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# Utilizing Expressive Art and Dance/Movement Therapies as an Embodied Practice to Inform Childbirth

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# Utilizing Expressive Art and Dance/Movement Therapies as an Embodied Practice to Inform Childbirth

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## Abstract

An eight-week curriculum developed by this researcher was implemented with a group of women in the Spring of 2018. The goal was to provide evidence, create resources, and demonstrate the effectiveness of Expressive Art Therapy and Dance Movement Therapy as an embodied practice to create connection, promote self-expression, empathy, embodied awareness, and healthy coping skills so that embodied childbirth seems obtainable and do-able. The shift away from embodied wisdom has moved women away from embracing their bodies and created risk in childbirth. In the United States of America, the maternal mortality rate is on the rise, which is unusual for developed countries. One way of providing preventative care and proactively addressing the issues of current birthing culture is to promote and normalize embodiment for birthing mothers.

This review of literature and development of a method can be utilized within the perinatal period to promote a better understanding of maternal mental health including childbirth education and history, theories of embodiment, attunement and mindfulness techniques to further develop self-awareness and a deeper sense of identity and self for the birthing mother. Embodiment seems missing from our current birthing culture and that implementing a method to incorporate embodiment practices, as well as partaking in standard medical care with access to screening for perinatal emotional issues, could greatly impact maternal mental health.

## Introduction

Developing an embodied practice to inform a sense of consciousness in the body (embodied childbirth), and access to quality psychological care as part of maternal health, can enable women to have a better childbirth experience with decreased mental health issues within the perinatal period. This research will provide an overview of the literature related to childbirth practices, --as well as methods of embodied practice such as Expressive Art Therapy and Dance Movement Therapy, to promote better access and understanding of embodied childbirth and maternal mental health. The hope is to bridge the gap between the medical experience of childbirth in the United States today and the development of an embodied practice within childbirth to increase positive and healthy birth outcomes.

The perinatal period is defined as the time during pregnancy and the first year after birth. Maternal mental health and perinatal psychology are interchangeable terms that will be used to describe the field of emotional health and wellbeing within the perinatal period of someone's life. Experiencing perinatal mental health issues are common, affecting up to 20% of women at some point during the perinatal period. (Centre for Mental Health, 2015). Perinatal mental illnesses are a major public health issue because the adverse impact on the mother directly effects the well-being of her child. (Centre for Mental Health, 2015).

Perinatal or maternal depression includes a range of mood and anxiety disorders that can affect a woman while she is pregnant, around the time of birth, and throughout her child's first few years of life. (Collaborative Care, 2015). If left untreated these disorders, called perinatal mood or anxiety disorders (PMADs), can become chronic mental illnesses for the mother, create barriers to bonding with baby by mother's lack of emotional availability, and cause negative

effects on the development of the unborn fetus, infant and child. These conditions can cause toxic stress in the developing child and therefore are considered an adverse childhood experience. (Collaborative Care, 2015). To understand the many obstacles that were overcome by modern, Western medicine and how we have come to where we are today in current birth culture we must go back in time.

**History of Childbirth**

The history of childbirth in the United States of America can be broken down into three different time periods. Until the late eighteenth century birth was a social event, rather than medical. Birth was facilitated by females; midwives, friends and relatives of the birthing mother. (Dye, 1980). The second period, from the late eighteenth century through the first decades of the twentieth century childbirth transitioned from a social event to a medically managed emergency. Slowly, midwives were replaced by male physicians. By the 1920's the third period begins as the norm of childbirth in the U.S shifted to the medical profession having control over birth management. (Dye, 1980).

Up until the last decades of the eighteenth century, midwives were the only American birth attendees. Midwifery practice was less formal and therefore less accurately documented than other parts of the world, like England, at that time. (Dye, 1980). History relies on bits and pieces that are documented of the midwives and birthing mother's experiences. As such it's easy to fantasize that this was a time of female bonding and an expression of love and nurturing among women.

Contrary to this picture there is evidence from diarists and literature that childbirth was a terrifying and confusing time for the birthing mother and attendees. (Dye, 1980). Data that does

exist suggests that maternal mortality was not high – at least compared to European rates. Some scholars suggest that fear of death is directly correlated to cultural and religious factors. Puritan ministers are among this group that described childbirth as a fearful time – a time to anticipate death. (Dye, 1980). Women may have feared birth more because of this cultural belief rather than actual high rates of mortality during childbirth. The experience of knowing someone who died in childbirth may have been common and that alone explains women's fears.

By the mid eighteenth century, Americans were travelling to Britain for medical education. Midwifery was taught as part of medical science. After the American Revolution, upper class, American women sought after these new physicians for perinatal care. (Dye, 1980). This normalization of 'new medical practices' is the start of the second period of the history of childbirth. Medicine was exclusively a career path for males only. Childbirth slowly shifted from not only a non-professional to professional, but placed control of the birth experience from female to male. Women turned to physicians as they promised to provide safer and less painful experiences of birthing. Increased knowledge of the birthing process and the intervention of modern medicine took over with the ability to better control challenging labors with the development of anesthesia and gynecological surgery. (Dye, 1980).

