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Touching the untouchables

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Abstract

This paper presents a model of dance movement psychotherapy/body psychotherapy that deploys touch and movement techniques from a somatic movement education and therapy approach called Body-Mind Centering® (BMC®). The case study is situated in the context of the UK National Health Service, in adult learning disability services. Reference to a case study serves to illustrate the value of touch to the therapeutic process and demonstrates that touch is integral to communication and relationship, including issues of capacity and consent. The case study clarifies the role that a humanistic, person-centred dance movement psychotherapy approach has to offer to address the patient's clinical need, and the socio-political implications of the work in a predominantly non-touch care culture. The devaluing of touch and confusion around the use of touch is considered within the context of health and social care. Staff training provision involving touch methods is presented as a constructive solution to improving the quality of care provided to clients, to enhancing understanding and providing effective strategies to deal with these issues. A review of non-touch policies is recommended, with due consideration of factors such as touch deprivation and in recognition of the contribution that human contact—and so touch—can bring to bear on the health and wellbeing of the most vulnerable in society.

KEYWORDS

case study, embodiment, movement, touch

This article presents an emergent integrative model of dance movement psychotherapy (DMP) founded in touch and movement principles from a somatic movement therapy (SMT) practice called Body-Mind Centering® (BMC®). Body-Mind Centering® and BMC® are registered service marks of Bonnie Bainbridge Cohen, used with permission. The Somatic Movement Therapy training is certified by International Somatic Movement Education and Therapy Association (see www.ISMETA.org).

Specific to the context of this journal I argue that BMC methods have an effective role to play in supporting the unspoken needs of people with profound and multiple learning difficulties (PMLD). The BMC approach provides a body-oriented, adaptive and accessible methodology for a humanistic person-centred psychotherapy framework (Hartley, 2004; Rogers, 1979). The ensuing case example indicates the empirical nature of BMC methods (Bainbridge Cohen, 2012) and situates this view within the context of a trend towards more integrative and pluralistic approaches in psychotherapy practice (Gallagher, 2005; Hanna, 1988; Hartley, 2004; Levy, 1995; Totton, 2015). The challenge remains to find a language to communicate the corporeal realm of the work, to avoid disembodying the process and reducing the body to an object or "tool" attributed to a theoretical perspective (Loman & Merman, 1996). I consider the context of my DMP clinical work and outline key BMC concepts that underlie and inform my reflection upon it (Cooper, 2008). I propose that embodied practices and experiential learning equip the practitioner with an understanding grounded in the body *and so* in "mind" and advocate the value of this for both client and therapist in the therapeutic processes (Bainbridge Cohen, 2012; Hartley, 2004). The ethical and political aspects of involving in statutory services learning-disabled people who lack capacity to consent and are subject to the vagaries of a non-touch culture are also addressed.

1 | A FIRST-PERSON ACCOUNT

This paper does not seek to persuade the reader that herein a universal truth resides, but rather that herein lies a perspective informed by insights of some significance. As the writer, I present a subjective view, the view of a practitioner for whom the impact of touch has been significant in clinical practice and the subject of a PhD study, and for whom there is an interest in continued debate and research into this topic. Having declared this interest I immediately counter the idea that "interest" necessarily implies that there is unmitigated bias in my view. I present a case I experienced and learned from and provide a reflexive account, aware that this will meet the mind, and so the "bias" of you, the reader. You may not share the same agenda but you may be touched by something that could influence your practice and so your clinical outcomes—you may seek to work with people with PMLD.

