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Improvising on the ward: Exploring somatic dance and potential in paediatric health care

ABSTRACT

This article documents the pilot From Where You Are *project, which researched the effects of improvised, somatic dance practice with children and young people on the Neuromedical and Oncology wards of Alder Hey Children's Hospital (AHCH), UK, in 2008–2009. It considers how the non-judgemental, inclusive and implicitly phenomenological methodology of dance improvisers, whose practice is informed by somatic and environmental approaches, is particularly appropriate and successful in a clinical setting. This is substantiated through an interpretive phenomenological approach, incorporating first-person description and case studies, and provides tangible evidence of the benefits of this practice in paediatric health care.*

KEYWORDS

somatic dance
phenomenology
improvisation
paediatrics
living body
breath
touch

INTRODUCTION

In writing this article I am sharing the research of 'Small Things Dance Collective', facilitated by Co-Artistic Directors, Cath Hawkins and myself. I am acutely aware also that I am sharing some of myself, who I am – an absence

of objectivity created by a research methodology that interweaves my own perceptive processes and entangles them with others. This piece is imbued with my experience through a heartfelt connection to the children, young people and adults I have been privileged to work with during this research and makes the case that phenomenological artist-led research parallels patient-centred and patient-led creativity.

The research took place during 2008 and 2009 and involved facilitating one to one somatic dance improvisation sessions with children on the Neuromedical and Oncology wards of Alder Hey Children's Hospital (AHCH) and observing the effects.[1] On the Neuromedical Ward the children with whom I worked included those who have acquired brain injury undergoing rehabilitation and children who have complex and multiple learning disabilities including chromosomal, genetic and neuromuscular disorders. My colleague, Cath Hawkins, on the Oncology Ward worked with children who have Cancers.

1. This research is part of a wider multi-disciplinary arts programme at Alder Hey Children's Hospital co-ordinated by Vicky Charnock and supported by Alder Hey Arts Chair Dr Jane Ratcliffe, Consultant in Paediatric Intensive Care. Small Things would like to acknowledge the support of Hospital Play Specialists Julie Sellers, Helen Traynor, Caroline Bibby and Phillipa Bradshaw and Hospital Teacher Sue Ashley.

APPROACHES TO MOVEMENT PRACTICE

Somatic dance or somatic movement are terms that are increasingly utilized within the field of dance practice, research and education.[2] As umbrella headings they offer a flavour or sense of a way of working although there are many approaches that are growing and evolving within the field. Somatic Movement Educator and Therapist Martha Eddy likens the field to one of '… wildflowers with unique species randomly popping up across wide expanses', as numerous practitioners, many of them dancers, synthesize their personal experience and somatic trainings, 'to discover the potency of listening deeply to the body' (2009: 6). Small Things' work is located within this field and shares the same fundamental perspective. Thomas Hanna who coined the term 'somatic' maintains, everything we encounter in our lives is a bodily experience as mind and body cannot feel in isolation of the other (1988: xii). This is akin to the phenomenology of Merleau-Ponty whose premise is summarized by Nettleton thus: 'all human perception is embodied, we cannot perceive anything and our senses cannot function independently of our bodies …' (2010: 56). This is not to say that the body–mind relationship is fixed and unchanging, rather both Merleau-Ponty and somatic practitioners postulate a fluid, dynamic system that oscillates in response to context. In this way, somatic practitioners see the whole person, connecting with and celebrating what is healthy and functioning well as the basis for promoting further health and wellness. This approach harmonizes with medical intentions, encapsulated here by Hanna,

> The Somatic viewpoint complements and completes the scientific view of the human being, making it possible to have an authentic science that recognises the whole human: the self-aware, self-responsible side as well as the externally observable 'bodily' side.
>
> (1988: 21)

Each practitioner's approach is necessarily unique as they bring their individual selves to the work. 'Small Things' apply studies in Somatic Practices such as Body-Mind Centering® (BMC®) and Klein Technique, both founded by practitioners included in the 'new generations of somatic leaders' beginning in the 1960s and 1970s (Eddy 2009: 16). At the same time, we share experience of postmodern and experimental dance practices, which also evolved in the 1960s and 1970s including improvisation and Contact Improvisation (CI).

2. This is evidenced through the emergence in recent years of the academic journal Dance and Somatic Practices, conferences and study programmes such as Somatic Movement Educator (SME), licensed through the School of Body Mind Centering to the Embody-Move Association, UK and M.A. Dance & Somatic Well-Being: Connections to the Living Body, UCLAN, UK, amongst others.

