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An Inquiry into the Use of Interpersonal Touch in Dance Movement Therapy with Adults with Profound and Multiple Learning Difficulties/Disabilities


Dance Movement Therapy
Dissertation DMT045L407Y
Roehampton University, London, UK

This dissertation is submitted in partial fulfilment towards the award of MA in Dance Movement Therapy

Submission date: 14th December 2007

Signed:

Date: 14th December 2007

Word count: 14,997 including headings and footnotes, plus acknowledgements, references and appendices

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Abstract

This paper is the synthesis of a small-scale inquiry spread over two years. It documents the reflection of four Dance Movement Therapists (DMTs) on the Use of Interpersonal Touch (IPT) in their clinical practice with adults with Profound and Multiple Learning Difficulties/Disabilities (PMLD). In the literature review the author integrates medical and social theoretical frameworks which inform her DMT practice with this client group. The inquiry combined an Art-based research framework with a Heuristic methodology which enabled the author to use the arts in the process of inquiry and to include herself in the process of inquiry. The inquiry sought to gather participants’ reflections on their experience and understanding of the part IPT plays in their DMT practice with adults with PMLD. Following the literature review and the presentation of her methodological choices, the author introduces a ‘Polyvocal Metaphor’ as a narrative re-presentation of the subject of inquiry. The use of IPT is of significance for the building of relationships with adults with PMLD, consequently this inquiry has implications reaching beyond the field of DMT.
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Acknowledgements

To start with I would like to thank the NHS Trust where I work for their supporting my work through funding this Research. I would also like to thank my Managers for their trust in my clinical work and for their giving me Study Leave to concentrate on this inquiry. Thank you to all the staff at Roehampton University for their answers to my emails and phone calls over the past two years. A special thank you to my academic supervisor, Dilys Griffith for our stimulating discussions and for her continued support and encouragements for the past two years. I also want to thank my clinical supervisor, Adrian Benbow, who has been following me and supporting me since I qualified as a Dance Movement Therapist and who has reminded me, at times when I needed it, to value my intuitive clinical judgment and who has supported my on-going reflection on my practice.

I want to thank Penelope A. Best and the late Gabrielle Parker who were Course Leaders in the earlier phase of my training as a Dance Movement Therapist, and who, with their academic rigor and creative spirits, encouraged me to find my own voice as a Dance Movement Therapist. Thank you to my friends and colleagues for accepting to take part in this inquiry and for their support throughout this inquiry (I do not disclose their names for confidentiality reasons). A particular thank you to one of them for reading my many drafts, for their astute feedback and loving encouragements.

A warm thank you to my family for their patience and love.

Finally, I want to thank my clients, who inspire my work and life, and for whom I have written this paper. I hope this inquiry contributes to their being seen, heard and understood more.
‘What we see depends mainly on what we look for’

(John William Lubbock, 1803-1865)
Introduction to the area of inquiry

I chose to research the use of Interpersonal Touch\(^1\) (IPT) in Dance Movement Therapy (DMT)\(^2\) with adults with Profound and Multiple Learning Difficulties/Disabilities (PMLD) (see below for definition) because I sometimes use IPT in my DMT practice with adults with PMLD though I have often found it difficult to talk about and value my approach. On the one hand IPT takes place in the non-verbal realm of communication and is not always easy to describe verbally, and on the other hand IPT is a sensitive topic I have often chosen to be cautious about discussing.

 Adults with Profound and Multiple Learning Difficulties/Disabilities

The client group concerned in this inquiry are adults with Profound and Multiple Learning Difficulties/Disabilities only. The diagnosis of PMLD comes as a subgroup of a bigger umbrella: Learning Difficulties/Disabilities (LD)\(^3\). The LD spectrum regroups individuals diagnosed with Mild, Moderate, and Profound and Multiple LD (also referred to as Complex Needs). In its definition, Valuing People tells us that a Learning Disability diagnosis includes:

A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
A reduced ability to cope independently (impaired social functioning);
Which started before adulthood, with a lasting effect on development.
(Valuing People 2001: 14)

MENCAP, the largest UK charity for children and adults with Learning Disabilities, gives the following definition for children and adults with Profound and Multiple LD:

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\(^1\) Interpersonal touch refers to touch which takes place between two people.  
\(^2\) The abbreviation DMT is used to refer to the practice of Dance Movement Therapy and to Dance Movement Therapy practitioners.  
\(^3\) I use the abbreviations LD and PMLD in which the ‘D’ can interchangeably be translated as ‘Difficulties’ or ‘Disabilities’. This represents services users’ preference for the word ‘Difficulties’ (Roets, Van de Perre, Van Hove, Schoeters and De Schauwer 2004, Watson 2007) and the continued use of the word ‘Disabilities’ in official documents and diagnoses (i.e. Valuing People New Strategy for Learning Disability for the 21st Century, 2001).
All people who have profound and multiple learning disabilities will have
great difficulty communicating. Many people will have additional sensory
or physical disabilities, complex health needs or mental health
difficulties. The combination of these needs and/or the lack of the right
support may also affect behaviour. Some other people, such as those
with autism and Down’s syndrome may also have profound and multiple
learning disabilities. All children and adults with profound and multiple
learning disabilities will need high levels of support with most aspects of
daily life. (MENCAP definition factsheet 2007)

The literature indicates that there is a lack of recognition that individuals with PMLD are
a marginalised client group whose needs are different from those with Mild and/or
Moderate LD (Carnaby and Cambridge 2002, Dobson et al. 2004) due to the complex
interplay between communication challenges, physical and sometimes mental health
problems. Kieron Sheehy and Melanie Nind suggest we consider children and adults with
PMLD as people ‘having substantial barriers to learning and participation in community
life, which arise from interaction between organic impairments and an often unresponsive
and unsupportive environment’ (Sheehy and Nind 2005).
**Aim of this inquiry**

My aim through this inquiry was to:

Review current theory and practice concerned with the use of IPT in Psychotherapy, in DMT and with adults with PMLD.

Reflect on a specific theme relevant to my DMT practice with other practitioners.

Further develop ways to communicate about the use of IPT in my practice.

Deepen my understanding of the benefits (or otherwise) of touch for adults with PMLD, and thereby enhance my skills in supporting my clients with their on-going personal development.

Contribute to the current discussion on the use of IPT in DMT and in psychotherapy.

Contribute to DMT research and the research of clinical practice with adults with PMLD.

Through this inquiry I did not aim to assess the efficacy of DMT, objectively assess therapeutic outcomes, or test the use of IPT in DMT.

This paper is the synthesis of a two-year inquiry presented in six chapters:
Chapter 1: Literature Review. I consider the place IPT is given in theoretical frameworks which inform my DMT practice. I then move to the literature concerned with the use of IPT in clinical work with clients with PMLD. The literature review finishes with a social constructionist perspective as an alternative way to approach my research question (p.22).

Chapter 2: Methodological Choices. Here I contrast several methodologies and explain why an Art-based research methodology and a Heuristic methodology complement each other and inform the structure and content of this inquiry.

Chapter 3: Data Collection and Treatment of the Data. Here I present the data collected throughout this project and how I treated the data.

Chapter 4: Creative Re-construction of a Polyvocal Metaphor in Context. I start with the key factors informing this inquiry. I then present an analysis of the questionnaires collected. Finally, I offer the transcript of a virtual Creative Reflective Practice (CRP) session as a narrative re-presentation of the data collected.

Chapter 5: Reflecting on the reflection. I consider implications for the practice of DMT and DMT research, and other areas this research may benefit. I also highlight the strength and limitations of this inquiry.

Chapter 6: Conclusion.
Chapter 1: Review of the Literature

1.1 Interpersonal Touch in Psychotherapy

Mic Hunter and Jim Struve (1998), David Tune (2005) and Graeme Galton (2006)’s papers illustrate the discussion currently taking place on the part touch plays in psychoanalysis. Hunter and Struve consider the use of touch from an ethical and historical perspective. They remind us that the use of IPT is still controversial in the current practice of psychotherapy and highlight that ‘the traditional psychoanalytic model came to see touch as serving the detrimental purpose of seductive fulfilment.’ (1998: 54). From this perspective, it is argued that the use of touch is a way to avoid ‘working through whatever painful experience [is] at hand.’ (Ibid 1998: 54). These significant beliefs indicate why the use of IPT is sometimes prohibited in the practice of psychotherapy. Hunter and Struve also remind us that ‘Freud developed his theories during the Victorian era, a period that was characterized by unyielding sexual prudishness and a strong emphasis on the products of the mind’ (1998: 55). This suggests that the strong reservations on the use of touch in Freudian psychoanalytic psychotherapy may have been influenced by the historical and cultural origins of the practice of psychotherapy.

Sándor Ferenczi (1952) and Wilhelm Reich (1972) and many others chose to pursue their belief in the benefits of the use of touch in some instances and developed theories and techniques accordingly. For example, Ferenczi believed that therapeutic touch was nurturing and provided the client with an opportunity to heal earlier traumas, and Reich argued a link between muscular tension and ‘bound up’ emotions. He would use touch in his practice in order to identify physical tension, and would work with emotions through techniques which involved touching the tensed body part in order to attain release. More
recently, Valerie Sinason (2006, 1992, Mittler & Sinason 1996), a psychotherapist who has
done some pioneering work with adults with Learning Disabilities in the UK (Hernandez-
Halton et al. 2000), echoed Ferenczi’s thinking, reminding us that ‘in some circumstances,
touch withheld may be experienced as a re-enactment, in the transference, of the

The above examples point to a long-standing controversy in psychotherapy around the
use of touch in practice. The diverging opinions suggest that there is a depth and a
complexity to the part IPT plays in our life which needs to be considered, researched,
explored and reflected upon by practitioners. Factors such as the life history of the client,
their diagnosis, the theoretical beliefs of the practitioner, their culture, their personal
experience of IPT and the setting within which the therapy is taking place, all inform the
therapeutic relationship and guide the therapist’s clinical decision. This also indicates that
when considering the dynamics of the psychotherapeutic relationship, one may locate IPT
on a spectrum ranging from detrimental to beneficial to the client.

1.2 Neuropsychoanalytic and Neuropsychological Perspectives

In the last few years neuropsychoanalysis and neuropsychology have brought together the
fields of neuroscience, psychology and psychotherapy. Jaak Panksepp argues that in order
to understand the neurology of human emotions, we explore the ‘emotional neurology’
of animals (Panksepp 2006a: 25). Since the mid-nineties, Panksepp (1998, 2003, 2006a,
2006b), Antonio Damasio (1994,1999), Mark Solms (Solms and Kaplan-Solms 2000; Solms
and Turnbull 2002), Colwyn Trevarthen (2004, Trevarthen and Aitken, 2001), Allan
Schore (1994, 2003a, 2003b) and Rose Carroll (2003, 06, 07) have used neuroscientific
knowledge to explain and illustrate how ‘neuroscience is useful to psychotherapy where it can confirm, or reframe, or challenge intuitions which have become established clinical theory’ (Carroll, 2006: 50). These sciences bring some light on the intricate complexity of the communication that happens within the mammalian body and suggest that as human beings, our emotional and physical health are both interlinked and deeply affected by the world in which we live.

These observations invite me to wonder about the neurological development of an adult with PMLD and how he is, on the one hand, affected by people around him, and on the other hand how - or indeed whether - he is equipped to process his own affects. Neuropsychology encourages the DMT to bear in mind that affects are registered at a primal level, developmentally considered a pre-verbal level, (Carroll, 2006) and that in the absence of any tool to reflect and process his affects (i.e. possible impairment of the cerebral cortex), the client with PMLD may respond to his environment through his instincts, then using movement, sounds and touch. Such distinctions deserve consideration and have implications on therapeutic interventions. Subsequently this informs the DMT when considering the use of IPT in her practice with this client group.

Colwyn Trevarthen argues that,

The non-verbal therapist, employing (…) dance, or touch-and-movement techniques, stimulates and supports impulses and feelings of human contact, and this can change a patient’s emotional experiences and motives to communicate. (Trevarthen 2004: 10)

This suggests that the use of IPT in DMT may be helpful to the continued development of adults with PMLD. Indeed, DMT in essence offers a therapeutic relationship wherein non-

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Throughout this paper 'he' is interchangeable with 'she' and vice versa.
verbal communication is valued and held creatively and within which the body in movement and in relation to another body is central. In the same way as the masseur’s hands are highly developed to tune in with the client’s body through a set of specific tools; the whole body -the whole self - of the DMT is highly developed to tune in to the client’s non-verbal and verbal communication.

