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Virtual Dance/Movement Therapy as a Mechanism of Change for Patients Experiencing Chronic Pain: A Literature Review

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Abstract

The purpose of this literature review is to discuss data on the prevalence of chronic pain, current treatment options, and the effectiveness of dance/movement therapy (D/MT) as a successful treatment approach. This literature review discusses the etiology of chronic pain, numerous treatment paradigms, an alternative model of care based on D/MT principles, and new considerations for facilitating D/MT groups. According to the literature, clients who participated in D/MT groups for chronic pain experienced an expansion of their movement vocabulary, a decrease in their movement-based fear response, a feeling of being seen, heard, and validated, a sense of control over their bodies, and an increase in identifying sensations in the body. This was achieved using a D/MT group structure including an opening, warm-up, theme development, discussion, and closing. Additionally, this review of the literature analyzes the consequences of facilitating virtual D/MT groups as well as addition considerations when approaching this population, such as practicing self-compassion, assigning homework, offering opportunities for shared leadership and seeking permission. Future study is needed to identify the effects of D/MT on chronic pain populations, particularly how to achieve long-term change and favorable outcomes after the group has ended.

Keywords: dance/movement therapy, chronic pain management, mind/body pain

Author Identity Statement: I have a history of chronic low-back pain which inspired me to research the effects of dance/movement therapy on the chronic pain population.

Dance/Movement Therapy as a Mechanism of Change for Patients Experiencing Chronic Pain: A Literature Review

Introduction

In 2019, the World Health Organization reclassified the definition of chronic pain as "pain in one or more anatomical regions that persists or recurs for longer than 3 months" (Majore-Dusele et al., 2012, p.1). Recent research suggests that 20% of people in the U.S. are affected by chronic pain (Ashar et al., 2022); making chronic pain a global health crisis. According to authors Gaskin and Richard (2012), the total cost of chronic pain each year in the United States is more than $600 billion. The annual expenses of pain as a result of lost productivity, as well as the annual healthcare costs connected with pain, define these costs (Gaskin and Richards, 2012). Persons affected by chronic pain experience side effects far beyond the physical, including disturbances to sleep, social isolation, relational disturbances, low self-esteem, depression, anxiety, suicide, financial strain, tremendous loss, and many other overwhelming feelings, including guilt, shame, and anger (Minjung, 2019).

Given both the emotional and psychological effects as well as the societal and financial burdens, finding an effective method for treating patients with chronic pain has been recognized by the Centers for Disease Control and Prevention as a national priority (Minjung, 2019). Currently, the most prescribed treatment for chronic pain is pain management, including the administration of opioid analgesics. However, these treatment options are accompanied by a range of adverse side effects, including overdose, abuse, and death (Minjung, 2019). Due to the risks of these common treatments, paired with the realization that those with chronic pain experience some of the poorest quality of life than individuals with any other disease, the need to find an effective and holistic treatment method is imperative (Minjung, 2019). The solution is not

reducing the availability of opioids, nor is it using opioids for short- term relief. The solution must come from an entirely new approach, one that incorporates the body.

Chronic pain can be experienced in many different forms. For some, it is a result of an injury, for others, such as those suffering from medically unexplained symptoms, the cause is less clear (Payne, 2020). In the following literature review, there are several definitions of the various types of chronic pain one experiences when the cause of the pain is not clear. The literature review section will also cover the current treatment model, an alternative treatment model, and the various attachment styles that can contribute to experiences of chronic pain. Lastly, the literature review will provide the reader with information regarding the benefits of using dance/movement therapy (D/MT) with this population as well as a current D/MT model for group work. This section will provide the reader with necessary background information to better understand the implications of this work on the chronic pain population and additional considerations described in the discussion section.

Literature Review

Manifestations of Pain

There are times when a patient's pain has a clear structural explanation, such as an injury, and other times when it has no clear medical cause. The following section will discuss several potential causes for the onset of a chronic pain condition, including variations of mind/body pain as well as emotional considerations.

Mind/Body Pain

There are times when a patient's chronic pain has no clear medical cause, including fibromyalgia, back pain, headaches, stomach pain, and neck pain (Schubiner, 2021). When this

occurs, medical professionals label this as mind/body pain (Gordon, 2021), or medically unexplained symptoms (Payne, 2018). According to Schubiner (2021), mind/body pain happens when neural circuits in the brain create pain in the absence of physical injury, like phantom limb pain. Back pain is the most prevalent type of chronic pain, and in around 85% of instances, no specific cause can be found; instead, central nervous system activities are assumed to play a role in the pain (Ashar et al., 2022). Mind/body pain specialists have determined that perceived emotional threat and physical injury are processed in the same central mechanism that causes physical pain. When the neural circuits become more activated, pain tends to increase over time or can spread to new areas of the body (Schubiner, 2021).

Medically Unexplained Symptoms

Medically unexplained symptoms (MUS) can be described as "chronic bodily complaints for which examinations do not show explanatory structural or other specified pathology" (Payne & Brooks, 2020, p. 2). Payne (2018) reveals that 75% of the 10 most presented symptoms at the general practitioner in London are medically unexplained symptoms, including chest pain, numbness, dizziness, insomnia, back pain, headaches, and abdominal pain (Payne, 2018). Patients with MUS are reported to have higher levels of depression, anxiety, and social isolation, adverse childhood experiences, and a lower quality of life (Payne, 2019).

Tension Myositis Syndrome

Tension myositis syndrome (TMS) is a term coined by Dr. John Sarno (Sarno, 1991). Sarno discovered in his patients that the areas of physical complaint often moved around to different parts in the body and disagreed with the limited western explanation for structural abnormalities and the way they presented in the human body. Sarno began to ask patients how

they were feeling emotionally and discovered that many had feelings of anger and rage; they felt these emotions were not appropriate to express socially, and this repressed rage presented in the body as pain (Sachs, 2021). Based on this discovery, Sarno proposed that most chronic pain patients experienced a psychosomatic disorder, "in which emotional phenomena bring about real, not factitious, physical symptoms with suffering" (Raschbaum & Sarno, 2003, p. 77). Sarno (2003) later suggested that TMS be referred to as "the mind-body syndrome" (Raschbaum & Sarno, 2003, p. 77), which includes several psychophysiological conditions.

