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# Exploring Kinesthetic Empathy in the Medical Setting: A Heuristic Inquiry

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EXPLORING KINESTHETIC EMPATHY IN THE MEDICAL SETTING:  
A HEURISTIC INQUIRY

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in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies

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## **Abstract**

The purpose of this heuristic inquiry was to understand how I used kinesthetic empathy while working with children hospitalized on the general pediatric unit and pediatric intensive care unit. I was also interested in exploring whether aspects of kinesthetic empathy might be useful for child life specialists in relationship building. Data were collected using journal entries that depicted my use of kinesthetic empathy after 15 individual dance/movement therapy sessions. The data were analyzed using Forinash's qualitative data analysis approach. The findings demonstrated that I engaged in kinesthetic empathy by being present, self-referencing, embodying, and using touch. The findings were shared with child life specialists of a similar population to determine if any aspects of kinesthetic empathy were applicable to their work. The child life specialists resonated with the themes of embodying and sensations. This research informed my understanding of my own ways of practicing kinesthetic empathy as an emerging dance/movement therapist in the medical setting. Exploring the use of kinesthetic empathy in the child life profession elicited further inquiry into the collaborative work of creative arts therapists and child life specialists.

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## **Chapter One: Introduction**

In many hospitals across America, patients' treatment teams encompass many staff members who provide multidisciplinary care, in addition to the doctors and nurses. These multidisciplinary teams may include social workers, psychologists, case managers, chaplains, physical and occupational therapists, speech therapists, child life specialists, and creative arts therapists. The reason for the use of multidisciplinary teams is that they address the medical and psychosocial needs of the patient. According to the Section on Developmental Behavioral Pediatrics (SODBP) within the American Academy of Pediatrics, the developmental, physical and behavioral health of a child are all connected, and strengthening treatment team members' relationships optimizes the care of children in the hospital (American Academy of Pediatrics, 2014).

Child life specialists are members of the multidisciplinary team who fill a key role in addressing the psychosocial needs of children and families when admitted to a hospital.

Child life specialists are one type of staff member on a multidisciplinary team who provide developmental and behavioral support for hospitalized children. A child life specialist, helps infants, children, youth and families cope with the stress and uncertainty of acute and chronic illness, injury, trauma, disability, loss and bereavement. They provide evidence-based, developmentally and psychologically appropriate interventions including therapeutic play, preparation for procedures, and education to reduce fear, anxiety, and pain. (Association of Child Life Professionals, 2017a).

There are over 400 child life programs established in hospitals across North America (American Academy of Pediatrics, 2014). The child life teams contribute to a patient's care by taking into consideration the patient's and the patient's family's psychosocial needs, culture, and previous

experiences. Child life interventions are most effective when in collaboration with other providers on a multidisciplinary team (American Academy of Pediatrics, 2014).

Child life specialists and creative arts therapists may work on the same team in hospital settings. I worked within a multidisciplinary team as a dance/movement therapy intern and was supervised by a Child Life Specialist in a large medical hospital. My role there was to provide dance/movement therapy sessions to patients, and I was the only dance/movement therapist on the team. Dance/movement therapists may be included in the multidisciplinary team in medical hospitals (Goodill, 2005) due to their training in, and assessment of, the mind-body connection (Cohen & Walco, 1999). Dance/movement therapy emphasizes the mind-body connection and how it promotes integration of an individual (American Dance Therapy Association, n.d.). This is important because dance/movement therapy can be used to help patients use their cognition to process the physical changes occurring in their bodies. Dance/movement therapy is defined as the “psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual” (American Dance Therapy Association, n.d.). Medical dance/movement therapy differs in that it specifies that dance/movement therapy is offered to “people with primary medical illness [and can also include] their caregivers and family members” (Goodill, 2005, p.17). Meanwhile, medical literature has been exploring the relationship between somatic and psychological processes and how one effects the other (Cohen & Walco, 1999). Dance/movement therapists can work alongside child life specialists in order to enhance the patients’ healing processes (Goodill, 2005).

I have always been interested in working with children in the hospital as a dance/movement therapist. I believe dance/movement therapy is valuable in the care of children in the hospital, as part of countering the possible deterioration of their mental and physical

functioning during their hospitalization. For example, a child placed on isolation precaution is required to stay in their room and interact with staff members who wear disposable garments that cover their whole body. Their movements are confined to one room, and they do not have the ability to engage with other patients or staff. This limits the patient's opportunity for self-expression and social interaction, which in some cases, can negatively affect how patients cope with their hospitalization. As an intern, I became aware of my own difficulty with understanding how the patients felt physically and emotionally due to their hospitalization. Each patient has a different experience while at the hospital in addition to their unique situation outside the hospital. This makes it difficult to generalize and understand how they might be feeling. Patients who typically have numerous ports and monitors attached to their bodies, may experience discomfort or pain related to their treatment and undergo procedures that involve inspection or reconstruction of their bodies. As a dance/movement therapy intern, I wanted to find a way to relate and understand the patients' experiences to better understand their needs.

Some of the dance/movement therapy interventions I used to better understand and relate to patients in this environment included movement observation and assessment, kinesthetic as well as reflective empathy, and therapeutic relationship. Dance/movement therapists working in hospitals may use movement observation and assessment in their work when first meeting a patient, and in subsequent encounters (Goodill, 2005). This assessment helps the therapist to understand the patient's felt experiences which can be shown through movement difficulties or qualitative changes in movement (Goodill, 2005). In the process of movement observation and assessment, attunement occurs when the senses of sight, hearing, and kinesthesia are used to achieve a general understanding of another's movement. Attunement is used to help the dance/movement therapist determine what parts of his or her client's movements possibly



indicate emotional distress and are most important to focus on during the observation (Moore & Yamamoto, 2012). This, then, informs the treatment goals.

The therapeutic relationship is defined by Rogers (1961) as a “relationship where at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other” (pp. 39-40). A unique aspect of the therapeutic relationship for dance/movement therapists is the therapeutic movement relationship. This is defined by Young (2017) as, “a shared presence of body, mind, and spirit between the dance/movement therapist and client where healing occurs within the safe containment of a creative collaboration resulting in resonance” (p. 17). Dance/movement therapists in the medical setting use the therapeutic movement relationship to promote physical and emotional healing for their patients. Goodill noted that the therapeutic relationship in the medical setting is different than other therapy settings. Dance/movement therapists in the medical setting may adjust their boundaries while in relationship with the patient (Goodill, 2005). Dance/movement therapists may self-disclose more, or keep in touch with a patient and family after they have discharged (Goodill, 2005).

Empathy must be present in order to establish the therapeutic relationship (Federman, 2011; Fischman, 2009). Empathy is “the therapist’s ability and willingness to understand the client’s thoughts, feelings, and struggles from the client’s point of view” (Rogers, 1995, p. 85). Without empathy, the therapeutic relationship would not benefit the client because the therapist could not feel a sense of what the patient was experiencing in order to provide support. One way that dance/movement therapists utilize empathy in the therapeutic relationship is kinesthetic empathy. Kinesthetic empathy takes the traditional cognitive based understanding of empathy into the somatic experience of the clinician. Kinesthetic empathy is operationalized for this study

as the engagement of empathy in the sensing, imaging, feeling and thinking experience of the clinician. The clinician uses the somatic, body-felt experience (along with the cognitive experience of empathy) to form an integrated body-mind understanding of or insight into how another might be experiencing themselves and the world around them (Siegel & Bryson, 2011; Tortora, 2006). The observer can use attunement, mirroring, and resonance as inroads to create a shared experience in relationship with the other. Mind-body awareness is used to process the observations and create empathy through the soma. Kinesthetic empathy is a teachable skill that requires a specificity of focus on the body to enhance the relationship. According to Tortora, kinesthetic empathy occurs in the therapeutic relationship and Young (2017) specifically identified that kinesthetic empathy is experienced within the therapeutic movement relationship. Dance/movement therapists may use movement observation and assessment, the therapeutic relationship, and empathy in specific ways to gain insight into the patient's experience to engage in accurate assessment of the treatment needs as well as offer effective interventions.

Kinesthetic empathy is sometimes referred to as empathic reflection, but there is an important distinction. Empathic reflection is

a verbal and nonverbal process that occurs in the present moment experiential synchronous relationship between a dance/movement therapist and a client [...]The process relies on the therapist's ability to engage in a synchronous or parallel process, a relational experience in which the therapist is constantly aware of personal body-mind connection (including kinesthetic sensations) while at the same time joining aspects of the client's body-mind experience expressed through their verbal and nonverbal communication (Downey, 2016, p. 55).

The empathic reflection process moves beyond kinesthetic empathy when the therapist reflects (though words, sounds or movement) some aspect of the client's verbal or nonverbal communication resulting in a communication response that is based in the mind-body communication between the therapist and client that is informed by kinesthetic empathy (Downey, 2016). The reflection back to the client after engaging in relationship to them is what distinguishes kinesthetic empathy from empathic reflection. In addition, as the reflection can be in movement form, empathic reflection is a technique specific to the practice of dance/movement therapy while kinesthetic empathy can be learned and utilized by others from different fields. When a dance/movement therapist utilizes empathy, kinesthetic empathy, and empathic reflection in the therapeutic relationship, the therapist is better equipped to understand the client's point of view, which leads to more effective treatment.