CI is a non-codified improvised form with two or more participants, moving together through touch. It is characterized by listening through a point of contact and receiving information through touch and the kinaesthetic sense about oneself, in relation to another person and/or environment. As a dance or movement practice there is a distinctive connection with David Abram's articulation of Merleau Ponty's 'subject-body', 'the sensing body is not a programmed machine but an active and open form, continually improvising its relation to things and to the world' (1996: 49).

This dance can be athletic and acrobatic, possessing momentum and utilizing gravity to fall and fly, and it can also be sensate, quiet and still. As an inclusive form, each participant brings something of themselves to a shared dance. Of the form and its proliferation, veteran Contact Improviser Nancy Stark-Smith says, 'Each individual who engages in the dance is an essential ingredient in its present and its future-his or her choices as a dancer, teacher, artist, researcher, and human strongly influence the work' (2009: 3).

Approaches that foreground the individual are embedded in 'Small Things'' attitude to movement with others, whether with students in the dance studio, artists in a performance context or children in a hospital setting. This way of working gives value to personal expression, whatever the possibility may be, and travels the landscape of the living body exploring potential. Richard Coaten explains, 'This kind of dance, the dance of potential, is very different from learning technique or a particular style. It invites us to be open, to be vulnerable, and to uncover what waits beneath the surface to be expressed' (Coaten 2000: 102).

Therefore rather than learning steps or a form, as in the traditional conception of dance, this approach values spontaneous, non-stylized movement described by environmental and non-stylized dance pioneer Helen Poynor as:

> A process-orientated approach to movement based on the natural structure of the body rather than a stylised vocabulary, practising in any condition – that is one's personal condition (physical, mental and emotional) – and the conditions in the environment in which one is working.
>
> (Poynor 2005: 15)

The emphasis on the instinctive and spontaneous is underpinned by our experience in working with landscape and the environment. Much of 'Small Things'' performance work has taken place in unusual sites, creating work that resonates in a profound way to place, as a living, breathing entity with which we have a relationship. Our process has been to work with the environment in collaboration, so we explore how we as individuals resound within that landscape; our physical and sensual association.

By observing and following our young children in the creation of film on a remote coastal area of North Wales, we discovered how we could allow children to enter the artistic process, valuing their contribution and learning from their plasticity to the environment then capturing this through improvised and intuitive approaches to film-making.[3]

As practitioner-researchers it is through the manifold and diverse experience as dance artists in many contexts that our practice evolves, rather than a method we have learnt, which we transpose. 'Small Things' have found pre-school children to be impressive teachers of embodied movement, still within the developmental stages where attention, intention and action are aligned.

3. The From Where You Are film project took place in 2009 and created film, installation and improvised performance incorporating young children (pre-school and primary). It toured to North West England and Wales.

In addition, these environmental dance practices awaken us to our natural bodies in a way that supports our connections with others, as Abram reveals:

> So the recuperation of the incarnate, sensorial dimension of experience brings with it a recuperation of the living landscape in which we are corporeally embedded. As we return to our senses, we gradually discover our sensory perceptions to be simply our part of a vast, interpenetrating webwork of perceptions and sensations borne by countless other bodies.
>
> (1996: 65)

Practising movement outdoors and observing nature shifts my awareness of how we as humans inhabit spaces. As a tree grows and takes its form in response to the space and light around it and its relationship to its neighbours, I am drawn to reflect upon how our environment shapes us, our movement, our perception and what this could mean for a child or young person who spends long periods of their life in a hospital setting. In inviting the children to improvise with us and play in their current ward territories, are we able to bring them into a place of intuitive spontaneity, creativity and make a bridge to wellness?

A PHENOMENOLOGICAL PROCESS IN A CLINICAL SETTING

When discussing approaches to art-based research, pioneering Art Therapist Shaun McNiff states: 'I have also consistently found that trying to fit my experience into another's theoretical framework results in missing opportunities for experiencing the experience in a new way' (1998: 64). Therefore in designing our research we utilized a practitioner-researcher model, considering our practice, 'as a life-long mode of research' (1998: 63), an active process that is not merely in the pursuit of theory, but a fluid and evolving growth of embodied knowledge through praxis. Furthermore as Robin Nelson illuminates, practitioner-researchers within performance are able to offer insight into their own practice from both first-person reflection and the experience of others of their practice through phenomenology (2006: 110). As dance phenomenologist Maxine Sheets-Johnstone contends for dance improvisers who, 'dance the dance as it comes into being at this particular moment at this particular place', a phenomenological account through first-person description is essential to understanding, 'the incarnation of creativity as process' (2009: 29, 2009: 30). To this end 'Small Things' drew on first-person description of their own experience and an Interpretive Phenomenology to gather and discover meaning from participants.

