

**DEPARTMENT SOCIAL, THERAPEUTIC AND COMMUNITY STUDIES**

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Trauma in relation to psychosis: a case study in dance movement psychotherapy

Abstract

This essay is the work of a trainee dance movement psychotherapist with a case study of a patient with chronic schizophrenia in an urban setting. This patient suffers from chronic physical pain and psychosis of hearing voices. The psychosis causes the patient re-experiences in the traumatic experience over and over again. This essay looks into the literature of how psychosis and trauma are linked and the relationship between cognition, emotion and body. When any side is disorganised, the other two are affected. This individual dance movement psychotherapy (DMP) work demonstrates how the disruption of cognitive self by traumatic psychotic experiences increase the patient’s bodily pain and how the working on body-awareness in turn affecting cognitive thinking and dealing with emotion.

**Key words:** trauma, psychosis, dance movement psychotherapy, psychodynamic

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**Introduction**

In this essay, I will provide an individual dance movement psychotherapy(DMP) case with a women diagnosed as schizophrenia. I adopt the free-associative method of psychodynamic DMP but with the Chacian approach, ie. in the sessions, she started with a flexible structure of verbal check- in, warm up, free movement and verbal reflection back on her movement experiences. I will use pseudonym ‘Kate’ to keep confidentiality.

The definition of schizophrenia includes long term psychotic experiences, disorganised speech and behaviour or occupational or social dysfunctional symptoms.(DSM-5) Psychotic experiences, by which I mean delusion and hallucination, and other traumatic experience, such as flashbacks, are hard to explain verbally but typically involved strong false belief, hearing unreal voices or seeing visions. The experience of self has been disturbed. The disturbed ego-self is decreased in self-awareness while the sensitively painful aspects of the patient’s experiences are exaggerated ( Sass and Parnas, 2003).

First, I will present the literature review on schizophrenia and psychosis, the relationship of psychosis and trauma, and how traumatic psychotic experiences associate bodily and may increase the resistance in the road to recovery. Second, I will look at the psychodynamic approach and DMP with this patient group. Then, I will introduce setting of this clinical work, general setting, the client profile, and the DMP referral.

I will present the clinical work from the assessment, followed by 5 stages of the DMP work in 13 sessions, organised client with the themes. As low attendance might be related to resistance to the therapeutic relationship, I will include my understanding of the relationship inside and outside of the DMP sessions.

I will conclude this paper by discussing and evaluating my work relative to the literature.

**Literature Review**

The mechanism of psychosis in schizophrenia is currently an issue of interest and research. The applicable use of psychotherapy treatments is discussed with consideration of the possible cause of the distress, despair and disorientation. I am interested in how psychosis is related to trauma, and how to DMP could be used to facilitate the emotional modulation of ego and traumatic stimuli. In this literature review, I will start with the relationship between psychosis and trauma. Next, I will look into how the relationship between psychosis and trauma connects to bodily experiences and resistance. Last, I will look at the psychodynamic approach and how this works with dance movement psychotherapy.

**Psychosis and traumatic experiences**

Psychosis was defined as hallucination, delusion and other symptoms by Kapur (2003), and is definitely found in the criteria of schizophrenia diagnosis. However, there is a huge variety of psychotic experiences: some might be positive and encouraging, while some people have ongoing difficulties with severe and distressing experiences.

Because delusions and hallucinations are constructed within the individual, they could be related to the cultural or social context of individual experiences, which give rise to the reasons for neurological dysregulation that may be seen as bizarre behaviours in a different culture (Kapur, 2003). Within different cultural contexts it is often considered that the differences in patients’ experiences, particularly where there is a loss of spiritual explanation(ie. mostly in western countries) are more likely to feature negative thoughts and unwillingness to believe that their situation can improve(Castillo, 2014). Sartorius, Jablensky and Shapiro (2016) give further support that within the social context of developed countries, the symptoms of schizophrenia are viewed more negatively. It might make things even worse for immigrants, who have a higher chance of experiencing delusions and hallucinations due to epidemiological biases and social isolation in moving from one culture to another. While searching for a warm and safe shelter, they are typically more stressed than local people economically, socially, and culturally. The social- environmental stressors could be a factor of trauma (Foster, 2001) and psychosis (Dealberto, 2007).

Though trauma is often related to Post-traumatic stress disorder (PTSD), an exposure to actual or threatened death, serious injury or sexual violation (5th ed.; DSM–5; American Psychiatric Association, 2013), there could be other reasons arising from dysfunction in mental health. There are some links to how psychosis is caused by early child trauma, including child neglect, abuse, low economic status, ethnicity, loss, which have been evaluated by Read, Van Os, Morrison, &Ross, 2005; Read & Gumley, 2008. Others state that psychosis itself, hallucination and delusion, can crush the person’s world of inner self and their relationship with others like other trauma ( Baley, 1996; Davidson&Straus, 1992)

Patients with psychotic experiences might have similar painful feelings as those diagnosed with PTSD symptoms. Schafer& Fisher (2011)suggest there is a strong relationship between psychotic experience and self-report trauma due to distorted perception of self and strong sensitivity to stress. Often when the experiences are related to trauma, the rewinding of the difficult feelings and memories in patients is constantly reminding them of the terrible incidents. When it’s a long-term unresolved issue, my belief is that this is more likely to cause mental illness like schizophrenia. Read et al. (2001, 2005), and Gearon &Jean et al( 2003) have also talked about how traumatic life events cause or can be linked to psychosis in schizophrenia.