There are still unanswered questions about the birthing process in the nineteenth century. There is no complete data particularly pertaining to mortality which is crucial for the understanding of birth in the past. Social class is a factor that is often overlooked in the research and data collected throughout history of childbirth in America. There is little that is known about a woman's social class and how that effected the medical treatment she received. There is much more to know about social attitudes of women and the treatment they could access. The

dominant piece of this time period is the consolidation of medical control. Although midwifery was introduced in the United States in the 1920's, physicians were the go-to birth attendees. (Dye, 1980).

It wasn't until recently, in the twenty first century that midwifery became more of normalized alternative for birthing mothers. In the 1920's 75 percent of births took place in the home. By the 1960's 96 percent took place in hospitals. Richard and Dorothy Wertz (1977) describe a picture of the transition from in home births with midwives to hospital births with physicians. Hospitalizing birthing women was the medical response to high maternal and infant mortality rates. But by the 1920's many physicians were practicing new and then obscure methods in childbirth using forceps, episiotomies, anesthesia and forced inductions. (Dye, 1980).

After the 1940's most birthing mothers were expected to follow expectations and guidelines of medical professionals surrendering control of their bodies and the birth process itself. The hospital was safer and less risky because aseptic conditions could be maintained rather than at home.

## Literature Review

### Current Treatment

The literature review objective was to identify published papers that gave any notion to embodiment in relation to giving birth. Health and social science databases were searched using terms such as 'embodiment', 'childbirth' and 'embodied childbirth'.

The College of Nurse Midwives (2014), explains how much childbirth makes up America's health care system and how traditional ways of quality of care have focused on

prevention of rare events – medical emergencies – rather than promoting a positive and healthy birth outcome. Implementing a strategy around normalizing birth increases the general well-being of families, acknowledges pregnancy and labor from a strength-based perspective and uses preventative care towards rare outcomes. (Birth Matters, 2014)

Reiger and Dempsey (2006) explain that post-modern, Western culture has a childbirth emergency. Rates of medical interventions are still rising, and physiological birth has a stigma of being fearful, pain-ridden and unattainable. There is a decline in women's confidence (individually and within society) and in the idea and ability of birthing itself. (Reiger & Dempsey, 2006). "Worship of the body and its wisdom was slowly phased out as modern religion and science came to power. The impact of this destruction of reverence for the body is still felt today in our violent and disembodied culture of childbirth." (Ruben, 2017, p. 114).

This shift away from embodied wisdom has created a negative stigma around women's natural bodies and created unnecessary risk in childbirth. According to Potter (2017), Perinatal emotional complications (emotional distress or issues) are the most common pregnancy complications in the United States. There are many strongly held cultural beliefs and values about motherhood in the United States. Normal expectations are that bringing a new baby into this world is a happy time, that mothering comes naturally, and that women can manage responsibilities easily.

Parallel to this, Beckett (2005) suggests that approval of women's preferences for whatever birth plan they'd like to follow, can ignore the ingrained social constructs that shape these choices – for example choices may be based on inadequate information, 'as well as subtle and not-so-subtle invocations of women's obligation to make...sacrifices on behalf of their

sexual partners or children-to-be' (p. 269). The author refers to notions that vaginal birth might harmfully affect one's sex life or that choices might have to be made between the woman's desires and the needs of her baby.

Hunter (2006) examines two differing health paradigms and their influence on the culture of Western childbirth practices. Specifically explored are the differences in perspectives between the dominant paradigm/culture (the biomedical model) and the alternative paradigm/culture (a holistic model). Examples of language from the medical, midwifery and nursing literature that affect childbirth culture and the care of birthing women are explored. The author argues for the use of a woman-centered paradigm for childbirth experiences. There is a need for an integration of childbirth embodiment theories, offered collaboratively with compassion, relationship-focused maternity care, particularly when labor complications develop, or perinatal emotional issues arise.

> Truthfully, up to 80% of new mothers experience periods of mood swings, sadness, and feeling overwhelmed after giving birth, a phenomenon known as the baby blues, often due to rapid hormone changes. 10% to 20% of women will experience mental health complications such as depression or anxiety within the first year of giving birth. (Potter et al., 2017, p. 453).

Potter (2017) reviewed studies that display the prevalence of and risk factors for perinatal emotional issues and sheds light on the inconsistency of screening by health care providers in acute care and outpatient settings. She described an example of nurse-led quality improvement initiatives aimed at implementing universal screening in a rural New England county, which resulted in 100% screening with the Edinburgh Postnatal Depression Scale (EPDS) across health

care facilities within the community, as well as a system-wide change in the approach to identifying and treating perinatal emotional complications.

Despite wide-spread support for universal screening, limited legislation, and the growing number of women affected, universal screening for perinatal emotional complications is not consistently implemented throughout the United States. Universal and consistent screening within systems prepared to adequately treat women at acute risk, is a practical step toward increasing quality care. (Potter, 2017).

In practice, nurses have the opportunity to provide individualized, woman and person-centered care by providing risk assessments within the perinatal period, implement screenings (with the EPDS mentioned above), plan prevention strategies, provide psychoeducation about perinatal/maternal mental health issues to raise awareness, provide referrals and resources as needed, and coordinate with other providers of the healthcare system. In-depth teaching about perinatal emotional complications within maternal mental health, including assessments, interventions, and advocacy, should be included in nurse education programs. Nurses also working in WIC offices, NICUs, pediatric offices, and public health nurses in the community can create opportunities to do this. When universal screening is implemented consistently, the issue of perinatal mental health will decrease as quality care becomes more accessible. (Potter, 2017).

