Pratt, Watts, & Whatmore, 2009). According to Goodill (2005), quality of life is a concept gaining attention in psychology and behavioral medicine as a relevant health outcome worthy of clinical focus. While the term quality of life is not yet clearly operationalized for mental health populations, several overarching components have been identified (Gladis, Gosch, Dishunk, & Crits-Cristoph, 1999; Goodill, 2005). Goodill (2005) revealed that quality of life is directly linked to both objective and subjective perceptions of the patient themselves. Health related quality of life, which specifically pertains to those individuals living with a medical illness focuses on, “the specific impacts that disease, injury, and their prevention and treatment have on the value of survival” (Hall, 2007, p. 5).

Rokach (2013) stated, “The patient experiences a range of consequences and effects due to being hospitalized for illness” (p. 69-70). Rokach (2013) discovered that regardless of the length of their hospital stay, whether short-term or long term, each patient undergoes similar, yet unique experiences at the hospital. In addition to changes of a child’s well-being, hospitalization can also shift a child’s perception of self.

## **Hospitalized Children and Self-Perception**

“The lived body is the seat of subjectivity and the point from which the world is perceived and understood. The lived body is ambiguous in that it exists as both object and subject. Consequently, bodily changes associated with illness may affect how the environment is perceived” (Ekra & Gjengedal, 2012, p. 6). Therefore, children’s self-perception is significantly impacted by hospitalization, specifically their connection to their bodies.

There is power in perception because it contributes to one’s understanding of their current reality. “Perceiving is a way of acting. Perception is not something that happens to us, or in us. It is something we do” (Dowler, 2013, p. 169). Perception is an interactive process, whereby we perceive the world as we move through and within it (Dowler, 2013). Along with self-perception, children in Piaget’s concrete operational stage who have the ability to identify a more concrete way of thinking, may have difficulty perceiving abstract concepts such as illness and death (Ayaz & Varlikli, 2012). Can these additional stressors disguise or morph the hospitalized child’s perception as well as emotional state?

## **Hospitalized Children and Mood**

Negative mood and stress has found to affect health. Negative emotions can affect the body and mind in various ways, especially during hospitalization. Inhibiting the expression of negative emotions may in fact result in poor health outcomes (Mayer, Caruso, & Salovey, 2000) as these increase stimulation of the sympathetic nervous system, increasing heart rate and blood pressure; this unintended stimulation delays recovery (Hendon & Bohon, 2007; Rozanski & Kubzansky, 2005).

Body language is a valuable lens especially in situations when patients are less verbal, like children, who may have trouble expressing themselves. Body language can reveal mood and

emotional state which includes facial expression, eye contact, body gestures, posture, and proxemics, among others can reflect nonverbal communication (Patel, 2014). Hendon & Bohon (2007), in their study examining hospitalized children's mood differences during play therapy and music therapy, identified that smiling among patients increased their pain tolerance (Zweyer, Velker, & Ruch, 2004). This finding is important because positive emotions assist patient coping (Tugade, Fredrickson, & Barrett, 2004) and enhance healthy perceptions, beliefs, and physical well-being through multiple pathways (Salovey et al., 2000). During the compilation of this literature review, limited data was found regarding mood impacted by DMT. This is a good reason why mood is a potent area for dance/movement therapists to consider because the modality has shown success with mood improvement in some populations, including the psychiatric setting (Goodill, 2005). The next sections will reveal examination of DMT in a hospital setting and DMT within a pediatric medical setting.

### **Dance/Movement Therapy (DMT) in a Hospital Setting**

DMT has several different applications within general medical care. DMT serves the geriatric population, adults, adolescents, and pediatric patients in various ways. Within the medical setting, DMT serves the geriatric population and adults with cancer, chronic pain, psychogenic somatic disorders, and neurological conditions, among others. Within the adolescent and pediatric population, DMT serves patients with cancer, chronic pain, and respiratory disorders (Goodill, 2005).

DMT has been effective in the treatment of people with development, medical, social, physical, and psychological impairments (Strassel, Cherkin, Steuten, Sherman, & Vrijhoef, 2011). It has been widely used to treat people with mental and psychological problems, as well as to reduce stress and anxiety associated with chronic diseases and cancer (Strassel et al., 2011).

DMT in the medical setting has coined the term medical dance therapy, defined by Goodill (2005) as, “the application of DMT services for people with primary medical illness, their caregivers and family members” (p. 17). This specialized field within DMT has been developing since the 1970s (Vincent, Tortora, Shaw, Basiner, Devereaux, Mulcahy, & Ponsini, 2007), and is growing rapidly.

### **Pediatric Medical DMT**

Pediatric medical DMT is practiced across a wide spectrum of healthcare settings, from the pediatric intensive care unit (PICU) to the inpatient units to out-patient work (Goodill, 2005).

In pediatric medical applications, DMT aims to: decrease anxiety connected to hospitalizations and procedures; aid in the adjustment to temporary and permanent changes in the body and in functional abilities; affirm the positive aspects of the body image; provide an active rather than passive experience with one’s body; provide an environment in which feelings about the illness or hospitalization can be appropriately expressed; address the total child rather than focusing on disease or dysfunction alone (Goodill & Morningstar, 1993). DMT is uniquely suited to helping children in the medical setting by allowing them to express themselves in a safe and contained space, providing emotional support, and giving them the opportunity to connect to their body without illness or disease.

DMT is utilized in various ways in the hospital setting. DMT is used as an assessment tool (for less verbal patients), a coping tool to shift mood, and a resource for expanding movement options and therefore overall flexibility in the hospital setting. DMT can also create a therapeutic space in the hospital setting and provide support to hospitalized children through the therapeutic relationship. This gives the child an opportunity for socialization and developmental growth.

Susan O. Cohen and Gary A. Walco (1997) conducted a study with DMT in pediatric oncology where they discussed how Laban Movement Analysis (LMA) can be utilized as an assessment tool within the context of chronic illness in childhood. Cohen (1997) pinpoints four basic elements for observing and evaluating movement behavior: effort, shape, body, and space. Effort refers to the qualitative aspect of movement action, directly connected to an individual's inner state. Shape describes the manner in which a body forms in space. Body pertains to anatomical aspects of movement behavior. This provides a functional lens and explains how the body is integrated. Space refers to movement in geometric planes and dimensions, pathways, and kinesphere (Cohen & Walco, 1997). LMA is the universal language for analyzing movement and may be integral to discovering the inner state or mood of an individual.

Goodill and Morningstar (1993) observed that the body tells us about a child's emotions. Emotions were identified by observable indications such as change in posture, movement or avoidance of movement, quality of movement, initiative or lack thereof, and patterns of breathing. "These are all external manifestations of the child's state of mind" (p. 66-67). Mendelsohn (1999) drew this conclusion during work with pediatric patients at Hadassah Medical Center in Jerusalem. A goal within this setting is to envision how to decipher what the body behavior of hospitalized children is trying to communicate in order to help medically ill children cope better with their illness and hospitalization (Mendelsohn, 1999). A major difficulty in the evaluation process was determining whether a child is suffering from a purely physical dysfunction or weakness, or whether a child is suffering from emotional stress and anxiety (Mendelsohn, 1999). This difficulty displayed a possible downfall to using a DMT lens to observe in the medical setting. However, the ultimate goal to enable these children to express their feelings in a safe environment and provide them with unconditional emotional support was

upheld. Also, through individual case studies, Mendelsohn (1999) found that DMT encourages medically ill children to discover and use their full movement potential. “Such therapy helped reduce the movement limitations that result from emotional tension, decreases anxiety, improves body image and enables these children to participate in an active, rather than passive, experience” (Mendelsohn, 1999, p. 78). The theory is that increased movement repertoire increases flexibility in dealing with stressors in the hospital setting and overall increases quality of life in a medical setting.

Suzi Tortora, an avid pioneer within this specialized modality, has designed a program for children who are hospitalized with chronic illness and cancer (Vincent et al., 2007). This specialized program highlights how DMT is utilized in a pediatric hospital setting, and creates a therapeutic space within the hospital setting (Vincent et al., 2007). “Frequently, in self-protection or in anger, children become withdrawn and disengaged in the hospital setting, many times rejecting support they may need to cope with a complex system of emotions and relationships” (Vincent et al., 2007, p. 54). Tortora’s program consists of goals that include: “pain relief and management, creating an environment that supports emotional self-expression concerning the patient’s experience of their illness through symbolic imagery and improvisation, using movement, dance and music, and providing emotional support, information and movement activities to family members, offering them additional ways to engage their child” (Tortora, 2006, p. 53).

“The benefits of this program include creating a therapeutic space and holding environment in which children have some distance from medical equipment and invasive procedures that may feel threatening” (Vincent et al., 2007, p. 54). Within this program, children are free not only to expand their movement, but are also released from the stressors of their

treatment. Here, they may process and share experiences, socialize, have fun, and be silly. (Vincent et al., 2007). “Programs like this are presently broadening their reach in both medical and educational settings” (Vincent et al., 2007, p. 57). These benefits increase the opportunity for socialization and self-perception to increase within hospitalized children.

Blanche Evan worked with children utilizing creative movement. Evan’s operationalized DMT as the “utilization of creative dance to promote mind-body unification through expressive movement while still providing instruction in the basic skills of dance” (Levy, 1992, p. 35). Evan believed that children can express in movement and metaphor what they cannot express in words (Levy, 1992, p. 35). Blanche Evan used specific interventions within her work with children. Her interventions and approach relate to the key themes in this literature review: self-perception, quality of life, socialization, and mood. Her interventions consisted of three approaches: a) projective technique; b) sensitization to and mobilization of potential body action; c) in-depth or complex improvisation (Levy, 1992, p. 40-41). Projective technique utilizes creative categorical themes, mostly consisting of nature themes. For example, the client is asked and facilitated to be an animal or water in any form. Always providing the client to fill in their own image which inevitable is a projection of one part of his/her own feeling state (Levy, 1992, p. 41). This acts as an emotional warm-up or barometer in that it attunes the individual to a specific feeling which presses to express itself physically (Levy, 1992, p. 41). This is equivalent to meeting the client where they are at and creating a safe space for self-expression. This also creates a platform for the therapeutic relationship to form which relates to socialization. Sensitization to and mobilization of potential body action has a goal to bring potential movement into actual movement through stimulating the elements of dance (i.e., time, space, intensity, rhythmic flow, content) (Levy, 1992, p. 43). This is accomplished by providing different images, stimuli, and

directives through the utilization of instruments and/or props (Levy, 1992, p. 43). This explores full movement potential and expands movement repertoire. The expansion of movement repertoire can relate to quality of life and self-perception in that movement can expand ones ideas, beliefs, thoughts, and feelings about the self. This can also provide children with resources and coping skills to increase their perception of self, overall promoting a greater quality of life. In-depth or complex improvisation is structured movement suggestions around thoughts and feelings the client has about his/her own body, including fear, fantasies, illusions, as well as somatic identifications of oneself with others (Levy, 1992, p. 44). This intervention may teach the child how to regulate their emotions through movement which relates to mood and emotional shifts.

## **Conclusion**

This literature review highlights the importance and impact the physical and social environment have on the experience of children in the hospital setting. Coad and Coad (2008) stated that children's perspectives of the hospital environment have more recently been taken into account in research, which underscored the importance of paying attention to children's own views and experiences. The interweaving of consequences and effects due to hospitalization create changes in physical health and emotional well-being within a child. "Their suffering and distress while hospitalized puts the body into a state of continuous stress while negatively impacting their emotional state" (Rokach, 2013, p. 69). This influences how children inhabit their subjective hospital experience.

Multiple studies addressed the importance of the negative impact hospitalization has on pediatrics and literature explains how it can affect a child's self-perception, socialization, and overall quality of life. Yet, there was limited data regarding hospitalized children and the

influence it has on their mood or emotional state. More importantly, there was a gap in the literature in regards to how DMT may be utilized as a tool for coping with mood disturbances in hospitalized children. This research study will help fill the gap, illuminating how DMT may be used to influence mood in a more positive way. It will also report how Blanche Evans-based DMT influenced five cases in the hospital setting.