In designing our research and a question to frame it we consulted Director of Research AHCH, Dr Matthew Peak. Interpretive Phenomenology allows us to track 'the twists and turns of the terrain in which we are interested' (Conroy 2003: 5), and we arrived at the question, 'An investigation of measures to evaluate the practice of dance improvisation, on the Neuromedical and Oncology Wards of Alder Hey Children's Hospital'. This allowed us to open up the process of discovery to include participants, their understandings and meaning, inviting them into the hermeneutical spiral, rather than impose our ideas from previous experience of measures that could be used to evaluate our practice. In discussing Interpretive Phenomenology, Assistant Professor of Nursing, Sherrill Conroy offers the metaphor of 'footprints' as

layers of experience and meaning from participants, 'It is appropriate to think of participants as placing their footprints on the world in the dance of life. Footprints are unique, but they blend with the earth's contours or with others' tracks and fade or stray from a pathway in the woods' (2003: 5).

To support this means of enquiry we devised an observation sheet. Within the sheet there was space for patient information, parental consent and also the context of the session. Then over two sides of A4 there was space for those involved to communicate their experience through words or drawing. This included a box for the practitioner-researcher, the patient, the parent or caregiver and hospital staff. This non-judgemental approach allowed each person contributing to write or speak ('Small Things' artist would transcribe), from their personal perception of what had happened.

Over nine months between 2008 and 2009 we facilitated weekly day long sessions on the above mentioned wards. Ethical approval was granted by AHCH Department of Research and Edge Hill University and ethical considerations are implicit within the research design and the process of somatic improvised dance. The participant and their parent/caregiver could choose to take part in a session and could choose to end their participation at any point. In this way they were therefore not allocated this 'intervention' through clinical protocol, it was through choice.

In addition, we had been exploring movement and dance practice on Neuromedical and Oncology since 2007. According to the National Research Ethics Service research activity into an existing practice that is 'designed and conducted solely to define or judge current care' and whereby the patient is not allocated an intervention can be described as a 'Service Evaluation' and does not require Research Ethics Committee approval (NRES 2013). This highlights the distinctive use of the term 'research' between disciplines in particular arts-based and health research or more generally the arts and sciences. Although within the field of dance improvisation and Somatics this study could potentially deepen and expand knowledge and understanding of our practice, it was not our intention to generate generalizable new knowledge as is commonly understood in NHS contexts (NRES 2013).

Our approach empowers participants through following and responding to their interests and desires. Nisha Sanjnani characterizes skills fundamental to improvisation as, '… an openness to uncertainty, an attunement to difference and the aesthetic intelligence to track significance' (2012: 79). By attuning to the participant, listening with our whole being, in the way defined by the Chinese character for the verb 'to listen', which is compounded from the formatives for *ears, eyes, undivided attention* and *heart*, we enter into an unfolding duet whereby practitioner and participant act as '… co-subjectivities, supplementing rather than truncating each other's possibilities' (Leder 1990: 95).

Although each session was unique as the practice involves paying attention to the individual and the present moment, the process could be divided up into three phases; with no time allocation applied to each, this being determined collaboratively, guided by the child or young person involved. First, there is a *meeting place*, where the practitioner enters the space of the participant. For a patient with multiple disabilities or brain injury this could be through touch and the practitioner gently introducing herself verbally. For others this could be through talking or offering sensory objects to explore and deciding together how to progress. This is a time for connecting and holistic listening to another, opening up, offering choice and holding a creative space. The second phase is

the *duet*, a time to explore movement and creativity together from the subtle movement of breath to a more physical and expansive moving through space. This, like Contact Improvisation is about sharing a dance, collaborating and deciding non-verbally, moment to moment, what that dance will be. Finally, *ending* arrives through rest and relaxation together. This could be by using objects like feathers and balloons with a soft quality or restful touch, rolling body balls or drawing. This is a reflective space, a quiet time, where those present can allow the experience to settle, before transitioning. Following this participants and the artist-researcher would describe and reflect on their experience through writing and drawing.

At the centre of such an approach is intuition. Sanjnani points out that whilst the 'intuitive and empathic practice of improvisation' may often not be considered significant within a world where emotion and practice are held to be inferior to reason and theory, the reality is we exist in a world of uncertainty (2012: 81). According to medical doctor Richard Baron this is no less true in health care. He concedes that treatment rarely cures insofar as a patient seldom returns to their full state of health before treatment and 'prognosis is always statistical and in that sense rarely tells a particular person what will happen to him or her' (Baron 1985: 609).