Is it possible for you, the reader, to suspend your preconceived expectation, to withhold your need to be persuaded with more statistical data, or to concur with my agenda? Can you allow for the possibility that there is no intention to persuade or attempt to claim a truth (Butler, 2005; Depraz, Varela, & Vermersch, 2003)? Rather than persuade, I seek to set out the terrain of inquiry for you, the reader, to witness the "work" and consider the sense I make of it, reflexively. Having not had my experience, or been present in the room, can you legitimately counterclaim against the interpretation I make of it? I propose you seek answers to your questions experientially, through your own "reflexive relationships" (Etherington, 2007, p. 599) and practice-based research as a DMP or other kind of therapist (Meekums, 1993, 2002, 2006, 2014). Etherington (2007, p. 599) discusses the ethical issues and "vulnerabilities experienced by researchers when using reflexivity" and requests that we "come from behind the protective barriers of objectivity and invite others to join with us in our learning." As well as discerning status and hierarchical relationships, we may "observe the behaviours involved in respecting the autonomy, dignity and privacy of participants (or not!); the risk of failing to do so; the ethically important moments that might have occurred; and the means by which they are ethically negotiated" (Etherington 2007, p. 604).

In writing this paper I am continuing a process of discernment and research. My interests are firstly "political" in the sense of challenging the statutory non-touch agenda, and secondly "professional" as I challenge the apparent complicity of the "traditional" non-touch psychotherapy approach (Smith, 1998; Bloom, 2006; Tune 2005; Totton,

2015), on behalf of the untouchables in society—such as people with PMLD (Simmons & Watson, 2015). I support a pluralistic and integrative approach to practice and research in the creative arts therapies and in particular DMP, to enable this valuable, supportive, and holistic healing profession to grow.

2 | INTRODUCING THE "UNTOUCHABLES"

The disenfranchised position of people with PMLD in society has been recognised by national campaigns run by MENCAP (2004, 2012, 2014). Children and adults with PMLD live in a reality of complex medical issues and dependency, social isolation and deprivation (Gale & Hegarty, 2000; Williams, Marriott, & Townsley, 2008). The case for greater representation of people with PMLD in decisions made about their care and wellbeing is made by the in-depth research undertaken by the Nora Fry Centre in Bristol over the past 25 years (Williams & Tarleton, 2015). This addresses how "the mechanisms and infrastructure of research" are experienced by disabled researchers "as potentially oppressive . . . and at worst, running counter to their own interests by merely shoring up a social system that pathologizes them" (Williams & Tarleton, 2015, p. 89). The position of a person with learning disabilities in society is determined by policy and procedures that are often inappropriate to their individual complex personal and practical needs (MENCAP, 2014; Williams & Tarleton, 2015). This results in systematic distancing of professionals from the person with PMLD and failure to recognise the underlying causes of illness and distress. It is against this backdrop that I present a single case to show the unique lived experience of a person with PMLD and the need for care providers to adjust to the singularity of each individual in care. A greater need for collaboration and multidisciplinary consultation is required to manage the personal care and health needs, the social and emotional needs of a person with PMLD (Jepson, 2015; Williams et al., 2008; Williams, Ponting, & Ford, 2015)—the social system needs to change (MENCAP, 2014).

The demise facing people with PMLD is that their happiness depends on choices made on their behalf by others. If the duty of care provided is out of their hands, the risk of deprivation is in shadow. Take touch. If touch is maligned as a conduit for abuse and regulated out of the care role, then a lack of understanding of the need for touch is inevitable. How can the need for touch be identified, or the impact of touch deprivation in others be diagnosed in a touch-*exclusive* culture (Johnson, 2000b; Piper & Stronach, 2008)? In my experience, and as this case reveals, the absence of touch can conceal its necessity and justify its ignorance across the care profession.

