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# Performance as Therapy: An Intervention for Adults with Developmental Disabilities

Emily A. D'Annunzio  
*Columbia College - Chicago*

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**PERFORMANCE AS THERAPY: AN INTERVENTION FOR ADULTS WITH  
DEVELOPMENTAL DISABILITIES**

Emily A. D'Annunzio

Thesis submitted to the faculty of Columbia College Chicago

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in

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Committee:

Susan Imus, MA, BC-DMT, LCPC, GL-CMA

Chair, Dance/Movement Therapy and Counseling

Laura Downey, MA, BC-DMT, LPC, GL-CMA

Research Coordinator

Andrea Brown, MA, BC-DMT, LCPC

Thesis Advisor

Kris Larsen, MA, BC-DMT, LCPC, GL-CMA

Reader

## **Abstract**

The research thesis titled, “Performance as therapy: An intervention for adults with developmental disabilities” examined how adults with developmental disabilities (DD) respond to this specific dance/movement therapy intervention. It shows how this intervention method addresses the psychosocial goal of increasing interpersonal skills. The research took place at a day rehabilitation center, located in Chicago, IL. The co-researchers are participants of a day rehabilitation program, which offers creative arts therapies. The co-researchers are both male and female who range in age from 21 to 60. Caucasian, African American and Hispanic ethnic backgrounds are represented. Co-researchers have DD, which include diagnoses of mental retardation, down syndrome and some mood disorders. The research is inspired by artistic inquiry methods that used choreography and performance to collect and analyze data. The co-researchers engaged in a process of performing both dance improvisation and set movement for each other in seven dance/movement therapy sessions. Co-researchers also created a dance show as a final performance for the day rehabilitation center and Chicago community. The show was made up of a set series of dance improvisations. As a result, the co-researchers created a unique structure for performance as therapy that was conducive to fitting their needs as a population. They experienced universality and altruism which are both therapeutic factors of change, achieved both group and individual therapeutic goals, had high overall group attendance, and engaged in social interpersonal skills. These results show how performance as therapy is in fact a promising intervention for adults with DD.

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## Table of Contents

Chapter One: Introduction .....	1
Chapter Two: Literature Review .....	6
Therapeutic Dance .....	8
Anna Halprin.....	9
Bill T. Jones .....	11
Liz Lerman.....	12
Axis Dance Company .....	13
Therapeutic Dance verses Performance as Therapy .....	15
Influences on the Performance as Therapy Models.....	16
Marian Chace .....	17
Janet Adler .....	19
Performance as Therapy Models .....	22
Application of Performance as Therapy Models .....	28
Summary .....	33
Chapter Three: Methods .....	36
Methodology .....	36
Methods.....	37
Co-researchers.....	37
Procedure .....	39
Data Analysis .....	43
Chapter Four: Results .....	46
Group Attendance .....	47

Goal Achievement .....	48
Themes.....	50
Roles .....	51
Being Seen .....	53
Structure .....	54
Summary .....	58
Chapter Five: Discussion .....	59
Group Attendance and Goal Achievement .....	60
Themes.....	62
Study Limitations.....	69
Summary and Future Research .....	71
References.....	73
Appendix A: Definition of Terms.....	78
Appendix B: Informed Consent/Assent Sheets.....	80
Appendix C: Attendance Sheet.....	85
Appendix D: Goal Tracking Sheet.....	87

## **Chapter One: Introduction**

As both an emerging dance/movement therapist and a dancer I have often found choreography and performance to be powerful therapeutic tools. Like many dance/movement therapists, my love for movement began at a young age when I was starting dance classes at six years old. Even when I began technical training, I found performance to be my favorite aspect of dance—I highly anticipated the recital at the end of each dance year. I enjoyed showing off my newly obtained dance skills and my dance costumes, as well as the overall atmosphere of the stage, both behind and on.

This passion for performance continued on as I grew older and began studying dance during my undergraduate career. Much like before, I anticipated upcoming dance concerts as a means to express myself artistically in front of my collegiate community. Further, I found that I created a deep bond with those I was dancing and choreographing with. Through the process of rehearsing for the show, performing and reflecting upon the show post-performance, my fellow dancers and I created a strong bond, a non-verbal bond.

I have carried my passion for performance with me during my graduate studies at Columbia College Chicago in the Dance/Movement Therapy and Counseling Department, as I see this will define the type of therapist I will be professionally. From the beginning of my studies, I valued the importance of performing and I ultimately became interested in how performance could be used in a therapy setting. As a professional therapist I intend to utilize this intervention method within my therapeutic practice. My motivation was heightened further when I completed “Performance as Therapy,” an elective course co-taught by Goldman and Larsen. Goldman and Larsen are dance/movement therapists and pioneers in the theory of performance as therapy. From that experience as well as reviewing the current DMT literature, I

have defined performance as therapy as a dance/movement therapy (DMT) intervention that utilizes both the process of creating choreography and performing as a means to address outlined therapeutic goals and promote therapeutic growth within clients (Cook, 2008; Gates, 2006; Goldman & Larsen, 2011, Malling, 2012) (see Appendix A).

In my second year of studies I began my internship at a day rehabilitation center, located in the Chicago area, which would later become the location for my research. I specifically worked within the creative arts program, which provided DMT, art therapy, and music therapy. The main goal of both the program and the center was creating a healthy community, one that focuses on increasing social interpersonal skills. The center specifically services individuals with developmental disabilities (DD), whom I worked with on a daily basis.

The term developmental disabilities is not an actual *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.)(*DSM-IV-TR*) diagnosis, but rather an umbrella term for an array of diagnoses. Developmental disabilities is a categorical term given to individuals who, by age twenty-two, have impairments in three areas of physical or mental health that influences their development growth (Morrison, 1995) (see Appendix A). While providing DMT services to these individuals, I began to notice that traditional methods of DMT were not effective in engaging the clients. Traditional methods utilize the Chacian approach that includes a warm-up, rhythmic group movement, theme development, and closure (Levy, 1987). This theoretical approach, as I understood it in my graduate program, fell flat in the DMT studio due to its emphasis on abstract concepts. My clients could not comprehend such abstract concepts explored in verbal processing because of the nature of their diagnoses. Instead, it appeared that a more improvised structure was more beneficial for engaging clients in the group process.



During my internship experience I began to wonder if performance as therapy, as an intervention method or a therapeutic technique in a DMT setting, could be utilized with adults with DD. I wondered if performing would help engage clients in the therapeutic process. I was interested in using or developing structures, also known as interventions that would help clients achieve their interpersonal goals. I also wondered if it would increase social interpersonal connection amongst group members, much like it had for me and my dance peers in the past. The group's two primary therapeutic goals were active group participation and increasing interpersonal skills. I began to lead my own group titled, "Performance as Therapy" as a means to see if clients would be interested in this type of group. In addition, I read literature about performance, performance as therapy, creativity, and adults with DD.

I began to discover that the enthusiasm my clients expressed for DMT and the "Performance as Therapy" group was not represented in the literature. Although there is little research on performance as therapy as an intervention, I found that there is an even smaller proportion of literature discussing performance as therapy with adults with DD. In fact, adults with DD are underrepresented in the DMT literature in general. As I read through the literature, I got the impression that there was an underlying assumption that this type of therapy could not be utilized for this population. There also appeared to be a bias that such clients could not participate in the creative process of DMT, but rather only in group rhythmic activities (Levy, 1987). Creative process is defined as when an individual or group partakes in creating some type of art, such as dance. This process is spontaneous and authentic to the group or individual, is most likely improvised, and the content produced may be used to create a set work of art (May, 1975) (see Appendix A). Not only did I find this sentiment amongst the published DMT literature, I also found it amongst the literature of other helping professions. There appeared to

be an overall notion amongst helping professions that adults with DD are unable to express themselves creatively or participate in therapy sessions that have an improvisational structure.

However, some creative art therapists suggest that adults with DD in fact can be creative and appear to be frustrated that helping professionals' think otherwise (Macdonald, 1992; J. Salemi, personal communication, March 23, 2012; Stamatelos & Mott, 1986). I too found myself frustrated with the bias within the DMT community about the clients I was working with during my internship. There was an apparent disparity between the representation of adults with DD in the DMT literature and the enthusiasm my clients had for DMT and performance. After realizing this disparity, I understood the importance of conducting my research so that it might shed light on the current bias, and give dance/movement therapists a better understanding of adults with DD. Ultimately, the motivation for my study was my clients' enthusiasm for the "Performance as Therapy" group, as well as the lack of research and literature about how this intervention may be used with my clients.

The purpose of my research was to understand performance as therapy as an intervention within DMT. I hoped to showcase performance as therapy as an intervention method by utilizing it with adults with DD. Further, it appears that the creative nature of this intervention is more conducive to this specific population's needs and therapeutic goals. My research provides an example of how adults with DD can, in fact, engage in a creative process. I hoped to realistically answer: How can performance as therapy be utilized as an intervention when working with adults with DD in a DMT setting?

In conducting my research I not only examined this question, but also hoped to add to the representation of this population within the DMT literature. Further, the motivation and purpose of my research is to instill hope in mental health professionals, specifically dance/movement

therapists, in realizing that adults with DD are creative individuals who can engage in the creative process. I was able to witness their creativity on a daily basis, and how this assisted them to achieve their therapeutic goals of group engagement and increasing interpersonal skills.

## **Chapter Two: Literature Review**

Performance in the dance world is imperative to a choreographer and a performer's work. Often a performance is an integral part of the choreographer and performer's creative process. Performance has been defined as a showing of set choreography, which may take any range of time to create (Carlson, 1996; Schechner, 1988). Typically, a performance serves as a means to showcase the creative process and the end product of that process. The end product may manifest as a choreographed dance piece, one that has been rehearsed thoroughly before the performance. The creative process might be: a choreographer finds inspiration to create a dance, elicits dancers to work with, choreographs movement, and teaches it to dancers (Minton, 1986; Smith-Autard, 1996). The dancers rehearse (Minton, 1986), the choreographer edits the dance, and then the work is showcased at a performance venue for an audience (Minton, 1986; Smith-Autard, 1996). This series of events may reflect the creative process of the choreographer, or it may be a collaboration between the choreographer and the dancers (Minton, 1986; Smith-Autard, 1996). Regardless, the performance brings the creative process full circle until the next creative venture occurs.

Although the performance usually serves to showcase the end result of an artist's creative process, it may also serve a different purpose. The concept of performance may transcend the confines of the creative process and into a new realm—the therapeutic realm. A therapeutic phenomenon may occur during the performance in a variety of ways in both the rehearsal for the performance and during it (Nash, 2005). Therapeutic dance may provide “therapeutic experiences involving group interaction, individual expression, and heightened body awareness for the participants” (Caplow-Linder, Harpaz, & Samberg, 1979, p. 36). The experience may elicit change or emotional catharsis for either the individuals involved or the community in

which the dance and performance take place (Nash, 2005; Worth & Poyner, 2004). The dance and performance may also be healing or transformative for those involved (Nash, 2005). A therapeutic phenomenon may occur between the art and the artist who created it, such as a dancer finds rehearsing the choreographed movement healing in some way (DeCosta, 1991). The phenomenon might also occur between the choreographer and performers themselves—possibly during rehearsal, the performance, or both (Lerman, 2011). There might also be a therapeutic aspect of the performance for the audience that watches it. An audience member might be touched by the dance performance and is moved to tears while watching it (Carlson, 1996). No matter how the phenomenon manifests, performance can be therapeutic to those who create it, perform it, and witness it.

The therapeutic aspect of dance, creativity, and performance has begun to transition from performance venues into more traditional therapeutic domains, such as hospitals and rehabilitation centers. Recently, creative arts therapists (including dance/movement, music, art, poetry, and drama therapists) have begun to explore the use of performance as a therapeutic intervention. Creative arts therapists have tapped into the therapeutic elements of creation, rehearsing, and performing various art forms. They have begun to use this intervention method as one way to address varying clients' therapeutic goals. The outlined goals may include personal goals, such as possibly working on relieving stress. Goals may also include group goals such as increasing interpersonal skills. Within the creative arts therapy realm, the therapeutic phenomenon is not an intangible experience that occurs between performers and audiences. Instead, the therapeutic phenomenon is a real occurrence between therapists and clients that is outlined by therapeutic goals supported by clinical environments (Gates, 2006).

Although this intervention method is currently used by some dance/movement therapists (Allegranti, 2009; Cook, 2008; Gates, 2006; Goldman & Larsen, 2011; Malling, 2012), there is no one definition or structure that defines it. Performance as therapy, as an intervention, has not yet been codified. This literature review will first explore the difference between therapeutic dance and performance as therapy as an intervention in DMT. It will then explore the varying definitions and theoretical approaches of the performance as therapy models in the creative arts therapy fields, specifically in the DMT profession. Next, it will discuss the research that has been conducted on its effects. The scope of literature review will then shift to how performance as therapy is used with a specific population, adults with DD.

### **Therapeutic Dance**

The dance and therapy professions have co-existed for years, and at times they have even begun to merge. Their mergence became salient during the modern dance movement in the early twentieth century. At this time, dance and choreography began to expand its parameters from pure technicality to a more expressive art form (Kassing, 2007). The themes of choreographic works and performances shifted away from story-telling, as seen in ballet, and began to explore topics relevant to the human condition. Dancers and choreographers began using movement to explore social and political topics. The movement in choreographed works also included pedestrian movements, such as simple gestures. In modern dance, artists were trying to, “communicate with audiences” (Kassing, 2007, p. 213), so that the experience of watching dance was not pure entertainment, but an experience that was emotional and thought provoking.

The shift from story-telling to exploration of humanistic themes changed the process of choreographing dance and the overall experience of dance performance. Modern dance choreographers found inspiration for dances in every-day experiences (Kassing, 2007), such as

loss, poverty, and love. Some dance choreographers not only included pedestrian gestures in choreographed works, but also began to incorporate non-dancers in the choreographic process (Grubin, Meyers, Jones, & Bender, 1997) or in the dance performances (Halprin, 2000; Kassing 2007; Worth & Poynor, 2006). The shift of exploring humanistic themes and the inclusion of non-dancers not only shifted the creative process, but also shifted the experience during performances. Dance performances became thought provoking and emotive, possibly becoming a therapeutic experience for both the performers and the audience members. Dance choreographers Anna Halprin (2000), Bill T. Jones (Grubin et al., 1997), Liz Lerman (2011), and Axis Dance Company (2011) are all examples of a therapeutic creative process, pushing the boundaries of the dance profession into the therapeutic realm.

