

Sarah Lawrence College

DigitalCommons@SarahLawrence

Dance/Movement Therapy Theses

Dance/Movement Therapy Graduate Program

5-2017

Accepting Mortality: Using Dance/Movement Therapy in Nursing Home Care

Wesley Johnson-Klein
Sarah Lawrence College

Follow this and additional works at: https://digitalcommons.sl.c.edu/dmt_etd



Part of the [Dance Movement Therapy Commons](#)

Recommended Citation

Johnson-Klein, Wesley, "Accepting Mortality: Using Dance/Movement Therapy in Nursing Home Care" (2017). *Dance/Movement Therapy Theses*. 32.
https://digitalcommons.sl.c.edu/dmt_etd/32

This Thesis - Open Access is brought to you for free and open access by the Dance/Movement Therapy Graduate Program at DigitalCommons@SarahLawrence. It has been accepted for inclusion in Dance/Movement Therapy Theses by an authorized administrator of DigitalCommons@SarahLawrence. For more information, please contact alester@sarahlawrence.edu.

Accepting Mortality: Using Dance/Movement Therapy in Nursing Home Care

Wesley Johnson-Klein

Submitted in partial completion of the Master of Science Degree in
Dance/Movement Therapy at Sarah Lawrence College
May 2017

To my dazzling parents, Sandie and Mitch. There is a sort of magic in the world and I see it in everything you do.

To the most intelligent person I have ever known, Alexander. You are an inspiring creation and it is such an honor to be your sister.

To the 13 other members of my graduate program. I admire you all deeply.

To the faculty that have been there with us through it all. Your patience and generosity is unmatched.

To all my friends and family. Your support has meant the world to me.

To all of you, I am beyond grateful.

Abstract

As the elderly population continues to grow, there is new importance put on changing perceptions of the aging process. Long-term care in the form of nursing homes are seeing a shift in life expectancy as elderly individuals are living well into their eighties and nineties. This brings to light a lot of difficulties for the aging population who are experiencing major physical and cognitive declines. This also shows gaps in nursing home care when looking at the needs of elderly individuals who are facing their mortality. The medicalization of long-term care has put an emphasis on prolonging life, but is not working to help the entire individual, both body and mind. Examining Erikson's theory provides psychosocial context for the need of holistic care. Self-management practices take Erikson's work and apply the psychosocial stages to realistic goals for today's elderly. The challenge is to find an approach that meets the physical, emotional, social, and cognitive needs of this elderly population. Dance/movement therapy (DMT) works as an age-specific discipline that accomplishes the numerous goals the aging elderly have. DMT works to repair the connection of mind and body to help this population find satisfaction in their final days.

Keywords: death, dying, elderly, aging, despair, dance/movement therapy, isolation, self-efficacy, dementia, therapeutic approach, holistic, body, mind, nursing home, long-term care

Table of Contents

Mortality	5
Nursing Home Care	5
Limitations.....	6
Psychosocial Development	11
Erikson's Theory Continued.....	15
Self-Management.....	17
Dance/Movement Therapy: A Solution.....	18
References.....	24

Mortality

Death. It's one of two occurrences guaranteed in life; second only to taxes. Humans have a complicated relationship with death and dying. It's a difficult reality to face and one that isn't often discussed because of how unsettling it can be to think about one's own death. The realization that humans are mortal beings is challenging to grasp. Conceptualizing death is different from confronting it. Understanding that the life cycle ends with the ending of life is a theoretical perspective that isn't tangible. Death is a certainty and an aspect of life that all individuals encounter. What makes death so hard to understand is that it is not an event that is experienced until the end of life, which makes empathizing with those going through it a challenge. How can we maintain a sense of being when our existence is challenged?

Nursing Home Care

A significant proportion of American society is reaching the end of life much later in life. The term "elderly" refers to those individuals who are 65 years and older. According to this definition, the elderly make up 8% of the population worldwide (Ehlers, Banducci, Daughtery, Fanning, Awick, Porter, Burzynska, Shen, Kramer, McAuley, 2017). There are 43.1 million elderly people living in the United States and this amount is projected to double by 2050 (Ortman, Velkoff, & Hogan, 2014). This accounts for roughly one in seven people, most of whom will not live past 100.

This elderly, or aging, population has also grown in recent years. Due to advancements in medicine, the elderly population is predicted to have a distinct size increase by 2030: a growth of more than 25% for those who are 65 years and older, and more than 50% for those who are 80 years and older (Plunkett, 2011). On top of a sizeable increase within the elderly population, there is also a change in its distribution. Life expectancy has

now shifted and the aging population is, itself, aging. This refers to what an aging person can look like today. While 65 marks the beginning age for the elderly, there appears to be an even more aged group within that elderly category and those individuals are 80-100 years old. The idea isn't that those who are 65-80 years old would not need the same care or assistance, but rather that society isn't always able to fully understand what it looks like to surpass 80 years old because, until recently, it has not been a common achievement.

