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# The Effects of a Single Session of Dance/ Movement Therapy with Adults in Crisis Stabilization: A Mixed Methods Study

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**THE EFFECTS OF A SINGLE SESSION OF DANCE/MOVEMENT  
THERAPY WITH ADULTS IN CRISIS STABILIZATION: A MIXED METHODS  
STUDY**

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Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Dance/Movement Therapy and Counseling Department

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## **Abstract**

The purpose of this thesis is to identify the effects of a single session of dance/movement therapy (DMT) for crisis stabilization with adults in a short-term residential facility. Over the course of 14 weeks (14 sessions) surveys were administered before and after each session to participants who were new to the group. These surveys, along with the researcher's observations and written notes about the group were collected in order to gain information about the participants' experience of symptoms and wellbeing before and after the group. The change in symptoms and wellbeing was analyzed quantitatively and qualitatively through the use of numerical scales on the surveys and the presentation of themes of the effects of the DMT group.

Quantitative data analysis of this small sample size (N=31) included the calculation of mean percentage differences, which suggest the positive effects of a single session of DMT. A larger sample size is required to provide more statistically measurable data. Qualitative analysis illuminated clear themes that emerged, including the experience of movement itself, and the use of movement as a gateway for other experiences: social support, personal fulfillment, and the lack of benefit. Each of those themes is thoroughly discussed with implications for this and future studies.

## **Acknowledgements**

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## **Chapter 1**

### **Introduction**

The purpose of this thesis is to examine the effects of a dance/movement therapy (DMT) group on the symptoms and wellbeing of adults in a phase of crisis stabilization in a short-term residential mental health facility. Adult crisis stabilization refers to the process by which adults receive brief support in a residential setting in order to be able to return to a long-term living situation. The stabilization unit provides a safe atmosphere for adults to gain emotional strength and confidence in their ability to return to a more independent situation in the community. (The stabilization unit is also referred to as the site, the facility, and the home.) The unit's procedures involve clients' formal and informal "check-ins" with the staff about their physical and emotional health as well as participation in therapeutic services, including individual and group therapy. (Throughout this manuscript, depending of the context of the sentence, the clients will be referred to as participants [of the research], members [of the group therapy], residents [of the facility], and in citing some sources, the word patients will be used.) The residents' behavior is monitored during this stabilization period by the staff in order to help support medication compliance and general self-care and to assess readiness to return the person to his/her previous living situation or a new one, possibly aided by crisis stabilization staff.

There was little therapeutic programming at this site; thus residents were left with much unstructured time during which they often slept, ate, and watched television. Though free time in this safe environment also gave residents an opportunity to talk, cook, make phone calls and feel a general sense of ease, there seemed to be a need for more structured programming according to most on-site staff members. Together with a

crisis worker at the site who was a Board Certified Dance/Movement Therapist (BC-DMT), I developed the idea to have a weekly DMT group. In order to assess what members of the groups experienced in DMT work and ultimately gained from having engaged in such treatment, I set out to develop a way to collect and analyze information about this topic. This thesis aims to clarify how adults with mental illness who are experiencing their symptoms at a heightened level can benefit from engaging in a single session of DMT during their stabilization period. How does just one group help to decrease the symptoms experienced in this population, and how does the group affect the overall sense of wellbeing of group members? Documenting some initial, yet thorough responses to these important questions may illustrate ways that DMT can help those in crisis gain stability and return to their daily life, perhaps with new found coping skills. Can the principles of DMT be adapted to the needs of residents in this setting? Support for this possibility will be introduced in this section, further described in the Literature Review and substantiated in the findings of this study.

This study finds its theoretical basis from the pioneers in the field of DMT and therapeutic group work. The primary founder of DMT, Marian Chace, who has recorded some foundational ideas in the field of DMT and who has been written about extensively by subsequent and contemporary practitioners and authors in the field, worked in an inpatient setting with people experiencing highly disturbing mood fluctuations and psychotic symptoms. Literature about Chace's work emphasizes the use of movement activation, symbolism, and empathy. These principles guided my theoretical understanding and choices of intervention in the DMT sessions. This study uses Chacian

theory as a starting ground and attempts to look more closely at how these principles apply to a less acute short-term setting where group members attend a single session.

Irvin Yalom, a renowned author on group psychotherapy, including short term inpatient treatment, wrote of the importance of group work for clients experiencing acute symptoms. His theories also form a foundational understanding for this research study. His 1983 publication, *Inpatient Group Psychotherapy*, makes a strong argument for group therapy as an integral part of recovery for those in the midst of severe emotional and mental crisis, even if those individuals can attend only one group. His inpatient guidelines focused on the concept of using the group to instill hope, raise self-esteem, and offer the participants a here-and-now experience, all of which may offer a glimpse of therapeutic work to be continued, and a better future. Yalom's expertise on group dynamics for adults in inpatient settings helped to guide my theoretical orientation, practice, and writing process.

There are many ways that Yalom's group dynamic theories overlap with Chacian-style DMT work. There are also many ways that the frameworks can enhance one another. Yalom's (1983) emphasis on developing a supportive, non-challenging way to process patterns of interaction can be used to help understand ways to observe, facilitate, and record verbal and nonverbal aspects of a group. Similarly, the use of DMT can help orient group members to the here-and-now focus that Yalom (1983) advises. Bringing one's whole self into the present moment through body awareness and movement is a mainstay in DMT. The powerful work of Chace and Yalom was utilized to form a structure for the sessions, and the integrated insights of both of these theorists provided illustrative guidelines throughout the stages of the research process about the sessions.



The next chapter will review the writings about Chace's and Yalom's group work and will outline other relevant literary sources pertaining to the use of DMT with adults with mental illness. The subsequent chapter, Chapter 3, will discuss the methodology of this study, including a description of the methods used, the participant population making up the group sessions, the actual procedural guidelines for conducting this study, and the process for data analysis as gathered from the sessions. Chapter 4 is a presentation of the results of the data analysis, both qualitative and quantitative results. Chapter 5 is a discussion of these results (and the limitation of such results) as they relate to relevant literature and the field of DMT.

## **Chapter 2**

### **Literature Review**

This literature review provides an overview of DMT work with adults, through the literature describing Chacian group DMT and the principles of Yalom-style group processing. Additionally, a review of published literature about DMT with adults with mental illness informs this inquiry. Specifically, writings about the effects of movement-based interventions for those with depression, schizophrenia, and addiction will be explored. The sources were selected based on their relevance to the understanding of the facilitation and analysis of effective group work. Most of the literature in the field focused on acute inpatient group work and outpatient individual group work. Little of the published work addresses a sub-acute level of crisis in adults nor does it approach the single session timeframe; therefore, one must take from the literature piecemeal to provide a framework for exploring a single session of DMT in a crisis stabilization setting. The relevant aspects of the selected literature served to construct an overall guideline for facilitating, observing, and analyzing the sessions in the study.

#### **Chacian Dance/Movement Therapy**

The Chacian method lays the groundwork for DMT group work in this study. Authors and clinicians in the field of DMT, such as Fran Levy and Susan Sandel have recorded the fundamental components of such a group. The process includes a warm-up, theme development, and closure, with an emphasis on the circular spatial formation of the group members (Levy, 2005). By focusing on the health of a person whose mental illness is often the focus, Chace developed a supportive and engaging style of working with patients (Sandel et al., 1993). Much literature refers to Chacian methods directly or

expands upon similar themes. Monika Steiner (1992) a dance/movement therapist from the United Kingdom, for example, wrote of the way that the body's natural response to music and rhythm is "almost involuntary and contagious" (p. 148) and can be drawn upon to facilitate a group process for adults with chronic mental illness. By inviting the healthy impulses of the people into the room, Chace and therapists following in her footsteps have sought to facilitate self-expression and group-based activities.

**Activating motivation on a physical level.** In order to prepare the participants for emotional expression, Chace's technique helps participants create energy at a body level. Kalish-Weiss (1982), an experienced dance/movement therapist, referred to such internal motivation for movement as reminiscent of childhood urges, as well as, movements seen in utero. She related the "active motility" and "locomotion" described by the late child analyst, Bela Mittlemann, to the development of self-assuredness in movement and overall (Kalish-Weiss, p. 256). This concept relates to Chace's concept of body action, the core emphasis of accessing energy at a primal physical level. This activation is key to DMT in general and relevant when understanding the use of Chace's framework for helping adults to access their internal motivation.

**Symbolism: Imagery and the movement metaphor.** Imagery is a tool that can be used in powerful ways by dance/movement therapists. Chace explained that the therapist develops movement themes "based on a patient's symbolic movement expressions" (Sandel et al., 1993, p.89). Imagery arising from movement is also referenced in the use of metaphor in DMT groups for adults. Stanton (1992), in an article about DMT in a psychiatric outpatient setting, referred to imagery and metaphor that

comes forth in movement exploration as a representation of the unconscious processes of a group.

Symbolic exploration in a Chacian-style DMT group also relates to the movement metaphor, explained by respected author in the DMT field, Bonnie Meekums (2002). Meekums described movement as “expressive of the intrapsychic material of the individual and of the shared themes in the group,” and suggested that it “becomes metaphoric; that is, it symbolizes something for clients, whether or not they are consciously aware of its meaning” (p. 17). The movement metaphor can be explored in a basic way by examining posture. For instance, a slumped position may represent feeling low, burdened, and/or spineless. The movement metaphors within nonverbal interpersonal interaction can also be explored, for instance, in the act of reaching out for someone (Meekums, 2002).

**Empathy: Mirroring and mirror neurons.** “*Mirroring*, which may occur as part of the empathy process, involves participating in another’s total movement experience” (Sandel et al., 1993, p. 100). The concept of mirroring has been researched from a neurological perspective through the examination of mirror neurons in human interaction. In one such article documenting the neuroscience of mirroring in DMT, dance/movement therapist Cynthia Berrol (2006), explained that witnessing movement and/or self-expression activates the observer on a neural level, creating vicarious feelings and an opportunity for embodying the experience of the other. “Empathic reflection” (Berrol, 2006, p. 309), is a significant aspect of DMT work and Chacian group process that creates a sense of support and validation. Chace connected nonverbally with group members by mirroring the *essence* of their movement expression. She developed

therapeutic relationships with inpatient adults through such skillful sensitivity (Sandel et. al., 1993).

Winters (2008) similarly discussed the concepts of mirror neurons and empathy as they relate to DMT. “Kinesthetic empathy” is a way that a movement therapist addresses the connections among the body, movement, and emotions (p. 88) by offering the dance/movement therapist an inroad into the essence of what a person is experiencing. Winters emphasized the importance of factors such as the context of the setting, the individual’s posture, facial expression, and other visual cues when discussing kinesthetic empathy. In her study, Winters (2008) compared the emotional changes of participants witnessing certain postures to the emotional changes when they physically embodied the same postures. The results revealed that people tend to have the same emotional response whether witnessing the posture or embodying the posture. The exception was the response to the emotion of anger, possibly because this emotion activates “lower” levels of the brain, including the primitive responses of fight or flight. Understanding the feelings of empathy and activation of mirror neurons in those witnessing another’s movement and expression allows a therapist to draw from group members’ responses to others and in this study helped me to continually engage participants in the here-and-now of the group.

The aforementioned Chacian concepts are relevant to the DMT work in this study. Activating group members in an interactive movement-based activity, accompanied with symbolic exploration allowed for enriching interactive group content. Empathy and mirroring offered a basis for creating a therapeutically validating atmosphere in one session. Imagery was a tool useful for exploring emotional material especially for

participants of this study who were less comfortable with movement. The focus will now shift to the work of Irvin Yalom, followed by an integration of the frameworks of both Chace and Yalom.

### **Yalom-Based Group Work**

Yalom (1983) developed methods for facilitating group work in a short-term inpatient setting in order to help participants become involved in an interactive here-and-now focus on the events in the group. These include helping members to process their satisfaction and disappointment with the group process, emphasizing each person's autonomous functioning and decision-making power, and providing support and encouragement to members as they try new things. Sometimes, an effective single inpatient group experience leads a participant to pursue further treatment in his/her recovery and stabilization, which is a satisfactory outcome for such a brief timeframe. Though Yalom (1983) focused on a process-oriented interpersonal work, he cautioned against the use of in-depth processing of patterns and conflict in brief inpatient settings so as to maintain the focus on emotional stabilization.

### **Integrating Yalom and Chace**

Yalom's focus on bringing one's self into the present moment, paired with the Chacian foundation of bringing one's whole self into the group on a literal, physical level, provide a complimentary framework for this study. Both Yalom and Chace have written about specific strategies for helping group members take more initiative in their experience and participation in the group.

**Apparent discord.** While there at times appears to be surface contradiction between the two theorists, understanding where the compatibility lies and using their

techniques for the needs of this adult population allows the practitioner to draw upon the strengths of each clinical theory in an integrated way. One example of small discord in their theories is Yalom's (1983) recommendation to not explicitly point out nonverbal behavior so as to avoid anyone feeling shamed, whereas such identification happens often in a Chacian DMT group right from the start of the warm-up in a skillful and sensitive way.

Another apparent discord is Yalom's focus on verbal social interaction and his understanding that movement is an "indirect" mode of communication (Yalom, 1983, p. 311). Chace, as described in Sandel et al. 1993, accessed empathy on a physical movement level as a very direct way to help ease the separateness one with mental illness feels. In this context words can get in the way of such direct connection. Chace did, however, recognize a "game-like distance" that symbolism can create from personal emotions (Sandel et al., 1993, p.115).

**Yalom-informed DMT as a primary therapy for inpatients.** Chace stressed the importance of "find[ing] every possible means for helping mental patients...gain confidence, self-respect, and initiative" (Sandel et al., 1993, p. 226). To this end, she viewed dance as a tool for therapeutic gain, "useful in the broad picture of a full program," referring to "dance" as an "adjunctive therapy" (p. 226). Yalom also referred to the creative art therapies as being adjunctive. Yalom (1983) recommended casual movement exercises meant for recreational and relaxation purposes for low functioning groups, however this represents a limited scope of the use of movement in addition to the narrow understanding of the applicability of movement therapy. For the purpose of this study, DMT will be discussed as a vital and primary mode of therapy with its own

distinct therapeutic framework. Offering a movement-based processing group as a primary aspect of treatment -- rather than an auxiliary form -- is key to the basis of this study.

**Expanding the understanding of the group experience.** Chace stressed a sense of relaxation and wellbeing through movement and also provided a case example of how even observing such movements is actually still being engaged in the group process (Sandel et. al., 1993). This relates to Winters' (2008) discussion about the experience of observing others' expression and movement and to the concept of empathy and mirror neurons, previously discussed. Yalom (1983) also valued the vicarious experience of learning; however, he stressed that participants can have a directly personal corrective experience through practicing different ways of relating to others. In this way, Yalom stressed the opportunity for members to be conscious of a new experience as a break from old, unwanted interactive styles and interpersonal patterns. Spontaneous movement in a DMT group invites people into a new experience. For groups of adults with mental illness, the "primary focus is to activate and motivate patients to use movement as a means with which to experience new ways of interacting with others" (Stanton, 1992, p. 126). This is a key concept for effective DMT and must be applicable to the participants' real life goals. "In an environment of tolerance one can create the possibility of taking risks in the hope that these new experiences are 'good enough' and will carry over into everyday life" (Steiner, 1992, p. 148).

### **Yalom and Chace on Short-Term Group Work**

As mentioned in the Introduction, Irvin Yalom is a powerful proponent of group therapy, even in a short-term inpatient setting when the group members are different each



time. Yalom (1983) offered a perspective on the effectiveness of short-term group work, including a single session. He found that participants who experienced the power of discussing their issues and feel supported by others were more likely to seek out therapists, friends, and confidants in their life.

The single session timeframe, as relevant to this thesis, requires a high level of activity on the part of the therapist, according to Yalom (1983). A therapist must help participants unfamiliar with group work engage and begin to understand how to use the group as an opportunity to learn, grow, or even just to begin to feel better. Similarly, Chace explained that in a single session there will be a lot of body action potential, requiring much facilitation on the part of the therapist. In an initial session, only some imagery will emerge according to Chacian theory, as this thematic process happens over time as a group comes to trust and understand DMT, the facilitator, and each other (Sandel et al., 1993).

The idea of “cohesiveness” in a group (Yalom, 1983, p.44) is a major principle of group dynamics beginning from the initial session. Yalom explained how the participants must view the activities of the group as intrinsically rewarding in order for a real sense of cohesion among the members to exist. This cohesiveness can be difficult to develop within an initial group, but the use of movement can help. Spontaneous movement and the use of music and group imagery is a wonderful way to create enjoyment and a sense of immediate benefit (e.g., relaxation, play) in the room. Furthermore, movement done in a traditional Chacian circle with rhythmic action (Sandel et al., 1993) bringing members into synchronized movement together provides momentum towards cohesiveness. This

allows for connection among members and for interactions ripe with content for processing and opportunities for interpersonal risk-taking.