Therefore for patients existing in a vulnerable place of ambiguity, improvisational practices, whereby they have choice, influence and are listened to, rather than compounding a sense of the unknown, can empower and foster a sense of self in a situation in which it is forces from outside themselves, which affect their future e.g. Diagnostics and treatment. As skilled improvisers we are able to work outside of form and allow the session to evolve through intuition and relationship. As dance scholar and phenomenologist Fraleigh states: 'As a phenomenologist I want to forget what I know and slip into learning' (2004: 2).

This phenomenological paradigm sees the 'lived body' 'as a dynamic, organic site of meaningful experience rather than as a physical object distinct from self or mind' (Hudak et al. 2007: 32). Therefore, the body is not an object of study but the place from where perception begins.

As movement practitioners it is through our sensing, breathing, living bodies that we create art. This suggests an ability to facilitate and support others in making movement, which is our primary mode of perception. Throughout our earliest experiences as human beings in utero, it is through movement that we first learn about ourselves and our environment. This concept is supported by the chronological development of the nervous system. As the twelve pairs of cranial nerves myelinate in utero, the vestibular nerve initiates this process, enabling the fetus to register its movement in its environment. At this early stage of our lives, movement is an essential function of our survival and our primary mode of learning, providing a baseline for our perceptive processes (Bainbridge-Cohen 2008: 115). As artists whose primary mode of communication is movement, our approach is accessible to all, especially those who have recently transitioned to life outside of the womb, when touch and movement are the languages most readily available. Hawkins demonstrates this through her description of a session with a four–month-old baby on the Oncology ward:

> Mum gave me permission to record this. It (working with the dance artist) may seem a small thing, yet it is a big thing for Mark. He finds it enjoyable and relaxing and would cry to express his feelings if this was not the case. He had a lot more wires attached to him yet the nurse

> encouraged me to work with him as soon as I arrived … Within minutes he was enjoying the soft ball being rolled over his torso and his hands being relaxed and stimulated by a very soft brush. He smiled, made baby talk, chewed his hands, gripped my finger and held the ball … He is very ill yet as mum says he enjoys the movement session.

Alva Noe states: 'perceiving is a way of acting. Perception is not something that happens to us, or in us. It is something we do' (2004: 1). If perception is an interactive process, whereby we perceive the world as we move through and within it, then creating movement, for those who are unwell, could offer the opportunity for them to shift their perceptions of self and environment in a transformative way.

A quote from a participant's grandparent on the Oncology Ward demonstrates this transformation: 'The treatment she's having at the moment is so strong she's really zapped. But the smile on her face says it all. The treatment is the last thing on her mind'.

For patients in a hospital setting what makes this holistic methodology different is that it explicitly acknowledges, and values, patient experience. As a medical doctor, Baron has observed first-hand the vast distance between the clinical staff and patients, which traditional medicine has created, 'It is as if physicians and patients have come to inhabit different universes, and medicine, rather than being the bridge between us, has become one of the major forces in keeping us apart' (1985: 606). He argues that the human context in which illness and disease arises is deferred as patients are objectified and become defined by their disease or illness, 'In a profound sense, we say that an entity "is" the disease, thus taking illness from the universe of experience and moving it to a location in the physical world' (Baron 1985: 606).

Drew Leder asserts that this objectification of the body, branching from Cartesian conceptions of a rational, intellectual mind and a subordinate, passive, mechanistic body was essential in many ways to the immense successes of western medicine, enabling the body to be compartmentalized, tested and repaired. However, he acknowledges that the effects of this on the individual can be catastrophic and dehumanizing:

> Modern Medicine, profoundly Cartesian in spirit, has continued to use the corpse as a methodological tool and a regulative ideal … in the beginning of the nineteenth century classifications of disease shifted from a basis in the experienced symptoms of the patient to a system of definition according to the organic lesions found at death.
>
> (Leder 1990: 146)

This paradigm enables medicine to make generalizations about conditions as well as observing a person as body parts. This can further compound the disruption of body-self unity an individual may experience as a result of illness, as illness creates: 'ruptures in persons' ability to live in their usual way rather than as a simple breakdown of a machine-like body' (Hudak et al. 2007: 32).

