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Dance/Movement Therapy and Responsive Classroom: A Theoretical Synthesis

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DANCE/MOVEMENT THERAPY AND RESPONSIVE CLASSROOM: A THEORETICAL SYNTHESIS

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Abstract

This theoretical synthesis combines concepts from Chacian dance/movement therapy and the Responsive Classroom approach to teaching and learning, and suggests a proactive behavioral management style for dance/movement therapists that incorporates aspects from these two frameworks. For this synthesis, Chacian dance/movement therapy and Responsive Classroom techniques were adapted and implemented. Through combining these two methods, the researcher suggests a unique treatment model as a way to prevent and confront violent and aggressive behaviors of children that present in a dance/movement therapy session.

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Chapter I: Introduction

As a result of the unprecedented rise in youth violence in the United States from 1983 to 1993, the U.S. Surgeon General published a first-of-its-kind report summarizing how research could affect the magnitude, causes and prevention of youth violence (U.S. Surgeon General's Office, 2001). Additionally, the report suggested action the American public could take to foster the safety and well-being of our nation's youth. Although incidents of youth violence as measured by arrest records, victimization data and hospital emergency room records show a national decline in youth violence since its peak in 1993, the level of self-reported violent behavior (see Appendix A) by youth remains the same, creating cause for continued concern (2001).

As society experienced this rise in violence, so did the field of kindergarten through twelfth grade education, as the vast amount of literature on violent and aggressive behavior in the classroom presents (U.S. Surgeon General's Office, 2001; Safe Schools Healthy Students, 2006; National Center for Injury Prevention and Control, 2006). To address this behavior, curricula that focused on social learning and behavior management were developed. Currently, there is an expansive amount of literature detailing management of difficult, inappropriate, disruptive and never before seen classroom behaviors that interrupt academic learning and provide new teaching challenges for educators as evidenced by the increasing number of school-based violence prevention programs (Hervey & Kornblum, 2006; Miller, 2003; Mytton, DiGuiseppi, Gough, Taylor, & Logan, 2002; Safe Schools Healthy Students, 2006). So what happens when this behavior cannot be managed in a classroom setting? One option, and possibly a

necessary intervention, may be external treatment for problematic individuals, such as that received at a behavioral health facility.

The urban school district where I was employed for three years was not exempt from experiencing the national trend in violent behavior within the schools, and subsequently began tracking violent behavior through records of disciplinary actions such as out of school suspensions. As data continued to show an increase in violent behavior, the school district where I worked authorized curricula to address behavior management and social learning in an attempt to restore focus on academic education. One curriculum endorsed by the district was the Responsive Classroom.

Based in educational theory and developmental science, the Responsive Classroom (RC) approach to elementary teaching and learning was developed in 1981 by classroom teachers to foster a developmentally appropriate learning environment where students thrive academically as well as socially (Bechtel, 2003; Northeast Foundation for Children, 2006; Rimm-Kaufmann, 2006). This approach deliberately applies its methods both within the classroom and school wide.

During two years of RC training and implementation, I witnessed a communal change in the school environment where I worked; violent behavior decreased and self-regulation increased. Moreover, relations between administration, staff, faculty and students improved. As behavioral changes occurred through the use of the Responsive Classroom approach, time spent on academic instruction increased and disciplinary actions decreased.

In August 2006, I began an internship as a dance/movement therapist in an outpatient hospital program at a behavioral health hospital for children ages four to 12

years where an Expressive Therapy Department provided services as an integral part of treatment.

According to the Expressive Therapy Outpatient Program Manual at this behavioral health hospital, Expressive Therapy (see Appendix A) is a form of psychotherapy, and includes dance/movement therapy, art therapy, music therapy and recreational therapy. Based on the philosophy of cognitive behavioral therapy, which is clinically applied in their outpatient programs, Expressive Therapy provides patients with non-verbal therapeutic opportunities and tools by:

- Guiding patients to explore knowledge of both body and mind as it relates to their illness and wellness.
- Helping patients identify individually creative methods of regulating mood and behaviors.
- Assisting patients in achieving suitable leisure skills to help cope with life's difficulties.
- Preparing patients physically to develop their cognitive processes and sustain healthy lifestyles.

Therefore, one responsibility of the Expressive Therapist in this hospital is to facilitate progression toward the attainment of these goals.

School age children are commonly admitted to this outpatient program as a result of a school referral for evaluation or treatment because of extremely aggressive, disruptive or unmanageable behavior (see Appendix A) as well as for emotional and/or cognitive concerns. When children presented this behavior in dance/movement therapy groups that I was facilitating, I turned to hospital policy and staff, including my

dance/movement therapy supervisor, for guidance. I found that although some patient's program goals identified specific behavioral interventions for severe conditions, such as injecting medication and/or removal from sessions with physical assistance if a patient became a danger to self or others, there was not a codified way for addressing behavior. In search of proactive behavior management strategies (see Appendix A), I reviewed the dance/movement therapy literature, where I found chapters describing how dance/movement therapy can be used in school settings to help children who are dealing with trauma (Tortora, 2006), articles discussing the integration of dance/movement therapy with techniques such as therapeutic holding (Lundy & McGuffin, 2005) and movement-oriented disciplines to provide environmental structure, stimulation and freedom to elicit creative expressions. However, the literature did not provide proactive behavior management strategies or methods incorporating dance/movement therapy.

Dance/movement therapy (DMT) as defined by the American Dance Therapy Association (ADTA) is, "the psychotherapeutic use of movement as a process which furthers the emotional, cognitive, social and physical integration of the individual" (American Dance Therapy Association, 2006). It is a creative arts therapy, sometimes also called an expressive arts therapy, (see Appendix A) based on the belief that movement reflects an individual's inner mood, and pattern of thinking and feeling; that the body and mind are interrelated. Marian Chace, a pioneer in the field of DMT, developed what is commonly referred to as Chacian dance/movement therapy, The Chace Technique or the Chacian approach (Levy, 1988); techniques from this approach were used for this thesis**.** A brief description of Chacian DMT is included here and is discussed further in Chapter III.

Comprised of four core concepts, b*ody action, symbolism, therapeutic movement relationship* and r*hythmic group activity*, Chacian DMT supports a structure that helps foster a safe environment in which participants are encouraged to explore the movement of their individual and internal dance; the ebb and flow of breath, heart rate, feelings and emotions (Chaiklin, Lohn, & Sandell, 1993).

According to the ADTA, dance/movement therapists:

> . . . focus on helping their clients improve self-esteem and body image, develop effective communication skills and relationships, expand their movement vocabulary, gain insight into patterns of behavior, as well as create new options for coping with problems. Movement is the primary medium dance/movement therapists use for observation, assessment, research, therapeutic interaction, and interventions. (American Dance Therapy Association, 2006)

As a dance/movement therapy intern, I found that prior to addressing any of the above listed goals, both those defined for Expressive Therapy in the behavioral health hospital setting and those of the ADTA, it was necessary to manage the presenting behavior. As an educator, I was trained specifically in addressing aggressive or disruptive behavior with proactive behavior management strategies, but as a dance/movement therapist, I was not. Although behavior management was occurring in this hospital program, there was no training or defined system for addressing it; this approach to behavior management, or lack of a codified approach, was very different than the Responsive Classroom approach taught and implemented in the school setting where I had worked. Additionally and as previously stated, through research I discovered the DMT literature was lacking proactive interventions incorporating dance/movement

therapy methods for addressing unmanageable behavior in a clinical setting. From these experiences, the motivation for this theoretical synthesis developed; I felt the need was evident for dance/movement therapists who work with children exhibiting extremely aggressive, inappropriate, disruptive or unmanageable behavior to have a behavioral management approach comprised of proactive behavioral management strategies and concepts from DMT.