3 | TOUCH AND MOVEMENT—THE "INSEPARABLY REALISED" ATTRIBUTES OF EXPRESSION AND CONSCIOUSNESS

Over the past decades touch has become more widely debated and more openly accepted particularly in person-centred, humanistic and body-oriented models in which the role of the therapist adapts to the client's need (Hayes, 2013; Levy, 1995; Lewis, 1984; Rogers, 1979; Totton, 2015). A greater understanding of the affective role that touch plays in social engagement on the one hand (Porges, 2011), and emotional regulation, post-traumatic stress disorder and trauma healing on the other (Ledoux, 2015; Levine, 2008, 2010; Levine & Frederick, 1997; van der Kolk, 2014) supports its wider recognition as an integral aspect of the therapeutic relationship. The concept that touch and movement share the same proprioceptive sense organ is core to Body-Mind Centering. Maxine Sheets-Johnstone considers the phenomenology of movement, the tactile-kinaesthetic aspects of experience, to be primary to consciousness and thinking. Through movement, our internal and external subjectivities are 'inseparably realised' establishing a sense of our animate body, as intrinsically intersubjective. (Sheets-Johnstone, 2010: 113) Body psychotherapists and dance movement psychotherapists, practitioners who have specialist training in the intricacies of touch-based methods (Johnson, 1997, 2000a) have advocated for touch for many years and for more experiential training for professionals (Caldwell, 1997; Chodorow, 1991; Dymoke, 2000; Hartley, 2004; Johnson, 2000a; Totton,

2015; Westland, 2011). This is in acknowledgement of the complexity of touch as a nonverbal form of communication and of the fear that touch is, by its very nature, invasive of the client's body, violating the boundary of the self, and soliciting the power status of the therapist (Bloom, 2006; Smith, 1998). However, research into the value of touch in human development and affect regulation, highlights its interpersonal and reciprocal nature and serves to place it as a boundary setter rather than as a boundary violator (Dymoke, 2000; Porges, 2003, 2011; Sinason, 2006). Trauma specialist van der Kolk (2014) reiterates how touching the skin re-establishes a boundary that has been lost, a sense of the "whole" body; "the most natural way that we humans calm down our distress is by being touched, hugged and rocked. This helps with excessive arousal and makes us feel intact, safe, protected and in charge" (van der Kolk, 2014: p. 215).

4 | BMC—A SOMATIC MOVEMENT THERAPY APPROACH FOR DMP PRACTICE

Linda Hartley, an integrative transpersonal psychotherapist, DMP and BMC teacher, proposes that "(s)omatic therapy … offers a foundation for the development of a psychology based on somatic process" (Hartley, 2004, p. 28). The BMC SMT approach provides an embodied perspective for the psychotherapist and enables an awareness of somatic transference grounded in a deeply embodied presence. This presence is not "static" as the word "embodiment" may imply (Sheets Johnstone, 2010, p. 115) but a place of attunement and response, of understanding gained from the study of human development (ontogenetics).

Since the 1970s BMC has provided a framework for the experiential study of human development and anatomy. These two aspects are explored and investigated using touch and movement methods to differentiate the body systems and inform our understanding of the integration of the body-mind in movement (Bainbridge Cohen, 2012; Miller, Ethridge & Morgan, 2011). Through consensual movement observation and hands-on repatterning methods BMC supports self-regulation. With an experiential foundation in her own psycho-physical intersubjectivity, the therapist meets the client and provides a facilitating environment for healing. The therapeutic process involves assessment, differentiation of the body systems and movement facilitation as the relationship evolves, through observation and reference to the developmental movement sequence. The therapist may attend to the systems in shadow to re-establish a sense of balance and interrelationship (Hartley, 2004). BMC offers a reciprocal, interpersonal and unconditional therapeutic relationship to contain the client's "inner" being *in touch* and in movement with the "outer" environment.

What becomes apparent is that the ability to self-actualise depends on having a safe, protective, and caring environment and, if not, there is a negative impact on development and social engagement (Ledoux, 2015; Porges, 2011; Stern, 1985, 2010; Winnicott, 1990). In the field of BMC and somatic practice (Hanna, 1988; Johnson, 1997; Juhan, 2003) and more recently in body-oriented psychotherapy and DMP (Hartley, 2004; Hayes, 2013; Totton, 2015) embodiment and reflexive self-observation have become integral to the role of the therapist, deeply enhancing her "view" of the intersubjective therapeutic relationship (Gallagher, 2005; Varela & Shear, 1999). Bainbridge Cohen notes the reciprocity and mutuality of this two-person method: "The initiation of intent, based upon what each person is perceiving may be shared consciously and/or unconsciously by both people" (Bainbridge Cohen, 2012, p. 6).

