The Dialogue of Movement: An Interview/Conversation with Ilene Serlin and E. Mark Stern

Ilene Serlin
E. Mark Stern

INTERVIEWER'S INTRODUCTION

I decided to interview Dr. Ilene Serlin because of her talents as a dance therapist. Dance therapy is a highly expressive body-focussed adjunct to psychotherapy. Yet as a psychotherapeutic discipline in its own right, dance therapy aims at the awakening and cultivation of a keen appreciation of the ways in which the client moves. Dance therapists, as a group, assume that people are only partially aware of themselves and then only as they concentrate and talk. The intention of dance therapy is to further advance an awareness of body moods. It employs and recognizes sad dances, happy dances, sensual dances and dances that signal others to keep a safe distance. Dance therapy concentrates on appreciating, and, where appropriate, changing sensory and emotional patternings. The discipline focuses on the interaction of bodies, the body's relationship to the environment, and the cultivation of emotional insight while the body is at rest or in deliberate or spontaneous motion.

Ilene Serlin, PhD, is affiliated with the Saybrook Institute, San Francisco, CA.
E. Mark Stern, EdD, ABPP, is Professor Emeritus at Iona College and a clinical psychologist in private practice in New York City.

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Dance therapists are trained in a variety of settings. Most have earned a master's level degree from institutions such as Leslie College in Cambridge, Massachusetts or the Pratt Institute in Brooklyn, New York. Others, with prior credentials in one of the mental health fields, go on to add dance therapy to their professional resources through continuing education workshops. And then there are accomplished dancers who have developed dance therapy skills through mentorships with psychotherapists and master dance therapists as well as on the scene activities in mental hospitals, rehabilitation centers, and special education settings to name but a few of the settings. Dr. Serlin, who is a trained licensed clinical psychologist, is a professor at the Saybrook Institute in San Francisco. She is also qualified as a dance therapist. And so the dialogue begins:

E. Mark Stern: I'm curious: How do you keep sight of boundaries in your work? More importantly, how do you manage to work within the boundaries which provide the space you require in dance therapy?

Ilene Serlin: Let me begin by commenting on how I see boundaries, and how problematic their acknowledgment becomes. It's a joke among dance therapists that we are better at merging than at separating. Still the structure of good therapy is built of strengths and weaknesses. We're trained kinesthetically to empathize, so that we are able to move in rhythm with the other. Therefore, the whole issue of boundaries is how *not* to get merged with the other. There are several means to accomplish this. One is that the dance therapist's personal verbal and/or movement psychotherapy helps in her or his knowing the differences between what's the "you" and what's the "other." This can only happen after knowing what it means to intuit the other. As a consequence of the practitioner feeling the other so intensely, the question of boundaries is even more powerful than it might be in the more usual psychotherapeutic encounter. Kinesthetic countertransferences are established in the presence of the other. Countertransference, when understood, provides the therapist with the means of distinguishing what's "mine" from what belongs to the other person. Obviously the client needs to be experienced on many levels. I see this as the strength of the process. Ensnaring traps along the way are potential weaknesses which require moment-to-moment reflectiveness. How else is one able to make the necessary discriminations for good therapy to take place?

EMS: Please give me an example of moment-to-moment therapeutic discriminations.

IS: Somebody comes into my office who I sense is in need of mothering. I feel that "need" in my own body. It may take the form of a desire to

enfold, to make safe, to put my arms around the person and so forth. I now have to gauge how much of a comforting voice to use and how to mediate/ moderate what is and is not "motherly." My attention focuses on the maternal archetype which I often feel in my whole bearing and demeanor. Much of what happens is consummated in how I manage these feelings; how I become conscious of what is being constellated in the relationship. Based on this kind of information, I aim to work with sufficient attachment as well as detachment.

EMS: People who are in need of help are capable of provoking all sorts of feelings in the therapist. Earlier you alluded to kinesthetic countertransference as a physical sensitivity to what the client is trying to express. What's your impression of how the client reacts to your feelings?

IS: Let me speak from the complexity of the question itself. Suppose I am feeling degrees of maternal sensibility. Could these sensations be some way of being called forth as a comforting presence? It is my responsibility to attempt to discern whether, in that moment, what the client truly wants is growth producing. Or is the client simply in need of a safe place, and in that state of need, playing with old patterns? I must try to be clear whether what I see as a need for nearness is possibly fostering claustrophobia. In other words, my first felt inclination to offer safety may not be what is most needed. So how to discriminate between what is regressive and what is helpful? My moment-to-moment decisions on how to move become quite consequential for that person. I must always ask myself, am I being asked to help reinforce what has been stifled and restricted in the past, or is the request a means of calling forth satisfaction of that which had never been there for the client in the past?

EMS: What is it that makes you feel you "know"?

IS: There are so many streams of information coming in at any given moment. I come to each situation with a rich background of experiences which inform me of what may be subtly taking place. I have learned the dangers of overprotecting even those who ask for it, while at the same time, I've come to appreciate my way of searching for what is most appropriate for one person and not another.