This theoretical synthesis combines concepts from Chacian dance/movement therapy and the Responsive Classroom approach to teaching and learning, and suggests a proactive behavioral management style for dance/movement therapists, that incorporates aspects from these two frameworks. Trainings and experiences working in an urban school district combine with various DMT methods to inform my theoretical orientation as a dance/movement therapist. Concepts have mingled to create this orientation; however, my theoretical framework is continuously evolving. Therefore, I am unable to concisely solidify a specific perspective from which I always work as a dance/movement therapist, and I do not embrace the pure application of a singular theory or method. For this synthesis, however, Chacian dance/movement therapy techniques were adapted and implemented as they seemed to parallel numerous methods from the Responsive Classroom approach. From my repertoire, these methods seemed to best fit the needs of the specific situation and milieu where I was a dance/movement therapy intern.

Throughout the following chapters, I explore the integration of these two methods, the Responsive Classroom approach and Chacian dance/movement therapy. The next chapter contains a review of the literature pertaining to youth violence and

aggression, dance/movement therapy, the Responsive Classroom approach to teaching and learning, and guidelines for evaluating effective intervention programs.

Chapter II: Review of the Literature

Youth Violence and Aggression

Perhaps one of the most comprehensive, or at least most current statistical representations of school violence, comes from a jointly produced online publication by the National Center for Education Statistics (NCES) (Guerino, Hurwitz, Noonan, and Kaffenberger, 2006). This annual report is the ninth of its kind in a series of publications that the NCES, Institute of Education Sciences (IES) in the U.S. Department of Education, and the Bureau of Justice Statistics (BJS) in the U.S. Department of Justice collaboratively produced. According to Geurino et al.:

> The indicators in this report are based on information drawn from a variety of independent data sources, including national surveys of students, teachers, and principals, and data collections from federal departments and agencies, including BJS, NCES, the Federal Bureau of Investigation, and the Centers for Disease Control and Prevention. (2006, p. 1)

These annual reports allow for a comparison of findings over the last nine years, which show a decline in reported primary school violence (Guerino et al., 2006). However, shocking events such as the 1999 shooting by students at Columbine High School near Denver, Colorado, have sent governmental agencies scrambling to respond to the need for an intervention to the nationwide epidemic of youth violence (Constitutional Right Foundations, 2006; Guerino et al., 2006; National Mental Health Information Center, 2004).

Currently, there is an expansive amount of literature detailing management of difficult, inappropriate, disruptive and never before seen classroom behaviors that

interrupt academic learning and provide new teaching challenges for educators as evidenced by the increasing number of school-based violence prevention programs (Hervey & Kornblum, 2006; Miller, 2003; Mytton et al., 2002; Safe Schools Healthy Students, 2006). Although there are many recommended interventions and preventative violence programs, there are discrepancies in the scientific standards for what is actually a consistent and an effective approach. Furthermore, what works for one age group may be ineffective with another age group, making it challenging to identify a coherent and reliable approach to combating youth violence (U.S. Surgeon General's Report, 2001).

According to the Surgeon General's report, "we are well past the *nothing works* era . . . and we possess the knowledge and tools needed to reduce or even prevent much of the most serious youth violence" (2001, p. 3). There are many traditional as well as innovative interventions that are being explored and employed, but most agree that a comprehensive, developmental, multi-systemic approach is needed (Bloomquist & Schnell, 2002; Hervey & Kornblum, 2006; Twemlow, 2004). One of these innovative approaches is dance/movement therapy.

Dance/Movement Therapy in the United States

Dance/movement therapy (DMT) as defined by the American Dance Therapy Association (ADTA) is, "the psychotherapeutic use of movement as a process which furthers the emotional, cognitive, social and physical integration of the individual" (American Dance Therapy Association, 2006). It is a creative arts therapy based on the belief that movement reflects an individual's inner mood, and pattern of thinking and feeling; that the body and mind are interrelated (Learndirect, 2006).

The roots of DMT in the United States can be traced to the 20th century, when the *Grande Dame* (Levy, 1988) of dance/movement therapy, pioneer Marian Chace, encouraged students in her dance classes to use movement as a form of emotional self-expression instead of focusing on technical aspects of dance (Chaiklin et al., 1993; Levy, 1988; Schmais, 2004). Students reported feelings of well-being after these classes, generating a buzz that eventually reached the medical community. In 1942, around the same time doctors began sending patients with psychiatric illnesses to Chace, she responded to a nationwide call to support the efforts of World War II by volunteering as an aide at St. Elizabeth's Hospital in Washington, D.C. (Chaiklin et al., 1993). Here she led groups under the premise of dance for communication, and thus began the development of what is known today as the four core concepts of a Chacian DMT group: *body action, symbolism, therapeutic movement relationship* and *rhythmic group activity* (Levy, 1988; Chaiklin et al., 1993). Although there are five additional pioneers recognized as instrumental in the foundation, development and theories of dance/movement therapy, this theoretical synthesis will focus mainly on the style and approach developed by Marian Chace, whose technique is described in detail in Chapter III.

In 1966, the American Dance Therapy Association (ADTA) was formed to promote the highest standards in education and practice in the field of DMT. Fittingly, Chace served as the first president (ADTA, 2006). Today, dance/movement therapists work with people of all ages, in a variety of settings ranging from individual to group sessions, who have social, emotional, cognitive and/or physical problems. According to the ADTA, dance/movement therapists, "are employed in psychiatric hospitals, clinics,

day cares, community mental health centers, developmental centers, correctional facilities, special schools and rehabilitation facilities" (ADTA, 2006), in addition to private practice, across six continents. They partake in research, and work as consultants and creative art therapists. As the awareness and practice of DMT continues to expand to various settings, innovative applications evolve. For example, although a relatively young field, DMT was recognized in 1975 by the U.S. Board of Education and Federal Government in the Education for All Handicapped Children Act, PL 194-42 (1975) amended several times (1986, 1990), which was eventually renamed the Individuals with Disabilities Education Act (IDEA) (ADTA, 2006). This has created a pathway for the use of DMT in school settings.

Dance/Movement Therapy and Violence Prevention

While there is an abundance of dance/movement therapy literature about DMT and children with behavior disorders (Erfer & Ziv, 2006; Kornblum & Halsten, 2006; Koshland, 2003; Lundy & McGuffin, 2005; Payne, 1992; Rakusin, 1990; Tortora, 2006), there are currently only two dance/movement therapy-based violence prevention programs designed for schools: *Peace Through Dance/Movement (*Koshland, 2003) and *Disarming the Playground: Violence Prevention through Movement and Pro-Social Skills* (Kornblum, 2002). Both of these programs have recently undergone evaluations by dance/movement therapists. In a review of *Peace Through Dance/Movement*, Lynn Koshland (2003) found this approach, "effective in reducing aggressive behaviors . . . however, there was not significant increase in pro-social behaviors noted." In 1995, dance/movement therapist Rena Kornblum began developing *Disarming the Playground*, a body-based, school violence prevention curriculum that was published as a training

manual and activity workbook in 2002. A 2006 evaluation of this program found a, "notable reduction in the kind of problematic behaviors that can contribute to violence in schools" (Hervey & Kornblum, 2006). This report does not comment on pro-social skills or proactive behavior management strategies specifically, but findings suggest an increase in interpersonal communication, as indicated by the use of *I* statements, and heightened self-awareness, as indicated by more effective emotional self-regulation through such interventions as self-soothing (Hervey & Kornblum). In reviewing the school-based violence prevention evaluative literature, it seems increasing pro-social skills while decreasing negative or problem behavior is an important aspect of an effective intervention program. The Responsive Classroom approach is a curriculum implemented school-wide that incorporates both of these aspects.

Responsive Classroom

The Northeast Foundation for Children (NEFC) is a non-profit, private organization that is the primary advocate for Responsive Classroom (RC) and provides week-long training sessions across the United States. According to the NEFC:

> The *Responsive Classroom* is an approach to elementary teaching that emphasizes social, emotional, and academic growth in a strong and safe school community. The goal is to enable optimal student learning. Created by classroom teachers and backed by evidence from independent research, the *Responsive Classroom* approach is based on the premise that children learn best when they have both academic and social-emotional skills.