**Anna Halprin.** The work of dance choreographer Anna Halprin is a specific example of this phenomenon. Early on in Halprin's career as a dance choreographer, she moved away from traditional approaches of modern dance. Although modern dance was more humanistic than other types of dance techniques, Halprin's choreography pushed the boundaries even further. She did this by creating dance works that incorporated emotional content drawn from the artists she worked with. Worth and Poynor (2004) state, "Authenticity increasingly became the touchstone of Halprin's aesthetic as daily life situations and personal psychological material were introduced into performance" (p. 75). Halprin's dance pieces were often performed in nontraditional environments like nature or community spaces. In doing so, she deconstructed the traditional relationship between the performers and audience members, making the relationship less formal. Halprin also hoped to create change within both the performers and the audience members' personal lives and the community in which they live (Halprin, 2000; Worth & Poynor,

2004). This emphasis demonstrates how Halprin's work is intended to be therapeutic for all of those involved in her creative process.

Many of Halprin's dance pieces exemplified her emphasis on personal emotional processes. Yet her dance piece titled *Intensive Care* demonstrated Halprin's use of therapeutic dance as inspiration for performance. The inspiration for the dance was drawn from Halprin's own experience as a cancer survivor, as well as her fellow dancers' experiences with terminal illness and working in hospice care. Halprin's choreography explored themes of illness and death by transforming personal emotional experiences into choreography (Worth & Poynor, 2004). After the performance, Halprin would often hold talk back sessions with audience members to process what they had witnessed. This often took the form of verbal dialogue between Halprin, fellow dancers, and audience members about the creative process of the piece. Such talk back sessions heightened the therapeutic aspect of *Intensive Care* (Worth & Poynor, 2004). Halprin's motivation for the dance and discussion sessions with audience members illustrated how much of her artistic work can be considered therapeutic.

Halprin is also known for leading what is termed as the expressive arts healing movement, a movement that emphasized the therapeutic aspects of dance making and dance performance. Halprin (2000) has created her method of using dance as healing, what she calls the "Life/Art Process" (p. 20). Her methodology was created based on her work and experience with cancer patients in a hospital setting. The Life/Art Process emphasized the importance of creating dances that directly relate to one's life issues. During the process, Halprin invited cancer patients through an experience of sensing, moving, feeling, and creating visual imagery as a means to help heal themselves. Throughout the process, Halprin (2000) emphasized the relationship between patients' life struggles and the art they created (Worth & Poynor, 2004).



There is no emphasis on performance specifically throughout this process. However, Halprin's work with cancer patients again demonstrated how, as a dancer, she used dance as a therapeutic tool.

**Bill T. Jones.** Another famous choreographer, Bill T. Jones, has also used a similar process to choreographic work. To provide inspiration for choreographing his famous piece *Still/Here*, Jones facilitated what were known as "Survival Workshops" with terminally ill individuals (Hervey, 2000, p. 96). Within the Survival Workshops, Jones invited the individuals to use movement as a means to explore ideas of life and death. He did this through the use of touch, abstract movement gestures to express emotions, visual art, mirroring, dance improvisation, and performing for each other (Grubin et al., 1997). Throughout the Survival Workshops, Jones asked the individuals to process their feelings about their movement and how it related to their illness, and more specifically, how it related to their lives and possible deaths (Grubin et al., 1997). Again, Jones' process is not traditional therapy but rather a therapeutic catharsis facilitated through dance.

Jones choreographed *Still/Here* based upon the movement he witnessed and the stories he heard. The dance piece included exact movement motifs from the terminally ill individuals who worked with Jones in the Survival Workshops. Jones also expounded on these motifs and created new movement sequences that were inspired by the movement he saw. Further, he also included quotes from the terminally ill individuals, giving the piece a spoken word component (Grubin et al., 1997). Much like Halprin, Jones' piece *Still/Here* incorporated people outside of the professional dance world. Both choreographers allowed their experiences with non-dancers, specifically individuals with terminal illness, to shape their creative processes. They drew upon their experience to choreograph dances that explored themes of life and death, often leading to a

therapeutic effect for the individuals involved. Jones (Grubin et al., 1997) and Halprin (2000) both used the experiences as inspiration for choreography, as well as inviting these individuals to be a part of their professional performance repertoire.

**Liz Lerman.** Similarly to Halprin (2000) and Jones (Grubin et al., 1997), dance choreographer Liz Lerman (2011) has a creative process outside the norms of the dance profession, one that has pushed the boundaries of both dance and therapy. Lerman (2011) created dance works that explore the “relationship between art, the artist, and society” (p. xv). In her works, Lerman incorporated non-dancers in her community-based creative process and performances. Non-dancers are most often community members in the community in which the art making takes place. Lerman’s inclusion of non-dancers has been one of her major influences on the dance profession (Cohen-Cruz, 2005). Like Halprin (2000), almost all of Lerman’s dances have been created around the inclusion of non-dancers and this artistic process. Both Halprin and Lerman have created thought-provoking art that was intended to elicit change in those involved. Their work emphasized therapeutic catharsis over aesthetic norms in the current dance profession.

One specific example of Lerman’s community-based work is a workshop she led in a Washington D.C. Jewish community during October of 2003. The workshop occurred during the community’s celebration of Yom Kippur. The community consisted of 400 Jewish congregation members who were previously surveyed by the rabbi concerning their sins committed during the past year (Cohen-Cruz, 2011). During this workshop, Lerman choreographed movement motifs to the community’s most commonly noted sins. She then taught the movement motifs to the community members, engaging them in a profound interchange between religious ritual and art making (Cohen-Cruz, 2011). Lerman’s work with this specific community was also important

because of the community's demographic. Unlike most community-based art projects that included underserved individuals, the Jewish community members Lerman worked with were individuals of a higher social economic status and were powerful in this specific community (Cohen-Cruz, 2011). Her inclusion of those with wealth and power showed Lerman's commitment to change in the community, and how change in a community must represent all of the people who a part of it to be truly therapeutic.

Lerman's artistic process has often been confused as therapy for the dancers and the community members she worked with. Much like Bill T. Jones' (Grubin et al., 1997) during the Survival Workshops, Lerman's process did look similar to what one might do in a therapy setting because she used participants' personal experiences for inspiration and facilitated dialogues between performers and audience members (Lerman, 2011). However, Lerman differentiated her work from creative arts therapies by stating her main objective is to create art. The goal of creating art always takes precedent over the goals of individuals or the group as a whole. The therapeutic aspects that are elicited during her process are merely an offshoot. Although Lerman creates art in settings an individual may receive therapy services (prisons, schools, or elder homes) her process is not therapy (Lerman, 2011). Therapeutic catharsis may occur, but Lerman's intention in her work is to create humanistic and community-based art.

**Axis Dance Company.** Creating art is also the intention of the physically integrative dance company, Axis Dance. Axis Dance Company (2011) included dancers and non-dancers who have an array of abilities. The company, founded in 1987, was inspired by a movement class offered for women who used wheelchairs. Since then, the company has conducted workshops and presentations, has taught classes, and has held panel discussions about physically integrative dance, also referred to as "mixed ability dance," or "adaptive dance" (Axis Dance

Company, 2011, para. 3). Creating dance pieces is the main objective for the Axis Dance Company, and it does not provide therapy for company members. Instead, they hope to bring a different aesthetic to the dance profession by including dancers with an array of physical abilities (Axis Dance Company, 2011; Davies, 2010).

Because Axis Dance Company does include non-dancers and dancers with an array of physical abilities, similar to the dance choreographers discussed above (Grubin et al., 1997; Halprin, 2000; Lerman, 2011), the company is often viewed as therapy or therapeutic. Although a therapeutic phenomenon might occur among company members or audience members, Axis Dance Company, as well as other integrative dance companies, are trying to differentiate themselves from therapy (Axis Dance Company, personal communication, November 9, 2011; Byzek, 2010). Axis Dance Company is a professional performance dance company. They do not to provide therapy to company members, but rather intended to alter the way the role of a dancer is perceived within the dance community (Axis Dance Company, 2011; Davies, 2008). Instead of muddling the boundaries of therapy and dance, Axis Dance Company has attempted to push the boundaries of what physical abilities a dancer must have to perform professionally. Further, they have intended to change the way the dance profession views dance that does include dancers and non-dancers (Axis Dance Company, 2011; Davies, 2008), so that integrative dance is considered a valued art form.

Halprin (2000), Jones (Grubin et al., 1997), Lerman (2011), and Axis Dance Company (2011) all use nontraditional methods when creating and showcasing dance works. This often includes involving non-dancers in both the creative process and performances. The themes of the work are usually humanistic and are derived directly from the artists' own life, or the life of co-artists. Most importantly, however, the choreographers intended to create change in the

individuals and communities that are involved within the creative process. This may have manifested as change in the artist, the dancers, or the audience members who witnessed the professional work. Although their artistic process may serve as a therapeutic outlet, convoluting the lines between therapy and art, it still is not therapy, specifically DMT.

### **Therapeutic Dance verses Performance as Therapy**

Choreographers, performers, and audiences alike may have felt some type of therapeutic benefit from being a part of the creative processes outlined by Halprin (2000), Jones (Grubin et al., 1997), Lerman (2011), and Axis Dance Company (2011). Therapeutic catharsis or community change was often the intention of the choreographer, or it happened to be a positive outcome to the creation of making art. In referencing the dance making process of *Still/Here*, Jones stated there is a, “healing power of art” (Grubin et al., 1997). These artists’ work displayed the therapeutic aspects of dance, yet this work is not therapy, specifically DMT.

One of the major differences between therapeutic dance and performance as therapy is that the latter is a therapeutic intervention used by credentialed dance/movement therapists. Dance/movement therapists are often individuals who come from a background that includes dance technique training. They are creative arts therapists who have obtained a specialized education in using dance in therapy settings. There are two ways a dance/movement therapist may earn this education. One, individuals can earn a master’s degree from one of the six DMT programs that have been accredited by the American Dance Therapy Association (ADTA). The course work in these program includes education on DMT theory, counseling techniques, movement observation and analysis, and research methods. Students must also complete an internship with a dance/movement therapist (ADTA, 2009). Second, individuals who already received a master’s degree in a helping profession may do an “alternate route” in receiving DMT

credentials (ADTA, 2009, para. 2). These individuals must take coursework in DMT theory and techniques, and are also required to fulfill an internship with a dance/movement therapist (ADTA, 2009). These credentials allow dance/movement therapists to provide individuals with therapy in clinical settings such as hospital, rehabilitation settings, and prisons. The credentials of dance/movement therapists who use performance as therapy is one of the major differences between it and choreographers who create therapeutic dance works. Choreographers most likely have specialized training, such as a masters in fine arts, but not necessarily in therapy or counseling like dance/movement therapists.

Another major difference between therapeutic dance and performance as therapy is that dance/movement therapists use performance to help address the specific therapeutic goals of the clients they are working with. Often the DMT intervention resembles the creative process that is used in making therapeutic dance (Goldman & Larsen, 2011). However, the creative process needed to choreograph and perform a dance work in performance as therapy is directly related the clients' therapeutic goals (Gates, 2006). Further, dance/movement therapists rely on their counseling training to verbally process the aspects of performance as therapy (Cook, 2009; Gates, 2006; Goldman & Larsen, 2011; Malling, 2012), again hoping to address clients' therapy goals. Therapeutic effect and growth are not merely offshoots of the creative process, as seen in Lerman's (2011) work, but the main goal. Because of this intention, performance as therapy is a therapeutic intervention or technique, and not merely a therapeutic phenomenon that occurs during the creative process.

### **Influences on Performance as Therapy Models**

Despite the important distinctions between therapeutic dance and performance as therapy, the intervention technique has only recently emerged within the DMT literature. However, it has

its underpinnings in previous dance/movement therapists' approaches and theoretical frameworks (Adler, 1987/1999b, 1996/1999a; Chace, 1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Chase & Bunny, 1962/1993; Olsen, 2007). The founder of DMT, Marian Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d) used performance with individuals with schizophrenia that shows support for this intervention method. In addition, performance as therapy also draws influence from dance/movement therapist Janet Adler's (1999/1987b, 1999/1996a) DMT theory, known as Authentic Movement. Performance as therapy has often drawn from these two dance/movement therapists' theories, both of whom have shaped this DMT intervention.

**Marian Chace.** Although performance as therapy is only recently emerging as an intervention method within the DMT literature, Marian Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d) the founder of DMT, has written about using performance with her patients. Chace (1955/1993b) was not a registered dance/movement therapist (an important distinction between performance as therapy and therapeutic dance), because licensure was not possible at this time. However, her work created the framework for DMT and she is acknowledged as a pioneer in the field. Chace (1955/1993b) does refer to herself as a "dance therapist" in her writings (p. 278). In her work, she used performance in two ways. She used this intervention when working with individuals with schizophrenia at St. Elizabeth Hospital in Washington D.C. This manifested as a theater and dance show that her patients performed at the hospital for fellow peers and hospital staff (1954/1993c, 1955/1993b, 1958/1993a). She also used performance while working with individuals with schizophrenia at Chestnut Lodge in the form of spontaneous theater performances that centered around patients' personal life issues (Chace & Bunny, 1962/1993).

While working at St. Elizabeth Hospital, Chace used a form of performance as therapy, which has influenced the intervention method today. The idea of creating a show was actually based upon the volition of Chace's patients. The show titled, *Hotel St. Elizabeth* was created as a parody of what it was like to be a patient at the hospital. All of the material for the show, the rehearsal process, and the final performance were controlled entirely by Chace's patients, individuals with schizophrenia (1954/1993c, 1955/1993b, 1958/1993a). Although Chace (1955/1993b) felt that using performance was unusual, stating, "It was quite a departure in therapeutic methods" (p.278), she noticed her patients working on social interpersonal skills, group cohesion among members, a capacity to problem solve (1954/1993c, 1955/1993b), and engaging in meaningful discussions about life issues throughout the process of creating *Hotel St. Elizabeth* (1958/1993a). Chace helped facilitate her patients through a creative process, specifically creating a theater and dance show. During the process she witnessed therapeutic growth in her patients, thus supporting the use of performance as therapy in a DMT setting.

