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THE OXFORD HANDBOOK OF

DANCE AND WELLBEING

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CHAPTER 48

DANCE/MOVEMENT THERAPY AND BREAST CANCER CARE

A Wellbeing Approach

ILENE SERLIN, NANCY GOLDOV, AND ERIKA HANSEN

Introduction

Breast cancer causes the second highest mortality rate for any type of cancer, and will affect approximately one in eight US women over the course of their lifetime (US Breast Cancer Statistics 2014). Due to new treatments and research, as of 2008 there were more than 2.6 million breast cancer survivors in the US alive ten years after diagnosis (Cancer Facts and Figures 2012). Because cancer survival is a transition through a difficult period of time that can cause severe anxiety, distress, and impaired quality of life, many women must sort through a confusing array of physical and emotional therapies (Lethborg et al. 2000).

Medical dance/movement therapy (MDMT)—a subspecialty of dance/movement therapy (DMT)—is a holistic therapeutic method uniquely suited to working with women with breast cancer. It aims to support the development of personal resources by creating a safe and supportive environment that encourages creativity (Serlin 2007), and enhances physical, cognitive, and spiritual functioning (Serlin 2000; Stockley 1992). The literature suggests that MDMT brings positive changes for patients coping with severe illnesses (Cohen and Walco 1999; Palo-Bengtsson et al. 1998; Yang et al. 2005), increases positive social skills (Aktas and Ogce 2005; Webster et al. 2005), and utilizes archetypal dimensions (Ayres 1973). Recent discoveries in neuroscience (Schore 2012; Siegel 2012; Marks-Tarlow 2012; Wright 2009) provide further support of the power of mind–body

approaches to healing; the connection between mind and body is indeed a core component of DMT and MDMT practice.

Cancer treatments can cause extreme fatigue, loss of physical functioning or disfigurement (Dimeo 2001; Jereczek-Fossa et al. 2002), and emotional distress. These include feelings of helplessness, uncertainty, anxiety, depression, loss of identity and meaning, and feeling betrayed by one's body (Clark et al. 2003). MDMT addresses these issues 'primarily as a psychosocial support intervention, complementary to conventional and standard medical treatments' (Goodill 2005, p. 17). Interventions of MDMT intersect with the psycho, social, and spiritual dimensions of women's lives at a time when their life trajectory has been interrupted, forcing them into a new assumptive world (Fawzy et al. 1995). Resuming their forward life trajectory (Fawzy et al. 1995), constructing new meaning making systems (Brown 2008), and experiencing wellbeing—all goals of MDMT—originate with the simplest instruction: to move.

This chapter engages in an extensive review of the literature by exploring ways in which this particular approach will support women struggling with issues around breast cancer revisit their sense of self, and create new stories about who they are in themselves and in the world.

Breast Cancer, Wellbeing, and MDMT

The experience of breast cancer radically diminishes the person's sense of wellbeing, and MDMT is an approach that supports wellbeing. The word 'wellbeing' is essential for this chapter and for the entire book, and has been defined in different ways across cultures. Our definition of wellbeing is essentially holistic, including physical, emotional, and social dimensions. For example, Prilletensky and Fox (2007) defined wellness as 'achieved by the balanced and synergistic satisfaction of personal, relational, and collective needs, which, in turn, are dependent on how much justice people experience in each domain' (793). Five domains of wellness criteria can diminish one's sense of justice: (a) affective or emotional responses, (b) polarized or cognitive, (c) acquired or educational, (d) situational or historical, and (e) invested or political (Prilletensky and Fox 2007). Assessments of wellbeing use self-report and socially constructed terms to observe social relationships, work, physical health, and other demographic variables. Interpersonal relationships can affect happiness and wellbeing, increasing quality of life, confidence, and success (Diener and Ryan 2009). Living with breast cancer can also negatively impacts intimate relationships, creating problems of self-confidence and communication (Fletcher et al. 2010).

Wellbeing is also associated positively with creativity, as shown in recent studies of the role of creativity in health and healing. The creative process involves novelty, learning,

and the reduction of stress, which can promote mental wellbeing (Evans 2007; Hanna 2006), and in which 'each individual has the opportunity to enjoy and benefit from that which is rightfully his [*sic*] possession—the power to create' (Hawkins 1988, p. 8).