### **Purpose of the Research Study**

Of these concepts, kinesthetic empathy intrigued me the most because I wanted to understand the patient's experiences from a body perspective, as the nature of the treatment affects their physical body. The purpose of the study was to understand how to use kinesthetic empathy in my work as a dance/movement therapy student intern working with children and adolescents in the hospital. I wanted to understand this to learn how I use a major concept in the field of dance/movement therapy, specific to the environment and population where I was working.

I also desired to share what I learned about using kinesthetic empathy with child life specialists—a group of professionals that I continued to work with after my internship ended. I wanted to explore whether there were simple, general aspects of kinesthetic empathy that could inform child life specialists' work with children and adolescents in the hospital.

## **Theoretical Frameworks**

Theoretical influences in dance/movement therapy and counseling psychology informed my clinical work in the medical setting. First, I naturally found myself gravitating towards the work of Goodill, a leading dance/movement therapist in medical dance/movement therapy. Medical dance/movement therapy aligned with my study in that I was working as a dance/movement therapy intern in a hospital setting and practicing medical dance/movement therapy. This type of dance/movement therapy is specialized because it offers services to individuals with a medical illness, and includes the individual's family and caregivers (Goodill, 2005). Goodill explained that "if phenomena and changes in the physical body are a source of pain, distress, anger, or isolation, then a somatically oriented method of psychosocial support and intervention will have meaningful impact" (Goodill, 2006, p. 52). The emphasis on the mind-body connection in dance/movement therapy seemed most fitting to use for patients and their families in the hospital. As a dance/movement therapy intern, I could address the physical changes to the body in addition to the emotional and psychological reactions to hospitalization. Using medical dance/movement therapy with hospitalized patients allowed me to address multiple areas of a patient to promote integration.

Blanche Evan served as a theoretical influence for this study due to her work with children. Evan believed that children could use movement to express what they could not with words (Levy, 1988). The goal of Evan's work was to connect the body and mind through dance. Dance could bring forth repressed feelings and enliven the body (Levy, 1988). A child in the hospital may find it easier to communicate their feelings with movement as opposed to words. Throughout the day, children in the hospital are visited by medical staff who ask them questions

about how they are feeling physically. When working in a dance/movement therapy session, children can use movement and play to communicate and express their feelings with their bodies.

Evan's System of Functional Technique also applied to my work with children in the hospital. This technique anatomically rehabilitates and educates the body in a way that is adapted to the individual's unique needs (Levy, 1988, p. 34). Due to some of the physical limitations for many children in the hospital, it is important that their movement abilities are recognized. This might mean that movement takes place while the child is seated in their bed, or the use of a child's arm is reduced because of an IV placement. Many of the goals of Evan's System of Functional Technique were used in my work because I worked with a child to increase their range of motion within their movement potential—expanding their movement repertoire and helping them to feel more secure about expressing themselves, given their medical condition.

Rogers, the creator of person-centered counseling, believed that the task of the therapist is to help patients become in touch with their inner self, through self-actualization, to move towards their goals (Ivey, D'Andrea, & Ivey, 2012). I wanted to honor each patient's individual self and help patients to maintain and expand upon themselves while undergoing medical treatment. I wanted each patient to be felt and heard and find trust in their bodies' abilities to heal. I wanted to provide a sense of specialized treatment specific to the patient. I did this by reflecting back what the patients had shared with me in sessions to help increase their self-awareness.

As well intentioned as I was, using a person centered counseling and Evan's System of Functional Technique in medical dance/movement therapy, sometimes was not enough. When I first began my internship, I felt a disconnect with the majority of the patients that I worked with. I found myself asking numerous questions to try and discern what it was like to be in the

hospital, but was still lacking information. I was trying to empathize with the patients, but wanted to know about their experiences in the body. I created this study to understand how I use kinesthetic empathy with children and adolescents in the hospital to create kinesthetic understanding and relational connection. I believed that using kinesthetic empathy would help me understand the patient's somatic experiences, which would help me to connect with my patients while they were in the hospital.

## **Chapter Two: Literature Review**

This literature review begins by introducing arts in healthcare and the specialized field of medical dance/movement therapy, contextualizing where this study took place. The profession of Child Life is summarized to provide an understanding of members of the multidisciplinary team with which I worked, and to highlight Child Life's relevance to the research question. The therapeutic relationship is introduced, as it is relevant in both the work of dance/movement therapists and child life specialists. Finally, kinesthetic empathy is defined and informs the reader about the main concept used for the study. This chapter concludes with a summary to explain how the research questions are supported by the literature and identifies where more research is needed in these areas.

### **Medical Dance/Movement Therapy**

Arts in healthcare is a multidisciplinary movement which aims to improve health through the arts (Society for Arts in Healthcare, 2011). This movement was formally recognized in the early 1990's when the Society for the Arts in Healthcare was established (Lambert, Rollins, Sonke, & Cohen, 2016). The movement is currently supported through the National Organization for Arts in Health [NOAH] (National Organization for the Arts in Health, 2017). The arts in healthcare align with the holistic treatment model as they provide care to other aspects of the patient besides their physical body (Lambert et al, 2016). The inclusion of arts in the healthcare system provides therapeutic, educational, and expressive opportunities for patients and their families (Americans for the Arts [AFTA], n.d.). Examples of healthcare systems include private for-profit and nonprofit health facilities, hospice programs, long-term care facilities, mental health programs, and wellness programs, amongst others (AFTA, n.d.). The various fields of art include dance/movement, drama, music, visual, literary arts, performing arts, and design (AFTA,

n.d.). Within these fields exist artists in residence and creative arts therapists (Goodill, 2016). It is important to distinguish between these two roles because of the education and training, and treatment goals of each specialty. An artist in residence uses his or her medium to foster the creative process with patients to normalize the healthcare setting, whereas a creative arts therapist offers psychotherapy sessions during which the art form is a means of assessment and treatment (University of Florida Health Arts in Medicine, n.d.).

Dance/movement therapy is one of the creative arts therapies offered in healthcare systems (Goodill, 2005). Dance/movement therapists use the body and movement to provide assessment and interventions for patients in healthcare settings (Goodill, 2005). Due to the prevalence of dance/movement therapists working in healthcare, a narrower form of dance/movement therapy was identified and documented called medical dance/movement therapy (Goodill, 2005). Goodill (2005), a leading clinician in medical dance/movement therapy, defined medical dance/movement therapy as “the application of dance/movement therapy services for people with primary medical illness their caregivers and family members” (p. 17). Medical dance/movement therapy can decrease anxiety, address body image concerns, provide an active experience with the body, foster expression of feelings related to illness or hospitalization, help motivate movement, use play to communicate emotional pain, aid in physical pain management, and provide opportunities for relaxation, amongst other interventions (Goodill, 2005; Mendelsohn, 1999; Tortora, 2009).

Medical dance/movement therapy can be performed in both individual and group sessions. Dance/movement therapists can see patients in their individual hospital rooms, in playrooms on the unit, or other common spaces in the hospital (Tortora, 2009). The frequency and length of sessions vary depending on patients’ treatment. Dance/movement therapists



working in a hospital must be flexible to accommodate each patient's daily schedule and tolerance for movement. Sessions may take place while the child is in his or her hospital bed, or the child might feel well enough to move in his or her room (Mendelsohn, 1999).

In order to best support a patient in a medical dance/movement therapy setting, the therapist must acknowledge the unique aspects of the patient. Tortora (2009) suggested assessing the patient's way of moving and relating to understand the patient's experience of his or her illness. She also explored what it felt like to experience movement through the patient's presented repertoire. Cohen and Walco (1999) stressed the importance of development when selecting interventions for patients. They recommended that the content of each intervention be related to the child's developmental stage. Mendelsohn (1999) believed that engaging children in play while they are in the hospital may help to express their deepest fears and thoughts relating to their illnesses. In these cases, the individual experiences of the patient are revealed and attended to in session.

Plevin and Parteli (2014) further addressed assessment in describing the importance of assessment and relationship for dance/movement therapists working with children on an oncology unit of a pediatric hospital. They wrote that the therapist should be open and receptive to the child so that they can "become a source that can nourish a child through a particular intervention" (p. 245). The concept of *corpo ambiente* was described as a therapeutic state the therapist brings to their session, which encompasses the ever changing hospital environment (Plevin & Parteli, 2014). *Corpo ambiente* can be used to resonate with a patient in the hospital and support that patient during his or her session (Plevin & Parteli, 2014). Therapists can fluctuate their presentation while in relationship to each patient and provide support and process these frequent changes.

When practiced in the medical setting, dance/movement therapy complements traditional medical care as a means of psychosocial support (Goodill, 2005). Dance/movement therapy in a hospital system contributes to the greater multidisciplinary team. Dance/movement therapy can aid in the treatment of the individual in addition to their diagnosis. This treatment approach is part of the biopsychosocial model which addressed the body and the mind (Goodill, 2005). Multidisciplinary teams in hospitals limit adverse events, decrease length of stay, improve patient outcomes, and increase job satisfaction for staff (Epstein, 2014). Medical dance/movement therapists may work alongside psychology or social work services, or may be combined with Child Life services for pediatric populations (Goodill, 2005).

