12-14-2016

Moving For Freedom: Development of a Dance/Movement Therapy Based Resilience Promotion Program for Children of Individuals With Substance Abuse Disorder

Maria Torres
Columbia College Chicago

Follow this and additional works at: https://digitalcommons.colum.edu/theses_dmt

Part of the Dance Movement Therapy Commons

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License.

Recommended Citation
Torres, Maria, "Moving For Freedom: Development of a Dance/Movement Therapy Based Resilience Promotion Program for Children of Individuals With Substance Abuse Disorder" (2016). Creative Arts Therapies Theses. 81.
https://digitalcommons.colum.edu/theses_dmt/81

This Thesis is brought to you for free and open access by the Thesis & Capstone Collection at Digital Commons @ Columbia College Chicago. It has been accepted for inclusion in Creative Arts Therapies Theses by an authorized administrator of Digital Commons @ Columbia College Chicago. For more information, please contact drossetti@colum.edu.
MOVING FOR FREEDOM: DEVELOPMENT OF A DANCE/MOVEMENT THERAPY
BASED RESILIENCE PROMOTION PROGRAM FOR CHILDREN OF INDIVIDUALS
WITH SUBSTANCE USE DISORDER

Maria Torres

Thesis submitted to the faculty of Columbia College Chicago
in partial fulfillment of the requirements for
Master of Arts
in
Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies

December 2016

Committee:

Susan Imus, MA, BC-DMT, LCPC, GL-CMA
Chair, Dance/Movement Therapy and Counseling

Laura Downey, EdD, BC-DMT, LPC, GL-CMA
Research Coordinator

Shannon Suffoletto MA, BC-DMT, LCPC, GL-CMA, MPAC
Thesis Advisor

Kristy Combs, BC-DMT, LCPC
Reader
Abstract

The purpose of this program development project was to design a dance/movement therapy (DMT) resilience promotion program for children of individuals with substance use disorder (SUD). The program aims to develop protective factors through resilience promotion in order to prevent future drug abuse. The program will be called Moving for Freedom and will focus on working with children of individuals with SUD because they are at the highest risk for developing SUD (Kumpfer, 1999). Moving for Freedom was developed through this thesis project and has not been implemented. The proposed implementation site of this resilience promotion program is within an urban mental health center with a partial hospitalization program (PHP) and intensive outpatient program (IOP) for individuals with SUD. The prevention program is intended to be implemented during weekly family programming. Children ages 8-10 would participate in this program while parents and adult family members attend their respective groups. A theory approach logic model was utilized to design a program and develop an evaluation plan to understand program effectiveness once implemented. I collaborated with experts with background experience in the target issue of SUD. Information regarding the design of the program was gathered utilizing the Delphi method. The Delphi method consisted of three rounds of interviews with each collaborator. Moving for Freedom is focused on recognizing resilience and promoting protective factors such as self-esteem and self-expression through a strengths-based approach. The program is a movement-based program utilizing art as a means of expression and exploration of addiction related concepts.
Acknowledgements

The completion of this thesis would not have been possible without the unwavering support of a number of important individuals. First, thank you to my collaborators for taking the time to share your ideas and wisdom. Jessica Young, your spirited ambition never ceases to amaze me. Thank you for encouraging my ingenuity. Kim Pinkston, thank you for always believing in me and being my person of infinite resource. Andy Young, I am honored to have had your insight and expertise on my side throughout this process.

To my rescue thesis advisor Laura, thank you for bringing quick time into my timeless world. I would like to express my deep gratitude for your support and the time you dedicated to me. Shannon, thank you for your guidance and assistance along this journey, and for giving me the extra little push when I needed it. To my reader, Kristy Combs, thank you for being a part of this project and imparting your knowledge.

To all of my friends and family who supported and encouraged me throughout my graduate school and thesis experience, my love and appreciation for you is boundless. A mi Weeta, mi prenda, esto es para ti. Gracias por hacerme fuerte y resistente y por ser mi protector. Yo no estaría aquí si no fuera por ti. Siempre voy a trabajar duro para hacerte sentir orgullosa. Te amo y te extraño mucho.

To Cameron, my number one support, my person, my world, what would I do without you? Thank you for constantly pushing me and believing in me when I was running low on optimism. Thank you for the pep talks, the tough love, and the acknowledgements of the small victories along the way. We have finally made it.
# Table of Contents

Chapter One: Introduction 5
Chapter Two: Literature Review 12
Chapter Three: Model and Process 39
Chapter Four: Program and Program Evaluation Plan 48
Chapter Five: Discussion 91
References 102

Appendices
  Appendix A: Definition of Terms 114
  Appendix B: Logic Model 115
  Appendix C: Informed Consent 116
  Appendix D: Referral 117
  Appendix E: Introductory Overview 118
  Appendix F: Group Rules 120
  Appendix G: Facilitator Planning Sheet 121
  Appendix H: Body Warm-ups 122
  Appendix I: Group Closings/Goodbyes 123
  Appendix J: Pre/post-test Superpower Session 124
  Appendix K: Pre/Post-test Addiction Session 125
  Appendix L: Pre/Post-test Safe People Session 126
  Appendix M: Pre/post-test Feelings Session 127
  Appendix N: Pre/post-test Anger Session 128
  Appendix O: Pre/post-test Play Session 129
  Appendix P: Pre/post-test Problem Solving Session 130
  Appendix Q: Pre/post-test Superhero Performance Session 131
CHAPTER ONE: INTRODUCTION

More than 28 million children in America are impacted by alcoholism and other substance use disorders (SUDs) (SAMHSA, 2002). SUD was previously classified as either substance abuse or substance dependence with specific criteria for each (American Psychiatric Association, 1980, 1994). In the fifth edition of the Diagnostic Statistical Manual of Mental Disorders (DSM), these classifications were consolidated into one single disorder called SUD (American Psychiatric Association, 2013). Children with the highest risk for developing SUD are children of individuals with SUD (Kumpfer, 1999). There is a strong association between substance use by parents and substance use by their adolescent children, which can be attributed to both genetic and environmental factors (SAMHSA, 2002). Children of parents with alcoholism have been found to be four times as likely to develop problems with alcohol or other drugs (Grant, 2000).