**How the traumatic psychotic experiences associate to our body**

Negative responses to selfhood are reflected in the body in posture, breathing, movement flow and even physiological functions. These somatic experiences influence the way traumatized people interact with the world and how they translate the meaning of subsequent experience. (Ogden, Minton and Pain, 2006) The body could remember through physical sensations, abnormal arousal and involuntary movements, and can trigger emotions, such as terror, dread, helplessness, hopelessness, shame and rage. In addition, the unresolved trauma might be significant in the disintegration of body and mind. (Janet, 1889)

The brain operates hierarchically at the cognitive, emotional and sensorimotor levels (Fisher, Murray, & Bundy, 1991), and the human being is in an integrated state when these levels function as a whole (Panksepp,1998).

The highest level of trauma impacts at the cognitive level when people form inflexible thoughts, maladaptive interpretations of the trauma or other life experience, such as ‘ I am bad’ , ‘I am ugly’, ‘it was my fault’. Thought is a mental process correlating with emotions and sensorimotor reactions (Maturana& Varela, 1987), and each could influence the others. For instance, positive thoughts could change the emotional brain making life happier, and also changing the body with more free flow. It is also possible to alter thinking and emotion with flow adjustments in tension flow (Amighi et al., 1999, p. 66) Emotion makes life meaningful and the emotional processing of life experience helps in the understanding of trauma . According to Damasio(1999), our mental life depends on the balance of cognitive and emotional brains; while the former is consciously interpreting the outside environment, the latter is unconsciously dealing with the internal self. People with trauma easily move into trauma-related emotions, lacking awareness of other stimuli or alternative emotions for their current situation. (Ogden, Minton and Pain, 2006), and their brain and body are not functioning as well as those of others. Furthermore, the emotional brain often ties up with the body. It is more powerful to act on the emotional self through the body rather through language (Servan-Schreiber, 2003,p13-25). For instance, the high intensity of tension flow is often appearing when a person is angry, stressed or anxious (Amighi et al., 1999, p. 67), so violent and self-harming behaviour are obvious and the body seems the only way to process feelings. However, some motor patterns are important to the brain in terms of chances of survival (Fishman, 2002). ‘I’ is the integration of stimulation of outer world and internal motivations, which can allow pre-judgement on different strategies in order to adapt to the outer world (Fishman, 2002 ). It begins from the preverbal stage. When communication through language is not available, we cannot create memories and judgements, so the body takes charge and remembers. Many trauma-related memories start from bottom-up processing in childhood, through damaging the body and affecting cognitive thinking; some top-down processing in childhood starts with a bizarre concept of self and results in mistreatment of the body. Children feel the world through senses, which is how they get in touch with the body. Traumatised people frequently experience themselves losing capacity to integrate their body and their emotions and thus lose cognition. Movements form sensory perception and sensory perception in turn shapes fixed thoughts. (Ogden, Minton and Pain, 2006) The same movements being made over and over again create physical pattern and further influence chronic functioning of body; therefore, they cause physical problems such as back, neck and shoulder pain or inner bodily pain. For instance, people who are easily stressed might contract and hollow their bodies, and if that happens again and again, they could have more chance of chronic abdominal pain. However, if they learn to expand and stretch their bodies, the pain could be relieved.

Higher levels of functioning integrate and provide more flexibility over regular organic body functions. The lower levels can also work another way round as well, for example, involving flash back memories.

However, the integration of three levels may not apply to people with less sensitivity to the body, such as psychotics, according to Cobos et al.(2002), and Vianna et al. (2006). Their neurological findings are that there is no difference before or after the psychological treatments. Van de Kolk (2014) and Stauffer(2009) support self-regulation through mirroring and repairing of the damaged neural activities through stimulation. With increased capacity in the body, the interventions could assist in the possibility of neural renewal.

**Psychodynamic approach**

The psychodynamic approach offers clients a safe environment to look into their repetitive behaviour delusion and hallucinations, listen to the unconscious level and release the repressed inner self (Monika, 1992, Payne edited). The psychodynamic approach was started by Freud looking at the ego(Freud,1927), which is a complex of external stimuli and internal physiological mechanism. Klein (1946) suggests that people with psychotic conditions have been obstructed at a certain developmental stage. With ‘good enough’ parenting ( Winnicott, 1960), infants build up a bridge for integration and are ready for separation from the mother; otherwise, the emotional growth of the infants is inhibited and this may result in chaotic development at certain key stages. This analytic approach contains patient and therapist- working within the dynamic of transference and countertransference together. The therapist finds parallels with earlier traumatic experiences brought by the patients (Sandler, 1976). In the therapeutic relationship, the levels of development are unconsciously expressed towards the therapist through different types of transference, and help the therapist to identify what patients need or what they have offered; while countertransference, another important element, is useful to assist the patient’s emotional state (when properly used) but could sometimes inhibit recognition of the therapist’s own feelings ( Dosamantes-Alperson, 1987).

The psychodynamic approach for people suffering from psychosis could be useful through early mothering exploration, following the patient’s emotional progress( Shrem,2004) The ‘fear without solution’ is hypothesized in their experiences and the disconnection is their way to defend the painful feelings( Luyten, et al., 2015) According to Shrem(2004), this traumatized experience leads to psychotic-level breakdown and the patients keep suffering from the traumatic event. In addition, I believe that the experience of psychosis intensifies the degree of trauma by being relived repeatedly.

*Resistance in traumatic experience*

One important and obvious issue in this psychodynamic analysis is resistance to embarking on an unknown journey, which clients both ‘reveal and keep hidden aspects of themselves’ in therapy( Messer, 2002). Freud (1894, 1896) first talked about the defensive mechanism as it related to trauma. When the defensive actions are effective, the dangers are avoided. (Ogden, Minton and Pain, 2006) This tendency to re-enact defensive responses appeared broadly in different aspects. Traumas might even result in true feelings of pain, and make the person go into mourning, when the grounding object is lost. (Berlant, 2007) However, it could be a resistance mechanism to shift the attention from emotional pain to bodily pain.