### **Child Life Specialists**

The beginning of the child life profession started with programs that allowed adults to play with children in the hospital. The profession was first established by Emma Plank in 1955 (American Academy of Pediatrics, 2014). She explained the specific needs of children in the hospital, which elicited further education on the subject (American Academy of Pediatrics, 2014). Plank (1971) stressed that children in the hospital will cope better when they are able to incorporate their normal way of living into the hospital environment. If possible, children should continue to interact with other children and adults, play, and learn (Plank, 1971). Today, child life specialists can be found working in hospitals with pediatric units, ambulatory clinics, emergency departments, hospice and palliative care programs, camps for children with chronic illness, rehabilitation settings, and some dental and physician offices (American Academy of Pediatrics, 2014). A child life specialist,

helps infants, children, youth, and families cope with the stress and uncertainty of illness, injury and treatment. [They] provide evidence-based, developmentally-appropriate

interventions including therapeutic play, preparation and education to reduce fear, anxiety, and pain (Association of Child Life Professionals, 2017b).

A child life specialist may meet with the patient and the patient's family while in the hospital and provide interventions for each person to understand and cope with hospitalization. The child life specialist speaks with patients to gather and share necessary information relating to them and their needs for hospitalization. Communication allows for the child to express his or her needs and receive support when appropriate (Association of Child Life Professionals, 2017b). A child life specialist provides support to patients through play, education relating to diagnosis and treatment, and establishing therapeutic relationships with patients and their families (Kaddoura, Cormier, & Leduc, 2013).

A child life specialist works to reduce the negative impact of stressful or traumatic situations that a child experiences through establishing a therapeutic relationship and communication (Association of Child Life Professionals, 2017b). Optimal coping and adjustment of the child is the desired outcome upon completing work with a child life specialist (American Academy of Pediatrics, 2014 ). One aspect of achieving this outcome is the therapeutic relationship that is established between the child life specialist, the child, and the child's family (American Academy of Pediatrics, 2014). The therapeutic relationship is built on trust and respect to enable the child to deal with challenges in health, development, and wellbeing (Association of Child Life Professionals, 2017b). The child life specialist establishes goals in the therapeutic relationship for the patient in relation to the patient's reason for hospitalization (McCue, 2009). The therapeutic relationship is used by child life specialists to prepare the patient and family for when he or she will no longer require support from the specialist (McCue, 2009).

### **Therapeutic Relationship**

The therapeutic relationship is used by child life specialists to help support the patient during their hospitalization (American Academy of Pediatrics, 2014). McCue (2009) defines the therapeutic relationship for child life specialists as, “a state of mutual interest or involvement that has to do with healing or curing” (p.57). The therapeutic relationship is built with trust, and advocates for psychosocial adjustment and coping for the patient (McCue, 2009). Child life specialists use play as a tool for establishing the therapeutic relationship (McCue, 2009).

Similarly, mental health professionals use the therapeutic relationship to facilitate change for their clients (Gaston, 1990). The therapeutic relationship, sometimes called the therapeutic alliance, plays a major role in all forms of psychotherapy (Gaston, 1990). Different theorists have created definitions for the therapeutic relationship. Gelso and Carter (1985) defined the therapeutic relationship as “the feelings and attitudes counseling participants have towards one another, and the manner in which these are expressed” (p. 159). Rogers (1961) added the concept of the therapist helping the client in some way through their relationship. He defined the therapeutic relationship as a “relationship where at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other” (pp. 39-40). Gaston (1990) classified the therapeutic relationship into four dimensions: the therapeutic alliance, the working alliance, therapist’s empathic understanding and involvement, and the patient-therapist agreement. These dimensions identify the requirements of the patient and therapist in the relationship (Gaston, 1990). Gaston’s (1990) study illustrates the complexity of the therapeutic relationship by identifying each of its components. It also supports the belief that the presence of the therapeutic relationship enhances the outcome of therapy (Gaston, 1990).

The therapeutic relationship in dance/movement therapy has the potential to be actualized differently than traditional forms of therapy because the therapeutic movement relationship involves the nonverbal dialogue. Young (2017) explained that the therapeutic movement relationship is “a shared presence of body, mind and spirit between the dance/movement therapist and client where healing occurs within the safe containment of a creative collaboration resulting in resonance” (p. 17). Although this definition was recently formalized, the use of the therapeutic movement relationship has early roots in the dance/movement therapy field (Sandel, 1993). First generation dance/movement therapists Marian Chace and Mary Whitehouse were both noted to use a therapeutic relationship with movement in their work (Levy, 1988). Both practitioners believed that they needed to start work where their clients were ready to begin, and establish a relationship from there (Levy, 1988). The therapeutic movement relationship was one of four main concepts in Chace’s approach where it was used to establish empathic interactions as Chace took aspects of patient’s movements to inform her understanding of their experiences (Sandel, 1993). The use of the therapeutic movement relationship by early pioneers demonstrates its importance in the field of dance/movement therapy.

There is limited research on the therapeutic movement relationship outside of Young’s (2017) study. One study (Tropea, 2009) examined the effect of self-disclosure through movement by the therapist in the therapeutic relationship. She found that in working with children with limited verbal abilities, movement self-disclosure created and fostered the therapeutic relationship (Tropea, 2009). A shared understanding was created after the therapist self-disclosed, using communication from the body (Tropea, 2009). This study shows how communication and shared understanding are created in the therapeutic movement relationship.

### **Kinesthetic Empathy**

Similar to the therapeutic movement relationship, kinesthetic empathy has been an essential component of dance/movement therapy practice since the field began. The founder of dance/movement therapy, Marian Chace used kinesthetic empathy with hospitalized psychiatric patients to then engage in empathic reflection during her groups (Levy, 1988). Her goal was to experience what her patients were experiencing through nonverbal communication. Kinesthetic empathy was used to gather information about the patients in Chace's sessions (Sandel, 1993). Chace's students called this information gathering "picking up," which acknowledged the movement patterns, effort qualities, and themes present in the patients (Sandel, 1993). Chace engaged the patients in nonverbal and verbal dialogues to respond to their movements and then used their reactions to assess the accuracy of her perceptions (Sandel, 1993). The knowledge Chace gained from mirroring her patients' movements informed her of their experiences. She entered their experiences with an open mind and used self-referencing to further her understanding (Sandel, 1993). As the facilitator of groups, she used the information from her patients to form a cohesive group that empathized with each other (Sandel, 1993). This is one of many major contributions that Chace made to the field of dance/movement therapy (Levy, 1988). As Chace was a teacher and a mentor for numerous dance/movement therapists, there have been many other clinicians who have expanded upon kinesthetic empathy in their own practices.

Fischman (2009) credited Chace for her contributions to kinesthetic empathy. Fischman explained that dance/movement therapists use emotion and embodied cognition to gain understanding when using kinesthetic empathy (Fischman, 2009). Two techniques for performing kinesthetic empathy are mirroring and resonating (Fischman, 2009). As the dance/movement therapist observes their clients in session, they mirror their presentation. The act of mirroring movements, postures, affect, and emotions provides the therapist with an

internal sense of the client's experiences, producing kinesthetic empathy (Fischman, 2009). Establishing kinesthetic empathy relies on the common experiences shared by the therapist and client in relationship which provides insight into the present experiences of the client (Fischman, 2009; Young, 2017).

**Mirroring.** One technique commonly used by dance/movement therapists in order to create a common experience is mirroring. Mirroring as defined by Tortora (2006) is “literally embodying the exact shape, form, movement qualities, and feeling tone of another person's actions, as if the therapist were creating an emotional and physical mirror image” (p.259). Tortora (2006) also indicated variations of mirroring; mirroring modified, mirroring exaggerated, and mirroring diminished. Depending on the session, dance/movement therapists will choose between the mirroring types to best suit the needs of their clients. A dance/movement therapist mirrors clients—responding to and replicating aspects of clients' movement (Sandel, 1993), and creating an emotional connection and sense of presence of other (Tortora, 2006).

Navarre (1982) researched the effect of shared or mirrored postures. In the study a participant ( $n=43$ ) was paired with a research assistant and was asked to mirror the other with similar positions in space and movement qualities. Participants reported positive feelings of themselves and other, and felt similar to the other participant. The feelings of sameness can also be considered empathy. The results demonstrated the need for mirroring of both posture and movement quality to produce positive feeling of the individual and other. These findings support the work of dance/movement therapists using mirroring, as they are trained to observe and reflect the specific movements of an individual's position in space and quality of movement.

Fraenkel (1986) conducted a study which examined the interaction between medical residents and their patients. The study explored whether the medical residents used synchrony

and echoing when sharing information in a medical consultation, and what effect the behaviors had on the patient's satisfaction with the medical resident and the comprehension of the information shared. The Fraenkel-Franks Index of Shared Behaviors was created and implemented in the study to record instances of synchrony and echoing. Synchrony was observed when the medical resident and patient move at the same time. Echoing was observed when one of the individuals began to move and was followed by the other. The results revealed a positive correlation between synchrony and accurate recollection by the patient of the information shared by the medical resident. There were no positive correlations with echoing or neutral interactions. These results are significant because they show how movement based behaviors have an impact on cognitive aspects of patient care.