The risks for these children extend beyond future drug abuse. Parental SUD puts children at risk for an array of physical, mental, behavioral and emotional deficits, which can predispose them to future maladjustment (SAMHSA, 2002). Risks for these children include familial issues, abuse, neglect, as well as poor social, emotional, and educational functioning (SAMHSA, 2002). The generational continuity of SUD poses great costs for the well-being of these families, as well as for society as a whole.

Children of parents with SUD face difficulties that entail immense economic costs for society including increased costs for health care, mental health, child welfare, education, as well as police and juvenile justice systems (SAMHSA, 2002). A high percentage of these children end up in the welfare system (SAMHSA, 2002). SUD is estimated to account for 70-90% of all child...
welfare spending, amounting to $10 billion in federal, state, and local government spending (SAMHSA, 2002). The daily cost for drug-exposed infants who are abandoned or kept at hospitals is estimated at $460.18 (SAMHSA, 2002). Fetal alcohol syndrome is prevalent in about 0.2 to 1.5 out of every 1,000 infants. It is estimated that the lifetime cost for each individual with Fetal Alcohol syndrome (FAS) is $2 million (Center for Disease Control and Prevention [CDC], 2015). Annual costs for FAS in the United States is estimated at $4 billion (CDC, 2015).

The multidimensionality of risk factors suggests that SUD is a complex and deeply rooted issue that affects each child in different ways. Longer exposure to parental substance use increases risk of substance use in the future (Biederman, Faraone, Monuteaux, & Feighner, 2000). Aggressive early interventions and preventative care for children at high risk for SUD are consequential, as SUD is easier to treat during formative stages before becoming a chronic condition (Biederman et al., 2000).

Prevention and intervention strategies have shown to be effective with interrupting the cycle of SUD from parents to children as well as decreasing societal costs and risk to children. The implementation of prevention programs has proven successful in enhancing these children’s protective factors through exploration and expression of feelings in a safe and supportive environment (Biederman et al., 2000). The prevention program developed through this thesis project, Moving for Freedom, aims to address these matters.

Motivation

My initial interest in the substance use population stems from my own personal experience as a child with family members who suffered from SUD. I deeply understood the
effects of SUD on my childhood. As a graduate student pursuing my degree in dance/movement therapy and counseling, I worked an internship placement at an inpatient substance use rehabilitation center for adults. My internship experience became a journey of self-exploration and acceptance. I became more aware of how SUD affected many aspects of an individual’s life, particularly the family unit. I heard countless stories of clients growing up in a household where substance abuse was common, and how they never knew their life could be anything different. I wondered, had there been intervention early in their lives, would these individuals be in this position today? This question guided my interest in working with the children in these families.

As a dancer and an emerging dance/movement therapist, I believe strongly in the power of movement for healing and am motivated by the opportunity to promote healing, growth, and resilience through this modality. I learned that prevention programs existed for this population, but I found nothing that included dance/movement therapy (DMT) or other movement-based interventions. DMT provided my adult clients with a creative and healthy outlet for expression as well as body-awareness, a higher self-esteem, and body-based coping skills. I became curious as to how I could use DMT with children in a prevention program that might aim to accomplish some of those goals. My interests in this particular population, along with my passion for DMT, motivated me to create a prevention program that would aim to interrupt the generational continuity of SUD.

**Purpose of the Project**

This program development project resulted in a DMT strengths-based resilience promotion program for children of individuals with SUD. The goal of this program development project is to develop a DMT prevention program that will help address and prevent the
generational continuity of SUD from parent to child. Existing drug prevention programs are facilitated in school, family, and community settings with an emphasis on information, skill development, social support, socio-emotional needs, and healthy alternatives. These programs offer a space for children to express emotions in a safe space with verbally implemented intervention strategies. A focus on the body-mind connection and movement-based approaches are not included in existing programs. Movement based interventions through DMT can offer a creative approach for children to explore and express feelings. The purpose of this program development was to collaborate with experts to discover the needs of this population and how DMT can fulfill these needs through a prevention program.

**Theoretical Framework**

My clinical work integrates Chacian DMT and counseling psychology with a trauma-informed, strengths-based approach rooted in positive psychology. Moving for Freedom is a DMT-based program utilizing DMT approaches and theories as the foundational components that guided the program development. My belief that all individuals have inherent strengths that can help them to create positive change is a worldview that is incorporated in this program through a trauma-informed, strengths-based approach. The DMT approach provided the methods to how strengths were recognized and supported in this program.

**Chacian dance/movement therapy.** Marian Chace, a DMT pioneer, believed that dance fulfilled a basic human need because of its communicative nature (Levy, 1988). The Chacian approach utilizes dance and movement for communication and self-expression, to unveil the parts of individuals that want to “be heard and be well” (Levy, 1988, p. 21). Similar to Chace, I utilize the nonverbal communication through dance and movement to help individuals out of
isolation, create a sense of universality, and to allow individuals to be seen and heard. Chacian ideologies and methods have always been an underlying part of my work.