P. Hudak et al. refine Gadow's theory of 'Body and self: A dialectic' and postulate a trialectical nature of embodiment, whereby body, self and the state of embodiment are 'influenced by interactions and relationships with others' (Hudak et al. 2007: 40). In their phenomenological study of patient satisfaction with treatment, they found not only are states of body-self unity affected or disrupted by illness and disease, but also by life context.

Therefore, for the children and young people who participated in our research it is conceivable that they could experience different states of body-self unity, through shifting perceptions of themselves, others and their environment, via facilitated embodied movement and play. Furthermore, the use of Interpretive Phenomenology as a method of documenting this process offers participants and their families the possibility of voicing their authentic embodied knowledge, a sentiment shared by Carel: 'a philosophical framework that views cognition as embodied, focuses on subjective experience, and provides a robust existential account of selfhood is well suited to understanding the experience of illness' (2012: 100).

OBSERVATIONS

By gathering the observations of children, young people, parents, artist practitioners and hospital staff in a way that allowed each to express from their own perspective, we found rich and textured layers of meaning. Interpretive Phenomenology asks: 'How does the lifeworld inhabited by any particular individual in this group of participants contribute to the commonalities in and differences between their subjective experiences?' (Lopez and Willis 2004: 729). As a dance artist whose life work is concerned with embodied movement, my experience is coloured in a very different way to a neuro-physiotherapist, who may be more concerned with positioning or range of movement. This again may vary distinctly from the perspective of a parent who may simply want to see their child play and have fun, and from that of the participant inside that play, a discrete experience once more of the same activity.

In the table below I offer selected observations from different groups of participants and witnesses.[4] Following this I give more detailed case studies of three patients and propose some analysis drawing on my own reflections and Somatic Movement Education (SME).

4. This is a selection taken from the booklet by Dowler and Hawkins (2010) *From Where You Are*.

CASE STUDIES

The first child I will discuss is a two year old boy, whom I will name Jake. He had endured a serious head injury that caused spasticity and dystonia and he was unable to communicate verbally. He had recently come to the Neuromedical Ward from Intensive Care. He had had a tracheostomy and was receiving oxygen and his overall tonal state, or residual muscle tension, was very high. He had some movement of one arm that was very jerky and disconnected from the rest of his body, and the clinical staff were unsure whether he could see or hear.

My intuition was to offer him reassurance and a sense of being supported where he was. I began with what in the somatic practice of Body-Mind Centering® (BMC®) is known as Cellular touch (Bainbridge-Cohen 2008: 70). It is a 'being with' touch as opposed to a 'doing to'. It is restful, non-directive and offers a steady presence. I noticed that in response to this touch Jake's tone softened, he became more relaxed and his breathing became less laboured. Over the following weeks I continued to work in this way and to offer other touch qualities. I worked with an early developmental pattern of navel radiation that develops in utero, whereby the navel is the mouth and organizing centre of movement. Through gentle touch with Jake I explored connecting the movement he had in his extremity to his centre (see Hartley 2004; Bainbridge Cohen 2008).

Parents/ Caregivers	'Beforehand Charlie was agitated and working hard whilst breathing. Afterwards he was completely relaxed in his muscles and breathing, and although the physio had been called earlier to give him chest physio, after the session he didn't need it.' Mother of Charlie aged 2 who has Cerebral Palsy, Epilepsy and Chronic Lung Disease, Neuromedical ward. 'Trying to get him to do something is so hard. He's becoming institutionalised and he's not very chatty. For me to see him enjoying himself is fantastic. He's struggling at the moment, as his mouth is full of ulcers, which is one of the side effects of the treatment, so to see him smile is wonderful.' Mother of Oncology patient, aged 7. 'Before the session Chrissey was apprehensive and didn't really enjoy physio, so didn't want to take part in the session. She is embarrassed that she has weakness and she is very frustrated with her limbs that do not work in the way they did before. During the session she needed to leave for hydrotherapy, she did not want to leave, she was having a good time. This was emotionally good for her as she has been depressed since she moved to the ward. Lisa was very adaptable and listened to me as a parent when I asked her to encourage certain movements. She was very approachable and friendly with the children; Chrissey can't wait to see her next week!' Mother of Neuromedical patient, aged 12.
Patients	'That was really good fun, it was cool!' Matthew aged 7, Oncology ward. 'I really enjoy making the dances up!' Sarah aged 11, Neuromedical ward. 'The dancing was really good. Cath is really kind.' Lucy age 7, Oncology ward.
Professionals witnessing/ participating	'…. I found it a moving experience to see Cath step gently yet purposefully into these children's space to offer something that can distract from their pain and transform their tired or fed up state, even when they looked like they were in a state not to connect with anyone. I was also moved to witness a shift in a child's mood from withdrawn, stressed and tired, to happier, motivated and with energy to create. …' Wendy Thomas, dance and shiatsu practitioner observing a session in the Oncology Ward. 'It was a real privilege to witness the project in action and to see how excited the children were. It showed in a very practical way how culture can help make life better.' Right Honourable Jane Kennedy, MP observing a session on Neuromedical.
Hospital staff	'I love it when Laura has worked with you, she is so much easier to dress afterwards.' Nurse reflection after movement session on Neuromedical 'I always give Cath an update on the children, what treatments they've had that day, their general health, how they are feeling. Sometimes they say they don't want to do something, then they surprise you and have a go!' Caroline Bibby, Hospital Play Specialist, Oncology in-patients. 'The child is empowered to choose their level of activity during the session. This is important as in a health setting it is often the case that the child doesn't have a lot of choices and activities can be structured towards health needs. Here they have choice of activity and level of engagement at their own pace.' Julie Sellers, Senior Play Specialist, Neuromedical. 'It calmed and soothed Laura, who had been previously upset. Her movement improved during the movement session with brushes and she smiled a lot. She was also very keen to interact.' Student nurse, Neuromedical.