### **Chapter Three: Methods**

**Methodology.** This research study utilized the qualitative case study framework. Case study research, defined by John Creswell (2007), is a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time. Through detailed, in-depth data collection involving multiple sources of information, the researcher reports a case description and case-based themes. This research study presents more than one case and is therefore considered a collective case study. The qualitative case study methodology coincides with the constructivism paradigm, which illuminates that there is an unlimited reality. Rather, reality is constructed by those experiencing it (Cruz & Berrol, 2012). The prominent qualities of this paradigm include subjectivity, multiple realities, inductivity, multiple participant understandings, and is often used as literary style and for theory generation. Cruz & Berrol (2012) explain that within this paradigm, it is not important to pursue a truth. Rather, the importance focuses on examining how individuals construct reality through experiences that they share with others (Cruz & Berrol, 2012, p. 142). The constructivist ontology, or worldview, aligns with my personal paradigm. I am curious in nature about the “how,” or narrative experience, versus the “what,” or finding an absolute truth or meaning.

Cruz & Berrol (2012) state that the use of qualitative research in the creative arts therapies field is documented as early as 1983. The use of qualitative methods has multiplied in the past decade amongst the creative arts therapies and has become a reliable paradigm in the research field (Cruz & Berrol, 2012). During the development of this research study, a collective case study served as the best avenue in presenting an examination of mood in hospitalized children. Incorporating a series of cases provided the opportunity to examine the hospital experience for multiple patients. Additionally, more data was collected to enhance the quality of

answering the research questions at hand. The intention of conducting qualitative research was to understand the hospital experience within pediatrics in a unique and meaningful way.

**Participants.** The population consisted of hospitalized children within the inpatient pediatric medical unit at a leading hospital in the Chicagoland area. The population within the medical unit includes individuals with a vast array of diagnoses and symptoms. The spectrum is rather large and covers all medical needs that require medical inpatient care. Common conditions seen are asthma, chronic pain, cystic fibrosis, muscular dystrophy, and cancer. The coed unit includes boys and girls who are infants and children up to 18 years of age. In this research study, I included only those patients who were ages 7-12. These patients included children who were admitted for longer inpatient care as well as patients who needed frequent hospitalization. Participants of this research study were selected based on availability during my internship days. Further recruitment procedures will be discussed in the next section.

**Recruitment procedure.** During the first part of the recruitment stage, the child life specialists (see Appendix A) with whom I worked on a daily basis referred patients for DMT as a complementary modality of treatment. The child life specialists compiled a list of patients ranging in age and diagnoses for DMT. Next, I reviewed each patient's electronic chart in a compiled list to gain understanding and knowledge of diagnoses, treatment plans, and progress notes created by the medical team. This highlighted various data including symptomology, presenting problem, biopsychosocial goals, medical history, and the patients' daily schedules regarding planned procedures, tests, and other therapies. It was important to know each patient's background history, symptomology, and diagnosis for the purpose of preparing for a DMT session. This informed the evolution of the biopsychosocial goals and movement goals. This also reflected how much restriction and mobility the patient would have during the session. Knowing

the patient's daily schedule was beneficial in order to set up a DMT session when they were available. The first part of the recruitment stage was similar to my daily routine during my internship.

The second part of the recruitment stage consisted of identifying patients who met the following research criteria. The research criteria required identified patients during caseload recruitment to be between the ages of 7-12. During my first contact with patients who were potential participant candidates, I introduced myself as a DMT intern in the hospital. I explained what DMT was and how it could be useful during their hospitalization. Next, I introduced the study in a clear way, highlighting the research question and the structure of the session. I explained the session would be one hour in length and stated there would be interview questions immediately following the DMT session. I emphasized the caretaker should be present to witness the entirety of the session. This was for research purposes to include the perspective of the caretaker in the data collection. While presenting to both patient and caretaker, I provided thorough explanation of the research study with the opportunity for questions and explanation of process, I allowed time and space to discuss confidentiality measures. If interested, I invited them to be included in this research study. I proceeded by providing them with written consent forms and verbal assent which took place during the second point of contact (see Appendix B and C).

**Data collection methods.** My data collection methods for this qualitative case study included journaling and interviews. I collected data following each one-hour DMT session with the participant. My journal entries included:

- Participant pseudonym
- Session date and time

- Three biopsychosocial goals
- Three movement goals

Data and observations included:

- Diagnosis
- Medical history
- Future procedures
- Current stressors
- Patient stories
- Therapeutic intervention(s) used based on Blanche Evan's model
- Descriptions and observations of the patient's response to the intervention
- Specific observations regarding mood through body posture, affect, and quality of movement, both functional and expressive
- Personal kinesthetic responses

Data was additionally collected via audio taped individual interviews, guided by six to eight semi-structured interview questions (see Appendix D). The interview was conducted immediately following the one-hour DMT session. I conducted this interview at the conclusion of each session with a participant. A similar interview was conducted with the participant's caretaker who was invited to witness, observe the session, and complete proper written consent (see Appendix E). It was important to have the caretaker involved in this study to capture their observations of the session to contribute to the data collection process and used as a validation strategy. I created a template and set interview questions for participant and caretaker (see Appendix F & G). However, the interview questions remained unstructured and fluid based on the needs and responses of the participants and caretakers.

**Post data collection process.** After the interview process, I utilized a personal system where I journaled on the Pediatrics medical unit at the hospital where the study was conducted. It was a spacious room where I had privacy to process, move, and complete embodied writing (see Appendix E). Movement and embodied writing occurred to capture my kinesthetic and cognitive understanding of the session. Movement evoked my own kinesthetic responses post-session followed by embodied writing. Embodied writing seeks to reveal the lived experience of the body by portraying in words the finely textured experience of the body and evoking sympathetic resonance in readers (Anderson, 2001). Introduced into the research endeavor in an effort to describe human experience, especially transpersonal experiences, more closely to how they are truly lived, embodied writing itself is an act of embodiment, entwining in words our senses with the senses of the world (Anderson, 2001). The utilization of movement and embodied writing acted as my creative synthesis immediately following each DMT session. This process evolved into a validation strategy that I utilized during triangulation. “In triangulation, one corroborates evidence from different sources to shed light on a theme or perspective” (Creswell, 2007, p. 208). I used movement and embodied writing to cross-reference journal entries and interviews as a way of deepening the data analysis process. This supported the process of finding the essence of each narrative. Therefore, the use of my embodied experiences with the patients along with the interviews, informed the overall narrative. Furthermore, the embodied writing portion contributed to the creation of titles for each narrative.

**Data analysis methods.** Journal entries were analyzed for movement analysis using both Laban Movement Analysis (LMA) and the researcher’s observation lens including body, posture, and affect. Within LMA, there are categories that comprise this system. Effort is the approach to “how” we move. Moore (2014) describes that Effort reveals something about how a person is

feeling (p. 65) and the inner attitude can become visible. “Effort is comprised of Space, Time, Weight, and Flow – are the building blocks of Laban’s effort taxonomy” (Moore, 2014, p. 65).

Space is the effort exerted to aim and orient movement. A fighting attitude is expressed in direct motion, in which linear aim with a singular focus is noted. An indulging attitude is expressed as indirect motion, in which curvilinear plasticity and continuous changes in the direction prevail (Moore, 2014, p. 66).

Time is the effort exerted to pace the movement adroitly. A fighting attitude is expressed as sudden action or accelerating, in which quickness and acceleration are noticeable. An indulging attitude is expressed in sustained movement or decelerating, producing a lingering action in which deceleration prevails (Moore, 2014, p. 66).

Weight is the effort exerted to apply the right amount of pressure. A fighting attitude is expressed as strong weight or increasing pressure, in which firm pressure and forcefulness prevail. An indulging attitude is expressed as light weight or decreasing pressure, in which delicacy and a gentle touch are noticeable (Moore, 2014, p. 66).

Flow is the effort exerted to control movement. A fighting attitude is expressed as bound flow, in which the motion is restrained and easy to stop. An indulging attitude is expressed as free flow, in which the action is relaxed, on-going, and difficult to stop (Moore, 2014, p. 66).

Final data analysis included a version of narrative analysis, with a focus on the conversation between interview data and journal entries. “Narrative analysis brings attention to the ‘storied form’ of interview data, focusing on how the participant and caretaker might assemble or sequence events, utilize language or visual images, and communicate nonverbally via gesture or body movement” (Riessman, 2008, p. 12). Narrative analysis focuses on the

intention and particulars of language by asking, “How?” and “Why?” within the data analysis process (Riessman, 2008), directly related to the therapeutic experience. As the study proceeded, I chose the specific kind of narrative data analysis-thematic, structural, dialogic, visual, and/or combinations - in response to the research process. After the creation of the narratives that revealed the conversation between journal entries and interviews, I decided to hone in on thematic analysis to capture the essence of each narrative. During the conversation between data collection methods, specific themes were immediately illuminated. Each participant’s narrative is written as a creative short story to highlight the unique experiences of each case. Each case will also explain how Evans-based dance/movement therapy influenced mood within each session.

The next chapter will present the case studies of five patients and their DMT sessions written in narrative form. The patients’ names have been changed to pseudonyms to preserve anonymity and were chosen by this writer. Their ages range from school age 7-12 years and all suffer from various medical diagnoses. Each case study title was created based upon the content of the session and inspired by the embodied narrative (see Appendix E) written after each session.

## Chapter Four: Narratives

### **The Warrior Connects to his Inner Strength: Michael**

**Presenting information from hospital chart.** Michael, an 11-year-old male with a past medical history of mild intermittent asthma and heart murmur previously undiagnosed, presented with a right hand injury sustained at school during recess. “Michael” is the pseudonym I created to maintain anonymity for this paper. Michael was the name of his favorite basketball player. Michael reported that he engaged in a fight with another classmate where Michael’s right hand came in contact with his classmate’s teeth.

Michael presented with cellulitis of the right hand. Cellulitis is a spreading bacterial infection of the skin and tissues beneath the skin (Medicine Net, 2016). Cellulitis appears in areas where the skin has broken open, such as the skin near ulcers or surgical wounds (Medicine Net, 2016). Symptoms of cellulitis include redness and swelling of the infected site. Prior to infection, Michael underwent a post-injury surgery to repair damage located at the dorsum (the upper side) of the right hand. Post-surgery, Michael reports pain of the right hand at 9 out of 10 on the pain scale. Current life stressors that Michael struggles with are coping with disruption of routine, lack of a relationship with mother, and an absent father. Michael’s current legal guardian is his older sister.

Biopsychosocial goals that were created based on medical chart information included decrease anxiety related to hospitalization, promote connection and interpersonal relationship, and foster emotional release through emotional processing. Movement goals were to foster expansion of posture and breath, increase flow within the body through breath to reduce tension in the upper body, and expansion of kinesphere and space to promote interpersonal connection.

**Conversation between journal and interviews.** Prior to our session together, I learned that Michael had movement limitations and was advised by the medical doctor that he should

rest in bed for the majority of the day, with stabilization in the right hand, wrist, and arm.

Michael requested that this session take place in his hospital bed as full body movement was not possible at this time.

“I am feeling good,” Michael reported while sitting upright in his hospital bed. Immersed in this moment, Michael gestured with a shrugging motion in his shoulders. White blankets covered his lap in the midst of an impeccably clean space. Clutter free, Michael’s personal belongings were organized in a systematic way amongst the machines and battle wounds.

“I am feeling good,” was Michael’s response to Blanche Evan’s *projective technique* (see Appendix A). This intervention was utilized at the beginning of the session as an assessment tool. Michael was unable to identify a more specific feeling word other than good. Michael’s body posture and affect appeared incongruent to “feeling good.” Michael’s body posture presented as tight and rigid with a slight concavity in the upper body. There was no apparent evidence of breath flowing easily throughout the upper body, so he appeared tight and rigid. His shoulders jutted forward showing a misalignment in the neck and jaw. This was displayed by the neck and jaw slightly forward and disconnected from the spine.

Prevalent shaping qualities of sinking and enclosing were observed in his torso. His right hand was held as well as the extension of the right limb into the wrist, elbow, and shoulder joint. Michael’s affect was observed as blunted with minimal movement in the apparent facial region. Blunted reflects a reduced intensity in emotional expression. I didn’t have access to his medication list at this time, but I wondered if his affect was influenced by medication.