A key principle of DMT is that of the mind-body connection, in which changes in movement affects a change in one’s functioning (Berrol, 1992). The body-mind connection is also a principle underpinning my program, such that goals of the movement interventions are to create positive changes in self-esteem and to increase resilience. Chace used nonverbal communication through movement with children to “help achieve a more relaxed, open child, more aware of self and therefore more able to interact with others” (Chace, Sandel, Chaiklin, & Lohn, 1993, p. 324). The Moving for Freedom program incorporates the use of movement to express and communicate feelings, as well as increase self-awareness and self-esteem. Movement is also used to promote group cohesion, connection, and universality through shared movement experience and group rhythmic activity. Also included throughout the program are opportunities for movement improvisation and performance, which makes use of creative process for the child to experiment with new ways of being and opportunities to be seen and heard.

Trauma informed care. Many children who live in homes with SUD have experienced trauma (SAMHSA, 2002). Thus, a trauma-informed approach is pertinent when working with this population. The Moving For Freedom program applies principles of a trauma-informed approach highlighted by the Substance Abuse and Mental Health Services Administration (SAMHSA) including: safety, trustworthiness, transparency, peer support, collaboration, empowerment, voice, and choice (SAMHSA, 2014). Through the use of these principles, resilience and recovery are promoted for children affected by trauma.
A trauma-informed approach puts emphasis on teaching skills such as self-soothing, self-trust, self-compassion, self-regulation, and communication of needs (Klinic Community Health Center, 2013). The program developed through this project uses a DMT approach to facilitate the acquisition of these skills in order to foster resilience and care that is trauma-informed. The Moving for Freedom program is focused on resilience promotion, which creates a climate of hope by acknowledging the client’s ability to survive and grow from adversity. Trauma-informed care is rooted in a strengths-based approach (Klinic Community Health Center, 2013).

**Strengths-based approach in counseling psychology.** The strengths-based approach puts emphasis on an individual’s assets rather than their issues or shortcomings (Smith, 2006). This therapeutic perspective is based on the idea that people are resilient and possess self-righting tendencies that allow them to overcome disadvantageous circumstances (Smith, 2006). Effective prevention has been facilitated through the use of strengths-based approaches with at-risk populations (Smith, 2006). Using strengths-based counseling has been shown to prevent depression and anxiety, and reduce risk for violence and SUD in at-risk adolescents (Seligman, Reivich, Jaycox, & Gillham, 1995). The strengths-based approach is grounded in both prevention and resilience research, and has been shown to increase self-esteem. This research provides support for the value of a strengths-based approach for my prevention program.

Using a strengths-based approach provides an atmosphere where clients feel respected and validated, which may provide a climate for clients to achieve their goals at a higher rate (Weick & Chamberlain, 2002). Moving for Freedom provides a space where children’s feelings and experiences are validated through a strengths-based approach. These children may have endured many struggles as a result of the chaos and unpredictability of living with a parent
struggling with addiction. Many times these children remain confused, feel ashamed, and/or suffer from low self-esteem (Lander, Howsare, & Byrne, 2013). Despite their struggles, these children carry strength and resilience that help them get through the hardships of their everyday lives (Park & Schepp, 2014). A goal of the Moving for Freedom program is to help children recognize and identify their strengths as well as discover ways they can employ them. Inherent strengths are explored and brought to light through imagination and the metaphor of superheroes with superpowers. The focus on strengths is an underlying component of the program that aims to nurture self-esteem and positive development.

**Conclusion**

This project was guided by my personal experiences, which motivated me to initiate this project, as well as my theoretical framework based in Chacian DMT and counseling psychology with a strengths-based approach based in positive psychology. Also, guiding best practice for the development of this thesis project was the review of literature on substance use prevention programs and dance/movement therapy applications. The program developed through this thesis project is a DMT strengths-based resilience promotion program for children of individuals with SUD.

SUD is an issue that affects many individuals and families alike. When an individual suffers from SUD, the family unit may also be negatively affected. Particularly, children of parents with SUD are at risk for a multitude of adverse effects on emotional, behavioral, educational, social, and physical functioning (Thombs & Osborn, 2013). These issues will be further reviewed in the following literature review.
Chapter 2: Literature review

The majority of clients in treatment for substance use disorder (SUD) either have parents or relatives with SUD (Jennison & Johnson, 2001). A Swedish adoption study found the risk for SUD in adopted children with at least one biological parent with SUD to be more than twice the risk of adopted children with no biological parents with SUD (odds ratio, 2.09; 95% CI, 1.66-2.62) (Kendler et al., 2012). If both biological parents reported SUD, the risk increased significantly (Kendler et al., 2012). Existing is a cycle of SUD passed down from parent to child through generations. Children of those with SUD are at risk for a multitude of other problems including: emotional, behavioral, educational, social, and medical issues (Thombs & Osborn, 2013). This literature review will discuss the influence of parents with SUD on children, current prevention programs for this population, and dance/movement therapy and its applications. It should be noted that in this literature review, DSM-5 terminology is used in all instances referring to SUD, even when discussing articles that reference the classifications listed in the DSM-III and DSM-IV.

Influence of SUD on Children

In addition to future SUD, parental SUD puts children at risk for a great number of issues. Children’s positive development in emotional, behavioral, educational, social, and physical functioning are negatively affected (Thombs & Osborn, 2013). Information on these issues is relevant for the purpose of creating a curriculum that may address these problems. The following section discusses the influence of parental SUD on children in greater detail.
Dysfunction within the Family

Parental dysfunction often leads to family dysfunction. Decreased family cohesion, increased family conflict and stress, decreased family organization, and home management skills, increased family isolation, and poor parenting skills, was found in families with parents who use substances (Brook, Brook, Richter, & Whiteman, 2006). Parents with SUD are at increased risk for mental and emotional problems, including narcissism and depression (Brook et al., 2006). Individuals with SUD are often not able to meet the needs of their children because of the many stressors affecting them (Brook et al., 2006).