McGarry and Russo (2011) argued that mirroring in the therapeutic relationship enhanced empathy because the process of mirroring activates the mirror neuron system in the brain. Berrol (2006) clarified that once mirror neurons are activated in the brain, this might allow for the development of empathy to be traced. As a dance/movement therapist establishes empathy with clients through mirroring, the therapist is better able to understand clients from his or her point of view and can progress with treatment in the therapeutic relationship (McGarry & Russo, 2011).

This relationship between cognitive empathy and mirroring was studied by Fraenkel (1983). She recruited pairs of friends and traditional talk therapists and their clients ( $n=8$ ). The friends were asked to talk about things that were important to them, while the therapist and client participated in a therapy session. Two trained raters watched recorded videos of these interactions and noted the number of times mirroring occurred. Raters were doctoral candidates, a counselor, a curriculum evaluator, and a dance therapist. One of the friends in the pair and the clients were asked to rate the amount of empathy they felt during their videotaped conversation.



The results showed that synchronous movement, or mirroring, was correlated with cognitive empathy in both types of participant pairs. These results are significant as they indicate how mirroring in relationship produces empathy. This study exemplifies how the body and movement can elicit empathy between two people. While mirroring is one technique used to establish kinesthetic empathy, other practitioners have identified additional methods of establishing or using kinesthetic empathy with their clients.

Tortora (2006) included kinesthetic empathy in her assessment and intervention approach for infants and children called *Ways of Seeing*. There are three components of *Ways of Seeing* that are used for self-observation: witnessing, kinesthetic seeing, and kinesthetic empathy. The therapist watches the actions of a child and is aware of his or her personal responses to these observations. Kinesthetic seeing acknowledges the therapist's sensory experience in relation to the child, and kinesthetic empathy informs the therapist of the child's emotional experience as the therapist emulates the child's movements. Tortora's use of kinesthetic empathy focuses on gaining understanding of the emotional experiences of a child as the therapist embodies the child's movements. The *Ways of Seeing* approach provides instruction for practicing kinesthetic empathy and validates its use with children.

More recently, Philpott (2013) conducted a qualitative study on the experiences of dance/movement therapists ( $n=3$ ) who worked with grieving children. Participants were asked a series of questions pertaining to their work to understand how their experiences with the children impact the interventions that are chosen in the therapy sessions. Kinesthetic empathy emerged as a significant theme in the results of the study. All participants agreed that kinesthetic empathy was at the foundation of their work with grieving children. The participants noticed their own internal responses to mirroring the movements of the children, which created a deeper

relationship with the child. The work done in sessions was enhanced by the knowledge the participants gained through utilizing empathy. The results of this study show that kinesthetic empathy was utilized by dance/movement therapists in their work with children. This study supports the use of kinesthetic empathy with children in the hospital as they may be experiencing loss in some form or another. Aside from this study, there is no recent research exploring kinesthetic empathy with children.

It is important to note that kinesthetic empathy has had different names since the field of dance/movement therapy was established and evolved. Chace's students referred to her "picking up" as mirroring in addition to other techniques (Sandel, 1993). She visually and kinesthetically observed her patients' movements and put this information into her own movements. In doing so, she was better informed as to how her patients felt. This established empathic interactions (Chaiklin & Schmais, 1993). Chace's "picking up" was termed empathic reflection by Sandel (1993). In empathic reflection, a dance/movement therapist observes patients' expressions while they move, and the therapist responds to the expressions in an empathic way (Sandel, 1993). Empathic reflection is different from "picking up" because it includes a response by the dance/movement therapist through movement or dialogue once the therapist has gathered information through their body and movement. Levy referred to "picking up" as kinesthetic empathy. In this description of kinesthetic empathy, mirroring and a verbal narrative are used to reflect back to patients what was observed in their bodies (Levy, 1988).

Both Sandel and Levy's definitions represent empathic reflection and not kinesthetic empathy. These definitions note that the therapist responds back to their patient once they have gathered information, which occurs in empathic reflection. Kinesthetic empathy can be used as a process in empathic reflection. The therapist establishes empathy for the patient through

mirroring, attunement, and resonance, which inform them of the patient's experience. This is kinesthetic empathy. Empathic reflection takes the information gathered from kinesthetic empathy and uses it to respond back to the patient through discussion or movement.

For the purpose of this study, kinesthetic empathy is the engagement of empathy in the sensing, imaging, feeling and thinking experience of the clinician. The clinician uses the somatic, body-felt experience (along with the cognitive experience of empathy) to form an integrated body-mind understanding of or insight into how another might be experiencing themselves and the world around them (Siegel & Bryson, 2011; Tortora, 2006).

## **Conclusion**

Kinesthetic empathy is a core component to the practice of dance/movement therapy. Kinesthetic empathy is used as a way to understand other's experiences through the body and is a necessary component of establishing a therapeutic relationship. I understood from my training that kinesthetic empathy could be an inroad to therapeutic relationship, empathy, and connection for me and with my patients. But I did not fully understand how I could go about using it for that purpose in the medical setting and in the situations that I was experiencing. Therefore, I embarked on a study to determine how I, as a dance/movement therapy intern, utilize kinesthetic empathy. I also wanted to determine if any aspects of kinesthetic empathy would apply to the work of the child life specialists with whom I worked. As shown in the literature, dance/movement therapists and child life specialists use the therapeutic relationship in their work (Levy, 1988; McCue, 2009; Young, 2017). This unifying factor between the two disciplines lead me to believe that there may be an opportunity to explore whether kinesthetic empathy could be applied to the work of child life specialists. The current literature gives a historical summary of how kinesthetic empathy was developed by early dance/movement therapists (Levy, 1988;

Sandel; 1993), but there is limited research on how dance/movement therapists have used kinesthetic empathy with children, and none on the use of kinesthetic empathy with children in the hospital. Additionally, there are no studies, to date, which specifically compare and contrast the work of child life specialists and dance/movement therapists in a hospital setting.

### **Chapter Three: Methods**

When I worked with children in the hospital, typically something was happening to their bodies that needed treatment and caused them to experience their bodies differently than they did outside of the hospital. A patient might be experiencing back pain after a chemotherapy treatment or might have the urge to itch skin where a large bandage is placed. To better relate to these feelings, I utilized the concept of kinesthetic empathy to help me to understand the patients' somatic experiences through kinesthetic empathy. Kinesthetic empathy was especially important because I had never been hospitalized as a child and was not able to relate to the children and adolescents with whom I was working. I wanted to learn about the physical experience of being hospitalized while honoring each child's individual experience.

#### **Methodology**

In order to study kinesthetic empathy while respecting individuals' experience, I chose a heuristic methodology for the study, influenced by social constructivist paradigm theory. In heuristic methodology, "one seeks to obtain qualitative depictions that are at the heart and depths of a person's experience" (Moustakas, 1990, p. 38). Heuristic methodology was selected because the nature of this research focuses on my experiences as a researcher. I was the only person practicing dance/movement therapy at my internship site. Because of this, I did not have anyone onsite to use as a resource for my work. This was challenging because I was in a medical setting, which was a different environment than what was typically presented in classes and my previous dance/movement therapy experiences. I had to determine what kinesthetic empathy looked like for me as a sole emerging therapist in a medical setting working with children. Therefore, heuristic inquiry best fit my needs, as I was exploring my personal work as a dance/movement therapy intern.

Moustakas' (1990) stages of heuristic inquiry also felt concrete to me and provided steps to follow in my research process. The steps are; initial engagement, immersion into the topic and question, incubation, illumination, explication, and culmination of the research in a creative synthesis (Moustakas, 1990). The steps that are followed for conducting research as a heuristic inquiry were appealing to me as a researcher. Having preexisting instructions for conducting this type of research helped provide clarity during the research process. There is flexibility in each step of the heuristic inquiry, which makes it adaptable to each researcher that utilizes this methodology. This flexibility was important because I could tailor my research process specific to my needs and processing style.

A social constructivist paradigm was utilized because it states that multiple realities are created through lived experiences and interactions (Creswell, 2013). The social constructivist paradigm honors individual values (Creswell, 2013), allowing for the reality that I, as the researcher, may have different values than the child life specialists and the people who read my research. This paradigm aligns with my beliefs as a clinician and researcher because I believe that there is no correct way to perform kinesthetic empathy. Each person may approach kinesthetic empathy differently—so the social constructivist paradigm accounts for this variation. The methodology and paradigm fit with my research questions because I conducted a self-study to understand my own unique experience of a preexisting technique.

### **Participants**

I was the only participant in this self-study. I am a 25-year-old, Caucasian female, enrolled in Columbia College Chicago's Dance/Movement Therapy & Counseling program. I held an internship at a leading urban medical center working as a dance/movement therapy student intern through Child Life Services. I had had no personal experience being hospitalized,

nor had any of my immediate family members. Before this internship, I had not had any knowledge about or experience with child life specialists.

I worked with children and adolescents ages 3-18 who were admitted to the general pediatric unit and pediatric intensive care units. These children and adolescents had a wide variety of diagnoses. Most common were diagnoses of cancer, kidney disease, sickle cell anemia, or acute asthma episode. I worked closely under the child life department of the hospital and had a certified child life specialist as my site supervisor. I worked with patients individually in their hospital rooms for no more than an hour each day. Depending on the census for the day, I typically saw one to five patients per day. During individual sessions with patients, I explored kinesthetic empathy.