There are also forthcoming books that focus specifically on topics relating to pregnancy and motherhood. Nurture (Chronicle, Sept.) is a guide to pregnancy and the first weeks of motherhood by Erica Chidi Cohen, a doula and the cofounder of Loom, a wellness center for pregnant women and new mothers in Los Angeles, California. The book includes worksheets,

lists, and illustrations that support the birthing mother step by step through her pregnancy and birthing process. (Ruben, 2017).

In addition to these suggested interventions, the current birthing culture could benefit from including methods and specifically embodied practices of Expressive Art Therapy and Dance/Movement Therapy.

**Expressive Art Therapy**

Expressive Art Therapy (EXAT) is an integrative and participatory approach to therapy that combines the innate desire to create with healing. Expressive art therapists may use a person-centered combination of music, art, dance, drama, poetry and play as a therapeutic tool to initiate change within treatment. EXAT was founded by Shaun McNiff, Paolo Knill and others at Lesley University in the early 1970's (though mark-making is an ancient practice that has been used in rituals and medicine all around the world). (Kossak, 2015). The approach was impacted by Carl Roger's Person-centered Theory and Natalie Roger's *Creative Connection*, which– interweaves movement, sound, drawing, painting, writing, and guided imagery -- to tap into creativity. (Rogers, 1993). The goal focuses on freedom and safety – "to reclaim ourselves and then help others reclaim themselves as actively playful, spirited, and conscious individuals." (Rogers, 1993).

Expressive Art Therapy is used with children and adults in individual and group settings. The use of modalities in therapy are carefully considered by the therapist. The accessibility of the expressive arts does not require artistic talent, as the focus is instead on the creative process – using multiple senses and imagination to nurture a meaningful connection within ourselves and the outside world. EXAT can be used with a variety of behavioral, emotional, and mental health

conditions including ADHD, Intellectual and/or Developmental disabilities, Eating disorders, Anxiety, PTSD, Depression, Chronic Medical Illnesses, Brain injuries and Trauma.

The goal is to create self-awareness, enhance relationships by creating trust and safety, and encourage emotional growth. Art comes from an intuitive place, providing us with access to a deep understanding of ourselves and a road to self-discovery and acceptance. Accessing an intuitive place is an embodied practice.

**Dance/Movement Therapy**

Dance/Movement Therapy (DMT) is built upon psychodynamic theories and the idea that one's overall health is based on a harmonious and intertwining relationship between mind, body, and spirit. The American Dance Therapy Association (ADTA) defines DMT as the psychotherapeutic use of movement to promote emotional, social cognitive and physical integration of the individual. (American Dance Therapy Association, n.d.).

DMT is focused on movement behavior as it emerges within the therapeutic relationship. Physical movement acts as a pillar of dance and all other expressive modalities; providing the ability to assess for diagnosis and treatment while allowing an opportunity for the individual to feel safe and at home within their bodies.

According to Mettler, "the language of movement cannot be translated into words. It must be sensed in the muscles. We have a muscle sense, technically called the kinesthetic sense. It consists of nerve endings in the muscles and joints which send messages to the brain telling us exactly how we are moving". (1985). Everything is always in movement, even when still. Our

body conversations and the information that we receive and transmit to each other is how one learns of the other and in turn leads to a better understanding of ourselves and the other.

Dance/movement Therapy is practiced in mental health treatment, rehabilitation, medical, educational and forensic settings, in nursing homes, day care centers, disease prevention, health promotion practices, and private practice. DMT is effective for a wide range of diagnosis including but not limited to; developmental, medical, social, physical and psychological issues. DMT can be used with individuals with all ages, races and ethnic backgrounds in individual, couples, family and group settings.

A catalyst of EXAT and DMT is an embodied practice. Methods within these fields could drastically inform current birthing culture. To develop an embodied practice, there must be acknowledgment of a mind-body connection.

**Mind-Body Connection**

Dr. Benson from Harvard Medical School discusses the integration of alternative medicine – mind-body medicine at his mind-body clinic. He describes the mental state when angry as an involuntary response. Heart rate and blood pressure go up automatically when escalated. The mind-body clinic conducted research on the relaxation response as a physiological state; the opposite of fight/flight response. Research proves that the relaxation response can come about with two phases.

Phase one is repeating a word or movement like a mantra. Phase two is letting go of all thoughts as best as possible. The relaxation response has been proven to decrease metabolism, decrease blood pressure, decrease rate of breathing, and produce slower brain waves with

management of stress, utilization of coping skills, healthy eating and exercises. Dr. Benson assures these measurements can cure 60-90% of disorders including depression, anxiety, insomnia, and a wide variety of physiological disorders and issues. Biofeedback is shown to participants of the mind-body clinic and proves that neurobiology is showing us mind and body cannot be separated. (Gallagher, 2007).