Wellbeing approaches are traceable to psychological, medical, aesthetic, and spiritual roots because they are based in a philosophical vision that recognizes individual and collective strengths and meaning in experience (Christopher 1999). However, wellbeing for women with breast cancer can also be very unique due to the value a woman attaches to the breast, the severity, results and side-effects of the treatment, the impact on intimate relationships, and body image issues (Hopwood et al. 2001; Hormes et al. 2008; White 2002). Some argue that wellbeing can simply be associated with normal, 'good day' activities such as sleeping well, taking care of personal needs, and doing the normal things one did 'before you got cancer' (J. Cohen, personal communication, 26 July 2009).

Dance and Wellbeing

Relevant literature suggests that dance has numerous health benefits (Arcangeli 2000; Bremer 2007; Cannon 1967; Hanna 2006). Hanna (1987), for example, argues that dance is a cultural necessity that has been implanted in 'emotional expression, play, work, duty, union with the sacred, theater, ceremonials of authority, and art" (p. 13). It can show and mirror important dimensions of human existence: transcendental practices in religion, and individual and group self-exertion, education, and induction in secular society. It echoes practices of ancient healing rituals (Kiev 1964), while reproducing sociocultural patterns and politics as a vehicle for imparting information, maintaining cultural customs, and beliefs (Kraus 1969).

It is our belief that the arts speak to our souls in a time of increasing speed and mechanism. Ancient traditions in the arts have provided restoration in times of imbalance. Sometimes they have helped us articulate our pain, while at other times they help us transcend our pain and lift us into a larger dimension. We believe that through the arts, people can express their experience of having the illness, explore their own imagery and resources for healing, and decrease loneliness by deeply sharing rhythmic and non-verbal connectedness. Martha Graham tapped into the 'collective unconscious' to discover symbols of renewal and regeneration in her dancing. Armitage (1978) quoted Graham:

> It is the affirmation of life through movement . . . to impart the sensation of living, to energize the spectator into keener awareness of the vigor, of the mystery, the humor, the variety and the wonder of life; to send the spectator away with a fuller sense of his own potentialities and the power of realizing them, whatever the medium of his activity. (pp. 102–3)

Dance/Movement Therapy

DMT was established in 1966 as 'the psychotherapeutic use of movement to further the emotional, cognitive, physical, and social integration of the individual (American Dance Therapy Association 2013). Dance/movement therapists use movement for diagnosis and treatment, as movement reflects patterns of coping, defences, memories, inner states, and relational patterns which are concretized as qualities in relation to space, time, weight, and flow. The direct use of the body as a tool allows dance therapists to explore body image and its distortions, as well as to discover unfamiliar or disowned parts of the psyche (Chaiklin 1969; Serlin 1999). This very specific understanding of the language of the body is a key element in working with the physical and psychological changes accompanying breast cancer. There are a number of approaches within DMT, one of which is MDMT, which highlights the need to address the person as a whole.

MDMT: A Whole-Person Perspective

A whole-person approach does not focus on symptom reduction, but considers the person in the context of his or her world (Serlin 2007). This approach seeks to understand the meaning of symptoms, as well as their biological and behavioural causes. In a whole-person approach, mind and body are interrelated (Rossi 1986). Candace Pert's (1997) groundbreaking work on psychoneuroimmunology demonstrated that the processing of emotions often affects physical illnesses and the ability to heal. Research on healthy humans, as well cancer and HIV-positive patients, has shown that significant increases in immune function and positive health outcomes correlate with constructive emotional expression (Pert 1997).

Within MDMT a whole-person perspective is often associated with a wellbeing approach that embodies humanistic values such as positive strengths, meaning, resiliency, creativity, and self-actualization (Engler 2003). The humanistic approach to trauma encourages us to confront our death anxiety; for example, discover new meaning and identity, and move from beyond prior levels of functioning to transcendence (Calhoun and Tedeschi 1998; Epel et al. 1998; Parapully et al. 2002; Serlin and Cannon 2004; Updegraff and Taylor 2000). It is not only positive, however, but also encourages us to learn from life's struggles and value growth through adversity (Joseph and Linley 2008). Telling the story of the disruption and the reconstruction of a meaningful life can provide a narrative to deal with the existential loss and help recover meaning, faith, and courage (Epting and Leitner 1992, Feinstein and Krippner 1988; Howard 1991).