Since its inception, the number of schools using this approach continues to steadily increase as does the number of certified trainers (Delisio, 2006). According to

Ruth Sidney Charney, co-founder of the NEFC and a pioneer of the RC approach, "the [current] demand for [Responsive Classroom] exceeds our capacity to meet it" (Delisio, 2006).

There are seven *guiding principles* and ten *classroom practices* that ground the RC approach (Bechtel, 2003; NEFC 2006; Rimm-Kaufmann, 2006), and five *schoolwide* practices for deliberately helping children build academic and social-emotional competencies (NEFC, 2006). (See Appendix B for a complete listing of RC principles and practices.)

Dr. Stephen Elliot, currently Professor of Special Education at Vanderbilt University's Peabody College of Education, conducted the first studies on the contributions of RC in the early 1990s at economically and racially diverse schools located on the east coast of the United States. The first study conducted in West Haven, Connecticut during the 1991-92 school year found that after a year of exposure to the RC approach, students were perceived to exhibit higher levels of social skills and fewer behavioral problems compared with students who had limited or no exposure (Elliot, 1993). During the 1993-94 school year, a second study in Washington, D.C. produced essentially the same findings: Students in classrooms taught with the RC approach did better socially and behaviorally than those without (Elliot, 1995). Finally, a two-year study conducted during the 1996-97 and 1997-98 school years in Springfield, Massachusetts, found that students with strong social skills perform better on evaluations such as the Iowa Test of Basic Skills (ITBS), and that over time there is a correlation between improved social skills and improved ITBS test scores (Elliot, 1999).

The RC approach incorporates practices that many educators intuitively know foster learning and academic growth (Rimm-Kaufmann, 2006). Sara E. Rimm-Kaufmann, Associate Professor of Education at the University of Virginia's Curry School of Education and Center for Advanced Study of Teaching and Learning, asked whether this intuitive knowing could be supported by scientific data, as well as if children exposed to the RC approach would demonstrate a higher level of social skills and a decrease in problem/negative behavior in the classroom, as found by previous research (Elliot 1993, 1995, 1999; Rimm-Kaufmann, 2006). To answer these questions, Rimm-Kaufman conducted the first longitudinal, quasi-experimental RC study that was published in October 2006. Using the No Child Left Behind guidelines discussed in the next section, and those provided by the Institute for Educational Science (IES), the research arm of the U.S. Department of Education, Rimm-Kaufman conducted a quasi-experimental study from 2001-2004 in an urban Connecticut school district in which the findings support previous research by Elliott (1993, 1995, 1999) that the RC approach contributes to better social and academic outcomes (Rimm-Kaufmann, 2006, Conclusion). The No Child Left Behind Act of 2001 (NCLB) provided criteria which Rimm-Kauffman used to evaluate this inquiry.

No Child Left Behind. In the No Child Left Behind Act of 2001 (NCLB), the U.S. government called on educators to use, *scientifically-based research*, to guide their decisions about which educational interventions to implement and suggested criteria to qualify intervention programs as effective (U.S. Department of Education [USDE], 2003). One purpose of these guidelines is to assist educators in evaluating and implementing evidence-based interventions in order to improve the educational and life

outcomes of school children (USDE, 2003, p. iii). The NCLB guidelines suggest criteria to evaluate if educational intervention programs are supported by, "'*strong'* evidence of effectiveness," as evidenced by either quasi-experimental or randomized, controlled research designs and quantitative effectiveness in two or more school settings (USDE, 2003, p. 5-9).

Evaluating methods using standardized criteria is important as it allows us to gather information and learn about what works and what does not work, as well as provides understanding and advances, all within a framework so research can be measured and/or replicated. The RC approach is a curriculum that has been evaluated using standardized criteria as referenced in the previous section.

Questions and Purpose

As previously stated, as a dance/movement therapy intern in an outpatient hospital program, I began facilitating dance/movement therapy groups for children. However, when children presented extremely aggressive, disruptive or unmanageable behavior, behavior management became the focus of the DMT group instead of therapy. When this behavior presented, so did numerous questions. First, I wondered how to manage this behavior. Then I wondered how to facilitate therapy. These two questions together led me to wonder how to address this behavior so therapy could commence, and if that happened, how to manage the behavior throughout the therapy session so therapy could continue. As questions arose, I realized that as a dance/movement therapy intern, I was not trained in proactive behavior management, however, as an educator, I was.

Through my DMT training, I was introduced to a dance/movement therapy based behavior management program, *Disarming the Playground*, a body-based, school

violence prevention curriculum developed by dance/movement therapist Rena Kornblum, and published as a training manual and activity workbook in 2002. However, this is not a proactive behavior management curriculum and I was not trained sufficiently in or experienced with the implementation of this program. Therefore, I felt something was missing in my dance/movement therapy training, and more specifically in the field of DMT.

As previously stated in this literature review, there is an exhaustive amount of information on youth violence and school-based intervention programs in the United States, and a dearth of information on addressing this behavior when it presents in a DMT group. The result of this, and my observations and experiences as an intern in a behavioral health setting, is the inception of this theoretical synthesis.

The purpose of this study, in addition to extending the research presented in this Literature Review, was to explore the integration of two methods, the Responsive Classroom approach and Chacian dance/movement therapy; to consider what the RC approach has to offer when combined with Chacian DMT and conversely, what Chacian DMT could provide the RC approach. These objectives culminate to form this graduate thesis, and are further discussed in the ensuing chapters.

Chapter III: Theoretical Synthesis

In this chapter, a synthesis of Chacian dance/movement therapy and Responsive Classroom will be introduced in several steps. First, a brief introduction about each method is provided. Then, the core concepts of both approaches are described. Finally, a chart comparing these methods is presented. The synthesis of Chacian DMT and RC is illustrated through several examples in the following chapter.

Chacian Dance/Movement Therapy

As previously stated, dance/movement therapy is a creative arts therapy based on the belief that movement reflects an individual's inner mood, and pattern of thinking and feeling; that the body and mind are interrelated (ADTA, 2006; Chaiklin et al., 1993; Levy, 1988). Although there are various dance/movement therapy styles, methods and techniques, the form developed by pioneer Marian Chace, know as Chacian dance/movement therapy, the Chacian approach or The Chace Technique (Levy, 1988) is one of the two foci of this synthesis.

Underlying Chace's work is the belief that dance is communication and therefore fulfills a basic human need (Chaiklin et al., 1993). Although not specified by Chace as such in her writings or work, four core concepts or theories are inferred because of their repetition and emphasis: *body action, symbolism, therapeutic movement relationship* and *rhythmic group activity* (Chaiklin et al., 1993; Schmais, 2004). These concepts are comprised of techniques such as mirroring, empathy and attunement (see Appendix A) through which Chace fostered verbal and non-verbal communication with patients. In addition to the four core concepts, Chace's contributions to the field of DMT are the

recognition and specification of certain dance elements as therapeutic, the interpersonal role of the therapist on a movement level, and the development of group interaction through dance as nonverbal communication (Chaiklin et al., 1993). These elements of Chacian dance/movement therapy are described below.

Concept I: Body action. A Chacian dance/movement therapy group often begins in a circle, with the dance/movement therapist making verbal and non-verbal contact or connections with group participants as a way of noticing how they are feeling, while leading a body based warm-up. The circle formation provides a space and structure where equal sharing, visual contact among group members and a sense of security in a clearly defined space allows patients to move away from and return to the circle without disrupting the group. Patients can be inside, outside or on the periphery of the circle; the circle can contract or expand, and leadership can easily be shifted allowing people to choose who to follow, who to be near or who to avoid (Chaiklin et al., 1993).