## **Procedure**

### **Data Collection**

I conducted individual dance/movement therapy sessions with the patients on the general pediatric unit and pediatric intensive care units for a five-week period. Immediately after each individual dance/movement therapy session where I identified that I used kinesthetic empathy, I documented my experiences about my use of kinesthetic empathy in a journal. I dedicated 10-15 minutes for journaling per session, and wrote about at least one session per day. In total, I collected 15 journal entries reflecting my use of kinesthetic empathy in individual dance/movement therapy sessions.

Data were collected using journals that reflected my experience working with patients using SIFT as a way to focus documentation of my experience. SIFT is a model created by Siegel and Bryson (2011) that helps bring aspects of inner experience into awareness. The components of the SIFT model are sensations, images, feelings and thoughts. Physical sensations

are identified to reflect what is going on inside the body. Images that surface can reiterate the inner experience. Feelings and emotions that are present during experiences indicate the response towards the experience. Thoughts are recorded as the inner dialogue used to narrate the experience. The journals recorded many aspects of my SIFT experience, and did not always include all components in each entry. Journal entries did not include identifiable information about the clients or protected health information.

### **Data Analysis**

Forinash's (2004) qualitative data analysis approach was used for data analysis. There are six steps in this process that I followed to analyze the data: (a) data was reviewed and organized into categories, (b) significant or meaningful parts of the data were noted, (c) themes were created, (d) the themes were referenced with the embodied writing, and (e) a description of how I used kinesthetic empathy was created.

After the data was collected, I re-read through each of the entries numerous times to review them. I kept the entries in chronological order to see if there were any changes that could be noted as time progressed. As I read through each entry, I pulled out words, phrases, or concepts I believed were significant to my process of using kinesthetic empathy. In doing this, I created smaller concentrated versions of each entry. I then looked for themes in each condensed entry. Once I found the themes, I re-read each original entry to reference whether the theme fit that particular session. I used the themes for each entry to document my process of utilizing kinesthetic empathy.

Once I had established themes, I presented them and my study to the child life specialists with whom I currently work in a one hour meeting. I had an open discussion with the child life specialists to see if there were any aspects of my themes that they were currently using in their



practice or were interesting in using. I was leading the meeting in my presentation and discussion of my thesis findings. All child life specialists employed at the hospital were invited to attend. Eight child life specialists attended the meeting.

### **Validation Strategies**

Two validation strategies were used: rich description for the purpose of transferring findings and a resonance panel. During data collection, I documented my experiences of practicing kinesthetic empathy in embodied writing with as much detail as possible. The details recorded were my thoughts, feelings, and sensations. With rich descriptions of my experience, readers would be able to adapt the information to other settings (Creswell, 2013), allowing for the findings to be applicable to child life specialists or others who read this research.

A resonance panel served as a second form of validation. The members of the panel aided me in assessing the accuracy of the data and data analysis (Creswell, 2013). My panel consisted of my thesis advisor, a child life specialist, and a peer student in Columbia College Chicago's Dance/Movement Therapy & Counseling program. My thesis advisor and peer were selected due to their familiarity with kinesthetic empathy and related subjects. The child life specialist was selected due to her experience in the field and availability. The panel evaluated the journal entries for accuracy and the themes that emerged in the data analysis. The resonance panel met once after data analysis was completed. The panel was presented with preliminary findings in a PowerPoint format, and findings were revised with the feedback from the panel.

### **Ethical Considerations**

To protect my confidentiality as a researcher, my journal stayed in a locked office when it was not being used. I only documented my own experiences related to kinesthetic empathy during data collection. No information relating to the patients with whom I worked during the

data collection process was documented. I evaluated the data after it was recorded and eliminated any parts of it that did not directly relate to my research with the help of the resonance panel.

## Chapter Four: Results

The purpose of this study was to learn how I use kinesthetic empathy as a dance/movement therapy intern. I chose to work with children in the hospital because I was curious about how dance/movement therapy could benefit patients in the hospital. When I first began working as an intern, I felt like I was unable to connect with the patients because I did not have my own experience of being hospitalized to inform my work. I wanted to find a way to understand patients' experiences and used kinesthetic empathy as a technique to do this. I believed that if I could learn more about patients' somatic experiences, I could better connect with them. I also took my findings to the child life specialists with whom I currently work and led a discussion to see if any of the ways that I practiced kinesthetic empathy were being used by child life specialists or could be applied to their future work.

I wrote 15 journal entries documenting SIFT (Siegel & Bryson, 2011) experiences with patients after facilitating individual dance/movement therapy sessions with children in the hospital. In analyzing the data, I found four main themes that answered the question of how I used kinesthetic empathy: being present, self-referencing, embodying, and touch. The self-referencing theme included deductive sub-themes of sensations, imagination, feelings, and thoughts. The theme of being present, emerged as the first step in establishing kinesthetic empathy. There was no particular order for the following themes. Not all themes were present in each session. By considering all journal entries as a whole, I could understand how I used kinesthetic empathy over several sessions. Journal entry excerpts are denoted through italicized font in this chapter.

### **Being present**

As I began exploring kinesthetic empathy, I knew that I needed to be attentive to my own responses and experiences while I was working in sessions. I needed to document my experiences of each session in detail, in relationship to the patient, per the heuristic methodology. I wanted to give full attention to the patient whom I was with, and in turn record my experiences while working with them. To begin the session in the present moment, I took time before entering patients' rooms to give myself a conscious reminder of what I was going to do and how I needed to be to be successful in exploring kinesthetic empathy. This was evident in my very first journal entry:

*As I enter the room I set an intention for myself to be present and focused. I want to be able to sense my own internal responses and I need to rid my mind of as many extra thoughts as I can.*

Being present was important for me in the beginning of a session, but it was also necessary to continue to stay present throughout the entire session:

*I noticed there was a lot of conversing during the session. The presence of talking made it more challenging to tune into my kinesthetic awareness. I had to be thinking of being present more so because there was the cognitive component of constantly verbalizing.*

I was challenged to stay present when more talking occurred in a session compared to moving. When I had to process information that was shared verbally, in addition to paying attention to my own experiences, I was more focused on making sense of what was happening, instead of focusing on the present. I found that I was most successful in staying present when I set an intention before entering a session and limited the amount of mental processing to only what was necessary during a session.

## Self-referencing

Being aware of my own internal responses and perceptions while working with my patients was very important in my exploration of kinesthetic empathy. I was using my own knowledge gained from the session to understand the experiences of the patients. To me, self-referencing was tuning into what I was noticing in my body and mind. Because my journals documented my SIFT experiences in sessions, four deductive sub-themes of self-referencing emerged from the data: sensations, imagination, feelings and thoughts.

**Sensations.** Sensations were noted in my journal entries as observations using my five senses or felt changes in an area of my body. One example during which my sense of smell was present occurred when working with a younger patient in a session: *“This patient’s room smelled like a dirty diaper.”* I was aware of this smell immediately as I walked into the patient’s room. Based on this smell, I knew the patient most likely had a dirty diaper and used this information to inform my work with the patient. Through my use of smell, I learned about the patient’s experience of having to rely on someone else to meet basic needs. This patient did have his diaper changed by his nurse during the session.

Other examples of sensations occurred in the musculature of my body. When working with a young girl with a nasogastric (NG) tube, *“I felt a restriction in my nose and throat that did not allow for full breaths.”* This session was the first time I had seen a patient with a NG tube. As I looked at the patient, I could tell that the tube traveled externally from her face, internally through her nose and down her throat. My initial response when I saw this was a tightening in my throat, which caused restriction of my breath. In another example, I was working with a patient and practicing relaxation through yoga poses. After moving through a few

postures and settling into the session, *“I could sense a release in my muscles.”* I was not gripping or holding my muscles after I felt this release. I was more relaxed and could find the postures easily. When I felt my muscles soften, I knew that I was successfully finding a more relaxed state, and I believed the patient had as well based on the release of tension in my muscles. At the end of this session, the patient reported feeling more relaxed, so my internal sensations matched the patient’s experience.

There were instances when I noticed a sensation that led to a feeling in my sessions. I began to mirror a patient in their postural shifts, and as I did so *“I then [felt] my heartbeat quicken and experience[d] feeling slightly nervous.”* A fast heartbeat indicates to me that I am nervous. I experience this often—when a sensation is correlated with a feeling. In a different session, I worked with an infant and held her because she was crying. After the patient stopped crying, *“I matched her breathing and felt myself become calmer as time went on.”* Breath is another sensation that can signal certain feelings for me. I used this patient’s breath to lead my own. In doing so, I felt her breathing slow slightly over time, which signified to me a feeling of calm.

**Imagination.** When I could not easily connect with a patient on some level through previous experiences, I relied on my imagination. I wanted to put myself in patients’ shoes, and in many cases needed to use a creative way to relate to their situation. One of my patients had both of her parents with her in the hospital. I took a moment to reflect on how I might feel if I were hospitalized: *“I envisioned myself in the patient’s position. I would personally feel more comfortable with my parents present if I were in the hospital.”* By determining my own preferences for comfort, I could relate to the patient and her desire to have her parents with her in the hospital.