### **DMT with Adults with Mental Illness**

A closer look at the use of DMT for specific types of mental health issues will follow, covering depression, schizophrenia, and addiction. The uses of movement in a therapeutic setting is addressed in this section, but the focus is on the application of specific DMT principles and frameworks, not just the use of movement as cited in some sources. Even Yalom (1983) referred to movement activities for inpatient work but his research was not based on a deep understanding of the creative art therapies, especially DMT, which incorporates the physical self directly into the work. He suggested using movement for non-stressful, clear communication with inpatients and lower level functioning groups, and he discussed ways to create recreational activities for the group when people are in need of easy and simple interaction. The playful activities he described are very much in line with DMT warm-ups, however, there are many therapeutic tools available to a dance/movement therapist to expand on the nonverbal process even for those considered to be very low functioning.

**Purpose of DMT group work for adult inpatients.** The purpose of DMT for adult psychiatric groups according to Pallaro and Fischlein-Rupp (2002) is to increase body awareness and interpersonal functioning, and to allow a safe space for emotional expression. The co-authors of this article have clinical backgrounds in this area and have documented their theoretical understanding of DMT with this population. Yet, the main goals and effects of DMT for this population vary among sources. For example, Heber (1993) similarly described the effects of DMT for adults in a psychiatric setting and

found that there are three different levels of benefits: relaxation on a physical level, feeling happier on an emotional level, and feeling more alive on a holistic level. When working with adults with mental illness, DMT can alleviate anxiety, low self-esteem, and tension according to this article, which is based on six sessions with this population. These two sources describe the same setting, but reveal different approaches. The effectiveness of therapeutic work depends on the needs of the people in the room and how the therapist can work with them as much as it depends on an understanding of the frameworks of those who have experience facilitating sessions with the specific population. Steiner (1992) remarked that a leader's preferences and those of the participants largely determine the overall style of a session.

**The nascent group.** A nascent group has been defined as a group that does not develop an integrated cohesiveness nor does it produce growth through commonly expected phases due to the low ego strengths and narcissistic characteristics of the members (Sandel & Johnson, 1983). Susan Sandel (previously mentioned as an author documenting Chacian group style) and David Read Johnson, a clinical psychologist and professor of psychiatry at Yale University offered a basic understanding of the concept of the nascent group. The perspective of the nascent group in a long-term residential setting is provided by Vicky Karkou, a clinician and researcher in the field of DMT in Edinburgh. Karkou (2006) described group DMT with adults with chronic mental illness. Because many of the residents at this type of facility are severely disordered mentally and emotionally, Karkou (2006) associated the nascent group process to the work with this population. She described DMT as part of a "life support system" (Karkou, 2006, p.42) for this population, rather than as a *cure* for their symptoms.

At best in the nascent group, the therapist is the “container of the group identity” (Sandel & Johnson, 1983, p.133). Karkou (2006), however, differentiated the phenomena witnessed in the groups in the community setting from the typical nascent group, as some intimacy was evidenced in interactions among group members over time, allowing for more patterns of group development to sprout in subtle ways. Chronic patients in the nascent groups described by Sandel and Johnson (1983), can have personality disorders, psychotic symptoms, schizophrenia, and, in general, a very acute sense of depersonalization and other disturbing feelings. Those fitting this description might remain silent, frightened, or feel forced to participate. Not surprisingly, the therapist of a truly nascent group grapples to make meaning of any vague signs of progress. If the direct support that the therapy provides is taken away, any such improvements typically disappear, thus making treatment effectiveness difficult to assess.

**Safety and crisis stabilization in DMT with adults.** It is essential to maintain safety in a room of people who are experiencing acute or sub-acute symptoms and for therapy work in general. Herman (1992), in her masterful book on trauma, emphasized the importance of individuals feeling safe in order to feel empowered, to be expressive and creative, and to interact and connect with others. The author defined adult stabilization as creating safety on a physical and emotional level. Herman (1992) also discussed the possibility of working in a more removed way from the intensity of feelings and thoughts so as not to re-traumatize a client.

**DMT for adults with depression.** Steiner (1992) explained that those with depression require structure in a group setting and at the same time need encouragement to attempt individual initiative. As an experienced clinician, Steiner (1992) warned that

playing a “teacher” role for those feeling helpless, empty, and unworthy may be tempting but could increase their dependency and discourage self-expression. Much of Steiner’s description of DMT with depressed individuals reiterates how Chacian DMT and Yalom’s approach would address issues related to depression, such as low self-esteem and social isolation. This section will therefore proceed to focus on the ways other researchers have documented the effects of dance, movement and movement-based therapies through controlled experimental designs.

Koch, Morlinghaus, and Fuchs (2007) conducted an experimental study looking at the effects of a single dance intervention on psychiatric patients with depression. This study comes from the Department of Psychology at the University of Heidelberg in Germany and controls for the experience of the dance for the participating individuals in the study. Participants who engaged in The Joy Dance (Hava Nagila) showed less depression on self-report posttests than did a group doing physical exercise and a group listening to music. The use of movement to energize and awaken joy, especially movement that is specifically intended as a joyful celebration, clearly affected their moods. Items on the self-report (1-9 ratings) included *relaxed, in good mood, motivated, lifeless, tired, positive*, and a few others. The participants’ perspectives shifted after engaging in dance. However, there is no basis in the research for understanding how this affected participants beyond the time immediately post-intervention. Although this study did not look at the effects of DMT per se, the use of dance is a major therapeutic basis for DMT practice and is clearly shown to have an effect distinct from that of exercise and music.

A key aspect of group therapy as described by Yalom (1983) is the ability of participants to internalize a positive experience and carry it over to their everyday life. Participants of the Koch, Morlinghaus, and Fuchs (2007) study could have gained insight into their ability to awaken joy that they perhaps hadn't realized was accessible. This study raises relevant questions. Could sharing a joy dance with others have helped participants shift their perspective to a more positive one and opened them to more positive thoughts and interactions? Does inviting the positive, healthy expression of many individuals into a room for one positive experience (even if it's not all about just feeling joy, as in this study) begin to create opportunities for steps towards growth? Though long-term effects may not be obvious and were not tested by Koch, Morlinghaus and Fuchs, is a shift in mood, perception, and energy level significant for those in the midst of a crisis, as Yalom would suggest? Long-term studies about how participants internalize what they have learned from such interventions are, for obvious reasons, not easy to conduct, and this researcher was unable to locate such a study.

In another study about depression reduction with inpatients, Stewart, McMullen, & Rubin (1994) used a self-report mood assessment as well. However, this single-case design focused on the use of what the Canadian authors called movement therapy. Though the exact nature of *movement therapy* was not clearly operationalized in the methods of the study, it is comparable to DMT with a focus on facilitating group interaction and the use of music and movement and was conducted every other day over the course of a few weeks. The Depression Adjective Check List (DAACL) was administered each day at the same time, and each participant's responses on days with movement therapy were compared with their responses on days without movement

therapy. There was a statistically significant reduction in the depressed mood for five of the 12 participants on the movement therapy days. Because the movement therapy clearly helped several participants and had no significant negative effects for the others, the study claimed to have supported the hypothesis that movement therapy can provide mood improvement. Though the strength of the quantitative results of the study could not be easily generalized for the inpatient adult population, movement therapy showed “immediate antidepressant effect” (Stewart et al., 1994, p. 27) for five of the 12 participants. After taking a look at quantitative evidence of the effects of movement and movement therapy on depression in psychiatric adults, the focus will now turn towards a qualitative understanding of DMT with adults with schizophrenia.

**DMT for adults with schizophrenia.** Yalom (1983) also wrote about his work with lower functioning groups. Those experiencing breaks with reality and symptoms of schizophrenia are included in this population. Yalom specifically advised facilitators to focus on strengths with those group members who have schizophrenia and to help psychotic individuals feel successful in the group. For example, if someone whose reality is altered offers some advice, it is most therapeutic to praise the participant for his/her intention to offer support to others, rather than ignoring or in any way denigrating the advice. Groups whose participants are not functioning at a very high level can be met with physical/recreational activities and relaxation, such as moving body parts and having a ball toss, according to Yalom. As previously discussed, movement is a great way to encourage indirect and light-hearted discussion for those who cannot benefit from process-oriented work. DMT however uses movement in skillfully direct and indirect ways to inspire communication, expression, and growth.

In an article about the consciousness of people with schizophrenia, Mates (1992), explained how difficult it can be for those experiencing psychotic symptoms to verbally express themselves. Even if they are able to speak about their symptoms, their feelings about the symptoms can be overwhelming (more so than the actual symptoms) and so symbolically exploring symptoms and/or feelings can be less threatening. “Because he [the adult with schizophrenia] is frequently unable to report his emotions or absorb his circumstances, dance therapy, for example is recommended” (Mates, 1992, p. 217).

By activating the sense of self nonverbally and interacting with others through movement and music, individuals experiencing psychotic symptoms might be more easily able to engage and therefore not feel so isolated or different from others (Sandel et al., 1993). Oganessian (2008) discussed what the author called dance therapy as it is used in Russia with adult psychiatric patients. Activating the “I” (Oganessian, p. 104) in interpersonal engagement on a nonverbal level is a valuable therapeutic goal. This article discussed the ways that dance therapy provides a form of accessible communication for such individuals through the use of symbolic movement. The spontaneous, improvisational format of DMT provides a very effective structure for such individuals to interact with the world, rather than perpetuating their feelings of being misunderstood or confused, as a focus on verbal interaction can sometimes do.

Susan Sandel (1982) provided an overview of DMT work with adults with schizophrenia. She described the importance of allowing those with schizophrenia time to work through their anxiety and hesitation before they can initiate nonverbally and verbally in the group. Sandel proposed that patience on the part of the facilitator helps to prevent the common display of dependency and compliance in this population. Many



with schizophrenia seek out a caregiver and look to the therapist to take care of them. While maintaining a structure, a facilitator must also be careful not to intervene prematurely with group members who are schizophrenic as doing so may give them the message that the therapist doesn't trust their ability to be autonomous. Allowing them to develop their sense of independence and self-esteem can be very empowering. A facilitator must allow the person's movement initiative time to develop, rather than offering an intervention to shift it in some way. Sandel's recommendation parallels Yalom's advice to stay strength-based with this population. By not stepping in too soon to help such individuals express themselves, and by providing highly supportive feedback, a dance/movement therapist can achieve "a balance between gratifying infantile needs and providing [a] growth-promoting environment" (Sandel, p. 16).

The preceding sections have examined ways of facilitating effective DMT for those with various psychiatric illnesses. The next section is a similar discussion of the substance abuse population.

**DMT for adults recovering from addictions or with dual diagnoses.** Thomson (1997) presented DMT methods for working with those who are dually diagnosed with mental illness and substance abuse (MISA), which were originally developed by the author/clinician for presenting to staff at an inpatient hospital. In the article, Thomson discussed the low frustration tolerance attributed to this population. This inability to work with/through frustration manifests itself in a defensive exterior during new experiences and a desire to give up before "failing." Individuals with such complex issues as the MISA population may develop ways to avoid feeling such overwhelming emotions as shame as well as the accompanying physical sensations. "Rather than feel his/her loss of

control or dependency needs, a patient may instead devalue and resist the dance/movement therapy process” (Thomson, 1997, pp. 71-2). When working with this population in short-term format, therapy cannot penetrate these ingrained defenses. The article highlights the way that inviting play into the DMT session can be powerful because the experience of fun lightens the intensity of the therapeutic work. Experiencing fun without the use of substances is a large part of recovery.

Lynn Johnson specializes in the use of creative art therapies with the substance abuse population. Johnson (1990) remarked on the way that using play in DMT and other creative arts therapies with those with addiction can promote an atmosphere ripe with opportunity for creative self-expression. Her article has strikingly similar themes as Thomson’s article, such as the concept of defensively concealing one’s emotions and the power of a playful atmosphere in the therapeutic process. Johnson helped the reader to understand how heavy shame can feel and the extreme lengths to which those with addiction will go to hide this burden from others. Facilitating more playful activities helps the DMT group to become a nonthreatening place to learn and experience the positive effects of shifting one’s way of being in the world.

Dempsey (2009) portrayed the ways that the MISA population can be invited into DMT work through guided imagery:

When a thought, feeling, or emotion becomes too intense for him/her [a person with substance abuse issues] to tolerate, instead of falling into his/her typical pattern of numbing [the] self, he/she can shift to his/her imagination. The images an addict creates are a safe way for him/her to continue the process of discovering

parts about the self...preparing him/her to handle more intense feelings that might emerge later in the session through active movement. (pp. 165-166)

Rose (1995) described the use of the movement metaphor in addressing chemical addiction and also touched upon on a similar process of using metaphorical exploration to externalize the internal feeling state. The metaphor tends to provide enough space from the emotion to allow members to gain insight. The article also emphasized another recurring theme in the literature, that of being present in the moment: “because body action occurs in the ‘here-and-now,’ important insights can be derived from the immediacy of the movement experience” (Rose, 1995, p. 104). The ensuing feelings and thematic material may be intense, so a facilitator might choose to help the group remain metaphorical in nature. Much of the work around shame may be accomplished in such a way, as previously mentioned by Johnson (1990).

The themes of a DMT group struggling with substance abuse issues can overlap in many ways with themes in a group of people with mental illness. The MISA population may sometimes perceive their substance abuse to be their main issue and at other times may view their substance abuse as secondary to their mental illness. Milliken (1990), Rose (1995), and Perlmutter (1992) discussed using DMT with those with substance abuse, not necessarily MISA, and cite many goals similar to the articles on DMT with adults with mental illness. Promoting healthy risk-taking in the group setting, developing adaptive ways of interacting with others, receiving support, penetrating isolation, and encouraging nonverbal expression of feelings and unconscious material are some of the major purposes for group DMT. There is also a similar need in this population for guidance and structure balanced with encouragement for individual

initiation. The facilitator must be vigilant not to support “the false strength and omnipotence the patient uses to escape the reality of limitations and low self-esteem” (Milliken, 1990, p. 316). Milliken suggested using trust exercises to help increase the positive interpersonal risk-taking. When attempting such exercises, especially with those with substance abuse issues, a facilitator must be diligent not to let feelings of closeness with others overwhelm an individual to the point of feeling engulfed. According to Milliken’s article, this population is hyper-vigilant not only regarding being overwhelmed and encircled, but also to being rejected, both tendencies usually being guarded from consciousness through layers of defenses. Raising awareness around the interpersonal choice in the here-and-now of the group through movement and verbal sharing can be a major part of the work.

According to Perlmutter (1992):

An addict cannot afford to be unconscious ... I think a primary purpose in the treatment of addiction is to help the patient become increasingly aware of the choices he makes, the steps he is taking and whether the direction in which he is moving is toward recovery or relapse. When they get lost we must try to help them find their way. (p. 47)

### **Linking Literature to the Purpose of this Research**

In this research study, the effects of a single session of DMT with a sample of adults with mental illness in need of crisis stabilization are documented. There is a clear body of literature describing the goals and results of DMT in an inpatient setting and for long-term outpatient individual work. By focusing on a single session experience, this study may shed more light on the experience of DMT for those individuals who require

short-term therapy and who are able to actively engage in the process of group therapy. By facilitating 14 groups over 14 weeks with new participants each week, and collecting data from the participants and from observation, this researcher/facilitator sought to gain clarity on the effects of DMT interventions contained within one group experience. This is an attempt to answer the question, “What are the effects?” of such a DMT session based on tangible observations and data collected directly from the clients about their experience.

The literature included in this section often illustrated DMT work with adults in a case study format over the course of multiple sessions with the same group members. However, adults involved in a crisis stabilization program often have access to little or no group therapy work. This research study is therefore a preliminary look at the productive nature of just one group and the principles inherent in DMT that help in a brief stabilization treatment context.

## **Chapter 3**

### **Methods**

This section maps out the methods of this study, beginning with the research methodology, which is that of a mixed methods design. This is followed by a detailed description of the participant population, procedural plan, and concludes with the method of data analysis for both qualitative and quantitative data sets. This is all in attempt to clearly describe the inquiry into the effects of a single session of DMT for adults with mental illness involved in crisis stabilization.

#### **Methodology**

The mixed methods approach was used to determine the ways and the extent to which a single DMT session is helpful to participants. According to Berrol (2004), “the various proponents of mixed methods emphasize that the type of research questions posed ultimately determines the mode of inquiry warranted and unveils different perspectives of the same issue” (p. 208). This study looked at the effects of the use of DMT based on my own recorded observations and the participants’ numerical rating of their symptoms and wellbeing and their own spoken and written words about their experience.