Along with being immobile in the right hand and extension of the right limb, Michael also displayed resistance to move. Michael was guarded, quiet, and hesitant to verbalize his feelings, therefore I asked him what his favorite activities were. Michael abruptly shifted and

confidently shared his passion for basketball, as evidenced by an increase in volume in prosody of voice and little hesitation in sharing. Michael's affect and body posture remained the same during these moments.

Utilizing Blanche Evan's *in-depth or complex improvisation* (see Appendix A), I invited Michael to create movement that illuminated what basketball meant to him. This intervention was used to develop the therapeutic alliance. With a twinkle in his eye, Michael continued, "I want to be a pro basketball player someday." Using expressive movement, Michael created a movement that embodied his love for basketball. He reached up with his left arm into mid-to-far reach space, expanding his kinesphere while creating a "dunking" movement. There was a direct quality about this gesture with bound flow and accelerating in time. I looked on and cheered for Michael. I felt as if I was transported into the future, sitting on the sidelines at one of his basketball games. I just witnessed Michael score an epic basket. Though Michael's affect remained blunted, a slight smile emerged during this celebratory moment. In these moments, I met Michael where he was "at," being sensitive and rolling with resistance to move. I prioritized the therapeutic relationship and he responded by trusting me.

During this expressive movement, his left side body remained still and confined to the bed. Michael basked in this moment revealing that he felt basketball brings out the "leader" in him. "People look up to me," Michael said with a vivacious tone. His body shifted slightly as his spine enlivened and movement occurred in his torso. Now, breath visually emerged with ease and a free flow quality in and out of his upper body. He shared his love for helping others and being a leader.

Next, Michael revealed his thoughts and feelings about the fight at school. Michael confessed that he lied about what initially happened when reporting the event to his sister,

Michael's legal guardian. Michael admitted that he lied out of fear, fear of repercussions. During these moments of revealing information about the fight, Michael's facial expression transitioned to a flat affect revealing a decrease in emotional state. This shift occurred when the feelings of shame and embarrassment arrived in the room. Michael's eye contact also decreased as he looked down during the details of the fight. I felt a sense of heaviness and increasing pressure within my body. There was a vibrating energy that started in my collarbone, clavicle area and burst into my shoulders. I also felt a rhythmic sensation pulsating at the pit of my core. I suddenly felt as if my autonomic nervous system kicked into fight or flight response while Michael shared the details of his story. These moments increased connection and the interpersonal relationship between Michael and his sister. I supported both emotional processing and strengthened his bond with his sister through honesty and openness. I provided Michael with a safe space to tell his sister the truth about the fight.

Michael threaded his sister into his narrative, "She is my motor. She is my role model." Michael shared this while indulging in the presence of stillness to reveal this metaphoric moment. He continued, "She is my goingness...my flow." While reporting this meaningful golden nugget of illumination, Michael brightened in the facial region. His eyes brightened while connecting with my eyes. I felt a pull within my solar plexus and joy emerged within my being. I also felt awe and wonderment as Michael organically created the symbol of his relationship with his sister. Michael was inspired to create an expressive movement that embodied his "motor." Michael used his mobile hand to make a circular gesture in his near-reach space with direct and bound qualities. I encouraged Michael to soften and decelerate this movement. Michael responded with a gentle free-flow circular motion. His injured right hand remained held with fierce stabilization. I witnessed his right hand act as stability while his left hand made the

“motor” gesture. It is then I realized in one movement, a symbol of the relationship emerged: one between caretaker and son. Their polarity of stability and mobility were illuminated through the medium of movement. Michael’s sister looked on with curiosity. The biopsychosocial goal of increase in connection and interpersonal relationship was supported here.

Post-session, Michael’s sister shared that during our session together, “Michael was relieved that he was able to say his stuff.” Michael’s sister stated, “He was talking more than he talks even to his therapist that he sees every week.” She elaborated, “He said that I was his role model. This made me feel good! I wish he would have told me before, that’s how he felt.” This is further evidence of emotional processing through the self-report of his sister.

After our interaction concluded, Michael expressed that he felt “better” after our dance/movement therapy session together. I encouraged Michael to use more specific feeling words to explain his experience. Michael chose “fantastic.” Michael could not identify any difference on a body level. However, I noticed an increase in shaping in the upper body evidenced by an increase in spreading and openness in the torso. This was evidenced by less rigidity in the torso and an increase in breath support. Michael’s affect had brightened as displayed by an increase in facial expression. His mood, expressed verbally, increased from “good” to “fantastic.” Michael was able to identify that the most helpful intervention of the session was, “talking about what happened with my hand.” He also reinforced that speaking about his “motor” was special.

**Conclusions.** Based on the conversation between journal and interviews, Michael had four emotional shifts occur during our DMT session together. These moments were evident based on affect, posture, or body change. My approach to Evans-based DMT did not particularly

affect his mood. However, there were clear transformative moments illuminated by the thematic analysis of Michael's narrative.

The essence of Michael's story lies in the inner strength that he discovered during our journey together. Michael was able to connect to his love for basketball and helping others to utilize as coping strategies during his hospitalization. Michael identified and recognized that his peers look up to him. This created a new pathway to seeing himself in a positive light and provided an opportunity for an increase in self-perception and self-esteem. The discovery of this inner passion lit Michael's fire and became pivotal in reaching a moment of mood enhancement.

Another ingredient to add to Michael's inner strength was shown through the interpersonal relationship between him and his caretaker. Michael used metaphor and imagery to express a meaningful connection with his sister. Michael felt shame and guilt following the fight he was involved in at school. However, Michael identified what his sister provides him as a way to combat and cope with fear, shame, and guilt. Michael identified that his sister is his motor, flow, and going-ness.

It is clear that our DMT session revealed an overall expansion in Michael's consciousness and increase in transparency to process emotions felt in the fight, injury, and surgery that he endured. Blanche Evans' DMT was used more as an assessment tool and to support the therapeutic process in this session rather than evoke emotional shifts and mood changes. My initial goal was to simply connect with Michael and decrease his overall discomfort in his body, a worthy goal, but as the session unfolded, I addressed his overall anxiety by helping him process emotionally and strengthening his relationship with his sister.

## **The Baby Seal and Killer Shark Unearth Love: Lydia**

**Presenting information from medical chart.** Lydia, a nine-year-old girl with a past medical history of asthma, depression, and splenic cyst, presented with a splenic cyst post-operation. This procedure entailed laparoscopic unroofing of the splenic cyst. Upon our session together, Lydia was taking medication for depression and saw a counselor regularly. Lydia also had a history of suicidal ideation. “Lydia” is the pseudonym I created to maintain anonymity for this paper. Lydia was the name of this patient’s imaginary friend.

Lydia presented with a splenic cyst post-operation following a laparoscopic unroofing of splenic cyst. Cysts and tumors of the spleen are rare and often discovered fortuitously (NCBI, 2005). Laparoscopic surgery is a minimally invasive surgical procedure performed with the assistance of a video camera and several thin instruments ([www.surgery.usc.edu](http://www.surgery.usc.edu)). Lydia’s current life stressors included her parents’ recent divorce, her Mom having a new relationship with a man in their home, and her grandmother’s death three months prior to our meeting.

Biopsychosocial goals that were created based on Lydia’s medical chart included an increase in positive coping skills related to current life stressors, an increase in self-regulation through self-expression and creativity, and an increase of connection within the relationship with Mom. Movement goals were to expand her use of her kinesphere and increase spatial awareness due to Lydia’s fixed ball shape and limited access to the space surrounding her, access the core-distal total body connectivity in order to increase her sense of self, and modulate from Dream State to Awake State through time and space effort qualities to access more mobility and energy in the body.

**Conversation between journal and interviews.** Upon entering the room, I witnessed Lydia curled up in a fetal position lying stagnantly in her hospital bed. Lydia looked back at me and our eyes intertwined during a fixated moment as I approached her bedside. Her ball shaped

body motionless, neck free to move back and forth, using the bare pillow to stabilize her head. Lydia held her soul in her lap as I observed a blunted affect with minimal expression throughout her face. I learned quickly that Lydia was more troubled psychologically than medically, although a splenic cyst was the cause of hospitalization. When I arrived, I felt as if I walked into a labyrinth of shadows. Lydia displayed Dream State qualities represented by a preference toward increasing pressure in weight and a bound quality in flow.

Upon my arrival, Mom explained that Lydia was experiencing a lot of stress following Mom and Dad's divorce. Mom shared that she and Lydia had been verbally fighting frequently at home. Lydia remained still as she listened to Mom's words. The conflict between Mom and Lydia quickly emerged through symbolism and Blanche Evan's *projective technique*. I introduced this intervention here as an assessment tool. I asked Lydia what animal she related to today. Lydia stated, "I feel like a baby seal and my mother is a killer shark." Mom responded with laughter, "Yep! We represent tough love."

I introduced a prop, a streamer, at the beginning of our session to entice Lydia to abandon her hospital bed. Without hesitation, Lydia emerged from her bed and stood with force. Lydia held her upper body in space, especially throughout the torso and heart space. Though appearing fragile upon entering, Lydia exuded a powerful nature illuminated by her wide stance with grounded feet connecting to the earth. The intervention utilized was Blanche Evan's *sensitization to and mobilization of potential body action* (see Appendix A), exploration with a prop. This explored full movement potential and expanded movement repertoire.

Lydia clenched the streamer in her hand and her focus immediately increased to a direct quality. I invited Lydia to explore her space and surroundings while moving with the streamer. She interacted with the streamer directly with an accelerated time quality. This illuminated an

effort or energy modulation from Dream State to Awake State. Lydia started to dance with her streamer, initiating an expressive whip action with the prop. “I feel as if I am whipping a tiger,” Lydia exclaimed. Her body held the continuity of bound flow during this whipping action. Her spirit captivated me as I witnessed with curiosity and awe. As she moved, I watched her kinesphere enlarge and resistance fade away. Lydia’s affect enlivened. There was movement in her facial region increased as she moved with the streamer. It was as if a butterfly burst from its cocoon and emerged into the physical world for the first time. Lydia started to make circular, spiral movements with the prop. The streamer danced in space while Lydia kept her feet planted firmly on the ground. This movement triggered a new thought for Lydia, “I have an imaginary friend. She is here with us right now. She has long brown hair, pink nails, wears a lot of dresses, and high heels. She is pretty.” Her circular movement modulated into free flow and her kinesphere increased from near-to-mid reach space. Lydia’s facial region relaxed as her eye contact increased with me.

Lydia continued, “She holds my hand to help me through things. She loves to help others. She makes me feel calm.”

Mom interjected, “She sees things.”

I invited Lydia to explore hand movements during this revealing moment with her imaginary friend. Lydia put down the streamer and began to meander around her hospital room. She made a wringing motion with her hands while exclaiming, “She always gives my hand a gentle squeeze.” Her hand opened and closed repeatedly in a contracting rhythm. The image of a heartbeat manifested in my mind. There was a shaping quality in her hands that was enclosing and shrinking. An increase in upper body movement originated through the spine and breath

emerged in the shoulders and chest. I felt a release within my heart center and an anchor lifted off my chest cavity.

Employing Blanche Evan's intervention *in-depth or complex improvisation* (see Appendix A), I asked Lydia what images or feelings arose while she interacted with her imaginary friend. This intervention was used to deepen the therapeutic process and illuminate new emotions within the self. Lydia responded, "It feels like a burst of light."

A burst of energy flooded my body as I asked curiously, "Where does your light live?"

"My feet," Lydia said at once with ease and a downward gaze.

Mom looked on with wonderment, and I asked Mom, "Where does your light live?"

Wiggling her fingertip in space, Mom responded, "My finger." Lydia continued, "My imaginary friend's light lives in her heart."

The next moments that unfolded were a process of integrating each entry point of light. Lydia and Mom connected in a face-to-face dyadic moment where their eyes met. Mom wiggled her fingers on top of Lydia's feet. The next words that rolled off my tongue were, "What do baby seal and killer shark need from the light?"

Lydia stated in a soft, gentle tone, "Love."