KinAesthetic Imagining is a method of MDMT which is 'a theory and an experiential process . . . a dynamic embodied form of imagination in which participants as artists

compose themselves and transform their lives. KinAesthetic Imagining is both a theoretical understanding and a process of an embodied aesthetic psychology' in which 'the imagery and material arise from the participants and the group itself' (Serlin 1996: 32). It has three parts: 1) check-in and warm-up, consisting of meditation, verbal sharing, grounding, breathwork, and simple movements; 2) amplifying the themes through repetitive movements, imagery, metaphors, and archetypal themes; and (c) cool-down movements, reflection, and sharing (Serlin 2000). Through the expressive, creative, movement of DMT, participants can find kinaesthetic images on which they can focus which act as support for their healing (Ganahl 1995). It is then possible to find ways to explore aspects of themselves and reconnect positively with themselves despite the pain of their lives (see Video 48.1 on the Companion Website ▶).

Effects of Medical Dance Movement Therapy and Cancer Care

Individual and group MDMT services for women with breast cancer can be found in hospitals, outpatient clinics, rehabilitation centres, and many other settings where psychosocial support interventions are provided to breast cancer patients, survivors, caregivers, and family members. MDMT for women with breast cancer, along with pediatric oncology, has seen the most growth and expansion within cancer-specific applications of MDMT. According to Goodill (2005), 'it is an interdisciplinary field: a hybrid of the art of dance and the science of psychology adapted to human service. The field has a history of embracing theories and findings from various other fields' (p. 21). Hock et al. (2006) conducted a survey of ninety women with a diagnosis of cancer to explore each participant's preferences for an exercise outlet. The participants, with an average age of 52.4 years, ranked different forms of exercise on an ordinal scale with five positions indicating interest, from very interested to not interested. They ranked dance/movement among the second most popular forms of exercise.

The effectiveness of MDMT for outpatient psychosocial cancer rehabilitation has been documented for children (Cohen and Walco 1999; Goodill and Morningstar 1993; Mendelsohn 1999) and adults (Dibble-Hope 2000; Ho 2005; Mannheim and Weis 2006; Sandel et al. 2005; Serlin et al. 2000). Furthermore, the literature suggests that MDMT can enable breast cancer patients to cope with pain and ease depression by increasing vitality and supporting development of a healthier body image (Dibbell-Hope 2000; Goodill 2005; Goldov 2011; Lacour et al. 1983; Mannheim and Weis 2006; Serlin 2000; Serlin 2006). Dietrich's (1990) preliminary and descriptive multimodal Master's thesis introduced a teaching-tool video to promote mind–body integration with cancer clients. Results from the subjective reports of participants indicate that an integrative

approach using DMT can be a valuable method for increasing wellbeing and aid the healing process during a stressful time.

Serlin's (1996) pilot study measured the effectiveness of movement therapy with women with breast cancer. The measures included the Profile of Mood Scale, the Body Cathexis Scale, the Mizes Anorectic Cognitions questionnaire, a spiritual inventory, and semistructured interviews. 70% percent of the variance on the Body Cathexis Scale was predicted by the helplessness/hopelessness, coping, depression, confusion, and anxiety subscales, while 74% of the variance of total mood disturbance was predicted by vigour, confusion, fatigue, anger, tension, fighting spirit, helplessness/hopelessness, body cathexis, and spiritual belief inventory. Qualitative analysis of the interviews pointed to shifts from perceiving the body as enemy to friend, from a distant to a close relationship with the body, from a feeling of unreality and inauthenticity about the body to feelings of reality and authenticity. Although the study pointed to promising trends, it was possible that the scales did not accurately reflect the profound disturbances and changes in a woman's perception of her body during cancer.

The second phase of the study, therefore, focused on developing a body awareness inventory which drew from the women's own words to investigate changes in body awareness and image, since the available assessments of body image were normed on women with eating disorders and measured external or concrete evaluations of the body (questions such as 'Do you feel fat?'), and did not address the 'mutilating and desexualizing experiences of undergoing treatments for breast cancer' (Serlin et al. 2000: 130). The Serlin Kinaesthetic Imagining Profile (SKIP) (Serlin 1999) was developed to assess the subjective, symbolic, and qualitative inner experience of bodily change over time. The items began with and stayed true to the women's own words, and captured the layers of emotional and spiritual shifts. Statements from participants held metaphoric and symbolic content: ('When I started the group I felt like my body betrayed me, when I ended the group I felt like my body was my friend'). Section I of the SKIP was based on interviews asking for the subjective experience of change, and Section II was a Laban-based observational system.