Qualitative data were gathered to answer the question: What are the effects of a single session of DMT for an adult with mental illness requiring help with crisis stabilization? Quantitative measures further address this question and more specifically: To what extent are these effects apparent in one session? In designing the methods for investigating this question, it was necessary to determine how to gather as much relevant data as possible. Gathering data without a cumbersome data collection process while

allowing for a range of symptoms to be included was the main goal; doing so while in the role of the group therapist was also a concern. Creating a situation in which variables were controlled, or having access to enough participants to create a control group were not viable options. A major goal of the study was to gather open, authentic and personal data about the effects of the experience of the DMT session as well as more focused data about a few effects (such as symptom relief and increase in wellbeing) that could be simply measured. Therefore, the study was formative without having a specific hypothesis. Thus, taking all the above factors into account, a mixed methods approach was most appropriate for examining the effects of the group.

### **Participants**

The participant sample consisted of adults ranging in age from 24-62 with a mean age being in the low 40's. There were 20 women and 18 men. Thirty-two of the participants were Caucasian, two were Hispanic men, one a Hispanic woman, one a Native American woman and two were African American women. Most of the participants were from a low socio-economic status and had a long history of mental illnesses. The most commonly diagnosed mental health symptoms were depression, anxiety, posttraumatic stress, and schizoaffective traits. The most common secondary traits fell under the categories of substance abuse or borderline personality traits. The nature of the mental health diagnosis criteria for entrance to the facility will be described in further detail later in this section.

The DMT groups were conducted at an adult mental health crisis stabilization unit. This site is a large building resembling a house. There are multiple bedrooms on the second floor and one single bedroom on the first floor, with space to fit up to eight

residents at one time. (There were anywhere from four to eight people residing at the home on the days the DMT groups were conducted.) The residents refer to it by its specific title (which will remain anonymous in this thesis) followed by the word house or home. The residents of the site were admitted for a variety of therapeutic purposes including transitioning from a psychiatric inpatient level of care back to their home environments, experiencing an increase of psychiatric symptoms (such as depression or anxiety), requiring immediate psychiatric medication adjustments without requiring the safety of a locked environment, or being in need of respite from their distressing situations (such as domestic disputes, loss of a loved one or anniversary of such a loss).

Staff at this house described the DMT group and the nature of this study to the residents of the house the night before the group and/or during breakfast before the group started. The residents of the house who signed the informed consent form composed the participant population of this study. Other house members could choose to participate in the group without signing the informed consent form. These members were not given surveys to rate their experiences before and after the group and were not considered when evaluating quantitative and qualitative data. Over the course of the 14 weeks, there were about 20 participants who did not sign consent but participated in the group (usually 1-2 participants each week participated in the group without being part of the study with about 1-4 participants being in the group and in the study each week).

To further clarify the nature of the stabilization unit and the resident population that it serves, I gathered information from the staff at the site and from the crisis clinicians who screen potential residents. The process for admittance was as follows: A master's-level mobile crisis intervention clinician is called in to or stationed at a variety



of sites including outpatient clinics, hospital emergency rooms, inpatient psychiatric facilities, and other locations in order to determine whether or not individuals meet the level of care appropriate for admission to the facility. Clients who meet the criteria for this level of care are experiencing enough distress to warrant a more significant intervention than can be managed on an outpatient basis but are safe enough to be able to reach stabilization without needing to be placed or remaining in a locked psychiatric facility. The term sub-acute refers to the level of symptoms being less acute than those requiring hospitalization. Prior to their admission, clients must contract for safety, agreeing to refrain from harming themselves and others, and to not leave the building without permission. The individuals receive room and board during their stay on the unit while meeting with mental health clinicians daily, having their medications monitored and adjusted by psychiatrists, attending meetings that they may have (such as Alcoholics Anonymous, doctor appointments, or therapy sessions), and joining the therapy groups offered on site. The unit is not locked and clients may leave with staff supervision if they are deemed safe enough to do so. Clients remain there until they no longer meet level of care, which can range from two days up to several weeks depending on the individual's circumstances.

In order to further clarify the type of mental health distress being addressed in this facility and the DMT groups, it is helpful to describe the sub-acute range of symptoms for admittance. Adults who are experiencing mental and emotional symptoms related to an Axis I diagnosis are considered for a screening for admittance. Depressive symptoms, schizophrenia or other forms of psychosis, symptoms of mood and anxiety disorder, and eating disorders are some of the issues represented in this population. Many of these

clients may be experiencing secondary problems such as substance abuse, personality disorders, problems with current housing, recent change of medication or non-medication compliance, developmental delays, relational disputes as victim or perpetrator, and/or other similar social/emotional concerns. These issues often accompany the Axis I mental illness but cannot be the primary reason for being admitted to the house. The participants of this study therefore represent a variety of mental health concerns and are experiencing their symptoms to a high enough degree so as to be considered in a “crisis.”

### **Procedure**

I began facilitating the group DMT sessions as an interning therapist under the supervision of a crisis clinician who was a BC-DMT about four months prior to data collection in order to familiarize myself with the nature of the group work with this population at the site. I provided the site with consent forms (Appendix E) and flyers about the group (Appendix F) and explained the nature of the DMT group and the study during two staff meetings before beginning the study. Pre- and postsurveys were created based on my conversations with the on-site supervisor and other advising professionals. Copies of the pre- and postsurveys are located in Appendices B and C. In an attempt to avoid verbal prompting and face-to-face data collection with the participants, I developed the written surveys to gather candid feedback. Also, interviewing each person before and after group was not practical due to my dual role as researcher and group therapist.

The presurvey was constructed in order to have an overall understanding of how each participant felt before starting group and what symptoms were currently at the forefront of their experience and in need of stabilization. The postsurvey was constructed in order to have an overall understanding of the change in symptoms and what aspects of

the group led to such changes. The questions pertaining to wellbeing were included to balance the nature of the responses, as opposed to only inquiring about the negative symptoms. To focus only on the negative symptoms was also not therapeutically sound. The scales for symptoms and for wellbeing were included so as to have quantitative information about the degree of changes occurring over the course of the group. A Likert scale format was included for symptoms (10 being the highest) and for wellbeing (10 being the highest). The surveys were designed to be brief in nature and open-ended so as to allow for individualized responses and a broad understanding of symptoms and wellbeing. Symptoms and wellbeing were not directly defined for the participants, so for the purposes of this study, the terms were left open to the participants' interpretations.

On-site supervisors instructed staff to provide consent forms to participants the night prior to the DMT group session. These signed consent forms were placed in a confidential folder for me to retrieve and sign upon my arrival to the site in order to identify the group members that agreed to participate in the study. Staff at the site described the DMT group and the study to residents the Saturday evening before or the Sunday morning of the DMT group prior to my arrival at the site in order for me to be able to facilitate the group and conduct the research study.

The dual role I served as researcher and therapist was a concern in the designing of this study. This was managed in several ways. In facilitating a Yalom-style Chacian DMT group, I remained aware of bringing myself as a person, as a trained clinician, and as a healthy leader into the here-and-now of the group. This approach helped me to remain true to my role as therapist, acknowledging my researcher bias inevitably present, but not overtaking my ability to adapt to the therapeutic needs of the participants. All the

while, I consciously attempted to access my ability to maintain a somewhat objective observational stance throughout the process so as to record factual group occurrences. I aimed to report what observable actions happened during the group, what words were said, and what movement qualities I witnessed, and strictly limited interpretative statements. I also read and reread surveys while recording general and specific statements about the group so as to keep the notes on track with what was effective for the participants in the participants' perspectives. I did not discard any data that illustrated a possible lack of effect and regarded it as just as informative as any possible effect in order to continually minimize my researcher bias. I sought out supervision throughout the process and continued through each group in a very "here-and-now" focus with the participants and with the data so as to remain engaged, fresh, and open to observable data.

Returning to the discussion of procedural recruitment of participants, it is important to note that any residents who wished to participate in the DMT group but did not wish to be part of the study were welcomed to do so but were not included in the data collection. There were no pressures or incentives to entice residents to participate in the study. There was, however, an expectation at the site for residents to participate in the group (separate from being in the study). On rare occasions, residents were not asked to take part in the group based on the on-site staff's assessment of their ability to engage in the process.

Fourteen sessions of DMT were held on consecutive Sunday mornings at the site. Prior to the beginning of each DMT group session, I retrieved signed consent forms from staff for that day, blank copies of the pre- and postsurveys, and pens for participants

to use to fill out the surveys. After the on-site staff gave me the background information about the residents privately in the staff office and then helped to gather the residents into the front room for group, I began the group in the front room of the house. I introduced myself, described the nature of the DMT group, and provided information regarding the purpose of the study and the process of maintaining participant confidentiality. I gave each participant (those members who signed the consent form) the presurvey (Appendix B) to complete prior to beginning the verbal check-in. I was available to answer questions during this time and reminded participants that the surveys were confidential and would not be graded as an examination. Several participants throughout the study sought assurance that their spelling and grammar would not be held against them. I asked the participants to include their names on the survey if they felt comfortable to do so and explained that names would be changed for use in the study. I then collected the surveys after a few minutes. The participants did not see these pre surveys again once they were collected.

The group lasted an hour, from 11:30 AM until 12:30 PM. After the presurveys were collected, a brief verbal check-in ensued followed by the group's selection of music, a warm-up, group movement activity, and verbal processing. There were some variations to this format to address the mood and needs of the group within each session. Such variations included seated movement activities with more verbal interactions and movement-based role-play without music. The groups were facilitated from start to finish with the surveys as a minor addendum to the end of group. After the end of the DMT group, I handed out the postsurveys (Appendix C), waited several minutes, and then participants handed them back to me as they finished. (During the ninth group,

administration of the surveys was unintentionally delayed, resulting in two participants not waiting to fill them out.) There were opportunities for participants to approach me during the time in order to discuss their personal therapeutic issues. I referred them to on-site staff if needed.

Following the ending of each DMT group, I typed qualitative observations of the general impressions that I received and significant moments that occurred during the group. All written notes used pseudonyms in place of actual participant names to protect the confidentiality of the participants, resulting in data that was devoid of any identifying information and was saved on a password-protected computer. After each session, I went into the staff room to number each pair of surveys on the bottom right corner in order to keep each participant's pre- and postsurveys together. I then took the completed pre- and postsurveys from the facility each Sunday after blocking out all identifying information and making photocopies. I placed original and photocopies of the surveys, containing no identifying information in a personal file. I referred to these multiple times while recording the events of each group and reviewed them many times throughout the data analysis phase of the study.

I placed all of the signed consent forms back into the folder on-site in a locked cabinet. All data gathered during the process of this study will be deleted and destroyed upon thesis completion or 18 months following data collection, whichever is sooner.

During the study, there were some participants who were attending the DMT group for the second, third, and in some cases, even fourth time due to extended stays or repeated admissions. Surveys were collected from some of these participants, but these surveys were not included in the data analysis. Their group participation was recorded

and clearly marked as being multiple session participations. The presence of these repeat participants complicated the process of collecting data on a single session but allowed for a supportive atmosphere in the DMT group, while still working with a brief therapy format.

There was confusion for some participants regarding the nature of the scales on the surveys. As previously described, a Likert scale was included for symptoms (10 being the highest) and for wellbeing (10 being the highest), but some participants had difficulty understanding these scales (for instance 10 being the “worst” for symptoms and the “best” for well being was confusing for some). These issues will be examined in more detail in the Discussion section of the thesis.

There were no serious ethical concerns during the study as the DMT group was run just as would have been had the data collection process not been present. There was one woman who was a domestic violence survivor and who did not want to include her real name when signing the consent form or during the actual group. One other woman also chose to use a fabricated name on the confidentiality form for general anonymity. All the participants were assigned a pseudonym in the written thesis to protect their anonymity, but these two women did not use their real name on the consent form as well.

## **Data Analysis**

**Qualitative analysis.** The qualitative data consisted of my observations during facilitation of the groups and the written comments on parts of the pre- and postsurveys (see Appendices B and C). Review of the data began a few weeks into the data collection period, as phrases and patterns from the observations were noted. Each time that I read the notes through, I gathered or refuted ideas for themes. New data each week were

assessed as fresh information to redefine ideas for thematic analysis. The major analysis process began days after the final session took place. The data were analyzed through an extensive review process during which I completed three initial readings of the data set as a whole, reading the surveys of each participant before and after reading my own notes about the particular participant. After these first readings, I began to break the material down into phrases that captured the participants' experiences. I highlighted words that were repeated by more than one participant and read through the data set again to pull out more phrases and words exemplifying concrete experiences of participants. This data set review was repeated two more times until all outstanding phrases or words were identified. In order to “reconstruct” the data (Forinash, 2004, p. 134), I developed categories to organize the examples pulled from the data. I identified the categories using broad titles including: connection with movement, feeling joy, feeling better about oneself and one’s life, group members supporting each other, and lack of evidence of effectiveness. I reviewed each of these basic categories three times and developed clearer descriptions of each category. For instance, upon clarification, the category of feeling joy was not as distinctly understood as separate from the other categories. Each example in this category fit descriptions of other existing categories and so was absorbed into those. I then read through the categories again so that more succinct titles could be given to each. I then reviewed the categories again to more thoroughly reconstruct the data into subsections or subthemes.

**Quantitative analysis.** The sample size was 31 for analysis as not all 38 participants completed the pre- and postsurvey scales. Participants rated their symptoms and wellbeing on a scale of 0-10 on both the pre- and postsurvey. I read each survey



multiple times following each session in order to inform my recording of observations. As I noticed contradictory responses reflecting a misunderstanding of the scales, I gave future participants more direct instructions about filling out the scales, but the use of both scales continued to be included so as not to alter the methodology partway through the study. These quantitative data were analyzed by calculating mean percentage differences, as the sample size was not large enough to show any statistical significance. This calculation entailed subtracting the mean of the postsurvey scores from the mean of the presurvey scores and then dividing the difference by the mean of the presurvey scores and then multiplying by 100. The process was conducted separately for symptoms and wellbeing scores. The mean percent difference for decrease in symptoms among the participants was 17.35% and for increase in wellbeing was 15.65%. These percentages show the relative amount of change after participants engaged in the group.

Bar graphs were then created on an Excel program to show the mean scores for pre- and postsurvey scales for both symptoms and wellbeing. Pie charts were also created to show the percentage of participants who experienced an increase, decrease and no change in symptoms (one chart) and the same percentages for wellbeing (another chart). The bar and pie charts are presented in the Results chapter. All of the raw data were included for the 38 total participants and can be viewed in Appendix D. Please note that some of the raw data reflect inaccurate participant responses based on misinterpretation of the scales, with the most common inaccuracy being an increase in symptoms to match an increase in wellbeing despite the written narrative of feeling calmer and less symptomatic.

## **Chapter 4**

### **Results**

This section presents the results of the data analysis process, beginning with the qualitative results and followed by the quantitative. These results are a response to the research question, “What are the effects of a DMT session for adults with mental illness in crisis stabilization?” Themes and subthemes categorize the benefits in the qualitative section based on observations I made as a researcher and dance/movement therapist of the groups and based on the participants’ survey responses. Calculated average percentage differences and graphs depict the degree to which participants experienced a decrease in symptoms and increase in wellbeing.

#### **Qualitative Results**

Major themes and subthemes describing the effects of DMT emerged after an in-depth and exhaustive consideration of the qualitative data. I will describe each theme using my own words including direct examples taken from my notes and from the comments on participants’ surveys. Although overlap is evident, each concrete example is something witnessed, heard, or read (from the surveys) and each seems distinctly representative of a major theme. The themes are intricately related and examples from one theme will touch on other themes. In part, due to the focus on movement and the movement metaphor inherent in DMT work and in this study, much of the overlap of themes deals with the concept of movement as a gateway for other themes. The words “theme” and “category” are used interchangeably depending on the context of the sentence. The themes are as follows:

(1) *Movement*: enjoying the movement for purposes of relaxation, activation, and recreation; also experiencing movement as a gateway for other benefits.

(2) *Social Support*: finding a sense of connection with others through sharing personal material and being supported or offering support to others.

(3) *Personal Fulfillment*: experiencing a sense of being lifted up through a joyful sensation, a boost in self-esteem, or increased motivation or inspiration to improve one's life.

(4) *No Benefit*: experiencing no benefit or no change resulting from the whole session or aspect(s) of the group.

**(1) Movement.** Movement was a dominating therapeutic tool and had many examples of being an effective experience and a vehicle for other effective experiences. Though it is a dominating theme, it is understood to be an equal and separate theme because most participants did not focus on movement as more important than the other themes as a source of the effectiveness of DMT.

The group movement activity varied throughout the study. In some groups, the extent of the movement was walking and/or rocking in place. Other times, individually focused conscious breathing began, leading to more interactive engaging exercises. In other groups, the participants developed more of a group rhythmic dance from the onset. Some groups remained individualistic in their work and focused only on seated movement with arms. Movement is understood in broad terms as physical activation of one's body. Certain movement activity revolved around attention to nonverbal expression and interactive gestures, from looking to the ground to looking up at another's face, to swaying to another's humming, to walking across the room to put one's arm around

another. Still other groups were enthusiastic about having music with the movement and the positive associations of certain songs. Some participants even named music on the postsurvey as a factor for positive increase in wellbeing (one participant named only music), while some groups had no music. The subthemes of movement will now be presented.