1.5 million individuals who fall in this category seek residency within nursing home facilities (Degenholtz, Resnick, Bulger, & Chia, 2014). Research indicates that over 60% of elderly living within a nursing home were 81 years or older. This shows that over half of nursing homes across the country have rooms filled with patients who are even more aged than the original "aging" title distinction. End-of-life care has a new appearance. Care is now focused on the needs of those who are 65-80 and 80 and beyond. The aging of the elderly population brings new demands and challenges (Erikson, 1997). Implementing better long-term care is becoming more and more essential for nursing home facilities that are continuing to grow.

Limitations

Much of the age-related physical disintegration that occurs in older adults is inevitable. Although physical activity can often prevent loss of physical function, the loss of physical function that comes with aging can make physical activity difficult. The deterioration of muscle, bone, and joints increase the progression of physical deterioration. One of the main causes for age-related physical decline is sarcopenia, or the degeneration of muscle mass (Rolland, 2008). It is still unknown what causes sarcopenia, but reduction of muscle proteins and skeletal muscle fibers contributes to the loss of muscle strength and

increased weakness. The loss of bone density also increases frailty in older individuals. When microstructural weakening of the bone tissue occurs, on top of the age-related bone density loss, osteoporosis is the common outcome (Chen, Zhou, Fujita, Onozuka, & Kubo, 2013). Loss of bone density also accounts for higher risk of fractures that commonly occur in the vertebrae and hips (Hunter & Sambrook, 2000). Joint inflammation is another factor in the deterioration of physical function. Arthritis, a painful inflammation of the joints, is a typical chronic condition that has become the leading cause of physical disability in the U.S. (Barbour, 2017). Arthritis accounts for the one million knee and hip joint replacement surgeries annually (Barbour, 2017). These prominent anatomical areas of function directly relate to the loss of mobility in of an elderly individual's body.

Reduction in physical skills that relate to balance impact an aging person's ability to stand and ambulate independently. The age-related bone loss, joint inflammation, and diminished muscle responses all directly affect mobility and balance (Bräuninger, 2014). Reduction in physical capabilities that impact ambulation and posture increase the risk of falling. One in three elderly individuals fall each year, and 20% to 30% of those who fall experience injuries that end their ability to live independently (Krampe & Rantz, 2010). Fall risk factors can often be predetermined and many incidences of falls are preventable. Loss of balance and decreased mobility are the two major risk factors that increase the likelihood of falling. To control fall risk, preventative measures are often taken that then limit an elderly person's ambulatory independence. Walkers, canes, wheelchairs, and jerry-chairs are introduced as time goes on and mobility decreases. The problem with this progression is that, typically, once ambulatory independence is lost, it is never regained.

An element that can often accompany physical decline and can have a large impact on an individual's physical interactions with the surrounding world is pain. Pain is an occurrence that is challenging to assess because it is individually experienced and may be hard to describe. Managing an aging individual's level of pain can be difficult and caregivers often underestimate what is experienced (Dillenbeck, 2009). Aging individuals within nursing homes may not have an opportunity to discuss their pain with their care team. This means pain relief is often under-administered or inadequately managed (Dillenbeck, 2009). When pain is not managed properly, the consequences affect the individual in every aspect of their lives. An aging individual can experience a sense of inability to control their own well-being. This presents as a sense of loss of control and, again, loss of independence. These damages to an individual's identity can directly affect psychosocial circumstances (Dillenbeck, 2009).

Diminished sensory function, a common occurrence in the aging process, adds an additional challenge for this population. When sensory organs become less efficient it can challenge an individual's sense of autonomy. The dulling of the senses of hearing, sight, taste, smell, and touch, can make daily functioning increasingly difficult. Being unable to hear or see affects the trust an individual may put on their body and the trust that they have for the environment. Sensory changes are often dismissed and discredited because they are so common (Crews & Campbell, 2004). An elderly individual with vision or hearing loss may have trouble communicating with medical staff or with peers. Misunderstandings can lead to increased confusion, isolation, and agitation (Crews & Campbell, 2004). Diminished sensory function is associated with an increase in rate of cognitive decline (Crews & Campbell, 2004).