Pilarski (2008) conducted a multiple case study on the effects of DMT using a nested concurrent, mixed-methods design involving two participants. The objective of this study was to gain a better understanding of the effects of DMT on women living with breast cancer. After two sessions of DMT that focused on issues of body image and sexuality, the participants' experience was explored using the SKIP, participants' journal entries, and the researchers' field notes. Findings showed mixed results, suggesting further exploration of the relationship between body-image disturbance and the results of the SKIP.

In Goldov's research (2011), the effectiveness of individual MDMT to decrease body image problems in women with breast cancer was observed in a Cohen's *d* analysis, comparing means to examine the strength of a phenomenon (Cohen 1988; Goldov 2011). Goldov's study used a mixed-method, quasi-experimental, nonequivalent control group, A–B–A design, and three cancer-specific body image measures including the SKIP (Serlin 1999). The study examined the effects of a manualized intervention of

five sessions of MDMT, with a dyadic rhythmic component. In the study, the researcher provided the sessions for each woman in the experimental group, individually, within two weeks, according to each woman's schedule. Following the manualized intervention, each participant engaged in a creative improvisation beginning with a warm up, transitioned to moving more dynamically with rhythmicity as the researcher played a percussion instrument, and ended with slowing down, internalizing the experience, and reflecting on its meaning.

Remaining within the domain of oncology-specific measures, a cancer-specific body-image construct (White 2002) was utilized in Goldov's (2011) study to evaluate the strength of the MDMT intervention. White's (2002) heuristic cognitive behavioural body-image model for cancer patients integrates multiple dimensions of body-image problems into a dynamic understanding that ignores the illusory bidirectionality of body-image problems which commonly accompany discourses on body image. Terms such as 'good' or 'positive' body image and 'bad' or 'negative' body image are avoided in this model. The body-image dimensions in the model are self-schema, body image schema, investment in changed body features, self/ideal self-discrepancy, appearance assumptions, automatic thoughts and images, body-image emotions, and compensatory behaviours (White 2002).

This heuristic model of important body-image dimensions explains body-image problems as stemming from a self/ideal self-discrepancy between a woman's actual and/or perceived appearance and function of discrete bodily attribute(s), and her investment in the ideals concerning that bodily attribute(s). Investments in body ideals are maintained by one's self, one's thoughts of what others think they ought to look like, and from standpoints of actual others. The system of self/ideal self-discrepancies fosters beliefs that are disparate from who one is, and interferes with one's capacities for maintaining good feelings. As part of this model, situation-specific automatic thoughts and images can determine the primary emotional consequences and compensatory behaviours. Women with perceived or actual appearance changes, accompanied by the presence of a threat to their ideal selves, may experience negative appearance-related assumptions, thoughts, images, emotions, and behaviours if their self/ideal self-discrepancy relates to a physical attribute in which they have had significant personal investment. Self/ideal self-discrepancies adjudicate body-image problems, and negative emotional and behavioural consequences, which interfere significantly with normal routine, occupational functioning, social functioning, and/or relationship quality (White 2002).

In Goldov's (2002) study, three cancer-specific Likert-scale questionnaires and written responses to questions were employed to provide the quantitative and qualitative data. The Likert-scale measures were the Body Image Scale (BIS) (Hopwood et al. 2001), the SKIP (Serlin 1999), and the Body Image and Relationship Scale (BIRS) (Hormes et al. 2008). The items on the BIS addressed interpersonal dimensions of body image relating to features of attractiveness from an outerpersonal perspective on the body-image dimensions of self-schema, self/ideal self-discrepancy, appearance assumptions, and compensatory behaviours. Items on the SKIP encompassed women's intrapersonal experiences about bodily changes during and after cancer treatments, and addressed the

dimensions of self-schema, body image schema, self/ideal self-discrepancy, and body-image emotions. The items on the BIRS captured experiences related to appearance, health, physical strength, sexuality, relationships, and social functioning on the body-image dimensions of self-schema, body-image schema, and compensatory behaviours. For ease of comparison the scales were converted to numbers, with higher numbers representing higher levels of body-image problems across all assessments. When the means of the three Likert-scale measures were compared over the phases of the study, reductions in body-image problems for women in the experimental group were observed in a Cohen's *d* analysis, compared to women in the control group (Christensen 2004; Cohen 1988). The Cohen's *d* analysis revealed medium and large effect sizes immediately at the end of all five MDMT sessions, and then again two weeks later.