Families dealing with SUD often experience inadequate family cohesion. Family cohesion is defined as the “emotional bonding that family members have toward one another” (Olson, Russell, & Sprengkle, 1984). Family cohesion is measured through the following dimensions: emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests, and recreation. Based on the circumplex model of marital and family relationships, low family cohesion is classified as disengaged and is associated with low to levels of closeness, little loyalty, and high independence (Olson et al., 1984). Parents with SUD often lack effective parenting skills (Darragh, 2012). Some of the major parenting dysfunctions include: decreased parenting skills, discipline strategies, monitoring, supervision, positive reinforcement, and parent/child attachment (Brook et al., 2006). In addition to struggling with their own issues, it is likely that they were neglected and not modeled proper parental support and behavioral discipline techniques by their own parents (Darragh, 2012). The lack of parenting skills puts children at greater risk for behavioral and emotional issues.
Robinson and Rhoden (1998) found alcoholism to affect four essential family tasks: creating an identity, setting boundaries, providing for physical needs, and managing the family’s emotional climate. Without proper stability and regularity within the family, children are at a greater risk for developing behavioral deficits (Robinson & Rhoden, 1998). Families dealing with SUD often experience higher levels of family conflict as well. This conflict and disruption within the family is often a product of parental SUD (Robinson & Rhoden, 1998). Many factors influence familial conflict and magnify the levels of stress tending to occur within these families including: marital strain, financial troubles, frequent family relocation, employment problems, and illness (SAMHSA, 2002).

Children of individuals with SUD are many times negatively affected by inadequate parenting. The lack of structure and supervision in the family environment puts children at risk for a multitude of behavioral, emotional, and academic deficits. The case is often, in consequence of the generational continuity of SUD, that these parents were not modeled sufficient parenting skills by their own parents, who may have also suffered from drug addiction. Thus, the cycle continues, their children bear the misfortune of receiving poor training and role modeling of parenting skills.

**Child Abuse and Neglect**

Children in households with parents with SUD are at higher risk for being victims of child abuse and neglect. SUD is cited as the top cause for the dramatic rise in child maltreatment (SAMHSA, 2002). Parents with SUD are three times more likely to abuse their child, sexually or physically, and 4.2 times more likely to be neglectful than parents without SUD (Lander et al.,
2013; Cash & Wilke, 2003). When substance use becomes an issue in the family, safety becomes a significant concern for these children.

Studies have examined child abuse and neglect by analyzing parents referred to the child welfare system. One study found that children with parents with SUD were more likely to be referred for abuse and neglect than parents without SUD (Murphy et. al, 1991). They also found that these parents more often failed to attend court mandates and were more likely to lose custody of their children than parents without SUD (Murphy et. al, 1991). One study compared parents with babies born positive for cocaine to parents whose babies did not test positive (Kelley, 1992). About 60% of parents with drug-exposed children received reports of abuse or neglect, which was eight times the rate of the non-drug exposed group (Kelley, 1992). Within the first year, 50% of the children born positive for cocaine were removed from their mothers; in contrast, no children from the control group were removed from their homes (Kelley, 1992).

**Externalizing Behaviors**

SUD in parents could affect externalizing behaviors in children. Externalizing behaviors are defined as behavior problems that involve children acting negatively on the external environment (Liu, 2004). Externalizing behaviors may include aggression, delinquency, and hyperactivity (Liu, 2004). A direct association was found between parental SUD in adulthood and their children’s externalizing behavior (Brook, Balka, Zhang, & Brook, 2015). Parental SUD was also found to negatively affect the parent-child relationship, which in turn was associated with externalizing behaviors in children (Brook et al., 2015).

Marmorstein, Iacono, and McGue (2009) examined the risk for a full range of externalizing behaviors including attention deficit hyperactivity disorder (ADHD), oppositional
defiant disorder (ODD), early-onset cases of substance dependence (nicotine dependence, alcohol dependence, drug dependence), and antisocial behavior among late-adolescents. The study found that both parental alcohol dependence and parental drug dependence were similarly associated with increased risk for children’s externalizing disorders (Marmorstein et al., 2009). The authors proposed clinical implications for the study that are pertinent to this literature review. Noted in this study is that SUD had the latest onset of all externalizing behaviors. Therefore, it would be particularly beneficial to pay close attention to those exhibiting any of the other externalizing behaviors earlier in childhood as they may be at higher risk for developing SUD later in adolescence. Suggested in this study is the evaluation of children of adults who enter drug treatment programs and the implementation of preventative or treatment interventions for these children (Marmorstein et al., 2009).

**Bio-psychosocial Risk Factors**

Children of individuals who use substances face a number of bio-psychosocial risk factors that are possible causes of their own later substance use (Thombs & Osborn, 2013). Knowing these risk factors is the first guiding step for creating prevention programming. The bio-psychosocial vulnerability model of chemical dependency contains major biological and environmental factors that increase children’s vulnerability to SUD (Agarwal & Goedde, 2012). The model suggests that biological factors such as genetics, in utero variables, and psychological temperament/cognitive variables interact with the environmental factors of family, community, school, social environment, and peers to influence the child’s vulnerability (Agarwal & Goedde, 2012). The model contains a developmental progression from infancy to adulthood (Agarwal & Goedde, 2012). Early in infancy, biological variables are the most influential (Agarwal &
Goedde, 2012). Family is the strongest in shaping the child’s behavior and cognitions in early childhood (Agarwal & Goedde, 2012).