Implicit to the embodiment process is the aspect of emergent choice that is experienced at the level of body sensation rather than accessed explicitly through conscious intent (Totton, 2015; van der Kolk, 2014). An in-depth embodied experience becomes a locus of the meeting of self and other, with a repressed aspect of self or the imprint of an aspect of my environment. Contained safely within the therapeutic frame and in the embodied presence of the therapist, these selves attune, facilitated into expressive movement through sensory stimuli, indicated by the client's lead (Eiden, 1998).

5 | CONTEXT—TOUCH REVEALS ITS ABSENCE

Before becoming a dance movement psychotherapist I worked in dance and theatre anthropology contexts. Working in Denmark in the early 1990s, I encountered the exclusion of disabled, blind and deaf blind people. I observed that social isolation and cultural exclusion went hand in hand with lack of mobility—the ability to move freely and uninhibitedly. More crucially, I observed the lack of physical contact with others (Dymoke, 2000; Paxton & Kilcoyne, 1993). When provided with an opportunity to move with others, using contact improvisation and physical theatre techniques, unsurprisingly these issues were addressed (Dymoke, 2000, 2014). In touring with deaf blind, deaf and disabled performers we embodied the potential for inclusion in the arts and society, each one of us experiencing a subjective and communal sense of breaking with taboo and the conceived norm. A four-year practitioner training in Body-Mind Centering provided me with a skill set that took me into arts and health contexts and ultimately to dance movement psychotherapy and a post in the NHS Adult Learning Disability Services.

I present a case example here to provide insight into the effective use of touch in DMP and to provide an example of how the wider care community can benefit when confusion around touch/don't touch is resolved. I hope to provide some "purchase" to enable other professionals and services to revisit non-touch policies and redefine them, with guidance, particularly where touch deprivation and lack of consensus between professionals impacts on an effective duty of care (Caldwell, 1997; Sinason, 2006).

6 | SARAH: A BRIEF PEN PORTRAIT OF SARAH, AGED IN HER EARLY TWENTIES

Sarah has had a diagnosis of autism from early childhood and lives in sheltered accommodation with two other adults with PMLD and complex needs. She has her own room and access to a communal lounge and small garden. Her parents visit her every few months. Sarah responds negatively to changes in staff, to inconsistency in staff approach, and other challenges relative to her accommodation. As Sarah is nonverbal, communication issues arise between her and staff who struggle to find nonverbal ways of communicating simple instructions. Such clashes and issues leave her "stranded" (she appears hurt and dismissed) and aggravate her distress, which manifests in protest responses and self-harming.

At the time of her referral, Sarah's behaviour had worsened, and staff didn't understand why or how to manage her distress. She was referred for one-to-one therapy due to growing concern for the decline in her wellbeing. At triage and initial meetings prior to therapy commencing, care staff raised concern for her persistent self-harming; she pulled her hair out, had pica (putting inedible things in her mouth to swallow) oral overstimulation, and excessive masturbation. Staff wanted strategies to support her needs, to prevent self-injury and training in appropriate ways to relate to her. Multidisciplinary team meetings and best-interest assessments had led to the implementation of controls such as arm braces and a helmet.

Prior to therapy, initial therapeutic aims were identified in consultation with her care manager and key worker and refined over three assessment sessions. The clinical need was identified as high (Malcomess, 2009): she had little hair left, looked bruised around her face, was severely withdrawn and struggled to walk. The initial aims were to:

1 Establish a therapeutic relationship that engages with her in the **present**, and strategies to de-escalate her distressed state and mediate her self-harming.
2 Identify sources of stimuli and activity in which she shows **positive** response and identify and change aspects of her environment that are detrimental.
3 Establish a supportive **caring environment** for her and involve staff—resolve conflicting views of how to care for her needs.

6.1 | Objectives

1 Establish a **therapeutic relationship**, using BMC movement repatterning and developmental approaches.
2 Identify a base line of **sensory sensitivity** through assessments in real-life situations where she shows receptivity and capacity.
3 Assess her **communication and relational affinities**; identify activity to support transition, progression and an enlivened sense of self.
4 Develop a step-by-step strategy to enable **autonomy and self-regulation**.
5 Establish consensus and strategy to rebuild relationships with staff - involving staff training.