The writings of experimental-group women collected throughout the study, and then two weeks after their last MDMT session, confirmed the medium and large effect sizes. Comments such as 'I am taking responsibility for my body image', 'I feel good about my body', and 'I have a stronger connection to my emotions' were evidence of the changes taking place within the women who experienced MDMT (Goldov 2011). The writings by patient number 2 exemplifies the changes that took place in the majority of women who danced. Patient number 2 wrote: 'I feel strength in discovering various aspects of my body', 'I see my knees as weak, yet they do quite well with this movement', and 'I think that movement changes my mood' (see vignette number 1). Additionally, the majority of the women who danced described feeling able to take time to rebuild a better level of health and wellness. They also described new plans to maintain their body-image gains, such as joining a gym, taking a walk, and engaging in new behaviours, whereas the writings by women in the control group indicated that they were still struggling with body-image problems and self-discrepancies. Contained in their written responses were comments such as 'I believe that I don't really have a very good body image', 'I am embarrassed and miserable', 'I am more aware of the disjointedness of my body', 'I am dreading having my picture taken', and 'there is more work to do' (Goldov 2011). In addition to experiencing gains in body-image wellness after MDMT, women in the experimental group had reduced resistance to making other changes. They indicated their intentions to continue maintaining their body-image wellbeing by making plans and taking action. Prochaska and Norcross's (2003) integrative, biopsychosocial model of change describes planning to take action in the immediate future as the preparation state, and making modifications in one's lifestyle as the action stage. In contrast, the comments by women in the control group appeared to be in the pre-contemplation stage of change. They were learning to cope and unaware of what to change, with no actions planned for the foreseeable future (Goldov 2011; Prochaska and Norcross 2003). These results point to possible value for MDMT as a worthwhile intervention for improving body-image wellness in women with breast cancer.

Anna Halprin—choreographer, dancer, and movement teacher—was a pioneer in the field of dance as a healing art, beginning in 1980 (Halprin 2000). As she struggled with cancer, she knew how to engage people with life-threatening illnesses in sensory awareness exercise and expressive movement and dance to help participants 'begin the

journey into the body's endless mysteries' (p. 49) and 'act out the drama of the immune system in relation to the cancer cells' (p. 109).

Dibble-Hope (2000), using a form of DMT called Authentic Movement, looked at body-image, self-concept, mood state, and levels of distress using the Profile of Moods States, Symptom Checklist 90-Revised, the Berscheid-Walster, Bohrnstedt Image Scale, and also semistructured interviews and written evaluations. Results showed significantly greater improvements in physical wellbeing and vigour, reduction in fatigue and somatization, and greater body appreciation, acceptance, the benefit of social support, and positive feelings about participants' bodies.

Dance/movement therapist Susan Sandel used the Lebed Method (Sandel et al. 2005) to assess change in shoulder function and quality of life. The self-report measures used to establish outcome data were the Functional Assessment of Cancer Therapy-Breast (FACT-B), the BIS, the SF-36 Health Survey, shoulder range of motion measures, and a physical examination. The results of the BIS showed that both groups improved their body image after the movement intervention. On the FACT-B, the improvement in the intervention group was statistically and clinically significant as well (Sandel et al. 2005).

Rainbow Ho's pilot study (2005) using the Perceived Stress Scale (Cohen 1988) and the Rosenberg Scale (Rosenberg 1965) found that DMT reduced stress and increased self-esteem in Chinese cancer patients. In this study, the significantly lowered perceived stress scores and the improvement in self-esteem scores indicated that the programme was effective (Ho 2005). People reported that the programme helped them express their feelings and emotions more openly, increase their confidence, and obtain support. A content analysis of their evaluations identified the personal themes of relaxation, mind–body interaction, personal growth, and spirituality.