Table 1: Selected observations from different groups of participants and witnesses.

At a later stage I began to work with gently stimulating his reflexes (flexor withdrawal and extensor thrust), which again underlie developmental movement. I found that once he was relaxed through touch, he was able to respond by withdrawing or extending into stimulation with my support. This meant that he had the choice of moving into flexion as his usual state had been one of extension. I also stimulated his rooting reflex and he responded by turning his head and I supported this by moving into rolling and prone positions.

Parents and caregivers also gave their reflections:

> Jake relaxes during the sessions reducing any agitation and high tone. He is focused on the gentle movements and aware of his legs being moved. He responds to the touch by moving his arms towards Lisa. His flexibility is increased with this methodology and I feel it complements his physio beautifully.
>
> (Mother)

For Jake, movement patterns that he once had were no longer available to him. Initial observations of his responses suggest that supporting Jake in finding new movements and sensations through touch and other sensory stimulation could begin the selection of new patterns and/or awaken pathways that have been damaged. This re-education or 'repatterning' has a relationship with the physiotherapy, which the children receive at the hospital, which parents and staff, including the physiotherapists have picked up on.

Nonetheless the approach is very different to physiotherapy. Through listening to and witnessing the children, we dance a duet, without a beginning or ending, goal or target. If anything, what is important is that the child directs the session and feels empowered, providing a sense of ease, which creates the foundation for all that follows. Deane Juhan illustrates the significance of restfulness in realizing movement potential:

> Relaxation … considerably increases the suggestive potency of those freer movements; it creates a neutral ground where the information of new sensations can be introduced into a system normally locked into its old patterns; it produces a palpable hint of what it would be like to respond differently.
>
> (Juhan 2003: 190)

Consultant in Paediatric Intensive Care at Alder Hey, Dr Jane Ratcliffe explains this process from a medical perspective:

> Complex congenital or acquired brain injuries or neuro-developmental conditions are unique to the child or young person. Individually or in combination these may involve involuntary or paucity of movement, reduced muscle tone or spasticity and difficulties with coordination. Initiating or coordinating a movement may induce spasticity which inhibits its completion. Body positioning is common to both neuro-physiotherapy and dance in paediatric healthcare, but the latter may be able to achieve more because the environment is more conducive to overall relaxation and volitional enhancement by using sensory input in all its dimensions.
>
> (Ratcliffe 2010)

The second participant I want to discuss I have named Laura who was 12. Laura had been at the hospital for 18 months. She has cerebral palsy, and also an undiagnosed condition, whereby she can lose consciousness. For this reason she could not leave the hospital as when this occurred she needed to be moved to the High Dependency Unit.

I worked with Laura over an eighteen-month period and generally when I saw her, her tonal state was quite high. She is fully cognitively aware and sometimes felt depressed at her situation. Also due to her excessive tone she could struggle with her physiotherapy.

I tended to begin with Laura again with Cellular touch. Beginning with touch, for me, is a way of connecting with another and draws on my experience of Contact Improvisation whereby, 'Dancers use touch as the starting point for an active process of exploration, discovery and creativity in *relationship with others*' (Dymoke 2000: 95).