***Movement for relaxation and vitality.*** During the verbal processing of the groups, many participants from different groups mentioned feelings of “relaxation” or identified how “good” it felt to move. This could be seen in movement most commonly through a decrease in bound flow as the movement qualities displayed less tension in the members and the participants moved with less caution (see Glossary for a more in-depth definition of bound flow). Of particular interest was a specific written and spoken comment made by a man, Vinny, who reported feeling especially tense and appeared very bound in his physical movement during his first DMT group. (Vinny joined the group for two more sessions after this initial engagement, but his experiences in those sessions were not considered for purposes of this study.) He presented with schizoaffective symptoms and had many cognitive and emotional complications after a long history of alcohol abuse. After this session he explained that the group was a reminder for him to “take an active role in relaxing” and that he was hard on himself as he again attempted recovery.

It seems that Vinny’s focus on taking an “active” role in relaxation helped him balance his apparent motivation to work with the act of releasing tension. His initial attempt at releasing enabled him to laugh about being “hard on himself for being hard on himself.” He had to “shake things out” using fighting qualities, such as the use of quick time and strong weight. The fighting qualities of movement reflect a more aggressive

physicality, with quick time reflecting Vinny's sense of immediacy and strong weight reflecting his forceful approach to sensing his body weight (see Glossary for more in-depth definitions of time and weight). The movement was obviously also an inroad to some experience of relaxation and self-awareness about his approach to relaxing.

***Movement supported by imagery.*** As the process of the group movement activity developed into exploration of symbolic imagery, which it often did in these sessions, some participants experienced greater benefits than from the movement alone. For Booker and Tia, who had acute levels of anxiety and some psychotic symptoms, the imagery helped them to feel more engaged with the movement. These two participants were in different groups, but both wrote and spoke of their connection to the images that came up for them during the thematic exploration of the movement and that this helped them to feel "better" and for Booker, more "relaxed."

Tia's mountain imagery and Booker's images of fixing up the inside of his "house" gave their very active and anxious mental patterns something to focus on and to speak out loud to the group. During the exploration of the imagery both participants found some comfort in the movement associated with the images and experimented with a leadership role in the group, guiding others through their images. Booker took the group on a "tour" of his "house", during which his trembling (due to alcohol withdrawal according to staff and due to unknown causes according to Booker) significantly decreased. Tia described "climbing mountains" with such excitement in her voice and clear posture gesture merger that other group members began to try out the climbing action with her. Her arms gestured in a climbing motion as her postural stance reached upward with the movement and her head looked up at her hands (see Glossary for a more

in-depth definition). Imagery offered more opportunity for nonverbal expression and a way for nonverbal expression to integrate with the verbal during group.

***Vitality and increased engagement as a result of movement and non-verbal communication.*** There were some members who entered the group process in a disengaged manner presenting as drowsy, withdrawn, and/or otherwise preoccupied. Some of these participants began to engage during verbal check-in, but certain members only became alert and interested in the here-and-now of the group when movement, music and the opportunity for non-verbal interactions were introduced. Two participants in particular had a noticeable shift when moving with the group. Ana, a woman in her early 60's with schizophrenia, who came into the room appearing tired and disoriented, became more mentally focused and aware of her surroundings once she stood up and engaged in the movement. This engagement and mental focus was evident in more eye contact, smiles, and relevant verbal comments within the first few minutes of the movement warm-up, and continued through an exercise of sharing leadership and partnering.

Similarly, Daryn, a veteran of the military who remained in what the staff at the site explained to me as a “catatonic-like state,” seemed to come alive with the movement. He was smiling and alert and even chuckled during the group movement, after being hunched over while seated during the verbal check-in. Interestingly, he went back to this state after the movement, and did not speak during the verbal processing. (He did not write anything on the pre- and postsurveys.) Other members described feeling moved by seeing Daryn “come out of his shell” and being “more alive.” Daryn’s affective response to group interaction through movement allowed others in the group to understand more of

his capabilities. The nonverbal mode of expression was clearly a necessity for such participants as Ana and Daryn to explore their potential with the group.

*Experienced movers reconnecting with movement in a group setting.* The experience of movement as an overall theme is reflected in a more specific way for those who had a background in movement. They seemed to delight in being asked to move in a group setting right from the beginning of the movement warm-up. There were some women in this study, none of whom were in the same group, who spoke about feeling ease and comfort in movement and either wanting to have more or already having movement, dancing, and/or stretching in their lives. Three of these women, Yvonne, Lanie, and Anita spoke about their past experiences with movement, indulged in the movement portion of the group, and verbalized their appreciation for the chance to move. Yvonne enjoyed yoga and said she missed stretching her body. The movement group brought these memories back. Lanie enjoyed group rhythmic dancing, sharing leadership and receiving a compliment with her body when her mind rejected it. Anita explained how she moved all the time and was the only participant in the study who had some idea of spontaneous, healing, and authentic movement (as opposed to dancing, stretching, or taking a structured movement class) before experiencing the group. Each woman showed more positive facial affect and increased free flow during and after the movement. They moved, spoke, and gestured with more fluidity and less inhibition. Yvonne and Lanie, smiled more, while Anita closed her eyes more as she moved and verbalized no surprise in having enjoyed the movement. The personal connection with movement was evident as the women showed their reactions and specifically referred to their resulting positive

feelings. Lanie asked after the group where she could find such types of groups once she left the site.

These women's backgrounds in movement and their indulgent approach towards spontaneous nonverbal expression were more advanced compared to the rest of the group. These women provided other group members support to develop more spontaneous movement. At the same time, there was not ample opportunity for expanding on their movement range as they were "ahead" of the flow of the group. For example, Yvonne's lower body half (from her legs to her pelvis and lower torso) was not activated in a way that supported her large upper body movements (arms, head, and upper torso). I then suggested to the whole group to explore activating their legs, rather than individually helping Yvonne to access a more activated upper/lower connectivity. This connectivity helps to enliven the vertical connection (see Glossary for a more detailed definition) and was beyond the general patterns of the group in their warm-up movements. In this way there was a less advanced intervention aimed at the overall group process rather than Yvonne's individual movement range.

Another example of an experienced mover in one of the groups could be observed in Anita's experience. With the intense bound flow of the members of the DMT session she attended and with some participants seeming more comfortable with imagery than with movement itself, Anita's movements were not developed in a group format but were channeled into her garden imagery as she took us on a "walking tour." Experienced movers like Anita offer increased energy and body action potential in the warm-up. Often times they are catalysts for a more sophisticated movement exploration when other members begin to pick up the broader approach to spontaneous movement. There was



often more attention to the nonverbal aspects of group during verbal processing when members who were very comfortable with movement were present.

***Movement enjoyment and self-motivation.*** Less experienced movers still made a personal connection with movement. One man, Ralph, made an interesting comment that moving and engaging actively were what he needed to do with his day and life. This verbalization came up during our discussion towards the end of the group. After I read his postsurvey comment about feeling more confident and focused about knowing what he needed to do in his life, it seemed apparent that movement itself was a positive and motivating experience for him and became a metaphor for motivation itself. This represents another theme and an example of movement as a gateway towards personal fulfillment.

For another man, Rip, movement sparked a pull towards opening up to the group about personal motivations. He too was accustomed to neither dancing nor creative movement and remarked on how surprised he was at the way that movement turned out to be helpful. He further explained that he was surprised at how much he spoke up during verbal processing about what he needed to be doing in his life. The movement seemed to be a vehicle for internal activation, prompting participants' desires to be more activated in relation to their goals.

One woman, Ingrid, who was in her early 20's and liked to go out dancing, but did not have many other experiences with movement, displayed the pure enjoyment of rhythmic dancing. She smiled as she encouraged the group to move with her, using rhythmic arm pushing, foot stomping movement with indirect space and strong weight (see Glossary definitions) to reggae music. These movement qualities represented her

flexible and grounded approach to the group process in general. She was readily accepted and respected by other group members, inspiring her and encouraging others to move and to share. (Her movement connection with another woman in the group due to this rhythmic synchronization will be discussed in the Social Support section.) Ingrid remarked on her delight in the movement and talked about her motivation to continue on her sober path. She also showed further evidence of experiencing movement as a gateway for personal fulfillment (see Personal Fulfillment section).

***Movement leading to increased engagement.*** Initially, many participants were uncomfortable with the idea of movement, especially in a therapy setting while in a group of people. A slow, basic movement warm-up usually led to more ease in the movement and an increase in a sense of wellbeing; as evidenced by more positive facial affect, more inviting demeanor, content of speech, and survey comments. There were some members who found joy in the process of engaging in nonverbal group activity, despite their lack of ease in the physical movement. This was the a case for one group member, Babette, who became more playful and engaged when she stood up with other group members, but recorded slight increase in her symptoms on her postsurvey scale without identifying what caused the increase (see No Benefit section for a further discussion). She did however record a slightly higher score on her wellbeing scale on the postsurvey.

Babette, who was experiencing symptoms of posttraumatic stress from sexual abuse, was not engaged for most of the check-in, stating that she was tired. She was however awake and laughed during the movement and helped to pick out the music. This snippet seems most relevant to the theme of movement because this evidence of pleasure was not present unless she was standing and moving even the little bit that she did. The

group moved together in a playful way and provided an inroad for Babette to remain present in the here-and-now for a short time.

Many who did not connect readily with the actual physical movement found a way to play interactively with others and/or with certain thoughts or images that the movement brought up. They even found it enjoyable to laugh “with” the group and at their own awkwardness in the movement. A smaller number of members were not so accepting, resulting in no acknowledge benefits (see No Benefit section).

***Movement leading to positive feelings and increased social support.*** Yet another way that movement was effective in the groups was that it helped increase positive feelings and social connection among the members. Participants who enjoyed the movement typically engaged more readily with other members of the group and were more involved with the process of the group experience as a whole. One particular group session highlighted how the movement allowed participants to open up, provided an alternative to focusing on problems through talking, and created opportunities for valuable, supportive verbal processing afterwards. The experience of one woman, Raquel, provides a clear example of this theme.

Raquel was a participant who shared freely in the check-in and required some redirection to allow time for others to talk. The discussion that came from verbal check-in began to reach a dead end. There was a gloomy atmosphere after people shared their negative feelings. As people looked around the room, I offered the option of trying to literally “move this feeling.” The group agreed on some country music and stood up in a circle.

The movement in this group did not develop into extensive thematic exploration, but rather stayed on a very simple level of moving to the music. While the members did this, the group was directed to acknowledge the others in the room who were moving with them. As they began to make eye contact with each other, some people began to sing the words of the song. This resulted in some shifting of attention from one person to the next. Raquel especially appeared to be in a more light-hearted mood after this shift. She closed her eyes during the movement and when she opened them, she smiled at others. She listened more to others during the subsequent discussion with far fewer interruptions than during her verbal check-in. Furthermore she spoke using more free flow and light weight in her hand gestures and upper body movements. There was a more indulgent ease in her conversation. The content of her disclosure was still emotionally sad, however, she appeared to have more acceptance of her situation.

Each example tends to show that as people came into the group feeling hopeless, they left with some rejuvenated perspective or physical energy. Raquel wrote about how the group resulted in her “moving and laughing even though we discussed some emotionally deep [aspects] of our personal journeys.” The light-hearted atmosphere, which Raquel mentioned, often seemed to allow for a more productive exploration of heavy emotions during the group.

Movement has been identified as an energizing, relaxing, recreational experience in itself and as an avenue toward health and growth, such as socialization and internal motivation. The subthemes of movement included: *movement for relaxation and vitality, movement supported by imagery, vitality and increased engagement as a result of movement and non-verbal communication, experienced movers reconnecting with*

*movement in a group setting, movement enjoyment and self-motivation, movement leading to increased engagement, and movement leading to positive feelings and increased social support.*

**(2) Social support.** This theme was easily observable in the group sessions. Group members related to one another, moved together, and offered advice and encouraging comments to each other. During the verbal discussion following the group movement, members often shared with more openness, playfulness, and/or positivity. The social experience inherent in this therapeutic group setting was readily observable and was commented on verbally and on postsurveys by many participants. The power of social support was a common topic for group ending discussion.

***Validation and universality.*** Social support manifested in therapeutically effective ways as the group members listened to one another and validated each other's feelings. This allowed for a sense of universality and led to opportunities for healthy risk-taking among the members. During DMT groups, participants often shared feelings of despair, fright, and angst about their steps toward progress. It was common for participants to relate in a "me too" response, normalizing feelings, and creating a sense of universality around the experience of symptoms and stabilization. Group members often validated each other's intense feelings of sorrow and pain through verbal acknowledgement and/or support as well as through non-verbal gestures, such as an arm around another's shoulders. During one poignant moment in a group, Lanie, a domestic violence survivor remarked how she didn't feel she could accept positive comments from another group member. Ingrid offered the validating comment that she was "in the same place," being unable to accept positive feedback. Their moment of connection was

precipitated by an interactive movement experience in which Lanie was in the center of the circle. This gave way to a palpable connection between the two young women.

Another participant's experience illustrates how disconnection from one aspect of the group process none-the-less led to a socially supportive conversation. Wally, a Spanish-speaking participant, explained in broken English that he missed his family and that it was very hard for him to be new in this country without knowing the language. He could not understand why the group was moving together "not at night" and sat down. (This example will be further described in the No Benefit category.) When the group processed this with him at the end of the group, he did not say much more about the movement, but he did give an example of how slowly and loudly one needed to speak for him to understand. Members empathized with his difficult situation, which then led to a more general discussion about feelings of isolation that can come when the environment doesn't meet our needs, and the ways people can feel alienated. The ensuing conversation about not feeling accepted seemed to help everyone feel more accepted in the moment, as the conversation flowed easily around the room. Having one's feelings validated and then experiencing a sense of belonging in a group is a powerful group effect.

***The presence of nurturing feelings and interactions.*** The subtheme of nurturance among group members is another important example of social support. Towards the end of the group movement phase of one DMT session, Daryn (the older man who was a veteran of war mentioned in the Movement theme) looked down and his excessively withdrawn personality became more pronounced. Once the movement ended, he made no attempt to engage in a verbal exchange about closing the movement circle. He nodded when I asked him if he wanted to feel supported by the group nonverbally as

our movement came to a close. After some exploration about how to do this, the group members joined around him and Lanie started a lullaby. The group then joined in the singing, including Daryn. The group didn't know the words after the first verse, which resulted in group laughter, also including Daryn's. Afterwards, the group returned to a big circle and held hands before sitting down. Elba, who had been very withdrawn and fidgety during verbal check-in, stated during the verbal processing that watching Daryn "come alive" was touching. She wrote on her postsurvey about her realization that she still cares about others. (Note: Elba's realization after seeing Daryn engage more readily nonverbally was made during her initial session [Daryn's second session] and not the session just described).

During the movement warm-up of another group, Ursa, a middle-aged woman, held Ana's hands (Ana was the older woman mentioned in the Movement theme) and swayed side to side with her. Ana was not completely stable on her feet without her walker, so she readily accepted Ursa's gesture. After the movement continued to develop in a supportive way, Ursa and Ana shared how much it meant to them to feel as though they were "there for each other." Each displayed a posture gesture merger as they leaned towards each other and embraced for a few moments. After the movement they discussed how appreciative they were for the supportive feelings. The group for Ursa became a place to share warmth with others, as she felt comfortable with the people in the group. She offered kind words to Ana and helpful advice to May about staying at the house and focusing on her goals. Experiencing one's own desire and/or ability to provide nurturance for others not only appeared to be a positive individual experience, but also allowed for

group cohesion in a single session. Receiving nurturing gestures from others resulted in outward expression of happiness and palpable evidence of interpersonal warmth.

*Letting people into one's isolated world.* In many ways, social support came to be simply about opening one's self to others. For those who usually remained withdrawn in a group setting or in their lives, the non-threatening therapeutic group atmosphere of the DMT session seemed to be very powerful. One young man in his early 20's, Galvin, shared more than he was accustomed to in groups. He explained that he usually tried to "pretend to be asleep when group started" at the recovery center where he had previously resided. In this movement group, Galvin was hesitant to act in spontaneous ways, though he did engage in some playful activity. He looked around the room before he committed to any movement, especially at first. His willingness and desire to have fun, matched with the playful atmosphere in the room, seemed to allow him to take more risks in the group. Towards the end of the movement exploration, he was playing the "air guitar" along with the music and another member in the group joined him. There was an ease and flow in the verbal processing in this group, as many members spoke about their recovery from bouts of depression and some relayed their difficulties in recovery from substance abuse. Galvin, a self-reported withdrawn person, leaned forward as he joined in on the conversation. He shared more directly than he said was usual and ventured as far as to admit that he did not like showing his vulnerabilities.