Another area of decline that affects both cognitive and physical abilities is motor function. Decline with both fine motor skills, or smaller muscle coordination known as dexterity, and gross motor skills, or larger muscle coordination involving limbs, contributes to the challenges of aging (Hoogendam, van der Lijn, Vernooij, Hofman, Niessen, van der Lugt, Ikram, van der Geest, 2014). The decrease in motor skill function is due to a combination of disruption and degeneration of central nervous system and neuromuscular system structures (Seidler, Bernard, Burutolu, Fling, Gordon, Gwin, Kwak, 2010). Limbs, muscles, and nerves have less control over body motor functioning. These deficits slow movement and decrease accuracy (Seidler, et al., 2010). The combination of decline in sensory function and motor function challenges an elderly individual's independence with daily tasks. The elderly must rely on staff to assist them with eating, dressing, and tending to typical hygiene needs. This leads to increased feelings of inadequacy and depression; a continual loss of identity.

Memory loss is another inevitable part of the aging process. Age associated memory impairment is common, but has the potential to worsen over time. With increasing cognitive impairments, there is an increase in likelihood of developing Alzheimer's disease (Small, 2002). Alzheimer's disease contributes to a more rapid decline of an elderly individual as deterioration of memory impacts ability to complete daily tasks. Alzheimer's disease is also one of the main causes of dementia (Arlt, 2017). Two thirds of elderly individuals with the dementia diagnosis had Alzheimer's disease (Arlt, 2017). Dementia involves degeneration of both neurological and psychosocial abilities. This means that neurological factors, such as memory, reason, and comprehension, on top of psychosocial, or socialization patterns, are the areas that experience progressive deterioration (Kitwood, 1997). Dementia can appear

differently from person to person and like many other areas of degeneration, dementia speeds up the rate of decline (Kitwood, 1997).

Anxiety and depression have a high prevalence amongst the elderly population. Many factors can affect the onset of or exacerbate both depression and anxiety. For one, the relocation into a nursing home is a major transitional experience (Perry & Hassevoort et al., 2015). While this relocation may happen with the goal of improving and prolonging an individual's life, it is still a major alteration that can directly affect the health of the individual. Loss of independence, which can be caused by physical or cognitive limitations, increases distress (Dilleneck, 2009). Depression may stem from feelings of hopelessness. There is depression and anxiety when it comes to facing death, mainly because it is hard to fathom one's end. Depression also comes from the death of loved ones and those around the dying individual. It is difficult to come to terms with the amount of loss an elderly individual experiences.

Grief goes along with the anxieties and sadness experienced by the elderly population. The idea of "loss" appears in every aspect of this aging life. The phrase "partial grief" is used to describe the countless amount of losses experienced across an aging individual's lifespan (Pattison, 1977). Loss in an aging individual appears in the changes in their physical characteristics, their intimate relationships, their environment, and their psychological well-being. The reaction to loss can be viewed as either grief or mourning. Both grief and mourning processes are important for healing, but when loss surrounds a person in every aspect of their life, they may not reach that restorative closure.

One concept shared by most theories of aging focuses on the change in identity. The combination of decline within any or all areas of functioning, social, cognitive, physical, or

emotional, can have a negative impact on an individuals' identity. Aging causes transformations to occur in every part of the body. Loss of continuity and loss of control are frightening for the elderly and can perpetuate a loss of identity (Erikson, 1980). With the medicalization of nursing home care, there is often a separation between the body of a dying individual and the life that is being attended to (Gawande, 2014). On top of the changing identity, there is also the difficult issue for individuals to understand; that one day the self will no longer be (Dillenbeck, 2009). Identity is completely challenged when one goes through the problems of death and dying.

Social experiences change just as other changes take place, with the decrease in independence and the decrease of socialization. Nursing home life can be very isolating. An elderly individual is no longer around the people they once knew and built relationships with. The elderly experience a loss of social role. Those they are surrounded by show various forms of degeneration, which can make communication quite difficult. In addition, there is a concept of "social death" that can be experienced (Dillenbeck, 2009). This social death refers to the treatment of dying individuals by caretakers. Social death occurs when nursing home staff interact with the elderly for the sole purpose of maintaining the function of the body. Social death occurs when nursing home staff don't consider the elderly individual's overall well-being (Dillenbeck, 2009).

Psychosocial Development

Examining the current mental and physical state of elderly individuals living in nursing homes can be beneficial when working to improve conditions. It is also important to look at the psychosocial contexts of this population, specifically pertaining to factors that play a role in the development of the individual's identity. To work on improving the present

state of elderly individuals in long-term care, it is necessary to look at the psychological development that encompasses each stage of life.

Erik Erikson's psychosocial theory describes the development of personality. What is significant about Erikson's personality theory is that it was one of the first developmental models that looked at the entire lifespan. Erikson described eight sequential stages within human development. Each stage has an identifying psychosocial crisis that challenges one's identity (Fleming, 2004). The crisis is characterized by two contrasting emotional concepts. This is represented with a syntonic, or acceptable, and a dystonic, or distressing, disposition. In addition, each crisis has a basic strength that derives from successful completion of the stage. Individuals must encounter and find a resolution with the challenge at each stage in order to move onto the next one (Sokol, 2009). Individual identity is then shaped by how each stage is accomplished. Erikson's theory looks at identification during childhood, the formation of identity in adolescence, and the development of identity during adulthood (Sokol, 2009).