1.3 Interpersonal Touch, Developmental and Attachment Theories

Theories on infant development, particularly pre-verbal phases of development, parallel the non-verbal component of the therapeutic relationship and help us see why IPT is sometimes used during DMT sessions with various client groups. From his detailed observations, Daniel Stern (1977, 1985, 90, 98, 2000, 02) made the link between physical connectedness between mother and infant and the success of the infant’s psychic functioning. Carroll explains how the neurosciences make the link between what is the emotional and what is the physiological need for touch. She reminds us that ‘touch is considered ‘mother of the senses’ because contact gives feedback which helps organize other sensory information’ (Carroll 2007, unpublished). As infants, through the relationship with our primary carer, touch contributes to our learning how to regulate our responses to the environment and how to understand the world outside of us. As I consider adults with PMLD, I wonder whether they were, as infants, exposed to such tactile interactions. I am here reminded that people born prior to 1971 are very likely to have been taken away from their family and placed in long stay hospitals for the ‘mentally deficient’ and ‘sub-normal’ where they did not receive the nurturing interactions described above (Valuing People 2001: 16). I suggest that at times the DMT, in her work
with adults with PMLD may be picking up early deprivation and look for appropriate and meaningful ways to address this in the therapeutic relationship.

1.4 Interpersonal Touch in Dance Movement Therapy

Only recently have we seen an emergence of literature on the use of IPT in DMT, although Carlotta Willis tells us that DMTs ‘use touch and physical contact as part of the therapeutic process in a much greater percentage of cases than do the more traditional ‘talking cure’ type therapies’ (1987: 42).

1.4.1 With children and adolescents with Learning Difficulties/Disabilities

In 2007, nearly one in three registered DMTs in the UK practiced with clients on the LD spectrum. (Information gathered through email exchange with Andrew Clements, ADMT-UK administrator 19.09.07). However the literature with this client group is scarce and often limited to DMT with children and adolescents with Mild and Moderate LD. Janet MacDonald for example, presents the non-verbal and playing opportunities in DMT as a means to work both with the physiological and psychological functions of the client, his self-image and sense of belonging to his community (1992). Although she mentions the use of touch, MacDonald does not address it in detail. Diane Duggan explains how structured DMT sessions can provide creative and embodied means to foster ‘self-expression and relating to others’ for adolescents with LD (1995: 230). Susan Loman tells us that the Kestenberg Movement Profile5 is a helpful tool for the DMT in her assessment and treatment of a child with autism. She defines how ‘touch attunement’, which ‘involves

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5 A system of movement notation and analysis based on developmental movement observations (Kestenberg 1975, 99)
matching an individual’s muscle tension through the process of touch, can often be an effective way of making contact when other channels of communication fail’ (Loman 1995: 243). Sara Bannerman-Haig (1997, 2006) takes a psychoanalytic approach in her work with children and adolescents with PMLD and links her observations of infantile movements with her DMT practice with this client group. In his paper Matthew Wyatt (2001) expresses his concerns that people with PMLD are an ‘over-touched’ client group (Wyatt 2001: 25) due to their need for support with personal care and mobility, which raises issues of privacy and blurred boundaries. Wyatt emphasises the need for the DMT to be aware of such issues in order to understand and respond to the client’s mode of expression in the developing therapeutic relationship.

1.4.2 With adults with Profound and Multiple Learning Difficulties/Disabilities and other adult client populations

Vladimir Rokvic focused his MA research on the use of touch with a woman with PMLD. He confirms the lack of in depth research on the use of touch in DMT with this client group. In his study Rokvic also raises issues of boundaries, sexuality and institutional culture. Informed by Robert Shaw (2003) he reminds us that ‘the therapist’s body is a functioning dynamic intuitive tool which can capture important information’ (Rokvic 2007: 30). In other words Rokvic suggests that the DMT reflecting upon her intuitive responses to the client with PMLD gains insights into significant themes brought to the therapy by the client through non-verbal channels of communication. Yakura Sakiyama and Nana Koch consider the therapy session as a space for clients to practice ‘reaffiliation with a group and regaining a feeling of belonging and dependency’ (2003: 93) and consider ‘intrapsychic and interactional comfort’ as a therapeutic goal. Although the example used
by the authors relates to patients diagnosed with schizophrenia, the conclusions drawn from their research leave me curious about the therapeutic goal of DMT with adults with PMLD. I am particularly interested in the role IPT might play in my clients’ internal and external experiences of DMT, relationship making and sense of self. Indeed, I wonder what is meaningful to an adult with PMLD when developing relationships, and in what way adults with PMLD contribute to the relationships they build.

1.4.3 Contact Improvisation: a resource for the Dance Movement Therapist

In her MA paper Adwoa Lemieux (1988) underlines the importance of Contact Improvisation (CI) in her practice as a DMT and recommends it as a technique to use with clients with various pathologies including difficulties with verbal communication. Lemieux considers CI to be a non-verbal, embodied communication tool for the therapist to listen and respond to the client’s expression.

CI is a dance technique based on the principles of tuning in with another dancer through physical contact, and having an improvised ‘dance-dialogue’. As the dance unfolds, the point of contact naturally changes. For example, one dancer may lean against another dancer. At this moment in time, an infinity of possible responses are available to the dancing partner who can move away, lean back, push, receive their partner in the dance, etc. This response invites another response from the person who first initiated the leaning against action. Thus grows the improvised ‘dance-dialogue’ between both partners as they receive each other’s embodied feedback and move in response. Katy Dymoke, a CI dancer and Director of the UK CI focused company Touchdown Dance (1986)
underlines touch as a basic human need which is not so easily accessible in our current culture. She stresses that CI facilitates experiences of touch through creative movement interactions (2000: 84).

In my experience CI is a useful tool to engage with non-verbal communication. It invites me to keep my attention on the body and remain curious about ‘moving into the unknown and remaining in contact with another’ (Lemieux 1988). When using CI in my DMT practice, I bring my whole self in the moment in my relationship with clients and the therapeutic relationship is lived through non-verbal interactions which carry meaning (i.e. leaning against, pushing away, tensing up, letting go, etc.).

A CI perspective enriches the discussion on the use of IPT in DMT as it provides a technique whereby listening becomes an experience of the body in movement and in relation with another body. CI enables the DMT and her client with PMLD to have a dialogue through a mode of expression they are both able to engage with. Non-verbal creative expression through CI can then be understood as a metaphorical medium for self-expression, including the expression of emotions. In this context, the adult laden with a PMLD label is seen as a human being able to express himself through movement, and IPT becomes part of the therapeutic relationship when appropriate. The challenge for the DMT is to remain sensitive to the client’s expression and to the possibility that touch is not welcome sometimes. Being present to her client in the moment-to-moment interaction, the DMT allows the pathway between her embodied self and cognitive self to remain open, informing the therapeutic relationship accordingly; thus bridging the gap between the dance technique and psychotherapy, between IPT in the early relationship
and IPT in the developing psychotherapeutic relationship with the adults.

1.5 Interpersonal Touch in the life of adults with Profound and Multiple Learning Difficulties/Disabilities

In their research on touch, Susan Dobson et al. remind us that, ‘despite it being a constant factor in the care of people with profound and complex needs it [touch] is poorly explored’ (my italics) (2004: 113). Dobson et al. provide a comprehensive review of the literature on the use of touch in care settings and highlight that with people with LD ‘touch underpins most communication interaction and acts as a main means of both understanding and expression’ (2002: 360). Judith Samuel researched gender specific aspects of the use of touch with adults with PMLD in her thesis, focusing on male staff reflections on their use of Intensive Interaction (II) with adults with PMLD (2003). II is a method of communication which promotes the use of touch as a means to develop a non-verbal dialogue and social interaction with those for whom verbal communication is not accessible. II is based on the early mother-infant relationship (Nind & Hewett 1994, 2001); it is recognized by the Speech and Language Therapist from the Trust where I work (Personal notes, 15.3.7) and other care providers as a valuable tool to communicate with individuals with PMLD (Hewett & Nind 1998, Cameron & Bell 2001, Samuels 2003, Culham 2004, Sheehy & Nind 2005). Samuels (2003) names gender specific issues regarding the use of IPT with adults with PMLD and points to a need for more training on the use of touch with people with PMLD, particularly through reflective practice. Dobson et al.’s research (2004) indicate that the use of IPT is best understood in the social and cultural setting in which it is taking place. This echoes a social-constructionist perspective which reminds us that communication, verbal and non-verbal, develops according to our
cultural and social context. (Marks 1999, Pearce & Associates 1999, Barnett Pearce & 
that everything changes, that our world is constantly being constructed and that we are 
simultaneously actors and receptors in this construction. There is an emphasis on 
communication as a ‘primary reality’ and a ‘co-evolutionary process’ (Barnett Pearce 
1999: 10-11).

Bringing the reflection back to DMT practice with adults with PMLD, this perspective 
invites us to consider that the DMT session opens up a safe platform where therapists 
and clients mutually shape and inform one another verbally and non-verbally (Best 2003a, 
2003b). Clients and therapists co-create an experience informed by whom they are. The 
DMT relationship is therefore a constantly evolving dynamic process involving at least five 
forces or constructs: the client’s and therapist’s life experience, their physiological 
constitution, the client’s understanding and investment in the therapeutic relationship, the 
therapist’s presentation and holding of the therapeutic relationship and the context within 
which the therapy is taking place. John Bowlby (1969, 1979, 1988) and Montague’s (1971) 
observations of mother-infant interactions and the role of skin-to-skin contact in the 
process of growth, invite me to be curious about the role of IPT in our life as adults. They 
also invite me to consider the DMT’s and her client’s life story and culture, and the 
specific circumstances within which IPT is taking place when reflecting on this particular 
aspect of the therapeutic relationship.
1.6 Summary

In this chapter we have been reminded of the on-going discussion taking place on the use of IPT in the psychotherapeutic relationship. I highlighted how our human need for touch is understood within various theoretical frameworks: from diverse psychotherapeutic perspectives to current conclusions in neuropsychoanalysis and neuropsychology. Within each school of thought there are diverging opinions; whilst some psychotherapists categorically reject the use of IPT in the practice of psychotherapy others embrace it. Similarly, some DMTs welcome the use of touch in their practice, whereas others do not. The complexity of such theoretical thinking underpins this research and this inquiry is not aimed at coming to any categorical conclusion on the pros and cons of the use of IPT in DMT practice in general. A social-constructionist perspective enables the DMT to acknowledge her own life story, preconceptions and values as a DMT and to remain open to the unfolding dialogue with her client with PMLD whether the communication is taking place through the use of IPT or not. Interestingly, the non-DMT literature on touch with adults with PMLD identified that IPT is currently used in II, a technique taught to communicate with people with PMLD. The latter also points to a need for staff to develop their skills and understanding of the use of IPT in their work with people with PMLD through training and reflective practice opportunities.
Chapter 2: Methodological Choices

For the past few months, I have been holding the tension between my desire to talk about my work, my desire to write an academic paper about my work, and my desire to be ethical in my research process. The tension is great. What is the space where I can truly reflect on my work, bearing in mind that I cannot gain informed consent from my clients? (My Personal Diary, January 2006)

Norman K. Denzin & Yvonna S. Lincoln tell us that research is a representation of ‘the Other’ and ‘a metaphor for (…) knowledge, for power, and for truth’ (2005: 1). As far as I am aware, no DMT has yet presented a specific methodology to research DMT practice with adults with PMLD. I therefore looked for research methodologies which would enable me to be ethical in my undertaking research with this specific client group, and with the intention to integrate together different ways of knowing (Finley 2005). Thus looking to construct a framework which would enable me to:
Take into account my concerns about conducting research with adults with PMLD.

Hold the welfare of adults with PMLD and of research participants at the centre of the inquiry.

Use the body and movement as key components of the process of inquiry.