The community becomes a more predominant variable as the child gets older and more involved in activities outside of their family by doing things such as watching television, reading books, or going to the grocery store (Agarwal & Goedde, 2012). The social influence of friends begins to increase before the child begins school (Agarwal & Goedde, 2012). When the child reaches adolescence, the child’s peer group is the most powerful influence within the environmental clusters of family, community, and social group (Agarwal & Goedde, 2012). Parenting, familial, community, social environment, and school environment dysfunction are some of the possible psychosocial stressors that make children more vulnerable to SUD (Brook et al., 2006).

**Social and Emotional Functioning**

Difficulties with affect regulation, assertiveness, and poor communication is often modeled by parents with SUD (Lander et al., 2013). Communication is an essential social skill necessary for effective interpersonal relationships. Thus, these children often experience developmental, social, and interpersonal issues in the areas of social and emotional functioning (Lander et al., 2013).

Though clinical presentation varies within this population, some common emotions that are experienced by these children include fear, anxiety, depression, guilt, shame, confusion and anger (Lander et al., 2013). Though a child may be aware of their parent’s altered state, they may not fully understand their parent’s addiction and may be left confused about why their parent presents as moody, forgetful, and/or preoccupied (Lander et al., 2013). Many children of parents
with addictions grow up believing that they are the cause of their parent’s addiction. They may be expected to keep the addiction a secret from others or feel shame surrounding the addiction, thus inhibiting them to reach out to others for help or to express their feelings in a healthy way (Lander et al., 2013). The unpredictable and unstructured environment leaves the child wondering what is normal and wondering what will happen next.

When parents are unable to meet the needs of their children, “reversal of dependence needs” may occur, which involves children taking care of the parent and the parent’s needs coming before the child’s. Lander et al. (2013) described these children as parentified children. These children are forced to take on many parental duties at a young age for survival and must often take care of themselves, younger siblings, and caretakers (Lander et al., 2013). The social and emotional ramifications of reversal of dependence needs are considerable. Children can develop an inability to set healthy boundaries, may have poor self-awareness, and persistently put needs of others before their own (Lander et al., 2013). The ability to make triad connections between thoughts, feelings, and behaviors may also be impaired (Lander et al., 2013).

Many times, parent-child separation occurs as a result of chronic substance use by parents. Separation can negatively affect a child’s emotional functioning. Some common reasons for separation include out-of-home placement after intervention from child protective services, such as parental incarceration, long-term treatment, foster care, group home, residential home, or a relative’s home (Lander et al., 2013). In more severe cases, overdose, motor vehicle accident, or other substance-related illnesses or death can be the cause of parent-child separation (Lander et al., 2013). Long-term parent-child separation can have detrimental impacts on the child’s
physical and mental health, such as affect, the ability to form relational attachments, and regulation (Lander et al., 2013).

Children of individuals with SUD are at higher risk for nearly every diagnosable childhood disorder (SAMHSA, 2002). Eating disorders, behavior disorders, anxiety disorders, depression, post-traumatic stress disorder (PTSD), and SUD have the highest association (Lander et al., 2013). Affect regulation is learned from primary attachment figures through parental attachment and modeling. Parents with SUD are unable to provide modeling of healthy affect regulation, which makes their children susceptible to an increased risk for developing the aforementioned issues (Lander et al., 2013). One study found children who grew up in homes with parents who abused alcohol were more likely to have endured more frequent adverse childhood experiences (Anda et al., 2002). They also found a correlation between high number of adverse childhood experiences and depression in adulthood (Anda et al., 2002). Inpatient admission rates are 24 percent greater for children of alcoholics, with SUD and mental disorders being the most common problems. Higher rates of attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) were also found among children of parents with SUD when compared to children with non-addicted parents (SAMHSA, 2002). Some traits associated with behavioral issues exhibited by this population include lack of empathy for others, decreased feelings of social adequacy, and interpersonal adaptability (SAMHSA, 2002).

**Educational and Cognitive Functioning**

Lower academic achievement and cognitive functioning issues are prevalent in children of parents with SUD. These children score more poorly on academic achievement tests, have higher rates of absenteeism, are more likely to drop out of school or be referred to the school
psychologist than children of non-addicted families (Sher, Walitzer, Wood & Brent, 1991). Infants and toddlers are often deprived of learning-based stimulation from their parents, and parents often fail to provide homework assistance and monitor school performance of their school-aged children (Sher et al., 1991). Children’s basic needs of safety and security are often not met at home. Subsequently, they may experience a great deal of anxiety and stress in their home environment (Sher et al., 1991). As a result of their chaotic home situation, these children have difficulties with attention, concentration, and higher order thinking, which all affect their ability to learn and excel in school settings (Sher et al., 1991).

Serious truancy problems and school dropout is often preceded by childhood school absenteeism. One study found that 41% of parents with SUD reported that at least one of their children repeated a grade, and 30% reported at least one child had been suspended from school (Kolar, Brown, Haertzen, & Michaelson, 1994). This study, however, did not control for socioeconomic status, which may have confounded the data. Delinquency and truancy in school predict future SUD (Sher, Walitzer, Wood, & Brent, 1991). Due to parent’s preoccupation with their SUD, or perhaps their avoidance due to shame and guilt, communication between parents and teachers is often poor, and parents are often uninvolved with school related concerns (Sher et al., 1991).