In order to work with resistance in a psychodynamic approach, recognition is the first step. Resistance reveals the unconscious conflicts but the patient responds by lapsing into fantasy (Christopher, 2011). Resistance takes many forms, like showing up late, being angry, not talking, failing to turn up for the session, etc. Next, it is necessary to empathetically bring this to the clients’ awareness; the therapeutic relationship could help to explore the conflicts under the surface of the resistant behaviours. Working with the resistance, there are possibilities that client is re-enacting the transference of difficulty in the interpersonal relationship or therapist’s failure of empathy on the client (Messer, 2002). It can be an obstacle, but can also be a chance to explore the stress in therapeutic relationship.

**Dance movement psychotherapy**

Dance movement psychotherapy is defined by the Association for Dance Movement Psychotherapy UK (ADMP)as‘ an implicit and expressive instrument of communication and expression’ using the body to assist the integration of emotional, cognitive, physical, social and spiritual aspects of self (ADMP, 2016).Using DMP is a non-verbal and verbal psychotherapy choice for people with psychotic experiences. As all the human experiences are connected to our body, including concrete body, internal emotions, external environment, and the relationship to self and objects(Schilder, 1950; Capello, 2009; edited by Chaiklin and Mengrower), and they form who we are and how we think of our inner and outer world. From an infant, every individual senses the world through physical connection with the mother and body image is created through response to the environmental stimuli (Davis, 1964). From five physical senses, the infant has a body image, and adjusts her/his perception between ego and environmental stimuli ( Shalev, Yehuda, & Mcfarlane, 2013). Applied as a body-oriented psychotherapy, DMP assists the integration of bodily sensations and lingual perceptions.

Traumatic stories are hard to transmit through verbal language. It is a sensation, feeling or image. The external and internal self are easily disassociated to ensure survival. However, the lack of integration might result in anxiety, fear or even mental illness. Pines(1993) points out that a young woman’s distortion of body image is a means for her to deny and separate from her painful emotional state. DMP use movements and non-verbal communication as tool to connect with these experiences and deal with the emotions. When there are difficulties in the basic organisation of an individual- body and movements - there can be significant damage from the earliest stages of development (Gray, 2001). The broken bodily integrity could be expressed as being dead or disgusting, and tends to be cut off from the feeling and thinking (Bannister, 2003). In an effort to repair the sense of self with people with psychosis, reconstructing body awareness and increasing body image could reconnect with their perceptions.

DMP serves as a tool for ‘containment’ (Winnicott, 1971) with the effects of ‘space’ (Newman and Holsman, 1983) and ‘metaphor’ (Bennister, 2003) for traumatised clients and helps to increase self-potential. It creates the space to deal with the unresolved inner conflicts of the patients (Ro¨hricht, 2008). It makes use of body movements and emotions in coordination with cognitive mind in the rehabilitation of schizophrenia, helping patients to repair a broken relationship of inner and outer world verbally and non-verbally (Oganesian, 2008). With encouraging of body-awareness, people with psychosis can learn about their body boundaries (Capello, 2009; edited by Chaiklin and Mengrower) and discover their developmental stage. Through mirroring, DMP assists people with psychotics to separate self and others by identifying the therapists’ body counter-transference (Liebowitz,1992; edited by Payne H., p107; Sletvold, 2015). My hypothesis is that through making connections between body image and self-perception, traumatized psychotic memories should either benefit or at least should not harm patients in their social life. These memories can be contained without being parasitic, but held in a state of mutualism or commensalism. In other words, these memories can have a healthy coexistence within the patient’s understanding of self.

People with psychosis can aim at improving personal relationships, as evident from Oganesian‘s findings (2008) which proved that psychosis, the prime symptoms of schizophrenia, has decreased after DMP and the interpersonal skills have increased. Like a mother supporting a child to explore and to understand the world, DMP responds to the patients’ movements by helping them to be aware of the meaning of their behavioural patterns or thoughts (Liebowitz,1992; edited by Payne H., p107).

**General setting**

The DMP sessions take place in a mental health recovery day centre with high context cultures, social and economical levels in a metropolitan commercial setting. It opens daily from 10:30-4:30 and supports people with mental distress and unique sensational experiences. There are lots of different workshops, including key working, counselling, group and individual psychotherapy, holiday trips and social activities for members to attend with self-payments or governmental benefits. The services are provided through collective cooperation with the volunteers and the staff. However, there are high turnover of the volunteers, so the programs are adjusted in parallel with the flow of volunteers, leaving and joining the centre.

Clients, who are called members or service users, share the services. There is a huge variety of members in terms of age, race, how long have they been using the service and the benefits they get from the local borough to maintain their membership. Support is offered for those with mental health needs and who hear voices/ see visions and experience paranoia.

The room used for DMP sessions is in the basement, and can hold 7 people. All windows have closed blinds, tables and chairs are put away to create space for moving. I covered the transparent glass on the door with a sign indicating the session is in progress and not to interrupt to ensure the safety and security of DMP.