Within a hospital context it is not always appropriate, but when it is I find non-directive touch establishes for me and the other person, who we are as individuals i.e. where our being begins and ends. It also illuminates the place where we can meet. I find it the most powerful of the senses when working with another person, which could be because touch is:

> The chronological and psychological Mother of the Senses. In the evolution of sensation, it is the first to arrive and is rather well developed in a single cell amoeba. It defines our sense of reality more than any other. Our sense of our own surface is vague until we touch or are touched. At the point of contact two simultaneous streams of information begin to flow; information about an object, announced by my senses, and information about my body through the interaction with the object.
>
> (Juhan 2003: 29)

When working with Laura, I found that underneath my touch her muscles responded by softening, releasing her joints and allowing her to move more freely with a smoother quality, which isn't characteristic of someone with hypertonic cerebral palsy (Tilstone and Layton 2004: 146).

When Laura became more relaxed, I ask her what she would like to do. She can respond verbally, with yes or no. I offered brushing the skin, with large, soft brushes that she enjoyed very much. Sensitizing the skin or tactile surface of the body not only brings awareness of the interface between oneself and other, but it is also the crossing point of our thought processes and our physical existence. There is a clear association between the skin and Central Nervous System (CNS) in that they are both produced from the same primitive cells, from the ectoderm in the early embryo. As Juhan puts it, 'Depending upon how you look at it, the skin is the outer surface of the brain, or the brain is the deepest layer of the skin' (2003: 35). Gently caressing the skin could then be embracing the CNS, calming and soothing. From this place I offered Laura some more active props including scarves and ribbons, which she could move for herself. I worked with her grasp reflexes to help her hold objects. In a hospital setting the children are often quite passive, and this can be more so for children who have CP and have difficulty with movement. It was often very empowering for Laura to have control and in our duet I encouraged her to lead. She enjoyed brushing my face too.

After observing my sessions with Laura, her mother wrote:

> During our sessions Lisa has an awesome ability to really help our daughter. Laura relaxes to an extreme effect. Normally she is really rigid although she does have two one hour sessions of physio a week, but compared to just a few minutes with Lisa she becomes really relaxed. Not even in physio is she anywhere near as relaxed as she is with Lisa, due to her severe CP.

Senior Play Specialist, Julie Sellers observed, 'Laura was looking forward to Lisa's visit and was visibly enthusiastic, lifted and more co-operative. During the sessions she is very relaxed and clearly enjoying herself'.

Another session, where Laura had been emotional due to difficulty in her physiotherapy earlier, Play Specialist Helen Traynor wrote, 'Laura has had a very agitated morning and had been very tearful. Once Lisa started her session she became noticeably more relaxed, with decreased tone and was smiling'.

The difficulty that Laura has had with physiotherapy, and her enthusiasm to work with me, on some occasions led to collaborative sessions. The following comment from a physiotherapist followed a session during which Laura was placed on a tilt table to encourage weight bearing:

> During Laura's physiotherapy session today she was positioned in standing on the tilt table. A joint session was carried out with Lisa and Laura was distracted from standing. She participated in relaxation, upper limb activities and head control work, using different dance mediums i. e. Scarf, brushes, ball. Laura co-operated well throughout the session for 20 minutes.
>
> (Hospital physiotherapist)

Although Small Things would utilize different terminology in describing their work and Laura's activity, the discovery is in how we as somatic dance practitioners can work as part of a multidisciplinary team in supporting a child or young person in their journey to wellness. What we offer is not a variation on physiotherapy, it has a distinctive philosophical underpinning; nonetheless it can be complementary.

The final case I would like to refer to is that of Sarah aged 10. Until she was six Sarah was able to walk, then she was diagnosed with Arnold Chiari Malformation and Oesteoporosis.[5] She was at the hospital for about seven months whilst having her shunt valve changed, which regulates the flow of her cerebral spinal fluid, followed by rehabilitation. Sessions with Sarah were often much more lively. Like most 10-year-old girls she liked popular music and making up dances. She is a wheelchair user but she always came out of her chair and started on the waterbed in the sensory room. As she became stronger she used to stay in the hoist, which gave her a greater degree of mobility. We would start be stretching out our bodies to music and then we would make up dances together, using our upper bodies and sometimes ribbons and scarves. We would take it in turns to add a movement creating choreographies together which we would practice to music. Our favourite was to *Mercy* by Duffy, Sarah would want to repeat this dance over and over, and delighted in telling me when I had done the wrong movement. Her mother commented, 'Although Sarah can't move her legs, she can move her arms and upper body. And she can now tell her friends that she goes to dance class'.