In a similarly hesitant way, Noreen disclosed during the verbal check-in of another group that she was actively experiencing auditory hallucinations and she felt that people might not be able to understand her. The group responded that they did understand her, but disclosing her personal material brought on a rise in Noreen's hallucinations. I



encouraged her to take an active role in the movement role-play activity that evolved in the group. This attention to the here-and-now of what was happening with others in the room seemed to help her not get “lost” in her hallucinations. She wrote on her postsurvey that she felt “calm” and what helped was that she “focused on others.”

Opening oneself to social connection provided effective opportunities for isolated individuals to feel “better.” Beyond this, interpersonal experiences allowed for initial steps toward trusting that support is available when feeling hopeless and can even challenge negative self-beliefs. The subthemes included: *validation and universality, the presence of nurturing feelings and interactions, and letting people into one’s isolated world.*

**(3) Personal fulfillment.** The theme of personal fulfillment describes an individual’s experience of meaningfulness, happiness, and inspiration. The subthemes illustrate the ways that people felt uplifted through increased hope and self-esteem after engaging in the group process. Identifying the theme of personal fulfillment relied heavily on participants’ verbal and written self-report to better understand the internal nature of their experiences. The way that each person developed a sense of personal meaning from group events was not as readily observed as the way they connected with movement or with others in a socially supportive way. Participants often seemed hungry for symptom relief and once “distracted” from the symptoms, many found fulfillment through increased joy, self-esteem, and awareness of aspects of their life that they could gain control over.

*Freedom to feel joy.* Personally fulfilling experiences in the group often involved happy, uplifting feelings or at least a freedom from less pleasant feelings. Some

participants felt that the group distracted them from their symptoms, in some instances allowing for some respite from negative feelings. For example, Booker wrote that the group provided “distraction” and that he felt “less agitated...more relaxed.” Anita wrote that “distraction from thought” helped her, which related to her connection with physical movement described earlier. Participants such as these who simply felt *distracted* from their symptoms did not refer to any experience of actual enjoyment or more peace. They seemed to gain some inner space for experiencing emotions other than the unwanted feelings and thoughts with which they entered the group.

Creating a free, playful atmosphere in a therapy session invited some participants to create a similar free, playful space within themselves. (The movement, as previously discussed often helped with this, but this theme focuses on ways in which personally fulfilling experiences were not a direct result of engaging in movement.) Experiencing happiness can be profound for those who don’t often feel this way. One woman, Torey, felt “depressed” and was apparently very sleepy at the beginning of group, but felt “happier” at the end because of the “talking and music.” She was a fairly quiet middle-aged woman with a long history of depression and appeared sluggish and collapsed in her passive use of her body weight. Seated movement provided more physical support for her. The group’s verbal expression of imagery during the movement assisted her in engaging with the group. She smiled as the group imagined travelling through various landscapes, offering her own interjections during this imagery and movement exploration. During verbal processing, she spoke about how doing things other than her regular routine helped get her in a different mind state. She seemed to uncover joy that she was unaware of prior to the group experience.

Other participants who did not have much of a social outlet also found great benefit from tapping into joy through group activities. Whether or not this experience actually helped such individuals to become more social outside of the group is beyond the scope of the results, but was directly and/or indirectly touched upon during group processing. Thor, a very shy older man with intensive psychotic symptoms wrote “yes and no” in response to whether he received something from the group; “yes” in that he felt more “relaxed and happy.” The group vocalized in a supportive, nurturing way that he was “friendly” just “shy.” After checking in with him during group dialogue, Thor agreed that groups could be difficult for him. When an opportunity presented itself during the group, Thor agreed to practice initiating interactions with others verbally and nonverbally. He showed little signs of discomfort on a physical level and was greeted with much kindness from everyone. Through observation, it was difficult to identify what Thor gained from this experience, but the word “happy” on his postsurvey stood out, especially after he spoke and wrote (on his presurvey) about such lack of enjoyment in his life. Feeling a sense of joy in the group related to effectiveness under each theme, but specifically to personal fulfillment through feeling uplifted.

***Increased motivation and hopefulness.*** One very vivid example of personal fulfillment manifested in motivation towards one’s goals was the experience of Ingrid, who put “self-pity” in the group’s metaphorical fire at the end of the movement section of one group. With a posture gesture merger she threw her arms toward the center of the circle as she leaned towards the direction of the throw as she described her intentions with a determined voice. This release of self-pity was evident in other ways also. Her presurvey focused on ways that she felt helpless, while her postsurvey spoke of her

“excitement” and “serenity.” She was already showing a vague sense of personal initiative in her mental health treatment and recovery from alcohol during the check-in, but she focused on her limitations and her worries. After moving with the group, smiling, and being very engaged in the movement and in the thematic exploration, her focus seemed to shift toward a more uplifting outlook about her abilities and her motivation towards treatment and recovery, vowing to take “one day at a time.” She was very much a leader in the movement and a supporter of others as well.

Rip was an older man who appeared much more laid-back and less ambitious during the DMT group. He remained in decelerating time for most of his movement and speech patterns, and used other indulgent qualities, such as light weight and indirect space, reflecting his passive, receptive attitude in the group. When checking in with the group, he shared that he couldn’t stop thinking about a resident who had left the facility to use substances, a resident to whom he personally related. Partway through the movement exploration, he became more present in the here-and-now, and engaged in what the group was doing. During verbal processing, he showed little evidence of his ruminations about the resident who had left and reflected more on the way that the group experience surprised him by being enjoyable. It seemed that he also surprised himself by engaging in spontaneous physical movement and opening up about his experience. He seemed to have a revitalized perspective after the group about his own personal goals for stabilization. Rip wrote that he felt “better” and that he “opened up more,” according to his postsurvey. Many participants throughout the study seemed to have a mindset that group work was not an uplifting experience, as they often shared how surprised they were to feel better after the group and to not have been “bored.”

*Increased self-esteem.* Participants also showed clear signs of personal fulfillment as they experienced a boost in self-esteem during the group. Two particularly articulate participants helped to illuminate the ways that the group assisted with increasing self-esteem as they stated and wrote about this very occurrence with much clarity. Ralph said that he felt more confident and felt that engaging in the group lifted his self-esteem. He was focused on healing and took an interest in gaining insight about himself and how he could feel and do better. He alluded to this during the group and especially in the verbal processing, but wrote about it succinctly in his postsurvey. He took an active role in the group from start to finish and found much support from speaking about his situation. He was coming from the mental health hospital and gaining strength and momentum towards returning to his home life. He truly exemplified ways that a participant's decision to engage in the group and take initiative in this process brought about a personally fulfilling result.

After a different group, Tia wrote that she felt better about herself. The mountain climbing imagery stood out for her as evidenced by her excited tone and facial affect. She was climbing with her arms and looking up. Feeling better about *herself* seemed important as her verbal check-in focused on negative aspects of her personality and her symptoms. (Many participants focused on what was wrong with their lives, but Tia detailed what was "wrong" with *her*.) The group for her was about having fun and seemed to provide nonverbal feedback (participants moved with her and responded to her imagery) that she was perhaps "alright." This overlaps with movement and social support themes, however, the effective results involved personal fulfillment.

Nadine was a middle-aged woman (with slight cognitive limitations, but great verbal skills) who had a history of depression and anxiety. She was very proud of herself for explaining to the group the ways that she released anger. This to her was an altruistic gesture towards the men who were saying that they had difficulty in expressing anger. Simultaneously sharing a vulnerable part of herself, while offering what she felt was extremely helpful advice seemed to be uplifting for her. She wrote about this in her postsurvey and was later overheard sharing with other staff how proud she was of her helpful gesture. In a non-threatening environment, participants at times felt free to take perceived risks like this and showed evidence of being inspired by taking such risks. Others experienced a rise in self-esteem when receiving positive feedback from others, such as being told they were “worthy of more” or that others were “glad they met” at the home. Feeling better seemed not just to provide symptom relief on the surveys but also allowed for more hope about their basic ability to do well and feel good.

***Increased awareness.*** Personal fulfillment could also be seen as participants gained insight into their lives and therefore took more responsibility to achieve their goals. Spencer, a young man with a history of residential treatment and with a high level of emotional awareness was the only group member during the study who directly articulated feelings of anger and was able to briefly process this in a safe and appropriate way. His increased awareness in only one session is worth highlighting to illustrate this theme. Spencer seemed to become deeply involved in the exercise of finding where his anxiety built in his body and then identified it as a black hole in his stomach.

The members took turns sharing about their physical experiences of an unwanted emotion. One member, for example, felt that he released some tightness in his torso after

consciously locating it. The group remained standing in a circle as Spencer went a bit further with the process, verbally describing his internal connection. When Spencer was asked, “Where is ‘it’ [the anxious energy] now?” he said that his hands “tingled.” When asked how he would move that through his hands, he said, “flipping off.” In response to the question, “Who?” he stated “his parents” for not “letting him stay” (with them and his son at their home). He explained that they did not want to keep allowing him to go back to his old ways. He said they wanted him to hold down a job, find a place to live, stay sober...etc and that all at once, it was “too much.” Spencer related his anger to this sense of being overwhelmed with basic life tasks through the movement visualization. He stayed very internal throughout the process. During verbal processing, his quietness amidst the group’s activity was remarked upon and led to a discussion about his tendency to isolate, leading to his current state of crisis. The expression of anger seemed to have been processed on a surface level, but how it related to his tendency to isolate, become overwhelmed and frustrated, and his overall pattern not to seek the right kind of support was identified for future work.

In another DMT group, Serge offered a more basic example of gaining awareness that provided momentum for continued work toward stabilization. Serge “shook” his head during the movement warm-up. When asked what he was shaking, he said “the bad thoughts.” This led to others doing the same. Serge said that the group “brought things to the forefront” so that he was more aware of how to “shake this negativity” that he felt. Serge wrote about this distinctly in his post survey.

The examples given were the more articulated insights that evolved over the process of the group. Many members however had revelations that were meaningful for

them, but were not as extensive, such as becoming more aware or remembering that they could feel better if they engaged themselves in their own treatment goals. Other examples of increased insight overlap with and have been mentioned in other themes, such as gaining awareness of relaxation through movement.

Engaging in the group sessions was personally fulfilling for participants in various ways. Personal fulfillment has been defined and individual examples have been outlined. The following subthemes were mentioned: *freedom to feel joy, increased motivation and hopefulness, increased self-esteem, and increased awareness.*

**(4) No benefit.** Observations, comments, and surveys of some participants provided evidence of no benefit from the group. The illustrations that follow reflect the ways that participants felt uncomfortable, disinterested, and otherwise put off by part or all of their group experience.

*Excessive discomfort outweighing possible benefits.* Many participants expressed some initial discomfort with the idea of moving in a therapy group, however for some the discomfort didn't dissipate or grew even stronger. One woman, Bree, chose to escape from the group altogether. She explained that she felt "nervous" during the check-in and left the room after I collected the presurveys and started the group. She was the only participant who left in this way during the group. (One other woman, who will also be discussed in a later section of this category, left the group for the movement section and returned for verbal processing.) There was no chance to check-in with her about this. The staff were not surprised that she wanted to "get out of group" due to her discomfort with the idea of group work.



Another woman, Lyla, was the most vocal about her discomfort and clearly stated that she felt no help from being in the group. She engaged in the movement exploration, though she did not initiate any of her own movements and shied away from any direct attention. She moved with intensely bound flow through the duration of the group, even while speaking, which relayed a sense of persistent discomfort. It was not until the very end of verbal processing that she shared how “forced” everything felt for her. She said that she was very uncomfortable in the group setting and when asked if this discomfort was a common experience for her, she nodded her head yes. She was not interested in talking about this discomfort, but stated that she just wanted to go back to her real home.

Nakita, a woman in a different group was similarly distressed about engaging with group members and being asked to try movement. She spoke of the discomfort as it arose, saying she felt “silly” during the movement warm-up. She maintained a very rigid posture and later in the session reflected that other group members were “more outgoing” than she was. There were three other people in the group with Nakita and after a very brief warm-up with very little body action potential present, the group sat down and discussed what was going on in the room. Other members, including Nakita, shared how difficult it was for them to show emotion. They even shared how they would usually leave before showing this vulnerability. (During this talk, I reminded the group that the therapy setting was a supportive space to practice new ways of being in the world and that they were invited to trust their instincts about what they felt ready to share.) The group processed their fear of being judged or criticized, as Nakita silently became teary eyed. When the group checked in with her, she made no mention of the emotional expression being helpful or harmful and her demeanor did not shift throughout the group

process. Her pre- and postsurveys showed no change in levels of symptoms or wellbeing. She reported a sense of feeling “depressed” on her presurvey and “bored but unwilling to do anything about it” on her postsurvey. Her apparent unwillingness appeared to be keeping her from opening too much in a group process. It seems that Nakita experienced very little if any benefit from engaging in just one session of DMT.

Wally spoke very broken English and could not comprehend why we were dancing together “not at night.” He looked around the room, keeping his hands in his pockets and then sat down. The explanation did not reach him verbally, so the group movement continued to evolve without him. Later, during his verbal processing, the group discussed the language barrier and the clash of cultural understanding that had occurred. Wally described to the group the type of dancing he did in his home country and explained to the group how slowly and loudly he needed people to speak in order for him to understand. Further group processing about the disconnection he felt with the movement process ensued (see Social Support category).

There were a few participants over the course of the 14 sessions who felt uncomfortable for a part or all of the group session. Bringing attention to the apparent discomfort led to insight about the source of the discomfort. There were a couple of members whose discomfort increased when given any such personal attention and who chose not to explore. Participants who were unable or unwilling to explore the source of their discomfort were not challenged in this short-term setting.

*Aspect(s) of group triggering symptoms.* The phenomenon of the group process triggering participants’ symptoms happened twice according to the pre- and postsurvey scores for symptoms. (Other reports of increased symptoms on the postsurvey were

contradicted by accompanying narratives, a rise in wellbeing or a rise in symptoms such as “serenity.”) Group members often shared sad material that in the moment might have been unpleasant, but the group process left most feeling better. The two instances of symptoms being triggered seemed to show that the group left these individuals feeling more symptomatic. Ned, whose scale results went from 0 to 10 on symptoms and 10 to 0 on wellbeing, showed little behavioral evidence that supported or explained his pre- and postsurvey responses. (The numbers on the scale were not contradicted by his written narratives and did not appear to be a misinterpretation of the survey.) He also showed little evidence of gaining much benefit from having partaken in the group. During the movement, he half-heartedly would gesture at times with his arms and looked down most of the time. When I asked about these withdrawn behaviors he said that he couldn’t “find a beat” and avoided further engagement with the group. During verbal processing, when asked what kept him from feeling connected during the movement, he said “guilt.” He wrote guilt as a symptom on his postsurvey as well. He chose not to elaborate verbally or in written word about anything related to his guilt. The group was facilitated in such a way as to be sensitive to the nature of crisis stabilization. However, this calls into question a possible lack of sensitivity on my part as the therapist. Did calling attention to Ned’s disconnection with the group not only result in his awareness of his guilt but also trigger his guilt? The context of the question could have been more appropriately phrased “How was it to experience a disconnection from the movement and the group?” so as not to be interpreted as a direct criticism. It was unfortunately difficult to understand the nature of Ned’s “guilt” as he offered no elaboration.

The other participant, Babette, rated her symptoms as higher on her postsurvey even though she rated her wellbeing as having increased as well. Despite her numerical response, she wrote that her symptoms were the “same as before.” Her written symptoms on the presurvey were “flash back” but she did not want to check-in about this with the group. Her ability to make decisions around her self-care was respected in the group and she was personally reminded that she could participate to the extent that felt safe to her and ask for support if needed.

The female group members were very protective and supportive of Babette and they remarked that she was doing well considering “all that she was going through.” She explained that she didn’t mind standing and moving a little as long as she was not the only one. Her initial use of peripheral vision to take in the surroundings communicated an untrusting stance and discomfort in a group setting. She displayed sarcastic humor about this “weird” idea of moving together and did engage in some playful exchange with the members of the group. She swayed in the vertical plane, in a single body unit to the music, which appeared like waddling as her whole torso was bound. She smiled faintly and sang parts of the song. She was one of two participants in the study whose survey showed a clear increase in symptoms (from 7 to 9). However, she did show an increase in wellbeing (from 4 to 7) as well. This participant seemed to be triggered by any physical stimulation, but she chose to stay awake for the movement even though she was given the option of sitting down. Throughout the study, this was the one participant whose candidacy for group work came into question and was discussed with on-site staff. Though the group did not pose an overwhelming degree of threatening material to this

individual, she most likely required an individual intervention with skillful use of nonverbal techniques and limited use of movement.

Exploring ways that clients may have been triggered is important in the No Benefit category. Such experiences suggest the contraindication of a dance/movement therapy group for some patients. (On a side note, on-site staff reported no signs of negative effect when I inquired about the aforementioned participants.)