The first stage, basic trust versus mistrust, looks at experiences within the first year of life. Erikson noted that this descriptor "basic" is meant to signify that underlying feelings are not necessarily conscious. This also applies to the unconscious conflicts that happen within the next stages. There is importance in balancing trust and mistrust in early life so a child can learn how to trust others and trust themselves, which promotes self-regulation (Fleming, 2004). Developing trust is the essential foundation for navigating the world through each of the stages that follow.

Autonomy versus shame and doubt is the crisis faced in the second stage of life. This occurs within the second year of life, as the muscle systems strengthen and coordination

increases. During this stage, there is a struggle between holding on and letting go. There is a need to work with the polarities found in retention and elimination, rigidity and relaxation, flexion and extension in the battle for autonomy. In attempting to maintain autonomy, individuals also work with the balance between self-expression and its suppression (Erikson, 1980). The basic strength, will, is obtained when there is a sense of self-control and positive self-esteem.

In the third stage, Initiative versus guilt, a child begins to decide what type of person they wish to become. At this stage, individuals move around more freely, making discoveries. The ability to use language efficiently increases as the child understands concepts and asks questions when there is misunderstanding (Erikson, 1980). Initiative here refers to initiating and moving towards a new direction or way of thinking (Erikson, 1997). Both the increased physical ability found in locomotor movement and the increased linguistic ability allows for imagination to grow. Initiative also links to the development of the conscience. The crisis in this stage occurs when an individual is challenged with deciphering between right from wrong. Often, a child's decision can lead to feelings of guilt and self-restriction (Fleming, 2004). For this stage, the basic strength is purpose.

The time for education brings on the fourth stage, industry versus inferiority. In this stage, children both observe and actively participate in the learning process. They set goals, experience disappointments, and make achievements as they progress. There is an importance of developing one's own tools and maintaining skills. The basic strength of this stage is competence, which can only be achieved by preparation and mastery of conflicts from earlier stages (Fleming, 2004). However, anxieties may disrupt this time of increased learning, and then feelings of inadequacy are the result (Erikson, 1980). This inadequacy, or

inferiority, comes from comparisons to previous life stages and other individuals. To develop the necessary mastery of skills, inner conflicts must give way to productivity and the desire to learn.

Moving into adolescence, the fifth stage, identity versus identity diffusion, has the basic task of molding one's own identity. The challenge is not just learning about the self, but inventing and defining how an individual wants to be perceived (Erikson, 1980). In this stage individuals are given more responsibility and they learn to make positive decisions. With social adjustments and expectations, the self-image can suffer (Erikson 1980). Individuals fall back to previous conflicts as they attempt to find stability in their lives. As development continues, there is also a need to look back at the successes accumulated from previous stages. This ability to recognize where growth took place helps with identifying healthy role formation (Erikson, 1980). The basic strength, fidelity, is the idea that there is consistency to one's identity. Finding this continuity reinforces that the individual is accruing problem-solving skills that will guide them to their desired future.

By the time an individual reaches the sixth stage, intimacy versus isolation, they are entering adulthood. At this stage, identity needs to be firmly established so that intimacy can develop. Individuals seek interpersonal connections in order to reduce isolation. This interpersonal intimacy can be found through friendships, leadership roles, and loving relationships (Erikson, 1980). Individuals experience a desire to communicate and confide in others. They convey ideas, wishes, expectations, and plans during social situations. There is another challenge here as interpersonal satisfaction cannot be found with superficial relationships and without maintaining the connection to one's self. The crisis of this stage is

avoiding isolation while increasing socialization. The result, or the basic strength here is love.

The seventh stage, generativity versus stagnation, is a stage that encourages growth of the healthy personality (Erikson, 1980). The basic strength, care, is achieved when individuals devote time and energy to complete obligations and responsibilities. This can be found by involvement in the community, within an occupation, or by helping to guide the next generation. When an individual does not hold the mentality of caring for others, stagnation or self-absorption can take place (Fleming, 2004). A focus on connectivity is applied in this stage.

During Erikson's eighth stage, integrity versus despair, the goal for the individual is to find acceptance with their place in the life cycle. Gaining integrity is accomplished when an elderly individual maintains stability even when their physical and cognitive states are being challenged. Despair is experienced with the feeling that life is too short and that death is a more immediate and realistic concern (Erikson, 1997). This despair, if not managed, can appear as a lack of hope and disdain for the self. Wisdom, the basic strength, is achieved when an elderly individual can look back at their life's successes and challenges and see where growth and knowledge were gained. Only after successful attainment of wisdom, can elderly individuals accept their mortality and feel prepared in facing their end.