The two bodies intertwined and Mom embraced Lydia in a full body hug creating a shaping quality of spreading and enclosing in the upper torso. There was a free flow quality to the embrace and it is as if time stopped for a moment. It felt timeless, magical, and enchanting. The hug was not stagnant; instead it had a rhythmic quality. The contracting rhythm of Lydia's hand gesture made another appearance. I suddenly felt like their hearts were beating as one. Freedom and a sense of liberation beat within my chest.

"I love you," Lydia said with tenderness and certainty.

“I love you too,” said Mom without hesitation.

Deeply moved, a tear formed in my eye. Presence flooded Lydia and Mom and the two settled on a peaceful cloud. There was no verbal conflict in sight for the two. During this moment, Lydia’s affect brightened to a full smile and her facial expressivity increased.

Upon conclusion of our session, Lydia was able to identify a difference in feeling state.

Lydia explained “Before, I felt a little scared. And then after I felt happy.”

In response, I asked, “How did you know that you felt happy?”

Enthusiastically Lydia said, “Because I was smiling and I was doing fun things.”

Mom reinforced these feelings through her observations of the session, “She’s a little bit calmer and happier compared to what she was.”

Later, Lydia said with openness and transparency, “I feel like we let out what we held inside.”

Mom reinforced Lydia’s transparency during our conversation and said, “I observed her expressing herself, and openly talking about what was bothering her.” Lydia identified that, “calling my mom a killer shark,” made her feel the best during the entirety of the session. On a body level, Mom noticed a difference in Lydia’s “face,” specifically, “her facial expressions.” I noticed a free flow quality emerge from Lydia’s upper body. Lydia accessed an expansion in space and an increase in kinesphere. Lydia’s ball shape at the beginning of the session amplified and grew to a tetrahedron shape.

**Conclusions.** Based on the conversation between journal entries and interviews, Lydia had three emotional shifts occur during our DMT session together. These moments were evident based on affect, posture, or body change. Lydia responded to Blanche Evan’s potential body action with a prop intervention with increased energy and affect. Blanche Evan’s complex

improvisation intervention initiated an externalization of Lydia's light. Otherwise, Evans-based DMT acted as an assessment tool and to further support the therapeutic alliance. There were clear transformative moments illuminated by the thematic analysis of Lydia's narrative.

The essence of Lydia's story lies in the connection to her bravery. Lydia was not afraid to go within and enter the world of her psyche. Lydia surrendered to the present moment and released all resistance related to her current reality. DMT provided an arena for Lydia to enter a space that was full of wonder, ease, and comfort. Lydia was able to enter vulnerability and share her imaginary friend. This imaginary friend symbolized how Lydia was coping with her hospitalization and current life stressors. According to Dr. Eileen Kennedy-Moore (2013), having an imaginary friend may be utilized as a source of comfort when a child is experiencing pain or life challenges. Moore (2013) also explains that past research has shown that imaginary friends can help children learn how to cope with fears and explore new ideas through imagination and self-expression. Lydia's imaginary friend provided her with peace during a time of suffering. Lydia's imaginary friend may actually represent an unconscious piece of Lydia's Self and reveal how self-perception is helping her cope better.

Another ingredient in Lydia's brave adventure was the unfolding moments of being present with Mom. DMT became a medium for Lydia and Mom to connect through their light and love. Through the interpersonal gesture of a hug, the two bathed in each other's presence. The simultaneous exchange of giving and receiving provided a space for healing to manifest. DMT unearthed love for baby seal and killer shark to indulge in. Through the trust built in the therapeutic relationship, I promoted honest self-expression, increased interpersonal connection, and thereby shifted Lydia's overall mood.

## **The Ocean Overflows with Power: Ryan**

**Presenting information from medical chart.** Ryan, an eight-year-old boy with a history of asthma and sleep disturbances, presented with a chief complaint of staring-spell seizures. The purpose of this hospitalization was seizure analysis through continuous video EEG monitoring. During the summer of 2013, Mom and Dad noticed a change in Ryan's sleep habits as well as focus. On different occasions, Ryan was found sleeping at different locations of the house, other than his bed. These locations were under the kitchen table, in the dog kennel, and on the couch, among others. Previous reports of sleep disturbance include 12 hypopnea episodes and 10 apneic events, which are respiratory disturbances during sleep. This was Ryan's first official inpatient hospitalization. "Ryan" is the pseudonym I created to maintain anonymity for this paper. The name had no significance to the patient.

Staring-spells or absence seizures are a type of brief seizure, usually less than 15 seconds, with a disturbance of brain function due to abnormal electrical activity in the brain (Medline Plus, 2015). EEG-video monitoring refers to a continuous EEG recorded for a prolonged period of time with simultaneous video recording of the clinical manifestations. Ryan currently lives with his Mom, Dad, two sisters, and one brother. Ryan's current stressors included coping with a traumatic event within the family in 2013. Hospital records indicated Ryan's "cousin" was murdered by his cousin's mother. Ryan's family adopted the siblings of their late "cousin" because his cousin's Mom is serving a life sentence in prison.

Biopsychosocial goals based on Ryan's medical chart included to foster focus and concentration, foster positive coping skills through creativity and self-expression, and promotion of self-regulation. Movement goals included promotion of hand-eye coordination through the use of props to decrease the frequent shifting of eye focus and explore free flow qualities through effort modulation to promote flexibility and adapting to the environment in a more fluid way.

**Conversation between journal and interviews.** I walked down the sterilized hallway and overheard a sprite voice in the distance. A zap of energy ignited my entity and electrified the nape of my neck sending chills down my spine. Upon entering the hospital room, I saw a boy standing upright with thick, dense wires attached to his head. His hair frazzled with sensors and receptors, the wires were fastened to a head piece by medical tape. The other end connected to a pack secured tightly around his waist. His pelvis appeared held where the wire pack was secured. Another wire extended to a computer, logging his brain's electrical activity. The computer screen showcased a plethora of wavy lines. A visceral response was triggered within me. My head tingled with a vibratory sensation. Ryan's commanding presence stood tall and open as seen throughout his shoulders and upper body. His affect was observed as bright upon my entrance. He had a positive affect with substantial expressiveness in the facial region. This occurred during a playful interaction between Ryan and Mom.

Using open-ended questions with Ryan about the reason for hospitalization, I immediately noticed a shift in his affect and change in body shaping. Ryan said with a soft prosody in his voice, "I'm here because I have nightmares, but I don't remember what they are about." The upright quality in his body decreased. His facial expression declined to a blunted affect. Ryan displayed guarded qualities as evidenced by minimal eye contact and an indirect use of space represented by frequently shifting focus within the room

Mom shared that Ryan's abnormal sleep habits were triggered by a traumatic event that occurred last year.

"I'm afraid of the dark," Ryan revealed as he looked down, fidgeting with his wire pack.

"What is it about the dark that is scary?" I asked inquisitively.

He responded with certainty, "The unknown."

Ryan abruptly changed topics and burst at the seams, yearning to leave his room. With sadness he said, “I am so bored being cooped up in this room and hooked up to all these wires.”

I knew I must proceed with caution and awareness to Ryan’s limitations surrounding the machine, wires, and distance in which he was able to move. After checking with Ryan’s nurse, we received safety clearance to begin our movement exploration together. *Projective Technique* (see Appendix A) was interwoven into the session as an assessment tool and to elicit Ryan’s internal feeling state. I wondered what was hiding underneath the boredom, sadness, and fear. I asked Ryan what animal he felt like today. With hesitation, Ryan stated, “I feel like a rhinoceros.”

I quickly responded, “How do you feel like a rhinoceros? What qualities do you relate with?” Ryan identified that he felt “powerful” and “smart.” I was amazed by Ryan’s awareness and connection to self. He was able to examine himself without the pain of hospitalization and sleep disturbances. Ryan was also able to identify that Mom was a butterfly because of her “calm” and “fierce” qualities. Dad was a “gorilla” and his brother was a “wildebeest.”

I chose to offer a streamer to Ryan as a prop while incorporating Blanche Evan’s *sensitization to and mobilization of potential body action* (see Appendix A) to develop the therapeutic alliance. It was incorporated to explore his “rhinoceros” qualities. He clutched the streamer tightly in his hand as I positioned my body directly in front of his, acting as his mirror. Ryan slowly moved the streamer in space, accessing near reach space while keeping the streamer close to his body. Movement was minimal as I echoed Ryan’s movements, creating a dance of energy between us. His affect remained blunted. I invited Ryan to explore his “rhinoceros” qualities. I cued him to respond to the word “power” with movement. Ryan responded by accelerating in time and increasing pressure in weight. Ryan used a flicking motion with his

wrist and arm to throw the streamer into space. Ryan's kinesphere expanded and he accessed mid-to-far reach space. Ryan watched the streamer with evident focus as he continuously repeated this pattern. Ryan started flicking the streamer in all directions of space exploring the vertical and horizontal planes. Ryan's affect shifted and brightened as he moved with the streamer. Ryan shared, "I feel the energy flow in and out. It never runs out." Within that moment, I felt a burst of vibration through my fingertips. During this moment, Ryan made eye contact with me. I felt an interconnectedness and resonance in my core.

As movement with the streamer came to a close, I introduced another prop, the beanbag. After exploring his "power" in vertical and horizontal planes, I invited Ryan to explore power in the sagittal plane. I invited Ryan to imagine that his power lived inside the beanbag as a way of externalization. Without hesitation, Ryan cupped the beanbag in his hand and threw it softly down the hallway. I ran to the other end prompting Ryan to notice what it was like to throw his power. Ryan embodied play, giggling as he threw the beanbag with all his might. His affect was bright. The intensity of his throw increased slowly. I witnessed his joy emerge and his fear dissipate. I noticed evidence of increase in focus and mobility in the pelvic area where wire pack was fastened.

As our movement voyage with props came to a close, Ryan was suddenly reminded of the hospital stressors. He mentioned his head started to ache where the wires were attached and there was heaviness in his waist at the site of the wire pack. Ryan shared, "I want to move without these wires! I don't want to have to be here anymore." Sadness lurked behind the robust energy like a shadow in the night. I witnessed a shift in energy and his once bright affect transitioned to flat affect.

We returned to his hospital room where Mom cheered Ryan on, “You are playing so well, my little rhinoceros.” She embraced Ryan with positive feedback about our movement adventure. Ryan’s affect continued appearing flat and his body displayed upper body concavity. He looked defeated. I felt sadness and heaviness within my heart space during this emotional shift. Ryan exhibited guarded qualities as his focus went inward and his body transformed into a ball shape.

Mom soothed Ryan with her words, “Only one more day in the hospital, bud. You’ve made it so far.”

She asked, “What can you do today to make it through the day?”

Ryan quietly responded, “Watch movies, play with the iPad, and Wii.” Ryan was able to contain the wave of emotions that unfolded in those moments. I observed Mom channeling her calm “butterfly” qualities. Mom reached over to Ryan, taking his hand in hers. Silence filled the room as the two physically connected. Ryan looked over at Mom and smiled.

Upon conclusion of our session together, Ryan identified a difference in feeling state. Ryan stated that before the session he felt, “nervous because I didn’t know who you were.” Afterward, Ryan reported that he felt “happy and excited.” Ryan also identified that his body felt “tired,” after our session because “I don’t want to move anymore.” On a body level, Ryan accessed more mobility in the pelvic area. Ryan also increased movement exploration in different planes, such as horizontal and sagittal. When asking Ryan when the “happy and excited” feelings had emerged, Ryan responded, “When I got to throw the beanbag down the hall.”

I answered, “What did you throw it with?”

Ryan exclaimed, “My energy...power!”

Mom noted our session was filled with, “playing, dancing, and listening to music, asking questions, and what kind of animals you are.” In response to any evident changes of emotions or mood, Mom mentioned the shift towards the end of our session. She highlighted, “He got more connected. Then, he got reminded of what he could be doing instead of sitting in here, and being monitored.” She continued, “When he had to come back into the hospital room, he had time to think again.”

**Conclusions.** Based on the conversation between journal and interviews, Ryan had three emotional shifts occur during our DMT session together. These moments were evident based on affect, posture, or body change. My approach to Evans-based DMT did not particularly affect his mood. However, it was clear that props became a self-regulation resource for Ryan to utilize during our session together. There were also clear transformative moments illuminated by the thematic analysis of Ryan’s narrative.