EMS: On several occasions in the late 1950s, I was given the opportunity of observing Dr. John Rosen, then of the Department of Psychiatry of Temple University, work with a pioneering approach to psychotherapy with chronic psychotics he dubbed "Direct Analysis." His patients were

all withdrawn schizophrenics who were in residences in Doylestown, Pennsylvania. Each patient lived in a separate cottage shared with a staff of "assistant therapists." Dr. Rosen's interventions were certainly intensive. He rarely hesitated being verbally and physically confrontive and encouraged the same in round-the-clock therapy by his assistants. In "entering" the "worlds" of his patients, Dr. Rosen described himself as their "mother." This gave him permission to feed them, soothe them, and plead with them for a relationship. There were times that he used shaming devices and on at least one occasion wrestled a man down to the floor. His dedication to addressing the primary processes he assumed were active in his patients was amazing to watch. From what I saw of his work, and in two subsequent published interchanges with him, I knew that his particular style was unique. Even more so when he declared that, "so much of the mother have I become that the day I 'kick-off' (i.e., die), most of my cured patients will revert back to psychosis because of the separation that they felt in their infancies." I should mention that the bulk of his assistant therapists were people he described as his former now ex-psychotic patients. It's no wonder that my ears perk up when you speak of embracing the mother archetype in psychotherapy. Perhaps you do something other than what Dr. Rosen did. For one, you do not work with a primarily psychotic population. And from my knowing you, it's obvious that you try to give the client ample room to develop his or her own strategies. Why don't you amplify your notions of mothering in the dance therapy process?

IS: I've studied films made by the late anthropologist Margaret Mead which illustrate the centrality of cradling infants. Cradling points to a need for containment. The impulse to cradle is something I readily feel in my work. People are scattered and unable to focus in their lives. They need containment to assist them in prioritizing. In other words people who are lacking in the capacity to contain are hardly aware of their feet falling. A therapeutic ideal is to help these clients spatially contain themselves. There is a caution, namely that the dance therapist, in the process of motherly containing, doesn't inadvertently crowd in or squeeze. People may react negatively to the slightest feeling of pressure. There is a sort of holding space somewhere between too much and too little. It's beneficial to hold and offer steadiness, but not to the point of diminishing or controlling the client. On the other hand, it is sometimes unsatisfactory to diffuse a hold if the client is liable to fall. There must be a balance between freedom and feeling safe. Good therapy aims at providing enough safety in which the client is able to feel freedom. This doesn't necessarily imply touch. I may at times sit with the client. The best way to illustrate is to

examine the way I may inhabit the space, and the way I surround the person in the expanse we make together.

EMS: Do the clients who call on you for dance therapy necessarily know how to dance?

IS: Some have been specifically referred for dance therapy. Many do not know how to dance. Others who were referred for verbal therapy get the benefit of the way I sense their expressive energy through the archetypal sensibilities that flow through me. It may *look* to an observer as if we are just sitting and talking. Dance therapy clients have the opportunity of seeing the images in a more externalized way. Dance can be about closeness, apartness, small and big and so forth. Dance therapy physicalizes these emotions. As soon as the client enters my space, we begin to play out these affective states.

EMS: What do you mean by "play them out?"

IS: It's a matter of what the client is open for.

EMS: What it is to feel like receiving?

IS: Absolutely. I recall a client whose central concern was about being diminished. We entered into an improvised dance in which she was sinking and becoming smaller. This alternated by gestures of being bigger and bigger. As she sank and became smaller, I made very big gestures. As she followed my lead, I made sure to take on smaller dimensions. Allowing her to find what was comfortable helped her to understand how she made people bigger or smaller than life. I tend to use polarities as constructions to emphasize a theme. Near and far can trigger many issues. It is existential, since the process of dance therapy becomes a slow motion picture framed within the client's view of his or her time/space lived in world. Dance as a play form becomes an essential means of experiencing appropriateness. My role as therapist rests with helping the client understand when "near" or "far" threatens. Obviously early memories come into play when nearness and distance are so intimately experienced.

EMS: How do you sense that these memories are becoming activated?

IS: Sometimes verbally, but at other times, kinesthetically, that is in movements expressing quick/slow; big/little; near/far. Becoming sensitive to the underlying history and context of the client's emotional life is important to

the development of diagnostic skills. I must emphasize that I try to stay closest to characteristic/characterological structures which trigger themselves beyond what the client may have verbally reported.

EMS: So what happens on a day-to-day basis counts less than the movement structure which has been unconsciously choreographed. And what you do is to move or gesture in response to the client's bearing. This, then, is essentially a non-verbal task?

IS: Space and time and energy flow are non-verbal, but they can be expressed verbally. For example, if I ask a client, "What happens to you when I move toward you?" the answer is often a description after the fact. The experiential part of the equation is non-verbal. But I must sense how words are used by the client.

Do they amplify what has been experienced? Often the spoken word is used to ward off or distance from the experience. My work, both in dance and in verbal reflections, must emphasize the opening of the client's space.

EMS: Speaking of space, what kind of facility do you use to do dance therapy?

IS: One defines oneself and needs a place which is conducive to one's professional function. The room that I previously used provided a setting where all the furniture could fold-up and be removed as needed. I currently occupy two sunlit rooms. The smaller of the two serves as the talking room. The back room is very quiet and is multi-purpose and intimate. It is where I do dance therapy.

EMS: So, what I gather, is that your work relates to various formats of movement and arrangement. Spatial and temporal relationships tell the story of relationships, both between you and the client, and the client and the world of others. You've also spoken of boundaries you and the client set. While quite definitive, these boundaries tend toward flexibility and permeability. You appear to focus on the many ways of working with where the client is in functioning in life. And in your understanding, personal rhythm and dance themes define the way you become familiar with the client. The therapeutic processes that you use help the individual move from where he or she is situated to new and more productive places.

IS: Yes, you might sum it up by saying that therapy moves toward emancipation and mutuality. More likely, mutuality becomes the real landmark of the therapeutic process I engage in as a dance therapist.