Erikson's Theory Continued

Erikson revisited his psychosocial stages and became one of the only life-span theorists to make an additional, final stage that reflected the current lifespan. While the eighth stage crisis, integrity vs. despair, applies to older adults ages 65 and beyond, the final ninth stage focuses on the last sub-group; those in their eighties and nineties. Erikson called

for a need to reexamine and redefine old age. In this ninth stage, the crisis of each previous stage is revisited and the dystonic disposition is the primary element experienced. This ninth stage looks at the real challenges individuals face that interfere with finding closure with their life in approaching its end. Reevaluating the previous stages does not mean that the strengths have been lost, but rather that in old age they have become a different version of the same strength (Erikson, 1997).

When reexamining the basic trust vs. mistrust crisis in the final stage, elderly find an abundance of mistrust. Elderly individuals begin to question their capabilities. Daily life tasks become more challenging. Continuous decline leads to an increase in disintegration of body and mind. This is displayed by the decrease in hope which then leads to feelings of increased despair (Erikson, 1997). Elderly individuals can, however, still work towards maintaining that once-discovered hope. The elderly can find hope in the gift that each new day can bring (Erikson, 1997).

Doubt returns to elders when looking back at the second stage. This doubt comes from a loss of trust in autonomy experienced by aging individuals. There is a loss of autonomy over their bodies and a loss of autonomy over their life choices (Erikson, 1997). The basic strength of will is weakened. This sense of will is challenged by the environment. An elderly individual desires a sense of safety and comfort, but at this point in life, nothing feels safe or stable (Erikson, 1997).

During the ninth stage of life, childish enthusiasm and creativity begin to dissipate. An individual's sense of purpose fades as disorientation ensues. There is an increase in guilt when an aging adult is determined to accomplish a task that only benefits themselves. Guilt

also appears when an elderly individual experiences enthusiasm to accomplish a task that they may have lost the ability to complete (Erikson, 1997).

Aging adults in their eighties and nineties lose the industry that was once their motivation. Strength and urgency to accomplish tasks diminishes. There is also a continuous feeling of inadequacy that comes with the inability to complete a task. As Erikson describes it, aging is belittling because it challenges competency (Erikson, 1997).

When reviewing the fifth stage, elderly individuals experience a crisis with their existential identity (Erikson, 1997). There is an awareness that others find it difficult to understand the elderly individual's needs and feelings. The aging adult is unclear about their role in society, especially when compared to their previous roles for large amounts of time. The decrease in independence creates more feelings of inadequacy and lack of purpose (Erikson, 1997).

Another source for feelings of isolation can come from revisiting the sixth stage. In many settings, elderly adults have few opportunities to make connections with others and build relationships. Dependability is lost and changes into dependencies and inabilities. If intimate relationships were never accomplished, longing for those experiences can occur. The additional challenge when dealing with intimacy is that elderly individual's immediate community may shrink or expand, but is constantly changing (Erikson, 1997).

Along with generativity, there is also an awareness of diminished ability to adjust to changes in the world and in one's self. Elderly individuals revisiting the sixth stage realize that their caretaking duties are no longer expected and needed (Erikson, 1997). An overwhelming sense of uselessness comes to play as the basic strength of care is being tested. With fewer expectations from others, stagnation grows.

When revisiting the eighth stage, the dystonic factor, despair is at the forefront of the reevaluation. Despair seen in this ninth stage differs from when it was previously experienced because, at the end of life, an individual may not be able to look back on their achievements as fondly. Making it through the tasks of each day becomes a mighty challenge. The new focus is on enduring, rather than feeling a sense of pride in accomplishments. Despair is more prevalent because daily functioning just reaffirms the disintegration of body and mind. For integrity to rule out over despair, interaction is desired. This becomes difficult when loss of relationships and loss of identity are experienced every day. Erikson explained that the only way life satisfaction can be achieved is by finding a way to accept those dystonic factors and focus on the life experienced (Erikson, 1997).

Self-Management

While Erikson discussed theoretical ways of overcoming the crisis of the ninth and final stage, done by revisiting previous accomplishments, there was little explanation of how to do so with the realities of today's elderly. More recent findings have examined the success of self-management tools that are used to reestablish the psychosocial achievements gained over the lifespan. Self-management skills are those that deal with problem-solving, decision-making, and critical thinking (Perry, Hassevoort, Ruggiano, Shtompel, 2015). The emphasis is put on the ability to carry-out or complete a task. Field studies conducted by the School of Social Work at Wayne State University (Perry, et al., 2015) found ways of looking for practical application of Erikson's theory to guide older adults in achieving wisdom. The focus was put on self-management practices that can be used by elderly individuals to control their overall health. Findings highlight the need for elderly to repurpose the skills they have gained over their life span (Perry, et al., 2015).