Attachment and Pain

Attachment theory, formulated by John Bowlby (Bowlby, 1969), is formed during a crucial period occurring between six and 24 months (Payne & Brooks, 2019). During this critical period in which the social connection between child and caregiver is formed, the stage is set for future relationships. Bowlby (1969) states that connection and healthy attachment to caregivers is required in order to be able to feel a connection with oneself (Bowlby, 1969). Dance/movement therapist Suzi Tortora (2017) further explains that we need relationships with others to feel good about ourselves and to engage in the world around us.

Tortora (2017) believes there is often a connection between a patient's pain and certain adverse experiences from one's early life. Inadequate or difficult attachment between a baby and caretaker in early life stages can create problems in the way the individual connects with themselves and their body. Therefore, Tortora (2017) attributes certain somatic syndromes with unmet needs of closeness between self and others which can present as both a longing to connect accompanied with a sense of fear. Related to disorganized attachment, this longing to connect paired with a fear of rejection creates a sense of the body imploding on itself. Patients are often

afraid to express feelings, so they hold them in, which creates tension and the experience of chronic pain (Tortora, 2017).

According to Payne & Brooks (2019) attachment styles appear in adults when a person experiences a perceived threat, either real or imagined, to their wellbeing, safety, or survival. Under this threat, attachment behavior is activated in order to soothe or receive comfort from an attachment figure. When adults with healthy attachment are faced with a threat, oftentimes they can implement self-soothing and self-regulation behaviors for comfort (Payne & Brooks, 2019). However, for individuals with chronic pain, insecure attachment is common, (Adshead & Guthrie, 2015 as cited in Payne & Brooks, 2019) which can lead to bodily symptoms that may be felt as a threat to safety, survival, and wellbeing (Payne & Brooks, 2019). A study in 2002 found that only 34% of women in a health maintenance organization had secure attachment, with 22% exhibiting pre-occupied, 21% fearful, and 23% dismissive insecure attachment styles (Ciechanowski et al., 2002 as cited in Payne & Brooks, 2019).

Another study by Waller et al., (2004) discovered that in 37 patients with ICD-10 somatoform disorder, only 26%, compared with 60% of the healthy matched control group, were assessed as securely attached. Insecure attachment can create stress, which is linked to chronic pain (Sarno, 2003), and can also relate to a patient's relationships with healthcare providers. Certain insecure attachment styles lead patients to assume their healthcare professionals are unprepared to help them manage their pain, mimicking their first attachment relationship with their caregiver, who was unable to meet their requirements (Payne & Brooks, 2019).

Stress and Pain

Sarno (2003) believed that many patients with chronic pain experienced minor trauma in their lives (Raschbaum & Sarno, 2003). Sarno references several studies to support this claim, including a 1998 study in which patients with chronic low back pain demonstrated that symptoms can be worsened by stressful life events (Lampe, Sollner, & Krismer, 1998 as cited in Raschbaum & Sarno, 2003). Sarno also mentions a 2001 study in which over 5,700 patients in their twenties who were stressed were 2.5 times more likely to have lower back pain in their 30s than those who were not stressed (Power et al., 2001 as cited in Raschbaum & Sarno, 2003). Additionally, Sarno cites a 2001 study that states unsatisfactory work experiences, lower job satisfaction, stress, and high demands at work were more likely to contribute to employee's future back problems (Linton, 2001 & Raschbaum & Sarno, 2003).

Repressed Emotions and Pain

Sarno (2003) believed that mind-body syndrome is not caused from a "conversion of psychic into somatic symptoms" (Raschbaum & Sarno, 2003, p. 77), but from the "psychosomatic avoidance of physical conflict" (Raschbaum & Sarno, 2003, p. 77). Sarno thought the purpose of the pain was to distract patients from emotions that could be viewed as threatening, such as rage, which often arise from a patient's perfectionistic tendencies or external pressures (workplace, family life, developmental experiences, or financial problems). When the mind detects that the patient may not be able to repress emotions, that is when physical symptoms appear (Raschbaum & Sarno, 2003).

Emotional Dimension of Chronic Pain

In addition to stress and repressed emotions, numerous other emotional-affective states are experienced by the chronic pain population. These include feeling isolated, fear of movement (kinesiophobia), over-identifying with pain, and pain catastrophizing. Additionally, chronic pain can lead to feelings of anxiety, depression, and shame, and can contribute to relational strain and feeling misunderstood (Barnes et al., 2021; Minjung, 2019). When clinicians comment on the real versus imagined, or mind versus body symptoms, patients often feel their experience is delegitimized (Tarr et al., 2018). Aside from emotional and psychological distress, patients can experience such intense physical pain that it can be difficult to put into words. As a result, it can be challenging not to blame the body for being weak, fragile, or "wrong"; a condition known as somatophobia (Caldwell, 2018).

The Current Approach to Chronic Pain Treatment

In the last decade, MRI's, the use of opioids, and surgeries have dramatically increased, yet over the past 30 years the number of patients suffering from back pain has doubled (Schubiner, 2021). In 2017, the CDC reported over 56 million Americans were prescribed some form of opioid painkiller, with each patient receiving on average 3.4 prescriptions (Gordon, 2021). These drugs offer a form of short-term relief, but if used long-term, can lead to addiction and harmful side effects. Overdose from opioid use is now the leading cause of accidental death in the United States and is so common that the average American's life expectancy has decreased for the past three years (Gordon, 2021). As a result, the Centers for Disease Control has established new guidelines to reduce the availability of painkiller prescriptions, however this has only led to fear from chronic pain patients that they won't get the pain relief they need (Gordon, 2021).