6.2 | Assessment summary and analysis

Three assessment sessions are allocated to establish Sarah's consent to our relationship, to ascertain the level of clinical need presented (Malcomess, 2009) and her communication needs. The assessment sessions establish the therapeutic frame and relationship relative to the aims and objectives above.

At the first session Sarah attends the therapy room and doesn't want to stay there. She won't engage with me or any of the sensory stimuli—music, ball, fabric or the space. She goes to the door and I open it. She links my arm firmly and we go outside walking slowly with heavy flat-footed steps around the grounds. I speak intermittently, calmly, inviting a pause. I feel her clasping hand gripping my arm and her intent to continue walking. I wonder if she is in pain as she is so stiff. Sarah makes sucking sounds, short excited gasps and smiles. I feel her body's resistance, the density of muscle tone, her slightness, she feels brittle. I attempt to pause and release her grasp, squeezing her hand gently across the back of her hand. She doesn't protest and walks on, excitedly and dependent on my support.

We return to the therapy room. She will not sit and holds on to my arm. When her carer arrives I notice that they walk independently to the car. I arrange the next meeting at Sarah's house to see her in her home environment.

Touch and movement are Sarah's self-directed means of communication; to relate with me, they are her chosen support mechanisms and preferred modes of expression. As we walk arm on arm I perceive a distinct rhythm to her walking pace, her whole body tension, tight, restricted breathing and forward focus. I brace my arm and this provides the locus for our relationship—Sarah's expressed need for support precedes her ability to move, she can now self-direct and move spontaneously from this place. Through explicit embodied dialogue and somatic transference, Sarah communicates a desire to move into the world and through our embodied understanding we achieve it together, step by step.

Sarah's home provides a new relational sphere for the second session. In her room Sarah's carer puts on her preferred music. Sarah holds my hands and moves minimally, shifting from side to side. She stops and we sit on the sofa. There is no direct eye contact at this stage. Sarah is restless when her carer is nearby. She walks around the house and out onto the small terrace, as if to avoid contact with others and the TV. I speak quietly to acknowledge where we are. Brief moments of eye contact indicate a shift in her awareness and engagement with me. I felt the apparent self-regulatory effect of these moments following the high level of activation in the house.

Sucking and oral stimulation are more compulsive inside the house, a source of sensory self-activation—drawing in her mouth in an aggressive grasping way. Her hand clenched as she sucked, as if her whole body pulsed with the action. The sucking rhythm slowed down over a few minutes indicating self-soothing. This “sucking rhythm” (Kestenberg, 1975, p. 29) is perceived developmentally as a means to bond to self, to self-regulate and a form of conversing and seeking relationship (Bainbridge Cohen, 2012). To my mind, Sarah's activity indicates a sense of authority, it is her self-movement, (Sheets Johnstone, 2010, p. 114) her innate capacity to calm and balance, if just partially, her inner being. As I embody her activity, I remember that sucking is intrinsically tactile, involving the tongue and mouth, activating the digestive tract. I accompany the sucking rhythm with the rhythm of the steps which connect the breath. This whole-body activity is dynamic and gives a structure in which the need to express balances with the need to self-nourish and nurture. I ascertain soon in our relationship that, when stress levels are activated beyond a

certain level, this self-soothing is no longer enough and the need for regulation can turn self-stimulation to self-harming.