Chace also used performance while working with individuals with schizophrenia at Chestnut Lodge, a facility that offered services to the mentally ill. Chace's sessions were open to any patient who would like to join. During her sessions, she invited patients to develop a theatrical scene that embodied a specific life issue they were currently working on (Chace & Bunny, 1962/1993). The patients had to create the scene and then perform it for their fellow peers and staff members. After the performance, performers and audience members could offer suggestions or feedback, or Chace engaged the whole group in a therapeutic discussion. What differed this process from psychodrama, another creative arts therapy, is that the scenes were spontaneous and derived from patients' personal life matter (Chace & Bunny, 1962/1993). Instead of rehearsing a well-known play and using this as a therapeutic in-road, as is sometimes



the case in psychodrama, the vignettes in Chace's groups came forth organically from the individuals in the group (Chace & Bunny, 1962/1993). Again, Chace used performance and creativity to assist patients in not only processing their life issues, but also with addressing their therapeutic goals.

Although Marian Chace was not technically a dance/movement therapist, since this title did not exist while she worked, her work laid down the framework for performance as therapy as an intervention method. Unlike therapeutic dance, Chace used performance as a way to engage patients in creative processes within clinical settings. Her use of performance directly related to her patients' goals (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Chace & Bunny, 1962/1993). Much like Halprin (2000) and Lerman (2012), the personal material of the individuals involved were used as creative inspiration. What differentiates her work, however, is that Chace allowed her patients to create and perform the material, rather than using this material, choreographing a dance, and then placing the dance on professional dancers (Grubin et al., 1997; Halprin, 2000; Lerman, 2012). Her patients were involved in each part of the process, empowering them as creative individuals. Chace may not have called her work performance as therapy, but she certainly was using it as a therapeutic intervention and outlining the intervention for later use in DMT.

**Janet Adler.** In addition to Marian Chace's early DMT work, the dance/movement therapist Janet Adler has also influenced the use of performance as therapy. Adler's DMT theoretical framework is known as Authentic Movement. In Authentic Movement, Adler (1996/1999a) hopes to engage clients in a process of bringing, "unconscious material into consciousness through embodiment" (p. 197). She does this by inviting clients to work in pairs. During the Authentic Movement process, the individuals in a pair exchange roles of the witness

or the mover (Adler, 1987/1999b). As a mover, an individual is asked to move authentically, to allow the body to respond to inner impulses. While this occurs, witnesses are required to observe the movers and also any personal responses they have to the witnesses as they watch (Adler, 1987/1999b). The movers and witnesses then verbalize their reactions. Both the movers and the witnesses discuss their personal experience, stating any memories, sensations, or thoughts that occurred while moving or witnessing (Adler, 1987/1999b). The verbalization of this process assists the bringing forth the unconscious material into consciousness (Adler, 1996/1999a), because often times the mover may not recall what movement came forth while being witnessed.

The two main objectives of Authentic Movement are to assist clients in becoming their own witnesses (Adler, 1987/1999b), as well as increase their sense of belonging to the therapy group (Adler, 1996/1999a). During the process of dialogue between the mover and the witness, the mover begins to internalize the witness and their feedback (Adler, 1987/1999b). Through that process, the movers gain a heightened awareness of their own processes while moving authentically. Eventually, movers can act as their own witnesses, witnessing themselves while moving from inner impulses (Adler, 1987/1999b). In addition, the verbal processing between the mover and the witness is highly validating for the mover. The feedback offered both honors the mover's experience and acknowledges the authentic movements that occurred. In doing so, the process of Authentic Movement validates the uniqueness of each individual group member, so that each member feels a sense of belonging in the group (Adler, 1996/1999a).

Adler's theoretical framework of Authentic Movement does not necessarily use performance as an intervention within the therapy process; nor does she classify the Authentic Movement process as performance-based. However, the role of the mover and the witness does

reflect that of a performer and an audience member, both active roles within a performance (Olsen, 2007). The performer, whether performing choreographed movement or improvising, often draws upon a sense of themselves during the performance to make it a more authentic performance. This, of course, is witnessed by the audience, who often draw upon personal material to make sense of and give value to what they observed in a performance (Olsen, 2007/). Olsen (2007) suggested that both the performer and audience member are in a sort of Authentic Movement process together, which may or may not lead to some sort of personal change in either individual. The roles of mover and witness in Adler's (1987/1999b) Authentic Movement have a similar relationship as a performer and audience member. This gives support to the DMT intervention of performance as therapy, which often gives therapy clients an opportunity to perform for an audience while continuing to address their therapeutic goals in the process.

Both the work of dance/movement therapists Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Chace & Bunny, 1962/1993) and Adler (1987/1999b, 1996/1999a; Olsen, 2007) give support to performance as therapy as a DMT intervention. Chace used performance while working with individuals with schizophrenia both at St. Elizabeth Hospital and Chestnut Lodge. She worked with her patients to create shows and performance vignettes that helped her patients process personal material and work together in a creative process (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Chace & Bunny, 1962/1993). Adler's theoretical framework of Authentic Movement created the roles of mover and witness, which reflects the roles of performer and audience member seen in performance as therapy. Her framework emphasized the importance of belonging and mindfulness of self through the dialogue between these roles, oftentimes validating the movers' uniqueness in moving authentically (Adler, 1987/1999b). Both of these dance/movement therapists' work laid the

framework for the method of performance as therapy. Contemporary dance/movement therapists have built upon these frameworks to give both definition and depth to the intervention.

### **Performance as Therapy Models**

The influences of Marian Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Chace & Bunny, 1962/1993) and Authentic Movement (Adler, 1987/1999a, 1996/1999b; Olsen, 2007) have shaped the intervention of performance as therapy, however it is still not prevalent within the DMT community. The therapeutic effects of dance performance are apparent in professional dance and are known among dance/movement therapists. Yet, this intervention is not often used in DMT settings. Furthermore, there is little research and published work about this technique. As a DMT intervention, performance as therapy, appears to be a relatively new concept in DMT. The only DMT graduate program, of the six accredited by the ADTA that has dedicated an entire course about performance as therapy is Columbia College Chicago Dance/Movement Therapy and Counseling Department. The course is an elective titled Performance as Therapy (Columbia College Chicago, 2011). Although the therapeutic component of dance is prevalent in professional dance, the notion of performance as therapy in the DMT realm is somewhat elusive.

Despite its elusiveness, some DMT researchers have attempted to build upon the framework of performance as therapy, hoping to codify the intervention. Gates (2006) conducted three case studies, including a total of 18 young adult women, in hopes of further defining performance as therapy. From her results, Gates (2006) defined performance as therapy as “dance creation for the purpose of performance involving dance/movement therapy techniques within a therapeutic environment” (2006, p. 5). An important distinction that Gates made in her research is the therapeutic environment in which the creative process takes place. The

therapeutic environment, which may occur at an array of clinical settings, differentiates the intervention from therapeutic dance. Gates (2006) described the therapeutic environment as an environment that includes, “validation, trust, support, connection to self and others, and vulnerability” (p.5). These factors allow for therapeutic goal achievement and mindfulness for performance as therapy participants. Gates (2006) stated that if performance as therapy is to be defined as a DMT intervention it must be in the context of the therapeutic environment, again differentiating it from therapeutic dance.

Gates described performance as therapy further by outlining two techniques that organically arose during the research participants’ creative process. The first technique of performance as therapy facilitated participants (or clients) through developing and rehearsing choreography created completely by them. Participants explored themes salient to their personal lives, improvised movement around these themes, and then set whatever movement that felt authentic to these themes. This choreography would then be rehearsed and performed (Gates, 2006). This technique reflects the process in which Jones (Grubin et al., 1997) facilitated with terminally ill individuals in his survival workshops. Both Gates and Jones validated their participants as creative individuals; however, Gates (2006) did this for therapeutic growth rather than artistic purpose. In the second performance as therapy technique outlined by Gates (2006) the therapist created choreography for the performance as therapy participants. The participants then interpreted the movement in their own bodies. Gates noted that when the second technique was used the participants made the movement their own as they interpreted the choreography which deepened the meaning of movement, as it relates to their personal experience (Gates, 2006). Gates’ research further defined performance as therapy and outlined therapeutic

techniques to assist in the creative process. Her findings again differentiate the intervention from the therapeutic use of dance.

Goldman and Larsen (2011), have also defined performance as therapy within DMT. Goldman and Larsen are pioneers of the intervention, and are also the instructors for Columbia College Chicago's (2011) elective course Performance as Therapy. From their experience in teaching this elective course, Goldman and Larsen (2011) have outlined a framework for the DMT intervention. They viewed choreography and the process of choreographing as a means for performance as therapy participants to problem solve in a way that may outwardly express their inner world. Goldman and Larsen (2011) defined performance as therapy as a DMT intervention that allows clients to be seen within their creative process (K. Larsen, personal communication, November 1, 2011). Their emphasis on being witnessed in the process reflects Adler's (1987/1999b; Olsen, 1993) DMT framework of Authentic Movement. Like Gates (2006), Goldman and Larsen (2011) have offered a framework for performance as therapy.

Their framework encompassed a four stage process that includes request, claim, promise, and execute. The request stage parallels Adler's (1987/1999b) Authentic Movement, in that Goldman and Larsen (2011) defined this stage as an opportunity for performance as therapy participants to find "an inner impulse to move" (p. 6) that inspires unique movement exploration. As the impulses manifest, they may begin to repeat and become choreographed movement, taking the performance as therapy participants into the second stage, known as claim (Goldman & Larsen, 2011). During the claim stage, the participants notice and concretize which movement bests explores their personal subconscious thoughts and feelings. Goldman and Larsen (2011) believed that as the participants explore the meaning behind the set choreography, they transition into the promise stage. In this stage, participants must commit to not only the meaning of the

choreography, but the choreography itself as it will be later performed in the execute stage. During the promise stage, Goldman and Larsen (2011) hoped to deepen the performance as therapy process as it highlights the personal connection a participant makes to the movement and reflects any insight the participant gained. In addition, participants must also decide to perform as a soloist or with other participants during the promise stage (Goldman & Larsen, 2011). Goldman and Larsen (2011), like Gates (2006), also emphasized the therapeutic environment in this stage. They too stressed the importance of providing a safe environment that would help promote exploration in the promise stage. This exploration may elicit therapeutic growth as it relates to treatment goals (Goldman & Larsen, 2011). In the final stage of the process, known as execute, performance as therapy participants set the final choreography and perform in a “salon” (Goldman & Larsen, 2011 p.8) to receive feedback about the dance from peers and facilitators. Performances of the final choreography are then opened to the public; performing for peers, family, and community members (K. Larsen, personal communication, November 1, 2011). The feedback can restart the process and bring the process back to the request stage. These four outlined stages are one framework provided for performance as therapy within the DMT literature.

Goldman and Larsen’s (2011) framework reflects Gates’ first technique of performance as therapy. Like Gates’ (2006), their performance as therapy process allows the movers/clients to create and choreograph their own movement rather than the therapist choreographing movement for movers/clients to perform (Goldman & Larsen, 2011). This framework also parallels that of Halprin (2000) and Jones’ (Grubin et al., 1997) choreographic processes in creating therapeutic dance. Yet, instead it uses therapeutic techniques as a way to facilitate clients in a clinical setting to create and choreograph movement that will eventually be

performed (Goldman & Larsen 2011). Both Gates (2006) and Goldman and Larsen (2011) attempted to define and provide a practical framework for performance as therapy—allowing for future dance/movement therapists to use this intervention. They hoped to differentiate performance as therapy and therapeutic dance by stressing the therapeutic environment and techniques that facilitate the creative process in a clinical setting.

Allegranti (2009) has also outlined a framework for using performance in DMT. Allegranti's (2009) work is not referred to as performance as therapy, but rather, "offers a model of 'Embodied Performances' that combines elements of [DMT], performance, and feminism" (p. 17). Although bearing a different name, embodied performances is conceptually similar to performance as therapy. Allegranti's (2009) framework stemmed from her clinical practice as a dance/movement therapist and research conducted over a one year time span. Her research, a case study including a total of nine adults, used dance improvisation and performance as a means to explore and redefine sexual identity (Allegranti, 2009). Over the one year time span, the nine individuals met for three cycles consisting of six days, meeting at what Allegranti (2009) coined as "The Lab" (p. 19). The Lab resembles the therapeutic environment Gates (2006) and Goldman and Larsen (2011) stressed in their framework of performance as therapy.

Unlike Gates (2006), Allegranti (2009) specifically highlighted the physical elements of the therapeutic environment of The Lab. She did this by dividing the therapy room into four quadrants titled, "body, sexuality, gender, and relationship" (Allegranti, 2009, p.20). The research participants were invited to explore the four quadrants, improvising movement that felt genuine in relation to the four topics. The Lab was monitored by a video recorder. The improvisational nature of Allegranti's (2009) framework is similar to Authentic Movement (Adler 1987/1999b, 1996/1999a; Olsen, 2007). In her process, Allegranti (2009) invited



participants into an Authentic Movement like process with not only each other as witnesses, but also with the video camera. Allegranti (2009) demonstrated in her research that the video camera offered another way for participants to be seen. After movement exploration was finished within the four quadrants, research participants verbally discussed their individual process (Allegranti, 2009), as seen in the other two frameworks of performance as therapy (Gates, 2006; Goldman & Larsen, 2011).

The footage gathered during The Lab DMT sessions were then used to create a video that was screened for a live audience, individuals of the community in which the research took place (Allegranti, 2009). In screening the film from The Lab, Allegranti (2009) hoped to create a community dialogue about body, sexuality, gender, and relationships. This step in her embodied performance framework resembled the community activism apparent in both Halprin (2000) and Lerman's (2012) creative processes. However, Allegranti's (2009) background as a dance/movement therapist again differentiates her work from therapeutic dance. Allegranti (2009) did not emphasize the therapeutic outcomes of her research, but instead emphasized the structure of the embodied performances framework. Her research has provided dance/movement therapists with yet another framework for performance as therapy, one that integrated video recording in DMT practice. Allegranti's (2009) framework may be used to address therapeutic goals and treatment plans for specific clients based on the discretion of the therapist (e.g. increasing clients' self-awareness about body, sexuality, gender, and relationships). Further, it may also inspire thoughtful conversations within the greater community in which the performance as therapy is occurring.