In Ryan’s narrative, the hospital experience was clearly revealed as a stressor (see Appendix A), which was indicated when Ryan felt the heaviness and pain of the wires that were attached to him at the end of our session. This moment illuminated the negative impact that hospitalization was having on Ryan. The essence of Ryan’s story lies in the exploration of his power that became a distraction tool or coping strategy during hospitalization and current life stressors. DMT provided Ryan a safe space to connect and explore his inner power through props. Ryan was able to externalize his power and feel his energy flow in and out. This internal power helped Ryan see himself in a more positive, empowered way. This was evidence of self-perception without the attachment to illness and suffering. Connection to his power could also be a future tool to cope with his sleep disturbances, which were ultimately caused by fear. Ryan’s

family has just endured a traumatic event and loss in their family. The energy of that event still lingered on causing a major disruption in Ryan's overall well-being, mind, and body.

It is clear that our DMT session provided an overall expansion in Ryan's movement repertoire and an increase in self-regulation through connecting to his Self. Ryan connected to his energy that moved in and out like the ocean, overflowing with power.

## **The Lightning Bolt Bathes in Grace: Kristopher**

**Presenting information from medical chart.** Kristopher, a seven-year-old boy, presented with autism spectrum disorder, developmental/speech delay, and seizures characterized by staring spells, eye-fluttering, and vocal stuttering. Kristopher's past medical history included ADHD (provisional), obstructive sleep apnea, recurrent otitis media, right-sided unilateral hearing loss, torticollis, auditory processing disorder, and possible Landau-Kleffner Syndrome.

At 18 months of age, Mom and Dad noticed strange behavior that manifested as excessive biting, aggression, and speech delay. Due to increased agitation and seizure-like activity, Kristopher was being hospitalized for a 24-hour, continuous EEG monitoring to track seizure-like episodes. Kristopher lived with Mom, Dad, two siblings, and another sibling expected to arrive in a few months. Social stressors included Kristopher's delayed reading level. "Kristopher" is the pseudonym I created to maintain anonymity for this paper. The name had no significance to the patient.

Biopsychosocial goals based on Kristopher's medical chart included foster connection to emotions through creativity, promote self-expression, increase interpersonal connection, and increase body control. Movement goals included accessing bound flow and deceleration to promote body control, promotion of imagery through the utilization of props to enhance self-expression and creativity, and explore movement through mirroring to increase interpersonal connection.

**Conversation between journal and interviews.** "Today, I feel like a bull!" Kristopher exclaimed while whipping the dense ground with strong weight and accelerating speed. This

statement is in response to the *Projective Technique* (see Appendix A) utilized at the beginning of the session as an assessment tool.

He reiterated, “I am a bull because of its size and I am fast.” as he continued whipping into the vertical plane with quickness.

“I like to whip things,” he said as the wires that hung from his head were evidently not obstructing Kristopher’s space. His bright affect during moments of movement illuminated the freedom he discovered within the attachment to wires and a computer screen. During stillness, I observed Kristopher return to a blunted affect, the state in which I witnessed upon our moments together prior to moving. I also noticed involuntary movements occur when movement directives weren’t given. This was displayed through scratching of his head. While the streamer exploration continued, he was able to access mid-reach space within his kinesphere.

Kristopher continued whipping the streamer with indirectness, taking in his environment with an all-encompassing manner. During these moments, I felt chaos within me as evidenced by a dancing swirl of energy in my chest and heart center. It felt as if a storm had emerged. I invited Kristopher to further explore the space around him using different levels. He crouched down accessing his lower level while using the same movement qualities with the streamer. Kristopher began whipping the streamer as it remained in contact with the floor, creating a snake-like image. He went to the tips of his toes, finding balance and whipping high above his head, creating a lasso image. The wires hanging from Kristopher’s head became entangled with the streamer, abruptly stopping his momentum. I approached Kristopher in efforts of disentangling the two objects. As I handed the streamer back to Kristopher, he whipped the streamer into my space and kinesphere. The streamer became an extension of Kristopher’s limb, like tentacles of an octopus. The energy pierced my skin, electrifying my vessel.

The next intervention used was *sensitization to and mobilization of potential body action with a prop* (see Appendix A) to develop the therapeutic alliance. The beanbag was introduced to stimulate a different movement repertoire. He threw the beanbag in the air and used his fist to hit it into space. The beanbag launched across the room with acceleration and force. He quickly accessed direct focus in space and strong weight. He repeated this pattern of movement. When hitting the beanbag with his fist, he used a punching motion and explored fighting movement qualities. These moments with the beanbag elicited an emotional shift with bright affect, giggles, and an increase in vocal expression. When his fist came in contact with the beanbag, Kristopher let out a squeal of high energy.

Utilizing the same intervention, a mirroring activity was introduced to access recuperating movement through indulging qualities to counteract the prevalence of fighting qualities. I moved within closer proximity to Kristopher. We both stood upright in the vertical plane focused on one another. I invited Kristopher to engage in a mirroring exercise honing in on energy modulation. Kristopher was appointed leader, and I moved to reflect his movement. I encouraged Kristopher to use slow, decelerating time and direct focus in space. I noticed Kristopher's focus increase while a calm flow of energy accumulated within me. A decrease in weight was also accessed by Kristopher. He looked as if he were floating in a magical bubble released into the sky. I noticed Kristopher had complete control of his movement and the spontaneous involuntary moments (i.e., scratching of the head) had stopped.

"If I had a super power, I would fly," Kristopher stated powerfully. *In-depth or complex improvisation* (see Appendix A) was employed to deepen the process and elicit movement suggested by Kristopher's fantasy of "flying." I invited him to explore movement that was in response to his "super power." His arms elevated like a bird travelling to its next destination. I

followed along. Slowly and gently, he flapped his wings with grace. Kristopher's space expanded as he was able to access the horizontal plane. I noticed his eye contact increase but his affect remained the same as he moved.

"We are flying high in the sky...together." I said. I noticed free flow and ease emerge within his chest as I witnessed him take a deep breath. During our reflective journey together, I felt a visceral change that exuded a calm and peaceful state. My heart rate decreased and my muscles became relaxed. Upon closure of our movement-voyage, Mom looked on in awe and celebrated Kristopher's journey with positive reinforcement and clapping with strong weight. Kristopher's facial expression increased greatly in response to Mom's celebration.

During my conversation with Mom post session, she noticed a change in Kristopher's mood and emotions, "He seems much more upbeat after lots of fun and playful movement."

She continued, "He had a good time and even got to burn off some energy from being in the room all day and all last night." Mom identified the changes of emotion were most noticeable "during beanbag and mirroring." She noticed that, "He was much more calm! I think it really helped."

After our dance/movement therapy session concluded, Kristopher stated that before the session commenced, he felt, "very stressed out."

"Do you feel stressed out now?" I asked in response to his feeling statement.

Kristopher replied, "No." Kristopher was unable to identify how he knew that he felt a decrease in stress.

When asked, "How does your body feel now?" He simply said, "I don't know." I asked if his body felt any different from before the session. Kristopher responded, "No, it feels the same." On a body level, I witnessed him access an expansion in space evidenced by exploration of

levels and an increase in kinesphere. Kristopher also had an increase in free flow in the upper body evidenced by breath support. Kristopher identified through dance and movement, he was able to relate to those around him better. Kristopher stated directly, “After getting the dance on, I got to know you better.

**Conclusions.** Based on the conversation between journal entries and interviews, Kristopher had two emotional shifts occur during our DMT session together. These moments were evident based on affect, posture, or body change. Kristopher responded to Blanche Evan’s potential body action with a prop intervention with increased energy and affect. Otherwise, Evans-based DMT acted as an assessment tool and to further support the therapeutic alliance. There were clear transformative moments illuminated by the thematic analysis of Kristopher’s narrative.

The essence of Kristopher’s story lies in the connection to his internal calming grace. Upon our first meeting, Kristopher exuded a chaotic, unorganized accelerated energy. Amidst spontaneous involuntary movements and multi-focus, DMT provided an arena for Kristopher to enter a space that was full of ease, deceleration, and organization. DMT also served as an outlet to use his explosive energy to harness body control and self-regulation. I modulated him through slashing/whipping to direct throwing. I helped his system regulate by supporting the energy that needed to be expelled and transformed it.

It is clear that our DMT session provided an overall expansion in Kristopher’s movement repertoire and an increase in self-regulation. Kristopher was able to connect to his imagination and explore his fantasy of flying. Within these moments, the lightning bolt manifested peace, tranquility, and calming grace. Kristopher learned how to fly for the first time.

## **Red Power Discovers Comfort through Connection: Tristan**

**Presenting information from medical chart.** Tristan is a 10-year-old boy with a significant medical history of prematurity (35 weeks), fetal hydrops, subclinical seizures (seizure disorder), attention-deficit hyperactivity disorder (ADHD), fever, and cough. Additional history included intractable epilepsy, learning difficulties, and pneumonia. Tristan presented with *Mycoplasma pneumoniae*, leg and bone pain, as well as fever. Specifically, Tristan contracted community-acquired LLL bacterial pneumonia. Other symptomology included persistent fever for 10 days and involuntary beating up-gaze or Nystagmus. “Nystagmus is abnormal involuntary rhythmic eye movement” (Brumback, 1993, p. 4).

Past medical procedures included electroencephalogram and previous respiratory therapy. An only child, Tristan currently lives with Mom and Dad. There were no other current social stressors listed at this time. “Tristan” is the pseudonym I created to maintain anonymity for this paper. The name had no significance to the patient.

Biopsychosocial goals based on Tristan’s medical chart included foster self-expression, promote positive coping skills, and foster positive socialization and interpersonal interactions. Movement goals included modulation to Awake State through exploration of space and time to increase energy, expand kinesphere through access of mid-reach space, and promote didactic and relational movement through utilization of play to increase socialization and connection.

**Conversation between journal and interviews.** Upon entering Tristan’s hospital space, I wore personal protective equipment (PPE) due to special droplet precautions. PPE is worn to create a barrier between self and germs. This barrier reduces the chance of touching, being exposed to, and spreading germs. “PPE helps prevent the spread of germs in the hospital, and can protect patients and health care workers from infections” (Medline Plus, 2015). A sign posted on Tristan’s hospital door alerted those who entered must do the following: wear a mask that covers

the mouth and nose to eliminate germ exchange via inhalation; wear gloves that protected the hands to help reduce the spread of germs; wear a gown due to an illness that is easily spread.

Droplet and contact precaution usually includes those who have respiratory illnesses and concurrently may be carrying contagious germs that can be easily transmitted. In Tristan's case, it was specifically because of his bacterial infection. I also learned upon arrival that due to Tristan's lack of energy and unsteady gait, he was bed bound for the remainder of the day.

A plethora of fluffy stuffed animals corralled Tristan's arena as he laid in tender stillness. He tightly embraced SpongeBob with bound flow and not attending to space at all. The shape of his movement evoked an implicit feeling of curiosity and empathy. His focus took in his complete environment. His eyes beamed over at Dad following a momentary glance at SpongeBob. Tristan displayed a flat affect with no apparent shaping in the upper body. His tight shoulders enveloped his ears. There was a thread of immobility throughout his fragile body. The only observable expression occurred as he simultaneously let out a series of coughs. During these moments, my insides shrieked and a stinging sensation emerged in my heart center rapidly travelling into my lungs.

While sitting alongside Tristan, I mirrored his body level. Explicitly, I validated Tristan's hospital experience by using words of support, "It must be difficult having to lie in bed for so long in an unknown place; a place where people frequently look at you and monitor your every moment."

Tristan opened his eyes wider and made direct eye contact with me. He nodded his head as if he agreed with my words. Next I asked, "If you could do *anything* with me right now, what would it be?" With an inquisitive tone I emphasized the word, anything. I offered Tristan the

opportunity to explore a fantasy through Evan's technique *in-depth or complex improvisation* (see Appendix A).