Name things as they emerged.

Recognise Creative Reflective Practice as research data.

Engage in my own personal and professional development, provide a context that benefits the development of other practitioners, and consequently benefit the therapeutic relationship with clients.
2.1 Locating this inquiry in current research paradigms

2.1.1 Participatory Research Methodology

I was initially guided towards a Participatory Research methodology, which is one of the current most favoured methodologies in the practice of research with people with LD (Chappell 2000, Burke et al. 2003, Gilbert 2004). Sally French indicates that Participatory Research ‘aims to involve at every stage of the research process – choice of topics, methods, evaluation and dissemination – those towards whom research is directed’ (French 1994: 141). Considering that the modes of evaluation used in a Participatory Research methodology mainly focus on people’s verbal input, it is clear that most of the research undertaken within a Participatory Methodological framework is not informing its outcome from input by those with PMLD (see p.3 for details about communication with children and adults with PMLD). This inquiry focusing on the therapeutic relationship with adults with PMLD, I looked for ways to include my clients’ voice in the research process bearing in mind that, by the very nature of their disabilities, their main medium for communication is not verbal. Besides, in agreement with Sheehy & Nind I question the current assumption that research-participants with Mild and Moderate LD are able to speak on behalf of people with PMLD (Sheehy & Nind 2005) due to the complexity of the experience people with PMLD encounter throughout their life (See p.3 for details).

I was also concerned with the issue of consent and people’s ‘right to choose if they wish to participate in research’ (NHS guidance on information sheets and consent forms, 2007: 51) as I faced the impossibility to obtain such consent from adults with PMLD themselves. Researching the therapeutic relationship, I felt that my clients may experience my
recording or videotaping sessions as invasive, and that this could re-activate some of the disempowering and intrusive experiences some of them have had in their life.

The above reasons informed my choice not to directly involve adults with PMLD in the data collection. I understand however the empowering aspects of using a Participatory Research methodology directly involving adults with Mild and Moderate Learning Difficulties. Keeping my focus on the DMT relationship, I therefore chose to involve Dance Movement Therapists in the inquiry; thus focusing the inquiry on adults who were in a position to give their informed consent to being involved in my inquiry. I am aware that in making my methodological choices, it might seem that I am one more researcher who is excluding people with learning difficulties from research. As Tim Booth said:

Methods that rely on reading or writing or abstract reasoning or verbal fluency may effectively exclude them [people with LD] from the role of respondent or informant in ways that mirror their exclusion from the wider society. (Booth 1996: 252) (My italics)

I suggest that working with practitioners through reflective practice (See p.22) is an indirect yet safe way to give a voice to adults with PMLD and a valuable means to improve the DMT relationship with adults with PMLD.

Holding such a position, I am offering a ‘complex epistemological and ethical criticism of traditional (’) research’ (Denzin & Lincoln 2005: x). Following my ethical concerns about the practice of research with adults with PMLD, I demonstrate in the following paragraphs, how specific aspects of different research methodologies can be integrated together in order to form a coherent and helpful framework to approach this inquiry.
2.1.2 Creative Reflective Practice

When designing this inquiry, I was reminded of Group Clinical Supervision (GCS) and Peer Group Reflective Practice (PGRP) weekends I have been attending since I graduated. I was particularly reminded of the quality of insights and sense of wellbeing I gained when participating in these groups. Both the GCS and PGRP hold creativity, the body in movement and reflective conversations at their core. This prompted my idea to open up a Creative Reflective Practice (CRP) space special to this inquiry. The CRP sessions would be an opportunity to reflect with colleagues on my research question:

*How do we, Dance Movement Therapists working in the same NHS\(^6\) Trust, make sense of the use of Interpersonal Touch in our Dance Movement Therapy practice with adults with Profound and Multiple Learning Difficulties/Disabilities?*

This echoes a belief in the DMT profession that as the DMT develops her understanding of the therapeutic relationship through safely contained reflective practice, she develops her skills as a practitioner, which directly benefits her clients when she walks back into the therapy room with them (Best 2003a, Payne 2004, Meekums 2006, Sills 2006).

I also thought that it would be helpful to reflect on my research question (above) with other practitioners in order to put my own views in perspective. (I.e. at the start of this project I considered that the use of IPT was inherent to the practice of DMT with adults with PMLD). Thus I set up three CRP sessions for the purpose of this project (see p.26 for an outline of the CRP sessions’ structure). The CRP sessions would also be the first

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\(^6\) NHS stands for National Health Services.
opportunity to gather with all the DMTs who work in the Trust where I work, and to reflect with them on a particular theme of significance in the life of our clients: Interpersonal Touch (as indicated in my introduction p.3 and in the literature review p.15).

Creative Reflective Practice can be explained in two stages: Reflective Practice and Creative Reflective Practice. On the one hand, Focus Group (Kamberelis & Dimitriadis 2005) and co-supervision (McLean & Whalley 2004, Miller 2005, Samuels & Betts 2007) offer clinical and research methods which use reflexivity and dialogue as a means to reach better understanding. On the other hand, Creative Reflective Practice implies the use of creative media within Reflective Practice and guides me to locate this inquiry in the field of Art-based research and Heuristic methodology.

2.1.3 Art-based research

‘Art-based research [is] a method of inquiry which uses the elements of the creative arts therapy experience, including the making of art by the researcher, as ways of understanding the significance of what we do within our practice’ (McNiff 1998: 13).

Insofar as I chose to investigate a controversial topic: the Use of Interpersonal Touch - a topic relating to the encounter between two (or more) bodies (or body parts) ’ I wanted to hold the body at the core of the research process. Both because bodies in relation were in question here, and because I was curious to listen to what our bodies had to tell us about my research question, before listening to what our minds knew. Penelope A. Best, in her poem ‘Embodied Choices and Voices’ (2005) reminds us that:
We live through our bodies
We learn through our bodies
In space, in time, in relation to gravity, in relation to others
(Best 2005: 87-88)

Later in the same poem Best asks:

Where is the body central to the process of inquiry?
The body constituting a model of knowing
Personal epistemology born out of touching the world
The body in touch ‘out of touch’ touching ‘others
My world? Your world? Our world? Whose world?
A virtual world?
(Best 2005:88)

The CRP sessions were an opportunity to use the body as a way into the research question and to listen to the verbal reflections of ‘practitioners’ bodies in conversation’. This reflects a belief that the arts and creativity are valuable tools towards greater knowledge and understanding (McNiff 1986, 87, 1992 93, 98, Allen 1995, Wadsworth Hervey 2000, Finley 2005, Simons & McCormack 2007).

2.1.4 Heuristic methodology

Clark Moustakas (1981, 1990, 1994, Douglas & Moustakas 1985) defines a heuristic methodology as follows:

‘Heuristic inquiry is a process that begins with a question or problem which the researcher seeks to illuminate or answer. (…) Heuristics is a way of engaging in scientific search through methods and processes aimed at finding the underlying meanings of important human experiences. The deepest currents of meaning and knowledge take place within the individual through one’s senses, perceptions, beliefs and judgements. (Moustakas 1990:15)

This approach invites me to value my taking part in the inquiry and to engage with my own experiences of the use of IPT in DMT with adults with PMLD as well as with
participants’ experiences. In the early stages of this inquiry, a Heuristic methodology informed my structuring this inquiry in four phases:

1. Initial engagement
2. Immersion
3. Incubation, Illumination and Explication

This reflects what I outlined in my Research Proposal:

- **Phase 1**: journal writing and drawing
- **Phase 2**: record the CRP sessions
- **Phase 3**: analysis of the data collected - thus shifting from first person position to third person position
- **Phase 4**: complete the final document as a synthesis of the previous phases. (Butté 2006: 9)

2.1.5 The role of researcher-facilitator-participant

I consider my role in this inquiry as that of researcher-facilitator-participant (RFP). As the initiator of this inquiry I was a researcher in this inquiry. As I offered a structure to the CRP sessions and led the process, I was also a facilitator of the CRP process. Choosing to take part in the CRP sessions (i.e. I joined in the warm-up and contributed my own reflections on the theme) I was then a participant. Throughout this inquiry and particularly throughout the CRP sessions I continually shifted from one position to the other. This shifting of position is a dynamic loop wherein one role informs the other (Best: 2003a, Parker & Best: 2005). (Figure 2.1.5.1 p.26) From the first session, I informed participants that I considered myself a researcher-participant and that I would be facilitating the creative reflective process; I also let them know that I wanted to be flexible about my role in order to be responsive to the process.

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1. ‘First person’ position corresponds to the conscious lived experience and ‘third person’ to the experience as related and described by the researcher (Varela and Shear 1999)
Figure 2.1.5.1 The role of researcher-facilitator-participant

The role of researcher-facilitator-participant enabled me to take part in a piece of reflective work which I wanted to engage in; it is a flexible, complex and challenging role at times. On reflection I realise that it might have been helpful to create a questionnaire specifically designed for me in order to have a more detailed understanding of the implications and dilemmas of the role of RFP. (See Appendix A for the template of this questionnaire).

2.2 Research design and implementation

2.2.1 The Creative Reflective Practice sessions’ structure

A Relational Creative Process Model (RCPM) (Best 2003a) informs the model of Creative Reflective Practice (CRP) used in this inquiry:

Within the RCPM model participants shift, not only between their personal and professional material, and between therapist and client positions, but also between modes of reflection and expression e.g. moving, sensing, drawing, writing, listening, playing with props and talking. (Best 2003a: 30).
Although the CRP sessions were akin to supervision sessions, it is more accurate to define them as peer supervision sessions insofar as they took place amongst colleagues. Besides, I was not SRDMT at the time of inquiry and choosing the term *Creative Reflective Practice* enabled me to be clear about this boundary. I also use this terminology in order to shed light on the format of the sessions, which *peer supervision* does not permit. The term *supervision* is used in a broad variety of settings and the format of supervision sessions may vary according to its context (i.e. managerial supervision or clinical supervision). It is common that the content of a supervision session is mainly verbal. Although the CRP sessions did involve verbal sharing, the therapists’ creative processes were central to the CRP sessions and ‘acted’ as a means towards understanding what gets created when relating to client material’ (Best 2003a: 29-30).

CRP1 was recorded on 9th February, CRP2 on 23rd February and CRP3 on 16th March 2007. My intention was to allow a minimum of two weeks between each session in order to leave time for the content of the sessions to inform participants’ clinical practice and for their clinical practice to also inform the CRP sessions. This allowed space for possible shifts to take place over time, for transformation to emerge and be fed back into the CRP sessions. Each session lasted an-hour-and-a-half in order to give time for participants to engage deeply with the process. This also allowed time at the end of each session for closure and for participants to complete a short questionnaire.

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8 The ADMT-UK Association uses a two tier system for professional registration: BRDMT (Basic Registered DMT) and SRDMT (Senior Registered DMT). (Criteria for Registration with the Association for Dance Movement Therapy UK). Only SRDMTs are qualified to run supervision sessions
Each session was structured as follows:

- Group gathering in a circle for verbal check-in
- Guided warm up in the space
- Guided Creative Reflective process through movement, drawing, use of props and/or music
- Group gathering in a circle for discussion and feedback
- Closure

The timing of each part of the session varied from one week to the next in order to accommodate the changing needs of the group.

2.2.2 Approaching research participants

All the DMTs who practiced in the same NHS Trust as me at the time of the project were invited to take part in the sessions. They were approached informally to start with insofar as I knew all of them (see p.44 for considerations on participants’ relationship with one another). I then sent them a letter of invitation with a brief description of my inquiry (see appendix B and C for details). They all had some experience of CRP as CRP is part of DMT trainings format, though it may be referred to as ‘experiential learning’ (Roehampton University MA in Dance Movement Therapy Course Information, and Goldsmith University MA in Dance Movement Therapy, online Prospectus, Meekums 2006, Payne 2006). CRP may also be used in DMT supervision (Best 2003a).
2.2.3 Timescale

The academic timeframe of this inquiry spread over two years.