When I worked with a young patient in his room, I put myself in a position of helplessness with my imagination to learn what he might be going through: *“This patient’s room smelled like a dirty diaper. I took this information in and processed what it might be like to not have the ability to change myself. I was uncomfortable and slightly irritated.”* In this example, my imagination elicited a feeling response and understanding of the patient’s current situation.

Regarding the aforementioned patient with the NG tube, I imagined where the tube might be placed and the associated experiences of having the tube placed and constantly present: *“She had a tube in her nose delivering fluids. I imagined what it would be like to experience this kind of constant intrusive presence, and I felt one side of my nose and throat tickle and itch.”* The combination of using my imagination along with observation produced a felt response in my body. I had a significant reaction in my body when I tried to assess what it would be like to be this patient. Imagination as a tool for self-referencing was most helpful when I did not have any small ways to connect with the patient in my sessions.

**Feelings.** Feelings were noted in the sessions as a theme because they were an experience that I could relate to outside of the medical field. They occur on a daily basis and can be very informative, depending on the situation. Feelings were an inroad to understand patients’ experiences, as I could easily determine the reactions and emotions present in a session. In one session, the expression of feelings was observed before the session began, *“The people in the room were joking, and this created more laughter. I could feel happiness and connection in relationship before I even set foot in the room.”* The sounds of happiness were most evident for me, as I made this observation before entering the patient’s room. The happy feelings were further solidified once I met with the patient and could visually observe her.

Another session elicited calm in my body, because of the lack of any other feelings of discomfort, *“The patient felt at ease. I felt this in my body as there were no anxious feelings or feeling uncomfortable.”* By being aware of my own feelings in response to a patient, I believed I was able to determine his or her mood, which could shape his or her behavior and interaction. I could easily empathize with a patient’s feelings as they were something that I was very familiar with and had many experiences to reference. As a dance/movement therapy intern, I have studied and encountered a wide range of feelings in my education and internship. I relied on my experiences in addition to the concept of universal emotions to guide the recognition of feelings in my sessions.

**Thoughts.** Thoughts were documented as the internal narrative that took place during the sessions. Thoughts reflected how I was processing a situation or how I responded cognitively in a session. One of the patients I worked with was on isolation precautions, which required me to wear a paper gown, mask, and gloves before entering her room; *“I wondered if these additional garments would get inhibit my ability to utilize kinesthetic empathy or get in the way of my attunement or embodying processes.”* Before this session began I was contemplating how these sterile garments would influence my work. I did not note any challenges in the session due to the garments. Taking time to think about how the garments might pose difficulties before the session helped me to be proactive.

In a different session, a patient was not allowed to eat due to an upcoming procedure. It was right around lunch time when I was working with him, and I could tell that food was on his mind. He asked me *“...if I was hungry. At the time I was not. I recalled how I feel when I am hungry. I am normally very distracted and cannot easily engage in tasks.”* In this session, I used my knowledge of what is like to be hungry and not have access to food. Using this knowledge



that I already have, I was able to understand more about the patient's experiences as a result of his upcoming procedure.

I worked with a patient while her mother was also in the room next to her. During the session the patient was quiet but would engage with me using toys that I brought for her. I matched the patient's movements and affect and sensed that there was something else needed—a need of the patient that I could not fulfill: *“The patient frequently included her mother in the session, and I welcomed her. I think the patient's mother provided validation the patient sought.”* Therefore, I made an adjustment based on what I thought was missing for the patient. When the patient's mother was included in the session, the patient became more interactive, which allowed me to establish a stronger relationship with her. In this session I learned that the patient's mother was an important part of her hospitalization. I think the mother was a source of support and comfort for the patient, which helped with her coping. In this scenario and others, thoughts that I recorded in my journals allowed me to track what I was thinking while in session. My thoughts influenced the choices that I made in session and allowed me to adapt what I was doing to better understand the experiences of the patients.

## **Embodying**

The theme of embodiment was important to link the patients' experiences to my own. Embodying my patients was different compared the embodying that other dance/movement therapists do because the movements of the patients are impacted by the presence of medical equipment and the medical environment. The presence of medical equipment can make embodying a challenge. The patient is impacted by the environment, medications, and equipment, and the therapist has to embody the patient without any of those elements actually

affecting them. In many sessions, I observed movements, postures, gestures, and facial expressions that were typically impacted by medical equipment or the hospital environment. I took these observations and put them in my own body. Sometimes this meant trying on the movement in a small way; other times I was trying to recreate the movement as accurately as possible. Facial expressions were examples of smaller movements that I reflected back to my patients. One patient displayed a few different expressions in the session, so *“I matched the smile and reflected it back, in addition to other facial expressions such as surprise or curiosity.”* Matching each facial expression was a way for me to track the patient’s affect throughout the session and get a better understanding of her experiences.

Another patient received news of an upcoming procedure: *“I saw the patient respond to this news with disgusted facial expressions. We processed this information, and I reflected back her expressions.”* She did not appear pleased with this information. I knew this as I reflected her expression back to her. Embodying a facial expression was a small way to take an observation and try it on in my body. I learned from this patient that she did not want to partake in the procedure and was showing this to me nonverbally through her affect.

Other examples of embodying happened with a larger use of movement. One patient had a splint on his arm to reduce the irritation of a peripherally inserted central catheter (PICC) line. I noticed that this patient had limited use of his arm, which made his movements stand out: *“The arm was bandaged, and this created a restriction in movement. I tried this on as I observed movement in the playroom.”* I wanted to know more about what it would be like to restrict the use of an arm. I held my arm to mirror how the patient was holding his. By doing so, I had a felt sense of how a splint reduces movement. Another patient demonstrated quickness in his movements. I adjusted my use of time to meet the patient’s energy, and *“as I used more quick*

*time to mirror the patient, I felt more awake, which helped me better attune to the patient.*” This adjustment changed my own state to match the patient. I noticed this shift bring me more energy, and I felt like I could be with him in the session more easily had I not made a change to match him. I gained more information when I was in the same state as the patient, which told me more about his current experiences.

The last examples of embodying occurred when I tried on a patient’s posture. This was difficult to do accurately, as many of the patients stayed in their bed during our sessions. I sat in a chair to emulate being seated in a bed. One patient’s posture and movements gave me insight into the level of comfort in the session based on my own responses as I mirrored her: *“As I sat next to her, I held my posture to match her similar movement style. As I sat like this, I felt comfortable but not fully relaxed.”* Another patient’s posture told me about the orientation of her body and how she might be feeling: *“I adapted my postures to mirror hers, and this informed my body of her alignment and [possible] areas of tension.”* This patient had numerous electrodes attached to her head to monitor seizure activity. She was required to stay in bed and had a limited range of motion due to the electrodes. I noted what places in my body were tight or uncomfortable and used that to guide my understanding of the patient and how her body was responding to the electrodes as well as to my movement directions in the session. Embodying felt like one of the easiest and most natural ways to understand a patient’s experience from his or her perspective. I could quickly put a movement into my body and gain information through my experiences that may have simulated what the patient was also experiencing in that moment.

## **Touch**

Using a form of nonverbal communication to gain information was an important part of my exploration of kinesthetic empathy. Touch allowed for a physical way to connect with the patient and learn about his or her body. One patient used touch to explore me, while I did the same with her: *“I offered my fingers as another introduction, and she responded by mirroring my movements until our fingers connected, and we could explore each other through distal touch.”* The movements that the patient used were directed to my body. The input that I received told me more about the patient and her interaction style. This young patient was very curious, and I felt this through her light and indirect touch on my hands. A different patient had a much different approach to touch: *“His close proximity continued to the point where we were touching and holding hands. By actually having a physical sense of the patient, I learned more about him. He used a strong grip and pressed my hands in different directions.”* I felt this patient use strong weight and indirect space. It felt like he was communicating with me through his strength. I believed this patient wanted to have power and control while he was admitted in the hospital.

## **Chapter Five: Discussion**

This study was designed to help me discover how I used kinesthetic empathy as a dance/movement therapy intern working with children in the hospital. I wanted to see if my use of kinesthetic empathy could help address my feelings of disconnection I felt from my patients. I also wanted to see if any aspects of kinesthetic empathy would be applicable to the work of the child life specialists with whom I worked. The findings helped me learn how I utilized kinesthetic empathy as an emerging dance/movement therapist. By sharing my findings with child life specialists and reviewing child life literature, I noticed connections between the work of dance/movement therapists and child life specialists. I believe capitalizing on these shared values and techniques will foster future collaboration between the two disciplines and an increased self-awareness in patient care in general. The findings show that I used being present, self-referencing, embodying, and touch to facilitate kinesthetic empathy in dance/movement therapy sessions. Each of these findings will be discussed in the following sections.