**Substance Use Prevention Programming**

The literature and science of substance use prevention has made progress to incorporate prevention programs that serve a broad range of populations and implementation settings. The National Institute on Drug Abuse (NIDA) highlights this research by providing a research-based guide to drug prevention programming for children and adolescents for the purpose of assisting
prevention practitioners in drug prevention programming for this population (Robertson, David & Rao, 2003). Included in this guide are prevention principles, risk factors, protective factors, community planning and implementation, as well as examples of research-tested prevention programs. These topics provide a useful guide for drug prevention development and programming. Principles discussed in the literature are specific to age and implementation settings (family, school, and community). In order to keep the focus of this literature review on the target population of this program development project, only principles specific to elementary school-aged children, school settings, and community settings will be considered.

**Prevention Principles**

**Risk and protective factors.** A child’s susceptibility to SUD is dependent on risk and protective factors. Consequently, a core principle for drug prevention programs is enhancing protective factors and reducing risk factors (Hawkins, Catalano & Arthur, 2002). Risk and protective factors are present in individual, parental, familial, and social levels. Thus, the most effective prevention would include a comprehensive approach to identification of community needs and implementation of relevant evidence-based strategies (Hawkins et al., 2002). Effective prevention programs should also be tailored to address risks and protective factors specific to the target population (Oetting, Edwards, Kelly, & Beauvais 1997).

**Identified protective factors.** Despite the risks, many children of individuals with SUD grow up without incurring any of the negative outcomes previously discussed. Some children are more vulnerable and some more resilient to their parent’s drinking (Park & Schepp, 2015). It is important to understand what protective factors lead to resiliency in order to tailor programming to those needs and promote those protective factors.
Resiliency is the process of struggling through adverse situations and the ability to recover and develop positive outcomes despite hardships (Desetta & Wolin, 2000). Literature on resiliency states that individuals are innately capable of recovering, thus possessing inherent strengths as well (Smith, 2006). Helping individuals discover their resilience and the strengths they possess, how they have used them, and can use them in the future through a strengths-based approach promotes self-esteem (Smith, 2006). *Protective factors* are factors that promote resilience and act as buffers against stressful life events that threaten one’s development (Vellemen & Templeton, 2007). Protective factors impact children on individual, parental, familial, and social levels (Park & Schepp, 2014). These factors are discussed in the subsequent paragraphs.

**Individual factors.** Individual factors are features a person possesses. Factors on an individual level take into consideration personal traits, characteristics, and abilities. Resiliency levels in children of parents with SUD can be affected by individual factors such as self-esteem, self-regulation, and temperament.

It was found that high self-esteem in children of alcoholics (COAs) is positively correlated with resilience in COAs (Kim & Lee, 2011). Thus, although COAs usually exhibit lower self-esteem than non-COAs, high self-esteem is more likely to promote resilience and may act as a protective factor against future SUD (Kim & Lee, 2011). The researchers of this study recommend that future prevention and resiliency programs for this population include goals to develop and enhance self-esteem in order to increase resilience.

Another individual factor that affects resiliency is self-regulation. Self-regulation is the “capacity for altering one's own responses, especially to bring them into line with standards such
as ideals, values, morals, and social expectancies, and to support the pursuit of long-term goals” (Baumeister, Vohs, & Tice, 2007, p. 351). Research shows that COAs are generally less able to self-regulate than non-COAs (Edwards, Eiden, Colder, & Leonard, 2006).

Though COAs generally have less self-regulatory abilities, a study found COAs who posses this ability show higher levels of resiliency against substance-related issues (Pearson, D'Lima, & Kelley, 2011). The study examined how self-regulation abilities moderated problematic drinking for first year college adult children of alcoholics (ACOA) by comparing ACOAs with high levels of self-regulation abilities against those with low levels. This study found that high levels of self-regulation abilities served as a protective factor against alcohol-related issues. Researchers suggest using their findings to help inform prevention strategies, proposing that self-regulation training may be a useful approach to drinking reduction for ACOAs.

**Parental factors.** Children who have negative relationships with their parents tend to have higher levels of risk for SUD than children who have positive relationships with their parents (Kelley, Pearson, Trinh, Klostermann, & Krakowski, 2011). ACOAs typically reported less positive relationships with their parents, which was determined by assessing perceptions of trust, communication, alienation, attitude, and emotional longing. When present however, appropriate parenting and secure attachments with parents or non alcoholic caregivers may serve as a protective factor against negative outcomes related to parental SUD (Molina, Donovan, & Belendiuk, 2010).

Parents with SUD who exhibited positive parenting and secure attachments involving consistency, sensitivity, emotionally availability, and parental monitoring with parental warmth
facilitated the child’s ability to cope with negative emotions, stressful situations, and decreased externalizing behaviors (Molina et al., 2010). Additionally, children with two alcoholic parents were more likely to exhibit higher levels of externalizing behaviors than children with one alcoholic parent (Park & Schepp, 2015). Implications of the protective factors in relation to the parent-child relationship suggest a need for programming and intervention with a focus on parenting skills and fostering positive parent-child attachments.

**Familial factors.** The presence of other supportive and trustworthy family members serves as a protective factor on a familial level. Werner and Johnson (2004) discussed the role of caring adults in the lives of COAs. This longitudinal study collected data from interviews and questionnaires from adult and children COAs over a period of 30 years. The data showed that Adult children of alcoholics (ACOAs) (write out adult if that’s what’s meant) who showed positive outcomes and effective coping relied on a significantly larger number of positive supports in their childhood than did ACOAs with coping problems by age 32 (Werner & Johnson, 2004). The study found that positive support from older siblings seemed to have a positive effect on COAs, particularly males (Werner & Johnson, 2004). Grandparents, especially the maternal grandmother, buffered the negative effects of the traumatic family environment. Other supportive family members, such as aunts and uncles, also positively affected the lives of COAs.