2.3 Ethical Considerations

The ethical considerations relating to this inquiry are informed by my understanding of human rights (Human Rights Act, 1998) and guided by official documents, protocols and procedures developed by the three organisations, which make it possible for me to practice as a DMT and carry out this piece of academic research:

- **Roehampton University**: undertaking a piece of academic research at Roehampton University I followed the University’s code of ethics (Roehampton University Ethics Board’s Guidelines for Research Practice and Teaching (RUEG) 2005)

- **The National Health Services (NHS)**: As an employee in the NHS undertaking research about my practice in this particular setting I adhered to up-to-date research procedures and policies. I followed the Clinical Governance Annual Report published by the NHS Primary Care Trust with whom I undertook this project (NHSEG 2004-2005), and national guidance compiled by the NHS National Research Ethics Service (NRES 2005-2006).

- **The Association for Dance Movement Therapy UK (ADMT UK)**: As a Registered Dance Movement Therapist I abide to the ADMT UK Code of Practice (ADMT UK Code of Practice 2003).

As addressed in details earlier in this chapter (p.20), ethics was one of the key areas which influenced my choice of research participants and data gathering methods. As I
chose DMT colleagues and me as research participants, I present below the main ethical principles and guidance I followed.

I was advised not to submit my proposal to Roehampton University’s Ethics Board (email notification from Dr. Janek Dubowski, Arts Therapies Subject Leader at Roehampton University, 09.10.06) and to submit it to the NHS Ethics Committee. This is in accordance with 3.2.a) of RUEG 2005 and with the NHSEG mentioned above (2004-5:13). This project received approval by the NHS Central Office for Research Ethics Committees (COREC) on 5th April 2006 (appendix D).

In consultation with my Academic Supervisor, Dilys Griffith, I realised that the CRP sessions may potentially raise issues of a ‘deeply personal nature’ for participants, so I put in place the necessary measures to safeguard participants as presented below.

2.3.1 Research Participants Consent

I sought written consent from participants (appendix E). The consent form was written acknowledging participants’ ‘right not to participate’, and ‘right to withdraw agreement to participate in any questionnaire survey or interview’ (RUEG 2005). Following Heuristic methodological guidelines, I also sought research participants’ consent to use the CRP sessions’ excerpts I included in this paper.
2.3.2 Safeguarding Research Participants and third parties

I understand the importance of keeping all information confidential. Due to the nature of this inquiry, it was very likely that those participants directly involved in the research would mention clients they work with within the Trust. Following 3.3 of RUEG 2005, I endeavoured to safeguard research participants as well as third parties whom research participants may refer to. In the references, I did not give the full details of specific documents which would identify the NHS Trust I work for, and which would subsequently identify participants. Likewise, I formatted the copy of the COREC letter of approval (Appendix D) so that the details of the NHS Trust I work for do not appear. Lastly, I coded participants’ identity and the identity of clients mentioned by participants so that none of them can be identified.

2.3.3 Informing Research Participants

Following 3.2.b) of RUEG 2005 and in line with the NHSEG 2004-2005 I wrote two documents with full details about my research, which I sent to participants when inviting them to be involved in my inquiry. (Appendices B and C).

2.4 Summary

In the above chapter I explained why ethical dilemma guided me to dismiss a Participatory Research Methodology involving adults with PMLD. We then saw how an Art-based methodology helped me to hold the body and learning from the creative process at the core of the research process. I then moved on to highlighting how a Heuristic approach enabled me to value my position as researcher-facilitator-participant and to structure the whole research process in four key phases. These methodologies, part of a broader
qualitative research framework, enabled me to stay open to the emergence of meaning from the process of inquiry. I then presented the CRP sessions as a containing format for my colleagues and I to engage with creative media and reflect on the theme of IPT in our practice with adults with PMLD. Finally I presented the key ethical principles I followed throughout this project.
Chapter 3: Data collection & treatment of the data

In this chapter I explain how I took guidance from several qualitative research methods in order to present, treat, analyse and/or synthesise the data collected throughout this inquiry.

3.1 Researcher’s diary

I kept a diary throughout the whole process of this inquiry. I used it to write notes relevant to the research question. They include insights gained during my own therapy sessions, movement practice, during clinical and academic supervision, during conversations with friends and colleagues, and book references. Keeping a diary is one of the methods recommended by a Heuristic approach in order to enable the researcher to capture thoughts, reflections and insights wherever and whenever these occur.

The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. Heuristic processes incorporate creative self-processes and self-discovery (Moustakas 1994: 17).

3.2 Researcher’s journal

The journal complements the content of the diary in greater details; it includes details of dreams, conversations and reflections. Tracing my own process in details enabled me to gain insights into my own preconceptions, beliefs and concerns regarding the use of IPT in the therapeutic relationship with my clients and is informed by Carl Jung’s idea that ‘one cannot help any patient to advance further than one has advanced oneself’ (Jung 1966: 78).
3.3 Supervision notes

As part of my clinical practice, I attend regular clinical supervision with a Senior Registered Dramatherapist. Throughout this inquiry I attended regular academic supervision sessions and had phone conversations and email exchanges with my academic supervisor. Both these forms of supervision enabled me to reflect on my clinical practice and its relation to this inquiry; they helped me clarify thoughts and engage with my inquiry from a different perspective.

3.4 Audio and video recordings of the Creative Reflective Practice sessions

I set up, audio- and video-recorded three one-and-a-half hour CRP sessions for the purpose of this project. The aim of the audio recording was to collect a detailed and accurate account of the verbal aspect of the three CRP sessions. The aim of the video recording was to provide a visual record of the three sessions, which I could come back to for clarification in the transcripts. The video camera was set up in a corner of the room in order to obtain a wide enough angle. Participants were invited to use the video camera if they wanted to.

3.5 Transcription of the recordings

I fully transcribed the audio recordings of the three CRP sessions. Although a time consuming exercise, this allowed me to ‘come out’ of the CRP sessions, thus facilitating my transition from first to third person whilst staying close to the content of the sessions.

\(^9\) CRP sessions 1, 2 and 3 are referred to as CRP1, CRP2 and CRP3 later in this paper.

\(^{10}\) See footnote 6, p.25.
3.5.1 Transcripts coding

CRP1, 2 and 3 were analysed following the guidance of Grounded Theory methods which involved coding the transcripts and writing memos from the codes. I did an initial coding (Charmaz, 2006: 47) which was followed by focused coding (ibid: 58). Charmaz explains that whilst the initial coding enables the researcher to remain close to the data and therefore helps him to avoid putting his own story onto the data (i.e. misinterpreting what a participant has said); focused coding enables the researcher to start finding themes and possible patterns, which guide the process towards abstraction and theorising. Due to the small scale of this inquiry I did not intend to build any new theory from it although I found Grounded Theory methods helpful, as it provided me with a structured method to look at the content of the transcripts from a different perspective.

3.6 Record of interview with P1

A couple of weeks after CRP3, I contacted participants asking them whether there was anything they wanted to share about the CRP sessions. P1 responded to the invitation. Our conversation which was recorded in the form of an interview, is an example of the importance I gave to participants’ welfare and wellbeing and of the benefits of a flexible format of inquiry.
3.7 Construction of a virtual Creative Reflective Practice session

At this stage in the process, I was inspired to create the transcript of a virtual CRP session: session which would represent a CRP session in its structure and which would contain key themes raised by participants. The transcript of the virtual CRP session, presented p.50 is a verbal narrative offered as an account of and insight into the rich interplay between non-verbal and verbal reflections on the use of IPT in DMT with adults with PMLD. I was encouraged to create a virtual narrative by Tim Booth (1996), Peter Clough (1996), Danny Goodley (1996) and Malcolm Richardson (1997) who have conducted research with children and adults with PMLD and who argue that creative writing is a valuable research method ‘in which storytelling can engage the reader’s imagination to enter another world of experience’ (Richardson 1997: 191). All that is said during the virtual narrative is truthful to what participants expressed during the original CRP sessions. Participants were given a copy of the virtual narrative prior to completion of this paper in order for them to check its accuracy and give their consent on its content.

3.8 CRP Participants’ notes and artwork

I collected artwork and participants’ notes created during the CRP sessions which participants consented for me to use. They inform this inquiry and are presented in full in the appendices (Appendix F).

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11 By ‘virtual’ I mean a session which is fictional in its format. Its content is informed by what participants said during CRP1, 2 and 3, and by the record of interview with P1 (p.35) although the original transcript excerpts have been edited.
3.9 Questionnaires

At the end of each CRP session participants were asked to fill in a questionnaire designed for participants to give me some feedback about the structure and content of the CRP sessions (Appendix G). I included the filling in of the questionnaire in the CRP session time as I considered it was part of the sessions and wanted to make sure that all participants would complete them. I allocated 5 minutes only to the filling in of questionnaires in order to encourage participants’ spontaneous response. The first question was for participants to rate on a scale from 1 to 5 (1 being ‘not so good’ and 5 being ‘excellent’) how ‘useful’ and ‘helpful’ they had found the sessions. Questions 2 to 5 were open questions inviting participants to let me know which aspect of the session they had found the most and the least helpful, suggest ways the sessions could be improved, and share any additional comment. An analysis of the questionnaires is presented on p.45.

3.10 Researcher’s poems and artwork

Poems and artwork I created during this inquiry are part of the data. They were significant tools in the process of inquiry as they enabled me to shift from non-verbal creative expression to verbal creative expression, towards a more formalised academic way of expressing myself, back to expressing myself creatively, etc. Thus constructing a constant flow between each mode of expression. Being able to hold creativity, curiosity and academic rigor was a challenge I endeavoured to embrace through this inquiry.
3.11 Linking the data together

Collecting different data, coding the transcripts and writing memos from the codes enabled me to first immerse myself in the theme of this inquiry and to then deconstruct the information I gathered. The later stage of the inquiry consisted in looking at the data from a new angle. Having filtered through a lot of information, I gradually developed what I entitled a ‘creative re-construction of a Polyvocal Metaphor\footnote{Polyvocal Metaphor refers to the narrative being a metaphor for the theme of inquiry, spoken by the voice ‘vocal’ of several ‘poly-clinicians.} in context’ (p.39) which aims to bring the most significant themes of this project into a coherent whole.
Chapter 4: Creative re-construction of a Polyvocal Metaphor in context

RP: (‘) as you know the focus is
P3: mmm’
RP: to investigate the use of interpersonal touch in dance movement therapy sessions with adults with Severe Learning Difficulties through reflective practice sessions.
P3: urrm’
RP: urrm’ my aim is for us to move together towards mutual and dialogic construction of meaning. And what I mean by this is, urrm, I mean verbal and creative dialogue, conversations. Thus we would mirror the approach that we take, also, in therapy. Umm, and that comes from my belief that reality is not understood as truth to be interpreted but as mutually evolving; and that information is co-created. Umm’
P3: rrr!
RP: And, and my role, I see it as being a participant researcher. Mmm, because I am seeking a collaboratively constructed story’ urrm’ where we are all working for the betterment of the therapeutic relationship with our clients. We’re engaged and part of this.
(CRP1: 9-15)\(^1\)

In the light of the question I raise in this inquiry, I give considerations to ‘interconnected systems’ (Bronfenbrenner 2005: 1) and concepts which inform the use of IPT in the therapeutic relationship with adult with PMLD (see figure 4.1.4 p.43). I then bring our focus back onto the CRP sessions, starting from reflections on participants’ relationship with one another. This leads us to consider the presence of a baby during the CRP sessions. I then focus on the analysis of the CRP questionnaires as a way into the structure of the session. Later, I present the transcript of a virtual CRP session as a narrative for the subtle interplay between the ‘doing’ of creative reflective practice and current significant themes on the use of IPT in DMT with adults with PMLD.