Another approach to treating chronic pain is to assume that it's both biological and psychological. The medical model typically focuses on either the body or the mind, ignoring the interconnectedness of the two (Payne, 2018). A multidisciplinary approach is typically taken, combining methods such as cognitive behavioral therapy (CBT), or acceptance and commitment therapy (ACT), alongside acupuncture, steroid injections, and physical therapy. The limitations of such an approach are that no specific diagnosis is determined for the cause of the pain, the methods are geared towards coping or living with the pain (CBT and ACT), and emotional processing is not actively encouraged (Payne, 2018).

Raschbaum and Sarno (2003) take a psychoeducational approach to treating chronic pain, including educating patients about the psychological and physiological aspects of pain. In this approach, individuals are encouraged to accept the psychosomatic process, resume physical activity, and discontinue treatments such as physical therapy in order to discourage the reinforcement of a structural abnormality. Additionally, patients are advised to join support groups to continue psychoeducation and to express thoughts and feelings. Raschbaum and Sarno (2003) established that approximately 20% of Sarno's patients required additional short-term psychotherapy to resolve symptoms. From 1983 to 1986, Sarno followed 109 patients with at least one lumbosacral herniated disc. Following Sarno's treatment plan, 88% of patients no longer experienced pain and resumed normal functioning, 10% reported mild improvement in function and symptoms, and 2% reported no improvement (Raschbaum & Sarno, 2003).

Pain reprocessing therapy (PRT) is a chronic pain treatment created by Alan Gordon and the Boulder Back Pain Study team of researchers to alter patients' fear and avoidance beliefs about the causes and threat value of pain (Ashar et al. 2022). In this study 50 patients with back pain ages 21 to 70 years were recruited to participate in twice weekly individual therapy sessions

for four weeks. 66% of patients randomized to PRT were either nearly pain-free or pain-free at the end of the study, compared with 20% of patients in the placebo group. The authors found that PRT shares similarities with existing treatment models, including CBT, mindfulness-based interventions, acceptance and commitment therapy, and the current treatment for panic disorder. PRT is designed to change patients' ideas about the causes of pain by presenting pain as a brain-generated phenomenon that is reversible. Overall, this research suggests that PRT encourages patients to participate in pleasurable daily activities by emphasizing that such activities do not cause injury and by providing patients with guided reappraisal of pain sensations while doing so. Other techniques address difficult emotions and ways to enhance self-compassion (Ashar et al. 2022).

Additionally, PRT reinforces the importance of helping patients lean into positive sensations in the body to retrain their brain and reduce the fear mechanism. Patients in chronic pain are constantly scanning their bodies for threats which turns into hypervigilance (Gordon, 2021). Patients become so caught up in scanning the body for negative sensations that they ultimately cut themselves off from feeling into the positive ones. When one has experienced chronic pain, the body becomes the enemy, and patients learn to not trust the body but to see it as a place of danger (Gordon, 2021). By consciously attempting to connect and lean into positive sensations patients can reinforce messages of safety in order to rebuild that relationship of trust in the body (Gordon, 2021).

Payne (2020) described her method, the BodyMind Approach (TBMA), as working with both the mind and the body simultaneously to help clients manage their own symptoms and restore wellbeing. TBMA helps clients unlock wellbeing by teaching progressive relaxation and movement interventions, by promoting self-compassion and mindfulness, and by teaching clients

how to say “no” to demands or requests that might overwhelm them (Payne, 2020). Researched in both the United Kingdom and abroad, Payne’s (2020) system consists of a facilitated group experience across 12 sessions which focus on offering compassionate support to help people get to know and accept their symptoms (Payne & Brooks, 2019). TBMA integrates body-based practices like dancing together, which causes assumptions about one's body's limitations to be challenged. Additionally, the researchers found that by helping clients become more connected to their bodies, they came to better identify bodily messages of pain and learn to more appropriately respond to these bodily cues. Furthermore, incorporating written reflections helps patients gain insight and connect knowledge with their own and family and cultural knowledge (Payne & Brooks, 2019). Patients who have completed the program report increased wellbeing, overall functioning, increased anxiety levels, and a decrease in symptoms of distress, anxiety, and depression. Overall, 97% of participants report they would recommend TBMA to friends and family without hesitation (Payne, 2018)

In conclusion, four out of five of the aforementioned chronic pain treatments take a patient's mental state into account. The BodyMind Approach is most closely related to D/MT and integrates practices such as dance and movement, mindfulness, self-compassion, and relaxation exercises (Payne, 2018). Pain reprocessing therapy considers a patient's fear and avoidance beliefs and encourages clients to resume their daily functioning (Gordon, 2021). Similarly, Raschbaum and Sarno’s approach discourages the reinforcement of any structural abnormality, offers patients’ psychoeducation, and advises patients to join support groups to express their emotions (Raschbaum & Sarno, 2003). The multidisciplinary approach doesn’t directly address patients' emotions but ultimately encourages patients to treat their pain with CBT or ACT therapies (Payne, 2018). Lastly, the pharmaceutical approach offers a potent form of short-term

relief, yet if used incorrectly, can lead to harmful side effects (Gordon, 2021). In order to promote mind/body healing, self-agency, and healthy expression of emotion, a new approach would need to integrate the body into the treatment, such as dance/movement therapy.

Dance/ Movement Therapy

The American Dance Therapy Association (ADTA) currently defines dance/movement therapy (D/MT) as the "psychotherapeutic use of movement to promote emotional, social, cognitive and physical integration of the individual" (ADTA, 2020). According to dance/movement therapist pioneer Marian Chace (1993), dance/movement therapy is "a purposeful and knowledgeable use of expressive action, as a potent means of direct communication" (Sandel, et. al, 2003, p. 247). D/MT is a body-based psychotherapy practice that helps clients integrate mind, body, and emotion to experience emotional growth. As a bottom-up approach, meaning that change arises from the body, a fundamental assumption in D/MT is that body movement reflects inner emotional states and that by changing movement behavior, changes in the psyche can occur (Caldwell, 2018 & Levy, 2005). Schultz (2021) states that D/MT can be used to treat clients of all ages experiencing neurological, psychological, physical, social, or developmental challenges. Using movement helps clients to process emotions and experiences in a less direct way, and to generate insight and behavioral change in a supportive environment. Dance/movement therapists help clients work towards a connection with the body, which many clients experiencing chronic pain have lost (Schultz, 2021).