**My client**

Kate is in her mid-40s, originally from a country of open and passionate culture, diagnosed as schizophrenia. Kate is a lively person in the day centre, who has attended for 25 years. Her body shape is large, but her movement quality is light when she is on her feet. She often shows passive weight to people or things she reaches, and I think it might be relevant to her insecurity to herself and dependency on others. Kate has a reported history of prostitution in the day centre and often annoys other members and staff and volunteers by either asking for money or touching without permission. When she socialises with others, her movement efforts tend to be, according to Kestenburg Movement profile ( Kestenburg& Loman, Lowis, and Sossin, 1999), neutral bound flow with strong in the upper body and light in the lower body. Her tension flow rhythm is running / drifting. During observation period, I found her having difficulty building up relationship with nearly all others, and it seems hard for her to find the balance in interrelationship and I thought DMP might be beneficial for her to find the way to differentiate with friends, families, or strangers.

However, she was interested in DMP because of chronic shoulder pain and she talked openly to several volunteers previously about the pain and loss of her father. There have been 14 sessions in total, with a Christmas break, from November 2015 till March 2016. It is a 45 minute session once a week.

**Referral**

Kate was referred by placement manager because of her long-term inappropriate behaviours and vulnerabilities in the day centre. She often breaks or is on the verge of breaking the centre’s rules. She would express her sadness of losing her father with some volunteers. Kate is having a really close and romantic relationship with another male client and often expresses intimacy explicitly in the social area.

In the day centre, she welcomes people she knows. She will loudly say hi to them, approaching to shake their hands, hug and kiss them, mostly without asking permission. She, from the perspective of my placement manager, is hard to communicate with due to persistent behaviours and, therefore, in need of assistance of working in DMP.

After observations and building up relationship with her several weeks, I introduce Kate to DMP. She raises her anxiety about her painful shoulder which was caused by an accident in childhood. However, she did not mention the pain of the loss of her father to me.

**Clinical Context**

I will present the DMP work with Kate from assessment, followed by 14 sessions with main themes separating them into 4 stages. Finally, I will deal with her unexpected ending request and her changing mind to continue.

**Assessment**

‘I hear voices. They call me ‘ho’ . Do you understand? They call me ho. I am afraid! They keep calling me a ho!’ When I first manage to bring Kate into the therapy room, she expresses her anxiety straight away.

Kate almost shouts, and leans forward with eyes unclearly looking at me. I feel afraid and helpless, feeling like I am in a tiny rubber ring under a roaring wave. ‘It sounds horrible.’ I say. ‘It is, I could not make them stop and I could not ask them to shut up, they won’t listen!’, she says. ‘ and also my shoulder, it is really hurt! But I have not yet got my specialist , I have to wait , I don’t know how long should I wait… Could you help me do some physiotherapy?’ I clarify with her that we can use dance movement therapy to help her deal with her emotional pain while she is waiting for her appointment with her specialist. I tell her we could think some exercises to help her explore movements in this safe place. We also talk about confidentiality, and I set up the session framework basing it on Chacian’s model of verbal check-in, warm-up, process and verbal closure (Valdivia, 2010), when we would talk about our experience of the movements occurring in the session.

*Reflection*

During the assessment, Kate seemed to lack self-esteem, affected hugely by her psychotic experiences and also showing confusion about her self-image. When she talked about herself, one thing in particular stayed with me: that she only had one meal a day cooked by her mother. I was really surprised and wondered if she is used to ignoring her physical signal cues and not responding to food except for what her mother provides. Infants who grow up controlled by the mother’s need become reliant and lack awareness of their own needs (Ward et al, 2001). They pay attention to their caregiver’s need rather than to their own and gradually lose touch with themselves. After my assessment of Kate, I started to think about how to increase her body awareness without too much stimulation.

**Stage 1-coming and running away: session 1-3**

Kate starts by talking about wanting to do the physiotherapy and being on the waiting list. I reply with empathy acknowledging how worrying it must be to wait for treatments. I also remind her how we can explore the anxiety and deal with the pain while waiting for her other treatments in DMP. Then, she expresses her fear that the worsening condition of her shoulder might put her into hospital. I ask ‘what is the fear of going into the hospital?’ She shares her previous experience of being in hospital after surgery and says she is allergic to operations. She said strongly that she will go mad because the voice she heard was more aggressive and intolerable after the surgery. However, while I asked her to describe more about her voices, she seemed really panicking and had indirect eye gaze around the room. Then she said ‘ it gets louder’ in a mournful tone. She seemed fearful and lack of self-esteem.

Based on Reich’s (1972) and Lowen’s (1975) holistic body-oriented psychology, self-awareness is my first priority in trying to increase her self-esteem and integration between emotions and body. Therefore, I start with body orientated warmup, in order to help her identify different body part. It might be beneficial for her to develop a better touch with herself, to increase her sense of owning her body and to accept different sensory and motor sensations- as proposed in Body-Oriented Psychotherapy (BOP)( Rohricht, 2008).

Kate follows my movement interventions, though bound and light. I noticed her lack of breathing and there was no flow in her movements. I then verbalized on the in and out of the breathing. She sighed and said she could not do anymore. I then suggested she could notice her breath more than her movements and I moved my shoulders up and down. I noticed her that shoulder was gently and slightly moving up and down, freer and with less anxiety.

She asks me to hold her hands helping her stretching forwards and backwards. I introduce her to use stretch bands rather than using direct touch because I do not want to hurt her shoulders, or make it difficult for her to do movements so that she might feel rejected. Hunter and Struve (1997) discuss the potential misuse of physical contact between patients and psychotherapists and I wanted to avoid the potential for this occurring. However, the pull and push with the stretch band triggers her shoulder pain. Therefore, I suggest she could throw and catch a soft ball. I also want her to keep the sagittal directions. She asks several times if she could finish the session because she had had enough exercise.