The therapist is a member of this circle and leads the group in simple, repetitive and rhythmical movements so all members can join the action. This warm-up mobilizes the groups' capacity for emotional expression and social interaction while providing, "motility of the skeletal musculature" (Levy, 1998; Chaiklin et al., 1993). During the warm-up, the dance/movement therapist may, amongst other things, establish eye contact, adapt motions of group members, support spontaneous changes and/or intensify movements, in order to make moment to moment interventions (Chaiklin et al., 1993). This process comprises the first concept, or body action, of the Chacian technique.

Concept II: Symbolism. As movement continues to present, "a session usually proceeds with the development of themes that may arise from gestures, movement

patterns, or feelings that are generated from the warm-up" (Bloom, 2006, p. 35). The therapist chooses themes from movement that has emerged in the warm-up, and facilitates the expression, development, and elaboration of the feelings or needs expressed. The therapist uses verbalization accompanied by movement to create a narrative reflective of the group process; to support the growth and development of individuals as well as the group. Through this, the therapist continuously clarifies the direction and intention of the group. Therefore, the dance/movement therapist uses non-verbal and verbal cues to broaden movement, clarify themes and find meaningful symbols, especially during the middle portion, or symbolism, of a session.

Concept III: Therapeutic movement relationship. In her work, Marian Chace used the term "picking up" to describe the process of gathering information about clients; to engage them in contact with the therapist and one another, and to develop a sense of mutuality which facilitates the communication and sharing of feelings (Levy, 1988; Chaiklin et al., 1993). As this term was imparted to her students, it developed a plethora of meanings, and eventually evolved to "empathic reflections," a phrase Chace herself never used. Empathy and the process of empathic reflection are foundational to Chace's work. This thesis will rely on the following definition of empathy as stated by Susan Sandel:

"Empathic reflection is the process by which the dance therapist incorporates clients' spontaneous expressions into the ongoing movement experience and responds to those expressions in an empathic way" (in Chaiklin et al., p. 98). To further explain empathy, Carl Rogers states:

> The way of being with another person which is termed empathic has several facets. It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive moment to moment, to the changing felt meanings which flow in this other person…It means temporarily living in his/her life…It means frequently checking with him/her as to the accuracy of your sensings, and being guided by the responses you receive. You are a confident companion to the person in his/her inner world. By pointing to the possible meanings in the flow of his/her experiencing, you help the person to focus on this useful type of referent, to experience the meanings more fully, and to move forward in the experiencing. (in Chaiklin et al., p. 99).

This creates a flow of interaction between therapist and client which is critical in the healing process (Chaiklin et al., 1993).

Also inherit in Chace's work, and used to establish a therapeutic movement relationship, is empathic reflection. Chace would visually and kinesthetically perceive a patient's movement expressions while incorporating the emotional content of the patient's behavior into her own movement responses (Chaiklin et al., 1993, p. 79), thus "attuning" to the patient. According to psychotherapist Dr. Daniel Siegel (1999):

> Attunement involves alignment of states of mind in moments of engagement, during which affect (see Appendix A) is communicated with facial expression, vocalizations, body gestures, and eye contact. This attunement does not occur for every interaction. Rather, it is frequently present during intense moments of communication… (p.88)

By observing and responding to patients' small idiosyncratic movements and gestures, the therapist attunes, fostering a connection or relationship with the patient (Levy, 1988, p.22)

Via empathy and attunement, a therapeutic movement relationship (concept III) is created throughout a Chacian DMT session (Chaiklin et al., 1993). A dance/movement therapist reenacts a patient's behavior in his or her own body, noticing how it feels, "trying it on" so to speak, then reflects, expands or completes the patient's movement in an attempt to convey understanding. To establish identity, develop trust, foster independence, recreate social awareness, and develop and maintain individual integrity while accepting social influences, the therapist establishes a connection in which repressed ideas and feeling may be expressed, and new risks and relationships can occur (Chaiklin et al., 1993).

Concept IV: Rhythmic group activity. The dance/movement therapist visually and kinesthetically attunes to participants which supports the development of rhythm or rhythmic group activity (concept four). A therapist brings awareness to patients' movements that are expressing emotions, combining music and dance (rhythmic action) and involving the entire group. Rhythm helps individuals internally organize, increases body awareness, and provides a shared experience while creating group cohesion. Rhythm is present in everyday life; evident in our breathing, heart beats, speaking, walking, working and playing. It creates structure for chaos, and when experienced with others, provides a feeling of more strength and security than any individual could feel alone (Chaiklin et al., 1993, p. 80).

Summary

These four core concepts, body action, symbolism, therapeutic movement relationship and rhythmic group activity, are the foundation of Chacian dance/movement therapy, and were consciously implemented for this theoretical synthesis as a way to provide structure for the facilitation of dance/movement therapy groups during this research.

Responsive Classroom

Background. The Responsive Classroom approach (RC) to teaching and learning was developed in 1981 by six public school teachers, and is supported by the Northeast Foundation for Children (NEFC) which is located in Massachusetts. Since its inception, publications, trainings, research and a partnership with a second organization (Origins, based in Minneapolis, MN) have developed to support the RC approach, which began as a shoestring operation and has now grown to a nationwide organization. According to the NEFC:

> Urban, suburban, and rural schools nationwide implementing the Responsive Classroom approach consistently experience higher teaching quality, increased student engagement, academic gains, and fewer discipline problems...The goal of the Responsive Classroom approach is to enable optimal student learning [and is] continually refined to meet schools' needs…Students learn best when their classrooms are places where they feel safe, challenged, and joyful—places that free them to learn (NEFC, 2006).

About Responsive Classroom. Foundational in the Responsive Classroom approach are seven guiding principles that direct, ten classroom practices that ground,

and five schoolwide practices for deliberately helping children build academic and social-emotional competencies that can be used along with many other programs (Bechtel, 2003; NEFC 2006; Rimm-Kaufmann, 2006). Together, these work to enable optimal student learning. They increase social skills, establish positive climates, increase learner investment and independence, and decrease disruptive behaviors (Bechtel, 2003). For this synthesis, one of the seven guiding principles, four of the ten classroom practices, and a single schoolwide practice were adapted and implemented. See Appendix B for detailed information about the RC approach.

One guiding principle. From the seven guiding principles of the Responsive Classroom approach, one principle seemed most applicable and adaptable to the goals of this setting and program:

- "How the adults at school work together is as important as their individual competence: Lasting change begins with the adult community" (Northeast, 2006).

Since I was not in an actual school environment, I adapted the RC language to apply to the hospital setting. I changed this principle to read:

- How the adults in *this children's outpatient partial hospital program* work together is as important as their individual competence: Lasting change begins with the adult community.

To implement this principle and enhance my relationship with the adults in this program, I asked the children's outpatient partial hospital program (OPHP) director and staff if I could participate in program activities throughout the day, to which they agreed. I immediately began attending the daily morning therapy group with children's OPHP staff and patients, which outlined individual as well as group goals set by the patients

and/or OPHP staff. As a result of attending these morning therapy groups, I felt better prepared to support both individual and group goals in DMT sessions. Furthermore, I confirmed the number of children in the program each day, as the numbers of patients fluctuated daily, so that when it was time for dance/movement therapy, the gymnasium where DMT groups were held was equipped with enough materials for all to participate.

Four classroom practices. From the ten classroom practices outlined in the Responsive Classroom approach, the following four seemed most applicable and adaptable to the goals of this setting and program:

- *Morning Meeting* - gathering as a whole class each morning to greet one another, share news, and warm up for the day ahead;
- *Interactive Modeling* - teaching children to notice and internalize expected behaviors through a unique modeling technique;
- *Positive Teacher Language* - using words and tone as a tool to promote children's active learning, sense of community, and self-discipline; and
- *Collaborative Problem Solving* - using conferencing, role playing, and other strategies to resolve problems with students (Northeast, 2006).