Werner and Johnson (2004) list many implications for social action in relation to this study. They note that the key ingredient to any intervention strategy is the promotion of self-esteem and self-efficacy. Self-esteem and self-efficacy seen in resilient children was nurtured
through the positive relationships with family and supportive adults in the community. They suggest that intervention be tailored around encouraging and strengthening these relationships.

**Social factors.** Protective factors have also been found on a social level. Werner and Johnson (2004) found that many resilient COAs found support from a teacher or an elder who served as a mentor who helped to build academic skills as well as confidence and self-esteem. These children also seemed to receive emotional support and experience positive family environments from friends and parents of friends (Werner & Johnson, 2004).

Moe, Johnson, and Wade (2007) examined strength and resilience of COAs through the child’s perspective. Methods included qualitative interviews that were audiotaped, transcribed, and thematically analyzed. One theme that emerged was the importance of the expression of feelings. In order to live a good life and be resilient, the children believed that they must be able to express their feelings and have someone trustworthy to talk to about their feelings (Moe et al., 2007). They also believed that positive life choices and involvement in activities was an important factor in being resilient (Moe et al., 2007). Children also touched upon the importance of education and knowledge of their parent’s addiction. They felt that understanding how drug use affects their parents and how addiction could affect them if they used drugs would help them become resilient. The researchers suggest that successful intervention and prevention programs will promote positive outcomes by providing opportunities for expression and education (Moe et al., 2007).

A common theme among the studies reviewed is the emphasis on promoting protective factors and/or reducing risk factors when developing intervention or prevention programs. Increasing and promoting self-esteem to buffer the impact of adverse childhood experiences
related to parental drug use is a prevalent concept in the literature. One downfall to the literature on this topic is the emphasis on alcohol addiction and not SUD in general; this population is still, however, pertinent to the target population of this program development. Being aware of risks can help to determine what the needs may be, while being aware of the protective factors will aid decision making regarding what goals should be included in a prevention program. Examining protective factors and resiliency is an important step for creating prevention programs that aim to encourage healthy outcomes.

**Prevention Implementation**

Prevention programs are designed for specific audiences and varying levels of intervention. Relevant to this program development project are *selective programs*, which target specific at risk groups, as opposed to universal programs targeting the general population (universal) or indicated programs targeting individuals already using drugs (Robertson, David, & Rao, 2003). The following section will consider current selective drug prevention programming in school and community settings.

**School programs.** School is the most common setting for drug prevention programming and is one of the most common providers of mental health services in the United States, in part because of the accessibility and availability of children (Prevention First, 2011). Prevention programs should be tailored to the developmental needs of the children. Research suggests programs intended for elementary school children should target improving academic and social-emotional learning to address risk factors of early aggression, academic issues, and school dropout (Ialongo, Poduska, Werthamer, & Kellam, 2001). Prevention should focus on
promoting the following skills: self-control, emotional awareness, communication, coping skills, social problem solving, and academic support (Ialongo et al., 2001).

The Student Assistance Program (SAP) is a selective prevention program found at elementary, middle, and high school levels aimed at providing prevention, early intervention, and referral services for youth dealing with non-academic barriers to learning (Prevention First, 2011). The program began as a SUD prevention and intervention model but has shifted its focus to support children through other non-academic issues as well, such as mental health, bullying, and relationship issues (Prevention First, 2011). Children can self-refer or be referred by a peer, parent, or teacher (Prevention First, 2011). The SAP intervention process follows these four steps: identification and referral, screening, problem-solving and case management, and monitoring (Prevention First, 2011). Monitoring involves a team reviewing the case, adapting the action plan as needed, and closing the case when the team feels SAP services are no longer needed. A core team approach is the most commonly utilized in SAPs. The core team approach involves a multidisciplinary team of individuals who work with students to implement school-based strategies and provide referrals to community resources. SAP services utilize a comprehensive approach to addressing student behavioral health concerns and have reported lower alcohol use rates and significantly higher academic achievement rates than schools without SAP services (Prevention First, 2011).

Another selective program targeting elementary school-ages children is the Strengthening Families Program (SFP). This program is a family-focused program that has been implemented in both school and community settings providing support for parents with SUD and their children (Kumpfer, Alvarado, Tait, & Turner, 2002). The primary goals are to improve parenting skills,
family communication, family organization, and youth social skills, as well as reduce children’s risk for conduct disorders, aggression, and SUD (Kumpfer et al., 2002). SFP is a 14-week program focusing on a behavioral parent training program, children’s skills training program, and family skills training program (Kumpfer et al., 2002). The first hour of the session focuses on treating children and parents separately in their respective groups, and brings them together for family skills training in the second hour. Childcare, transportation, and small incentives are provided as a way to reduce barriers to attendance. SFP has shown consistent positive results across multiple replications with ethnically and culturally diverse populations (Kumpfer, 1996).

**Community programs.** The Substance Abuse and Mental Health Services Administration (SAMHSA) developed curriculum for children of parents with SUD called the Children’s Program Kit: Supportive Education for Children of Addicted Parents (2002). This program is a selective prevention program designed for implementation in community settings. Objectives include enhancing resilience, reducing stress, and strengthening families. Groups provide education and a safe place for children of parents with SUD to freely share their feelings. The goal of the support groups is to provide a sense of belonging that will reduce feelings of isolation, increase resilience by teaching skills to help build upon strengths, and learn how to seek safety and supportive services. Six topic areas are covered in the curriculum: addiction, feelings, problem solving, treatment and recovery, safe people, and coping. Culturally sensitive, developmentally appropriate curriculum and activities for elementary, middle, and high school aged children are provided in this program.