A multimodal pilot study conducted by Klagsbrun et al. (2005) assessed the utility of focusing and expressive arts therapies on the quality of life of women with breast cancer using The Experiencing Scale, Clearing a Space Checklist, the Grindler Body Attitudes Scale, the FACT-B Scale, the Functional Assessment of Chronic Illness Therapy–Spiritual Wellbeing Scale, and observations, interviews, and written responses to specific questions. One randomly selected individual participated in a case study and took part in a follow-up interview. The Grindler Body Attitudes Scale assessed how well she kept a positive attitude toward her body and evaluated to what extent her body was perceived as being able to heal itself. Klagsbrun designed the study to 'help motivate women with breast cancer to care for their bodies more effectively, and participate in activities that enhance wellness' (Klagsbrun et al. 2005: 117).

Mannheim and Weis (2006) conducted a three-year pilot study to observe how MDMT improved physical and emotional wellbeing and impacted variables of health, anxiety, depression, and self-esteem. They used the Dortmund Questionnaire on Movement Therapy, the Quality of Life Questionnaire, the Hospital Anxiety and Depression Scale, and four subscales from the Frankfurt Self-Image Concept scales. They also gathered data from written responses to open-ended questions, Laban/Bartenieff Movement Notation observations, and movement analysis write-ups about

three participants in the dance therapy sessions. Mannheim and Weis (2006) found that participants reported significant improvements in physical functioning, a decrease in fatigue, and significant improvements in self-esteem.

Vignettes

The following vignettes illustrate the use of MDMT with individual, group, and healing rituals.

1: Individual MDMT

This example demonstrates the impact of MDMT on one of the six women who, as part of Goldov's (2011) study, received five individual MDMT sessions within a period of two weeks. In each session, the patient began with a warm-up and then moved according to her feelings and needs, improvising in movement, while being rhythmically accompanied by the dance/movement therapist playing a rhythmic instrument of the patient's choosing. Each participant was assessed using the three oncology-specific body-image measures, before the individual MDMT sessions, after the conclusion of the last MDMT session at the end of two weeks, and then one more time, two weeks post-treatment.

P2, a 55-year-old Caucasian female, was diagnosed with Stage I breast cancer, and had a lumpectomy and then radiation treatment. Her score means on the quantitative measures of the SKIP and the BIRS, before receiving the manualized MDMT intervention, were 2.73 and 3.53 respectively. Two weeks after taking part in her last MDMT session her score means on these measures decreased to 2.33 and 3.03 respectively. These score decreases represent a reduction in body-image problems (White 2002), as higher scores signify higher levels of body-image problems (Goldov 2011).

P2 joined the study approximately three months after her diagnosis. The data from her written responses to questions revealed that before her first MDMT session she was initially 'a bit apprehensive' and 'not certain what it might involve'. But after moving in her first MDMT session she wrote 'I was surprised at my ability to move' and 'I believe that this opened up my mind to various parts of my body that are reacting to the stress of treatment. She added: 'I discovered that I have more creative movement that I had thought.' She also wrote 'I felt the stress in my back—which I was not very aware of', and she visualized herself 'in the clouds moving freely—then in the water splashing up as though to cleanse my entire body and spirit.' She wrote that she was 'fighting off the cancer in movement (kind of like Pac-Man) and 'moving through the cancer', commenting that 'my body is stronger and I am more flexible than I thought.' P2 also wrote: 'I am a bit self-conscious but I found that you were very supportive and I appreciated the instruction that helped me move through the exercise and transition beyond various stages to explore further.' After the second session, she stated: 'I find this process interesting as

I open myself up to the concept and let go of the thoughts of programmed exercise.' She noticed how various elements of her body work together, saying that 'the sensation is that of connectedness.' She reported feeling different after MDMT saying: 'I feel strength in discovering various aspects of my body as they move. I found it interesting that I see my knees as weak—yet they do quite well with this movement.'

After the third session, P2 felt 'less inhibited', and realized 'how painful movement can be when you haven't utilized your body fully.' She remarked: 'My strength comes from inner being', and 'from knowing that I am taking steps to help my body become well.' At the fourth session, P2 wrote that she 'took a risk in self directing myself this time', and found that 'it was interesting growing in the freedom of movement.' After the fifth session, P2 wrote that the 'musical instrument helped to take me deeper into how my body is moving.' She also noted that 'I believe that I am healing' and 'I think that movement changes my mood' and 'centres me more'.