Tortora (2017) claimed that dancing, rather than simply moving, is an important component in the treatment of individuals with chronic pain, noting, "We move to function, but we dance to express" (Tortora, 2017). Dance offers clients a chance to express themselves and be seen, which is an integral aspect of recovering from chronic pain (Sarno, 1991; Tortora 2017).

Through dance, self-expression can occur, and personal input can be seen and expressed. “Movement is powerful, dance is revealing”, says Tortora (2017), further explaining that when clients simply move, they are often following others, yet when clients dance, the self plays an important role.

Additionally, D/MT can assist patients in learning new relaxation techniques, improvising movement, and enhancing self-expression and creativity, all of which contribute to increased emotional well-being, self-agency, social connectedness, resilience building, and mental and physical health (Minjung, 2019). Being able to free oneself from the imprisoned state of mind that chronic pain can create is one of the greatest benefits of D/MT for this population. Helping patients regain a sense of control over both their pain and their body has a significant impact on patients' outlook of their lives in general (Minjung, 2019). Dance/movement therapists often use elements of dance such as imagery, metaphor, and qualities of space, time, rhythm, intensity, and effort to help clients experience emotional states, open new avenues for creative expression, to develop a body language of expression, and to explore authentic emotion (Schultz, 2021).

Furthermore, D/MT not only allows opportunities for mindfulness but for escape/diversion work as well, which is equally integral to the healing process. Helping clients temporarily forget about their pain can instill a sense of hope that not every moment needs to be focused on their experience of pain (M. Joubert, personal communication, 2022). By externalizing their pain in a creative way, such as movement metaphors and imagery, clients were able to create a healthy distance from themselves and their pain (Minjung, 2019).

Minjung (2019) implemented a mixed methods clinical study for 20 individuals experiencing chronic musculoskeletal pain. Participants met over 10 weeks for 70-minute D/MT

groups which consisted of a verbal check in, semi-guided movement warm up, theme development, cool-down, journaling, and group discussion. Following the group, members were given follow-up surveys, which revealed that many participants found that movement relieved their discomfort, enhanced their sense of control over their pain, and made them feel more validated. Members also experienced an overall improvement in mood and an ability to manage emotions and were inspired to take a more active role in their healthcare. Minjung (2019) attributed five key mechanisms to these patient outcomes, including increasing self-agency, connecting to self through mind-body integration, connecting to others, enhancing emotional wellbeing, and practicing cognitive reframing.

Emily and Amelia Nagoski (Brown, 2020) explained that in order to effectively resolve the stress cycle, individuals must find a way to incorporate the body. “Wellness is a state of action, not a state of mind”; therefore, cognitively understanding that a stressful event is over is not enough. Nagoski found that physical activity, such as dancing or practicing a tension and release exercise, is the most efficient way to communicate to the body that you’ve completed the stress cycle. Other actions include sleep, crying, laughter, screaming, creative expression, and human connection. This research illustrates the importance of dance/movement therapy in helping chronic pain patients express and resolve their stressful emotions using the body (Brown, 2020).

Virtual Dance/Movement Therapy

Prior to the Covid-19 pandemic, dance/movement therapists had little experience offering individual or group sessions online, according to Garcia-Medrano (2021). Running virtual groups presents a new set of challenges for considerations of safety, privacy, member participation, and movement observation. Due to the limited view of the client’s body,

dance/movement therapists need to focus on visible areas of the body through the screen, such as the shoulders, the subtle details in the gaze, the tone of voice, and the muscles of the face. Because of such limitations, it's important for dance/movement therapists to become even more aware of what's happening in their own "internal body landscape" (Garcia-Medrano, 2021, p. 68) and to their own bodily sensations. Dance/movement therapist's use their bodies as sources of information regarding what's happening in the session and to practice embodied empathy in an online space (Garcia-Medrano, 2021).

Moreover, dance/movement therapists are encouraged to have clients create their own rituals in lieu of the therapist driven entrance and exit rituals that often accompany in person sessions. Clients are encouraged to light a candle, to inform family members not to interrupt them, or to make a cup of tea to help set the space. When facilitating online dance/movement therapy sessions, therapists may experience a greater degree of fatigue due to the lack of human interaction and the effects on the eyes and the body of staring at a screen. With this in mind, therapists are encouraged to take longer breaks in between sessions to dance and to pay greater attention to self-care practices (Garcia-Medrano, 2021).

On the other hand, Garcia-Medrano (2021) found that the limitations of conducting online sessions also include client comfortability dancing in front of a camera, issues of patient confidentiality, internet connectivity, sound issues related to music, lack of physical contact and playing with dynamics of space and distance and being able to view the client's body in its entirety. Despite these limitations, some clients preferred conducting sessions from the comfort of their home and the clients could still experience embodied empathy with group members. In addition, individuals from around the world were able to come together in dance, and members still had an experience that led them to feel part of a collective (Garcia-Medrano, 2021).

Structure of Group Dance Movement Therapy Sessions

Utilizing a group model for D/MT sessions is important when approaching this population for several reasons. Being in a group, according to Payne (2018), contributes to a sense of belonging and connection amongst members. The group also increases one's tolerance for pain and acceptance of symptoms. Furthermore, experiencing synchronized movement with one another through a well facilitated group allows participants to reflect on and symbolically represent their symptoms through movement (Embodiment Channel, 2018). Additionally, there is a broadening effect to groups that encourages members to manage their own symptoms outside of the group. When clients have a positive experience in group treatment settings, they may be more likely to become active members of their community and in their healing process (Wittig & Davis, 2012).