When we talk about her movement experience, she shares how surprised she is that the stretch band can give her support and that it is better than using touch. I realized that Kate cannot think about what being touched may mean for her yet, but she manages to offer a reason for enjoying touch: it is because of where she is from.

For the next two sessions, Kate comes up too late to have a session and she tries to change the session time. I find it really difficult and I am frightened. I have an image of ‘tug of war’: that this is a power struggle and I have to use all my efforts not to be pulled into it. I am afraid of being unable to get her to continue. After exploring it with my therapist and within the supervision, I manage to separate the fear of my own unresolved issues and try to understand her fear, using this countertransference to think about Kate. I am feeling sorry that she has missed two weeks between her initial assessment and her first DMP session due to my being away on placement training. So, when she misses two more sessions after the first one, I wonder if this is the acting out of telling me how anxious and fearful it is to wait for two weeks of DMP, being similar to her having to wait for her specialist.

**Stage 2-trauma and psychosis: session 4-7**

Over the following sessions, I provide Kate with a safe space within which to improve her grounding. Sometimes she wants to lie down in the session and, although this is not typical for DMP warming up, I have noticed that she often lies down on the sofa in the communal area. I decide that I should let her do the same, when she wants to, as this is a transition period and it enables her to stay in the session, beginning to make a relationship with me. I don’t lie down; instead, I bend my knees or stand next to her.

From the fourth session, I suggest we use the naming body parts game during the warm up to increase her bodily self-awareness as I was finding it hard to sense her body other than her shoulder. Therefore, when she comes in, she can give me a colour for her body parts, and then we start to move our bodies, followed by checking in with her if any colours have changed during the warm up. In this way, I hope to assist the integration of her body and her mind. From Kate’s feedback on the changes in her body, as represented by changes in colour (Critchley, 2005), I recognise her cognitive responses are being automatically aroused, thus affecting her behavioural decisions and her emotional state. Through moving with her body, evidence from her cognitive responses suggests implicit changes in her judgement. For example, in the fourth session, she was not able to give her hands a colour, but in the following sessions, she is able to not only give her hands a colour but she also responds with sound and movement in describing them.

*Reflection*

In supervision, I thought about how DMP was working on the relieving of the ‘here and now’ of the emotional struggle of relationship building, as well as the relief of physical pain. I thought about how this was happening in the early stage of our DMP work and that building up our therapeutic relationship was my first priority.

She seems to find week five even more difficult to manage because her psychotic experiences are increasing. She shows me with a movement how her pain is like twisting a towel really hard and with a sound of ‘hwai hwai’ like a machine which is not functioning very well. I then say ‘your muscles sounded pretty tense.’ I suggest that we bring that into the warm up to sense the tension and find a way to release it. We begin with squeezing the face and the legs. ‘It is strength. I can feel it’ she responds. ‘I cannot breathe.’ I then ask her what she is feeling. ‘it is like someone is choking me’ I am shocked and wonder if it is too much for her to be squeezing her muscles in this way. ‘Ouch! It is difficult.’ I say in acknowledging her feeling. I stop and put down my hands. I am trying to let her feel more, to perceive more clearly the various sensations in her own body, increasing her own self-regulation, but not to cause her to re-experience the pain. I then wonder how to get access to her emotional world with body movement and sound in our sessions, so I then introduce big and small postures where she can hold and release her muscles. I am curious about how much she would like to share, and how much she would like to keep to herself. I ask her to notice her breath while doing the postures and tell her to make a sound on the ‘in’ breath. She makes some uncomfortable sounds when she breathes in – it is as though she is having trouble taking in her difficult feelings. I relate it to her hollowing and shortening shape flow and speculate that it could be her pattern when connecting to herself is hard or even painful. She asks for a prop and I offer her the yoga ball because I think that this might make it easier for her to connect with herself. She quickly sits on the ball, adjusting her pelvis and seems comfortable. She looks into the prop box and I introduce each prop asking her how we use it. She initiates an imaginary play between the toy dolphin I am holding and her hand puppet while she sits on the ball. She says ‘hello dolphin, where are you going?’ I answer with ‘I am just swimming around.’ She puts her puppet onto the dolphin while I move the dolphin like it is swimming. Within the play, I add in horizontal and vertical directions so that the dolphin is going up and down and circling around her hand movements which become freer and more flexible. When she shares about the experience of session, she says ‘like having a baby’ and ‘pregnant’ while she is on the yoga ball. When we reflect on the image, I ask her what reminded her of pregnancy when sitting on the ball. She says she does not really know but she has seen it on TV. I ask her if there is any fantasy with the ball, or with the session and with me. She speaks about being comfortable in the setting of the room, but with eyes shifting around, which suggests to me that she is perhaps still unsure about what she is saying.

*Reflection*

Thinking about the theme in the supervision, I realized that the supporting and grounding of the ball facilitated Kate, in her lower body, to have more strength and also to find containment within the painful process of breathing. Furthermore, it seems like the breathing when ‘coming in and out of the water’ in the imaginary play (while I hold the toy dolphin and pretend to swim around the space) helps her to focus on her breathing. The props are ‘internal objects’ (Berzoff, Flanagan & Hertz, 2016; Mitchell, 1981; Klein, 1984), with my dolphin providing her hand puppet with support to explore the space. However, she asks to leave the session when the puppet accidently falls on the floor, and I wonder if this has led to her feeling anxiety about being left alone in her fear. I wonder if the image of being pregnant while supported on the ball is a link with thinking about being supported emotionally in our DMP session. The ball is the link between her fear and her support in the session, and she is trying to find the balance to stay grounded.