\(^{13}\) See footnote 3, p.3.
\(^{14}\) Each transcript was saved in an Excel format, which allowed me to have a line number for referencing and easy location of information, i.e. CRP1: 9-15 can be read ‘transcript of CRP session 1, line 9 to line 15’.
4.1 The Ripple Effect: This Inquiry in Context

4.1.1 Working with People with Learning Difficulties/Disabilities

The past few years have seen significant steps being taken to support the integration of children and adults with LD, highlighting key principles of ‘rights, independence, choice and inclusion’ (Valuing People 2001:3). ‘Valuing People’ (2001), ‘Our Health, Our Care, Our Say’ (2006) and ‘Valuing People Now’ (2007) are important governmental papers which review and guide the development of services for people with LD and their integration in the community. These documents promote partnership work between local authorities and National Health Services (NHS), the need to draw individualised Person Centred Plans (PCPs) (Valuing People 2001: 49-50), and to support the physical and emotional Health of this client group through Health Action Plans (HAP) (Valuing People 2001: 61). Latest investigations into the service for people with LD also point to significant institutional abuse still taking place in various NHS Trust in the UK (Commission for Healthcare Audit and Inspection 2007); together with ‘Valuing People Now’ (2007) these documents underline the need to continue the transition from institutionalised services to community based services, for more specialised training for staff working with people with LD and for training for members of the public to ‘help society understand more about serving people with a LD’ (Valuing People Now 2007: 62). These documents provide valuable information on how my inquiry can contribute to our understanding of people with PMLD, and offer insights into prospective development of services for this client group. For example, in her feedback about the CRP sessions in her answer to the questionnaire P3 tells us that it ‘felt wonderful to have a safe space to explore personal feelings towards clients and touch. To re-examine the purpose, power and consequences of touch and how/why I choose to use it.’ (CRP3-P3-Q5). This illustrates that the CRP sessions
opened up a discussion on the meaning of IPT, a theme of unique significance in the life of adults with PMLD. These sessions were also an opportunity for practitioners to learn from their own reflections as well as through the group discussions, and to consider their work with adults with PMLD in the light of the above-mentioned initiatives.

4.1.2 Practicing DMT in the UK

The Association for Dance Movement Therapy (ADMT-UK) Code of Practice (1997, last reviewed in 2003) informs the therapeutic relationship considered in this inquiry. Amongst the various standards stated within this code, one can read that ‘Dance Movement Therapists should be especially aware of the possible difficulties inherent in the use of physical contact within the context of Dance Movement Therapy’ (ADMT-UK Code of Practice: 5). In other words, ADMT-UK recommends that DMTs are cautious about the use of IPT in their practice although ADMT-UK does not indicate why and how this can be achieved. Such words of caution warrant further investigation which this inquiry contributes to.

4.1.3 Conceptual Context

I am interested in the new paradigms - ecological, systemic, cybernetic and holistic (Gerhardt 2003, Bronfenbrenner 2005) - underpinning current cross-disciplinary theoretical thinking. These concepts or paradigms invite me to think about the DMT relationship as embedded in concrete biological and social realities and to be curious about the dynamic relationship between these realities. From a medical model we have and still are exploring the intricacies of the functioning of the human body as a complete unit in itself, and have become very knowledgeable about the working of the human body. Paradoxically, a
medical model also holds a normative view of the functioning of the human body and
considers, from this perspective, that people have more or less developed and functioning
bodies. (i.e. the diagnosis of PMLD focuses on the depth ‘ Profound ’, complexity ‘
Multiple’, dysfunctional abilities ‘ Disabilities’, as far as the learning skills of an individual are
concerned). From a social model, one is drawn to consider geographical, historical, social,
cultural and political factors which shape the experience and reality of an individual.

It seems that current governmental guidelines, the partnerships developing at a local level
and multi-disciplinary work may enable more open sharing and mutual shaping between
the medical and social models, thus promoting the health of people with LD in a more
integrative way. This context is significant when considering the use of IPT in DMT with
adults with PMLD as it is reflected in the therapeutic relationship. Figure 4.1.4 (p.43) is a
representation of how these different elements interact and inform one another and how,
in turn, they inform this inquiry, itself informing the DMT relationship.
4.1.4 The Ripple Effect: this inquiry in context
4.2 Participants’ relationship with one another

Connections between research participants were multi-layered and complex. Although participants were only chosen because they worked in the same NHS Trust, I highlight below the different connections between them. For transparency reasons, this information was made explicit during the CRP sessions (see figure 4.2.1 below for a graphic representation of these relationships).

4.2.1 Participants’ relationship with one another

I suggest that the level of subjectivity relating to the many strands of connections between research participants may be representative of the size of the profession in the UK. The world of DMT is very small: 155 registered members with ADMT-UK in 2007. Between 2002 and 2004, there were only two universities in the UK which offered DMT Trainings at Postgraduate level: Roehampton University and Goldsmith University (information gathered through email exchange with Andrew Clements - ADMT-UK administrator, 19.9.7 and 23.11.07). It is therefore understandable that Roehampton University being in
South West London, trainees there might be more likely to live in South London and subsequently seek work in this area. Another factor is that there are very few NHS DMT jobs in the UK and consequently in South London.

As Carolyn Ellis puts it ‘ongoing and overlapping relationships may make loyalties, confidences, and awareness contexts more difficult for all to negotiate’ (Ellis 2007:13). A Heuristic methodology and Ellis’s paper were helpful in reminding me to discuss with participants what to tell and what not to tell in this paper and to value the richness of the circumstances within which this inquiry was taking place.

4.3 A baby in the CRP sessions?

Although I had intended to record the CRP sessions before P3 gave birth, the CRP sessions recording was postponed due to my resubmitting my Research Proposal and the time it took to gain ethical consent to carry out research within the NHS. Baby\textsuperscript{15} being born and very young, P3 told me that for her to take part in the CRP sessions, I would have to include Baby, otherwise she would have to withdraw. This was addressed in consultation with my academic supervision prior to CRP1 (AS\textsuperscript{3}, 10.01.07)\textsuperscript{16} and all other participants. I anticipated that the presence of Baby during the CRP sessions would have a significant impact on the process and content of the sessions, with the potential to take participants’ focus away from the research question. Bearing this in mind I also knew that participants were DMTs who had chosen to join in the CRP sessions in order to reflect on the theme of IPT in their practice. I therefore trusted participants’ ability to keep their focus on the theme reflected upon during the CRP sessions. I also anticipated that the

\textsuperscript{15} Throughout the paper P3’s baby is referred to as Baby.

\textsuperscript{16} Academic Supervision sessions are referred to as AS.
presence of Baby during the CRP sessions might be a gift to the inquiry. Having received all participants’ approval, Baby was present throughout CRP1, 2 and 3. Baby was 9-weeks, 11-weeks and 14-weeks old during CRP1, 2 and 3 respectively. The transcript of the virtual CRP session (p.50) reveals how Baby’s presence informed the inquiry. For example, it enabled research participants to link specific vignettes of their clinical practice to the developmental movement of an infant aged 9, 11 and 14 weeks. The presence of Baby during the CRP sessions therefore facilitated practitioners linking their reflections on the use of IPT with adults with PMLD to specific stages of developmental theories.

4.4 Questionnaires analysis

The questionnaires were designed to gain feedback from participants on each session. From Table 4.4.1 (p.48) we can see that participants had found CRP1 ‘useful’ and ‘helpful’ though not as much as during CRP2 and 3. Their answers to questions 3 and 4 of CRP1 questionnaire (see appendix H) provided me with specific ideas on how to design the structure of CRP2. Similarly, their answers to questions 2 to 5 of CRP2 questionnaire (Appendix H) informed the construction of the structure and content of CRP3.

Although all participants rated CRP2 and 3 with the highest scores in terms of their being ‘useful’ and ‘helpful’, answers to questions 4 and 5 (Appendix H) provided me with valuable information on specific areas of interest about the CRP sessions and guided the preparation of subsequent sessions. Participants’ feedback at the end of CRP1: longer in movement, speaking from an embodied place in movement’ (Q4-CRP1-P1)\(^\text{17}\), ‘clarity on what is allowed/required’ when warming-up and use of voice (Q4-CRP1-P2); ‘more movement

\(^{17}\) Q4-CRP1-P1 is the code used to indicate that this is P1’s answer to question 4 of CRP1 questionnaire. All answers to the questionnaire are presented Appendix H, and quoted in italics on the text.
opportunity and touch exploration’ (Q4-CRP1-P3); ‘asking specific questions in relation to touch in relation to themes that come up in the group’ (Q5-CRP1-P1), invited me to be more explicit on what is allowed during the warm-up, to increase the time spent in the movement and creative exploration of CRP2, and to offer a guided movement exploration during the exploratory movement part of the session. I found inspiration in Susie Orbach (2006: xvi) and offered participants to guide a process asking them the following questions in relation to a clinical vignette of their choice: *When and why did you touch? Why did you refrain? When did you feel inclined to touch? How did you respond when you were touched?*’ (Appendix I). Ratings of CRP2 (Table 4.4.1 p.48) show participants’ overall satisfaction with the structure and content of the session. This indicates that taking into account their feedback after CRP1 when preparing CRP2 meant that participants’ needs were met during CRP2.

At the end of CRP2, P2 commented that it felt wonderful to have a safe space to explore personal feelings towards clients and touch. To re-examine the purpose, power and consequences of touch and how/why I choose to use it’ (Q5-CRP2-P3). This encouraged me to provide further exploratory opportunities when planning CRP3.
Legend:
- **Participant code**: 1, 2 and 3 correspond respectively to P1, P2 and P3
- **Value of the session**: participants were asked to rate sessions on a scale from 1 to 5; 1 being 'not so good' and 5 being 'excellent'

**Table 4.4.1**: Participants’ evaluation of CRP1, 2 and 3
*(Question 1 of the questionnaire)*
Answers to questions 2 and 3 provided me with a record of what each participant had identified as most helpful about the sessions. At the end of CRP1, P3’s comment that the session had been ‘consolidating [her] use of touch and its importance in [her] own work / life and having an opportunity to move with [her] baby’ (Q2-CRP1-P3) reminded me of the value of CRP processes within which participants make sense of clinical material and consider it in relation to the reality of their personal story at a moment in time. P1 mentioning that the ‘guided process (…) enabled [her] to ‘go in deep’ into client experience and gain insights’ (Q2-CRP2-P1) confirmed the benefits of guiding an active reflective process (Best 2003a, Parker & Best 2005) in order to enable clinicians to gain insights into their relationship with their clients.

Understandably, participants did not answer question 4 of CRP3 (appendix H) as CRP3 was the last session.

These questionnaires were a useful tool in the design of the CRP sessions (Appendix I) and could be used for future CRP sessions. Informed from reading and participants’ feedback, I constructed a document presenting further questions which could inform subsequent research in the use of IPT in DMT (Appendix J).

On reflection I realise that asking participants ‘how useful’ and ‘how helpful’ the session had been were similar questions. It might have been beneficial to this inquiry to ask participants one of these two questions and to add further questions for them to rate the structure and the content of the sessions separately.
During the sessions, it did not occur to me that as a participant it would have been useful for me to fill in a questionnaire. Consequently my own responses were not monitored according to the format of the questionnaire. Conducting a similar piece of work, I would want to fill in a questionnaire myself thus taking into account my position and experience as a participant in the CRP sessions.

Let’s now go back to the narrative or Polyvocal Metaphor which provides us with insights into the use of touch in DMT with adults with PMLD. When discussing Contact Improvisation (p.13) I suggested that movement could be understood as a metaphorical expression of emotions, I now suggest that words can be read as a metaphor for the non-verbal relationship with adults with PMLD. The Polyvocal Metaphor is a verbal narrative which naturally flows from the creative to the cognitive, from the social to the medical, from the professional to the personal, from the past to the present, from the infant to the adult, and back.

4.5 A Polyvocal Metaphor for the use of Interpersonal Touch in Dance Movement Therapy with adults with Profound and Multiple Learning Difficulties/Disabilities

This excerpt is twenty minutes into the session. The group has already ‘checked in’ with one another and had time to connect to ‘self’ through guided movement exploring the theme of touch. A few minutes before the following conversation, RP had reminded participants that they could speak spontaneously, use sounds and creative expression whenever they wanted to during the session. The group was still moving when P2 starts speaking.18

18 Descriptions are indicated in italics and the conversation in normal text format.
L1-P2: When I started getting into my body now I felt as though I was getting inside this big bubble; like putting on something else, a new skin or something. And I got into this the other day at home, just patting my body’ exploring the idea of touch. *(P2 rubs his chest and arms vigorously as he speaks)* And I was thinking that there’s something that I really enjoyed. It is not something I normally do when I’m warming up my body; I warm up the joints, I think about the mobility, the muscles, all those things. This idea of self-massage, self-touch is not something I do a lot for myself and I realised how good it felt. *(.1)* This kind of touch has given me something new. It might be part of my own personal thing, where I’m missing personal touch, maybe that’s in my mind as well, but then thinking about the benefits of clients having that as well. What do they get from that?