These four classroom practices are the heart of the Responsive Classroom approach and build academic and social-emotional competencies that can be used along with many other programs (Bechtel, 2003). They increase social skills, establish positive climates, increase learner investment and independence, and decrease disruptive behaviors (Bechtel). For these reasons, I chose to utilize these practices.

Further discussion about, and examples detailing the implementation of, morning meeting and collaborative problem solving are included in the sessions examples in

Chapter IV, therefore, information about interactive modeling and positive teacher language are included here. Positive teacher language is described first for ease of understanding for the reader.

"In the Responsive Classroom approach, teachers use words thoughtfully, recognizing that language can encourage and empower children as they learn positive social skills and grow academically" (Bechtel, 2003, p. 87). Positive teacher language is used to, "engage with children, create a classroom where children feel trust and belonging, support children's intrinsic drive for social and academic competence, communicate a clear message of confidence in children's abilities to meet expectations and support and guide children's efforts to live the classroom rules" (p.88). The purpose of using encouraging and empowering positive teacher language is three-fold: to reinforce, to remind, to redirect; also known as the three R's.

Reinforcing language is used in RC to, "give positive feedback and recognize students' efforts at self-discipline. [It] is descriptive and focused on a child's specific actions, rather than general and evaluative" (Bechtel, 2003, p. 92). Reminding language is used, "when students are just beginning to get off track or just before a specific time or situation when the rules are particularly challenging to use" (p. 93), and redirecting language is necessary, "when a child is off track and needs to be stopped and pointed in the right direction. The teacher's tone is matter-of-fact rather than angry or judgmental," which reflects faith in a child's abilities, provides opportunity for the child to rehearse or practice the direction or task at hand, is neutral (without sarcasm), and is simple and direct (a statement not a question) (p. 94).

In addition to positive teacher language, and to further support an atmosphere of trust and belonging, teachers model specific behavior and ask for, "imitation within a very limited range of variations" (Bechtel, 2003, p. 83). This is called interactive modeling and is comprised of the intentional execution of a task, goal or behavior in which the teacher physically demonstrates how to execute said task, such as walking down the hall, shaking hands as a morning meeting greeting or putting things away, while students observe. When the task has been completed, the teacher "elicits recognition of specific actions, language and feeling tone" (Bechtel, p. 85). After students state what they noticed, the teacher asks for student volunteers to demonstrate, providing an opportunity to practice. If completed incorrectly, the teacher may ask students to observe as the teacher demonstrates the desired expectation again, and/or uses positive teacher language to remind, reinforce and/or redirect as the students repeat the task. This proactive strategy affords students the chance to describe as well as experience and practice what is expected of them for future success. Examples of how reinforcing, reminding and redirecting language, and interactive role modeling, were used in a Chacian dance/movement therapy session are included in Session Example I in Chapter IV.

One schoolwide practice. In addition to the one guiding principle and four classroom practices, I chose one schoolwide practice that seemed most applicable and adaptable to the goals of this setting and program:

- "Welcoming families and the community as partners: involving family and community members in the children's education by maintaining two-

way communication, inviting parents and others to visit and volunteer, and offering family activities" (Northeast, 2006).

For the purpose of this synthesis, "community" came to mean patients in the children's outpatient partial hospital program (OPHP) and staff, such as nurses, doctors, creative arts therapists, etc., who were part of the treatment team for patients in this program. "Family activities" included family meetings, family therapy and family activity nights. I was invited to attend and participate in meetings with parents and guardians where I applied the Responsive Classroom Schoolwide Practice of welcoming families as partners, by involving families in treatment planning, maintaining two-way communication and inviting them to family therapy and family activity nights. Although I became a more integral part of the treatment team, and participated in family meetings, I did not attend family therapy and family activity night due to scheduling conflicts.

The treatment model in the children's OPHP encompasses family involvement, providing treatment for the individual person as well as education and therapy for the family unit. To use the words of the RC approach, "this involves teaching children to notice and internalize expected behaviors through a unique modeling technique and using words and tone as a tool to promote children's active learning, sense of community, and self-discipline" (Northeast Foundation for Children, 2006).

In addition to fostering an adult community, focusing on these specific interventions provided an opportunity for me to educate staff, patients and parents about Chacian DMT and the RC approach. Although I was the lone implementer of these specific Responsive Classroom practices and techniques, some of the RC methodology seemed inherent to the outpatient partial hospital program, but was worded differently,

such as creating a partnership with parents, and interactive modeling and positive teacher language, which are defined below.

Summary. Guiding principles, and classroom and schoolwide practices, the foundational aspects of Responsive Classroom, were implemented for this synthesis as they seemed most applicable to the facilitation of Chacian dance/movement therapy groups in this setting. These components provided guidance for the preparation and set up before each dance/movement therapy session, while offering proactive behavior management strategies. The similarities of the Chacian approach and Responsive Classroom are discussed below.

Chacian dance/movement therapy and the Responsive Classroom approach

Chacian dance/movement therapy and the Responsive Classroom (RC) approach have some similar structures, practices and goals. Both methods provide structure through which creativity can be explored. Specifically, Chacian dance/movement therapy is comprised of four core concepts, body action, symbolism, therapeutic movement relationship and rhythmic group activity; and the Responsive Classroom defines seven guiding principles, ten classroom practices and five schoolwide practices (see Appendix B). Dance/movement therapy believes that the body and mind are interrelated. As Delisio (2006) states in the title of her article, "Responsive Classroom practices teach the whole child," incorporating the body-mind connection. RC incorporates practices that many educators intuitively know foster learning and academic growth, while DMT was born out of the intuitive methods employed by dance educators. Dance/movement therapy seeks to further the emotional, cognitive, social and physical integration of the individual, and RC attempts to foster a developmentally appropriate learning environment where

students thrive academically as well as socially. Both methods embrace goals that support personal development as well as group interaction (American Dance Therapy Association, 2006; Bechtel, 2003; Levy, 1988).

A table listing these comparisons and their functions is included here for ease of understanding.

Chacian Dance/Movement Therapy	**Responsive Classroom**	**Common Functions**
Four Core Concepts: I. Body Action II. Symbolism III. Therapeutic Movement Relationship IV. Rhythmic Group Activity	Foundations of RC: ·Seven Guiding Principles ·Ten Classroom Practices ·Five Schoolwide Practices	Provide structure
Belief that the body-mind are interrelated	RC teaches whole child	Incorporate body-mind connection
DMT born out of intuitive methods employed by dance educators	Based on practices educators intuitively know foster academic learning and growth	Created from intuitive perspectives
Seeks to further the emotional, cognitive, social and physical integration of the individual	Attempts to foster a developmentally appropriate learning environment	Supports growth of individual as well as that of a group

Although worded differently, the Responsive Classroom has goals similar to those of and in Chacian dance/movement therapy: building community, fostering active and engaged participation, becoming competent in specified goals, and creating a heightened sense of group identity (Bechtel, 2003, p.41; Chaiklin et al., 1993). These activities may enable optimal student learning in a Responsive Classroom setting and increase a patient's movement repertoire through Chacian dance/movement therapy, expanding and

allowing for enhanced internal connectivity and external expressivity (NEFC, 2006; ADTA, 2006).

The application of Chacian dance/movement therapy and the Responsive Classroom approach during this inquiry is discussed and described using three session examples in the next chapter. These session examples offer suggestions for ways these two methods may be integrated.

Chapter IV: Application

Various benefits and challenges presented themselves during the practical application and synthesis of the Responsive Classroom approach and Chacian dance/movement therapy. At times, during the implementation of these two methods, RC and Chacian DMT seemed to support each other, and at times, they did not. Included in this chapter are session descriptions in which these two methods were implemented and integrated. The usefulness and limitations of this synthesis are discussed in Chapter V.