### **Being Present**

According to Tortora (2006), beginning a dance/movement therapy session with a sense of presence is the first step in establishing kinesthetic empathy. My results supported Tortora's assertion in that to give my full attention to the patient during a session, I needed to stay present, and that presence strengthened my kinesthetic empathy. I did this by setting an intention before the session began: to clear my mind and focus on what was happening in the present moment. Siegel (2012) defined being present as mindful awareness. When we are mindfully aware, we make a point to pay attention to experiences as they happen—without judgements (Siegel, 2012). It was important for me to exclude any judgements during a session. Doing so allowed me to work with the individual and their specific experiences, without making comparisons or

assumptions. Beginning my sessions with the intention of being present, which elicited mindful awareness, increased my internal awareness and my ability to self-reference. As Siegel (2012) wrote, “Mindful awareness can enable the inner sense of knowing and subjective experience” (p. 44). My internal awareness helped me to learn more about my subjective experience in sessions. This led to self-referencing which is a requirement for practicing kinesthetic empathy.

### **Self-referencing**

As I have not had any experiences being hospitalized, I needed to learn from the patients to understand their experiences and empathize with them. When I worked with patients in session, I did not explicitly ask what they were experiencing to inform my work. Instead I found that I noticed my own experiences, which gave insight into the patients’ experiences. My findings show that I considered any sensations or feelings that I had while working with a patient. I also tracked my thoughts and used my imagination to try to get a better understanding of a patient’s experience. These findings align with the SIFT model created for identifying internal experiences (Siegel & Bryson, 2010), which I used to structure my journals during data collection. In this model, the user takes note of any sensations, images, feelings, or thoughts that are present for him or her. In my sessions, I was aware of sensations and feelings that I had in response to working with patients. Imagination is not an aspect of the SIFT model, but I believe it aligns closely with noticing images or thoughts. My thoughts during the session were documented to record my experiences in relation to the patient.

**Sensations.** During some sessions, I noted internal sensations while working with a patient. Examples of these sensations were increased heartbeat, warm temperature, smells, and muscle tension and relaxation. Each of these sensations gave me some insight into the patients’ experiences. Hindi (2012) explained that the identification of sensations is called interoception.

Dance/movement therapists may better know this term as “kinesthetic sensing,” popularized by Tortora (2006). Interoception is the process where sensory information from all over the body is tracked (Hindi, 2012). When I was aware of the sensations that I was experiencing, I could process how the sensations related to the patient, which further informed my work. Interoception is important for dance/movement therapists to understand because it can inform perception formation and emotional processing (Hindi, 2012) and establish kinesthetic empathy between the therapist and the client (Tortora, 2006).

**Imagination.** Imagination was important for me to use to gain an understanding of some aspect of a patient’s experience with which I was unfamiliar. I noticed that I used my imagination to learn more about the effect of medical equipment and procedures, and the perspective of patients. To empathize with my patients, I needed to put myself in their place, and the best way I knew how to do this was to use my imagination—confirming Greene’s (1995) argument that “imagination is what makes empathy possible” (p. 3). I observed the patients and used what I saw and heard as a basis for what it might be like if I were in the position of the patient; I used the knowledge that I gained from imagination to deepen my kinesthetic empathy. Using imagination to establish empathy in this way is consistent with Dewey’s (1980) beliefs. Dewey (1980) explained that imagination allows us to take the perspective of others, which produces empathy. Chodorow (2000) reported that there are many aspects of imagination that dance/movement therapists use in their work. Social and empathic imagination can be used to explore the interaction between two people, like my work in individual sessions, to understand more about the other (Chodorow, 2000). Another aspect of imagination that I utilized was the psychological imagination, which emphasizes self-reflection in imagination (Chodorow, 2000).

The various forms of imagination were used to gain understanding of my patients and their experiences.

**Feelings.** I recognized feelings in two different ways in my sessions: I noticed them in myself as I was working with patients, and I observed them in the patients while they were interacting with others before or after a session. Feelings were easy for me to empathize with because I experience them frequently. My familiarity with feelings helped to uncover the correlation between a specific feeling and the patient's hospital experience. Feeling or emotion recognition plays a key role in establishing empathy and in dance/movement therapy (Berrol, 2006; Fischman, 2009). Empathy requires emotional identification with another, as well as embodying the emotion (Berrol, 2006; Gallese, 2006). When I recognized a feeling in session, I would match the feeling in my body, as well as the patient's presentation, to be with the patient in the moment. I used my own knowledge of feelings to match the patient and better understand his or her experiences. Replicating another's emotions accurately has been shown to lay a solid foundation for establishing empathy (Decety & Jackson, 2004; Gallese, 2006). Early dance/movement therapists Marian Chace and Trudi Schoop used forms of empathic reflection in their work to better connect with and understand their clients (Levy, 1988). Both believed that by mirroring the client's movements, they could sense what the client was experiencing at that time (Levy, 1988).

**Thoughts.** My thoughts were recorded in my journals and acted as an internal narrative of aspects of my sessions. Documenting thoughts in this way follows the SIFT model of self-referencing (Siegel & Bryson, 2011). Recording my thoughts shows how I was being aware of how I was thinking in session. By giving my attention to my thoughts, I could direct the information that I was processing with awareness (Siegel, 2012). The added awareness helped to



stabilize my cognitive processes in session, which in turn deepened my own understanding of my experiences in relation to the patients' (Siegel, 2012). When I was aware of my thoughts, I was self-referencing what was going on in my mind. I gave attention to my thoughts, and was being mindful. When I was focused and aware of my thoughts, I could use the information to further my cognitive understanding of a patient's experience.

### **Embodying**

I embodied aspects of my patients' movements and presentation to inform my body of what they might be experiencing. In most cases, I was trying to replicate some part of the patients' movements. Hervey (2007) defined embodiment as moving a feeling, thought, word, expression, or movement of another's. Embodying must be done by a therapist in order to establish kinesthetic empathy (Fischman, 2009; Tortora, 2006). A therapist cannot know exactly what his or her patient is experiencing, but the processing of embodying produces knowledge for the therapist as he or she experiences movement with the patient (Tortora, 2006). Tortora (2009) used assessment and relating to the patient to understand the patient's experience. A dance/movement therapist can try on a patient's presented movements to feel in their own body what the patient may be experiencing (Tortora, 2009). By embodying another, the therapist's mirror properties enable internal simulation, which enables the therapist to feel what the patient is feeling (Siegel, 2012). Embodying is facilitated with mirror neurons and elicits the feeling of being with another. Once this connection is made, prior learning and present input shape the empathy that is expressed in the relationship (Siegel, 2012).

Recent research in the field of dance/movement therapy indicates the importance of embodying for dance/movement therapy in general as well as the therapeutic movement relationship. Downey (2016) clarified the definition of empathic reflection in the field of

dance/movement therapy—as previous literature noted the importance of this concept in the field, but did not specifically describe how it was achieved. Empathic reflection may include mirroring and attunement by the therapist. Participating in empathic reflection allows the therapist to engage in the therapeutic relationship and deepen his or her understanding of the client (Downey, 2016). Young’s (2017) study found kinesthetic empathy, understood as empathic reflection in this study, as a means in establishing the therapeutic movement relationship. Dance/movement therapists use their bodies to attune to clients, engage empathically, and self-reference to establish the therapeutic movement relationship (Young, 2017). These two studies (Downey 2016; Young, 2017) indicate that empathic reflection produces the therapeutic movement relationship, and that the therapeutic movement relationship requires empathic reflection. Embodying was noted to be part of establishing empathic reflection and therefore also plays a role in establishing the therapeutic movement relationship. These findings support the theme of embodying in my study. By replicating patient’s movements, I was able to self-reference to gain an understanding of their experience. I was also able to establish a therapeutic movement relationship using embodiment.

## **Touch**

During some sessions, I had physical contact with my patients. When this happened, I received feedback from their bodies, which informed my body about what they were experiencing. In this way, I could feel the patient and learn about their experiences through my own body. Touch can be used to give and receive knowledge about the body (Hackney, 2002). Touch can be used to empathically attune to another and provide information for a therapist kinesthetically (Kestenberg Amighi, Loman, Lewis, & Sossin, 1999). I took this body knowledge and let it inform my use of kinesthetic empathy. Matherly (2014) stated that “the human use of

touch literally frames and underlies the experiences of our entire lives” (p. 77). The importance of touch should be given attention by all hospital staff whether they are a medical employee or therapist. Touch happens in the hospital setting on almost a daily basis for patients. Nurses and doctors visit frequently and assess areas of the patient’s body, typically through touch. Touch can be informative for the medical profession as well as in dance/movement therapy.

Dance/movement therapists use touch as part of their treatment, more so than other therapies (Willis, 1987). This is likely due to the focus of the work incorporating the body in treatment. Willis (1987) suggested that dance/movement therapists obtain informed consent before using touch with patients for legal and ethical reasons. In some sessions, a patient’s parents were not present for me to ask whether I was permitted to use touch with their child. Other patients were not at an age where they could verbally give consent. In sessions, I did not initiate touch. If a patient engaged with me through touch, I allowed it to continue if it was safe and appropriate. I was aware movement restrictions for that patient and did not manipulate any part of the body that was healing or in pain. I used touch mainly on patients’ limbs and distal ends to keep appropriate boundaries. My decision to use touch occurred in the moment, when the patient initiated it, or if a younger patient displayed gestures which informed me of their desire to be held.