In her sixth session, Kate shares the image of a jet that she saw on TV bombing and killing in Syria, which particularly upsets her as the image also shows the death of a mother and her child. I pick up the theme of loss and separation, and then she links that into the death of her father a few years ago. Kate says ‘ my mother misses him and she is sad’. I ask ‘ how about you?’ She replies ‘I miss him too. I am my dad’s little girl.’ I want to ask more about this, but Kate looks as if she does not want to say more at this point, so I hold onto my thought and decide to wait until she is ready. I suggest, because I want to ground her, that we make a transition to explore this feeling in movement by Kate being seated and bringing her feet into contact with the floor.

Having introduced the idea of moving her fingers as if she were playing the piano on her body, Kate says that this helped her during her journey on the bus when she felt paranoia. I ask her how the movement helped with the paranoia. She repeats the words ‘ it helps’. She seems able to think about how the DMP session is affecting her and is starting to deal with the difficult situations in her life. Though the finger warm-up movements are light and free, the way she manages with the props is strong. She initiates with a naming of the animals and picks up a stress releasing toy - I suggest we hold the toy while we speak and pass it from one to another when we finish speaking. However, I notice Kate is pulling violently at the stress release toy. I think about how to reflect this empathetically and say ‘ouch, it hurts’, but then in the next minute she breaks the toy, and the powder spills out of it. After she has cleaned herself, she asks to keep going with another toy left in the box and expresses her eagerness to hold on to me at the same time. Due to my consideration of safety for Kate in the room as well as the remaining time, I insist that we should stop and think about her experience and then finish the session. I am very curious about her having created a situation seeming like that of a victim and then having the need of touch. She suddenly jumps up and says to me that she has heard a lot of voices recently. She says that the voices keep judging her as a good girl or a bad girl. Here I feel that it is not really important whether she is good or bad but that she is troubled by the unwanted voices. She keeps saying that the voices do not want to go away. I wonder how she comes to this conclusion and I ask her if she talks to the voices. She replies ‘ I say, go away. But they keep coming back’. She implies that this is why she needs the comfort of touch.

*Reflection*

The incident in the session might be related to Kate’s vulnerability and our unstable relationship. The crisis that occurred made me feel under pressure and I wonder if that is what she felt. When we were cleaning up the remains of the stress release toy, I struggled about whether I should touch her. By ending up in this messy state, was this how she expressed her need of attention and help? I felt like she could also be crying out for help because of the approaching Christmas break. The focus is now on our relationship. I am worried that it is on the edge of breaking down. Kate’s unexpected destruction of the stress release toy could possibly be linked to the circumstances of her father’s death.

I reflected on Kate’s reaction to the toy. I gave her the stress releasing toy because I hoped it would help her to transfer her tension to the toy, and we had talked about holding it in our hands when feeling that tension. However, it was clear that she was not able to use the prop to deal with the pressure – in such a situation I should think about using props that are indestructible.

The session before the Christmas break (week 7), Kate expresses her anxiety with regard to her psychotic experiences and her shoulder pain. We are 5 minutes late for the session because she is quite reluctant to come in. It occurs to me that the incident from last week might be linked to her resistance; therefore, I praise her for her courage in coming to the session. I think this encourages her to stay so that we could think about the ‘here and now’. She, nevertheless, begins with talking about the horrible time she had when she was in hospital. I ask if there is any relationship between her anxiety about the treatment for her shoulder and the painful memories from her childhood, in order to bring her back to the present. She then makes it clear that she is afraid of having more surgery on her shoulder, and she does not want to be put to sleep because of her fear of the intense and threatening voices she would experience afterwards.

In the session, Kate moves as if she were flying in a limited circle. She moves with heels against the floor and leaning forward, hands waving up and down from the side, initiating from distal to mid-limb. She keeps eyes and head down. In the beginning, she moves alone, and I use voice to verbalize the sound of waving wings. While I am wondering about her emotional state, she invites me to join her. After I join in, she starts to lean forward in front of me as she moves. It seems she is wanting to know if I could catch her and hold her when she falls, and that she needs me to stay holding the intensity of her anxiety. However, our interpersonal space is merging and expressing her neediness and I was thinking about what was going on within her unconsciousness. Should I stop her? Are there any supportive alternatives if I say no? My response is to mirror her movements and adjust my direction to be parallel with hers, so she can still sense I am supporting her. On reflection, what emerges for me is her continuous moving within a small circle and her leaning forward. I share my observations with her and she tells me that it is her life in the day centre. She enjoys being how she is and does not want to change anything, and she also mentions her wanting to be the centre of attention. She tells me her happiness is to be like an actress in the community area, and the day centre is her performing stage. She enjoys ‘staying in her comfort zone’ and wants things to stay exactly as they are.

*Reflection*

I am quite worried about Kate’s Christmas break after the sharing above. It seems she has started to bring herself into the session, but she will not able to use the space for two weeks. I am not sure about whether her ‘wanting to touch’ and ‘dependency’ are to grab attention from others or to do with her fear of being rejected or other needs. I realize in my responses to these two issues that my offer of catching her during the movements we made together might not actually support her to overcome her painful experience but reinforce her behaviour of blocking that experience. By accompanying her in the movements, I think I was helping her to think about her interpersonal relationships and to deal with her emotional pain.

**Stage 3-: fear of loss: session8-11**

During my scheduled two-week Christmas break, Kate’s inappropriate behaviours increased. She had a difficult relationship with most of the staff and some members because of her constant need of touch. Staff found it hard to have in depth conversations with Kate. Some staff seemed to see DMP giving her an anchor to hold on to and she was more anxious and acted out when she did not have the session. However, after the break, the therapeutic relationship seemed less effective and I felt everything we had built finished abruptly and I was curious to know what this was about. I felt punished, worried and anxious about Kate missing another two sessions after the break. It seemed she was telling me that she had regressed to a worsened state because of my Christmas break.