Two weeks after the last MDMT session, P2 reported that she 'began to listen to meditation tapes to get in touch with my emotions and regain physical strength.' She began 'walking for 30 minutes during the day . . . to reduce the stress in my work life', noting that she 'found freedom in just moving.' She stated: 'I always thought that you needed to have an exercise tape or something of that nature and didn't value the fact that you just got up and moved.' She wrote about her body image:

> I am working on taking responsibility for my body image. I have a different view of what I want to be and I am taking pride in the baby steps I am taking to better my body to respond to the things I want to do in life, which is different than just sitting on the sidelines and thinking I just can't do that anymore.

This patient's experience with MDMT began with her feeling apprehensive and self-conscious during the first session. With the presence of the dance/movement therapist who supported her mood, mirrored her rhythm, and played a percussion instrument while she danced, P2 was able to take risks, direct her own movement, and give herself experiences of personal empowerment. Her written comments, tracking her positive and varied experiences, are a testimony to the potential of MDMT to satisfy and balance personal and relational needs (Prilletensky and Fox 2007), increase quality of life, confidence, and success (Diener and Ryan 2009), reduce human suffering through creativity (Evans 2007), reduce body-image problems (White 2002; Goldov 2011), and promote health and mental wellbeing (Evans 2007; Hanna 2006).

2: Group MDMT

During the twelve-week session at the California Pacific's Institute of Health and Healing (Serlin 2000), women used movement to discover unfamiliar parts of themselves, including new discoveries of creativity, resourcefulness, and humour. Some found anger that energized their will to live, and used art to release normally socially

unacceptable parts of themselves. One woman, who had spent her life being a 'good girl' helped create a group 'bad girl' dance, and said:

> Oh, the Halloween and the Bad Girl. One of the things for me that happened as a result which was tremendously impactful for me is that, well, it started with the dance when we were dancing with the scarves on that one day I was in there and what I got in touch with was how when I was a young girl, I kind of shut down, I think, to my femininity . . . and I got really back in touch with that in the group, in the going back and remembering even when I was in first grade . . . about how I . . . loved to dance and I was in this recital and, for some reason, something happened in the recital that I somehow remember my father saying I was fat or something like that, that I would never dance again and in the group I got in touch with that pain through some kind of movement that we did . . . and then afterwards you said why don't you take this scarf and have the people hold it . . . and dance behind it . . . and so what happened to me was I felt really protected . . . with the scarf there, very safe with the people in the room and then danced my dance and out of that it freed up really in me the desire to dance and move, the fun that I had doing it, the joy and the love that comes into my life from it and also the essential woman that has been there that is . . . really afraid to come out because . . . it was always bad to be that way and bad to be interested in sensuality and sexuality . . . and so, as a result of that, the Halloween thing was we were supposed to come as our bad girl . . . so I came all dressed in black, black leather jacket, black top, black bottoms and just really felt I could be my awful self or the other self, that's in there that's part of me as well. And in doing that it just freed up really who I am because now I'm so much more embracing of all that part of me and none of that is bad and it's more fun . . . We've all been good girls . . . and I've never looked at it that way. It seemed like all of us in the group had that bad girl that we were really thrilled at allowing to get in touch with and to let out and that we always felt . . . that we had to be good girls all our lives.

From this dance, she drew a figure (see Figure 48.1) and called it Sultry Jet. Reflecting on her experience, she understood more about the meaning of her illness: 'Well, what is cancer? Cancer is a cell that's lost. Its nucleus takes over, right? And it goes out of control. Well, I think that what's happening is that as people we're out of control. We do not connect.'

3: Creating Healing Rituals

Rituals are dramatized symbolic enactments which help individuals move from one stage of life to another, and can help women prepare for treatments, mourn losses, and so on. While traditional rituals are passed down from generation to generation, constructed rituals are built on modern symbols and vocabulary. Victor Turner and Barbara Myerhoff argue that 'applied anthropology' allows us to give communal meaning to modern crises (Turner 1982, p. 25), and that today's lack of ritual makes these 'constructions of performance' essential. Such constructions can help women who are facing