After completing my study, I found that using kinesthetic empathy helped to eliminate feelings of disconnect with the patients that I worked with. Kinesthetic empathy gave me an inroad to understanding aspects of the patients’ experiences which I did not have in the beginning of my internship. Once I was able to connect with the patients through kinesthetic empathy, I found that the therapeutic relationship was enhanced and the dance/movement therapy sessions were more impactful. I found that kinesthetic empathy was an important tool for

me to use with patients because I was more informed of their experiences which then allowed me to address any areas of concern with an individualized understanding. I believe that using dance/movement therapy with children in the hospital is beneficial to their overall treatment, as dance/movement therapy stresses the mind-body connection. Sessions allow the patients to explore the connection between their body and how their medical treatment is affecting them, in addition to how they process their treatment. Dance/movement therapists provide support to patients that is different from child life specialists because dance/movement therapists are trained to understand the body from a physical and cognitive perspective. Child life specialists provide support that is more developmental and education based.

### **Applications to Child Life Specialists**

The themes identified in my study provided insights and inroads to kinesthetic empathy, allowing me to better understand patients' experiences and be more effective as a dance/movement therapist. Therefore, I was excited to share my results with the child life staff. The child life staff resonated with the themes of embodying and sensations. The other themes from my findings were not applicable to the work of child life specialists based on the sample of specialists present for discussion. I believe the themes are specific to the field of dance/movement therapy and would need to be translated to the work of child life specialists. The child life specialists with whom I spoke were already embodying their patients in some cases. They had an understanding that they are more effective if they adjust their posture and energy level to match the patient. Typically, this means adjusting to be at the patient's level in space; child life specialists frequently bend down to speak to a child face to face. My coworkers also gave the example of lowering their voices to speak at the same volume as a child. These subtle changes consider the patients' experiences and produce more informed care. The child life

specialists were interested in knowing more about the different ways that embodiment can be done. They reported that they would be more conscious of their use of embodiment and see what other ways they could try it for themselves.

The child life specialists were also aware of how sensations were present in their work. One of the important jobs of child life specialists is procedural support: they explain what a child might feel before, during, and after a procedure. The child life specialists wanted to be aware of their own sensations when working with patients in procedural support. They believed that this would give them more insight into how a patient processes the information being shared with them. It would also help the specialists be more accurate in their descriptions of sensations. For example, when describing the feeling of an IV start, the child life specialists could be precise in explaining the initial feeling of the needle being inserted.

### **Child Life Specialists using Kinesthetic Empathy**

There is no literature demonstrating child life specialists using kinesthetic empathy or any aspects of the technique in their work. This is likely because kinesthetic empathy is a technique used predominately by dance/movement therapists. One area where there may be similarities between the work of dance/movement therapists and child life specialists is in the assessment process. Upon meeting a child and their family in the hospital, child life specialists assess child variables, family variables, illness variables, and medical experiences (Koller, 2008). The assessment process can occur in many different ways. Turner and Fralic (2009) discovered ways that a sample of child life specialists ( $n=12$ ) assessed their patients. In their initial assessment, child life specialists used visual observation of the room and the people in it to get a sense of how a patient coped with hospitalization. They also gathered information from the patient through questions and payed attention to how the patient responded. The assessment process and

establishing therapeutic relationships were noted to be connected by the participants. Child life specialists reported that by providing genuine interest, a sense of connection and opportunities for choice and control while assessing a patient helped them to establish and build the therapeutic relationship (Turner & Fralic, 2009). When I worked with patients in session, I was curious about their experiences and wanted to learn more through kinesthetic empathy. Throughout the session, connection was established through the therapeutic movement relationship.

The child life specialists who were present for the presentation of this study connected with the theme of sensations. The child life specialists wanted to be more aware of their own sensations when providing procedural preparation and support to a patient. The steps to providing procedural preparation and support are sharing developmentally appropriate information, encouragement of emotional expression, and formation of a trusting relationship with a healthcare professional (Koller, 2007). It appears as though sensation identification would align closely with the first step of procedural preparation. The child life specialist should be as specific as possible in their descriptions (Koller, 2007). They also explain what happens during each procedure and why it is necessary in the child's treatment (Koller, 2007). If child life specialists are aware of their own sensations, they can precisely articulate what the patient will endure during the procedure.

The child life specialists also connected with the theme of embodying and were interested to see how else it could be used in their work. I believe embodying could be incorporated in the assessment process that child life specialists use to enhance the information they receive while observing. This might also help foster a sense of connection which would deepen their therapeutic relationship.

## **Implications for Future Research**

This heuristic study was intended to help me learn more about my own practices as an emerging dance/movement therapist. The findings gave me an understanding of how I use kinesthetic empathy in sessions with patients. This study could be expanded upon in many ways. A researcher could examine the themes that emerged related kinesthetic empathy in depth. It would be helpful to investigate if there is a definitive order that these themes occur when establishing kinesthetic empathy. Each theme could be explored to determine the necessary steps for executing each theme to capture a detailed description of the ways that therapists utilize kinesthetic empathy.

More research is needed exploring the work between the creative arts therapies and child life specialists. There are several hospitals that employ both fields, and it would be beneficial to explore how the disciplines can work together and complement each other. Exploring how the two fields can collaborate would enhance patient care. In some cases, child life specialists and creative arts therapists work on the same team. Research in how the two fields can work in partnership would help the staff with integrated resources and patient care.

Research exploring child life specialists' use of empathy is also recommended. Child life specialists utilize a therapeutic relationship with their patients (Association of Child Life Professionals, 2017a), but little is known about whether empathy is used to help establish the therapeutic relationship. If empathy is present in the therapeutic relationship for child life specialists, there might be more ways to see if aspects of kinesthetic empathy are applicable to the work of child life specialists.

## **Summary**

The goal of this study was to understand how I used kinesthetic empathy as a dance/movement therapy intern with children in the hospital. The findings show that I used being present, embodying, and touch to engage in kinesthetic empathy. I also wanted to examine whether any aspects of kinesthetic empathy would be applicable to the work of child life specialists. Child life specialists with whom I worked reported that they typically embody aspects of their patients' movements, but were interested in knowing the different ways that embodying can be performed. Self-referencing sensations was a second theme with which child life specialists connected. The child life specialists believed that by being aware of their own sensations when working with patients, they would be better informed in their interactions and procedural support. Exploring the use of kinesthetic empathy in the child life professions is an area of future research that may prove beneficial in the collaborative work of creative arts therapists and child life specialists.



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## **Appendix A**

### **Definition of Terms**

#### **Attunement**

Occurs when the senses of sight, hearing, and kinesthesia are used to get a general understanding of another's movement. Attunement is used to help the dance/movement therapist determine what parts of his or her client's movements are most important to focus on during the observation (Moore & Yamamoto, 2012).

#### **Child Life Specialist**

“Helps infants, children, youth, and families cope with the stress and uncertainty of illness, injury and treatment. [They] provide evidence-based, developmentally-appropriate interventions including therapeutic play, preparation and education to reduce fear, anxiety and pain” (Association of Child Life Professionals, 2017b).

#### **Empathic Reflection**

“A verbal and nonverbal process that occurs in the present moment experiential synchronous relationship between a dance/movement therapist and a client [...] The process relies on the therapist's ability to engage in a synchronous or parallel process, a relational experience in which the therapist is constantly aware of personal body-mind connection (including kinesthetic sensations) while at the same time joining aspects of the client's body-mind experience expressed through their verbal and nonverbal communication” (Downey, 2016, p. 55) The empathic reflection process moves beyond kinesthetic empathy when the therapist reflects (though words, sounds or movement) some aspect of the client's verbal or nonverbal communication resulting in a communication response that is based in the mind-body communication between the therapist and client (Downey, 2016).

#### **Empathy**

“The therapist’s ability and willingness to understand the client’s thoughts, feelings, and struggles from the client’s point of view” (Rogers, 1995, p. 85).

### **Kinesthetic Empathy**

The engagement of empathy in the sensing, imaging, feeling and thinking experience of the clinician. The clinician uses the somatic, body-felt experience (along with the cognitive experience of empathy) to form an integrated body-mind understanding of or insight into how another might be experiencing themselves and the world around them (Siegel & Bryson, 2011; Tortora, 2006).

### **Medical Dance/Movement Therapy**

“The application of dance/movement therapy services for people with primary medical illness their caregivers and family members” (Goodill, 2005, p. 17).

### **Mirroring**

“Literally embodying the exact shape, form, movement qualities, and feeling tone of another person’s actions, as if the therapist were creating an emotional and physical mirror image” (Tortora, 2006, p.259).

### **SIFT**

SIFT is a model created by Siegel and Bryson (2011) that helps bring aspects of inner experience into awareness. The components of the SIFT model are sensations, images, feelings and thoughts. Physical sensations are identified to reflect what is going on inside the body. Images that surface can reiterate the inner experience. Feelings and emotions that are present during experiences are indicated by the response towards the experience. Thoughts are recorded as the inner dialogue used to narrate the experience.

### **Therapeutic Movement Relationship**

“A shared presence of body, mind, and spirit between the dance/movement therapist and client where healing occurs within the safe containment of a creative collaboration resulting in resonance” (Young, 2017, p. 17).



### **Therapeutic Relationship**

“A relationship where at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other” (Rogers, 1961, pp. 39-40).