Brain imaging studies prove the connection between understanding language and body movement (Pulvermüller, 2013). The lived experience of a mind-body connection now in present times had the validation and support from a vast foundation of scientific literature.

This researcher's dance/movement therapy experiences at Lesley University demonstrated that the body is what makes our experience of living possible. Everything people encounter and express is through movement. Embodied, creative, and expressive movement encourages mindful exploration of self in relation to environment, to tap into and process old and new experiences.

Marsden Wagner, M.D., M.S., former director of Women's and Children's Health at World Health organization recognizes Ina May Gaskin as the most important person in maternity care in North America. Gaskin is largely known as the most famous midwife in the world as she resurrected and implemented home birthing back into American society in the 1970's. Ina May Gaskin has a method of birthing that relies on an embodied practice.

> Birth—as experienced by the mother—is the Mount Everest of physical functions in any mammal. Unless we have seen it before, we can barely imagine that something so relatively huge can come out of a place that usually looks so small. And yet, it happens every day" (Gaskin, 2019, p. 163).

Gaskin explains too the downfall of women-led births and the takeover of male physicians prior to the 1960's. Women today in American society do not believe their bodies are capable of withstanding childbirth naturally. However, women's bodies are designed, like all other mammals, to provide as vehicles for their unborn kin to enter this world. Gaskin further explains if relaxation and mindfulness practices are included in the birthing process, mentally we can withstand what physically is happening to our bodies. Many women acknowledge that birth is painful, yet less are aware that many birthing women have pain-less births in almost all other cultures (Gaskin, 2019).

Gaskin expands awareness of the great variances of possibilities within birth. Circumstances and attitudes effect birth outcomes. Fear is one of the many factors that impact pain in birth. Other factors include whether the birthing mother is healthy and able to move around on her feet opposed to being mandated to lay down. Gaskin believes that the pain of normal labor has meaning. She refers to contractions, as rushes, like rushes of energy. It is helpful in childbirth pain to imagine these rushes as energy that moves through the body and aids the mother in the opening up of her uterus so baby can be born. When avoidance and fear of pain (which is what we largely see today in mainstream medical care), the paradoxical effect is that more women must deal with pain after their babies are born.

The woman who gives birth without interventions is more apt to experience less pain after baby is born. Oxytocin, the love hormone, is released in the mother's brain as baby is crowning (when the head can be seen in delivery). If pain was present seconds earlier, it is decreased almost instantly because of this hormonal change. Also, after this, a woman has developed powerful relaxation methods, practiced during the most intense and memorable

moment of her life. She has learned that breathing slowly and deeply can change her body's physiological state and help her gain control of her physiological functions, and thoughts. She has experienced a mixture of extreme vulnerability and power, proving that her body is strong and capable and that deserves the utmost respect (Gaskin, 2019).

I believe this perspective can be executed by practicing Mitchell Kossak's theory of Embodiment. As such, it became evident to me that embodiment was missing from our current birthing culture.

**Embodiment**

Kossak (2009) identifies a theory of embodiment is practiced in Expressive Art Therapy. "The term "embodied" or "embodiment" refers to a body-centered intelligence that informs how one knows and experiences the world" (Kossak, 2009). Embodiment can be awareness of the breath, movement impulses, sensation, and associative emotions. A pioneer of Dance/Movement Therapy, Mary Whitehouse explains, "the kinesthetic sense or the sensation which accompanies or informs us of bodily movement which is developed in athletes, dancers, and actors if never developed or seldom used becomes unconscious and leads to distortions and a cutting off from instinctual functionality" (Kossak, 2009).

"All of the arts by nature affect the body, where meaning-formation is created from the corporeal rather than the cerebral (as opposed to a disembodied approach, which sees artistic meaning making as an analytic structure)" (Kossak, 2009). From a transpersonal perspective music therapist, Emile Jaques- Dalcroze, believed that the body is a vehicle that guides creativity and the impulse to express itself "It is a doorway from the physical realm into the imagination and spirit" (Kossak, 2009).

Carrying and bringing new life into this waking world is a heavy feat. Mothers experience emotional and physical variances unlike any other time in their life. It is a time when being embodied is crucial practice for remaining grounded and conscious through pregnancy, birth and parenthood. Everything we encounter and express is held in our bodies. As such, embodiment is missing from our current birthing culture.

**Embodied Childbirth**

Joy Ruben (2017), an inner faith minister, doula, yogi and Dance/movement therapist supports the thought that our current birthing culture in the United States is lacking embodiment practices. After reviewing current literature related to embodiment and current practices and treatment of childbirth, she concurs that transforming our birthing culture by realizing that medical procedures, which have become a normal part of birthing, are not always best practice.

Recognition and appreciation of the body and its wisdom was slowly phased out as modern religion and science came to power (as mentioned in Childbirth History). The impact of this is still felt today in our violent and disembodied culture of childbirth. Women's wisdom is resisted by modern medical practices, and the natural process of birth is mostly treated as a medical emergency. This shift away from embodied wisdom has shamed women for embracing their bodies and created unnecessary risk in childbirth. In the United States of America, the maternal mortality rate is on the rise, which is unusual for specifically first world countries. “Embodied wisdom is needed to return sanctity to childbirth” (Ruben, 2017). One way of proactively addressing the issues of current birthing culture is to promote and normalize embodiment for birthing mothers.