L2-RP: And what we get from being able to control our body moving and be able to touch ourselves, and what we don’t get if we can’t control our movement so easily.

L3-P2: Which makes me think about you and I *(P2 looking at RP)* having handover the other day. Talking about things that went on in the group since I haven’t been there but talking about very intimate soft touch between clients.

L4-RP: yes

L5-P2: and what one gets from that, the feeling of that. Ummm, a comfort of some sort, something. *(.12)*

L6-P3: mmm’ *(.4)* all the possibilities when you get control of your body.

L7-P1: there is so much we can do for ourselves as well and you were talking about missing touch. That’s what was just with me during the warm-up, feelings of sadness because at the moment my partner and I aren’t able to spend time together and I’m

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19 L1-P2 refers to Line one of the Polyvocal Metaphor and indicates that P2 is speaking.

20 *(.1)* indicates a pause of one second and *(.2’00)* indicates a pause of two minutes.
missing, that, touch, I’m missing that loving tender touch and then seeing the two of you (speaking to P3 and looking towards P3 holding and cuddling Baby) and thinking ‘there’s nothing that beats that’. You can’t replace it. Then thinking about clients and thinking about the absence of having that, particularly clients I work with who are institutionalised.

L8-RP: the absence of having touch?

L9-P1: yes, the absence of having touch and particularly clients that I work with who are institutionalised who maybe haven’t had that since they were babies. (.4) Yes... I was feeling quite hopeless. I was thinking maybe that’s a feeling that comes up when you don’t have that touch - Emptiness and loss.

As the conversation comes to a natural pause, RP invites the group to make a transition into a creative exploration of the use of IPT in their DMT practice. RP gives the main outline of the exploration. She then guides the group through the process.

L10-RP: so thinking of a client with whom you’ve used touch (.2) and just be with that memory and (.2) let yourself recall maybe at a bodily level first how it happened, (.4) what had happened before (.4) whether you initiate it (.4) or the client initiates it (.2) and (.2) think about when and why did touch take place? (.2) or maybe why did you refrain from touching? (.4) and (.2) when did you feel inclined to touch? (.6) how did you respond when you were touched? (.40). So, did you initiate touch or did the client initiate touch? (.30) What happened before, what happened afterwards? (.30) When and why did touch take place? (.40) Why did you refrain if you did? Or why did you feel inclined if you did? (.40) And how did you respond when you were touched? (3’00) Now I would like to invite you to find a shape that would respond-represent this experience’ . Your shape
could be a moving shape. (2'00) And when you feel that you’ve done this shape enough, this movement enough, letting it evolve, letting it grow, letting it change. So that you really stay connected to the experience and to your needs, right now. (2'30) And little by little (.2) you move away from remembering the client, back to being together with colleagues and peers (.4'00)

*During the above exploration participants use movement, sounds, music and drawing. The following conversation developed during the closing circle of the session.*

L11-P3: When I was thinking about the client and touching, what came to my mind is that it makes me feel more equal in a way, because it puts my vulnerability on the table. Whereas - I’m speaking about just this client group - if I’m using words I’m more powerful in some way; that’s how I perceive it.

L12-P1: the word `equality’ came up for me as well.

L13-P3: mmm and my vulnerability is very raw. Then the unknowingness of touch and how that will develop you know. Will I get scratched, will I get yanked, will I get pulled or will I be received? And how wonderful that feeling is when someone, you know, I was thinking about a client in particular, how long I had worked with her, you know, just putting a hand on her shoulder and walking around and coming back to place the same hand, on the same shoulder, with the same weight, you know week after week and eventually she started to take my hand and then guide me round and that’s all we did.

L14-P1: I had very much a sense of that being vulnerable and offering something, and not knowing how a client’s going to respond. And then by being the client now in the exercise, and just kind of reflecting on it really; how that relationship developed over time
and through touch and different movements, the sort of magical process that happened. It’s just quite amazing and that actually touch was the only way that a connection was made. We tried, it’s like we tried everything! (Smiles and laughs lightly) and it was through touch and then that building up over time; different kinds of touch that we got into together that then props could be used. So it was good to reflect on that.

L15-P2: That was just, when you were speaking that just made me think, just listening; I’m hearing we say touch. And I think, in some way I think it’s important to differentiate between sorts of touch.

L16-P1: yes (.2) um’ she’s a woman who has visual impairment and a lot of self-stimulating movement. (.2) I just thought I’d offer her a different kind of experience I suppose; I just did the same rhythm but just rubbed my hand gently on the palm of her hand and, I did that for a few weeks to see if there was any response and after a couple of weeks she then just reached her hand and just (P1 starts clapping her hands gently) started clapping hands with me. And over the weeks really that developed into a rubbing. We’d clap hands (P1’s clapping sounds increase and the rhythm accelerates); and then she started to move her foot towards me and I took her foot. I took her shoe off and (.2) started rubbing her feet, and she smiled (P1 smiles and laughs lightly) and so when I was embodying the client today I was like ‘Oh, all this lovely touch!’

P2 laughs

L17-P1: ‘Oh! She rubs my foot!’ ‘Oh! And I can clap hands with her!’ It was quite nice. I remember when I was with her; I was really tuned in with her, and very kind of into those very subtle shifts and feedback. And if she moved, you know I’d leave it and then come back. So there was something when I embodied being her of like ‘There’s nothing expected of me, I can do that, and then I don’t have to, that’s fine. I can do my own thing,
she’s still there but she’s not forcing anything’. That’s what I was feeling when I was the
client. And then I thought about trust and just over the weeks building that trust and
gradually the interactions lasted longer. This client is very kind of locked into her own
world so everyone in the group was like ‘Wow!’ you know, ‘there’s actually interaction.’
And then, after about 20 weeks she took my hand and put it behind her head. (1) And
when you said (looking at RP) ‘how did you feel?’ I just felt so kind of you know, really
privileged! It was like, ‘She’s letting me in’ (2) it was just very moving, Sometimes
afterwards I would have tears in my eyes, feeling quite moved.
L18-P3: I feel really moved hearing you.
L19-P1: yeah (.3) And so there was that and then, you know, I tried different things like
handing her one of these boom whackers, and she actually took it you know, towards the
end of therapy, she took it, whacked it on the wall you know. It just really developed into
something. (2) It did feel very developmental and I think I thought of that client actually
because Baby is here, because I’ve got lots of other examples you know of using touch
with clients. I was just lying next to Baby and it reminded me of her (.1). She’s at that age
developmentally maybe a bit older than Baby but similar kind of quality. Her movement
wasn’t so involuntary’
L20-RP: mm,mm (5.) yes. This makes me thing about the fact that ‘we’re adults, we work
with adults, how do we work as therapists in a way that that’s ok? You know, how do we
work with touch and the possibility that strong responses may be triggered through the
use of touch, sometimes sexual responses.
L21-P2: mmm, and is that something to do with our experience?
L22-P3: when does touch become sexual? Does it require some kind of consciousness of
sexuality and sex to make it sexual? Using Baby as an example: I’m cleaning his nappy, I’m
around that area, d’you know what I mean? Is he having a sexual response to that, or is it only me as an adult or someone who’s been through puberty, that is able to conceptualise it in that framework? You know, whose framework is it?

L23-P1: There are lots of different theories about that. When sexuality starts, and people say different ages so’ The clients that we work with their developmental age may be 9 weeks like Baby today or older (.1) maybe younger (.1)

L24-P3: sexuality might be the most important thing in their consciousness or it might be the least.

L25-P1: and then they’re adults as well(.2)

L26-P2: ummm, when you (looking towards P3 and P1) were talking about touch earlier, it made me think about, my own bodily felt sense of touch with a client. How sometimes with clients who are not communicative verbally or visually, the only way I can sense whether they’re responding to me is through touch and that with whatever form of touch I can feel the resistance or the moving away from or the moving towards. (.1) And whether the moving towards is a push or whether it’s a leaning into; like the head leaning on the side, taking their weight. So I think the use of touch might be in a bodily sense of holding whichever way touch is actually. Through touch you sense clients’ response of where something goes.

L27-P1: yes

L28-RP: mmm, (.3) we’ve just got 5 minutes for closure. Before we bring this session to a conclusion, I wondered what your thoughts are on how we could bring the work we’re doing together here back to our clients. Would anyone like to respond?

L29-P1: it has influenced my work already. Through the work we’ve done here, working with each other and exploring touch with each other and my responses to it for example,
I feel that I’ve become more sensitive to picking up subtle signs when proximity is too much for a client. The sessions have thrown light on maybe quite a limiting belief or assumption that I had, which was something about how touch being therapeutic, creating connection (.2). It is a belief I still hold though I feel more aware of how a therapist using touch can trigger past traumas without any intention of doing so. It’s made me think about how, every time I am reaching out to touch someone, I am taking a risk; because I don’t know whether, if, how my client’s body has been violated, intruded upon. And even something like putting my hand on someone’s shoulder – light touch- could bring back some kind of trauma or memory; who knows, you know. Particularly with this client group, people I work with who are non-verbal, sometimes unable to sign, maybe visually impaired, hearing impaired, physically disabled, who may have little resources to let me know whether my touch is welcome or not. (.2) Having said all of that, I do still feel that I will use my clinical judgement in the moment and that may sometimes involve reaching out and making contact.

Other participants share their view and the group makes a transition to filling in the questionnaires. Then everyone says goodbye and leaves the room.
Stage 5: Reflecting on the Reflection

I am 8 years old, walking into a room full of mirrors, some of them distort my body, like this one which pulls my face down to my knees and leaves me with very tiny legs and big fat feet; I laugh nervously at my image. I move to the next mirror and see a reflection of the room and of myself looking at my image standing in front of the mirror; and exactly the same image but smaller inside the mirror, and inside yet the same image in yet a smaller size, etc, etc, until all I see far into the depth of the flat mirror, is a dot.
(Childhood Memory, My Journal, 25.11.07)

As I reach the end of this project my perspective broadens; I am more aware of some of the paradoxes I need to hold in the therapeutic relationship with my clients and when carrying out research on DMT with adults with PMLD. Through this inquiry I have gained insights into my own relationship with IPT; when I engage with my clients, I now feel able to relate to them with more depth when the theme of IPT comes up for example. From this inquiry I offer the following considerations:

Considerations for the Dance Movement Therapy Profession

In my introduction (p.3) I share that I sometimes use IPT in my DMT practice with adults with PMLD; in the Polyvocal Metaphor, P1 tells us about her DMT work with this client group: ‘I do still feel that I will use my clinical judgement in the moment and that may sometimes involve reaching out and making contact’ (L21-P1, p.56), in the answers to the questionnaire, P2 tells us that the CPR sessions have been an ‘opportunity to share with other DMTs and an opportunity to realise my own passionate view on the use of appropriate touch’ (Appendix H, Q2-CRP1-P2), and P3 tells us that the CRP sessions have been ‘consolidating my use of touch and its importance in my own work / life’ (Appendix H, Q2-CRP1-P3) This indicates that at the time of my inquiry, 100% of research participants considered the use of IPT inherent to the DMT relationship with adults with PMLD. In the light of
these finding and considering the small scale of this project (four research participants) it would be helpful to research the use of IPT in DMT practice with adults with PMLD further.

When working with adults with PMLD, decisions are made following little verbal expression from the client (p.3) so the DMT focuses on movement, postures, facial expressions and use of sounds. The therapeutic relationship mainly takes place in the non-verbal and relies heavily on the therapist’s intuition and sensitivity.

To understand the therapeutic relationship we need to locate it within the context in which it is taking place (p.15). Subsequently, to understand the use of IPT in DMT with adults with PMLD, we need to understand the geographical, political, social and cultural context within which it is taking place (p.43).

To understand the use of IPT in the therapeutic relationship with adults with PMLD, the DMT needs to put her own experience, beliefs and preconceptions in perspective; this can be achieved within reflective practice sessions with other DMTs as indicated p.22 and as can be seen throughout the Polyvocal Metaphor (p.43).