Tristan surrendered playfully to this and stated, "Let's be Power Rangers. I want to be the red Power Ranger and go on missions together." He said this while holding a beanbag in his hand while looking at his Power Ranger toys. As an assessment tool, *sensitization to and mobilization of potential body action* (see Appendix A) was utilized with a prop coinciding with *in-depth or complex improvisation* (see Appendix A) structuring movement around thoughts and feelings about Tristan's fantasy. I invited Tristan to squeeze the beanbag to incorporate energy and weight into his body experience. He explored gripping the beanbag with different amounts of pressure. At the same time, I witnessed an increase in attention to space. His eyes watched the prop in a direct pathway. He held the beanbag very tightly for a long period of time. I noticed the energy travel to his shoulder, neck, and head. The expression on his face shifted from a flat to blunted affect. There was minimal expression around his mouth region. His eyes appeared more open whereas before, his eyes were heavy and halfway shut.

A scarf was introduced during *in-depth or complex improvisation* (see Appendix A) to develop the therapeutic alliance, and explore free flow movement to counterbalance the bound flow seen throughout Tristan's limbs and torso. Without hesitation, Tristan extended the scarf to connect with his Power Ranger toys. He caressed the toys with the scarf in a nurturing rhythm. I held a scarf in my hand and began to mirror Tristan's movement. He gracefully reached up with the scarf while expanding his kinesphere and accessing mid-to-high reach space. He directed the scarf up to the sky and released it, letting it float into his lap. I followed his expressive movements with synchronicity. Our scarves danced together in harmonious joy. There were periods of free flow movements accessed during this time. As Tristan's focus increased, a wave

of calm energy resurrected my body. My breath glided easily through exhalation and inhalation. There was a sense of freedom in my heart and lung pathway. I noticed Tristan's shaping in the upper body increase. There was spreading and opening seen in the torso, ribcage, and shoulders while he moved with the scarf. Without facilitation, Tristan used his Power Ranger toys to guide the scarf in space.

He proclaimed, "I am captain Red Power and I will drive our spacecraft to the next mission with the bad guys." Tristan positioned the toy underneath the scarf. He made noises to emphasize the movement of the spacecraft.

"I am your co-captain, Pink Power at your service!" I said, mirroring the playful prosody in Tristan's voice. Tristan escorted the spacecraft with accelerated time and continued making noises to reflect its pathway in space. "Bam," "Boom," "Weeeee!" Tristan exclaimed. There was an affect shift that occurred during our voyage. Tristan's flat affect escalated to blunted and bright, evidenced by an increase in expression in the facial region. Tristan's eyes were completely open and an incandescent smile occupied his face.

The scarf was discarded by Tristan while fighting commenced with the bad guys. Red and Pink Power engaged in quick, direct movements in the midst of battle. Red and pink powers united as one. Awake State was accessed in these moments. Tristan used quick, functional movements with increasing pressure to create slashing effects. He utilized near-to-mid reach space within his kinesphere. "We have swords that we must use to defeat the bad guys!" Tristan's voice increased in volume and expression. Music played in the background and Tristan's movement started to mimic the song's quick, rhythmic beats. There was a visceral feeling of empowerment that emerged. This was provoked by the use of fighting qualities that was explored through movement. Slash and punch action drives were revealed using strong

weight and quick time. Tristan approached his space through an oscillation of indirecting and directing.

The background melody shifted to a slower rhythm. Tristan abruptly modulated with the music and decelerated in motion. Tristan then revealed, “The hospital has been so boring...kind of like at home, I am the only child.”

I reply, “How do you feel about being the only child?”

“It is boring.” Tristan said with a soft prosody in his voice.

I noticed a shift in affect and mood during these moments. His bright affect transitioned to a blunted affect. His eyes that had fully blossomed before decreased in size. A wave of serene energy rushed into the space. Tristan’s vessel became still again with passive weight and internal focus. Recuperation set into Tristan’s body as he stated, “I am so tired.”

During the post session wrap-up, Dad stated, “You were able to grab his attention when you came in here.” Dad observed, “He was very active with the movement while he was engaging in the activity...Then later, he started getting tired and I noticed the music changed his whole mood.” He goes on to describe particular mood shifts within the session. Dad remarked, “I noticed at the end of the session, he calmed down.”

After our session concluded, Tristan identified that he felt “good” after our session together. “Do you feel any different than before our session together?” I asked with curiosity. Tristan stated, “The same.” Tristan expressed that his favorite part of the session was “playing” because it made him feel “good.” Tristan was unable to identify a difference in feeling state from before and after the DMT session. I asked Tristan to use other feeling words to describe his mood after the session. Tristan stated that he felt “calm.” Tristan was unable to identify any changes on a body level. I witnessed on a body level an increase of shaping in the torso, ribcage,

and shoulders as well as expansion in kinesphere. I also observed an increase of expression in the facial region and louder prosody in voice. Soon after, his eyes completely shut and sleep ensued.

**Conclusions.** Based on the conversation between journal and interviews, Tristan had three emotional shifts occur during our DMT session together. These moments were evident based on affect, posture, or body change. My approach to Evans-based DMT did not particularly affect his mood. However, DMT provided Tristan with an arena for play and a magical world of fantasy. There were clear transformative moments illuminated by the thematic analysis of Tristan's narrative.

The essence of Tristan's story lies in the comfort and connection that he discovered during our Power Ranger adventures. It was evident upon arriving that Tristan found comfort in the stuffed animals that surrounded him. DMT allowed Tristan to access more comfort. Comfort that felt empowering. Tristan was able to connect to his inner world of fantasy and become the hero in his story. This provided a new pathway to seeing himself in a positive way, providing an opportunity for an increase in self-perception. This exploration also became the catalyst for mood enhancement to take place. DMT also provided Tristan with the opportunity to harness control immersed in an uncontrollable environment and an uncontrollable situation. Tristan utilized movement and play as coping strategies during hospitalization.

It is clear that our DMT session provided Tristan with the tools to separate self from illness revealing positive self-perception. Tristan was able to connect to his empowerment and inner hero through play and fantasy. Blanche Evans' DMT was used more as an assessment tool and to further support the therapeutic process in this session rather than evoke emotional shifts and mood changes.

## Chapter Five: Discussion

### Final Summary

Dance/movement therapy provided support on a myriad of levels throughout this collective case study displaying five brave patients in the hospital setting. Each narrative carried an authentic voice. Within each story, DMT served as a medium to explore and display unique discoveries within each patient. However, there was a universal thread that connected these stories together to create a harmonious flow. The universal thread in this collective case study was movement. Movement became a support for emotional shifts through connecting each patient to their healthier, stronger, and more powerful parts. Movement assisted in shifting something internally to bring a more positive self-perception to the surface. Earlier, we discovered from the literature that positive emotions also assist patients with coping and enhance healthy perceptions, beliefs, and physical well-being. (Tugade, Frederickson, & Barrett, 2004).

Another universal thread among the narratives was therapeutic connection offering each patient an opportunity for socialization and the building of trust. Each relationship was established through nonjudgment, curiosity, and unconditional positive regard. This translated into trust within the therapeutic relationship which meant some were able to process emotions. This also allowed for deeper connections relationally. This fostered their internal growth because relationships shape who we become. Siegel (2002) reminded us earlier that a fundamental result of interpersonal relationships is to facilitate internal integration in a child.

DMT also provided an opportunity for each patient to experience their own bodies, connect to them in a way that was without a medical diagnosis. According to the literature, (Ekra & Gjengedal, (2012) found that children's self-perception is significantly impacted by hospitalization, specifically their connection to their bodies. This study gave hospitalized children the opportunity to connect to their bodies with a sense of freedom from illness, even for

just a moment. Goodill and Morningstar (1993) stated this as a vital goal for DMT within the pediatric medical population. This provides the patient with a more positive perception of self; therefore, improving their overall quality of life.

The exchange of energies through movement and DMT provided each patient with illuminations of the self. Some of these illuminations included connecting to inner strength, power, comfort, love, and light. These inner ingredients reveal evidence of increase in positive self-perception, self-esteem, and increase in positive coping strategies during hospitalization. The question still remains; did my Blanche Evans-based DMT influence their mood?

The purpose of this research study was to discover and understand how my Blanche Evan's based dance/movement therapy influences mood in hospitalized children. The subjective experiences in these hospitalized children were illuminated through their verbal and non-verbal communication in the conducted DMT sessions. My initial goals were to support their stories and be present to witness their feelings, emotions, and responses that were elicited by their hospital experience. Through these experiences, the intention was to gain a better understanding of what my DMT is providing for them regarding mood in their current reality.

Blanche Evan's specific interventions (see Appendix A) were used for assessment purposes, to encourage the therapeutic process, and to support emotional shifts. These interventions acted as a container to provide structure and theme development throughout each narrative. Evans-based DMT became part of the foundation or backbone to each session, allowing space for creativity and expressivity to flourish. My approach to Evans-based DMT focused on the therapeutic relationship and supported each patient's overall authenticity by inviting these hospitalized children to delve into their imagination and giving them permission to be free to express their authentic selves without illness.

## **Limitations to This Study**

There were limitations illuminated throughout the data collection and data analysis process that are worth mentioning should a future dance/movement therapy study happen within the pediatric medical setting. The few dance/movement therapy sessions per patient limited the data and therefore it was not possible to prove that mood was affected. One session provided this researcher with only one journal entry and one piece of interview data from both the caretaker and participant. The limitation that I am describing is that the sample size may not be generalizable. Also, this study was not quantitative or structured to prove a connection between DMT and mood but rather describe and tell a story.

A number of factors contributed to the challenge during the recruitment process, such as the patients' length of stay at the hospital, physical limitations and/or medical barriers, and their willingness to participate in a dance/movement therapy session. In addition to this, the caretaker had to be present at bedside during the entirety of the DMT session. Scheduling the DMT session in order for the caretaker to be present was challenging. Also, coordinating the DMT session around the patients' medical schedule became a barrier in the study.

In addition to this, a limitation occurred during the informed consent process. To receive signed consent meant retrieving the patients' signature and verbal consent, as well as the caretakers' signature. After the initial proposal of the study to each caretaker and patient, both had to verbally agree to participate. Once this was provided, the consent forms were left to view thoroughly. Ample time and space were given to ensure caretaker and participant knew exactly what the study entailed. There were other potential patients' with coinciding caretakers' who gave consent to participate in the study. However, the signed consent process took too long to receive and they were discharged before we could meet.

During the interview process, this researcher created a set list of questions to ask participants' and caretakers' based upon the session's content. Some participants' had a difficult time identifying how he/she felt before and after the session. Also, all participants' had a challenging time identifying differences on a body level. This researcher feels that incorporating a list of feeling words, phrases, or images for the participant to choose from may be a good idea in the future.

### **Implications for Future Research**

Examining emotional shifts and mood changes within the hospital setting may be impossible to be completely accurate because there are various stressors suffered within this environment that are contributing factors. In addition, it is challenging to know what exactly is causing a mood change within a child. A hospitalized child receives care from numerous providers and the possibilities are endless in terms of what or who created a mood shift. I was also inexperienced in treating hospitalized children as this research study was conducted during my internship. I still have considerable interest in utilizing dance/movement therapy as a tool to improve mood and working with pediatrics in the medical setting.

In future areas of research that include dance/movement therapy, it would be essential to develop a quantitative research study to increase validity purposes. Incorporating a pre-test and post-test could also increase the validity of the study. This option would create structure and points of reference to compare mood or emotional states before and after the DMT session.

In future areas of research and in future life experiences, I encourage you to be inspired and present to witness the unfolding of narratives. The narratives I was able to share in this research study, have forever shaped who I am as an individual and clinician. These narratives have inspired me to be bold and courageous; to confront fear; to connect to my inner light; and to

discover my inner hero. I will continue seeking out narratives and externalizing the beauty within each story.

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## **Appendix A**

### **Definition of Terms**

#### **Child Life Services**

Child life programs emerged and grew to aid in children's psychological and social adjustment (Carlson et al., 1985) in the hospital setting. Child life is based on a model that emphasizes normalization and social interaction as healthy coping mechanisms (Siarkowski Amer 1999) (as cited in Hendon & Bohon, 2007). Child life services constitute an essential component of quality pediatric healthcare and they have become standard in most pediatric hospital settings (Kaddoura, Cormier, & Leduc, 2013). Child life programs facilitate the coping and adjustment of children and families in three primary service areas: 1) providing play experiences; 2) presenting developmentally-appropriate information about events and procedures; 3) establishing therapeutic relationships with the patient, parents, siblings, and other family members to support informed family involvement in each child's care (AAP, 2000).