Before facilitating each DMT session described below, the outpatient partial hospitalization program (OPHP) staff walked with patients in a single file line to the gymnasium, where I greeted them at the door. During group, the program staff sat as observers around the periphery of the room in case emergency interventions were necessary, and until it was time to escort patients from DMT group to their next destination. Conversations with program staff before the implementation of this synthesis clarified their role and expectations during DMT sessions. This is an example of how the guiding principle, "How the adults at school work together is as important as their individual competence: Lasting change begins with the adult community" (Northeast, 2006), was adapted and implemented within this hospital setting.

Session Example I

When students arrived in a single file line at the gymnasium door, ready for dance/movement therapy, I greeted them and stated a goal, such as, "We are going to stay in a line and follow the leader. I am the first leader today. If I walk, you walk. If I am quiet, you are quiet." Using reminding language, I stated, "Think about how you will

enter the gym." I paused to allow time for everyone to think. Then continued by stating, "Get ready to show me what that looks like. Here we go!" Using interactive modeling, I demonstrated the directive; I entered the gym, walked at a slow pace without using my voice to make words or sounds, found a mat on the floor, and sat down slowly, with my legs crossed, modeling self-control and so as not to model "flopping" my body on the mat, or running and sliding onto the mat—things I did not want the patients to do. The group followed.

I used the three R's (reinforce, remind and redirect) throughout the duration of this goal to encourage and empower the children to successfully complete the task at hand. For example, one patient ran to a mat, and jumped up in the air before landing on his knees on the mat. Using reminding language I said, "Think about how we entered the gym today." I paused to allow time for him to think. Then I used redirecting language and said, "Walk back to the door. Show me how you slowly walk into the gym and sit with your legs crossed on your mat." The patient stood up, returned to the gym entrance, walked at a fast pace to his mat and with a slight jump, sat on his knees on his mat. Although this was not exactly how I verbally directed and modeled entering the gym, then sitting on a mat, this second attempt demonstrated a modification of behavior to what I believed the best of his ability at the time, therefore, I used reinforcing language to give positive feedback. Recognizing the groups' as well as his efforts at self-discipline, using reinforcing language I said, "Wow! I noticed we walked into the gym and safely sat down on our mats; great job listening to directions!"

From the Responsive Classroom approach, positive teacher language and interactive modeling were prevalent. This session continued with the integration of

Chacian DMT. With all of us seated on mats in a circle, we greeted each other and did a body based warm-up, which is described in Session Example II below.

Session Example II

From the first or body action portion of Chacian dance/movement therapy (described in Chapter III), group began in a circle with each patient taking a turn to state their name while at the same time doing a movement with their body to reflect or express their name. Then, collectively as a group we stated the patient's name while simultaneously repeating their movement. For example, in this session, I stated my name, "Shawna," as I crossed one arm over the other, wrapping both arms around my torso, essentially giving myself a hug. Then as a group, we all said my name while doing the "hug" movement. In choosing a "hug" movement, I demonstrated a caring way that all patients could execute moving; an example of interactive role modeling. As each patient stated their name, shared their movement, and repeated both with the group, patients began to smile, laugh and verbally state their experiences.

When one patient stated his name and stomped his feet, another exclaimed, "That's like elephants!" The movement introductions began to change to reflect animal movements, which became the theme or symbolism portion of the group (described in Chapter III). Once everyone introduced themselves, one patient suggested we were animals in a jungle. I invited him to show us what animal he was, and asked if I could join him in the jungle. He stated he was a lion and nodded his head yes, giving me permission to join him in the jungle. As I moved like a lion, crawling on my hands and knees, I asked if anyone else wanted to move like an animal. Most patients quickly participated. As movement, sound and interactions developed, I encouraged expression

through mirroring and positive teacher language, a combination of Chacian and RC techniques. As I moved through the jungle, I came face to face with the patient who was acting as a lion. He stopped and slowly tilted his head to look at me. I reflected this movement, stopping to tilt my head as well, and continued this interaction of tilting heads to the left and right, which seemed to last for only a few seconds before he began to make noises as if he were roaring loudly. When he finished making noise, I softly said, "You have a strong voice." He looked me in the eyes and smiled. This is an example of the third Chacian concept, the therapeutic movement relationship. To bring this session to a close, I began to make loud stomping noises as I pretended to be an elephant, moving back to the circle where we started group for verbal and non-verbal processing of the session. I verbally invited patients to begin returning to the circle, and some of them did so by joining the rhythm of my stomp. This demonstrates the fourth Chacian concept, or rhythmic group activity.

This session example articulates the four parts of Chacian dance/movement therapy described in the previous chapter: *body action, symbolism, therapeutic movement relationship* and *rhythmic group activity*, as well as provides examples of positive teacher language and interactive modeling from Responsive Classroom. Regardless of the methods being used to facilitate a DMT session, it is important to note that certain circumstances may require designated interventions, such as medication to calm a patient, removal of a patient or patients from a group session, and/or compliance with site and/or individually specific safety plans. For example, if a child had done something dangerous to herself or others while I was facilitating the above session, the OPHP staff would have been asked to intervene in order to provide the best care, and ensure safety, for all.

The final session example described below further integrates portions of Responsive Classroom and Chacian dance/movement therapy.

Session Example III

The group began in a circle with an activity, similar to morning meeting from Responsive Classroom and body action from Chacian dance/movement therapy, which was to create a pattern by passing a ball to someone and remembering to whom you passed the ball. Each person could only have the ball one time, so once everyone had a turn to pass the ball, the ball was returned to the person who started the ball passing. This was repeated until everyone knew the ball passing pattern, which was three times. Although a traditional ball tossing activity is described here, the purpose of this example is to demonstrate both rhythmic group activity and collaborative problem solving.

With the pattern established, I introduced a second ball. As the patients tried to pass two balls throughout the circle, following the same ball passing pattern, it became a little chaotic; someone would pass a ball and the recipient would not see it coming because they were watching the other ball; or the balls would collide in the middle of the circle, and patients would go running out of the circle to retrieve the balls. When this occurred, I stopped the game and used the three R's from Responsive Classroom: reinforcing (for example, "That was fun!"), reminding ("Think about what you were doing when you *caught* the ball.") and redirecting language ("Show me how your hands look when they are ready to catch the ball."), along with collaborative problem solving to strategize ways to be successful in not only passing two balls at once, but preparing for passing four balls simultaneously. To strategize, I asked patients what they noticed when we passed the balls. They replied that the balls were not being caught, and the balls were

hitting each other. I asked how we could change this. They said to use one ball instead of two. Before passing one ball again, I asked them to notice what they were doing when they passed the ball to someone; then, following the passing pattern previously established, we passed the first ball.

As the ball was being passed, someone stated an observation saying they looked at the person (to whom they were passing the ball). The ball continued being passed, while we verbally processed what was happening. I asked if anyone else did this (looked at the person to whom the ball was being passed). Some of the patients shook their heads yes, others seemed to consider this question, and others seemed not to be paying attention, but remained in the circle. We decided to try looking at the person to whom we passed the ball. We began passing the ball in the pattern again and someone said, "It works!" When the ball was passed to the last person in the pattern, we stopped passing the ball to once again talk about the process. I asked if anyone noticed anything else. Someone said, "I look at the ball." I asked him to show us what he meant. I observed him and stated that I noticed he watched the ball being passed around the circle. He said yes. Someone said, "That makes me want to puke." I asked, "I wonder if we could look at the person who passes the ball to us?" and asked them to try this, an example of collaborative problem solving from RC. We began passing the ball again, and as soon as the ball was passed, we looked back at the person who passed it to us, instead of tracking the ball around the circle. When this occurred, I observed an increase in focus through intentional eye contact and body movements; patients almost stared into the eyes of the person passing the ball to them, and their bodies began to organize to face the person passing the ball with what seemed to be anticipation of catching the ball. Some patients even put their

hands up in front of their stomach, ready to catch the ball. I stated these observations aloud, an example of positive teacher language from RC, and embodied these observations, an example of picking up or attuning from Chacian DMT. The patients responded with what seemed to be even more clarity in intention, visible in their eye contact and body movement/preparation stance.