***Lack of interest and/or low level of engagement.*** There were also some participants who never quite seemed to find a connection with any aspect of the group. Armond was a participant who disengaged from all aspects of the group and remained silent for most of the session. He refused to engage in check-in and appeared to be sleeping as the group movement activity developed. He responded to a question about his lack of engagement during verbal processing by explaining that he didn't feel that he could come to an understanding with people and so he usually kept himself away. When asked if this ever leads to loneliness, he nodded in agreement and shied away from group support or exploration of this issue. He hardly had any body movement and only moved his head up to speak. When others were talking and when the group moved together, he put his head back and closed his eyes. Armond was one of two participants who wrote nothing on either a pre- or postsurvey. He refused both times as they were passed out to the group. (Daryn, the older, mostly silent participant mentioned in previous themes also wrote nothing.)

Another young man who was in a different group, Nolan, showed little interest in the group or its members. He mentioned only physical pain on his presurvey, rating this symptom as 5 and his wellbeing as 10. (Nolan missed the postsurvey handout as he was

present the week that postsurveys were delayed in being handed to the group.) He then shared about his knee pain during the check-in and did not look at or respond to others as they shared. When the movement warm-up began, he went into his own world to “bop” to the music, then when the music ended, he took little interest in what others were saying and in general seemed disconnected from the process. He had some issues with substance abuse and displayed a start/stop rhythm (see Glossary definition), which reflected his child-like impatience as he seemed to change focus without any follow-through. A common issue that the residents at this site faced was trying to find adequate, affordable housing due to complications related to their mental health issues, substance abuse history, and/or larger social problems. Nolan spoke of his worry about housing and the group discussed this in-depth after several people revisited the issue. He still made little eye contact with others and at one point put on his sunglasses. Nolan exemplified a youthful narcissism that was not penetrated by an hour-long session of a structured group engagement. Many residents showed such traits, but eventually were able to be redirected towards a group experience of listening, sharing, and moving together. Nolan’s rating of 10 on the presurvey wellbeing scale, his lack of conscious identification of emotional symptoms (on the presurvey and during check-in), his preoccupation with a practical answer to his housing issue, and his casual demeanor in the group (for example putting on sunglasses) suggested that he had little interest in the therapy group. In a single session, in this setting, it proved difficult to engage those occasional members who had no inherent interest in any aspect of the group process.

***Interfering symptoms.*** Some participants were either too focused on their symptoms or experiencing them too deeply to be present in the here-and-now experience

of the DMT group. There was one young woman, Myra, with a history of borderline personality traits and deep visible scars around her neck where she had cut herself (staff relayed that she had done this) who was feeling excessively depressed as she checked-in with the group. She focused on negative feelings throughout the session, brought the topic of discussion back to her negative feelings when asked to respond to what others were saying about themselves, and displayed help-rejecting complaints towards the group members and myself. During a movement activity, she experienced a connection with another group member that felt “good” to her. The experience was not then internalized as she said at the end of the group that she still felt “empty” and wrote that she felt “no change” had occurred on her postsurvey, with no identification of anything being helpful. Her symptoms of depression, self-sabotaging traits, and difficulty in receiving social support proved to be a great barrier to receiving benefit from a single session of DMT. It was unclear if her expression of negative and positive symptoms were rooted in a desire for attention as is commonly associated with borderline personality traits. It was also unclear if her symptoms of depression or borderline personality traits were the main barrier to her receiving any personally identified benefits from the group.

During another group session, a tearful young woman named May checked-in with the group about her sense of despair and when the movement warm-up began, she said that the movement was “too weird.” May then explained that she needed to speak with the staff. She left to do so and then came back towards the end of group. She spoke of her need to be in a hospital for more therapy and when asked why she left this therapy group where people shared and supported each other, she didn’t have an answer. As this was examined further, the dichotomy of her desires became clear. She wanted to heal

through therapy, but she also desired to escape therapy. She briefly touched on the possibility that she did not want to, know how to, or believe that she deserved to feel better. She was less teary after speaking one-on-one with staff and became teary again when she reflected on how she did not feel worthy. I reminded of her ability to ask for what she needed (one-on-one time) and after she reflected a bit more on her feelings, I invited her to engage with others for the rest of the verbal processing. This participants' rejection of the movement therapy format was typified by her acute feelings of personal pain and conflict and her desire for a more "traditional" therapy. It is unclear exactly why she left the group, but there seemed to be a mixture of reasons. She suggested in some ways that she felt her level of symptoms were not taken seriously by the movement format, that she was in a defensive state of mind and not open to new things, and implied in verbal processing that her state of emotional distress and self-destructive patterns closed her off to an open group process. She stated that being "distracted from her thoughts" is what helped her in the group. Her symptoms decreased and her wellbeing stayed the same, however, it may have been the conversation with the staff helped her. This pattern of lack of connection leading to some kind of illumination is similar to experiences identified in the Personal Fulfillment theme, however, her lack of connection with the DMT work, absence for the majority of the group, and distressed and tearful state at the group's conclusion highlights this aspect of the No Benefit category.

From an example of overwhelming feelings at quite the other end of the spectrum, the case of a young man named Virgil also illustrates ways that occasionally, participants' symptoms were too acute for the group process to penetrate. Virgil apparently felt so out-of-touch with life that he was unable to experience and identify any



positive feelings from being in the group. He felt numb, anxious and hopeless according to his presurvey. During his group check-in, he said that he did everything “on autopilot.” An invitation to explore this further in the group through movement was met with a heavy shoulder shrug. The passive weight in his shoulders and heaviness of his entire body matched his sense of hopelessness. Later in the session, he agreed to allow the group to “witness” him in “his song” as he tapped his fingers and rocked himself slightly, looking down. He shook his head when asked about any possible desire on his part for more self-care or for nurturing from the outside environment. (In DMT rocking could be interpreted as a natural self-soothing rhythm.) He did not seem to internalize any of the group experience and was not even able to answer the question of whether or not he did the movement on autopilot, saying, “I don’t know.” He said and wrote on his postsurvey that he felt “indifferent.”

Members with acute levels of symptoms at times did feel better in the group. The participants discussed in this section of the No Benefit category seemed to have acute help-rejecting symptoms, such as deeply ingrained low self-esteem and were not affected by group interactions. The question arises, what type and degree of symptoms result in a participant experiencing little effect from a single session of DMT?

Overall the ways that the DMT group sessions lacked effectiveness has been thoroughly discussed. The subthemes of No Benefit were *excessive discomfort outweighing possible benefits, aspect(s) of group triggering symptoms, lack of interest and/or low level of engagement, and interfering symptoms*. In certain cases not much openness for group interaction was attempted or presented. Were some desperate participants not met with the type of support that they needed? Were these participants

unable or unwilling to engage in the here-and-now of the group? The examples raised these questions and provided illustrations of ways that “no benefit” was observed or reported.

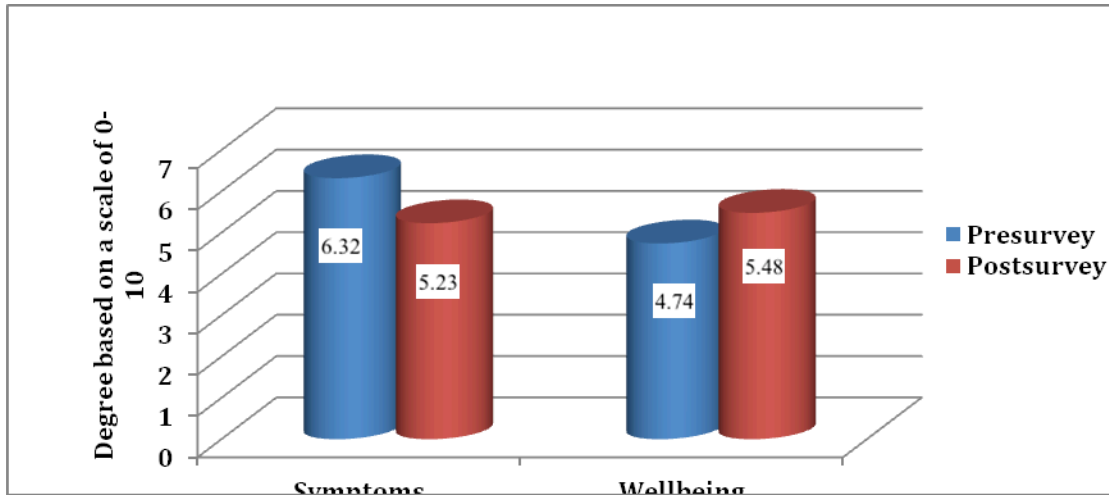
All of the themes have been presented as major aspects of the observable effects of a single session of DMT for this population. The theme of Movement was described as a positive experience for many participants and as a gateway to meaningful insights and interactive experiences. The theme of Social Support has been illustrated to show the ways that participants benefitted from therapeutically facilitated interactions with one another. The theme of Personal Fulfillment included the depiction of individualized ways that participants felt uplifted and gained a sense of meaning from the here-and-now group process. The theme of No Benefit was explored through various examples of participants not feeling connected or otherwise inspired by the group.

### **Quantitative Results**

The self-reported perceptions of wellbeing and symptom severity were used as indicators of crisis stabilization and measured through the use of pre- and postsurveys. As anticipated, participation in one DMT group tended to have positive effects on participants. While the sample size was too small to show statistical significance, the results indicate stabilizing effects of a single session of DMT for participants experiencing emotional crisis.

In sum, 31 of the 38 participants completed brief surveys rating their general sense of wellbeing and severity of symptoms prior to participation in the group and immediately after participation in the group. There were two participants who did not fill out any surveys and one participant who did not select a scale rating on her presurvey.

Four participants did not fill out a postsurvey for various reasons (leaving the group early, etc). Wellbeing and symptoms were rated on a scale of 0-10. The mean percent of change indicating improvement was 15.65% increase for general perceptions of wellbeing and 17.35% decrease for symptoms. Mean percentage change (or mean percentage difference) was calculated by subtracting the mean presurvey rating (for symptoms and wellbeing separately) from the mean postsurvey rating and then dividing the difference by the mean presurvey rating. (See Figure 1 for a bar graph representation of the means for pre- and postsurvey ratings for symptoms and wellbeing.) The absolute value of this calculated amount was multiplied by 100 in order to find the percentage of the amount of change that participants reported feeling. The quantitative calculations include the scale ratings of all participants who filled out both pre-and postsurvey scales. Raw data was included regardless of whether there was obvious indication of a participant's misinterpretation of the scales so as not to invite researcher bias. (See Appendix D for a summary of the raw data, including demarcation of scores that reflect contradicting narratives.)



*Figure 1.* Comparison of mean pre- and postsurvey scale ratings for symptoms and wellbeing, N=31

**Severity of symptoms.** In terms of each participant’s severity of symptoms, 65% of participant responses on the pre- and postsurveys showed a decrease in symptoms; while 19% indicated an increase in symptoms and 16% showed no change in their severity of symptoms. (See Figure 2 for a visual representation of these percentages.)

**General perceptions of wellbeing.** In terms of each participant’s general sense of wellbeing, 58% of participant responses on the pre- and postsurveys showed improvement in a general sense of wellbeing; while 19% indicated a worsening in a general sense of wellbeing and 23% showed no change in their general sense of wellbeing. (See Figure 3 for a visual representation of these percentages.)

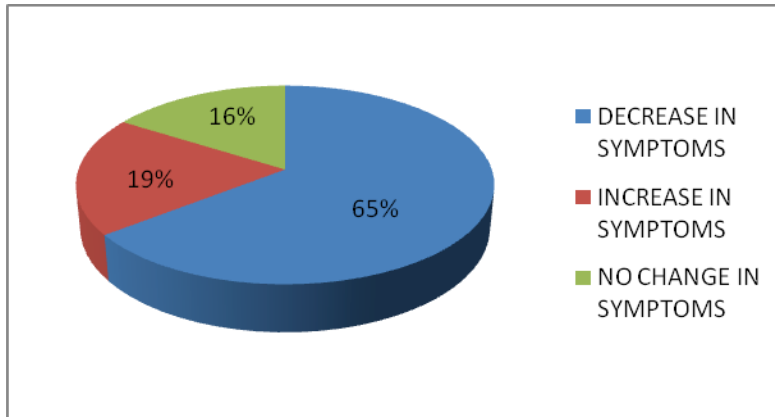


Figure 2. Comparison among participants' experiences of the possible outcomes for change in severity of symptoms, N=31

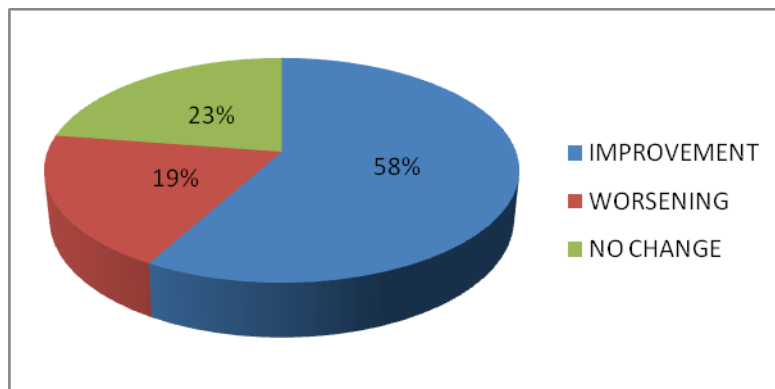


Figure 3. Comparison among participants' experiences on of the possible outcome for change in overall wellbeing, N=31

The qualitative results have been presented as major themes and subthemes of the effects of the DMT group sessions. The quantitative results have included numerical and visual data about the degree of such effects. Both qualitative and quantitative results indicated that notable positive changes occurred during the group for most members. The results also indicate that further exploration into the degree of these changes in the form of a larger scale study is needed. The next chapter will discuss these results in further detail and the implications of these results as well. Further recommendations for future studies will be presented at the end of the next chapter.

## **Chapter 5**

### **Discussion**

The study has ventured to find the effects of a single session of DMT for adults with mental illness in crisis stabilization. This section will discuss the results of the study as they relate to relevant literature, the limitations of the study, and the implications of the results as they relate to the field of DMT. Various considerations, complications, and insights that arose throughout the process of the study are also addressed. This discussion concludes with suggestions for future research.

Overall the results of the study are very encouraging regarding the positive effects of DMT in a single session in this setting. These effects fall into the categories of movement, social support, and personal fulfillment. The degree of such effects were shown through the use of mean percentage differences displaying the decrease in symptoms and increase in wellbeing across the participants' response to the pre- and postsurvey scales as previously discussed. Quantitative and qualitative results also indicate that some aspects of the DMT session had no effect for some participants and also that on occasion, participants experienced no noticeable effects from the group experience overall. (The results indicating No Benefit will be discussed later in this section.)

#### **Movement**

The use of movement was both a positive experience for the group members and a therapeutic tool to allow for social support, self- exploration and expression. The results show an abundance of examples of movement as an effective experience and as a gateway to inter- and intrapersonal development. Understanding the use of movement in

this way helps document the use of DMT as a direct intervention during crisis stabilization, rather than simply an auxiliary intervention used for relaxation and indirect communication, as Yalom (1983) suggests. The results illustrate examples of movement warm-up and group activities increasing cohesiveness among members in a single session, a key principle that Yalom (1983) emphasized for effective group work.

Chacian techniques for inpatient group DMT translated to the sub-acute population well, as the movement warm-up in a circular formation with the use of mirroring movements led to exploration of movement metaphor, imagery, and developed into group movement activities. These activities however were often modified from a traditional Chace format to meet the needs of each group.

Chace worked nonverbally with schizophrenic individuals in the inpatient setting and Mates (1992) described the way that movement is more readily accessed than verbalization for this population. There were participants with schizophrenia in this study who became more oriented to the here-and-now of the group during one session of DMT. This study has extended the DMT literature into the realm of the single session format at the sub-acute level. In addition, this study provides narrative evidence of the effects of movement in DMT for crisis stabilization beyond the basic use of movement or dance by non-DMT practitioners, such as Yalom.

### **Social Support**

According to Yalom (1983), a major goal of short-term inpatient group work is to provide opportunities for new interpersonal experiences. The group setting is a safe space for members to practice adaptive ways of relating to others and expressing themselves. This study found that for some, moving with others was a new experience, but this

experience led to participants opening up to the group as well as giving and receiving support. Certain participants remarked at their own surprise at how much they shared with others. For some more withdrawn participants, this supportive socialization felt very new. Showing vulnerability and not acting on a desire to flee was a theme identified verbally during certain groups. In this way, the results indicate the social effectiveness of just a single session of DMT.

Pallaro & Fishlein-Rupp, (2002) provided a case example of the theme of holding, comforting, and being held. In that study this holding theme was clearly illustrated in one client after a year of DMT group work. In the results of this study, one example that stood out to this researcher and to group members was a man who became more animated and was literally held by group members after having shown very little affect or verbal engagement during his stay at the facility. This example parallels results in other studies of more than a single session. This and other examples of social support were very remarkable in terms of effects of a single session, but could also be in part due to the nature of the residents' familiarity with one another through living together. This idea is revisited in the section on limitations.