To understand the use of IPT in DMT with adults with PMLD the therapist must consider her personal experience of IPT and her client’s experience of IPT and any relevant background information (i.e. abuse or trauma) so that interventions can meet the individual’s needs (this is illustrated p.53-57).
To understand the use of IPT with an adult with PMLD, the DMT needs to be aware of her client’s daily life. This can be achieved through reading the client’s Person Centred Plan, through conversation with the client’s key-worker, parents and/or carer, and the multi-disciplinary team involved in the care of the client, and through client observation in the day centre (or context within which the therapy is taking place).

Through the CRP sessions I have attempted to give a voice to the DMT’s body, thus attending to the wisdom of the body and its memory of the DMT’s relationship with her clients. In this inquiry I have offered a way to give a voice to adults with PMLD through DMTs’ reflections on the use of IPT in their relationship with clients. Keeping my focus on the experience of Interpersonal Touch as presented through clinicians’ verbal reflections during the CRP sessions, I do not offer my own analysis of the movement taking place during the CRP sessions due to wanting to narrow my focus of inquiry for this project. To analyse the movement during the CRP sessions would be a valuable piece of research in its own right.

Past and Future Developments

Through this research I identified the scarcity of the literature on DMT with adults with PMLD and on the use of touch with adults with PMLD. This inquiry is a step towards a clearer knowledge and understanding of the use of IPT in DMT with adults with PMLD.

In the course of this inquiry, I was asked by my academic supervisor to run a workshop on the therapeutic use of touch and to offer a presentation of my inquiry to the team of
Arts Therapists from the Trust where I work. These took place on 28.04.07 and 11.09.07 respectively.

I intend to present my inquiry to residential homes and to offer Creative Reflective Practice to residential homes where I believe there is a need for staff to creatively engage with colleagues and address various aspects of their relationship with clients. I anticipate that the structure of the CPR sessions would need to be adapted taking into account participants’ experience of Reflective Practice and the possibility that they do not usually use creative media to reflect on their work.

Although this inquiry was a wonderful opportunity to carry out research embedded in my practice, I am aware that a small-scale inquiry such as this one has its limitations and I suggest below areas where this inquiry could be taken further:

The role of participant-facilitator-researcher could be the topic of another research project; maybe using an adaptation of the questionnaire I created (Appendix A) and sending it off to researchers who are addressing their research from such an angle.

I also wonder about other means of researching the use of IPT with adults with PMLD and would be interested to read from other researchers on this topic.

Further research on Contact Improvisation and Dance Movement Therapy with different client groups would enrich the DMT literature too.
Finally, I would be interested in researching a project with multi-disciplinary teams working with people with PMLD and involving someone trained in Intensive Interaction in order to develop a training programme for those involved with this client group.
Chapter 6: Conclusion

Interpersonal Touch is a reality inherent to our life as human beings. It is of particular significance in our relationship with adults with PMLD for whom IPT is present through daily care and used by some as a means to communicate with them. Susie Orbach suggests that ‘psychoanalytic clinicians may need to gather and reflect on our own desire to touch, our fear of touching, our responses when asked to touch, our responses to being touched or wanting to.’ (Orbach, 2006: xviii). Through this inquiry I have responded to this invitation and opened up a reflective space on the use of IPT for DMTs, focusing on work with adults with PMLD. I have looked for a way to listen to and incorporate the DMT’s embodied experiences with adults with PMLD together with her cognitive abilities to know and make sense of these experiences. I have reflected on some communication dynamics, which take place in the non-verbal realm through the use of interpersonal touch. I was initially worried that something would be ‘lost in translation’ (2003) in my attempt to translate non-verbal experiences into words. However, I experience a sense of congruence when speaking from a social constructionist perspective and holding the narrative of the creative reflective process, movement and the body at the core of the inquiry. It enabled me to verbally re-present a non-verbal reality and locate it within its subjective and unique context. A heuristic approach challenged me to be both disciplined and creative and enabled me to bring my whole self to this inquiry. This inquiry has been an opportunity to learn about research methods, and to gain valuable insights into my practice as highlighted in Chapter 5 (p.58). This inquiry has been a challenging and rewarding journey, bringing together different aspects of my self, deepening my knowledge and skills as a DMT, a researcher and as a person.
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Appendix A

Researcher-Facilitator-Participant Questionnaire

1. Define the role of researcher

2. Define the role of facilitator

3. Define the role of participant

4. Note moments in the session when you considered yourself participant in the session

5. Note moments in the session when you considered yourself facilitator in the session

6. Note moments in the session when you considered yourself researcher in the session

7. Note moment when you experience any combination of the above

8. Note a moment when you decided to make a shift from being a participant to being a facilitator, from being a facilitator to being a participant. Why did you make this shift?

9. Note a moment when you decided to make a shift from being a facilitator to being a researcher, from being a researcher to being a facilitator. Why did you make this shift?

10. Note a moment when you decided to make a shift from being a researcher to being a participant, from being a participant to being a researcher. Why did you make this shift?

11. Any other comment? Suggestion?
Appendix B: Letter of invitation

‘An investigation into the use of interpersonal touch in dance movement therapy with adults with severe learning difficulties through reflective practice sessions’

A proposed Masters Research Investigation by Céline Butté, RDMT

Roehampton University

An Invitation

This is an opportunity to contribute to three reflective practice sessions (Please see information sheet for details) with other Dance Movement Therapists who work with Adults with Severe Learning Difficulties within this Trust. This investigation will take place between October and December 2006, in London.

The aim of this investigation is to expand on previous studies of the use of interpersonal touch in therapy. It is also an opportunity to take part in a peer supervision space in order to deepen our understanding of the meaning and/or role of the use of interpersonal touch in Dance Movement Therapy practice in this Trust.

This will be implemented, with your consent and participation, by video recording of three reflective practice sessions lasting one-and-a-half hour each.

In the first instance would you please reply to me at the address below and state your interest or disinterest in this project? I will be very grateful for an early response so that I am able to make arrangements that will be best suited to all who do participate. Please respond by … date

cel_butte@yahoo.co.uk
0794707450

If you agree to participate I will send you a ‘Participant Consent Form’ in line with Roehampton University and the NHS guidelines on ethical procedures.

I will welcome your input as co-research participant, so if you have any other queries or concerns then do discuss them with me.

Many thanks for your consideration and I look forward to your response.

Céline Butté, RDMT
Appendix C: Information sheet for participants

Reflective Practice Sessions

The reflective space within which the Reflective Practice Sessions (RPS) will take place is an opportunity for us to re-connect with ourselves at the end of the day as well as deepen our understanding of our practice in order to improve the experience of therapy for our clients. These experiential sessions can be considered a peer supervision space; they will be an opportunity for us to reflect both on group sessions we co-facilitate and one-to-one sessions we facilitate on our own. This will increase our understanding of the use of interpersonal touch in solo work and co-working relationships as well as identify issues around interpersonal touch when working on a one-to-one and within a group context.

Research Participants: All participants have already been identified; they are dance movement therapists who work in the same NHS Trust with Adults with Severe Learning Disabilities (ASLDs). All of them have had prior experience of sharing their thoughts experientially.

Structure: The RPS will consist of three sessions lasting one-and-a-half hour each. Sessions will take place in a dance studio, or community hall every two to three weeks depending on participants and studios availabilities. Each session will have a similar structure and will aim to reflect the structure of DMT sessions with clients: there will be time to ‘check in’ at the beginning, this will be followed by an ‘open creative space’ to reflect on the theme of interpersonal touch in our practice, and eventually the group will come back together for closure.

I am aware that, RPS being experiential, they might involve taking on some of our experiences with clients, which might bring up heightened energy. I understand the importance of creating a safe container for this energy and will therefore:

- Initiate a discussion about our working alliance, issues of confidentiality, safety, multiple relationships and group identity during ‘check in time’ of the first RPS.
- Pay particular attention to the ending of each RPS in order to facilitate a clear closure.

I would also like to encourage you to write notes from one session to the next and to share whatever feels relevant during the following session.

Transparency: I will encourage transparency throughout the RPS.

- I will inform clients and their carers that I am carrying out a piece of research.
- I would also like to come up with a system through which I can share the outcome of my research with my clients. At the moment, I envisage that this may take the form of verbal and non-verbal sharing with clients. There will be time allocated in the RPS to discuss this together.
Appendix D: Copy of COREC favourable ethical opinion

04 September 2007

Miss Celine N Butte
Dance Movement Therapist

Dear Miss Butte

Full title of study: ‘An investigation into the use of interpersonal touch in dance movement therapy with adults with learning disabilities through reflective practice dialogues’

REC reference number: 06/Q0806/34

This study was given a favourable ethical opinion by the Committee on 05 April 2006.

It is a condition of approval by the Research Ethics Committee that the Chief Investigator should submit a progress report for the study 12 months after the date on which the favourable opinion was given, and then annually thereafter. To date, the Committee has not yet received the annual progress report for the study, which was due on 05 May 2007. It would be appreciated if you could complete and submit the report by no later than 12 October 2007.

Guidance on progress reports and a copy of the standard NRES progress report form is available at http://www.nres.npsa.nhs.uk/applicants/review/after/progress.htm

There is also guidance on declaring the end of the study at http://www.nres.npsa.nhs.uk/applicants/review/after/endofproject.htm

06/Q0806/34: Please quote this number on all correspondence

Yours sincerely

Mrs Sheree Manson
Committee Co-ordinator

E-mail: sheree.manson@stgeorges.nhs.uk

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represent the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England
Appendix E: Research participant consent form

‘An investigation into the use of interpersonal touch in dance movement therapy with adults with severe learning difficulties through reflective practice sessions’

A proposed Masters Research Investigation by Céline Butté, RDMT
Roehampton University

Research Outline:

• The aim of this investigation is to expand on previous studies of the use of interpersonal touch in therapy. It is also an opportunity to deepen our understanding of the meaning and/or role of the use of interpersonal touch in Dance Movement Therapy practice in this Trust.

• This will be implemented, with your consent and participation, by video recording of three reflective practice sessions lasting one-and-a-half hour each (please refer to the information sheet for details – appendix 3).

• Any information that you offer/discuss will be used solely for research purposes. Analysis will be conducted in the session context, though anonymous individual quotes, with your consent, may be used in the final dissertation. You have the right to withdraw from this investigation at any stage and your data will not be included in the analysis.

Name and status of the investigator:

Céline Butté
Dance Movement Therapist, PGDipDMT, RDMT
Cel_butte@yahoo.co.uk
07947074507
Consent Statement:

Please complete two copies of the form below, one to be kept by you and one to return to the investigator at the above address.

• I have been given a copy of the Sharing Personal Information leaflet, I have had the leaflet explained to me and I understand its contents.

• I agree / disagree (please delete as appropriate) to take part in this research, and am aware that I am free to withdraw at any time. I understand that the information I provide will be treated in confidence by the researcher and that my identity will be protected in the publication of any findings.

Name. .................................................................

Signature. ............................................................

Date .................................................................

Please note:

1. If you have any concerns about any aspect of your participation in this research, please raise this with the investigator, or with the Head of School. He is Michael Barham, School of Human and Life Sciences phone number 020 8392 3617.