Warm-Up

According to Berroll and Katz (2005) and their work with severe head injury patients, there are five benefits to the group warm-up. First, the warm-up presents the group with an organizing mechanism. Second, members are offered a chance to organize the body parts, first by isolating different parts and then moving towards whole body exploration. Third, the warm-up serves to stimulate cognitive processes by asking members questions and encouraging the reflection on feelings, sensations, images, and memories which help "strengthen conceptualization and broaden movement repertoire" (as cited in Levy, 2005, p. 239). Fourth, the warm-up can offer members a chance to assume the role of the movement provider through the passing of shared leadership. This supports social interaction, independence, and a sense of initiative and community. Lastly, the beginning stage of the group lays the foundation for consequent theme development material (Levy, 2005).

Therapist Directed Warm-Up. To prepare participants to transition from verbal to nonverbal expression, group members are guided through various warm up exercises. In the early stages of a group, it's important to provide members with more directive interventions to foster a safe holding environment (Dokter, 2010). "Structured movement expression" (Levy, 2005, p. 156), according to dance/movement therapist Marcia Leventhal, is the "organizing basis of the relationship between the client and the dance therapist" (as cited in Levy, 2005, p. 156). This structure is reinforced when the dance/movement therapist introduces members to movement opposite ranges and various dance dynamics, including space, effort, and time (Levy, 2005). This structure provides clients with a sense of containment, without feeling overwhelmed, while the movement polarities allow them to identify their likes and dislikes, get to know their body's needs, and set a foundation for learning skills to manage their pain (M. Joubert, personal communication, 2022). Additionally, it is intended that by giving participants additional movement possibilities, they will feel more freedom in their everyday lives. Therefore, members of the group are encouraged to discover new ways to move their bodies (Mettler, 2006) in order to expand their movement repertoire and support the development of choice (Millrod, 2020).

Additionally, participants learn to connect with themselves, find autonomy in movement, release any tension, and reclaim their bodies (Millrod, 2020). Throughout the warmup, participants are encouraged to attend to three levels of awareness identified by expressive arts therapist and dancer Anna Halprin; first, the physical body, including any sensations, second, the emotional body, such as feelings, and lastly, the mental body, including any words, images, memories, and thoughts (Wittig, 2010). This therapist-led warm-up was essential for members who believed they had no control over their bodies, who were afraid of movement, or who

believed their body's limitations prevented them from enjoying movement in any capacity (Minjung, 2019).

Participant Led Warm-Up. After participants are comfortable with the therapist-led warm up, they are encouraged to claim responsibility for their own movement experience. This portion of the group is intended to assist participants in developing self-efficacy, a sense of empowerment, that allows individuals to take care of and stand up for themselves (Caldwell, 2018). Of equal importance, members learn to attune to and trust their bodies' messages and to initiate change by organizing themselves in ways that feel right for the present moment, rather than repeating old movement habits (Caldwell, 2018). Individuals are invited early on to make their own decisions, based on Whitehouse's (2005) methodology, by deciding whether they want to move from a seated, standing, or lying down position. Offering people a choice, Whitehouse argued, gave them the power to decide for themselves how comfortable they were and which direction they wanted to go with their movement (Lexy, 2005).

As participants take on the role of the leader in movement, the therapist assumes the role of the catalyst (Sandel et.al, 1993). This advances the therapeutic process by helping participants "develop an observing ego" (Millrod, 2020, p. 74). This observing ego "subjectively witnesses the self and reflects on the thoughts, feelings, and impulses within the self without acting on them" (Millrod, 2020, p. 74). Once a participant can increase awareness of their mind, body, and affective states, they increase their ability to make decisions that will enhance transformation and personal growth.

Another way participants can practice autonomy in movement is to engage in authentic movement practice. Mary Whitehouse was the founder of authentic movement, and believed that through this practice, patients could connect to the unconscious and produce changes in the

psyche (Levy, 2005). Authentic movement is a type of D/MT practice in which individuals engage in "natural movement" in the presence of a witness. The witness, developed by Janet Adler, can reflect to the dancer their emotional, physical, and imaginal elements of the dance without judgment or interpretation; describing movement, sensations, or feelings that came up as the witness watched (Levy, 2005). Overall, authentic movement is a practice in searching for a source of impulse, trusting the inner impulse, and allowing the movement to happen. This allows movers to have the experience of "being moved" opposed to "I move". It is a "moment of unpremeditated surrender that cannot be explained, repeated exactly, sought for or tried out" (Levy, 2005, p. 56).

Theme Development

The session theme can arise from any preceding material presented during the group. Typically, dance therapists practice what can be referred to as "structured flexibility" (Richardson, 2016, p. 74), meaning they know the framework of the session yet allow themselves the freedom to respond to the material that surfaces in the present moment (Richardson, 2016). Furthermore, this concept is explained by Chace (1993) as "starting where the patients are" (Sandel et al., 1993, p. 99). According to Berroll and Katz's (2005) work with severe head trauma patients, this phase of the group serves to explore greater themes of a patient's experience including anger, fear, remorse, loss, dependency and so on. "Movement is the vehicle with which all aspects of the individual's life – emotional, cognitive, social, and physical – can be dealt with" (as cited in Levy, 2005, p. 240). Additionally, the theme development section offers participants a chance to gain insight into and embody these presenting issues, mobilize thoughts and feelings held in the body, express emotions, and further access unconscious material (Millrod, 2020).

During the theme development, members might be encouraged to explore and express feelings across various group constellations, including individual action, dyads, small groups and large group formats (Levy, 2005). Chase (2005) integrated concepts such as picking up on nonverbal cues from group members and further developing them, using imagery, and role playing and symbolic action into her theme development section (Levy, 2005). For example, Trudi Schoop (2005) used choreography in order to help patient's gain mastery and control over their problems. Through intentional reproduction and repetition of movement motifs discovered in the warm-up, Schoop encouraged participants to arrange their experiences of "dynamic movement expression" (Levy, 2005, p. 63), This process of creating dance sequences slowed down the expressive process and allowed more time for individuals to explore inner conflicts (Levy, 2005).