In the 10th session, Kate comes in and wants to cancel the next session. I feel sad but remind her how many sessions we have done and how many she has missed, alongside the sessions we have remaining. She says that she found it helpful to attend DMP sessions but reveals her problem with the time-overlapping of the DMP sessions and her specialist appointments. I am quite frustrated and worry about her tendency to withdraw commitment. Consequently, I do not manage the shared space between us very well in that session. I sense her urgent need of intimacy including her use of touch when she talks about wanting a wedding, and I suggest we set up a wedding dance. She holds my hand and stays really close. I introduce some moves with changing body directions, turning circles and changing the distance between us with different steps. Though I intend to create a changing interpersonal space and dimensions in moving, it feels frightening for me to be in this couple dance. Kate’s movement is bound and hesitant, suggesting to me that she is trying to defend the intimacy of the dance.

*Reflection*

I reflected on the fear and confusion within supervision, and I realised that I was trapped into an overly intimate relationship with Kate for fear of losing her. This unconscious tension and ‘fear of loss’ between us affect my intervention of using intimate dance including touch. Though touch is an important language for communication, the use of touch in psychotherapy is a dilemma. Through supervision, I realized that my suggestion of the dance was not helpful but sexually charged and enhanced Kate’s resistance. When patients are suffering from loss, they might be keen to touch, but this might be triggered by unconscious fear. Without enough containments and patients may withdraw from, or even attack, the ‘helper’(Ramsden et al., 2006; edited by Galton). While some literatures support to use touch (Hartley, 2004; Kestenberg, Loman, &Sossin, 1999; Popa&Best, 2010); some think there are ethical questions to be considered(Willis, 1987; Wadsworth Hervey, 2007).

I was also wondering about the cultural differences of the boundaries around our therapeutic relationship, whether the fear is from my countertransference or our cultural differences. When I thought we were too intimate, I wondered how Kate recognised the space between us, and what was the most appropriate distance.

**stage 4-uncomfortable countertransference and termination: session 12-13**

It was a painful learning experience for me - the 12th session led to Kate’s decision to withdraw. The session seemed to raise her unconscious anxiety. I felt sad at the obstacles in the way of holding on to our therapeutic relationship. I realised the importance of working in this rocky situation but my fear of failing changed the balance and perhaps frightened her, leading to her running away. Kate seemed to have built up her defences around herself. While she had a desire to be overly close, she would then shut the door to any deepening intimacy.

I felt used by Kate after her 12th session. She had managed to persuade me to do things I did not want to do and I wondered if she did not want it either. I was angry that I did not manage the situation with more empathy.

During check in, she talks about her emotions (psychosis and panic attack) and physical pain but she keeps asking to go out. When I ask her for more detail, she turned around and played with the yoga ball. I feel quite nervous that she may be trying to accelerate the process and then attempt to leave. I intervene here to slow her down and remind her to go back to the warm-up. She asks to do the social dance after the warm up, but the dance could be really intimate again and I thought it might not be helpful to her. I suggest that we clap each other’s hand and step back in order to match her desire of touch but also to work within the boundaries. Kate then refuses to move and goes back to sitting on the chair. She also asks to do other activities, then loses her interest and seems really panicky and frustrated. In the end, she reflects on this DMP session angrily by saying ‘I felt you don’t like me, do you really enjoy being with me? I felt you don’t like it.’ Her voice is shaking and her whole body is hollowing and shrinking on the chair. I say ‘ I wonder what was it to that made you feel like that?’

*Reflection*

It might be that for Kate, my fulfilment of her requests during our sessions has created an intimate relationship. I became someone she is afraid of losing and someone she cannot face leaving. Therefore, she has to leave before anything can happen. I felt that she was looking for a way to deal with her unresolved loss. I wonder if this is relevant to the loss of her father. If I allow her to do whatever she wants, it could be like a daddy’s ‘little princess’, but this was not helpful when dealing with the loss of her father. What I think she needed is a therapist who could help her to find relief from the sadness.

The power dynamic within the therapeutic relationship has been more tested in this session. There is not a ‘negotiation from a position of power’(Bannister, 1983) but the opposite. My continuing anxiety of losing this patient contributed to my obedience to her request and enthusiasm to take the leading role throughout all the sessions. The power was more dominant for her and oppressive for both of us. She talked things like ‘if this does not happen, I am leaving’ and I was hooked in asserting my authority and misused the power (Proctor, 2002, p12), for example, when she managed to get the yoga ball during check-in. I imagined the best approach for her was to stay in the session but I ignored the possibility that what was really behind her wanting to leave could be fear. It is not helping if the truth is uncovered, and pretends it is not there (Totten, 2009). It was important that I should have explored her fear with more empathy and followed her emotional context to help her identify her pain, to notice the sensations in working with the props and what happened to her body (Van der Kolk, 2014). However, I was too concerned about managing her desire to leave rather than questioning myself about whether I had done anything wrong. Therefore, I passively focused onto the structure of the session rather than her relationship with me at that moment and this hindered the possibility of exploring our interpersonal space. When I checked my countertransference, the image of ‘tug of war’ was unbalanced and both of us fell onto the ground. This may lead to me and her both feeling insecure. What’s also increased my anxiety was that I was afraid of having to talk about failing a client in supervision, so I was making her stay by pleasing her. I wanted to be helpful in this dynamic, but it was contradictory to her thoughts of ‘staying in the comfort zone’.