Davis and Walker (2008) offer an exploration of theories of embodiment. They conclude through a review of literature relating to embodiment within midwifery practices. The complex fluidity of women's experiences of pregnancy, their body and birth liberate women from the limitations imposed by Western philosophical traditions that have been inherited in Western birthing culture.

Akrich and Pasveer (2004) introduce the idea that alienation, not embodiment (or disembodiment) negatively impacts birth. In their research, some women dissociated from their physical experience of pain, either through different pain management techniques like psychological management or an epidural. This apparent disembodiment (disassociation) was reported as positive while the experience of alienation was not. Alienation occurred when women felt that their body was frozen within the birthing process. They reported feeling unable to move and unable to feel anything. In one case the pain of home birth was all-consuming and in another because the epidural numbed the woman's physical experience completely. The lived experience of childbirth is unique to each woman. "Agency, rather like the layered concept of control in childbirth (Green 1999), can mean embracing embodiment's physicality which paradoxically can be a letting go/giving in to the body's primal power (Anderson 2000) or dissociating (disembodiment) as a way of coping with labour pain" (Walsh, 2010). Both reports are subjective, but alienation proves to be constant and undeniable. Alienation takes over until the birthing mother can ground herself again with an embodied practice.

Perhaps alienation is a pillar of birth trauma stories. During these times, achieving embodiment may be dependent on an interpersonal connection with a childbirth provider or companion. Hence, the emphasis of being connected is in so much of the phenomenological

research of childbirth experience (Thomson et al., 2007). This simply encompasses ongoing communication, kindness, empathy, acceptance, and additional clinical skills if necessary. (Walsh, 2010).

This researcher developed a method integrating elements of Expressive Art Therapy and Dance/Movement Therapy with perinatal mothers in the form of an eight-week curriculum (see Appendix 1). This was done by collecting and connecting evidence-based research and gathering data by observing and interacting with participants as they engage mindfully in expressive, embodied, and movement-oriented techniques.

The intent is to provide an accessible approach that informs maternal mental health to build community, develop empathy, self-awareness and transformation. Ultimately, these findings and the review of literature information make a case for implementing this method as complimentary treatment, as well as, a path to promote empathy and understanding toward new mothers. Literature review information regarding cultural characteristics were considered, along with current and past treatments, and the history of childbirth in the United States of America. Developing and utilizing this method, using EXAT and DMT techniques, gave this researcher the opportunity to include and implement the knowledge gained while attending Lesley University to explore and document observations of cultural appropriateness, initial reactions to treatment, and acceptance of this method.

The goal in creating this method was to provide evidence, create resources, and demonstrate the effectiveness of EXAT and DMT as a process to promote community, self-expression, empathy, embodied awareness, and healthy coping skills so that embodied childbirth seems obtainable and do-able. This review of literature and method development can be utilized

within the perinatal period to promote a better understanding of maternal mental health including childbirth education and history, theories of embodiment, attunement and mindfulness techniques to further develop self-awareness and a deeper sense of identity and self for the birthing mother.

## Method

An eight-week curriculum developed by this researcher was implemented with a group of women in the Spring of 2018. At the time this researcher was conducting individual and group sessions using Expressive Art Therapy and Dance/Movement Therapy techniques at a community action program in Maine. The group was offered to mothers within various phases of the perinatal period either pregnant or within the first year after the birth. Outreach was conducted by advertising with a flyer and on social media. The guidelines for eligibility asked that each participant that signed up was either pregnant or had an infant under one year of age. The goal was to decrease anxiety, increase a mind-body connection and develop a deeper sense of identity and self by means of psychoeducation, expressive art exploration, and connection.

To plan this eight-week course this researcher brainstormed themes and explored how to best implement group practices to develop safety, connection and growth. In preparation, this researcher used Renee Emunah's (1994) Five Phase Model, a developed method within Drama Therapy. The Five Phase Model provides interdependence; creating a sense of belonging for participants involved. It allows therapists to move at the group's pace and recognize when the group is ready to move on to the next phase.

The weeks scaffold on top of each other to present psychoeducation and interventions to the participant(s) at a timely and appropriate manner. Each session begins with a ritual of

meditating for five minutes, a warm-up, an activity or intervention, a wrap-up (to process and reflect), and a ritual to end. See appendix 1 for a thorough outline of this eight-week curriculum. What follows is a breakdown of the first and final treatment sessions to highlight growth and transformation throughout the eight weeks.

**Week 1:**

The first session began by creating a welcoming space for the group in an empty classroom at the Community Action program. It was a large room with no furniture except for a round table with eight seats around it, a water fountain and a closet with basic art supplies. There were two standing lamps in each corner that created warm, yellow lighting. Three participants walked in within ten minutes of each other. Coincidentally they were each under thirty years old, all lived within the same county, and all presented as Caucasian. Two were in various stages on pregnancies with viewable pregnant bellies. The third participant had a six-month-old baby at home. Each participant signed a sign in sheet upon entering and were invited to sit down in chairs placed in a circle with space in the middle. To begin each participant was asked to say their name and a fact about themselves. They each did this eagerly with contemplation on what was the best fact to share about themselves.