On top of self-management skills, making use of the resources one individual holds is essential for successful aging. Erikson explained the experience the elderly face when they lose the relationships and major life roles they once had, such as caretaker and employee. To help avoid despair from dominating the individual's experience because of the loss of role, replacing roles can lead to successful aging (Baltes & Lang, 1997). Looking at an elderly individual's skillset and providing opportunities for them to use those skills helps increase autonomy and self-efficacy. The challenge is finding a way to incorporate self-management skills within a nursing home care modality. Allowing elderly individuals to accomplish the final stage life tasks will offer them an opportunity to live their final days with greater satisfaction; something the average person would hope to gain at the end of their life.

Dance/Movement Therapy: A Solution

Dying is a hard aspect of life to conceptualize. The solution to managing the final life stage and the end of life is an attainable one. Erikson's psychosocial stages of development conveyed the need for finding a sense of satisfaction within life's final stage. Finding this satisfaction is difficult to achieve when there are challenging factors that individuals in their eighties and nineties experience, especially when living in a nursing home. There is separation between the elderly individual and their aging body which is common with the medicalization of prolonging life. Using a modality that works to integrate the body and the mind would be the answer to helping accomplish these end-of-life tasks. As a holistic therapeutic approach, dance/movement therapy (DMT) offers opportunities to fill the gaps found in nursing home care.

The goals for achieving end-of-life satisfaction, based on Erikson's theory, are to work on overcoming the dystonic elements found in previous life stages. This means it is

essential for elderly individuals to have opportunities to work through their previous crises that are presenting as new challenges. Further research has indicated that these life satisfaction goals can be accomplished by finding ways of completing self-management and resource-finding goals. The self-management skills can be attained when elderly individuals are provided with opportunities where they reapply their skill set in new productive ways (Perry et al., 2015). The emphasis for these needs is put on the importance of an age-specific modality that will benefit this aging elderly group. DMT is an approach that works with those components of nursing home care settings to reach those goals. DMT can look at those needs and work with goals in the physical, cognitive, emotional, and social functioning areas of an aging individual.

From the basic structure of the DMT session, there are optimal benefits for the elderly population. For one, the physical configuration, a circle, provides elderly individuals with a contained space. The circle that is used in sessions is the basic structure in most DMT sessions and was first described by the DMT pioneer, Marian Chace (Levy, 2005). Chace saw the circle as a container that offers safety. The circle also works to separate the group from the environment outside of the space, the nursing home. This formation increases a sense of unity and group cohesion (Levy, 1995). With one of the major concerns for the elderly population being isolation, DMT works to reduce isolation by increasing socialization. The circle formation allows for connection, the ability to hear and be heard, and the ability to see and be seen. This also helps re-define the power-dynamic. With a circle, no one person holds more power. The dance/movement therapist fills the role of facilitator and uses language to convey a sense that everyone is on an equal playing field. Removing the power-dynamic in this setting is important for maintaining a safe space.

At its fundamental level, DMT focuses on the connection between body and mind. In doing this, there is an emphasis put on what can be communicated by the body. DMT is a therapeutic approach that is fluent in the language of the body. DMT gives individuals the opportunity to communicate verbally, but it is not limited to verbal communication. DMT relies on the use of the body as a tool for expression. Having the ability to convey emotions, thoughts, or stories can be important for this elderly population. Realistically, many older aging individuals find it difficult to verbally express themselves, whether that be from a cognitive or physical decline. When patients are unable to verbally express themselves, their needs are not always met. During a session, the therapist may prompt the group with a question or idea and encourage them to respond with movement or a gesture. DMT provides opportunities for each person to express themselves in a way that is translatable to the therapist.

Thinking of the body as a means for expression may be challenging to conceptualize because of the physical degeneration that occurs with this population. When looking at the body on a physical level, with the elderly, the goal is to maintain function. DMT is a strengths-based approach. This means that the therapist focuses on the individuals' abilities and uniqueness. The emphasis is on the individual using what physically works and finding a sense of pride in that. Bringing attention and awareness to the body can promote a sense of aliveness. Through approaches such as grounding, elderly patients can gain better awareness of where they are in time and space. Grounding often involves guiding clients through exercises that allow them to feel the ground under their feet and feel differences in the body when shifting weight. In the aging elderly, sessions are most often held where group members are sitting in chairs or wheelchairs. For this population, grounding often involves

more directed exercises to work on mobility (deTord & Bräuninger, 2015). This can be accomplished by directing individuals to tap their feet on the ground or in footrests. When sitting in chairs, weight is shifted from feet to sits bones. The grounding practice then has a focus of targeting where the body is sitting within the chair. Directing clients to explore twisting movement or breath that raises the body upward and downward, all allow for a more grounded and stable sense. Grounding accomplishes physical and cognitive goals for this population. It is used to provide balance and re-centering to the body, two things that relate to the challenges of physical decline (deTord & Bräuninger, 2015). Grounding helps this population find sensory stimulation to strengthen bodily awareness. Physically sensing where an individuals' body is in the present moment helps with refocusing attention to the group environment and increasing stability.