Gates (2006), Goldman and Larsen (2011), and Allegranti (2009) have attempted to define and provide a practical framework for performance as therapy. They differentiated

performance as therapy and therapeutic dance by stressing the therapeutic environment and techniques that facilitated the creative process in a clinical setting. Their research emphasized the therapeutic value of facilitating DMT clients through an artistic process, one including dance improvisation and performance. All of the frameworks aligned the creative process to therapy goals and treatment plans (as outlined by a clinical setting) and drew upon counseling skills to make meaning of the process in verbal discussions. Gates (2006), Goldman and Larsen (2011), and Allegranti's (2009) theoretical frameworks have given future dance/movement therapists a guide as to how to use performance as therapy.

### **Applications of Performance as Therapy Models**

Gates (2006), Goldman and Larsen (2011), and Allegranti (2009) have contributed to the DMT literature by providing an outline for performance as therapy. Their work has given future dance/movement therapists guidelines on how to use this intervention technique in a clinical setting. Although Gates (2006) and Goldman and Larsen (2011) have suggested specific positive therapeutic outcomes in their processes, the strength of their work is that it defined performance as therapy and distinguished it from therapeutic dance. Other dance/movement therapist researchers (Cook, 2008; Lister et al., 2009; Malling, 2012; Snow et al., 2003) have begun to explore the implications of this intervention when working with a variety of clients in DMT settings. Cook (2008) and Malling (2012) refer to the frameworks of Gates (2006) and Goldman and Larsen (2012); whereas Lister et al. (2009) and Snow et al. (2003) have created their own framework, one that integrated the creative arts therapies. These researchers have demonstrated the explicit effects of performance as therapy on DMT clients and support how it is a promising intervention.

Dance/movement therapy researcher, Malling (2012), showed support for performance as therapy in her study which included a total of four deaf adults with severe chronic mental illness. Malling's (2012) research, mixing participatory research and artistic inquiry methodologies, spanned a two month period. In these two months, Malling (2012) and her participants, who she referred to as co-researchers, met for one hour long DMT sessions. They collaboratively worked together and created a performance, titled *Haunted House*, for their day rehabilitation community. Each DMT session included an, "informal check-in, review and [practicing] previous week's material, [continuing] choreographing [the] piece, and verbally [processing] the day's rehearsal" (Malling, 2012, p. 24). During the process, Malling (2012) drew upon the performance as therapy framework of Gates (2006) and emphasized the importance of the therapeutic environment. Although Malling (2012) identified as the facilitator of the therapy group, she noted that many of the performance aspects were based upon her co-researchers' artistic choices. This is not only drawn from Gates' (2006) framework by allowing the co-researchers' to choreograph the show, but is also similar to Chace's (Chace, 1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d) work with her patients in *Hotel St. Elizabeth*.

The results of Malling's (2012) study reinforced support for performance as therapy as an intervention that helped her clients address their therapeutic goals. Malling (2012) observed in her co-researchers an increase of interpersonal skills, group attendance, and engagement through the creative process. Also, there was an increase in her co-researchers' capacity of "authentic emotional expression" through the development of each individuals character (Malling, 2012, p. 34). All of these results addressed the treatment plans of the co-researchers and the overall treatment culture of the rehabilitation facility in which the research occurred (Malling, 2012). Drawing upon the aforementioned frameworks of performance as therapy (Gates, 2006;

Goldman & Larsen, 2011), Malling (2012) has provided the DMT literature with an example of how the intervention may affect DMT clients. Further, her research has provided support for the intervention, suggesting that it can be used to assist clients in obtaining therapy goals.

In addition to Malling's (2012) application of performance as therapy, there has also been research of using performance with individuals with DD. Some of this research (Cook, 2008) has been influenced by previous performance as therapy frameworks (Gates, 2006; Goldman & Larsen, 2011), whereas other research on the topic has not (Lister et al., 2009; Snow et al., 2003). Regardless of the influence, these studies are examples of using performance as an intervention tool for individuals with DD.

Cook's (2008) research, a clinical case study, is a specific example using performance as therapy involving individuals with DD. In her research, Cook (2008) used performance as an intervention technique when working with children with DD in a school setting. The study included a total of nine children described as "mild to moderately delayed" (Cook, 2008, p. 30). The participants of the study were chosen by Cook (2008) due to their prior involvement in DMT. The clinical case study consisted of weekly one hour therapy sessions for 10 weeks. At the beginning of the research process, Cook (2008) observed the participants while they improvised in a traditional Chacian DMT session (Levy, 1987). She then used this movement to choreograph a dance that she later taught to the group. Cook's (2008) choice to teach her research participants movement reflects Gates' (2006) second performance as therapy technique, where the facilitator gives movement to participants to perform.

Later in the process, the DMT group used the session time to rehearse for two performances and verbally process. One performance was held at Columbia College Chicago, and the other was at the school where the data collection took place (Cook, 2008). Cook (2008)

noted that verbally processing was “unattainable” for her participants (p.34). In order to maintain this important step of performance as therapy she would verbally reflect the process to the group. These reflections included accomplishments and therapy goals her participants had worked on during group time (Cook, 2008).

The results of Cook’s (2008) research showed support for using performance as therapy with individuals with DD, specifically children. Cook (2008) initially identified difficulty in engaging research participants in the structure of the group (warm-up, rhythmic activity, theme development, and closure), noting that they were not engaged in the group process and “acted out” (Cook, 2008, p. 51). However, as the creative process continued and involved rehearsal she noticed a shift in her research participants. The research participants worked on interpersonal skills and communication skills by processing various emotions that arose in the rehearsal and performance process (Cook, 2008). Like Malling (2012), Cook’s (2008) research showed the various therapeutic effects on DMT clients when using performance as therapy. Both researchers found using performance increased clients’ group engagement and social interpersonal skills (Cook, 2008; Malling, 2012). Furthermore, both researchers drew upon the frameworks provided by earlier dance/movement therapists (Gates 2006; Goldman & Larsen, 2011) and provided support for these frameworks as well as the intervention itself.

Further research about the use of performance with individuals with DD has been conducted at the Centre for the Arts in Human Development, located in Montreal, Canada (Lister et al., 2009; Snow et al., 2003). Dance/movement, drama, music, and art therapies are all provided at the Centre, which specifically services adults with DD. A theatrical show was produced every two years, drawing upon the influence and expertise of each creative arts therapies (Snow et al., 2003). The process of creating a theatric show at the Centre was done

with consideration to the specific clients' therapy goals and treatment. The rehearsal and performance process was community oriented and rehearsals occurred during the creative arts therapy sessions. In addition, verbal processing occurred after the clients performed (Lister et al., 2009; Snow et al., 2003), which again is an integral component of performance as therapy.

In a study conducted at the Centre, observation notes were collected over a three month period. There was a total of 20 participants in the study, who were interviewed both before and after the performance of *The Legend of Pinocchio* (Snow et al., 2003). The researchers found that as the rehearsal process continued, the cast of *The Legend of Pinocchio* expanded their creative abilities and showed signs of adaptability and an increase in social skills (Snow et. al, 2003). These results are similar to the results of Malling (2012) and Cook (2008) in their respective performance as therapy processes. Furthermore, the use of performance at the Centre when working with adults who have DD is much like Goldman and Larsen's (2011) premise—that rehearsing and performing provided an opportunity for clients involved to be seen in their creative processes and grow therapeutically (Lister et. al, 2009; K. Larsen, personal communication, November 1, 2011). Research conducted at the Centre (Lister et al., 2009, Snow et al., 2003) has further provided support for using performance as therapy when working with adults with DD, indicating that rehearsal and performance can help clients address their therapy goals. Although this research included other creative arts therapies, it still shows support for performance as therapy in the DMT literature.

The aforementioned research (Cook, 2008; Lister et al., 2009; Snow et al., 2003) is progressive because it used creative interventions, such as dance improvisation and performance, with individuals who have DD, as this is not prevalent within the published DMT literature. Instead, more concrete therapeutic techniques are offered in older literature (Leventhal, 1980;

Levy, 1987; MacDonald, 1992) when working with this specific population. Dance/movement therapy techniques historically offered for this population usually include rhythmic techniques, in the form of clapping or stomping, as a means to orient group members with DD (Levy, 1987, MacDonald, 1992). The use of movement repetition is also prescribed so that clients will experience mastery over various movements (Leventhal, 1980; Levy, 1987). The overall focus of treatment plans and goals with individuals with DD in the published DMT literature is usually to increase perception of body parts and the body moving in space, as well as increasing interpersonal skills among group members (Leventhal, 1980; Levy, 1987; MacDonald, 1992). Although these interventions engage DMT clients in creative movement, the interventions themselves are not necessarily creative. Unlike Cook (2008), Lister et al. (2009), and Snow et al. (2003), these interventions are concrete in nature; which may or may not reflect a bias within the published literature that individuals with DD lack have the capacity to partake in creative interventions (J. Salemi, personal communication, March 23, 2012; Stameltos & Mott, 1986), such as performance as therapy.

## **Summary**

There has been a long-standing emphasis on the use of dance and movement as a means to elicit therapeutic effects. In the dance profession, choreographers (Axis Dance Company, 2009; Grubin et al., 1997; Halprin, 2000; Lerman, 2011) have used this therapeutic phenomenon to create thought-provoking dances to elicit either change or catharsis in those involved with the performance process. Dance/movement therapists also understand the powerful effects of performing (Chace 1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Chace & Bunny 1962/1993) and being witnessed while authentically moving (Adler 1987/1999b, 1996/1999a;

Olsen, 2007). They related the clients' treatment goals and plans to the creative process and validated their clients as artistic human beings.

The theoretical framework and therapeutic components of performance as therapy has mostly been ignored within the published DMT literature. Only recently have dance/movement therapists attempted to define the intervention in hopes of concretizing what it is it looks like (Allegranti, 2009; Gates, 2006; Goldman & Larsen, 2011). Even more recently, dance/movement therapist researchers (Cook, 2008; Lister et al., 2009, Malling, 2012; Snow et al., 2003) have conducted research on not just the theoretical framework of performance as therapy, but also about the effect the intervention has when working with clients in a DMT setting. Their work has begun to give performance as therapy depth and context within clinical work.

Previous research has inspired me to expand my study of the DMT intervention, performance as therapy. In addition, my own personal positive experiences in creating and performing dance and my clients' enthusiasm for performance during my experience as a DMT intern has motivated me to further explore the DMT intervention. I wondered if this intervention was one that could be used with adults with DD in a DMT setting. Further, I wondered if this intervention would be helpful in addressing goals focusing on increasing social interpersonal skills, as this was the main treatment focus of the rehabilitation center where I did my research.

As a researcher, I questioned what the structure of performance as therapy would look like when working with adults with DD. Would it be more conducive to allow my clients to organically create movement as in Malling's (2012) research? Or, would it be more helpful to provide movement for my clients (Cook, 2006; Lister et al., 2009; & Snow et al., 2003) and have them perform that instead? With this in mind, I created my research question: How can



performance as therapy be used as an intervention when working with adults with DD in a DMT setting?

The purpose of my research was to further understand performance as therapy as a DMT intervention and how this intervention technique can be used when working with adults with DD. I hoped that the theoretical framework of performance as therapy outlined by my research would provide the DMT literature with yet another approach to this intervention. In doing so, my research might give further definition and depth to the use of performance as a modality of therapy in a clinical setting. Within my research, I explored the idea, as creative arts therapists have done before me (Cook, 2006; J. Salemi, personal communication, March 23, 2012; Stameltos & Mott, 1986), that despite their diagnoses, adults with DD want to be seen in an artistic way. Choreographing and performing movement may be a profound way to do this. In my research, I intended to deconstruct the bias that adults with DD are unable to partake in creative interventions that currently resides in the published DMT literature. My research may also serve as a guide to using performance as therapy for dance/movement therapists who work with this population. In addition, I hoped my research would give further visibility to adults with DD in the DMT literature, which is currently severely lacking.

## **Chapter Three: Methods**

### **Methodology**

I utilized artistic inquiry inspired methods in conducting my research. Artistic inquiry, as outlined by Hervey (2000), utilizes art making in any or all of the research process; art making may be used to collect, analyze, or present data. By nature, this methodology also engages researchers in a creative process, and thus is motivated by the researchers' creative aesthetics. Often research participants using artistic inquiry methods engage in the art making or creative process alongside the primary researcher. They also assist in many aspects of the research process, such as collecting and analyzing data. Due to their involvement in the research process, I considered the participants of my study as "co-researchers" (Reason, 1998, p. 262; Schneider et al., 2004, p. 564). Since the participants of my study actively and willingly engaged in a creative process to create a dance show, they will from now on be referred to as co-researchers.

I chose methods based on the artistic inquiry methodology as a means to inform my research due to its emphasis on creativity, as this supports the creative nature of performance as therapy. My intention throughout my research was to utilize performance as therapy as an intervention in order to engage my co-researchers, adults with DD, in a creative process. As Hervey (2000) points out, creating art helps artists discover new ways of conducting research, and that research, "evolves from a consciousness changed by emerging information" (p. 60). There is a lack of literature or pre-existing methods for utilizing performance as therapy with this specific population. The methods I chose, based on artistic inquiry, supported the notion that the structure of performance as therapy was something that could emerge from my co-researchers' creative process in the here and now. My methodology choice empowered my co-researchers by giving them permission to define performance as therapy as it fitted their needs. It also

emphasized that they were in fact creative individuals; a notion not seen in much of the previous literature (Macdonald, 1992; J. Salemi, personal communication, March 23, 2012; Stamatelos & Mott, 1986).

Further, artistic inquiry inspired methods emphasizes the importance of tacit knowledge, which is another reason why I chose this methodology. Tacit knowledge is the knowledge in which we perceive and know, but have a hard time expressing verbally (Hervey, 2000). Tacit knowledge exists somewhere between consciousness and sub-consciousness, but may be expressed as something we feel or express abstractly through art making (Hervey, 2000). Artistic inquiry's emphasis on tacit knowledge goes well with the nature of my co-researchers' diagnoses. The common diagnosis amongst all of my co-researchers is mental retardation which limits their cognitive processing skills. My co-researchers often have trouble expressing themselves verbally due to having limited vocabularies or difficulties with processing abstract ideas (Morrison, 1995). Artistic inquiry supports my co-researchers by allowing them to utilize art (and in this case, dance improvisation) to express themselves and what they know tacitly. Thus, this allowed my co-researchers to explore their aesthetic sense, an important component of the methodology. Engaging in artistic inquiry processes allowed them to further research what it is about dance improvisation, and more formally performance as therapy, that allows them to connect with one another, as well as express themselves artistically.