Centering

The next phase of group development is centering, which allows participants to return their attention to the group, to process internally, and to practice emotional presence (M. Joubert, personal communication, 2021). Additionally, within the centering process, D/MT utilizes integration, which enables group members to derive insight and meaning from their movement experiences (Caldwell, 2018). After a client has fully engaged in a movement process, they are encouraged to draw their awareness to any areas of the body that feel different and to write these thoughts down (Caldwell, 2018). According to Schmais (1985), insight comes from a "slow buildup of verbal, visual, and kinesthetic experiences" (Schmais, 1985, p. 27). Therefore, combining art and movement allows participants to access a range of experiences and emotions that may "otherwise lie dormant and inaccessible in the unconscious" (Wittig, 2012, p. 172). Participants are given the opportunity to further investigate expression through this process of

moving one's body and incorporating additional expressive therapy modalities, such as art making and writing (Wittig, 2012). Whereas dance can generate metaphoric symbols to externalize one's internal state, verbal symbols have the potential to "label, classify, reflect, and discuss this internal state" (Schmais, 1985, p. 29). Patient's in Minjung's (2019) study confirmed that when you externalize feelings and can tangibly witness them, it results in a sense of acceptance and being able to better manage those feelings.

Closure

The group's concluding phase is crucial because it allows members to shift from nonverbal to verbal processing, to share their experiences with the rest of the group (Millrod, 2020), and to leave them feeling satisfied and resolved (Levy, 2005). Whitehouse (2005) believed that verbal processing was necessary to both understand and integrate what took place in the individual's consciousness (Levy, 2005). It's critical in this section to help find ways to acknowledge members and build a sense of belonging through collective movement (Levy, 2005) and finally, to bring the group's process and experience to a successful conclusion (Margolin, 2019). Participants often give feedback to one another in the form of a verbal comment or movement response. Participants often yearn to gain a deeper understanding of what it was they experienced through movement, how it relates to living with chronic pain, and how it can translate to life outside of these sessions (Millrod, 2020).

Prior to taking the group through a closing activity, the therapist can use the discussion portion of the group to practice active listening, reflecting, and summarizing skills while also attempting to connect member experiences to one another (Margolin, 2019). In order to unify the group, D/MT uses all channels of communication, including connecting rhythmically and nonverbally, and through auditory, visual, and verbal feedback. The ability for members to

assess and recognize their own experiences, as well as having those experiences affirmed by others, is a crucial part of the group. The group validates one another through words and actions, and as the client's self-esteem grows, they are willing to reclaim those aspects of themselves that were previously hidden from others (Schmais, 1985).

New considerations in Dance/Movement Therapy

Shared Leadership

There are several therapeutic factors that can contribute to a positive group experience, the first being to offer shared leadership opportunities to members. Based on Chace's (1993) concept of encouraging members to "stimulate independent action away from the leader" (Sandel et al., 1993, p. 206), leaders can facilitate the group in a way that allows the session material to arise from the group members themselves. This deters the leader from assuming an authoritarian role and places responsibility and autonomy in the hands of the group members. Group facilitators can foster this by offering choices in music, and by asking the group how to best structure the session. Additionally, members can be encouraged to respond to one another during the group discussion section in order to avoid any "spoke-like" interaction in which the facilitator responded to each member's comments one by one (J.Wager, personal communication, 2022). Clients can be given the option to respond to one another using nonverbal communication options, such as a gesture, to encourage them to see their body as a positive tool for communication (M. Joubert, personal communication, 2022).

Assigning Homework

Assigning homework to clients is an aspect of cognitive behavioral therapy (CBT). Homework assists members in putting group learning into practice and integrating it into their

everyday lives (Corey et al., 2010). The aspect of assigning homework helps members practice new skills learned in the group and is important for the reinforcement of new thought patterns and behaviors (Schachter, 2011). Additionally, members alongside the facilitator, can co-create homework assignments that will be realistic for individuals to complete (Corey et.al, 2010). Furthermore, homework assignments can be used during the opening phase of the group as a way for members to check in with one another about any insights derived from or difficulties in completing the assignment (Schachter, 2011).

Practicing Self-Compassion

The chronic pain population has a high rate of experiencing perfectionism (Gordon, 2021), therefore integrating opportunities for members to practice self-compassion is important to their recovery. Self-compassion is the practice of approaching one's suffering with mindfulness and kindness. Additionally, clients who practice this learn to accept their suffering rather than avoid it. A 2012 study found that self-compassion helped chronic pain patients reduce their negative affect and pain catastrophizing behaviors. Moreover, a study by Costa and Pinto-Gouveia (2011) established that this practice helped patients accept their pain and better engage in daily activities (Barnes et. al., 2021). One participant in Minjung's (2019) study shared that D/MT helped them prioritize self-care which allowed them to love, take care of themselves, to value their feelings, and to give kind attention to their body. In this regard, D/MT fosters self-compassion, acceptance of pain, and a shift from judgement to kindness (Minjung, 2019).

Reinforce Change

Finally, to reinforce change, participants are invited to reflect on their movement experience in order to identify what helped them create a shift or a change in their affective state

or physical body (J. Wager, personal communication, 2021). It is imperative for group facilitators to help members identify what created a shift in experience for them and how they contributed to creating a successful group (Corey et al., 2010). The therapist can explain to participants if they can identify what created a shift, whether it be the music, a particular movement, journaling, or moving with others, they can often replicate it outside of the group. This reflection is intended to equip participants with the ability to continue this work outside of the group experience and to better prepare them for the group's termination (J. Wager, personal communication, 2021).

Overall, this literature review provided insight into the various types of chronic pain an individual might experience, such as mind/body pain deriving from attachment issues, stress, or repressed emotions. Next, the various current treatment models were discussed, including a pharmaceutical approach, the biological and psychological model, pain reprocessing therapy, and the bodymind method. Then, an overview of dance/movement therapy and a typical group structure was offered with a focus on the benefits of D/MT for chronic pain patients. Lastly, additional considerations for D/MT groups with chronic pain were explained, including opportunities for shared leadership, asking permission, and assigning homework. In summary, D/MT is an effective form of treatment for this population due to its focus on generating self-efficacy, offering relaxation techniques, social connectedness, and opportunities for self-expression and creativity.