#### **Child Life Specialists**

Child life specialists help young patients and their families overcome the fear and confusion that often accompany a hospital experience, and teach them how to best cope with unfamiliar procedures, equipment and environments. While child life specialists do not provide direct medical care, they play vital roles in caring for the social and emotional challenges of hospitalized children (Bellezzo, 2014). According to the American Academy of Pediatrics (AAP, 2000), child life specialists are certified healthcare professionals with a strong background in child development and family systems. Child life specialists typically work with a multidisciplinary patient care team, which may include physicians, nurses, social workers, therapists, counselors, teachers, parents, and others to help reduce anxiety, make the child's hospital visit more comfortable, child-friendly and, in many cases, fun (AAP, 2000).

## **Coping**

Aldwin (2007) defined coping as “the use of strategies for dealing with actual or anticipated problems and their attendant negative emotions” (p.125). She asserted that coping in relationship to physical health involves adaptation to a medical illness via certain adaptive tasks: “maintaining an emotional equilibrium, maintaining a sense of self (including competence and mastery), maintaining good relations with family and friends and preparing for future exigencies” (p. 197). Coping is considered as an emotional, behavioral, and cognitive process that contributes to the adaptation to changes within the environment (Sposito et al Nascimento, 2015).

## **Dance/Movement Therapy (DMT)**

This researcher used the lens and theory of DMT pioneer, Blanche Evan, during sessions. Evan operationalized DMT as the “utilization of creative dance to promote mind-body unification through expressive movement while still providing instruction in the basic skills of dance” (Levy, 1992, p. 35). Evan believed that children can express in movement and metaphor what they cannot express in words (Levy, 1992, p. 35).

## **Intervention**

The intervention that will be utilized during sessions is Blanche Evan’s improvisation/enactment. This consists of three approaches: a) projective technique; b) sensitization to and mobilization of potential body action; c) in-depth or complex improvisation (Levy, 1992, p. 40-41). Projective technique utilizes creative categorical themes, mostly consisting of nature themes. For example, the client is asked and facilitated to be an animal or water in any form. Always providing the client to fill in their own image which inevitable is a projection of one part of his/her own feeling state (Levy, 1992, p. 41). This acts as an emotional

warm-up or barometer in that it attunes the individual to a specific feeling which presses to express itself physically (Levy, 1992, p. 41). Sensitization to and mobilization of potential body action has a goal to bring potential movement into actual movement through stimulating the elements of dance (i.e., time, space, intensity, rhythmic flow, content) (Levy, 1992, p. 43). This is accomplished by providing different images, stimuli, and directives through the utilization of instruments and/or props (Levy, 1992, p. 43). This explores full movement potential and expands movement repertoire. In-depth or complex improvisation is structured movement suggestions around thoughts and feelings the client has about his/her own body, including fear, fantasies, illusions, as well as somatic identifications of oneself with others (Levy, 1992, p. 44).

### **Laban Movement Analysis (LMA)**

Within LMA, there are categories that comprise this system. Effort is the approach to “how” we move. Moore (2014) describes that Effort reveals something about how a person is feeling (p. 65) and the inner attitude can become visible. “Effort is comprised of Space, Time, Weight, and Flow – are the building blocks of Laban’s effort taxonomy” (Moore, 2014, p. 65).

Space is the effort exerted to aim and orient movement. A fighting attitude is expressed in direct motion, in which linear aim with a singular focus is noted. An indulging attitude is expressed as indirect motion, in which curvilinear plasticity and continuous changes in the direction prevail (Moore, 2014, p. 66).

Time is the effort exerted to pace the movement adroitly. A fighting attitude is expressed as sudden action or accelerating, in which quickness and acceleration are noticeable. An indulging attitude is expressed in sustained movement or decelerating, producing a lingering action in which deceleration prevails (Moore, 2014, p. 66).

Weight is the effort exerted to apply the right amount of pressure. A fighting attitude is expressed as strong weight or increasing pressure, in which firm pressure and forcefulness prevail. An indulging attitude is expressed as light weight or decreasing pressure, in which delicacy and a gentle touch are noticeable (Moore, 2014, p. 66).

Flow is the effort exerted to control movement. A fighting attitude is expressed as bound flow, in which the motion is restrained and easy to stop. An indulging attitude is expressed as free flow, in which the action is relaxed, on-going, and difficult to stop (Moore, 2014, p. 66).

### **Lifeworld**

Defined by Bengtsson (2001, 2006) as a concrete, preverbal human world of everyday lived experience that we take for granted, inhabit, and share with others.

### **Mood**

Mood, or emotional state, also impacts health. This occurs through direct physiological pathways and as a mediator of other factors such as coping and social support (Goodill, 2005, p. 43). Mood directly impacts the inner emotional process and can rapidly change an individual's perception, beliefs, and thought patterns.

### **Quality of Life**

Whitehouse & Slevin (1996) operationalized the term as “what makes life worth living.” Goodill revealed that quality of life is described and measured by both objective and subjective perceptions of the patient themselves. Health related quality of life, which specifically pertains to those individuals living with a medical illness, focuses on “the specific impacts that disease, injury, and their prevention and treatment have on the value of survival” (Hall, 2007).

**Self-perception**

An individual's ability to respond differentially to his own behavior and its controlling variables, is a product of social interaction (Skinner, 1957; Bem, 1967). Perception is an interactive process, whereby we perceive the world as we move through and within it (Dowler, 2013).

**Socialization**

A term used by sociologists, social psychologists, anthropologists, political scientists and educationalists to refer to the lifelong process of inheriting and disseminating norms, customs, and ideologies -- providing an individual with the skills and habits necessary for participating within his or her own society (Clausen, 1968, p. 5).

**Stressor**

Verbal concepts, expression, and affective responses elicited by external stimuli in an emotional state of stress (Cohen & Walco, 1999).

## **Appendix B**

### **Script: Verbal Assent Speech**

“I am Ashlea, the current dance/movement therapy intern. I am doing a study to figure out how my dance/movement therapy affects mood in hospitalized children. I am asking you to take part in the research study because you are currently a child in the hospital referred to me by Child Life.

For this research, we will do a dance/movement therapy session(s) together and then talk about our experience afterward. I will record our conversation. I will keep all documents as well as documentation of your thoughts, words, and feelings private. I will assign a different name (pseudonym) so I don't use your real name outside of the study.

During the dance/movement therapy session you may choose to take part in all or some of the activities. Participation is completely up to you. You may withdraw or stop the study at any time. We don't think that any big problems will happen to you as part of this study, but you might experience emotions or feelings associated with the hospital experience. When we're talking, you can stop talking to me any time. ”

There are good reasons to be involved in this study. You will share your thoughts and feelings about being hospitalized in a safe and supportive place. You will be able to use your creativity and imagination that may help you while you are here. Your story will be shared with others and add to the knowledge of other dance/movement therapists.

## Appendix C

### Consent Form

**Investigator:** *Ashlea Palafox*

**Contact Information:** *Columbia College Chicago 624 S. Michigan Ave. xxx-xxx-xxxx*

**Title of Study:** *Embodied Narratives: The Influence of Dance/Movement Therapy on Mood for Hospitalized Children*

**Sponsor:** *Columbia College Chicago 624 S. Michigan Ave Chicago, IL 60605*

## **Subject Information Sheet and Consent Form**

### **Introduction**

**Note: If you are the parent, guardian, or legal representative of a minor or person who is not able to consent for themselves the terms “you” or “your” refer to you and/or the person being asked to participate in this research.**

You are being invited to take part in this research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the information in this form carefully, as it may contain words you do not understand. You may wish to discuss it with your doctor, family, and/or friends. If there is anything that you do not understand or you would like more information, please ask questions and the principal investigator or study staff will try their best to answer them. Once the study has been explained and you have had all your questions answered to your satisfaction, you will be asked to sign this form if you wish to participate. Before anything is done for this study, you must sign this form. A copy of this signed form will be given to you.

You do not have to take part in this study. You are free to withdraw from this study at any time you choose without giving a reason. This will not affect any future care you will receive. No promises can be made about the outcome of this as far as your current condition, either positive or negative. People who take part in research are called “subjects” instead of “patients”.

### **Why are you being invited to participate in this study?**

You are being asked to take part in this study because you are currently a hospitalized patient or guardian to a hospitalized patient that I am doing dance/movement therapy sessions with while being in the hospital.

### **What is the purpose of this study?**

The purpose of this study is to discover how my dance/movement therapy influences mood in hospitalized children. This will be shown by creating a story about each participant based on their session(s) with the principal investigator.

### **How many study subjects are expected to take part in the study?**

Three-to-five participants will be enrolled in this research study to comprise a qualitative collective case study.

### **What will you be asked to do?**

If you agree to participate in this study, you will be asked to do the following:

Agree to be a participant in this study.

If you are currently a hospitalized child, you are in agreement to be engaged during our one hour dance/movement therapy sessions.

Participate in an audio individual interview in person, to answer 6-8 pre-set interview questions regarding the research topic. Questions will ask inquire about your experiences of the dance/movement therapy session, how this experience affected you, how it may have shifted your mood, and/or emotional state.

The research will be conducted during your hospital stay. Dance/movement therapy sessions will be one hour in length with a 10 minute interview after completion of the session. Sessions will be set up dependent upon length of hospitalization and schedule of any procedures and/or surgeries.

### **How long will you be in the study?**

Subjects are expected to participate in a minimum of one dance/movement therapy session, one hour in length. Duration of study depends on subject's availability, discharge planning, and any scheduled medical tests, procedures, surgeries, etc.

You may be removed from this study without your consent. Possible reasons may be that the study doctor decides that continued participation in the study will be harmful to you, you will need a treatment not allowed on the study, your disease becomes worse, you are unable to take the treatment as directed, or the study is canceled.

### **What are the possible risks of the study?**

The risk(s) in this study is (are):

The interview process may bring up physical, emotional, psychological, and social symptoms of your current hospital experience. These risks may occur immediately, before, during, or after the session and/or interview process. You will have permission to choose what you do or don't want to share.

The principal investigator will follow standard protocol if the principal investigator encounters an adverse reaction from study participants during the course of the research. Standard protocol is to immediately alert the NAME OF HOSPITAL's medical team who will then refer patient to the Child Psychiatry Department. They will take necessary steps to ensure the patient's treatment is uninterrupted and safety is enforced.

Shared details of written and audio interview narratives, and quotations in written findings may un-intentionally reveal your identity or the identity of others mentioned in your interview. To

minimize this risk, you will be assigned a pseudonym (different name) and any people you mention in your interview.

### **Are there benefits to taking part in the study?**

The possible benefits of being in this study include:

Sharing your hospital experience in a safe, supportive environment, with a witness.

The opportunity for potential relief, respite, and transformation of physical, emotional, psychological, and social symptoms or negative impacts from your experience of being hospitalized.

Receiving alternative contemporary treatment via creative arts therapy.

Contribution to research in the medical dance/movement therapy field.

### **What other options are there?**

The only alternative to participating in this study is not to participate.

### **What about confidentiality of your information?**

Within the study and the interview process, identifiable, private, or sensitive information may be obtained about the participants and other living individuals. Therefore, the following procedures will be used to protect the confidentiality of research participants and others mentioned within interviews, while maintaining confidentiality of data:

Confidentiality means that the investigator will keep the names and other identifying information of the research participants private. The investigator will change the names and identifying information of research participants when writing about them or when talking about them with others, such as the investigator's supervisors.

All email communications regarding this research study will be made with the principal investigator's supervisors. These email communications include edits and feedback regarding the study's final narrative. To ensure confidentiality, all research participants identifying information will be kept anonymous.

In order to protect the participant's privacy and confidentiality, audio recordings and written interview data will be protected via secure laptop password. Because this study will involve the use of the internet, email communication, and electronic record keeping, firewall protection will be used to help provide as much confidentiality as possible of electronic information.