## **Methods**

**Co-researchers.** The co-researchers of this study included individuals all of whom have been described as having DD. Developmental disabilities is an umbrella term to categorize an array of diagnoses (Morrison, 1995), and are not specifically listed in the *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.)(*DSM-IV-TR*). However, the diagnosis

of mental retardation is a diagnosis that all of my co-researchers shared. Mental retardation is a disability that influences an individual's intellectual capacity, as well as adaptability to daily life demands as it relates to biological age (American Psychiatric Association, 2000). An individual with mental retardation may be impaired in an array of skills, such as communication, relational skills, and self-care. Mental retardation is diagnosed before the age of 18 and is categorized as mild, moderate, or severe (American Psychiatric Association, 2000). My co-researchers are all diagnosed with mental retardation. Some of them also have diagnoses of autism, bipolar mood disorder, and pervasive developmental disorder.

In addition to this diagnostic commonality, all of the co-researchers are members of a day rehabilitation program, located in the Chicago area that focuses on providing services to adults with DD. The data was collected in the program's creative arts therapy track, specifically in the DMT studio. This studio is where I and the co-researchers met on a weekly basis, engaging in the dance/movement therapy group titled, "Performance as Therapy." Progress notes and session notes were either written in my office or at home.

The "Performance as Therapy" group contained a total of 10 members, five women and five men. The members represent Caucasian, African American, and Hispanic ethnicities, ranging in ages from 21 to 65. Co-researchers did not live at the day program where the data was collected, but instead lived in group homes or with family members.

Co-researchers were not selected for the research group, per se, but rather signed up for "Performance as Therapy" based upon their own volition. The research group was offered as part of the program's summer 2012 trimester curriculum, amongst other creative arts therapy groups. Co-researchers signed up for the research group through their personal case manager. During this process co-researchers had the opportunity to sign up for, in addition to my research

group, an array of groups offering other creative arts experiences, vocational opportunities, and social recreational activities. Some co-researchers, however, were pre-registered for the group by me before the start of the initial session. Co-researchers who were pre-registered expressed desire to be part of the group during previous personal contact with me, as the primary researcher of the study.

**Procedure.** Once co-researchers were registered for the “Performance as Therapy” group, we met before data collection commenced. In this meeting, I verbally explained the nature of the study. I also read the informed consent form (see Appendix B) out loud to the group and answered any questions the prospective co-researchers had. If the co-researchers were their own guardians they could ethically sign an informed consent form. However, not all co-researchers are their own guardians. Most co-researchers lived with their legal guardians (legal guardians were often family members) and were able to take the informed consent sheet home to be signed. If this was the case, the co-researchers also had to sign an assent form (see Appendix B), which allowed their legal guardians to agree to participation on their behalf. Two co-researchers’ informed consent forms were faxed to their legal guardians, as they did not live with these persons. After this meeting, co-researchers had two weeks to decide if they would like to be a part of the “Performance as Therapy,” research group, as well as submit a signed copy of all informed consent and assent forms.

After the allotted two weeks, 10 co-researchers submitted the informed consent documents and data collection began. For a total of seven weeks the co-researchers and I met once a week for an hour and a half long DMT session titled “Performance as Therapy.” In order to respect my co-researchers’ creative processes I allowed them to shape the structure of the group (Hervey, 2000), acting as a container for the group rather than the primary facilitator

(Winnicot, 1965). My co-researchers determined the sequence of events during each group session, and I would occasionally intervene where I saw necessary. My primary focus, however, was maintaining group safety by creating an environment where my co-researchers felt safe exploring their creative process.

The group began with a short verbal check-in. One of the co-researchers or I would verbalize the group norms of respect and safety during the check-in. Next, one group member would volunteer to perform for the rest of the group, choosing which music he or she would like to perform to. The performance could be described as a dance improvisation, and the movement was spontaneously chosen as the dancer performed.

After each performance, as the group's facilitator I would verbally ask what the co-researchers saw in the performance they had just witnessed. This sequence would continue throughout the group; however, some performances were duets, trios, or even the group in its entirety. Co-researchers had the volition to choose to perform and choose their performance music, or they could actively choose to be an audience member. At the end of the group, I again verbally checked in with the co-researchers in order to reflect the group's creative process as a whole.

Following each session, as the primary researcher, I would reflect on the group professionally in the form of a session report, and personally in the form of a research journal. In the session reports I objectively wrote what happened within each group and how this related to the primary group goal of increasing interpersonal skills among group members. In my personal journal, I reflected on my personal experience during each group, reflecting on co-researchers' movements and verbal expressions, as well as my own thoughts on possible group themes. I also noted the attendance of each session (see Appendix C), as well as tracked three of the co-

researchers personal goals (see Appendix D) that were associated with the “Performance as Therapy” group outlined by the day rehabilitation staff. Goals were recorded weekly within the program’s goal tracking binder by placing a check mark on the goal tracking sheet. All of the program’s clients had a personal goal tracking sheet within the binder, but only three were associated with the research group.

As the process continued, I encouraged the co-researchers to begin composing choreography they would like to set for a group piece (possibly movement that they had witnessed other co-researchers perform or movement they had performed themselves during a dance improvisation), as this was the intention at the beginning of the research project. Although co-researchers seemed enthusiastic about creating a group dance they postponed working on it. In the first few sessions there was a trend of postponing working on a group dance. However, the initial structure, a series of dance improvisations, remained constant.

Acknowledging the trend of hesitation to create a group piece, I suggested during session four the structure of the group mirror the structure of the show; that is, the show would consist a series of set dance improvisations. The co-researchers agreed. Herein lay one ethical concern that arose during the research process. Due to the nature of my co-researchers’ primary diagnosis of mental retardation, as the primary researcher I had to be mindful about the suggestions I gave during groups. The co-researchers lack of capacity to verbally express themselves or to understand abstract ideas may decrease their capacity to understand the suggestions I gave them. If this was the case, then the creative process which was emerging in the group would reflect my own aesthetic instead of my co-researchers’. In order to fit my co-researchers’ needs I delivered all creative suggestions concretely to ensure that they would understand.

To remain true to my co-researchers' aesthetic and creative process, I utilized member-checking. Member checking is imperative to maintaining credibility within the research process, and may be as simple as verbally checking in with the co-researchers during the data collection process (Mertens, 2010). During each session, I would verbally reflect back to co-researchers what was occurring. I did this both as a way to check-in with co-researchers but also as a way to inform me as the dance/movement therapist where the group was in their creative process. At the end of each group I would also verbally reflect the entirety of the group process to the co-researchers, and engage them in a verbal conversation about their personal experiences.

I also utilized member-checking when I would suggest ideas that had the potential to shape the creative process. When I suggested that the structure of the show reflect the structure of the group, I followed up by asking co-researchers if this was okay or if they had different ideas for the final performance. This gave my co-researchers an opportunity to veto my suggestion and suggest an alternative. Using these techniques gave my research credibility, and allowed the creative process to accurately reflect my co-researchers' artistic aesthetic.

Collaboratively, the co-researchers set the order of who would perform during the show. The show consisted of a solo, a duet, a trio, and a final group dance. At this time, co-researchers also chose the music they would perform to and the title of the show. The final performance was performed on-site at the day rehabilitation center. The audience consisted of other day rehabilitation participants, as well as staff members. The final performance was also video recorded. One week following the show, the group met a final time to verbally process the experience of the final performance. As the primary researcher, I also gave each co-researcher a participation certificate, as this was requested previously by one group member.



Another ethical concern which arose during the research process was refusing services to clients who were not a part of the research group. Although each of the day rehabilitation clients have a set schedule of therapy groups, it is a part of the community's culture and treatment philosophy to allow clients to attend whichever group they would like. This often results in clients who are not registered for a specific therapy group to attend any group at any given time. However, this poses an ethical concern for the "Performance as Therapy" group since this was a research orientated group. The only members who could ethically participate in this group were those who had previously signed an informed consent and assent document.

During the process, I had to turn away various clients who attempted to join the group in order to maintain ethical standards. Denying any day rehabilitation client of dance/movement therapy services does not appear to be in a client's best interest. However, I was able to do so with the knowledge that they would be able to receive comparable creative arts therapy services elsewhere. During the "Performance as Therapy" time slot a music therapy and an art therapy group were being held. If a participant that was not a part of the research group attempted to join "Performance as Therapy" I would verbally re-direct them to join either of the two other creative arts therapy groups to receive comparable services.

**Data Analysis.** As is the case with most qualitative research studies data analysis occurs during the research process. As Merten's (2010) points out, data analysis in qualitative research is "recursive" (p. 424), such that the findings come forth during the process and not solely at the end. During my own study, I allowed this notion to influence my data analysis, and I analyzed data on different levels throughout my research process. Initially, my co-researchers and I analyzed what was happening during the group verbally in each session, reflecting on the movement we had witnessed, as well as the overall group dynamic. We would often reflect on

what had occurred in previous groups to inform us about what we would like to do in the current session. This was our way of noting our first impressions about our creative process (Hervey, 2011; Mertens, 2010), and how this would influence our final dance performance.

In addition to member-checking and recursive reflecting, I also used dialogue transcript to analyze data. Dialogue transcript is a data analysis technique outlined by Hervey (2000), and is one of two ways to analyze data within an artistic inquiry. Such dialogue occurs between the artist and the art, as it is a way for the researcher to respond to the art being created. During my research, dialogue transcript occurred between co-researchers either during or after performances. Many times throughout the sessions co-researchers who took active roles as audience members would respond to the movement they were witnessing. As the performer was improvising while performing, audience members would actively reflect, mirror, or authentically respond via movement. In doing this, the co-researchers were responding simultaneously to the art that was being created in an organic way as it arose and engaging in a dialogue transcript. This type of analysis is important to note since many of the members in the group do not solely depend on verbal communication to express themselves, due to the nature of their disability. As the primary researcher, I also engaged co-researchers in a verbalization of a dialogue transcript by asking them to reflect on what they had witnessed after each performance.

Further, as the primary researcher I also used theme analysis to increase the meaning of each session report, as well as my personal journal entries. I also viewed the video recording of the final performance in order to gather more information about the creative process of the “Performance as Therapy” group. Mertens (2010) would describe this as a deeper analysis of the data collected, one in which the researcher attempts to find themes, commonalities, or differences in the data. This form of data analysis occurred after the data collection stage was completed.

To analyze the data further, I also compiled the final attendance numbers for each co-researcher as well the goal percentage achieved by three specific members whose goals were affiliated with “Performance as Therapy.” Simply, I calculated the amount of sessions attended by each co-researcher out of the total of seven sessions. During the research process I also tracked three of the members’ goals. An example of a goal tracked for one client is, “Client will engage as an audience member in Performance as Therapy 75% of the groups per month for the summer 2012 trimester.” At the end of data collection, I compiled the percentage achieved by each of the three members. Although this data is numerical I did not analyze this data in a quantitative way, which would ultimately shift the focus of my artistic inquiry. Instead, tracking the attendance and goals of co-researchers was to both support and supplement the qualitative data my study gleaned.

## **Chapter Four: Results**

The intention of my research was to examine performance as therapy, as a type of DMT intervention. I also hoped to contribute to the DMT literature by writing about a topic that is not heavily researched. Further, the study examined the use of this intervention when working with adults with DD in a DMT setting. My study hoped to realistically answer: How can performance as therapy be utilized as an intervention when working with adults with DD in a DMT setting? In addition, I also wondered if working together to choreograph a group dance would address the co-researchers' primary goal of increasing social interpersonal skills. I wondered if the process of performing for and witnessing each other would also address this goal.

Initially, I hoped that my co-researchers and I would collaboratively create a group dance that would be performed for the day rehabilitation community, because this modeled previous uses of performance as therapy (Cook, 2008; Gates, 2006; Goldman & Larsen, 2011; Lister et al., 2009; Malling, 2012; Snow et al., 2003). However, as noted in Chapter Three, the research group did not in fact create a group dance but rather performed a series of dance improvisations, or creative processes. This performance as therapy structure came forth organically and was based upon my co-researchers' volition, as well as my willingness to trust the co-researchers' creative process.

Although the format of performance as therapy that I initially hoped to engage my co-researchers in changed, my research questions were addressed. In fact, the new outlined structure of the intervention deepened the experience of the artistic inquiry and gave more meaning to my results, because it was my co-researchers who defined performance as therapy in their own way. They facilitated the creative process during the DMT sessions, which permitted the co-researchers to define performance as therapy. The structure they created still included

important aspects of previous uses of performance as therapy such as performing, witnessing, and verbalization of the performance process (Cook, 2008; Gates, 2006; Goldman & Larsen, 2011; Lister et al., 2009; Malling, 2012; Snow et al., 2003). The structure which my co-researchers created did help connect them with each other on an interpersonal level, thus increasing their use of interpersonal skills. The data which supports this statement manifested in various ways: overall group attendance; three group members' success in achieving their outlined program goals; the prevalent themes within session reports, my personal research journal, and the recorded video of the final performance. Themes include the various roles that came forth organically in this structure, the importance of being seen, as described by Adler (1999/1987b), as well as the structure of performance as therapy as created by my co-researchers.

### **Group Attendance**

As the primary researcher, I found it important to keep track of each of the co-researchers group participation in the form of group attendance (see Appendix C). Group therapy expert Yalom (2005) points out that group members' attendance may reflect their investment within the group, and therapy in general. Therapy groups that have a high rate in both attendance and engagement may have a stronger sense of cohesion (Yalom, 2005). A sense of group cohesion allows group members to experience and practice interpersonal skills, which was the therapeutic goal of my DMT group, "Performance as Therapy."

The co-researchers and I met for a total of seven sessions. The group used the first five sessions as rehearsal time for the final performance. The sixth session was the dance show for the day rehabilitation community. During the seventh and final session, co-researchers and I used group time to reflect on the show and what it was like to perform for a larger audience. I

tracked the attendance of each co-researcher for each of the seven sessions, marking this in the program's attendance tracking binder. Upon reviewing this data, there is an overwhelming amount of support suggesting that the "Performance as Therapy" group was, in fact, cohesive. Six of the 10 co-researchers attended each session, and all of the co-researchers attended at least four of the sessions. When co-researchers were absent, this was mostly because of illness or having to attend a doctor appointment during group time. As noted previously, I did not present this numerical data to change the nature of my artistic inquiry. I presented it to support Yalom's (2005) definition of group cohesion, which leads to engagement of interpersonal skills. Because many of my co-researchers could not verbally express that they felt group cohesion, their attendance suggested this instead.