### **Personal Fulfillment**

As Yalom (1983) explained, a goal of short-term therapy can be identifying specific issues to address in future long-term work. One session is not enough time to truly process certain themes in one's life, but there were many participants who identified goals for further therapy or who in general, felt more motivated to improve their lives. Kalish-Weiss (1982) in her description of major themes in DMT with adults, discussed internal motivation and active motility as basic drives connected to motor pleasure and



independence. In accessing their internal motivation through body action and group process work, participants gained momentum towards increased independence. The single session in this way can be understood as a step towards stabilization.

Many participants also experienced a sense of being uplifted through enjoyment of the group, especially those who began the session feeling hopeless and depressed. Thompson (1997) explained the power of the experience of fun for the MISA population in particular. The experience of enjoyment and fun allowed for more group cohesion, which facilitated a more meaningful group experience for most participants, not just those in the MISA category. In this study, participants who cited a joyous and fun experience of group usually also reported a decrease in symptoms and an increase in wellbeing. Joy was an integral part of each of the themes of this study, especially relating to the uplifting aspect of personal fulfillment.

### **Further Comparisons to the Literature**

**Depression symptoms.** Stewart, McMullen, & Rubin, (1994) looked at the effects of movement therapy with depressed inpatients. No effects were observed in the initial sessions. In the present study, data were collected about multiple symptoms and overall wellbeing. The DMT session did not “cure” depression and could not document any long-term effects, however in one session, certain symptomatic feelings associated with depression (i.e. hopelessness) were decreased and certain positive traits were accessed (i.e. serenity). This small-scale study could not show statistical significance of these effects with a small sample, however the data are suggestive of positive trends that could be tested in larger scale studies of a similar nature.

**Empathic observational learning.** Berrol (2006) and Winters (2008) described the effects of mirror neurons, vicarious learning, and the ways that observing an experience can provide similar or even the same effects of experiencing it personally. There were times when participants in this study remarked on the way that they felt after observing a group occurrence. This vicarious effect not only allowed for a personal emotional response in the observer, but on more than one occasion, allowed for further group processing and in some cases, more thematic non-verbal development. This brought about a sense of universality among the participants, which is a major therapeutic goal identified by Yalom (1983).

**Personal leadership style.** Steiner (1992) remarked on the way that a leader's style/preference, along with the preferences of the participants, largely determines the course of a group session. This concept is applicable to the results of this study. This is not necessarily a limitation of the study, however, it should be taken into account when questioning the generalizability of the findings to similar settings. It must be questioned if the findings are a result of this leader's unique leadership style, which could not be reproduced by others. (A discussion of the limitations of the study due to investigator bias is presented later in this section.)

This study can be viewed as a stepping-stone to bridge the literary gap surrounding the use of DMT at the sub-acute level of adult mental illness. It is also a preliminary attempt to acknowledge the value of a single session of DMT in crisis stabilization as a primary form of effective treatment.

### **The Category of No Benefit**

Nascent groups in DMT as described in Sandel and Johnson (1983) refer to

groups composed of highly disturbed adults in an inpatient setting that do not seem to develop clear group cohesiveness. The therapist of such groups is often left to hypothesize or even imagine possible benefits that the group members experience. In this study, certain observations of participants left me “reaching” during the data analysis phase. Their experiences were outlined in the No Benefits category so as to provide only evidence-based examples, rather than overly interpreted experiences illustrating questionable possible effects.

The No Benefit category reduced the researcher’s bias so as to avoid “throwing out” examples of ineffectiveness. Fleshing out the No Benefit category not only allowed for a balanced presentation of results, but also showed how ineffective aspects of group are inherent to facilitation and sometimes can overlap with effective aspects.

**No benefit and possible negative effects.** Creating safety is the first step of healing when working with trauma according to Herman (1992). Although feeling safe and contained was a basic goal of the group work for this study, there were two examples of participants feeling an increase in their symptoms. Of specific importance were one participant’s experiences that were symptomatic of posttraumatic stress relating to sexual abuse. Herman (1992) emphasized that safety must be felt at a body level and within the therapy setting in order for effective processing and healing interpersonal connections to occur. These group sessions focused on physical sensation, body activation, and sharing with others nonverbally, which can trigger physical symptoms of posttraumatic stress. A single group session of DMT may not be the best intervention for this situation. Though there are possible benefits associated with the group work, the increased symptoms must be assessed.

Upon assessing a group member's level of safety, it is also important to remember that personal empowerment and self-assertion are key to recovery and should not be overshadowed by a clinician's directive stance. Herman (1992) advised that "the survivor must be in control of the decision-making process" (p. 167), and that "recovery may be protracted and difficult because of the degree to which the traumatized person has become a danger to herself...[including] self-harm, passive failures of self-protection" (p. 166). In the situation that occurred in the study, one participant showed a slight increase in symptoms from pre- to postsurvey, however, she also displayed the ability to attend to her own self-care. While exploring ways of asking for support she said that she only wanted the females in the room to surround her and sway with her. Attention to the ways in which factors such as gender may trigger symptoms in members with posttraumatic stress is one way to establish safety. When assessing effectiveness, issues of safety must be in the forefront, so that inappropriate risks are not taken in hopes of greater "results."

Keeping safety in mind as a therapist for those in crisis stabilization as well as a researcher collecting data is an important ethical responsibility. I attempted to ensure safety by analyzing and discussing any concerns that arose in the group with on-site supervisors. Safety issues were fortunately minimal in this study. During the groups, I introduced the issue of safety as a responsibility of myself as a facilitator as well as a primary responsibility of all the group members present in order to maintain a supportive atmosphere. I encouraged people to remain aware of their needs throughout the group and on certain occasions, I checked-in with certain members who presented as vulnerable and/or distant in a brief, discrete way. In these ways, I attended to the ethical necessity to maintain safety throughout the study.

## **Limitations of the Study**

**The presence of researcher bias.** The design of researcher acting as group facilitator as well as data-collecting observer is one limitation of this study. It stands to reason that a certain level of bias would be evident not only in the data collection, but in the analysis of the data as well. In order to address this limitation, I relied on the pre- and postsurveys from the participants to provide direct feedback to consider when recording my observations of the group. The surveys provided some unequivocal data that could less easily be interpreted in a biased manner. Furthermore, the qualitative notes that I took were as objective as possible, stating what I concretely observed and avoiding language that might lead the analysis in a specific direction. I collected data after each session both about the apparent effects of DMT and the lack-there-of in order to consciously address the bias of wanting to “create” positive research results.

**The limitations of self-report.** The inherent limitations associated with the reliability of participants’ self-report also affects the accuracy of the data collected both from the surveys and as observed in their verbal comments during the group. Several participants wrote that they felt “no change” yet rated their symptoms as slightly lowered. They did not see the presurveys while filling out the postsurveys, so perhaps the slight decrease in symptoms suggested by the lower rating was not consciously realized. There is also the possibility that participants fabricated information on the surveys if they didn’t know what to say or did not want to share personal information. Additionally, participants may have exaggerated positive effects in order to offer what they assumed I, as a researcher, was looking for. Certain symptoms of mental illness and/or unhealthy patterns of communication could have resulted in such inaccurate self-reports. These are

very real possibilities, however, there was a basic consistency in what the participants portrayed during the group, spoke about, and wrote about. Finally, the principle format of the DMT group work was to help guide participants towards their inner process and to encourage them to share in a spirit of spontaneity and authenticity. In the group, negative and positive verbal responses about their experiences were typically welcomed equally from participants, so they might have felt free to make either kind of comment on their surveys strengthening the likelihood of valid self-report.

**Third party observation and interview.** Observational data collected during the group consisted of participants' verbal and informal self-reports that often occurred during the concluding verbal processing. I attempted to facilitate the group in the same way as if I were not collecting data. Though I refrained from interviewing the participants so as not to "dig" for results, additional data could have been collected through dialogue about the groups. If this study were repeated, an on-site staff member could gather additional verbal data from participants after the completion of the session. Measures would need to be taken to ensure that each participant was given the same amount of time to reflect and their comments would need to be recorded (on tape or written) for later analysis.

**The presence of multiple-session participants.** The study of the effects of a single session of DMT may also have been compromised by the inclusion of some group members who attended multiple sessions. The DMT sessions were offered to everyone on the unit and so denying services for research purposes was not a viable or ethical option. Most of the participants did only receive a single session; nine of the 38 participants came to multiple sessions (six came to two consecutive sessions, one came to two

sessions during her four-week stay, one came to three consecutive sessions, and one came to four consecutive sessions) as most participants stayed at the facility for less than two weeks. The data collected from such participants were kept to a minimum. I kept additional data separate from the main body of data and clearly marked it as “multiple-session.”

It is unknown whether these multiple-session participants in the DMT group influenced first-time participants via comments made to them before the session or by the nature of their participation during the session. These multiple-time participants more often than not demonstrated an increased sense of trust and comfort with the idea of DMT, the experience of moving in a therapeutic group, the process of sharing in this setting, and with myself as a facilitator. In the qualitative data analysis, I chose to include examples from groups in which there were multiple-session participants, but they were not focal persons. There were only three such examples in the observational data in which multiple-session participants played a secondary role. Only one such example was described in the Results section. Examples that included only the experience of any multiple-session participants or revolved around a multiple-session participant(s) were excluded from data analysis. Some surveys were collected from multiple-session participants and were considered when I notated about the group each week, but they were not directly used in quantitative and qualitative data analysis processes.

A problem similar to multiple-session participants who could not be included was participants in the group who chose not to sign the informed consent form. No data could be gathered from either of these participants but their experiences in the session probably impacted those who were included in the study. Also, there were four participants who

had also attended the group before the research study began. They were included in the data without consideration of their previous stay, as it was determined impossible to control for the prestudy experiences of any participants.

**The nature of the facility.** Participants resided at the site of the study for various lengths of time in close living quarters. The members came to know each other relatively well even after several days together and were relating to each other based on experiences as housemates, roommates, and commonly as situational friends and confidants. The most noticeable effect of this phenomenon on the results of the study was the greater cohesiveness and observable gestures of social support among members than might otherwise be expected in a single group session. The group structure provided an opportunity to utilize the social bonds for more in-depth therapeutic purposes. However, the results of the study (the effects of the DMT session and the degree of such effects) may be attributed to the setting, not just the actual single session of the DMT group. This does not detract from the overall effects, but limits the generalizability of this study to various settings for adults with mental illness. This limitation was somewhat foreseeable and inevitable in the process of designing the study at this setting. I did not want to design the study around the socially supportive experience of residents in their residential setting because I wanted to maintain a focus on the in-group experience of members for this preliminary look at the use of a single session of DMT in this setting. In addition, I realized that not all participants would experience a sense of community and support with others residents. Future studies about similar populations could focus on the interpersonal connections and dynamics among residents as they effect members' experience in the group.



Some of the limitations of the study were preventable and can be used as experiential learning for this researcher and others interested in undertaking a similar study. Other limitations are inherent in the process of gathering data about the effectiveness of therapy.

### **Other Considerations – Aspects of the Surveys**

The use of a written scale allowed for measurable information from the participants, but had many drawbacks. It was difficult for some participants in unanticipated ways. Some people with cognitive limitations had trouble understanding the directions and asked for clarification. I purposefully left the word symptom open for people to include what was at the forefront in their current experience. A couple of members mentioned only physical symptoms and no emotional symptoms. Some members did not understand the directions of “right now” and wrote what had precipitated their entrance to the home. In an unanticipated interpretation of “symptom,” some members wrote positive symptoms, such as “serenity.” A more thorough verbal introduction helped some participants, but others were preoccupied, tired, or delayed in their ability to understand verbal directions. Only two of the 38 participants made no attempt to write down their experiences on both the pre- and postsurveys. As described in the results section, 31 of the 38 participants completed both pre- and postsurvey scales in order to be included for quantitative data analysis.

Another consideration is that many participants had “anxiety” as a symptom. Two participants wrote that their anxiety was about facing the group experience. Perhaps others experienced a heightened anxiety about participating in the group, yet didn’t specify this. This could have magnified the effect of decrease in symptoms, but would not

reflect the actual effectiveness of the group. However, most participants who mentioned anxiety also identified other symptoms that decreased as well and specified aspects about the group that helped them to feel better. If anxiety about the group was at the forefront for certain participants, then perhaps facing that anxiety and having positive feelings in the group experience was still an effective intervention for crisis stabilization, as such participants may be more likely to engage in therapeutic group work in future, which is a major goal for short-term work as previously discussed and referenced (Yalom, 1983).

**The use of scales on the surveys.** I developed this scale in order to gain information about the extent of the changes that would occur for participants. There was not a preexisting scale available that assessed multiple symptoms and was reasonably brief for before- and after-group use. The reasoning for the scale was to help create more explanatory context for the effects, both to myself when notating about the group and making meaning out of the data, and then in the presentation of findings to readers.

With hindsight, I would not have included two scales where 10 could be considered the “worst” (symptoms) and the “best” (wellbeing), especially for those with cognitive limitation and preoccupied thoughts. Also the instructions on the surveys read as follows:

Please rate the degree of your current overall feelings of wellbeing on a scale of 0-10, with 10 being the highest feelings of wellbeing and 0 being no sense of wellbeing.

The latter part of the sentence could have been written explaining 0 first and then 10, so as not require the participants to switch the order in their minds.

Perhaps one scale that rated wellbeing before and after would have provided adequate information and would have cut down on confusion. The presurvey questions could read as follows:

Please rate your overall sense of wellbeing on a scale of 0-10 with 0 being no sense of wellbeing and 10 being the highest feeling of wellbeing.

0      1      2      3      4      5      6      7      8      9      10

Please provide some words to describe how you feel.

The postsurvey could have included the same two questions and then the following additional question (which would be the same from the original postsurvey):

Please describe what happened that changed the way you feel now as compared with before you participated in the group, if there is a change.

### **Gathering Information from On-Site Staff**

To the degree possible, I attempted to maintain systematic communication (as outlined in the Procedure section) with the staff at this facility regarding the residents' participation in this study. The staff gave the residents information about the DMT group and about the nature of the study, and they obtained signed consent forms from those who chose to participate in the study (see Procedure section). I exchanged practical information about participants with on-site staff before and after each session. The staff offered basic background information about the group members before the sessions included in this study and I offered basic information about the group members' participation after the sessions. Most of this information was for clinical purposes,

however some of the information was included in the study, for example a participant's age and race.

The information about the effects of the DMT group according to on-site staff was not included in the results section. This data might have provided a fuller context for understanding the experiences of participants. For this preliminary study looking at DMT to help with adult crisis stabilization, the inclusion of these data would have required a more intensive engagement with the facility staff, which was beyond the vision and design of this study. The data collection about the effects of the group was therefore contained within the setting of the group.

### **Consideration of Ethnicity**

Most residents, staff and I were Caucasian. Further details of ethnic or cultural background were collected from on-site staff as mentioned in the previous paragraph. The only direct discussion of ethnic background in this study was in the example of there being a language barrier with a Spanish-speaking participant during one of the group sessions. Larger scale studies might take such issues as race and culture into consideration when analyzing the effects of the use of DMT in this setting. Understanding how these effects might differ across race was not a direct focus of the study as the participant population was not a broad representation of different races.

### **Conclusion**

The purpose of this study was to gain information about the effects of a single DMT group session for adults in a residential crisis stabilization unit. Results were reported from the analysis of qualitative and quantitative data. Qualitative data included my notes about the group and the participants' written comments on pre- and

postsurveys. The qualitative data were analyzed using an extensive reviewing process in which themes and subthemes in the content were identified and described. Results indicated that participants' experiences fell into one or more of four categories including movement, social support, personal fulfillment, and/or no benefit. The ways that each of these effects relates to the other speaks also to the nature of the effects of the DMT session. For example, the use of movement in a group setting led to opportunities for social connection and personal fulfillment. There was also some evidence that certain participants did not experience any effects from one DMT group and also that certain aspects of the group were not effective for some participants. However, the experience of one aspect of the group not being effective sometimes led to an effective processing of the experience, which suggests the complexity of the relationship between the themes of effectiveness. A discussion of one participant's experience spoke to the possible negative effects of a DMT group triggering symptoms (in this case related to posttraumatic stress from sexual abuse).

The effects as presented through the aforementioned themes were also measured quantitatively. Participants rated their level of symptoms on a scale of 0-10 with 10 being the highest level, and rated their level of wellbeing on a scale of 0-10 with 10 being the highest level. These scales were completed on both the pre and post surveys. The sample size of 31 was too small to get reliable indications about statistical significance. Mean percentage differences were calculated to provide information about the possible evidence that DMT can provide symptom relief and increased wellbeing within a single session for this population. There was a 17.3% decrease in symptoms among the participants from their pre- to postsurvey scores and there was a 15.6% increase in

wellbeing among participants. Some of the participants' confusion with the scale minimally affected the percentage difference results. Overall, this study provides evidence of specific effects of a single session of DMT with adults in crisis stabilization.