5. ACM is a condition where the cerebellum protrudes through the foramen magnum. It can affect normal Cerebral Spinal Fluid pulsation.

However I noticed that whilst Sarah was in the hoist she did in fact move her legs, this was also observed by the Play Specialist:

> Sarah clearly benefits from the dance sessions, in gaining a sense of movement. Using the hoist for speed and access of different movement/ levels. She visibly enjoys her participation giving self esteem and positive body image in what she is able to achieve. These sessions are invaluable to Sarah.
>
> (Julie Sellers)

These sessions gave Sarah an opportunity to express her creativity and improve her confidence, whilst at the same time improving her movement and possibilities. By extending out through her upper limbs, Sarah connects with her core and lower limbs, mobilizing an area that is often compressed and quite static in her wheelchair. During these movement sessions, the children often generate movements outside of their usual vocabulary, as another quote from Sarah's mother demonstrates, 'Sarah loved the session and is already asking when the next one is. Movement to music is fun and I don't think the children see it as 'therapy' although it is and therefore very beneficial in their rehabilitation'.

CONCLUSION

The therapeutic benefits of this work appear obvious, although the sessions are primarily about creativity and expression, without a therapy-orientated goal. Through Interpretive Phenomenology general themes have emerged through description and reflection, providing specific viewpoints on the precise nature of what makes up the inter-subjective complex of responses to the sessions. 'Small Things' approach to research is complementary to clinical practice, and it enables the patient to complete a unique trialogue, each contributor having the space to voice what is meaningful and significant to them.

Through both the case studies and narratives in Table 1, the effects of improvised movement and dance are fruitful for participants, parents/ caregivers, staff and the artist-researcher. Nonetheless, how they are perceived and the benefits can vary depending on the viewpoint.

The children and young people see the sessions as an opportunity for them to be themselves, and behave how they feel at that given time and to have fun. For example, Sarah's own comments about her sessions reveal what is important to her, 'I really enjoy making the dances up!' So the skill of choreography is of greater significance to her than which part of the body she moves successfully.

For other professionals, for example nurses and play specialists, our research has shown what is valuable to them is how the children are emotionally and physically after a session and how this can affect their own relationship with the patient and their ability to undertake their professional responsibilities e.g. Completion of other therapies and interventions.

For parents to see their child happy is the most important thing for them, as a parent I know this to be true. Parents' reflections generally communicate their joy in seeing their child relaxed, without pain and having fun. I can relate to this as a parent and also as a dance artist I can be captivated by the beauty in the detail of the smallest movement a child can make for themself, an expression of mind made manifest in body.

Although the responses are influenced by the unique experiences and 'lifeworld' of those participating and observing, a reciprocated observation

that flows through the hermeneutical spiral like converging footprints on a path in the woods, is that this work is transformative; there is both inspiring and reassuring change that happens through this practice, which is felt collectively and individually by all of those involved.

Returning to our research question this interpretive enquiry has led us to the understanding that there are several measures that could be employed to evaluate the practice of somatic improvised dance in this context. The shift from withdrawn and introverted states to relaxation, an ease in movement and happiness could be measured through various validated pain assessment tools that are both appropriate to age and the patient's ability to communicate. Such tools incorporate both the physical and emotional aspects of pain and anxiety and would generate quantifiable data to support on-going narratives. To this end the hospital is supporting two subsequent research phases (2009–2011, 2011–2014).

Preliminary findings suggest strongly that dance artists working in the field of improvisation and Somatics have a lot to offer to health and well-being. Their embodied knowledge of anatomy provides them with a language, whether verbal or non-verbal to communicate with patients, parents and health professionals. The value placed on personal articulation and choice and the seeking of possibility and potential in a structured hospital setting is empowering to the child or young person, where for clinical reasons they cannot have much choice. In supporting this work, I believe Alder Hey staff acknowledge and deliver patient-centred approaches to health care. Of the movement and dance research, Alder Hey Arts Chair, Dr Jane Ratcliffe comments:

> In many instances, the experience … surpasses family, carer, neurophysiotherapists' or other healthcare workers' expectations. The professional terminology is different but there is mutual learning and respect within the multidisciplinary team around the child or young person.
>
> (Ratcliffe 2010)

This approach to health care, whereby the individual story, experience and creativity of a patient is valued, is imperative to health and wellness. The Planetree model in the United States recognizes this central concept:

> If we only focus on the patient's body, we are missing three quarters of who that person is …… What we are discovering is that as we treat the patient as a multidimensional being, we suddenly have the ability to heal in ways we have not had before.
>
> (Kaiser 2003: 196)

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