Not only does my co-researchers' group attendance help support the notion that our DMT group was in fact cohesive, but it also supports the finding that they sensed group solidarity. My co-researchers chose to come to my research group, despite being presented with other creative arts therapy groups that were offered during the same time slot. Despite having other options, my co-researchers came to group and were even enthusiastic about our creative process. Their enthusiasm for my group, DMT, and performance as therapy, as expressed by their attendance, is not something that I had found while reviewing the DMT literature (Levy, 1987; Leventhal, 1980) about this population. My co-researchers' enthusiasm seems unique to my research, and further supports the idea that performance as therapy can be used to help adults with DD with increasing their interpersonal skills, as well increase their sense of belonging and self-esteem.

### **Goal Achievement**

In addition to tracking the co-researchers' group attendance, I also tracked three of the co-researchers' personal goal achievement (see Appendix D). Within the day rehabilitation

center, each program participant is assigned a goal that is related to a one of their creative arts therapy groups. These goals are tracked each week in the program's binder. This was done by placing a check mark in the co-researchers' specific goal tracking sheet, if they achieved their goal. Three of my co-researchers' goals were aligned with "Performance as Therapy." The other co-researchers' personal goals were outlined and tracked outside of the creative arts therapy program. Their personal goals were documented in the other day rehabilitation programs, like the vocational or social recreation program. Because of this, I did not include their goal achievement in my data collection. The co-researchers' goals whose goals were aligned with my research group were personalized to each member and reflected their participation as an audience member or performer, as well as group engagement in general. The three specific goals were:

- Client will engage as an audience member in Performance as Therapy 75% of the groups per month for the trimester.
- Client will participate in Performance as Therapy without falling asleep 75% of the groups per month for the trimester.
- Client will participate in Performance as Therapy 75% of the groups per month for the trimester.

At the end of "Performance as Therapy" each co-researcher had achieved a 100% at their personal goal achievement.

My co-researchers' achieved 100% for their personally outlined goals. This helps support the notion that performance as therapy is a promising intervention when working with adults with DD. Obviously, the purpose of any DMT intervention is to help assist clients achieve their therapeutic goals, and such was the case during my research. One of the goals focused on

the role as an audience member, which will be discussed further below. Two of the goals focused on overall engagement within the group process. These goals were selected because they related to the roles in which group members could choose to participate in.

Further, my co-researchers' goal achievement may suggest their investment toward the group as outlined by group therapy theorist Yalom (2005). Although their involvement in the group determined whether or not these three specific co-researchers had achieved their goal for a given week, much of this was determined by if they were present or not. It is a part of the day rehabilitation's treatment philosophy to allow clients to attend any of the creative arts therapy groups offered. These three co-researchers could have attended any group they chose, but instead attended "Performance as Therapy" weekly, and thus showed that they were interested in working towards their personal therapeutic goals (Yalom, 2005). Having day rehabilitation program participants attending a group weekly was an unusual experience, and thus significant to my research. My co-researchers' goal achievement again shows support that performance as therapy is an effective intervention when working with adults with DD.

## **Themes**

Although I felt it was important to track attendance as well as goal achievement, much of the support for why performance as therapy is a promising intervention for adults with DD comes from the themes that organically arose through the creative process. The themes arose from the data collected in the form of my session reports for each group, my personal research journal, and the video recording of the final performance. The major themes I found were the various roles that were created by the co-researchers during the creative process, the importance of being witnessed (Adler 1987/1999b, 1996/1999a) by each other and the day rehabilitation community members, and the structure of the intervention itself. These themes were consistent



and salient through each form of a data collection. More importantly, they were driven by the co-researchers themselves and reflected their creative aesthetic (Hervey, 2000), which was an important aspect of my research.

**Roles.** The theme of roles within the group began early on in the creative process. As the primary facilitator, my approach to leading the group was heavily influenced by Hervey's (2000) notion of respecting my co-researchers' creative process, as well as Gates (2006) and Malling's (2012) research. I did this by allowing my co-researchers to shape each group session. My permission allowed the co-researchers to engage in the group's creative process in which ever way they felt comfortable. As mentioned before, my co-researchers' were on a varied spectrum of abilities (mental, physical, emotional, and cognitive), despite having the common diagnosis of mental retardation. I hoped that facilitating in this way would allow each co-researcher to creatively participate as it fitted their needs.

With this allowance, my co-researchers took the initiative to do just that—engage in the group creative process in a way they felt comfortable. Again, this initiative by adults with DD is not prevalent within the DMT literature. My co-researchers' were the ones to define the various roles that began to emerge.

With other uses and studies about performance as therapy (Allegranti, 2009; Cook, 2008; Gates, 2006; Goldman & Larsen, 2011; Lister et al, 2009; Malling, 2012; Snow et al., 2003) the roles of mover and witness emerged as they relate to Adler's (1987/1999b, 1996/1999a; Olsen, 2007) DMT theory. For my specific group, the mover manifested in the form of a performer, someone who was improvising dance in front of the group to their choice of music. The performer role was used loosely within our group culture, and could include a solo, duet, trio, or even the entire group. The witness role manifested in the form of an audience member, a person

who actively watched whomever was performing. Again, it was the co-researchers' choice to engage in either of these two roles. However, as the primary facilitator I would encourage some co-researchers to try out a role they did not often engage in. I would gently encourage a co-researcher who usually acted as an audience member to perform, or vice a versa. During the final performance, I also gave the co-researchers freedom to choose their role, despite the outlined dance show structure. If a co-researcher did not want to perform as planned, I did not force them to do so.

In addition to the roles of performer and audience member, two other roles manifested within the, "Performance as Therapy" group—the DJ and the announcer. These two roles were created by two specific co-researchers, who often took on these roles in addition to both performing for and witnessing co-researchers. The DJ controlled the radio player and would play the performers' music choice. The announcer role informed the audience members (or the group) who was about to perform. Often the announcer said "Now performing," or, "Everybody give it up for..." The two co-researchers took turns with these roles, they switched weekly. These two co-researchers also took turns with these two roles during the final performance.

The role of the DJ and announcer became a part of the group's creative process. Although these roles did not involve performing and acting as audience members, these two co-researchers engaged in the group's creative process as a whole. The role of the DJ and announcer helped facilitate the flow of the group, as in kept the group moving forward in the series of creative processes. These two roles also helped orient the members of the group during group time and they helped their fellow co-researchers with their performances. The DJ helped the performer by playing their music, and the announcer informed the performers when they could start dancing. This also assisted the audience in knowing which performer to watch and

when to begin watching. Although the DJ and announcer did not perform for the group per se, they helped facilitate the group's creative process and became leaders of the group in this way.

Sometimes these two co-researchers would also encourage me to become the announcer. As the primary facilitator, I would use the announcer role to center the group's attention to the performer as a way to maintain group cohesion and safety. I also modeled for my co-researchers the roles of performer and audience member. I too performed for the group in the form of a solo, duet, and as a part of an entire group dance; choosing my music like other performers did. However, I usually took on the role as an audience member and modeled that role for my co-researchers. I modeled what it meant to be an audience member by intently watching the performer, as well as cheering and clapping for the performer when they were done dancing. I also mirrored the performer and other audience members. I did this in hopes to affirm the performer and audience members in their movement choice, but to also encourage them to expand their movement repertoire and try on new movement. As the primary researcher, I was very active within the group's creative process by engaging in all of the roles outlined by the group.

**Being seen.** Another theme that emerged from the data analysis is that of being seen and witnessed by the group members themselves, as well as the greater day rehabilitation community. As previously noted, dance/movement therapist Janet Adler (1987/1999b) discussed the importance of being seen, in the process of becoming both a "mover" and a "witness." (p. 142). In being witnessed by others, clients feel validated and begin to witness themselves through a heightened consciousness. This consciousness is gained from the reflections of our witnesses (Adler, 1987/1999b).

The importance of being seen became inherent within the group through the role of performer. The co-researchers used the performer role as a way of being seen by their fellow co-researchers. Co-researchers also expressed their desire to be seen through their music choice too because this was an extension of who they were and what they liked. Further, this was met by the support of the performer's fellow co-researchers, who acted as audience members. Audience members validated the performers by cheering for them, mirroring their movement during the performance, clapping at the end of the dance, and verbally expressing what they saw and liked about the performance. The co-researchers engaged in this process in all seven of the "Performance as Therapy" groups.

The theme of being seen was not only apparent amongst the interactions of the co-researchers themselves within the DMT studio, but was also apparent at the dance show. All of the co-researchers who had committed to performing an improvised dance at the final show did in fact perform. This again shows that my co-researchers wanted to be witnessed by the day rehabilitation community at large, which included their peers and staff members. Also, at the end of the show, I informed the audience of our group culture in giving verbal feedback to the performers. I suggested that they could comment about what they liked or what they saw in the dance. The day rehabilitation community gave my co-researchers feedback about their creativity, their dance skills, and overall passion for dance. This again was an expression of being seen during our group's creative process, one that included the day rehabilitation community.

**Structure.** The final theme that organically arose in the "Performance as Therapy" group's creative process was the structure of the group itself. In previous uses of performance as therapy (Allegranti, 2009; Cook, 2008; Gates, 2006; Goldman & Larsen, 2011; Lister et al.,

2009; Malling, 2012; Snow et al., 2003) the DMT group would often work collectively in choreographing a dance. Sometimes this dance encompassed some type of internal or collective strife (Allegranti, 2009; Cook, 2008; Gates 2006; Goldman & Larsen, 2011), or sometimes it reflected a group's creative interest (Malling, 2012). Regardless of the topic, the group worked together in creating a dance, rehearsed this dance, and then performed it for an audience.

When the "Performance as Therapy" group started, I had full intentions in leading my co-researchers in a similar process, as I thought this is what the intervention looked like. During the first few sessions, at the end of the group I would suggest that we begin to work on the group dance the following week. Each week my co-researchers agreed to this idea, however, in the following group, the structure in which we engaged in remained and we did not work on a group dance. I began to realize my co-researchers hesitation, specifically when looking over my session reports and personal research journal. Their hesitation became a trend throughout both of these sources.

During group four, I noted in my research and personal journal, that my co-researchers seemed eager to begin dancing. Before we started our usual group process, though, I suggested we start rehearsing our group dance since the final performance was only three weeks away. My co-researchers did not respond to this suggestion and I noticed their eagerness had dissipated. Upon this response, I became aware that it was my own desire to rehearse the group dance. Not only that, but that it was my own desire to do a group dance in the first place and my co-researchers did not seem to desire this at all. My awareness led me to offer that our final dance show mirror the structure of the group itself. This structure seemed to be more true to what the co-researchers' desired because this was what they did in every research group. By offering this suggestion I validated my co-researchers' creative aesthetic and process. I was both supporting

and accepting their definition of performance as therapy. After my suggestion, my co-researchers' eagerness to dance returned, and the natural flow of the group process returned. We then decided the order of the group and agreed on performing a group dance improvisation to conclude the show.

The structure that emerged during our creative process can be described as a series of performed creative processes. Organically, co-researchers chose if and when they would like to perform for the group, as well as what song they would like to perform to. The dance performances were not necessarily rehearsed prior to group time, which is usually the case for a performances (Carlson, 1996; Schechner, 1988). Instead, the performance was mostly improvised; my co-researchers performed whatever movement felt right to them in the moment, and thus were displaying a personal creative process for the group (May, 1975).

After a co-researcher performed, the co-researchers who acted as audience members reflected back to the performer what they had just witnessed. This happened in one of two ways. First, this was done simultaneously with the performer, during the dance performance, in the form of mirroring (Levy, 1987). The co-researchers embodied the performer's movement. Secondly, I asked my co-researcher to verbally reflect what they saw to the performer after the performer was finished dancing. This interchange between performer and audience happened organically throughout the group. Both of these reflections helped affirm the performer and informed them that they had been witnessed (Adler, 1987/1999b) by the group. These reflections were also a way of maintaining the verbal processing aspect of performance as therapy models, as seen in other models (Alllegianti, 2009; Cook, 2008; Gates, 2006; Goldman & Larsen, 2011; Lister et al., 2009; Malling, 2012; Snow et al., 2003).

This process also allowed audience members to engage in what group theorist Yalom calls “altruism” (2005, pg. 13-15). Altruism occurs when one client provides a helpful insight or compliment to another client within the therapy group. In doing so, the client experiences what it means to be helpful, and may also sense a boost in self-esteem and a decrease in selfishness (Yalom, 2005). Within the “Performance as Therapy” group, audience members acted altruistically when providing positive feedback to the performers. Often co-researchers said, “I liked it,” or “He dances good.” Although audience members were being helpful to the performers, they were also able to experience a positive feeling from giving such feedback. My co-researchers altruistic acts are especially important for the adult DD population, since they are often viewed as being naturally selfish or lack awareness of others (American Psychiatric Association, 2000; Morrison, 2001). The altruistic acts both addressed seeing the performer, as well allowing my co-researchers to see themselves in a different way.

The group would then conclude with a verbal reflection on the group process as a whole. I facilitated the research group to reflect on the group from start to finish. During this time, co-researchers mentioned whatever felt salient to them during the group. Co-researchers often reflected on movement they had witnessed during the group, or that they had fun.

As the group got closer to the final performance for the day rehabilitation community, we set the order in which the dance improvisations would take place. Although the group was performing for the larger community, the structure of improvisations remained intact. Collaboratively the group chose who would improvise when during the show. The structure of the show reflected the structure of the “Performance as Therapy” group, a series of set dance improvisations. The structure of the group and the final performance is an important distinction

from other of uses of performance as therapy in the published DMT literature. The adults with DD defined the format which best suited their therapeutic needs.