2. If you give consent but want to put a limit on the type of personal information that is shared or whom it is shared with, please write down the details below.
### Appendix F: Participants’ notes and artwork

<table>
<thead>
<tr>
<th>CRPI</th>
<th>Individual Process Notes and Drawings made during the session</th>
<th>Words</th>
</tr>
</thead>
</table>
| P1   | ![P1 Image](image1)                                           | I exist  
When I am touched I sense my own body 
Sensation me/you – body boundaries 
Body awareness 
Developmental pathways 
Connection 
Developing interaction 
Desire to touch – institutional 
Support. Strength. Power. Roles reversed 
Opening possibility for new ways of being |
| P2   | ![P2 Image](image2)                                           | Sensing  
Colours 
Connections, Elastic, Feeling  
Flow  
Together, Alone  
Being  
Intention  
Energy  
Limits |
| P3   | ![P3 Image](image3)                                           | Indecision  
Disconnected movement  
Preparatory movement |
| RP   | ![RP Image](image4)                                           | New  
Bodily Knowing  
Links  
Trust  
Fear  
Layers upon layers  
What…?  
Map |
<p>|       |                                                               | Cloth is movement &amp; can create a relationship of touch, sensation, breath &amp; spontaneity |</p>
<table>
<thead>
<tr>
<th>CRP2</th>
<th>Images</th>
<th>Words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Touch</td>
<td><img src="image1.jpg" alt="Image of notes on interpersonal touch" /></td>
<td>Feeling different surfaces. Body parts. Soft and hard. To feel a boundary, know the limits, contained. To feel one's strength in relation to another. To support and be supported. A pathway into relating with objects. Making connections. To include. Store energy / theme. &quot;Can I come in?&quot; &quot;Will you let me in?&quot;</td>
</tr>
<tr>
<td>Reflective Practice</td>
<td><img src="image2.jpg" alt="Image of notes on reflective practice" /></td>
<td>Who leads? Inclusion. There's got to be a facilitator. Someone who makes suggestions of reflective work/approach/exercise. Could this be alternated between group members with clear understanding for shared responsibility for safety + right to ask for something specific &amp; say no.</td>
</tr>
<tr>
<td>Reflective Practice &amp; Interpersonal Touch</td>
<td><img src="image3.jpg" alt="Image of notes on reflective practice and interpersonal touch" /></td>
<td>Reflecting in action during movement + touching own body at start. Realising tension of touch &amp; personal space. Touch pierces boundaries, can be frightening and so brings personal primal feelings of trust, safety, sexuality &amp; infamy into the therapeutic relationship. It makes me feel real, reminds me of the Pandora box of possibilities it can create which words cannot reach. I am then equal.</td>
</tr>
<tr>
<td>P2's personal notes and drawings made during the session</td>
<td><img src="image4.jpg" alt="Image of P2's personal notes and drawings" /></td>
<td>Yes! No! Tension of touch.</td>
</tr>
</tbody>
</table>
Appendix G: Participant questionnaire

Date:
Questionnaire No.:

This questionnaire should take about 10 minutes to fill in.

1. On a scale from 1 to 5 (1 being not so good and 5 excellent) please rate the questions below:

   1.1 Was the session useful
       1  2  3  4  5

   1.2 Was the session helpful
       1  2  3  4  5

2. What do you think was the most helpful part of the session?

3. What was the least helpful part of the session?

4. Do you have any suggestion on ways to improve the session?

5. Please use the space below for any further comment

Thank you for taking the time,
Céline
Appendix H: Participants’ answers to questions 2 to 5 of the questionnaires

<table>
<thead>
<tr>
<th>Session &amp; Participant code</th>
<th>Question 2: What was the most helpful part of the session?</th>
<th>Question 3: What was the least helpful part of the session?</th>
<th>Question 4: Suggestions on ways to improve the session</th>
<th>Question 5: Further comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRP1</td>
<td>How I feel about work &amp; hearing others views on using touch</td>
<td>Longer in movement &amp; speaking from an embodied place in movement</td>
<td>Asking specific questions in relation to touch &amp; in relation to themes that come up in the group</td>
<td></td>
</tr>
<tr>
<td>P1</td>
<td>Opportunity to share with other DMTs &amp; opportunity to realise my own passionate view on the use of appropriate touch</td>
<td>Clarity on what is allowed - required when warming up and use of voice</td>
<td>Very enjoyable and rewarding start. Looking forward to more time to explore and develop position on touch</td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>Consolidating my use of touch and its importance in my own work / life &amp; having an opportunity to move with my baby</td>
<td>More movement opportunity &amp; touch exploration</td>
<td>Thoroughly enjoyed - good to move and discuss</td>
<td></td>
</tr>
<tr>
<td>CRP2</td>
<td>Guided process' this enabled me to 'go in deep' into client experience and gain insights</td>
<td>A similar structure would work well again. I liked the three part structure, it allowed freedom to explore and go into the unknown</td>
<td>I valued the space to embody, experience and reflect on my interventions with a client and gain insights about the relationship and my practice. Thank you!</td>
<td></td>
</tr>
<tr>
<td>P1</td>
<td>Having an array of creative tools for expression and the experience to use these</td>
<td>Beginning as I was late</td>
<td>Really enjoyable session with colleagues to realise personal process in relation to therapeutic work</td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>Having space to investigate / re-experience a client relationship with the lens of touch</td>
<td>Time to check in quickly even if late</td>
<td>Felt wonderful to have a safe space to explore personal feelings towards clients and touch. To re-examine the purpose, power and consequences of touch and how / why I choose to use it</td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>-</td>
<td>-</td>
<td>The session today met all my needs</td>
<td></td>
</tr>
<tr>
<td>Session &amp; Participant code</td>
<td>Question 2: What was the most helpful part of the session?</td>
<td>Question 3: What was the least helpful part of the session?</td>
<td>Question 4: Suggestions on ways to improve the session</td>
<td>Question 5: Further comments</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>CRP3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P1</td>
<td>Moving, exploring the use of touch with one another</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>Moving together and finding a comfortable way to touch in movement offering support and comfort</td>
<td>-</td>
<td>-</td>
<td>A rich and rewarding experience that gave time to discuss and embody valuable material relating to clients, therapists and touch</td>
</tr>
<tr>
<td>P3</td>
<td>All of it! Reflecting, exploring and understanding my practice on a deeper level</td>
<td>-</td>
<td>-</td>
<td>Thank you for this wonderful opportunity, I have enjoyed it thoroughly. Thank you also for incorporating my baby, it has been very special for both of us!</td>
</tr>
</tbody>
</table>
Appendix I: Creative Reflective Practice sessions  
Preparation notes

CRP1  
Introduction

my aim:

• ‘To move towards mutual, symmetrical, dialogic construction of meaning’ (Bishop, 2005:124). By dialogic, I mean verbal and creative dialogue, thus mirroring the approach we take with clients.
• Give space for our ‘somatic and bodily knowing’ (ibid: 118)
• To engage in the exploration of the language we use with our clients and subsequently further develop the already existing ‘constitutive metaphors’ of the therapeutic relationship (ibid: 123).

my belief:

• ‘Reality is [not] understood as truth to be interpreted but as mutually evolving’ (ibid: 124).
• ‘Information is co-created’ (ibid: 120).

my role as participant researcher:
I am seeking a ‘collaboratively constructed story’ (ibid: 122) where we ‘all work for the betterment of’ the therapeutic relationship with our clients (ibid: 123)

Guidelines for these 3 RPS:

• We can raise as many negatives as positives in these sessions.
• We will spend some time during our last session together thinking about what/if/how we want to feed something back to our clients.
• Practical note: it is possible to take the camera off the tripod and use it to film something you think would be beneficial to our work together.

Questions to participants:

• How do you feel about the timescale of the project?
• How long have you worked with this client group?
• What do we feel about working with this client group?
• I intend to go straight through the 1.5h, how does this work for you?

End

Has the presence of Baby influenced, not influenced your participation?

I would like to encourage you to keep a diary between sessions and to feedback from one session to the next.

Could you also please take the time to fill in this questionnaire before you leave.
CRP2

Preparation before session / checklist:
• 45min to prepare the room: move tables + mop + bring cushions downstairs + props + music
• Set up video (hold paper with date + session number + time in front of camera + sound stick + pens and paper and felt tips + crayons
• Jug of water + glasses
• Prepare video tapes + number them
• Stop and start the sound stick to create a series of short tracks (9.2.7 ‘Notes from feedback after RPS1)

My aim:
• To create a space where, together, we trust ourselves in relation to each other. I would like each of us to feel comfortable to speak when we want, touch when we want, ask for silence when we want and ask for someone not to touch you when we want.

Guidelines:
• Speak the name of the person we are talking about during the session
• ‘Longer in movement, speaking from an embodied place in movement’ (CRP1-Q4-P1), ‘clarity on what is allowed/required when warm-up + use of voice’ (CRP1-Q4-P2) ‘More movement opportunity and touch exploration’ (CRP1-Q4-P3), ‘asking specific questions in relation to touch in relation to themes that come up in the group’ (CRP1-Q5-P1).

Session in three parts:
Check in and Warm-up
Speaking from an embodied place + time to share thoughts and reflections we had since CRP1. 30min.

Movement Exploration
I facilitate a guided process: invite participants to focus on one particular client or vignette and ask yourselves the following questions (Questions Inspired from Orbach 2006: xvi) while reflecting on the work. You may want to move, use paper and crayons. ‘maybe for this part, I become the facilitator of the process and step out of my role as a participant 20min

• When and why did you touch?
• Why did you refrain?
• When did you feel inclined to touch?
• How did you respond when you were touched?

Closing circle
Sharing of experience. Feedback
CRP3 – Last session

Check in and Warm-up
General ‘arriving and checking in with each other’ using words, movement, sounds, finding a comfortable place to be in the space. Paying attention to our breath as if witnessing what it is doing, just letting it be and allowing the chest to rise and fall naturally

Exploratory movement
connection to sense of touch in relation to self
Noticing the parts of our body that touch the surfaces around us, the ground where we rest, our clothes, the walls
being curious about the messages we receive through our sense of touch right now

moving towards another/others and staying in connection to self
Gradually moving towards each other and taking all the time you need to notice what comes up for you as you enter someone else’s personal space.
Would you like to touch them? Not to touch them? Would you like them to touch you? Not to touch you? Do you feel comfortable? Not comfortable? How can you let others know what is ok and not ok for you right now, what do you do to impart this information?
As you make your next moves, how do you respond to the feedback you get from your partners?
Let this dialogue grow and evolve naturally – taking all the space and time you need, allowing yourself to move away if you need to, or come closer
You may want to use sounds, words, make eye contact, close your eyes
Allow yourself to go towards the experience which you would find most helpful right now
Let it change, let it grow
What can you do to be more comfortable
(Inspired by LIFEdance! Facilitator Training with Sara Boas, 2007)

moving away from each other again, moving on to being on your own again
Take a moment to be, here, now, to just be.

Closing circle
Group discussion. Closure of the CRP sessions. Feedback
Appendix J: Questions for Future Creative Reflective Practice workshops on the Use of Interpersonal Touch

Generic questions about personal experience and understanding of IPT
- What does normal touch mean?
- What is your personal experience of touch?
- What is sexual touch? What makes touch sexual? When does touch become sexual? (CRP3, P3: 164)\(^2\)
- How much touch do you receive in your life at the moment?
- How much touch do you give in your life at the moment?
- If you lack touch in your life, how does this influence how you feel about clients’ touching you, about you touching a client, and about clients touching one another?
- How do you feel about giving touch?
- How do you feel about receiving touch?
- What is your experience of touch in your intimate relationship?

Generic questions about clinical work
- How does your personal experience of touch influence your perception of and response to clients touching you, and clients touching one another?
- How do you decide whether you should touch a client or not?
- How do you decide whether a client should touch someone or not?
- How do you feel about giving and receiving touch in relation to your work with adults, children and with different client groups? Why?
- Is it your role to offer an experience of touch to those clients whom you know or assume have been deprived of it? Why?

Questions about a specific clinical situation
- When and why did you touch?
- Why did you refrain?
- When did you feel inclined?
- How did you respond when you were touched?

The above questions where inspired from Orbach (in Galton, 2006: xvi), which I used to prepare the structure of CRP2, from participants questions raised during the CRP sessions and from further reflections. They could be used for further Creative Reflective Practice sessions with clinicians, care workers, support workers, etc. They would be useful tools both for those working in caring and health settings in general and for students looking to work in such environments. The whole list would not need to be used at once and it would be useful to adapt the format of the CRP session to the group of people attending. Someone using these questions would have to make sure the group is safely held and contained as Interpersonal Touch is a sensitive issue. CRP sessions’ facilitators would need to apply their own professional judgement when choosing appropriate questions to bring to the reflection. It is also important that such questions are brought to the group after they have had some time for check in and warm up and that there is some time at the end of the session for participants to close the session, thus containing the group process. There should also be a space allocated for participants’ feedback to the facilitator; in the form of questionnaires and/or through an open discussion at the end of the session.

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\(^2\) CRP3, P3: 164 refers to CRP3 transcript line 164 and indicates that P3 was speaking.