The participants were asked to establish safety guidelines, expectations and rules as part of 'Housekeeping'. The group named qualities that created a safe and brave space for example: acceptance, confidentiality, ability to say "no" or "pass", dignity, healthy and positive communication, etc. The participants were able to verbalize what qualities were needed for them to feel safe. The intention was to establish mutual expectations for the group and lay out ground rules.

Mind-body connection and embodiment (Kossak, 2015) was introduced by defining and giving examples. A body scan was verbally facilitated while also guiding physically with my body. Participants had the option to lay down or close their eyes if they wish. A body scan brings presence and awareness to each part of the body. Starting at the toes and feeling each part of the body slowly all the way up to the crown of the head. The goal was to introduce a felt sense of embodiment and begin to develop a mind-body connection.

With hesitation and resistance, the participants were urged to quiet their inner critic. Often when in meditation a critical voice is heard also known as negative self-talk. The participants were offered to think of themselves as a dear friend, with acceptance and love. With any mindfulness work their must be self-forgiveness of allowing the mind to wander with the intention of re-focusing again. Helpful tips are thinking of thoughts like bubbles popping once they are thought of or imagining thoughts to be slippery liquid that drip out of the mind and off the body.

Participants were then asked to slowly open their eyes (if closed) and re-orient their attention back to the room. To wrap up they were given an option to sketch, move, or write for fifteen minutes. (Materials offered: markers, writing utensils, paper). After about twenty minutes (adjusted to fit the needs of participants) they were invited to share about their process and reflections. Each participant shared their experience willingly describing their collective resistance in the beginning and what shifted for them mid-exploration. Still sitting in the circle, the group was instructed to take three deep breaths at the same time to say goodbye. The participants were invited back for the same time, same place the following week. Space and time were also offered for any questions about birth or the phase of development in pregnancy or childhood that they had.

**Week 8:**

Five Minute Meditation ritual was conducted like each prior weekly session before. Participants were then invited to sit or stand in a circle. This researcher acknowledged this was the groups last time together. This researcher expressed how honored she was to witness them and spend time with them in this vulnerable and precious time in their lives.

For the warm-up circle, two check-in options were offered, combining two methods the group had partaken in previously.

Option 1

Take the elevator down and share:

1: What is the weather like? (This can be literal or symbolic.)

2: What is happening at a surface level?

3: What is happening at a deeper level?

OR

Option 2

Check in - High/Lows: Participants seated and going around in a circle shared a high (positive note) or a low (challenging note).

The intervention of the last session is an opportunity to move together – an authentic movement session. This researcher guided participants to close their eyes (if they wish) and move intuitively for 20 minutes as Native American flutes as background music. However, typically authentic movement is conducted to no music. Each participant moved with grace and with a quality of self-assurance that had not yet been witnessed. This researcher moved with

participants as they boldly and bravely moved their bodies about the room. One participant laid down and the other two participants, as well as this researcher lied next to her. As the twenty minutes came to an end, participants naturally ended up back in the circle.

To wrap up I offered participants to reflect on their time together. Participants shared getting to know each other and feeling vulnerable with one another created meaning and felt empowering. As a last activity I invited participants to imagine there is a symbolic fire in the middle of our circle. I moved my body accordingly using my arms to build the fire and wave air into it to make the flames grow. I said aloud "strength", offering one quality to the group I wished to give them as a gift. I asked the participants to follow my lead and we danced around our fire for a few moments. After we stomped on it and pretended to blow the ashes into the wind.

To end we took three breaths together and said thank to each other. The participants chose to share contact information to keep in touch and I provided them with flyers to perinatal resources in the area – like a local maternal health support group, Women, Infant and Children Nutrition services(WIC), and a home visiting service that provides educational and participatory home visits to prenatal and postnatal women in the community, much like a travelling public health nurse.

**Findings**

Over the course of the eight weeks, observations were collected through journaling, taking notes and movement observation, as well as self-reflection through artmaking. These methods of reflection were chosen because it provided an opportunity to process in various ways. Thus, it provided a broader understanding of what happened, what was observed and noticed, and how the researcher felt over all about implementing the curriculum. Using Emunah's Five

Phase Model (2009), allowed me to implement the structure of sessions I was hoping for but also enabled me to attune to the needs of the participants as I witnessed their process.

The results were compiled from personal self-reflections based on what was reported from the group and what was observed. A journal was kept and at the end of each class, served as a place to capture my thoughts and observations. I would conduct my own authentic movement sessions to process what happened in session.

**Discussion**

Developing and carrying out this curriculum created a shift in perception of self and others, along with a greater understanding of the use of the body, mind-body connection and embodiment. There is a need for an integration of childbirth embodiment practices, offered alongside compassionate, relationship-focused maternity care, particularly when perinatal emotional issues arise. (Hunter, 20016). Arts-based-inquiry allowed me to consider objectively and subjectively the participants' experience, providing insight for steps moving forward in normalizing embodied practice as part of maternal mental health.