When looking at memory loss and cognitive decline, the DMT methodology increases reorientation and comfort. The Chacian structure for sessions involves a gradual progression through warm-up, theme development, and closure (Levy, 2005). This setup gives opportunities for the elderly to be as physical active as they choose, while also encouraging them to challenge themselves. During the warm-up, the therapist may incorporate vocalization or exercises that promote breathing. The use of breath works to both energize and relax the individual. This gives the client a chance to prepare their body for the session. Theme development, in the context of this elderly population, is where the therapist works to encourage expression. This can be accomplished with a question or idea that is threaded into the session that focuses on eliciting hope, prompting reminiscence, or building a sense of community. These areas of focus relate to self-management in that they can prompt the client to look at their skills and accomplishments. After the theme has developed and moved

between verbal and non-verbal expression, the therapist finds a way to bring the session to an end. This can be with a specific song, use of a prop, or guided movement to provide group members with a sense of closure. For individuals with memory loss, having an opening and closing ritual that maintains a consistent structure within a consistent environment can be reorienting (Levy, 1995). Person-centered care is a newer way of rethinking dementia care. The focus is on “maintaining personhood.” This is achieved by meeting the needs of the individual. The therapist works to meet the client where they are in terms of what physical, social, emotional, and cognitive abilities they bring to each session. Once abilities are assessed, the therapist can meet the needs of each individual and work towards the group goals. Meeting the needs of the client with dementia gives them an opportunity to express their feelings and make choices (Kitwood, 1997). The person-centered approach comes from a more positive standpoint and mirrors the strengths-based modality.

The therapeutic relationship is an integral part of the success of DMT. The encouragement, guidance, and non-judgmental language used by the therapist reinforces the individual’s abilities. Directed opportunities for problem-solving allow the elderly to feel a sense of success, and allow the elderly to look back on their accomplishments, which is important for navigating this final life stage. DMT provides many opportunities that help individuals accomplish this, mainly through increasing self-efficacy. Self-efficacy relates to an individual’s ability to think they can accomplish a task. This works in a reciprocal way since the positive thinking allows for the individual to make more attempts at accomplishing tasks, and with every success, there is an increase in confidence. In DMT, there is encouragement for individuals to move and use what they can and what is working (Levy, 1995). Through the guidance of the dance/movement therapist, individuals are able to think

positively about their abilities. There can be opportunities from problem-solving. Self-efficacy comes into play if an elderly individual is unable to lift the left arm, but they find a sense of accomplishment in being able to lift the right. The therapist often verbalizes observations in a way that reinforces their successes. They verbally acknowledge what they see in their clients and the group as a whole. The therapist validates emotional expression through verbal and non-verbal communication. They instill confidence by commenting on their observations of the elderly client's physical abilities. These interventions help the elderly individual to reestablish their accomplishments.

Dance/movement therapy offers a holistic and age-specific approach that benefits the aging elderly population. While the goal for nursing home care is to prolong life, this does not result in elderly individuals finding life satisfaction that is essential for encountering death. With the medicalization of death, individuals are experiencing a disconnection between body and mind. Elderly individuals are also experiencing an abundance of despair at this final stage. DMT can be used to increase self-management and resource skills that are important for finding wisdom and closure with the approaching end of life.

References

- Arlt, S. (2013). Non-Alzheimer's disease-related memory impairment and dementia. *Dialogues in Clinical Neuroscience, 15*(4), 465–473.
- Barbour KE, Helmick CG, Boring M, Brady TJ. Vital Signs: Prevalence of Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation — United States, 2013–2015. *MMWR Morb Mortal Wkly Rep* 2017;66:246–253. DOI: <http://dx.doi.org/10.15585/mmwr.mm6609e1>
- Baltes, M. M., & Lang, F. R. (1997). Everyday functioning and successful aging: the impact of resources. *Psychology and Aging, 12*(3), 433–443. <https://doi.org/10.1037/0882-7974.12.3.433>
- Bräuninger, I. (2014). Dance movement therapy with the elderly: An international Internet-based survey undertaken with practitioners. *Body, Movement and Dance in Psychotherapy, 9*(February 2015), 138–153. <https://doi.org/10.1080/17432979.2014.914977>
- Chen, H., Zhou, X., Fujita, H., Onozuka, M., & Kubo, K. Y. (2013). Age-related changes in trabecular and cortical bone microstructure. *International Journal of Endocrinology, 2013*, 213234. <https://doi.org/10.1155/2013/213234>
- Crews, J. E., & Campbell, V. A. (2004). Vision Impairment and Hearing Loss among Community-Dwelling Older Americans: Implications for Health and Functioning.