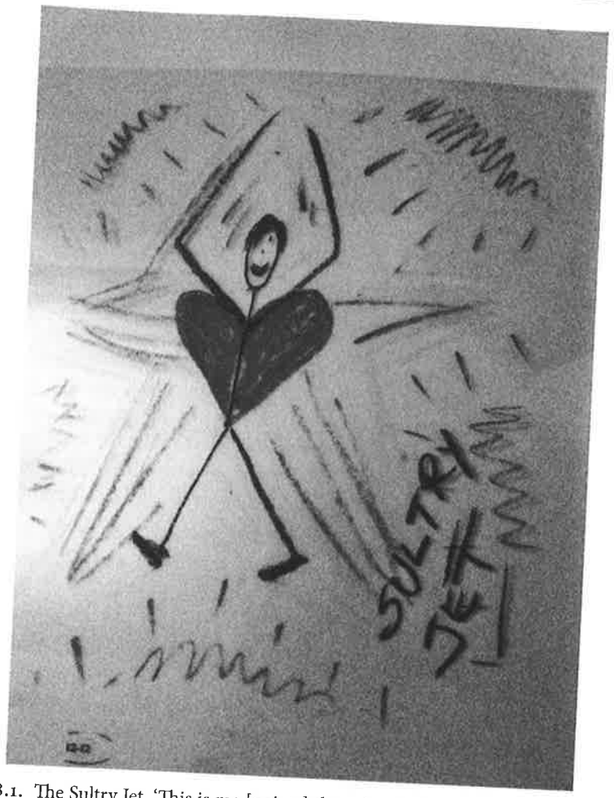

FIGURE 48.1. The Sultry Jet. 'This is me [points] the sultry jet. I don't remember much about growing up except one time I was dancing as the Jet—it was anti-feminine. Black leather. smoke-filled room, sultry poetry, silence. Hey Mom, I'm a beatnik and I wanna dance Sultry Jet.' (Photo credit: I. Serlin.)

breast cancer alone feel part of a group, reduce fear and isolation, and express and share feelings in a common symbolic structure. In fact, taking the initiative to construct a ritual with a trusted group can bring out courage and creativity in a participant and help her move from passivity to empowerment.

In the MDMT group, boundaries were different from those in a usual support group. For example, the group became involved in some activist activities in the community that took us outside the therapy or clinic room. One such example of work in the community is the annual Race for the Cure, sponsored by the Komen Foundation as part of Breast Cancer Awareness month in San Francisco's Golden Gate Park and attended by approximately 8,000 participants. An Opening Invocation led by Ilene Serlin began the

race at 7.30 am on 19 October 1997. Emerging out of four years of working together, eight women who are trainees and/or ex-group members led participants in the meadow in a special choreography called a Movement Choir. Movement Choirs were created in the early 1900s by Rudolf von Laban, a Hungarian architect, visionary, and grandfather of modern dance (Laban 1971). Based on simple forms like notes, accompanied by live drumming, and combined into structures like chords, ritualistically repeated patterns create vibrations and resonances which unite the participants in an attitude of harmonious reverence (Bartenieff 1974). A contemporary use of the Movement Choir in Golden Gate Park is shown in Figure 48.2.

Another kind of healing ritual grows organically from the movement and the group's creativity. One woman was going through bone marrow transplant in the spring, and she was forbidden to work in her garden. So our support group decided to offer help, and organized a Garden Party to which we took a picnic lunch. She organized shovels and equipment to plant her precious rose bushes, and the group planted, sang, and ate lunch together. A month later, the group returned to check on the plants, and weed. This ritual gave them support in a tangible yet symbolic way. While the ritual was reminiscent of old-fashioned traditions such as neighborhood barn-raising, this one grew naturally from our group work in creating a sense of safety, trust, and collaboration.

FIGURE 48.2. Race for the Cure. Leading the Opening Invocation with a Movement Choir for the annual Race for the Cure, Golden Gate Park, San Francisco, 15 October 2000. (Photo credit: I. Serlin.)

Conclusion

A life-threatening illness confronts patients with the reality of their mortality. A diagnosis and treatment of cancer can have a profound effect on one's experience of self. The shock of the diagnosis, the confusing choices about medical treatment, and a radically altered body leaves many patients with the difficult task of having to integrate these changes into their self-concept.

MDMT makes possible changes in women's experiences of themselves through expressive creative movement. Movement helps them uncover and explore the meaning of their illness both verbally and non-verbally. Existential fears such as the confrontation with mortality and spiritual fears, such as loss of meaning or hope, call for a therapy that addresses mind, body, and spirit in a framework of a whole-person, wellness perspective. Through MDMT, patients can express loss and fears symbolically, find new images for themselves, and reconstruct new lives and wellbeing.

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