Discussion

There are many ways to apply this information to a group setting. In the appendix, I have offered a six-week sample session outline, including activities for a check in, warm-up, theme development, integration, discussion, and closing (see Appendix). Most dance/movement

therapy interventions can be applied to this population, so long as they are done so with certain considerations in mind, such as the ones mentioned in the literature review. Such considerations include offering choices and opportunities for shared leadership, asking permission, integrating themes of self-compassion, co-creating homework assignments with members of the group, and considering implications for virtual groups.

Virtual Considerations

As described in the literature review, virtual classes require specific considerations and have unique benefits and limitations. First, it is important to consider background noise and to potentially ask each member to "mute" themselves in order to minimize this. Additionally, facilitators must consider whether members have their cameras turned on or off and if they have any related safety policies. Furthermore, it is important for facilitators to provide members with a thorough overview of the many features of zoom, especially "pinning" and "breakout rooms" should there be any partner or small group work required. Lastly, the group facilitator should have a plan in the event if their internet connection fails and thus, might warn participants of this possibility at the start of the session.

One of the positive aspects of meeting online is that members can also gather from all around the world, which diversifies the group and can enhance the group discussion (Garcia-Medrano, 2021). Additionally, for members experiencing chronic pain, removing the hinderance of getting dressed and leaving the house to attend an in-person class makes the group more accessible to those with pain or mobility issues. Other factors to consider are the "self-view" feature, which allows members to see themselves moving alongside others. Lastly, members have the option to "go off screen" or turn their camera's off when witnessing others, which

would not be possible in an in-person environment. All in all, these options can provide increased opportunities for creativity yet come with a certain set of challenges as well.

Conclusion

Historically, chronic pain has been treated with a combination of psychoeducation (Raschbaum & Sarno, 2003), opioids (Gordon, 2021), or a biological and psychological approach, including CBT or ACT therapy in conjunction with acupuncture or physical therapy (Payne, 2018). Given the current chronic pain crisis in the United States, a new model of care is needed to address the mental, emotional, and physical needs this population requires to experience healing. Such an approach must consider the "psychosomatic etiology" (Rashchburn and Sarno, 2003, p. 23) of chronic pain, as well as considering the need to incorporate the body. In light of this, dance/movement therapists are well suited to work with this population because their training is physically and somatically based (Levy, 2005).

Overall, D/MT has implications for clients across factors such as learning how to practice better self-care, self-compassion, and more closely examining perfectionistic tendencies. Furthermore, members may learn to reduce their fear around movement, to enjoy dancing, and to create subtle shifts in their relationships with their bodies. The group experience can provide members with a unique opportunity to feel seen, heard, and validated by others living with similar conditions. Future research is needed to both (a) determine the impact of D/MT on chronic pain patients, especially how to create long-term improvement and positive outcomes after the group has concluded and (b) understanding the implications and effectiveness of virtual D/MT work.

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Appendix

Sample six-week D/MT Session

During my research, I discovered several models for D/MT groups and the chronic pain population. As a result, I combined the work of several influential dance/movement therapists to develop a model best suited to working with this population. The model below combines the theories of Marian Chase (Sandel et al., 1993), Suzi Tortora (Tortora, 2017), Barbara Mettler (Mettler, 2006), Helen Payne (Payne & Brooks, 2020), Janet Adler (Levy, 2005), and psychotherapist Alan Gordon's work with chronic pain patients (Gordon, 2021). The model consists of a facilitator guided warm-up, a participant-led warm up, theme development phase, integration section, group discussion, and a closing activity.

Week 1

Opening

Setting group norms, D/MT background, group expectations, member introductions

Facilitator-Led Warm-Up

Introduce members to dance dynamics such as stretching, reaching, twisting, bending, undulating, swinging, bouncing, shaking, and throwing

3. Theme Development

I Come from Poem. Ask members to respond to the following prompts (a) I come from (b) I carry (c) I offer (d) I hope for. Next, ask members to explore each prompt in movement, and then create a short movement phrase, pose, or gesture for each phrase. As members are moving (with or without music), the group leader is reminding members of each prompt, and when to

start creating a phrase/gesture/or pose. When all phrases have been moved, the group leader repeats all four in a row several times, allowing members to create a longer movement phrase.

Integration

Invite members to take a few moments to write down any reflections from this exercise before refocusing their attention on the group.

Discussion

Members are invited to share their gestures, and the group leader will ask members if they would like the group to mirror it back to them. Another option, aside from mirroring, is to have the group respond to each member with a gesture.

Closing

Create a group dance using one gesture from each member to summarize their "I come from" dance

Week 2

Opening

Begin by asking members if there were any unresolved issues or questions from the previous week. Have members share a gesture and a word for how they are showing up to group this week

Facilitator-Led Warm-Up

Continue with the Mettler warm-up from week 1, and introduce themes of opposites, such as moving slowly/quickly, big/small, or heavy/light.

Member-Led Warm-Up

Ask members to revisit any of the previously mentioned qualities or to move on their own for a few minutes.

Theme Development

Intention Crafting. First, ask members to reflect on and create a gesture for how they are feeling right now. Explore this for a few minutes to music before settling on a pose, movement phrase, or gesture. Next, ask members to reflect on how they would like to feel, is it different? Repeat the same process of exploring and creating a gesture, pose, or movement phrase. Finally, members will move between the two; how they feel now, and how they want to feel. Have members focus on the transition. What does it take to get from A to B?

Integration

Have members reflect on the experience through writing or art making for 5-10 minutes

Discussion

Members have an opportunity to share their experience verbally or to share their gesture(s) with the group. Next, ask the group, now that they've experienced this work, why they think dance/movement therapy might be helpful for processing chronic pain.

Closing

Next, have clients reach their hands to the far edges of their Zoom screen to mimic the act of holding hands with one another

Week 3

Opening

Rose, Thorn, Bud. Ask members to reflect on verbally or respond in writing to the following prompts. (a) Rose, something that went well from their week, (b) Thorn, something challenging or stress inducing from their week, (c), Bud, something that is developing, or something they are looking forward to. Next, ask members to create a gesture for each prompt to share with the group.