As we passed one ball, then two, then three and finally four, we stopped to collaboratively problem solve when necessary. At one point, the rhythm of the passing of four balls became quick, and the balls went flying in all directions. Patients observed this, and together we created a slower rhythm for passing the balls and brought conscious awareness to this rhythm. This incorporated rhythmic group activity from Chacian DMT. Through RC collaborative problem solving, we were able to successfully discuss what strategies helped us accomplish the goal of passing four balls and which strategies did not. When this activity was complete, we discussed the experience. Patients talked about working together (i.e. teamwork) to successfully complete the designated task, which represented symbolism from Chacian DMT.

Throughout this session example, various techniques from Chacian dance/movement therapy and the Responsive Classroom were implemented, and have been explained.

Summary

Since many of the patients in this children's outpatient partial hospital program were admitted for social and behavioral concerns, I used Chacian dance/movement therapy as the structure for facilitating dance/movement therapy groups and proactive strategies from the Responsive Classroom approach, such as organizing the space,

interactive modeling and positive teacher language as interventions to create rapport and foster trust and a safe environment, as well as to provide a positive social experience while teaching coping skills through modeling behavior and language. These strategies were used in conjunction with the Responsive Classroom guiding principles, classroom practices and schoolwide practices previously described in this thesis (see Appendix B).

The likenesses of some of the Responsive Classroom concepts and Chacian dance/movement therapy methods seem to innately compliment and support each other as described through the similarities in structure, practices and goals stated in Chapter III and in the session examples above. Limitations of this inquiry and further consideration of the integration of these two methods are discussed in the ensuing chapter, as are possible contributions to the field of dance/movement therapy and to the Responsive Classroom approach.

Chapter V: Discussion

As presented in the Literature Review and throughout this thesis, there is a vast amount of information on youth violence and school-based intervention programs in the United States and minimal information on proactively addressing this behavior when it presents in a dance/movement therapy group. Where the dance/movement therapy literature has yet to address a preventative approach to confronting violent or aggressive behavior during a dance/movement therapy session, the Responsive Classroom approach to teaching and learning directly addresses this throughout its curriculum and, as discussed in the Literature Review, is successful, as evident by scientific research (Rimm-Kaufman, 2006). The purpose of this inquiry, in addition to extending the research presented in the Literature Review, was to explore the integration of two methods, the Responsive Classroom approach and Chacian dance/movement therapy; to consider what the Responsive Classroom approach has to offer when combined with Chacian dance/movement therapy and conversely, what Chacian dance/movement therapy could provide the Responsive Classroom approach.

Challenges and Contributions of Implementing This Synthesized Approach

During this theoretical synthesis of the Responsive Classroom (RC) approach and Chacian dance/movement therapy (DMT), both challenges and contributions presented in various forms, and are categorized below. Clinical challenges implementing this synthesis, combined with limitations of and challenges to implementing these two methods are also outlined below.

Clinical challenges of synthesis implementation. While implementing this synthesis of methods, I experienced clinical challenges. A minimal amount of time was allotted for the application of this synthesis; the length of my internship itself was only nine months. Naturally, because it was an internship, a lot of learning occurred, especially through trial and error. This, combined with being the only staff member to have heard of and/or to have been trained in Responsive Classroom (RC), meant I was without someone to observe its implementation, and to discuss and understand this synthesis from a Responsive Classroom perspective; there was not time nor another trained staff member on site to explore the depths or evaluate the effects of this work with me.

Since Responsive Classroom is a school wide program in which all staff participate, I needed to explain to co-therapists and program staff what I was doing, and why I was doing it. Although receptive, supportive and interested, the workload of staff in this setting was demanding, therefore, staff had to meet mandates before they could learn about RC. As a result, I began implementation of RC before meeting with staff to explain how I would implement this approach. However, I found that through exposure, staff began to model RC words and behavior they observed me using. For example, one dance/movement therapist began meeting patients at the door of the gym before she facilitated dance/movement therapy (DMT) groups. After observing a DMT session that I facilitated, an Art Therapist asked questions about RC, specifically, what techniques I was using and why.

As staff began adopting and implementing RC, I realized this could be a benefit or a limitation of this synthesis. As a benefit, some consistency was happening in the way

staff interacted with patients (such as meeting patients at the door of a room as stated in the previous example). As a limitation, not being trained in Responsive Classroom potentially meant staff were not informed of techniques and implementation strategies; the reasons and research behind the approach. However, overall, I found that even with these challenges, I did not encounter roadblocks or conflicts between the two philosophies themselves.

Limitations of and challenges to this research. Limitations to the implementation of this synthesis as a whole became obvious during the research and are described here. The overarching challenge to this research was time, as previously stated. My internship was nine months, during which only eight sessions over the course of four weeks included the conscious application of this synthesis; a minimal amount of time for gathering data. Therefore, this research is presented as an inquiry and a theoretical synthesis; data analysis and results are not presented.

Furthermore, I was unable to simultaneously facilitate sessions, track observations and note if interventions were effective or not effective. In this specific setting, due to hospital policies including patient confidentiality, video recording dance/movement therapy and Responsive Classroom interventions for documentation was not permitted.

Yet another limitation of this synthesis was the absence of testing and a system for measuring effectiveness, such as that outlined by the No Child Left Behind guidelines, referenced in Chapter II and used by educational researcher Rimm-Kaufmann in evaluating the Responsive Classroom approach. These limitations provided challenges to this research as well as suggestions for changes in future research, both of which are discussed below.

Contributions to Dance/movement therapy and Responsive Classroom

During this inquiry, I found that the Responsive Classroom (RC) approach supported the use of Chacian dance/movement therapy (DMT) by providing proactive strategies for preparation and set up before each Chacian DMT group. Additionally, RC offered ongoing interventions throughout the Chacian style group to manage and address behavior before and when it presented. Through the use of both RC and Chacian DMT, the therapist verbally reflects observations back to group participants. In Responsive Classroom, emphasis is placed on reinforcing positive behavior through verbal acknowledgement, such as when stating, "I see Jamie *walking* through the room." This technique emphasizes the desired behavior (walking, in this example) while also ignoring other behaviors and redirecting participants. Picking up or attuning in Chacian DMT is similar in that the therapist provides feedback so as to tell the patient, "You are being seen and heard." Although not directly stated in the Chacian literature, this method also reinforces behavior, ignores other behavior and redirects patients.

Conversely, the abilities to attune to patients and empathize with them are integral components of Chacian dance/movement therapy, as outlined in Chapter III and defined in Appendix A, that contribute to the development of an embodied self (see Appendix A); an important element that I feel would enrich the Responsive Classroom approach. I believe Responsive Classroom briefly begins to introduce the embodied self, although not in those words, through interactive modeling (see Appendix B), which asks school personnel to model behavior expected of students. However, this could be taken a step further by consciously and fully incorporating the DMT concept of the embodied self into the Responsive Classroom approach, thus creating embodied educators. By increasing

conscious awareness of your own body, body sensations, and body experiences, by becoming aware of how you interact, react, manifest, and present your internal world externally, you would learn how you behave and interact in the school setting. *And* how you may affect students, staff and others. To me, this is an essential component missing from the RC approach.

Future Research

Since the dance/movement therapy (DMT) literature has yet to address difficult, inappropriate, disruptive and violent behavior in a DMT group, I offer this synthesis as a foundation for discussion, development and evaluation to possibly begin to fill this void. Future research could include video recording DMT sessions to track interventions, and developing a controlled design to evaluate effects. Supporting this inquiry with empirical data will clarify specific interventions and techniques from the Responsive Classroom (RC) approach and Chacian DMT that are deemed effective based on scientific research, offering a new method for teaching and practicing dance/movement therapy.