The next week(13), Kate came in to the centre, determined to discontinue the DMP sessions and refused to discuss it. I persuaded her to attend the therapy room the following week to end our sessions properly. In supervision, I learned that ‘ending is more important than the beginning’, and it strengthened my will to have a ‘good enough ending’ (Valdivia, 2010). Holms(1997) suggested that a ‘too early’ ending happens when the therapist, by projective identification, has become ‘unconsciously shaped as a figure of the client’s inner world’. Therefore, I tried to have a proper ending with her.

**Ending and Beginning, session 14**

We do not use any movements the following week but talk about what happened to Kate’s decision of finishing abruptly and strongly. I am curious about the reasons for stopping and want to debrief how I have seen her progress and figure out what can I do to help her reconsider the decision. However, she does not want to take in any words I say about thinking of the whole process and the change I have seen from her. At first, I feel frustrated about the resistance from going through traumatic experiences, but Wright (2005) reminds me that sometimes the words we are using are insufficient. Therefore, I let go of thinking how to breakthrough her defence but I am empathic to her difficulties and simply stay with her in the moment. I provide her with the space and time to repair, but leave the decision to herself.

Two few weeks after, Kate comes to me and admits her regret at wanting to finish the sessions. She wants to continue again as the psychosis has worsened when she was not coming and then she realised how much DMP work helped her. She says ‘ it is part of me, I felt regression sometimes.’ I then say ‘we both felt challenged and perhaps need time to repair. This space is left open for you if you wish to continue.’ Then she asks ‘could we have the dance, hands and the light? Could we have it from next week?’ At that moment, I find her to be in a more organised mindset and eager to be contained through DMP.

Kate still missed all the sessions after the break and I felt anxious about this difficult ending. Previously, I had noticed that she always missed sessions after a break and when she finally came into her session, the movements could be quite intimate. I linked that to the voices she mentioned before, which kept coming back until she could not tolerate the horror anymore and would ask them to leave. Kate’s voices may be connected to her difficulty with separation, despite her wish to build positive and encouraging relationships. The despair experienced in the therapeutic relationship, reinforced by my own hopes and expectations, might lead Kate to finish DMP. Maybe her difficulty in separating from me increased the impact of the non-stop horrible voices, the source of her trauma. I was hoping to explore these issues in future sessions.

**Discussion**

DMP enhances Kate’ recognition of emotional stress and her fear of emotional pain as well as physical pain. Kate could identify the differences between the wounded body parts and the healthy body parts through movements. Though it is a painful process that she found hard to continue at this moment, she has not given up. She has gained some strength and grounding, developed through DMP, but she needs to have more time and containment to explore her traumatic psychotic experiences more deeply. She may have been somatising the feeling of physical pains rather than her emotional ones, and it is understandable that she could not tolerate the cause of chronic physical pain as well as the emotional trauma of the psychosis (Landale, 2009, edited by Linda Hartley). DMP provides her a relationship to link her psychosis and traumatic experiences, to understand her pattern of life and personal history and to find a way to look into her emotions.

The use of props is frequent in this work as a container to help Kate identify and explore difficulties. She can even label the unbearable traumatic experiences and can give herself a space to think about her emotions symbolically and creatively (Orlowska&Parker, 2016). Using props to think through reality and in metaphors (Winnicott, 1971) facilitates her to find containment. The props are ‘objects’ between the real world and inner world (Greenberg, 1983), and they can represent her wish to get rid of all the painful feelings. This could be relevant to her regression - due to the fear of not being able to ‘let the voices go away’.

Unresolved trauma can lead to struggle in relationships and this is obvious in Kate; that she had an ‘either close or away’ response with people resulting from her fear going through her pain again(Feldman, 2015). Infusion and isolation are the extreme situations of relationship building. She is hypervigilant to threat but also desires merging space with vulnerability. Therefore, my interventions firstly focused on Kate’s sensations and the re-establishment of her interpersonal skills. The traumatised fear was ongoing as the psychosis was non-stop in her life. I was always worried about her flooding of emotions when I thought of how to take interventions and in the end she really found it hard to hold those emotions. When the patient manages to integrate the bodily experience, she is likely to be in a state of hyper-arousal( Gray, 2001) However, Kate was more able to recognise her emotional state and though she still tended to hide within a comfort zone, she began to explore weight and be curious of her sensation and imagination.

Overall, Kate articulated the frustration of psychosis and in the beginning she just threw things out, but gradually she seemed to identify them through body and build up body strength to cope with them. She could internalise my movements to manage the outer world, for example, she shared how the warm-up calmed her down in certain situations where the hallucination occurred.

Throughout the whole process, the attitude of her pulling in and throwing out touched some part of my relationship with my father, who I am afraid of owning as well as losing due to a constant threat when he comes to me. It is an intense relationship for me to be in and I had a similar struggle when working with Kate. I felt our conversations were sometimes catastrophic - for me, it was like telling me ‘if we had not done it, it is the end of everything and everything is horrible’, and I found it really hard to build the relationship. I wondered if she felt the same struggle when dealing with other relationships. However, I still sense her as a gift as part of learning in DMP, because we have managed to build up a close relationship through sharing the fragility but gaining more emotional bond and capacity. I learned to use my feelings to break the resisting deadlock in therapy (Yalom, 2002). Kate once seemed less needy, especially in her desire of touch in the day centre. This indicated her progress to become self-contained in the external environment and DMP could be ongoing in her life. However, in future DMP sessions till in the end, though it might still be difficult to work with her resistance to come in to the session due to the upcoming separation with me, there is also a need to work hard on her body awareness to help her in integrating her cognition and emotion when she is in the session.

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