Participants reported feeling empowered by their newly developing embodied practice and because of being connected to one another. This directly relates to my findings of birthing mothers needing to feel connected interpersonally by a sense of safety and belonging, in most of the phenomenological research of childbirth experience. (Walsh, 2010). This experience shed light on the vast possibilities for embodied practices and methods of EXAT and DMT to reduce stress, isolation, physical/psychological discomfort while also developing self-awareness, empathy, healthy coping skills, social engagement (connection), and creativity- all constructs

beneficial to mothers within the perinatal period that may or may not struggle with perinatal emotional issues and/or carry a diagnosis.

Further thoughts would be for this thesis to encourage state and county representatives and providers within the medical field to recognize and utilize EXAT and DMT methods as an evidence-based treatment for women within the perinatal period, developing common sense policies to offer options in safe and complimentary therapy methods.

**Conclusion**

An eight-week curriculum developed by this researcher was implemented with a group of women in the Spring of 2018. The goal in creating an eight week curriculum as a method was to provide evidence, create resources, and demonstrate the effectiveness of Expressive Art Therapy and Dance Movement Therapy as a process to promote community, self-expression, empathy, embodied awareness, and healthy coping skills so that embodied childbirth seems obtainable and do-able.

The shift away from embodied wisdom has moved women away from embracing their bodies and created risk in childbirth. In the United States of America, the maternal mortality rate is on the rise, which is unusual for developed countries. One way of providing preventative care and proactively addressing the issues of current birthing culture is to promote and normalize embodiment for birthing mothers.

This review of literature and development of a method can be utilized within the perinatal period to promote a better understanding of maternal mental health including childbirth

education and history, theories of embodiment, attunement and mindfulness techniques to further develop self-awareness and a deeper sense of identity and self for the birthing mother.

Embodiment is missing from our current birthing culture and implementing a method to incorporate embodiment practices, as well as partaking in standard medical care with access to screening for perinatal emotional issues, could greatly impact maternal mental health.

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# APPENDIX 1

**Week 1/Session 1:**

Ritual to Begin: Five Minute Mediation

Warm-up: Introduction

Sitting in a circle (preferably in chairs) each participant offers their name and a fact about themselves. The facilitator goes first as example and offers the introduction to go left or right to a willing participant.

Activity:

Establish safety, expectations and rules. Name qualities that aid in creating safe and brave space for example: acceptance, confidentiality, ability to say "no" or "pass", dignity, healthy and positive communication, etc. Ask participants to verbalize what qualities are needed for them to feel safe and then brave to share and connect. The goal is to establish mutual expectations for the group and lay out ground rules.

Intervention:

Introduce mind-body connection and Embodiment (Kossak, 2015) by defining and giving examples. Facilitate a body scan verbally while also guiding physically. Suggest getting comfortable. Participants can lay down or close their eyes if they wish. Bodies are rooted into the floor offering an essence of being grounded. A body scan brings presence and awareness to each part of the body. Starting at the toes and feeling each part of the body slowly all the way up to the

crown of the head, the participant becomes aware and physically conscious. The goal is to develop a mind-body connection.

Wrap-up:

Offer for participants to take a moment to reflect on the process and re-orient themselves back into being with others. Suggest sketching, moving or writing for fifteen minutes. (Offer materials: markers, writing utensils, paper). After allotted time come to circle and invite participants to share.

Ritual to End:

Take three breaths together, say goodbye.

**Week 2/Session2:**

Ritual to Begin: Five Minute Meditation

Warm-up: Check in - High/Lows: Participants seated and going around in a circle share a high (positive note) or a low (challenging note).

Intervention: Mind/Body Exploration with movement. Introduce Dance/Movement Therapy technique, Authentic Movement. Connect embodiment and authentic movement. Listening to the body to become embodied to authentically move. Offer twenty minutes of simultaneous Authentic Movement with no music however voice is welcome. Movement is sometimes stillness. Everything is always in movement even in stillness.

Wrap-up:

Offer for participants to take a moment to reflect on the process and re-orient themselves back into being with others. Suggest sketching, moving or writing for fifteen minutes. (Offer materials: markers, writing utensils, paper). After allotted time come to circle and invite participants to share.

Ritual to End:

Take three breaths together, say goodbye.

**Week 3/Session 3:**

Ritual to Begin: Five Minute Meditation

Warm-up: Check in – Take the elevator down and share:

1: What is the weather like? (This can be literal or symbolic.)

2: What is happening at a surface level?

3: What is happening at a deeper level?

Intervention: Mind/Body Exploration with movement and connection. Mirroring another's movement embodies empathy and develops connection. Participants can partner with another participant, with facilitator, or with their baby in utero. Partners mirror the other's movements. With baby in utero, mother can place hands on belly and 'play tag' or mimic movement back if there is any movement. This can take some practice. Invite prenatal mothers to move and play at home. Mirroring movements prenatally and mimicking facial expressions after baby is born develops mirror neurons, creating secure attachment.

Wrap-up:

Offer for participants to take a moment to reflect. Suggest sketching, moving or writing for fifteen minutes. (Offer materials: markers, writing utensils, paper). After allotted time come to circle and invite participants to share.

Ritual to End:

Take three breaths together, say goodbye.

**Week4/Session 4:**

Ritual: Five Minute Meditation

Warm-up: Check in – Seated or standing in a circle, taking turns, each participant offers one word that symbolizes their experience or mood at this time.