Due to the apparent stress factors of the home environment I propose the third session take place in a quiet garden used by day services: it has plants and pathways, and a small centre in case it rains. We continue to meet there for the duration of the relationship, weekly over six months. Sarah holds my arm and her grip lessens over time. We walk in rhythm, attuned in pace and time, following her lead and pausing to converse—with the plants, trees, or each other. I always go at her pace, make up a rhyme, and she responds, leaning more or less on my support. I offer tastes of affective touch interaction for affect regulation and with her positive responses I bring in more direct touch-based methods. I use a gentle "sponging" touch, down along the length of her arms, and she stands and absorbs this, looking forwards, then looks at me and laughs. On another occasion I stroke down the nerve pathways of her limbs to the ground. Her grip on my arm becomes less intense and more responsive; she removes her hand from time to time when we stop. I explore facing her holding both hands so that as she walks forwards I walk backwards—to her amusement. Sarah starts to vocalise with me and care staff who attend to her, give positive feedback and seek to make changes in the home.

In a few weeks she looks much better and she stops self-harming. Staff report greatly improved relationships at home and inquire as to what it is I "do." I report back at team meetings and propose staff training in embodied relating including touch. Adjustments are made, such as turning off the TV and scheduling quiet time. I summarise the key outcomes here.

7 | THEORETICAL UNDERPINNING AND CLINICAL OUTCOMES

7.1 | Objective 1. Establish a therapeutic relationship, using movement repatterning and developmental approaches

In BMC touch and movement are primary, developmentally preceding and underlying the other senses (Bainbridge Cohen, 2012, 2018). Sarah sought relationship directly through touch and movement and I attuned with her there, careful to maintain that relational sphere of proximity and safety to establish a clear boundary and understanding. I recall the unconscious/conscious dialogues in our embodied therapeutic relationship, referred to above; in touching me Sarah is being touched deeply. Like a membrane her touch is a locus of meeting self and other—a membrane for communication, for an expression of a desire for support and a means to sense and feel herself in relationship to another (Dymoke, 2014, 2017). At this place she is able to sense her corporeality as a unity, contained and enlivened. By holding and being held she is able to meet and hold herself—and then becomes able to engage from a place of ease and self-affirmation in her therapeutic process. Repatterning of her self-percept takes shape and is affirmed by her growing autonomy and reciprocal relating (Hartley, 2004; Totton, 2015; van der Kolk, 2014).

In BMC fluid system qualities (such as blood, lymph and cerebro-spinal fluid), support nervous system function and so movement. If the body is very tense and the autonomic nervous system is highly activated, introducing a "sponging" touch quality enables the tissues to release holding patterns and the blood and interstitial fluids to flow more freely, and supports sensory and motor nerve pathways. Such intervention requires knowing what the therapeutic benefit of the hands feels like and the ability of the body to change and to embody this theory in practice (Hartley, 2004; Johnson, 2000a; Juhan, 2003).

7.2 | Objective 2. Identify a base line of sensory sensitivity

During the assessment process Sarah's sensory sensitivities manifest as a lack of emotional support. At first hesitant to stop, to acknowledge me or see me, she continues to hold on tight to my arm and walk on purposefully. Her high physiological tone disables her ability to modulate and be receptive. Her physical instability is aggravated by her emotional instability and further by her inability to manage her stress levels alone. She brings her need for support

directly into our relationship and in "holding" her I witness her grip of my arm and the support this gave her to feel safe and contained. I increase the tone of my own body in response to the transference of hers, to meet her and accompany her rhythmically, in space and time, feeling the effort and the need to pause. We walk and explore in a playful relational way facilitating rest or movement and vocal expression as she directs. Her interest in the environment stops initially with me but over time Sarah looks at plants or a bird singing in the trees. Over time Sarah re-establishes sensory receptivity and regains congruence with herself; she learns to sense and feel her inner resources and mechanisms for self-regulation, though contingent on empathic resonance and congruence with another (Schore, 2003, 2011).