### **Implications of the Results to the Field**

In some short-term residential settings, people are likely to have exposure to just one group session during their stay, so literature about the single session is relevant, but unfortunately not prominent. This study provides some initial insight into the effects of a single session of DMT for those in crisis stabilization and yet is applicable to any setting where people are likely to have only one group therapy session. Some single session studies have looked specifically at the use of movement, for example the work of Koch, Morlinghaus, and Fuchs (2007), but not at the effects of dance/movement therapy as a modality. Most relevant literature focuses on a case study of multiple sessions with clients, however this study created a narrative description about the relevance of having only one single session of the work. Documenting the benefits people can receive from such work can help to broaden the scope of the uses of DMT as a primary intervention in even the settings with only brief client stays. Utilizing the power of the group, the power of movement, and bringing the mind/body connection to the forefront was clearly well received by most of the people in the study. In addition, group therapy is time and cost effective in comparison to individual therapy.

After reading such documented accounts as this study, a reader might be able to perceive the potential of such programming to create a more supportive and effective stay in general for short-term residents. The potential of group DMT as a motivating, enjoyable, and social intervention for the stabilization process is also displayed in the

results. From a clinical perspective, DMT group work inherently provides stabilizing, uplifting effects and allows for a sense of cohesion among members even in one session. The results of the study tended to show the positive affects of movement for people in a state of emotional crisis. In addition, many of the participants of the study became more engaged and active interpersonally and/or in their own self-improvement once they became actively engaged in movement.

From a researcher's perspective, the mixed methods approach in this study offers an example of qualitatively and quantitatively collecting data from a single session. The use of the survey in particular provides an example of gaining information directly from participants and illustrates the possible complications that arise in doing so. Anyone in DMT or related fields venturing with a similar method could learn from the limitations of the study in relation to the survey and the data collection in general and have more clarity in planning.

In addition, much of the relevant research in the field covers inpatient settings with adults at very acute levels of care. This study provides information about the use of DMT with short-term residential programming for sub-acute symptoms. The results of this study in the most general terms relate to working with adults with mental illness and and/or substance abuse problems. For those interested in learning more about the use of group DMT with adults with mental illness outside of a hospital setting, outpatient setting and/or community setting (residential but not in crisis), this study provides some basic thematic material about possible goals for the work.

### **Recommended Future Research**

This study set out to observe and document the effects that a single session of

DMT would have for adults in a short-term stabilization unit. The question, “What are the effects?” could be furthered by future research endeavors. Each of the four categories of results could be measured individually. One could set out to focus more directly on the experience of social support in a DMT session with this population, for example, including the social experience leading up to and following the group experience(s) as previously described in the limitation section about the nature of the facility. The areas of overlap among the themes could also provide a researcher with a directive for inquiry. How movement provides a gateway to interpersonal connection, for example, provides an opportunity for further research in a similar setting. Studies reviewed previously in this manuscript have looked at the feelings of joy and the alleviation of depressive symptoms from the use of movement, but the interpersonal aspect that DMT encourages could be its own stimulating research topic.

Another avenue for research would be to expand the idea of the pre- and postsurvey. For example, the data collection could extend from the time each participant enters the facility to the time the person leaves and so more longitudinal information about the effects of the DMT could be uncovered. If this were the case, then perhaps the focus could be on short-term crisis intervention with daily DMT, incorporating more than one session. If only one session remains the focus, then perhaps another postsurvey for participants remaining at the site the day after the group occurs could show any evidence of basic internalization of any meaningful group experience. This idea relates to the previously stated possibility of researching the social experience of group members throughout their residential stay (see the Limitations section about the nature of the



facility), but incorporates other aspects of their experience and would focus more on creating a context for understanding the DMT work.

Yet another recommendation for future research would be to explore the No Benefit category. Investigating what about DMT feels “forced” or ineffective for those experiencing it for the first time could help facilitators understand how to expand their techniques in order to encompass more perspectives and possibly work more effectively with initial defensiveness in group members. Many studies, including this one, seek to elaborate on the effectiveness of DMT. Elaborating on the areas of ineffectiveness could be very illuminating with an organized look at a participant’s lack of engagement.

Crisis stabilization services are not found in all areas of this country and the use of DMT as a primary framework for crisis stabilization is not thoroughly explored in literature. I introduced the DMT group to the site as the only group therapy available for residents and have since been leading the group on a per diem basis due to the effects of the group on participants. A larger scale DMT program and subsequent program evaluation format for research could thoroughly and statistically relay the effects of DMT in this setting to the world of human services.

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## **Appendix A – Glossary**

## Definition of Terms

### Efforts – Fighting and Indulging

“Effort reflects the mover’s attitude toward investing energy in four basic factors: Flow, Weight, Time and Space...Each of the factors is defined by two polar elements.” (Hackney, 2002, p. 219). The efforts are defined below, as are the polar elements of each effort. The polar elements relate to the attitudes of either “indulging in” or “fighting against” (Moore & Yamamoto, 1988, p. 197). The examples given for each polar element are taken from Hackney, 2002, pp. 219 – 221.

**Flow.** “Flow is the baseline “goingness”, the continuity of the movement out of which the other effort elements emerge and return. Often Flow becomes the major expressive statement. Flow is frequently related to feelings – either outpouring or containing them” (Hackney, 2002, p. 219).

**Free.** Outpouring, fluid (indulgent quality).

**Bound.** Controlled, contained (fighting quality). Bound flow is associated with controlling one’s movement or a sense of holding back. One’s flow can be bound to the point of having no visible movement.

**Weight.** “Light and strong are *active* attitudes toward using the weight of your body. It is also possible to be sensing the weight of your body...[which] underlies your ability to actively yield weight into the earth” (Hackney, 2002, p. 220).

**Light.** Airy, fine touch (indulgent quality)

**Strong.** Forceful, firm touch (fighting quality)

**Passive weight.** Surrendering to gravity is related to a passive attitude toward weight.

***Limp.*** Weak, wilting

***Heavy.*** Collapse, “it’s hopeless”

**Time.** This effort reflects one’s inner attitude toward the time one has and one’s sense of timing when committing to action (Hackney, 2002).

***Sustained.*** Leisurely, gradual (indulgent)

***Sudden.*** Urgent, quick (fighting)

**Space.** This effort is about how one attends to space (Hackney, 2002).

***Indirect.*** Multi-focused, flexible attention (indulging quality)

***Direct.*** Single-focused, channeled (fighting quality)

### **Posture Gesture Merger**

“If all parts of the body are transcribing the same shape, this is Posture. If only a part of the body is “performing” – a hand and arm, or the head, then this is Gesture... What Warren Lamb found was that in everyone’s behavior there is a point at which the two merge.” (Davies, 2006, p. 66) “A person with fully integrated behavior... with clear merging of Posture and Gesture will project a very clear image of themselves” (Davies, 2006, p. 68).

### **Start/Stop Rhythm**

This is one of the ten rhythms “characterized by sharp transitions” (Amighi, Loman, Lewis, & Sossin, 1990, p. 43). It is associated with the developmental stage of toddlers (two and a half years) as they develop the ability to stop at will. Also associated with this rhythm is the short attention span and impatience of this age as they explore increasing control over themselves. “Using this rhythm people initiate action but tend to



interrupt themselves, which creates feelings of urgency or irritability.” (Amighi et al., 1990, p. 44)

### **Upper/Lower Connectivity**

The Upper/Lower Connectivity used in DMT relates to the integrated connection between the Upper and Lower body. The Lower Body activates for support and locomotion, which frees the Upper Body to interact and relate with the outside world. Yield & Push Patterns and Reach & Pull patterns help to enliven this vertical connection. (see Hackney pp. 111-119 for more information).

## **Appendix B – Presurvey**

## **Pregroup Survey**

*Please answer the following questions honestly.*

Please describe the symptoms you are experiencing right now.

Please rate the severity of your symptoms right now on a scale of 0-10, with 10 being the worst and 0 being no symptoms.

0    1    2    3    4    5    6    7    8    9    10

Please describe how you feel overall at this time.

Please rate the degree of your current overall wellbeing on a scale of 0-10, with 10 being the highest feelings of wellbeing and 0 being no sense of wellbeing.

0    1    2    3    4    5    6    7    8    9    10

## **Appendix C – Postsurvey**

## Postgroup Survey

*Please answer the following questions honestly.*

Please describe the symptoms you are experiencing right now.

Please rate the severity of your symptoms right now on a scale of 0-10, with 10 being the worst and 0 being no symptoms.

0    1    2    3    4    5    6    7    8    9    10

Please describe what happened that changed the way you feel now as compared with before you participated in the group, if there is a change.

Please rate the degree of your current overall feelings of wellbeing on a scale of 0-10, with 10 being the highest feelings of wellbeing and 0 being no sense of wellbeing.

0    1    2    3    4    5    6    7    8    9    10

## **Appendix D – Raw Data from Participants' Surveys**

### Responses on Pre- and Postsurvey - Degree of Symptoms

N=38. The scales ranged from 0-10 in order to represent the degree to which a participant experienced symptom(s). The 31 participants with both pre- and postsurvey scores were included in the statistical analysis, but all 38 participants are included in this chart. The identifying words are taken from the surveys and/or capture lengthier narratives. Note: No single-session participants attended session 8. Participants' real names are not used.

<u>Participant</u>	<u>Presurvey Symptom Score</u>	<u>Postsurvey Symptom Score</u>	<u>Session Number</u>	<u>Presurvey Symptom(s) Description</u>	<u>Postsurvey Symptom(s) Description</u>
Yvonne	5	6*	1	Anxiety	Calmness
Lyla	9	7	1	Boredom, anxiety	Anxiety, loneliness
Saul	5	3	1	Depression, anxiety	Anxiety
Lanie	8	None	2	Anxiety	-
Daryn	None	None	2	-	-
Ingrid	8	9*	2	Anxiety, overjoyed	Excitement, serenity
Vinny	8	3	2	Nervous, anxiety	More relaxed
Rosie	6	4	3	Burning sensation, fear	Burning feeling, fear
Ned	0	10	3	Claustrophobia, mental stability	Guilt and regret
Elba	6	4	3	Depressed, anxious paranoia	-
Ralph	2	0	4	Anxiety, stress	Confident, free focused
Tia	3	1	4	Violent in the home	Better about self

Cont.

<u>Participant</u>	<u>Presurvey Symptom Score</u>	<u>Postsurvey Symptom Score</u>	<u>Session Number</u>	<u>Presurvey Symptom(s) Description</u>	<u>Postsurvey Symptom(s) Description</u>
Torey	6	8*	4	Depressed, sleepy	Happier
May	10	4*	5	Anxiety, anger, depression	Overwhelmed
Ervin	6	4	5	Hallucinations, depression	-
Ana	-	5	5	Anxious, sleepy	Anxiety, loneliness
Ursa	5	3	5	Awful when at own home	Feeling better now that over
Armond	None	None	6	-	-
Booker	7	4	6	Agitation, boredom	Distracted, relaxed
Anita	8	4	6	Anxiety, depression	More rested
Nakita	5	5	7	Depressed	Bored, unwilling
Spencer	4	None	9	Nervous, Anxious	-
Bree	2	None	9	Fine	-
Nolan	5	None	9	Leg hurts	-
Galvin	6	5	10	Glad, anxious	Relief, glad to go home



Cont.

<u>Participant</u>	<u>Presurvey Symptom Score</u>	<u>Postsurvey Symptom Score</u>	<u>Session Number</u>	<u>Presurvey Symptom(s) Description</u>	<u>Postsurvey Symptom(s) Description</u>
Nadine	5	8*	10	Anxious about doing group	Calm, ready for tomorrow
Rashid	5	4	10	50/50	Fine
Rip	7	5	10	Scared about issues on mind	Better
Wally	5	3	11	Safe, believe in treatment	Nice experience
Virgil	7	7	11	Numb, anxious	Numb, indifferent
Serge	7	7	11	Depression	Depression, more insight
Ida	10	8*	12	Depression anxiety	Hopeful, awake
Raquel	8	1*	12	Arthritis	No symptom (Tylenol)
Babette	7	9	12	Flash backs	Same as before
Kane	7	4	13	High anxiety, little depressed	Still anxious
Thor	8	8	13	Scared of group, tired	Thoughts of better life
Noreen	7	6	14	Depression, hallucinations	Calm
Myra	8	8	14	Low self- esteem, voices	Hear voices, empty

\*Score represents likely misinterpretation of scale, based on narrative.

### Responses on Pre- and Postsurvey - General Sense of Wellbeing

N=38. The scales ranged from 0-10 in order to represent the degree to which a participant experienced a sense of wellbeing. The postsurvey open-ended question asked about the change one felt as a result of group. The 31 participants with both pre- and postsurvey scores were included in the statistical analysis, though all 38 participants are included in this chart. The identifying words are taken directly from the surveys and/or capture lengthier narratives in some cases. Note: No single-session participants attended session eight. Participants' real names were not used.

<u>Participant</u>	<u>Presurvey Wellbeing Score</u>	<u>Postsurvey Wellbeing Score</u>	<u>Session Number</u>	<u>Presurvey How Feel Overall</u>	<u>Postsurvey Description of Change(s) the cause</u>
Yvonne	3	4	1	Depressed, scared, failure	Movement music - good
Lyla	6	6	1	Lonely, anxiety	No change
Saul	6	7	1	Overwhelmed, a bit sad	Kind of happy
Lanie	8	None	2	Confused, angry, empty	-
Daryn	None	None	2	-	-
Ingrid	6	9	2	Confused, good-depressed	Feel ok with me
Vinny	2	8	2	Fearful, but hopeful	Active role in relaxing
Rosie	0	2	3	Panicky, uncomfortable	Expressing self, energy
Ned	10	0	3	Okay	Different mental state
Elba	3	5	3	Last	Realized care about other
Ralph	0*	10	4	Upbeat and happy	Confident and focused

Cont.

<u>Participant</u>	<u>Presurvey Wellbeing Score</u>	<u>Postsurvey Wellbeing Score</u>	<u>Session Number</u>	<u>Presurvey How Feel Overall</u>	<u>Postsurvey Description of Change(s) the cause</u>
Tia	3	1*	4	Better, but anxious	Climbing mountains
Torey	4	8	4	Sad	Music and talking
May	1	1	5	Extremely scared	Talking ignoring
Ervin	5	6	5	Calm	I felt a Little better
Ana	-	5	5	-	-
Ursa	6	8	5	I feel good being here	People were here to help
Armond	None	None	6	-	-
Booker	3	4	6	Agitation, boredom	Imagery quite helpful
Anita	8	5	6	Anxiety, depression	Physical movement
Nakita	5	5	7	Okay	Ask to help someone
Spencer	7	None	9	I feel good proud of me	-
Bree	3	None	9	Better	-
Nolan	10	None	9	-	-

Cont.

<u>Participant</u>	<u>Presurvey Wellbeing Score</u>	<u>Postsurvey Wellbeing Score</u>	<u>Session Number</u>	<u>Presurvey How Feel Overall</u>	<u>Postsurvey Description of Change(s) the cause</u>
Galvin	6	5*	10	Up and down feelings	Having fun
Nadine	5	9	10	Feeling better, new meds	Opened up in the group
Rashid	5	7	10	-	Good music
Rip	7	5	10	Depressed	I opened up more
Wally	5	3*	11	Feel good but miss family	Before no participation
Virgil	4	4	11	Hopeless	-
Serge	6	6	11	Hopelessness over a situation	Knowledge about my ills
Ida	1	2	12	Alone frightened	People understanding
Raquel	8	9	12	Happy to sit on chair cushion	Moving laughing
Babette	4	7*	12	Have to do work	No
Kane	8	8	13	Better but still anxious	Stay in group situation
Thor	8	8	13	Feeling unsure anticipation	Yes/no relax and happy
Noreen	7	6	14	Self	Focused on others

Cont.

<u>Participant</u>	<u>Presurvey Wellbeing Score</u>	<u>Postsurvey Wellbeing Score</u>	<u>Session Number</u>	<u>Presurvey How Feel Overall</u>	<u>Postsurvey Description of Change(s) the cause</u>
Myra	2	2	14	Just existing, feel depressed	No change

\*Score represents likely misinterpretation of scale, based on narrative or other clue (for example symptom and wellness the same score on both and slightly contradictory narrative).

## **Appendix F – On-site Flyer for Group**

# **MOVEMENT THERAPY GROUP**

**SUNDAYS**

**11:30-12:30**

**FRONT ROOM**

**WITH A FOCUS ON:**

**WELLNESS  
SUPPORT  
SELF-EXPRESSION**

**ALL RESIDENTS WELCOME!**