American Journal of Public Health, 94(5), 823–829.

<https://doi.org/10.2105/AJPH.94.5.823>

de Tord, P., & Bräuninger, I. (2015). Grounding: Theoretical application and practice in dance movement therapy. *Arts in Psychotherapy*, 43, 16–22.

<https://doi.org/10.1016/j.aip.2015.02.001>

Degenholtz, H. B., Resnick, A. L., Bulger, N., & Chia, L. (2008). Improving Quality of Life in Nursing Homes Structured Resident Interviews: The Q, 2014, 2008.

Dillenbeck, M., & Hammond-Meiers, J. A. (2009). Death and dying: Implications for dance/movement therapy. *American Journal of Dance Therapy*, 31(2), 95–121.

<https://doi.org/10.1007/s10465-009-9074-2>

Ehlers, D. K., Banducci, S. E., Daugherty, A. M., Fanning, J., Awick, E. A., Porter, G. C., Mcauley, E. (2017). Effects of gait self-efficacy and lower-extremity physical function on dual-task performance in older adults, 2017. <https://doi.org/10.1155/2017/8570960>

Erikson, E. H. (1980). *Identity and the life cycle*. New York: Norton.

Erikson, E. H., & Erikson, J. M. (1997). *The life cycle completed*. New York: W.W. Norton.

Fleming, J. S. (2004). Erikson's Psychosocial Developmental Stages. *In Childhood Development*, 1(1), 9–24.

Gawande, A. (2014). *Being mortal: medicine and what matters in the end*. New York: Metropolitan Books, Henry Holt and Company.

- Hoogendam, Y. Y., van der Lijn, F., Vernooij, M. W., Hofman, A., Niessen, W. J., van der Lugt, A., van der Geest, J. N. (2014). Older age relates to worsening of fine motor skills: a population-based study of middle-aged and elderly persons. *Frontiers in Aging Neuroscience*, 6(September), 259. <https://doi.org/10.3389/fnagi.2014.00259>
- Hunter, D. J., & Sambrook, P. N. (2000). Bone loss: Epidemiology of bone loss. *Arthritis Res* 2000. 441–445. <https://doi.org/10.1186/ar125>
- Kitwood, T. M. (1997). *Dementia reconsidered: The person comes first*. Buckingham, England: Open University Press.
- Krampe, J., & Rantz, M. J. (2010). *Dance-based therapy to decrease fall risk in older persons*. Columbia, Mo: University of Missouri-Columbia.
- Levy, F. J., Fried, J. P. and Leventhal, F. (Eds.). (1995). *Dance and other expressive arts therapies*. New York, NY: Routledge.
- Levy, F. J. (Ed.) (2005). *Dance movement therapy: A healing art* (2nd rev. ed). Reston, VA: AAHPERD.
- Ortman, Jennifer M., Victoria A. Velkoff, and Howard H. (2014). An Aging Nation: The Older Population in the United States. Current Population Reports. P25-1140. U.S. Census Bureau, Washington, DC. 2014.
- Pattison, E. M. (1977). *The experience of dying*. Englewood Cliffs, N.J: Prentice-Hall.
- Payne, H. (2006). *Dance movement therapy: Theory, research, and practice*. New York, NY: Routledge.

- Perry, T. E., Hassevoort, L., Ruggiano, N., & Shtompel, N. (2015). Applying Erikson's wisdom to self-management practices of older adults: Findings from two field studies. *Research on Aging, 37*(3), 253–274.
- Plunkett, S. E. (2011). *Palliative and Nursing Home Care: Policies, Challenges, and Quality of Life*. New York: Nova Science Publishers.
- Rolland, Y., Czerwinski, S., Van Kan, G. A., Morley, J. E., Cesari, M., Onder, G., Vellas, B. (2008). Sarcopenia: Its assessment, etiology, pathogenesis, consequences and future perspectives. *Journal of Nutrition, Health and Aging, 12*(7), 433–450.
<https://doi.org/10.1007/BF02982704>
- Small, G. W. (2002). What we need to know about age related memory loss. *Bmj, 324*(7352), 1502–1505. <https://doi.org/10.1136/bmj.324.7352.1502>
- Sokol, J. (2009). Identity Development Throughout the Lifetime: An Examination of Eriksonian Theory. *Graduate Journal of Counseling Psychology, 1*(2), 139–148.
Retrieved from
<http://epublications.marquette.edu/cgi/viewcontent.cgi?article=1030&context=gjcp>