7.3 | Objective 3. Communication and relationship affinities

Sarah is clearly communicating her needs nonverbally. Assessing her movement as we meet and move, I feel Sarah changes from session to session. As she settles into our relationship, her movement is less hesitant. Her body moves as a tense unsegmented whole, but over time we pause together and she moves her head to look, or lets go of my arm. At times she changes the pace and rhythm of our walking, indicating a gradual sense of an ability to self-support, to let go of being dependent upon me, physically and emotionally. In time she is able to support herself; as her energy is no longer self-repressed it can be used to communicate and move her through space, engaging her kinaesthetic sense and affirming her active, motile awareness (Meekums, 2002; Siegel, 1984; Totton & Edmonson, 2009). I experience Sarah's self-actualisation in our therapeutic relationship and facilitative sphere, which is distinctly different from her previous withdrawal from engagement and self-harming behaviour. Sarah's growing ease and engagement arises from having a space and time to feel her responses are understood and cogent. Touch connects her to her experience and to me. Moving with this membrane, a sphere of dual intersubjectivity, she experiences synergy, the meaningful source of her self-realisation and ability to relate outside the constraints of functional social relationships (Dymoke, 2000: 85).

7.4 | Objective 4. A strategy for autonomy and self-regulation

From time to time Sarah stopped in her tracks, and looked ahead but remained in contact with me, as if taking a moment to pause, for herself and, rather than insisting on walking, I paused with her to see what would transpire. These pauses became "stations" for change, a space for something else to happen, which seemed to come from "nowhere" but came directly from Sarah. This was crucial to Sarah's healing process as she grew into these moments, taking a breath and feeling accepted (Levine, 2010; Rogers, 1979). Acceptance becomes a key concept in touch and movement interaction—as well as with her vocal responses—by feeling accepted Sarah began to regain and reclaim her "self." I could reciprocate as I felt accepted. Our mutual engagement animated Sarah with a sense of self-assurance and a repressed "shadow" emerged from hiding (Hartley, 2004; Totton, 2015; van der Kolk, 2014).

In the moments of pausing—the moments of suspension or "pendulation" (Levine & Frederick, 1997) between states of fear and safety—I felt Sarah's inhibition open to allow something new, to a sense of anticipation and excitement. This took place in the body first, as the body let go of holding as we walked. I felt her nerves tighten and then release after a few minutes, as the blood flowed, supported by the breath, and an altered state of mind as we established a rhythm and changed pace. As I touched Sarah, her body responded; she discovered a way of relating with others that supported her to return to her body as a place of safety and well-being rather than the site of self-abuse. I felt in myself the release in her body tissues, and somatic transferences back and forth, the sense of self expanding—allowing space for the breath, and dynamic shifts. The visceral effect of this change allowed for ease, for vocalising and expressing, for rest and receptivity, for an integrated and socially engaged response (Bainbridge Cohen, 2012; Porges, 2011). I felt these aspects implicitly, but expressed these changes; her staff agreed how much better Sarah communicated at home through movement and sound and was able to go out more.

Over the months of working together Sarah no longer needed the arm braces or helmet, her hair grew back and her pica stopped. The feedback at team meetings was conclusive, and the positive outcomes allowed staff to discuss and put in place new strategies and guidelines.

7.5 | Objective 5. Staff Training

Issues to address in the home environment became apparent during the initial home visits. The care staff and key worker disagreed about how best to support Sarah, to address her "inappropriate touching" and self-harming. Confusion about the ethical issues caused concern as staff lacked understanding of the impact their conflict had upon the quality of care Sarah received.

In this training we explored the use of touch on each other, as a means to communicate nonverbally and establish secure relationships (Bainbridge Cohen, 1994, 2012; Eiden, 1998; Gale & Hegarty, 2000; Hartley, 2004). The response was initially very sceptical and some (both male and female) were reluctant to touch each other. They were given a task to touch their partner on the shoulder and notice what they noticed—one male support worker said to his male partner "I'm not gay, you know—just so you know!" Following the session they were all reassured by their own experience, touch had calmed them down and made them more attentive to the importance of physical sensation—and in perceiving this they were more attentive to others. The male support worker followed up by being Sarah's key worker and taking on more responsibility for her wellbeing. Changes in relating took immediate effect and they were more confident in maintaining physical contact with Sarah.