Facilitator Led Warm-Up

Continue building on the Mettler based warm-up principles but focus on encouraging members to lean into positive sensations felt in the body. Can they first identify and then follow a positive sensation while exploring movement?

Member - Led Warm-Up

Ask members to revisit any of the previous movement qualities and to move for five minutes on their own

Theme Development

Mirroring. First, pair members in breakout rooms or ask them to "pin" their partner. Instruct members to decide which person will be the leader and the following first, knowing they will switch roles. Next, the leader is instructed to guide their follower in slow movements, so that their partner can easily mirror them. Leaders are instructed not to turn their backs or move too quickly, to make sure their body can be seen in the frame, and not to move in an overly complicated way. Members are told the objective of this exercise is to practice kinesthetic

empathy, and to experience what it's like to be witnessed and seen by another person. If the members are instead in breakout rooms, the group leader "broadcasts" a message to all participants telling them it's time to switch partners.

Integration

Members are offered several minutes to discuss the experience with one another before returning to the whole group

Discussion

Members share their experience with the whole group

Closing

Group Hand Dance. To music, ask members to dance with their hands and upper body. Members have the option of engaging in their own movement as well as "picking up" movements from the rest of the group to tie in the experience of mirroring in a whole group format.

Week 4

Opening

Ask members to share something they are proud of.

Facilitator Led Warm-Up

Guide members through various planes of movement, including the vertical, horizontal, and sagittal planes. Continue to encourage participants to follow positive sensations in the body.

Member-Led Warm-Up

Ask members to revisit any of the previous movement qualities and to move for five minutes on their own. Introduce members to the concept of authentic movement, whereas they try not to plan or judge movement, but to follow the movement impulses that arise from their body.

Theme Development

Lilian Espenak Warm-Up. First, ask members to respond to the following prompts: (a) I am feeling, (b) I am thinking, (c), What is my body doing right now? Next, have members explore improvisational movement to music with the theme of "I am moving towards comfort" in mind. Following this, members will respond to the same prompts again. Then, have members move to a mid-tempo song, with the theme of "I am competent". Following this, members will once again respond to the same prompts. Next, have members move to music with the theme of "I am confident" in mind, and respond to the prompts. Lastly, have members move in a relationship group dance, with the theme, "I am in connection", and respond to the prompts one last time.

Integration

Throughout the intervention, following each prompt, members were given opportunities to integrate the material. Therefore, further integration is not necessary.

Discussion

Members share their experience verbally with the whole group

Closure

Have members share a gesture for something they are both taking away from the session and leaving behind. If time allows, the facilitator can ask members to put each movement into a sequence, creating a group dance.

Week 5

Opening

Ask members to share any thoughts or feedback from any homework assignment, such as dancing for ten minutes throughout the week.

Facilitator- Led Warm-Up

Guide members through various movement polarities, including expanding/contracting, heavy/light, sharp/soft, confident/unsure. Continue to encourage participants to follow positive sensations in the body.

Member- Led Warm-Up

Ask members to revisit any of the previous movement qualities and to move for five minutes on their own. Reinforce concepts of authentic movement introduced last week.

Theme Development

Meditation for Discomfort (a) Ask members to focus on an area of their body that is causing discomfort. Ask members to be curious about the pain, and to spend a few moments

getting to know it. What is the color, texture, shape, sound, etc. (b) Ask members to keep their attention on this area of discomfort, imagining that they can breathe in the discomfort, and exhale light. In this way, members are transforming the discomfort, rather than disposing of it. (c) Ask members to recognize that this is a part of them that needs love and attention, and rather than dismissing it, or blowing it out with the breath, they can draw it in, accept and love it for what it is, let it be seen, and then transform it into something that feels good in their bodies. (d) Ask members to continue with this visualization of drawing in the pain, transforming it into something that feels good, and then exhaling that light through that same area of discomfort. Continue with this visualization for as long as time allows. (e) Members can then be asked to create a phrase or gesture for both the inhale and the exhale. Ask them to use movement to reinforce this theme of inhaling the pain and exhaling positive feelings (f) Lastly, ask members to notice how they move from discomfort to comfort. What movements are required? What happens to their breath, to their energy, to their body? What thoughts or images are arising as they make this transformation?

Integration

Offer members 5-10 minutes for a written or artistic reflection

Discussion

Members can share any thoughts from their experience, a gesture or a movement phrase with the group

Closing

Ask members to create a gesture to share with the group. Each member will pass a gesture to another person in silence (this is prompted by the facilitator). This can be completed several times.

Week 6

Opening

Ask members to share any thoughts or feedback regarding their experience with the group. What did they learn, did they meet their goals, how will they continue this practice after the group has ended? Create a gesture for how you entered the group and how you're leaving.

Facilitator-Led Warm-Up

Guide members through various movement qualities such as constricted, relaxed, alive, expanding, pressure, spaciousness, and light. Continue to encourage participants to follow positive sensations in the body.

Member- Led Warm-Up

Ask members to revisit any of the previous movement qualities and to move for 5 minutes on their own. Introduce members to the concept of authentic movement, whereas they try not to plan or judge movement, but to follow the movement impulses that arise from their body.

Theme Development

Group Affirmations. (a) Using the whiteboard feature on Zoom, members will type in the chat positive messages or affirmations/words of praise for each member, one at a time. (b) The group facilitator will type these messages on the whiteboard for everyone to read. (c) Upon conclusion of this, the facilitator will re-read the messages to the member of focus, or ask the member to read them aloud themselves and to take in these messages of praise and affirmation (d) Lastly, the member of focus will share a gesture of appreciation and thanks to the other members of the group (e) This process is repeated for each group member

Closing

An affirmation for the group and yourself (a) Ask members to take a moment to look at each group member's box and say silently to themselves a wish, prayer, or affirmation for each person. Lastly, members are instructed to look at their own box, and offer themselves the same sentiment.

THESIS APPROVAL FORM

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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