Intervention: Expressive Art Therapy technique to develop self-esteem and a healthy self-image through self-acceptance and forgiveness. Educate participants on the idea of the inner critic. Define this with the group and provide examples. Invite participant to quiet their inner critic by means of meditation while being still or moving. Offer suggestions like imagining black frames of thought or envision each thought to be a bubble that floats away and pops. Each thought must be forgiven. Each participant must be gentle with themselves. Facilitator offers that participant imagines themselves as a friend to encourage acceptance, forgiveness and self-love.

Wrap-up:

Offer for participants to take a moment to reflect on quieting the inner critic. Suggest sketching an image or symbol that represents a quiet inner critic. Allow enough time for participants to finish

image. (Offer materials: markers, writing utensils, paper). After allotted time come to circle and invite participants to share.

Ritual to End:

Take three breaths together, say goodbye.

**Week 5/Session 5**

Ritual: Five Minute Meditation

Warm-up: Check in – Seated or standing in a circle, taking turns, each participant offers one movement that symbolizes their experience or mood at this time.

Intervention: Expressive Art Therapy technique to develop self-esteem and a healthy self-image through self-acceptance and forgiveness. Facilitate ten-minute guided meditation. Researcher used script of the Warrior from Laury Rappaport's *Focusing and Orienting within Expressive Art Therapy.* The Warrior is an internal character that represents our whole self in infinite being. The goal is to create space for self-forgiveness that is necessary to accept and be gentle with oneself while also identifying one's strength and resiliency. (Rappaport, 2009).

Wrap-up:

Offer for participants to take a moment to reflect on the Warrior. Suggest sketching an image or symbol that represents this or their process during this session. Allow enough time for participants to finish image. (Offer materials: markers, writing utensils, paper). After allotted time come to circle and invite participants to share.

Ritual to End:

Take three breaths together, say goodbye.

**Week 6/Session 6**

Ritual: Five Minute Meditation

Warm-up: Check in – Seated or standing in a circle, taking turns, each participant offers a sound that symbolizes their experience or mood at this time. Sound can be using their hands as percussion instruments or their voice.

Intervention: Discuss ambiguity – being okay with the unknown. Ask the group to brainstorm a list of expectations they have or had for their birth and/or for their baby. Compare expectations to reality. Ask the group so far what expectations they have had that did not follow through as planned. How did they cope with the let down of not having the expectations be met? Perhaps ambiguous feelings come up about not being a good enough parent. Explore what the idea of the good enough parent means. Offer drawing materials and paper. Instruct participants to create an abstract self portrait of themselves as the good enough parent for a realistic baby. Allow enough time for participants to finish image; no more than thirty minutes.

Wrap-up:

Offer for participants to reflect on their process. After allotted time come to circle and invite participants to share any revelations or thoughts that came to mind or feelings that arose in their bodies while creating their images. Offer feedback about how to further manage ambiguous feelings through utilizing coping skills.

Ritual to End:

Take three breaths together, say goodbye.

**Week 7/Session 7**

Ritual: Five Minute Meditation

Warm-up: Check in – Seated or standing in a circle, taking turns, each participant offers one word, movement, sound (or all) that symbolizes their experience or mood at this time.

Intervention: Parenting is not done in isolation. Support systems are made up of community, friend and family supports. Some of these supports are natural, some on them are found, like resources in the community that new parents can rely on. Brainstorm some of these supports with participants. Instruct them to create a social atom of these supports with themselves in the middle. Offer materials like paper, old magazine clippings, glue and scissors to create the atom. The social atom looks like a web – the participant places themselves in the middle, next is close family and friends they can rely on, then community supports like school, church, a social club, medical and mental health providers, then larger supports that are less available and not tangible (like online support groups). Offer resources and referrals if needed to fit the participants' needs.

Wrap-up:

Offer for participants to reflect on their social atoms. After allotted time come to circle and invite participants to share any revelations or thoughts that came to mind or feelings that arose in their bodies while creating their images. Offer time to reflect on process.

Ritual to End:

Take three breaths together, say goodbye.

**Week 8/Session 8**

Ritual: Five Minute Meditation

Warm-up: Offer two check in options:

1. Check in - Take the elevator down and share:

    1: What is the weather like? (This can be literal or symbolic.)

    2: What is happening at a surface level?

    3: What is happening at a deeper level?

OR

2. Check in - High/Lows: Participants seated and going around in a circle share a high (positive note) or a low (challenging note).

Intervention: As this is the last time to meet offer one more opportunity to move together – an authentic movement session. Guide participants to close their eyes (if they wish) and move intuitively for 20 minutes. This may look like someone laying down still. Remember even in stillness we are always in movement. Offer themes of self-love and empowerment. Bodies are strong and capable.

Wrap-up:

Offer for participants to reflect on their time during these last 8 weeks. What has been helpful? What has been challenging? Offer time to ask questions and share thoughts. Brainstorm ways to

stay connected. As a last wrap-up activity invite all to a standing circle. Imagine there is a symbolic fire in the middle on the circle. Move body accordingly using the arms to build the fire and wave air into it to make it grow. Say aloud one thing to the group you wish to give them as a gift. Ask the participants to follow lead.

Ritual to End:

Take three breaths together, say goodbye and thank you.