## **Summary**

Through my research I found support to help showcase why performance as therapy is an intervention that can be used when working with adults with DD in a DMT setting. Further, I found that this intervention helps this population with increasing their interpersonal skills, a goal that was not only outlined for my therapy group but is also common for this population in general (Levy, 1987; Leventhal, 1980; MacDonald, 1992). Support for this finding was expressed in the group's overall attendance; personal goal achievement; and the themes of roles, being seen, and the structure of this intervention as defined by my co-researchers. Again, these themes were brought forth by my co-researchers volition, which gives these themes more meaning and support as to why such a creative intervention style can be used for adults with DD. Despite what is commonly found in the DMT literature (Levy, 1987, Leventhal, 1980; MacDonald, 1992) adults with DD can engage in a creative process, especially one with an improvised structure. Although the performance as therapy intervention looked structurally different from other performance as therapy applications, this intervention still is a useful method for this population.



## **Chapter Five: Discussion**

When I began my research, I hoped to further understand performance as therapy as a DMT intervention. My initial motivation to research this topic was my own personal experience when performing dance and the positive effects it has had on my life. I knew early on in my graduate experience at Columbia College Chicago that performance would become an integral part of my style as a dance/movement therapist. However, once I began my internship at a day rehabilitation center that provided creative arts therapy services to adults with DD, my motivation shifted.

While at my internship, I began to realize that traditional DMT approaches, such as the Chacian approach, sometimes fell flat when working with this population. It did not seem to engage them in therapy due to its emphasis on cognitive processing and abstract ideas, like theme development (Levy, 1987). During our work together, I realized that my co-researchers did not depend solely on cognition to process therapy content. As a result, I began to use performance, a more creative approach, as an intervention method instead. My co-researchers, who then became my co-researchers, were enthusiastic about this intervention choice. Their enthusiasm altered my motivation, in that no longer did I want to exclusively research performance as therapy as an intervention method, but how this intervention could be used with adults with DD. I wondered what this intervention would look like when working with adults with DD in a DMT setting. Further, I wondered if performance as therapy would be a useful intervention method when addressing this population's common goal of increasing interpersonal relations.

As the results of my research point out, the DMT intervention of performance as therapy is, in fact, a promising intervention when working with adults with DD. More specifically, it

points out that this creative intervention helped address this population's goal of increasing social interpersonal skills. The support for this intervention manifested in the group's attendance during each scheduled group, their personal therapeutic goal achievement, as well as prevalent themes that came forth organically throughout the research process. The results of my study are important because they support this intervention when working with adults with DD. My research is also important because the results showcased my co-researchers in a way not previously seen in DMT literature. My research results highlight how this specific intervention brings forth the creative and innovative nature within adults with DD. During my study, my co-researchers were artistic, innovative, motivated, collaborative, and enthusiastic; all descriptive words that are usually not associated with this specific population.

### **Attendance and Goal Achievement**

My co-researcher's enthusiasm both for DMT and the intervention of performance as therapy was evident within their overall group attendance. As stated before, over half of my co-researchers attended each of the seven research groups, despite having other therapy groups offered at the same time. Since many of my co-researchers did not depend on verbalization as their primary mode of communication, their attendance suggests they were committed to "Performance as Therapy" and their peers. Further, their overall attendance shows that they felt a sense of group cohesion and solidarity (Yalom, 2005). The group's cohesion and solidarity created a therapeutic environment for my co-researcher's to engage in social interpersonal skills. By attending group, my co-researchers were nonverbally supporting their peers, in both a therapeutic and artistic sense. Overall attendance was crucial for the structure of our group, since the role of audience member was an important compliment to the role of performer and overall group creative process. In showing up for group, my co-researchers were validating both

of these roles and thus validating each other within those roles which encouraged them to engage in interpersonal relationships with each other.

Although the goal of increasing social interpersonal skills is often a stated goal for this population in the DMT literature (Levy, 1987; Leventhal, 1980; MacDonald, 1992) my research is unique in that it used a creative approach in working towards this goal. Other dance/movement therapists have suggested using group rhythmic activity, a Chacian method (Levy, 1987; MacDonald, 1992), in hopes of creating a sense of solidarity among group members with DD. Although this approach may in fact work, my research suggests that solidarity can be created by engaging this population in an artistic process. My research validated my co-researchers as artists (in this case, as dancers/performers), which in turn allowed them to validate both themselves and each other as artists as well. Such validation motivated my co-researchers to attend research group, which led them to engaging in social interpersonal skills.

Further, my co-researcher's goal achievement, both in the 'Performance as Therapy' group suggests that this creative intervention helps adults with DD achieve their therapeutic goals. The three co-researchers whose goals related to "Performance as Therapy" achieved 100% of their goals. My co-researchers' goal achievement, much like their overall group attendance, showcased their investment in their therapeutic process. Not only does this show their investment towards the group's creative process, but their commitment to personal therapeutic growth as well.

Again it is important to note that performance as therapy, a creative intervention, elicited such positive goal achievement within my co-researchers. As stated above, historically, DMT literature often suggests using group rhythmic activity to address goal achievement for adults with DD, stating that, "the use of repetition is especially important for this population." (Levy,

1987, p. 235). The use of group rhythmic activities seems to be used to stabilize or orient the clients in the here and now; thus, increasing their awareness of each other (Levy, 1987; Leventhal, 1980; MacDonald, 1992). However, within my research repetition was seen in the overall structure of performance as therapy. As a group, we repeated the overall structure of serial structured improvisations as performances, and reflected back to the performer what we witnessed both verbally and nonverbally. My co-researchers did engage in group rhythmic activity by clapping or stomping together during the “Performance as Therapy” group. This activity was found organically within the group structure and based on the initiation of my co-researchers. As the therapist, I did not impose group rhythmic on them or use it as a DMT intervention. Instead, they found group rhythmic activity themselves. The results of my study support the use of repetition when working with adults with DD. However, it demonstrated how this intervention can be creative in nature and can manifest from the clients themselves; it need not be imposed on them while in a DMT setting.

## **Themes**

The themes which organically emerged within the research process also highlighted my co-researchers’ capacity to be innovative, collaborative, and artistic. As the primary researcher, I discovered the group themes by reviewing the data collected in my session reports, personal research journal, and the video recording of the final performance. The themes that emerged were the roles within the group’s creative process, the importance of being seen (Adler, 1987/1999b; Olsen, 2007), and the outlined structure of performance as therapy. These themes came forth based upon my co-researchers’ volition since they were the ones to create them. Although I facilitated the group, I took a supportive role similar to Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d), Gates (2006), and Malling (2012), and created a

therapeutic and supportive environment. I allowed my co-researchers to shape each group session, and thus the overall group process throughout the research.

The group roles that emerged during the research group were performer, audience member, DJ, and announcer. The roles of performer and audience member support another group theme of being seen, and will be discussed more in detail below. However, what is important to note is that within the group process the co-researchers were allowed to choose if and when they wanted to engage in either of these two roles. If co-researchers wanted to perform (either as a solo, or with other co-researchers), they performed. If a co-researcher wanted to witness, they acted as an audience member. This process is similar to Olsen's (2007) concept of Authentic Movement that occurred between performers and audience members. Engaging in either of these two roles helped address the co-researchers goal of engaging interpersonally with each other.

As the performer, co-researchers presented themselves to their peers. Co-researchers were saying, "Look at me. I'm worth looking at!" My co-researchers' ability to perform in front of their peers showcased their courage, sense of self-esteem, and capacity to be vulnerable. Further, individually standing out within a therapy group is not a part of the therapeutic culture at the day rehabilitation center. In fact, most creative arts therapy groups offered there are just that, groups. The overall emphasis of the day rehabilitation center is group work in hopes of addressing the population's common struggle with interpersonal skills. However, "Performance as Therapy" provided an opportunity for my co-researchers to relate to their peers in an independent way that still addressed their therapeutic goal. They were able to stand out from their peers, be witnessed by their peers, receive feedback about their performance, and ultimately

be validated by their peers. Such validation is important for any type of interpersonal relationship.

As an audience member, another role my co-researchers often engaged in, my co-researchers were again validating their peers and working on social interpersonal skills. Although this role seems to be more passive, it was an integral part of the group's creative process. Acting as audience members the co-researchers encouraged their peers by cheering, clapping, and mirroring their movement. The audience role gave my co-researchers an opportunity to act altruistically (Yalom, 2005), as well an opportunity to be a support system for their peers. Both of these behaviors are not usually discussed in literature about adults with DD. In fact, this population is usually describe as naturally self-absorbed (American Psychiatric Association, 2000), hence why the addressed goal of increasing social interpersonal skills is so common for adults with DD. However, by engaging my co-researchers in performance as therapy, a creative intervention, they were able to act outside of this so-called determined behavior. My research is unique in that is shows adults of DD have the capacity to be not only aware of each other, but supportive of each other as well.

The other two roles, that of DJ and announcer, also provide support that my co-researchers have the capacity to be innovative and collaborative. Although these roles did not involve performing for the group or witnessing the group, they were still a part of the group's overall creative process. These two roles became a manifestation of interpersonal skills in a physical way. They embodied the overall helpful and supportive nature of the group by helping group members concretely; assisting the performers with their performance, and informing the audience member when to begin watching. In addition, the role of DJ and announcer also helped facilitate the overall group process, in that it kept the process moving forward within each

specific research group. Again, this showcases the collaborative nature of my co-researchers with “Performance as Therapy.”

Furthermore, these two roles were usually executed by two of the specific group members. While one co-researcher was the announcer, the other co-researcher was the DJ. Again, it was their volition that created these roles to begin with. More importantly, these two co-researchers traded the responsibility of each role weekly. If one co-researcher was the DJ last week, the other co-researcher would be the DJ the current week. The process of sharing these two roles again suggests my co-researchers capacity to work collaboratively and interpersonally.

The roles which were defined by my co-researchers both support and relate to the theme of being seen, as described by Adler (1987/1999b). Specifically, the roles of performer and audience member support the theme of being seen as they are an extension of it. My co-researchers were engaging in a form of Authentic Movement, Adler’s (1987/1999b; 1996/1996a) approach to DMT. In “Performance as Therapy” my co-researchers took on the role of the mover and witness by engaging in the roles of performer and audience member, as described by Olsen (2007). The audience members acted as witnesses to the performer, and helped give the performer verbal and nonverbal feedback. Although much of the feedback given was concrete (i.e. “He dances good.”), in comparison to the deep, subconscious material often elicited in Authentic Movement, it still provided the performer with useful feedback. Such feedback helped the performer internalize a witness (Adler, 1987/1999b) and sense a feeling of belonging (Adler, 1996/1999a) within the group. Currently, there is no DMT literature which suggests or provides an example of using Authentic Movement, or a form of adaptive Authentic Movement, when working with adults with DD. This aspect became an important result of my research.

Not only did the sense of being seen manifest in the more traditional Authentic Movement approach of creating a conversation between mover and witness, but also simultaneously during the performance in the form mirroring. This phenomenon happened often, but specifically between three of the 10 co-researchers. One co-researcher wanted to lip synch to one of her favorite pop songs. Upon watching her movement, which was limited to only hand gestures, another co-researcher volunteered to be her back-up dancer. The lip synching co-researcher agreed to this and allowed the other co-researcher to dance around her, often mirroring her hand gestures. Upon witnessing this, a third client got up and began dancing along with the back-up dancer, mirroring his movements.

Within this specific dance improvisation, the process of mirroring each other's movements was a way for my co-researchers to nonverbally see each other. What first began as a solo resulted in a trio. The interpersonal relationships occurring between the trio was one of mirroring each other's movements. As a result, the dance looked cohesive and planned although it was merely improvised. This specific instance again shows how my co-researchers engaged in the theme of being seen and working on interpersonal skills. The back-up dancers were validating the lip synching client and her artistic choice. Not only that, but the dance demonstrates adults with DD working together in an artistic endeavor using their definition of performance as therapy.

Finally, the overall structure of performance as therapy, which is the final theme explored by myself and my co-researchers, reveals adults with DD as creative individuals who can work collaboratively. What is so important about this theme is that it was my co-researchers who defined the intervention method. Their definition of performance as therapy differed from previous uses noted in the literature (Allegianti, 2009; Cook, 2008; Gates, 2006; Goldman &



Larsen, 2011; Lister et al., 2009; Malling, 2012; Snow et al., 2003). This distinctive structure of performance as therapy made the intervention specific to my co-researchers' therapeutic capabilities and needs. Upon responding to being asked about the structure of group, one co-researcher replied, "We figured out everything together," again showing the collaborative nature of our process.

There was a delicate balance between structure and lack of structure within my co-researcher's definition of performance as therapy, which resulted in a series of improvised dance performances. As the primary researcher, I validated my co-researchers' creative aesthetic (Hervey, 2000), as well as created a holding environment (Winnicott, 1965) which allowed their creative processes to happen safely and organically. The creative process of creating our dance show was not overly organized, and thus not overly limiting as may be the case in Cook's (2008) research. However, there still was a sense of structure (performer performs, then the audience comments) which provided enough stability so that chaos would not ensue. Such chaos would ultimately jeopardize any therapeutic gain or group solidarity within the therapy room.

The verbal processing at the end of each group, another aspect of the structure of our group, elicited many deep verbal discussions not usually associated with adults with DD. Verbal processing about choreographed movement is an integral part of other defined performance as therapy methods (Allegranti, 2009; Gates, 2006; Goldman & Larsen, 2011; Lister et al., 2009; Malling, 2012; Snow et al., 2003). This is also an important component of Authentic Movement, as it helps bring new awareness to unconscious material (Adler, 1987/1999b). The material that was brought forth by verbally reflecting on the group's creative process at the end of group was similar to other performance as therapy models and Authentic Movement.

During a discussion in research session three, one co-researcher stated, “I just hear music and do it.” Upon hearing this I realized that my co-researcher was speaking to his personal creative process. When he improvises dance, he simply listens to music and lets the music move him. As the primary researcher, and dance/movement therapist, I reflected my observation back to him. I then used this as an opportunity to ask other group members about their creative process or what dance and performance provided for them. One group member said dance made him, “happy,” while another group member said it helped her, “calm down.”

The verbal processing in which my clients engaged in demonstrates that adults with DD can take part in such conversations about creativity and what performance provides them. It may be said that the creative intervention of performance as therapy helped elicit this. I did not depend on traditional DMT methods, such as the Chacian approach, to engage my co-researchers in this conversation. In fact, I would argue that such methods would limit my co-researchers or undermine their potential of being creative. These approaches seem to dumb down DMT for adults with DD and fail to understand or believe their potential as creative individuals. The culmination of the flexibility in the structure and the holding environment created gave space to my co-researchers’ creativity and capacity to reflect on our group process, and our interpersonal relationships.