If future evaluation documents the success of this integration, perhaps dance/movement therapy students will be taught Responsive Classroom techniques, such as the RC interventions used in the session examples included in Chapter IV. The integration of the RC approach with DMT could contribute to the fledgling field of dance/movement therapy, revolutionizing the way DMT is taught and practiced. I believe the integration of RC and DMT, for example, providing proactive strategies for therapists and facilitating the creation of embodied educators, could influence the way children, adolescents and adults interact with one another.

Teaching dance/movement therapists to use these techniques would support work with people of any age, as well as various populations. This could positively affect the way we interact with others in settings outside of therapy; proactive behavior management strategies (see Appendix A) could be acquired and implemented in our personal lives, in relationship with ourselves and others.

Furthermore, incorporating Responsive Classroom interventions, such as the schoolwide practice of welcoming families and community as partners, could contribute to a decline in violent behavior of youth. Future generations of parents and adults would be educated about, and experienced in, proactive behavior management strategies that decrease the propensity to lead a violent lifestyle, as shown by research detailed in the U.S. Surgeon General's Report (U.S. Surgeon General's Office, 2001). A decline in violent behavior could positively affect the populace by bolstering the success of future generations to be contributing members of society.

By combining aspects of Chacian dance/movement therapy and the Responsive Classroom approach to teaching and learning, this theoretical synthesis suggests an innovative approach to expand both the field of dance/movement therapy and education.

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Appendix A

Definition of Terms

Affect. "The way an internal emotional state is externally revealed" (Siegel, 1999, p. 128).

Attunement. "Attunement involves the alignment of states of mind in moments of engagement, during which affect is communicated with facial expression, vocalizations, body gestures, and eye contact" (Siegel, 1999, p. 88).

Creative arts therapies, expressive therapy or expressive arts therapy. "The creative arts therapies include art therapy, dance/movement therapy, drama therapy, music therapy, poetry therapy, and psychodrama. These therapies use arts modalities and creative processes during intentional intervention in therapeutic, rehabilitative, community, or educational settings to foster health, communication, and expression; promote the integration of physical, emotional, cognitive, and social functioning; enhance self-awareness; and facilitate change. Each member association has established professional training standards including an approval and monitoring process, a code of ethics and standards of clinical practice, and a credentialing process" (National Coalition of Creative Arts Therapies Associations, 2009).

Embodiment/embodied/embodied self. "The act of embodying or the state of being embodied" (Soukhanov, 1994, p. 426). "Embodiment is another way of describing the integration of parts-mind, body, feelings, internal and external worlds" (Bloom, 2006, p. xvi). "A humanistic perspective that seeks to widen interpretation to include all dimensions of social existence and experience by rooting any understanding of it in the

way that experience is developed through the senses of the body and cognition of the self in intellectual, physical, aesthetic, and affective terms" (Embodiment, 2010).

Empathy. "Identification with and understanding of another's feelings, situation, and motives" (Soukhanov, 1994, p. 428).

According to Carl Rogers:

> The way of being with another person which is termed empathic has several facets. It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever that s/he is experiencing. It means temporarily living in his/her life, moving about in it delicately without making judgments, sensing meanings of which s/he is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensing of his/her world as you look with fresh and unfrightened eyes at elements of which the individual is fearful. It means frequently checking with him/her as to the accuracy of your sensings, and being guided by the responses you receive You are a confident companion to the person in his/her inner world. By pointing to the possible meanings in the flow of his/her experiencing, you help the person to focus on this useful type of referent, to experience the meaning more fully, and to move forward in the experiencing. (as cited in Chaiklin, 1993, p. 99)

Extreme, violent, aggressive, and disruptive behavior. For this thesis, the definition of extreme, violent, aggressive and disruptive behavior comes from the Surgeon General's Report which states:

> The research described here focuses on physical assault by a youth that carries a significant risk of injuring or killing another person. (U.S. Surgeon General's Office, 2001)

Mirroring. "Mirroring involves participating in another's total movement experience, i.e. patterns, qualities, emotional tone, etc. It implies a quality of selflessness, a sense of entering another's experience, in an open manner. Mirroring is often the first step in establishing empathic connections . . ." (Chaiklin, 1993, p. 100).

Proactive behavior management. For this thesis, proactive behavior management includes "planning, environmental arrangements, curriculum, sequence of activities, and a structured environment to maintain order in the classroom" (Sevierville, 2010). Additionally it includes using logical consequences, versus "punishment," which is often reactive and counterproductive.

Self-regulation. Self-regulation is the way the mind organizes its own functioning, is fundamentally related to the modulation of emotion, and involves the regulation of the flow of energy and information via the modulation of arousal and the appraisal of meaning of cognitive representations of experience. It is the manner in which the process called the "self" comes to regulate its own processes (Siegel, 1999, p.8; 156).

Appendix B

Responsive Classroom

About Responsive Classroom.** The Responsive Classroom is an approach to elementary teaching that emphasizes social, emotional, and academic growth in a strong and safe school community. The goal is to enable optimal student learning. Created by classroom teachers and backed by evidence from independent research, the Responsive Classroom approach is based on the premise that children learn best when they have both academic and social-emotional skills. The approach therefore consists of classroom and schoolwide practices for deliberately helping children build academic and social-emotional competencies.

Guiding principles. Seven principles, informed by the work of educational theorists and the experiences of practicing classroom teachers, guide the *Responsive Classroom* approach:

- The social curriculum is as important as the academic curriculum.
- How children learn is as important as what they learn: Process and content go hand in hand.
- The greatest cognitive growth occurs through social interaction.
- To be successful academically and socially, children need a set of social skills: cooperation, assertion, responsibility, empathy, and self-control.
- Knowing the children we teach-individually, culturally, and developmentally-is as important as knowing the content we teach.
- Knowing the families of the children we teach and working with them as partners is essential to children's education.

- How the adults at school work together is as important as their individual competence: Lasting change begins with the adult community.

Classroom practices. At the heart of the *Responsive Classroom* approach are ten classroom practices:

Morning meeting. - gathering as a whole class each morning to greet one another, share news, and warm up for the day ahead

Rule creation. - helping students create classroom rules to ensure an environment that allows all class members to meet their learning goals

Interactive modeling. - teaching children to notice and internalize expected behaviors through a unique modeling technique

Positive teacher language. - using words and tone as a tool to promote children's active learning, sense of community, and self-discipline

Logical consequences. - responding to misbehavior in a way that allows children to fix and learn from their mistakes while preserving their dignity

Guided discovery. - introducing classroom materials using a format that encourages independence, creativity, and responsibility

Academic choice. - increasing student learning by allowing students teacher-structured choices in their work

Classroom organization. - setting up the physical room in ways that encourage students' independence, cooperation, and productivity

Working with families. - creating avenues for hearing parents' insights and helping them understand the school's teaching approaches

Collaborative problem solving. - using conferencing, role playing, and other strategies to resolve problems with students

Schoolwide practices. Schools implementing the *Responsive Classroom* approach schoolwide typically adopt the following practices:

Aligning policies and procedures with Responsive Classroom philosophy. - making sure everything from the lunch routine to the discipline policy enhances the self-management skills that children are learning through the *Responsive Classroom* approach

Allocating resources to support Responsive Classroom implementation. - using time, money, space, and personnel to support staff in learning and using the *Responsive Classroom* approach

Planning all-school activities to build a sense of community. - giving all of the school's children and staff opportunities to learn about and from each other through activities such as all-school meetings, cross-age recess or lunch, buddy classrooms, and cross-age book clubs

Welcoming families and the community as partners. - involving family and community members in the children's education by maintaining two-way communication, inviting parents and others to visit and volunteer, and offering family activities

Organizing the physical environment to set a tone of learning. - making sure, for example, that schoolwide rules are posted prominently, displays emphasize student work, and all school spaces are welcoming, clean, and orderly

**This is an excerpt from the Responsive Classroom website retrieved December 2, 2006 from http://www.responsiveclassroom.org/about/aboutrc.html