Study records will be kept for two years in a locked office safe in the main researcher's home, with access available only to the principal investigator. Audio taped interviews will be transcribed and viewed only by the principle investigator. After a period of two years, the audio recordings will be destroyed.

Audio recordings, written interview data, journal entries, and all accompanies study records will be destroyed after the accumulation of two years.

Personal study notes may be kept indefinitely in a personal journal with the data stripped of all identifiable information, including names and identifying information of research participants.

Personal study notes are notes that include the principal investigator's introspective thoughts, feelings, and personal reflection for future growth in the clinical setting.

When study data is released, it will be furnished to the principal investigator's Faculty Advisor, Kristy Combs, BC-DMT, LCPC, kloucombs@yahoo.com and to the Columbia College Chicago Dance/Movement Therapy and Counseling Thesis Committee. Information to be furnished will include selected interview narrative data, direct interview quotes, nonverbal body and direct

observations, along with data analysis and research findings. If provided by participant, additional creative and visual representations may also be furnished. The purpose of this disclosure is to represent and share, as accurately and authentically as possible, the experiences and stories of hospitalized children provided by participants. The confidentiality feature of each individual participant as indicated on their consent form will be honored in regards to use of a pseudonym (different name) and identifying information in the study.

The following procedures will be used to protect the confidentiality of your information:

The principal investigator will keep all interview, narrative, and study records safe with password and firewall protection.

Any audiotapes will be destroyed after two years.

All electronic files containing personal information will be password and firewall protected. Information about you that will be shared with others will respect your confidentiality as indicated on this consent form.

If you withdraw from this study, the data already collected from may not be removed from the study records. The principal investigator and/or study team may ask you whether they can continue to collect follow-up data on you. If follow-up information will be requested, you will be asked to sign a separate consent form before this information can be collected.

Confidentiality and disclosure of your personal information is further described in the attachment to this form. The attachment is titled HIPAA Authorization to Share Personal Health Information in Research (2 pages).

The NAME OF HOSPITAL Institutional Review Board (IRB) will have access to your files as they pertain to this research study. The IRB is a special committee that reviews new and ongoing human research studies to check that the rules and regulations are followed regarding the protection of the rights and welfare of human subjects.

## **RIGHTS**

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

Thoughtfully consider your decision to participate in this research study. We will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Ashlea Palafox (xxx-xxx-xxxx) or the faculty advisor, Kristy Combs (kloucombs@yahoo.com).

If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board (IRB) staff at 312-369-6994 or IRB@colum.edu.

### **What are the costs of your participation in this study?**

There will be no costs for participation related to this study.

### **Will you be compensated or paid?**

There will be no compensation or payment for participation related to this study.

### **What happens if you experience a research related injury?**

If you agree to participate in this study, your consent in this document does not waive any of your legal rights. If you experience any injury or illness as a direct result of your participation in this research study, immediate treatment will be provided. However, in the event of harm arising from this study, the researchers are not able to give you money, insurance, coverage, free medical care or any other compensation injury that occurs as a result of the study. For this reason, please consider the stated risks of the study carefully.

If you have any medical problems during the study, please contact the principal investigator or study team. He or she will explain your treatment options to you and/or help you find a place to get treatment.

THE NAME OF HOSPITAL has no program for financial compensation or other forms of compensation for injuries which you may incur as a result of participation in this study.

### **What happens if you need emergency care?**

If you need emergency care while you are participating in this study, it is important that you tell emergency personnel of your participation in this study and notify the principal investigator or study team as soon as possible.

### **Whom do you call if you have questions or problems?**

Questions are encouraged. If there are any questions about this research study or if you experience a research related injury, please contact: [Ashlea Palafox, xxx-xxx-xxxx]. Questions about the rights of research subjects may be addressed to the NAME OF HOSPITAL's address and telephone number.



**SIGNATURE OF THE PRINCIPAL INVESTIGATOR**

I attest that I am aware of the enrollment of this subject in the study discussed in this consent document.

\_\_\_\_\_

\_\_\_\_\_

**Signature of the Principal Investigator**

**Date of Signature**

Check here if Principal Investigator obtained consent and a separate signature is not required.

## **Appendix D**

### **HIPPA Authorization Form**

#### **HOSPITAL NAME**

#### **AUTHORIZATION TO SHARE PERSONAL INFORMATION IN RESEARCH**

Name of the Research Study: Embodied Narratives: The Influence of Dance/Movement Therapy on Mood for Hospitalized Children

Name of Principal Investigator: Ashlea Palafox

The word “you” means both the person who takes part in the research, and the person who gives permission to be in the research. The word “we” refers to HOSPITAL NAME, its employees and affiliates, including the study doctor and his/her research staff. You will be asked to sign this form along with the attached research consent form.

We are asking you to take part in the research described in the attached consent form. To do this research, we need to collect, use and possibly share information that identifies you. Some of this identifiable information may come directly from you and some may come from results of questionnaires or interviews. We will only collect information that is needed for the research. This information is described in the attached consent form.

If you sign this form, we will collect your identifiable information until the end of the research. We may keep the information forever, in case we need to look at it again for this research study.

Your information may also be useful for other studies. We can only use your information again if a special committee in the hospital gives us permission. This committee may ask us to talk to you again before doing the research. But the committee may also let us do the research without talking to you again if we keep your identifiable information private.

If you sign this form, you are giving us permission to collect, use, and share your identifiable information.

You do not have to sign this form. If you decide to NOT sign this form, you cannot be in the research study. We cannot do the research if we cannot collect, use and share your identifiable information.

If you change your mind later and do not want us to collect, use and or share your identifiable information, you need to send a letter to the researcher listed above. The letter needs to say that you have changed your mind and do not want the researcher to collect, use and share your identifiable information. If we cannot collect, use and share your identifiable information, we may decide that you cannot continue to be part of the study. We may still use the information we have already collected. We need to know what happens to everyone who starts a research study, not just those people who stay in it.

If you sign this form, we may continue to share the identifiable information collected for this study with the people listed in the Confidentiality section, without any time limit, unless you withdraw your authorization. This authorization does not expire.

## CONFIDENTIALITY

We may share your information with people who help with the research. Some of these people may be other researchers outside of the hospital or are in charge of the research, pay for, or work with us on the research. Some of these people make sure we do the research properly. Some of these people may share your information with someone else. If they do, the same laws that HOSPITAL NAME must obey may not protect your health information. For this study, we will share information with:

Research Study Staff - Department of Creative Arts Therapies at Columbia College Chicago:

- Primary Supervisor
- Secondary Supervisor
- Peer Auditor

If your information is transferred outside of the United States, different privacy laws may apply. Additionally, if one of the companies or institutions listed above merges with, or is purchased by, another company or institution, this authorization to use and disclose protected health information in the research will extend to the successor company or institution.

Any questions? Please ask the researcher or his/her staff. Their phone numbers appear in the attached consent form. You can also call x-xxx-xxx-xxxx at HOSPITAL NAME with general questions about your rights and the research use of your health information. The researcher will give you a signed copy of this form.

## SIGNATURE, DATE, AND IDENTITY OF PERSON SIGNING

The health information about \_\_\_\_\_ can be collected and used by the researchers and staff for the research study described in this form and the attached consent form.

Signature: \_\_\_\_\_

Date:

Print name: \_\_\_\_\_

Legal authority:

## Appendix E

### Embodied Narratives

**The Warrior Connects with his Inner Strength.** My core enlivens in witness of his masculine, barbaric spirit. The warrior evokes strength within my soft, sensual organs. Infusing them with blue power laced with fear. My insides tremble vibrantly as words slowly roll off his tongue. I embrace his narrative by spreading my wings and hugging the sky. The rays of sunshine beat powerfully in a heartbeat, palpating blood vessels and creating clouds of oxygen. Fight or flight, the warrior acts on instinct in defensive wonderment. My inertia calculates fire, burning deeply into my chest. The motor of his vessel resurrects his spirit to calm the waves of the storm. My body feels the breeze of the engine and ignites peace within me. The thick, dense connection between the motor and warrior leaves an imprint on my soul. The tapestry of colors paints a rainbow for the entire world to enjoy...and indulge in.

**The Baby Seal and Killer Shark Unearth Love.** I sit in wonderment of her vivacious power seamlessly beaming from her bright insides. Colorful remnants of pain ooze from her empowered soul. My bones caress the floor with grounded senses. Her hard shell decomposes like ashes, becoming one with the earth. The shell lay on the floor stiff with hardened emotion. Her insides light up like the fireworks on the Fourth of July. The baby seal emerges with her killer shark while fear transforms into love. Light dripping from her nimble feet firmly planted into magical beauty. My heartbeat decelerates into slow motion, like water slowing down time. Their playful, courageous spirits dance in the cloudy movement while I observe on with fond admiration. The killer shark bathes her baby seal with tender light, tightly connected to her babe forever. It fills my entity with wealth and sanctuary.

**The Ocean Overflows with Power.** My heart sinks like a ship submerged in the tremendous ocean as blue as the sky. Clouds drift within my body as the seas part, revealing

unconscious matter. Particles drip off my fingertips like sand. The coarse granules fill his effervescent eyes as they pierce my soul. The powerful heavy flow of energy bounced off the open waters. Sadness lurked behind the robust energy like a shadow in the night. The fear of the unknown startles him and heaviness lingers throughout his dreams. The haunted sleep is a mysterious wonderment for all to be baffled by. The sweet nectar of the calm butterfly drizzles magic on the Rhino's horror. Her fierce wings gracefully dance in the moonlight. My mind oozes with a mix of glory and serenity. At that moment, the ocean realizes it is filled with infinite love. Nothing could stop it from overflowing, and life continues pouring out of it.

**The Lightning Bolt Bathes in Grace.** He is fast as a lightning bolt that strikes the ground while his feet glide to the golden rhythm of the sky. Within a morsel of joy, rainbows light up the world. His smile is contagious, as energy rushes through my chest. The whipping sensation pulsates and spectators look on in awe. The communication of his furious movement resemble the bolt of light. I hear thunder in the distance and feel a polarity of gentle clouds pass through my heart center. The breeze feels cold on my skin and vibrations imbue my being. Flying, soaring, bathing in white light; he decelerates into oblivion. We connect in reflection. The mirror resonates with his heart and the music of his desire. Fluidity radiates to the outer world. I hear applause in the distance and laughter beaming from his playful soul.

**Red Power Discovers Comfort through Connection.** His eyes lay heavy like fog thickly encompassing the magical twilight. He held SpongeBob ever-so-tightly squeezing its melting shell. The shape of his movement gave me an implicit feeling of curiosity and empathy. The power he conjures follows him like a dark shadow. He craves love and nurturing comfort that he only receives from the soft, whimsical animals that encircle his body. My lungs feel tingling and jar with every shriek of his cough. It cut like a knife assaulting my ear drum with

harsh vibrations. The raw, red power calls out his name. I hear it echoing in the distance among the boredom and sadness. “Tristan...Tristan,” louder with every breath. Our mind and bodies conversed with play and imagery. Red and pink powers unite as one. The unstoppable team fights crime and intruders while fear lurks behind. A calm wave of emotion bestowed upon his royal ruby. Goodnight sweet boy. Farewell...

**Appendix F:**  
**Participant Interview Questions**

1. Do you feel different after dance/movement therapy sessions?
2. How did the dance/movement therapy session make you feel?
3. Did anything change after the dance/movement session regarding your emotions?
4. What part of the session made you feel the best?
5. How does your body feel?
6. What were your thoughts after the session?

**Appendix G:**  
**Caretaker Interview Questions**

1. What did you observe during the dance/movement therapy session?
2. Did you notice any changes in the participant's mood or emotions?
3. What part of the session were the changes most noticeable?

**Appendix H:**  
**Researcher Journal Entry**

Participant name/Pseudonym

Date

Time

Session number

Biopsychosocial goals

1)

2)

3)

Three movement goals

1)

2)

3)

Data/observations: (including Diagnosis, medical history, upcoming procedures, current stressors, patient stories)

Intervention(s) (Projective technique, Sensitization to and mobilization of potential body action,

In-depth and/or complex improvisation)

Responses (how the patient responded to the intervention)

Specific observations regarding mood through body posture, affect, and quality of movement  
(functional and/or expressive)

Kinesthetic responses during the session