In summary, my research showcases how adults with DD can engage in a creative intervention such as performance as therapy. It further supports the notion that the use of a creative intervention may actually serve my co-researchers better therapeutically. In the case of my research, this specific intervention helped assist my co-researchers in engaging in their therapeutic goal of increasing social interpersonal skills. More concrete and rigid DMT interventions may restrict adults with DD and their capacity to be artistic, innovative, motivated,

collaborative, and enthusiastic. This notion is unique to my research and not previously stated in DMT literature.

### **Study Limitations**

Although my research found support for using performance as therapy with adults with DD in a DMT setting, my research is limited. The research group only contained 10 co-researchers, a small sample, making it difficult to generalize the results of the study. Not only that, but was it something about the co-researcher's personally that made the intervention successful? Was my co-researchers' enthusiasm for both performance as therapy and DMT specific to them as individuals? Further, did their enthusiasm underlie their own inclination towards a creative process, and thus make the process a successful one? If my co-researchers did not have this preference towards engaging in a creative process my research may not have been successful. Again, this suggests that the results of my study are hard to generalize to other individuals who have DD and are in a DMT setting.

In addition to my co-researchers' possible proclivity towards creative interventions, the group members may have had a specific group dynamic, as described by Yalom (2005). Did these specific co-researchers act and respond to each other in a specific way while performing and engaging as audience members? It may be possible that these interactions might not be able to be created again, even if performance was used as an intervention, as it may have been specific to this group. There is a possibility that the overall process of my research was specific to my co-researchers and their group dynamic.

Further, my role as the primary researcher and facilitator of both the research and group process must also be considered. This may have placed limitations on the research. My own enthusiasm for the intervention may have also led to its success during the research process. The

way I executed my role within the group's dynamic may have influenced the group's creative process.

Another limitation of my research is the lack of the performers' verbalization about their experiences during post-performance processing session. Adler (1987/1999b) questions the importance of the movers (or performers) verbalizing after their experiences of moving in Authentic Movement groups. She wonders if the mover's body knowledge is sufficient to process the experience, instead of depending on verbal processing (Adler, 1987/1999b). I too wondered if my co-researchers processed what happened on a bodily level. This is especially important since many of my co-researchers do not solely depend on verbalization as their main processing skill. However, I did not provide an option for the performers to verbalize their thoughts and feelings if they wanted to. During the research process I did not ask the performers to speak to their experiences or their dance, but instead focused on facilitating audience feedback to the performer in hopes of working on interpersonal skills. As the primary researcher, had I focused more on the performer's experience it may have changed the results of the study, possibly gleaning different relevant themes.

Finally, the structure in which performance as therapy manifested may be another limitation of my study. Hitherto I have argued that this was a result of the study, one that showed my co-researchers' capabilities of creative and artistic expression. However, I must also wonder what my co-researchers may have missed by not engaging in another structure of performance as therapy (Allegranti, 2009; Gates 2006; Goldman & Larsen, 2011). It may be possible that had I attempted to use one of the outlined performance as therapy models, my co-researchers may have also benefitted. I could have reached similar conclusions, or other salient themes may have arisen in the research process. The other models of performance as therapy

may have also addressed the goal on interpersonal relationships, but these may have manifested in a different way. The improvisation structure of performance as therapy model that my research used limits my study. The outlined structure specifies my research so that the results may not be generalized when considering other approaches to performance as therapy. It is difficult to compare my results to the results of other performance as therapy models produced.

### **Summary and Future Research**

The purpose of my study was to further examine the DMT intervention performance as therapy. More specifically, I hoped to understand how this DMT intervention would manifest when working with adults with DD. During my research process I hoped to realistically answer: How can performance as therapy be used as an intervention when working with adults with DD in a DMT setting? I intended to not only give further definition to performance as therapy, but also give adults with DD more visibility as creative individuals within the DMT literature. As the results of my study showed, performance as therapy is a promising intervention for adults with DD. This intervention allowed my co-researchers to engage in interpersonal skills, engage in a creative process, and be innovative.

If my research were to be repeated there are important factors for future researchers to consider. Firstly, it would be important for a future researcher to tease out whether it was my co-researchers' personal proclivity towards a creative process, this specific groups' dynamic, the researcher's own enthusiasm, or the intervention method itself (performance as therapy) was what made the process a successful one. Repeating my research may help tease these factors out and give clarity to which factor it was that helped adults with DD to use interpersonal skills.

In addition, it is important for future researchers to be mindful of both the structure of performance as therapy that I have offered in my results, as well as what also feels organic to

groups that use the intervention. My research showed support for performance as therapy when working with adults with DD, but this is because it was my co-researchers who defined what the intervention looked like. I would hope future researchers both explore the structure of performance as therapy that I have presented, but also discover new forms of the intervention method. Hopefully future researchers will discover how specific structures may support the therapeutic growth of the specific population they are working with.

Defining new methods of performance as therapy will hopefully give depth to this intervention method. Further research may also motivate the DMT community to codify this currently elusive intervention method. At one time, dance/movement therapy and performance as therapy were viewed as separate entities. Only recently has this mode of thinking shifted (Allegranti, 2009; Cook, 2008; Gates, 2006; Goldman & Larsen, 2011; Malling, 2012).

Performance as therapy structures are now seen as intervention methods which dance/movement therapists can use as resources in the therapeutic realm. I hope that future DMT researchers will persist on this path and continue to mold the intervention method—giving it weight within our community. Further, I hope my research encourages other dance/movement therapist to be more open with use of this intervention method. Giving our DMT clients an opportunity to perform, in whatever that means structurally for them, is an important gift. This gift not only addresses their therapeutic goals, but also allows them to express themselves as both artists and performers.

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## **Appendix A**

### **Definition of Terms**

#### ***Creative Process***

The creative process is when an individual or group partake in creating some type of art, such as dance. This process is spontaneous and authentic to the group or individual, is most likely improvised, and the content produced may be used to create a set work of art (May, 1975).

#### ***Developmental Disabilities***

Developmental Disabilities is a categorical term given to individuals who, by age twenty-two, have impairments in three components of physical or mental health that influences his or her developmental growth (Morrison, 1995).

#### ***Performance as Therapy***

Performance as therapy is a dance/movement therapy intervention that utilizes both the process of creating choreography and performing as a means to address outlined therapeutic goals and promote therapeutic growth within clients (Cook, 2008; Gates, 2006; Goldman & Larsen, 2011).

#### ***Performance***

A performance is a presentation of an individual or group's artistic work. This work is premeditated, planned, rehearsed and executed a specific way (Schechner, 1988).

## Appendix B

### Informed Consent/Assent Sheets



### Informed Consent Form

Consent Form for Participation in a Research Study

**Title of Research Project:** Performance as therapy: an intervention for adults with developmental disabilities.

**Principal Investigator:** Emily D'Annunzio

**Faculty Advisor:** Andrea Brown (ADTR, LCPC), akbrowadtr@aol.com, 312-655-7449

**Chair of Thesis Committee:** Laura Downey MA, BC-DMT, LPC, GL-CMA

#### INTRODUCTION

You are invited to participate in a research study titled, "Performance as therapy: An intervention for adults with developmental disabilities." This consent form will give you the information you will need to understand why this study is being done and why you are being invited to assist as a co-researcher in this process. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over. You are also encouraged to ask questions now and at any time. If you decide to become a co-researcher, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will receive a copy of this form for your records.

You are being asked to become co-researcher to make the research process more authentic and to explore performance as therapy as an intervention method. The primary investigator finds it important to include the participants' experience, and views them as experts during the study.

#### PURPOSE OF THE STUDY

The purpose of this research study is to explore performance as therapy as a tool when working with adults with developmental disabilities in a dance/movement therapy setting. If so, what is it about performance as therapy that makes it effective? Performance as therapy is a method that believes seeing one another dance and perform can address specific therapeutic goals.

## **PROCEDURES**

- The research study will be conducted in an eight week time span, during the 2012 Summer Trimester at NAME OF SITE. The research session will be held on Wednesday from 10:15 to 11:30 a.m. During this time the researcher and co-researchers will explore performance as therapy, both by dancing and choreographing with each other. The co-researchers are required to participate in most, if not all, research sessions during the eight week period. The final dance performance will be during the Summer Trimester Festival Week between August 24<sup>th</sup> and August 31<sup>st</sup>. The performance will be at NAME OF SITE for participants and staff members, as well as outside community members.
- The final dance performance will be videotaped. The videotaping will be included with the final written thesis, which will be available for public viewing in the Columbia College Chicago library.
- The research study will be finished after the final dance performance in August. The co-researchers will not be contacted in the future.

If you agree to participate in this study, you will be asked to do the following:

- Attend Performance as Therapy groups during the 2012 Summer Trimester on Wednesdays from 10:15-11:30 a.m.
- Perform in a final dance showcase at NAME OF SITE for peers, staff and community members. The performance will be videotaped.

## **POSSIBLE RISKS OR DISCOMFORTS**

- There are minimal risks that might occur during participation of the research study. Co-researchers might experience some anxiety before or after the final dance performance. This will be minimized by properly rehearsing the dance so that each co-researcher feels prepared to perform.
- Physical discomfort might occur if movements of the dance are too difficult. However, co-researchers will be encouraged to only do movement they feel comfortable to do. Also, each research session will begin with a warm-up to prepare the co-researchers' bodies to move.
- Participating in the research study should not pose any inconveniences for co-researchers since the research will be conducted during normal NAME OF SITE program hours.

The risks in this study are possible anxiety and physical discomfort.

## **POSSIBLE BENEFITS**

The possible benefits of being in this study include experiencing an increase in self-confidence and building new friendships with co-researchers. By participating, co-researchers will also be given the opportunity to express themselves through dance and performance.

Also, by serving as a co-researcher you will help identify the effectiveness/ineffectiveness of performance as therapy within the dance/movement therapy field. This will help expand the knowledge of the field.

## **CONFIDENTIALITY**

Confidentiality means that the investigator will keep the names and other identifying information of the co-researchers private. The primary investigator will change the names and identifying information of research participants when writing about them or when talking about them with others, such as the investigator's supervisors.

The following procedures will be used to protect the confidentiality of your information (Note: This is an example. Be sure to describe procedures specific to your study:

1. All electronic record files containing personal information will be password protected.
2. The researcher(s) will keep all study records locked in a secure location.
3. The research data will be kept one year after the study is complete. Data will then be destroyed.
4. No one else besides the investigator will have access to the original data.
5. The video recording of the final performance will not list names of co-researchers as a way to keep performers anonymous.
6. At the end of this study, the researchers may publish their findings. You will not be identified in any publications or presentations.

## **RIGHTS**

Being a co-researcher in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

Take as long as you like before you make a decision. We will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator Emily D'Annunzio (734-536-9817/EAD'Annunzio@NAME OF SITE.org) or the faculty advisor Andrea Brown (ADTR, LCPC), akbrowadtr@aol.com, 312-655-7449

If you have any questions concerning your rights as a co-researcher, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at 312-369-7384.

### **COST OR COMMITMENT**

- Co-researchers should not experience any costs while participating in the study.
- Co-researches are asked to commit to the fifteen week Summer Trimester from May to August 2012.

### **PARTICIPANT STATEMENT**

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the study or my rights as a co-researcher, I can ask one of the contacts listed above. I understand that I may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form.

_____	_____	_____
Participant/Parent/ Guardian Signature:	Print Name:	Date:

Relationship (only if not participant): \_\_\_\_\_

_____	_____	_____
Assent of Minor Signature:	Print Name:	Date:

_____	_____	_____
Signature of Person Obtaining Consent	Print Name:	Date:

_____	_____	_____
Principal Investigator's	Print Name:	Date



## Informed Assent Form

My name is Emily D'Annunzio and I am a Columbia College Chicago master's student. I am currently studying dance/movement therapy and conducting research on the therapeutic effects of performance. The title of my research project is, "Performance as therapy." I am asking to participate because you are a NAME OF PROGRAM participant at NAME OF SITE.

- Positive effects to participating in the research study are building new friendships with peers and increasing self-confidence.
- Negative effects may occur too. You might experience anxiety or frustration while rehearsing and/or performing. If this occurs please seek counseling services offered by NAME OF SITE staff.
- There will be a video recording of the final performance during the summer festival week.
- I will keep your personal information private. Your name will not be disclosed with this video in order to keep your identity confidential. If you decide not to perform in the final performance you can help the project in another way, like helping with costumes.
- By dancing in the final performance audience members will know you participated in research.

I, \_\_\_\_\_, agree to participate in the research study called "Performance as Therapy." By signing this form I know that I am required to meet in the NAME OF PROGRAM Studio once a week on Wednesdays from 10:15-11:30 a.m. beginning June 20th and ending August 15<sup>th</sup>. I also know by participating that I am being asked to perform during the summer 2012 trimester festival week.

I agree that this study has been explained to me. I understand that I can withdraw my consent at any time. If I change my mind at any time I can stop participating in the study:

_____	_____
Participant	Date

_____	_____
Primary Researcher/NAME OF SITE Staff	Date

If you have any questions please contact:

Emily D'Annunzio	Andrea Brown MA, ADTR, LCPC
Primary Researcher	Faculty Advisor
EAD'Annunzio@NAME OF SITE.org	akbrownadtr@aol.com
734-536-9817	312-655-7449

Sheryl Hipps	Laura Downey MA, BC-DMT, LPC, GL-CMA
On-Site Supervisor	Chair of Thesis Committee
shipps@NAME OF SITE.org	Ldowney@colum.edu
773.929.8200 x215	312.369.8617

## **Appendix C**

### **Attendance Sheet**

Group Name

Year

Staff Name(s)

Day &amp; Time

Months

DATE OF GROUP e.g. 11/13/07

## Attendance

[illegible]

**Y/N** - Select whether client attended group.

**Total - 1<sup>st</sup> Box = Total # of "Y"s. 2<sup>nd</sup> Box = Total # of "N"s.**

**Participation - 1** = participated with minimal direction from staff **2**= participated with moderate direction from staff **3**= participated with continual direction from staff

**Appointment - List time out of program.**

[illegible]

# Appendix D

## Goal Tracking Sheet

Client Name:		Staff Name:		Year: 2012																											
Goal 1:		Objective 1/date:																													
Objective 2/date:		Objective 3/date:																													
Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January																															
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