Together the clinical team and support staff learned new ways to assess and support Sarah's mood with touch occurring naturally. As Etherington (2007) requests—by not hiding behind "objectivity" we meet our vulnerabilities and learn from our "reflexive relationships". Sarah's case illustrates a new "normal" and challenges the utilitarian ethic of a non-touch culture to be renegotiated. Sarah's happiness had been decided and provided for, but this had been deficient of touch. It now requires the care staff to be open to a change of mind to cater for Sarah's basic human need for touch and to provide for her choice of where "happiness" resides.

In the case of acute distress or nervous system disorders, touch and movement may be inappropriate (Hartley, 2004; Levine, 2010). It is only through assessment that a therapist can know which methods to proceed with and establish the therapeutic relationship. In Sarah's case the need for touch to relieve distress was manifest in her self-harming behaviours and our unique touch-based relationship provided the outlet she needed whilst restoring her sense of self. Staff had sought to facilitate Sarah's masturbation and minimise self-harming, but the cause had not been addressed. Although masturbation appears inappropriate, it provides the outlet and a means to relate directly to her needs, "unconscious" as they maybe. Over time the self-harming intensity of her masturbation reduced and staff appreciated how this was affected by the regular "dose" of touch and physical contact. I clarified that, when Sarah takes my arm, I experience active touching as a direct sensory stimulus for the body to sense and feel itself—and that the other touch methods that arise in our relationship support her self-regulation and relate more directly to her need to discharge her overactivated state.

The benefit of the BMC experiential approach to touch and touch qualities was part of the learning experience for the staff, and provided the clarity that they had in their relationship with Sarah following this. The attention paid to the intricate sensitivity of touch in the BMC training and approach (Johnson, 2000a) could be considered of relevance across the care profession.

8 | CONCLUSION

Touch connects us to a reciprocal level of being that is not consciously attended to in day-to-day life—the inner landscape—and awakens us to the moving body as the primary location of "mind"—"the body moves as the mind moves" (Bainbridge Cohen, 2012, p. 1). Sarah experiences herself directly and her distress ebbs away. Much of what we

experience is not brought to mind (to consciousness) and we don't have complete control of what does come to mind at any point. Touch is our mutual language and establishes our therapeutic understanding. The intimacy of the touch connection and the sphere of communication between us provide the ground, the membrane, through which to sense and feel, to listen and express even the smallest response, and the means to register the slightest movement or transference. This dialogue is "ethically negotiated" within the DMP therapeutic frame.

Movement is at the heart of DMP (Levy, 1995; Meekums, 2002; Siegel, 1984), and touch and movement are intrinsically intersubjective, necessitating sensory receptivity and movement response which is the essence of our perceptive ability and sense making (Bainbridge Cohen, 2012; Sheets Johnstone, 2010). It is through touch and movement that I perceive tension, tone, resistance, hesitancy, acceptance, amplification, release, change and choice, the movement of the unconscious in dialogue with the conscious, the constituents of an embodied relationship that our therapeutic relationship is contingent upon (Hayes, 2013; Meekums, 2002; Totton, 2015). It felt as if Sarah had returned to a "former" self, a familiar place of comfort. I am reminded of Jill Hayes (2013) who writes pertinently about transformation and transpersonal DMP, which resonates with the BMC approach:

> *In Transpersonal DMP it is the living body which helps to restore soul and spirit; which helps us to connect with a living force and to feel our inner stories. By breathing deeply into our body we begin to know our first physiological and emotional and imagined responses to the rhythms which travel through us and to know our first responses to the relationships which life offers. (pp. 38–39)*

I perceive Sarah's inner desire to be met at the surface of her body and to be accompanied intimately on her life's journey into the world. This is not separate from my duty of care, this is part and parcel of it and it is possible because of the in-depth experience that brought me "in touch" with my own perceptual understanding of the foundation to all relationships—touch. Movement is the common denominator for DMP and BMC, but BMC provides an empirically sound approach to rectify the deficiency of skill and trust in touch. As a dance movement psychotherapist I trust in my own body's experience and examine what it brings to the therapeutic understanding, this is grounded in the subtle, intimate and deeply embodied reflexivity that is BMC.

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