The Focus on Families (FOF) program is a selective program for parents receiving methadone treatment and their children. The program begins of a 5-hour family retreat to learn
about the program, set goals, and engage in trust-building activities (Haggerty, Skinner, Fleming, Gainey, & Catalano, 2008). Following the retreat are 32 parent-training sessions that teach parents relapse prevention, coping skills, anger management skills, and family management skills (Haggerty et al., 2002). Objectives also include teaching parents how to teach these skills to their children and assisting children with academic success (Haggerty et al., 2002). Children practice developmentally appropriate skills by attending 12 sessions with their parents. The program aims to decrease children’s exposure to risk factors and increase protective factors in order to decrease future SUD and delinquent behavior (Haggerty et al., 2002). Evaluation of FOF showed positive changes in parenting skills, rule-setting, domestic conflict, drug refusal skills, and drug use. The program also showed trends toward positive effects on child outcomes.

Alateen is a self-help community-based program for children of alcoholics (Al-Anon Family Group Headquarters Inc., 2003). Meetings are held in community settings such as churches or community centers (Al-Anon Family Group Headquarters Inc., 2003). It is based on the 12-step program of recovery used in Alcoholics Anonymous (Al-Anon Family Group Headquarters Inc., 2003). Alateen is not a prevention program, but rather a support group with the purpose of promoting support, understanding, and hope by providing a space for children to share their experiences so they may recognize they are not alone in their family’s addiction. Little research has been done evaluating the effectiveness of Alateen, however, one study found that those who participated in Alateen reported higher self-esteem than did children of alcoholics who did not attend Alateen groups (Dadich, 2006). Another study found that group counseling had more positive effects in improving self-worth while reducing withdrawal and antisocial tendencies than did Alateen (Emshoff & Price, 1999). This finding implies that the structure or
facilitation of Alateen groups is not as effective as group counseling in achieving the positive effects indicated in the study. This also suggests that interventions and/or programs incorporating counseling or therapy techniques may be more effective than community lead, self-help, support groups.

Common goals amongst these programs include decreasing risk factors while increasing protective factors, coping skills, academic functioning, academic achievement, and social-emotional learning. Research has shown high self-esteem to be a protective factor in these children; however, many programs do not overtly state increasing self-esteem as an objective (Kim & Lee, 2011). Additionally, though all programs aim to increase protective factors and resilience, few programs have considered a strengths-based approach. Smith (2006) suggests that the recognition of one’s resilience consequently increases self-esteem. Thus, a strengths-based approach with a focus on increasing self-esteem could be of great value for a prevention program.

Dance/Movement Therapy and Prevention

Currently, there are no known dance/movement therapy (DMT) prevention programs and few creative arts therapy programs for children of individuals with SUD. Although there is little to no research on dance/movement therapy as a prevention method for children of individuals with SUD, there are DMT and other creative arts therapy-based prevention programs in the field. These programs may provide information about how prevention programs may be tailored to incorporate DMT, as well as provide support for the use of DMT in prevention programming.

Creative arts and prevention. Highlighted in Drewes and Schafer’s (2010) guidelines for utilizing play therapy for COAs is the benefit of utilizing creative modalities to help this
population explore their feelings. Verbal therapy may not provide the setting that will allow children to fully express themselves because of the minimization and denial of feelings that often occurs with this population (Drewes & Schaefer, 2010). Children may feel more comfortable with expressing their feelings in a creative setting, in which there is more room for flexibility and spontaneity (Drewes & Schaefer, 2010). This flexibility, in turn, may also prove beneficial for this population in which children may often exhibit rigid and perfectionistic traits (Drewes & Schaefer, 2010). Thus, creative arts therapies may be a valuable approach to increase self-expression and feeling identification for these children.

One prevention program integrated the creative arts in an elementary school prevention program by using music and psychodrama as a complementary approach to substance use prevention (Wager, 1987). Wager believed the modalities of music and drama could “involve participants cognitively, affectively and physically, thus enhancing the learning experience” (p. 137). The implementation of this program was well received at the school. Teachers stated the inclusion of creative arts in programming was effective in enabling children to discuss their feelings about this difficult topic. Though formal program evaluation has not been conducted, facilitators reported that the children enjoyed the program and were highly attentive (Wager, 1987).

Rena Kornblum (2002) provided movement-based prosocial skill development and violence prevention sessions in public schools. Her program involves structured movement activities that focus on prosocial skills such as socialization, body image, boundaries, energy modulation, and attention span (Kornblum, 2002). She also stressed the integration of the mind and body as essential to the three major skills necessary in preventing violence: pro-active
abilities, anger management, and meeting one’s own needs without hurting others (Kornblum, 2002). Children learn to get along through the physical experience of moving with one another while respecting boundaries (Kornblum, 2002). She believes that the importance of body awareness and movement skills are often overlooked in other prevention programs (Kornblum, 2002).

The Making Connections Suicide Prevention Program is a DMT-based program with the mission of preventing suicide through fostering connections with self, others, and the community (Columbia College Chicago, 2012). The program is a two and a-half hour workshop facilitated in colleges, universities, and high schools for students, faculty, staff, and administrators. Program objectives include identification and application of suicide prevention steps, risk factors, warning signs, and protective factors against suicide. In addition, movement objectives include increasing body-mind awareness, identification of body signals of others, and learning Movement Thinking Strategies (MTS) for empathy building. Skills are taught through experiential methods and creative engagement. The program also aims to teach the three steps in suicide prevention—observe, understand, and explore (O.U.R)—and uses these steps as an underlying approach to the curriculum.

**DMT Application**

Beyond DMT prevention programs, DMT has shown to be effective for promoting emotional regulation in children, and increasing self-esteem, which are relevant to an effective strengths-based SUD prevention program (Baudino, 2010; Betty, 2013; Corteville, 2009; Bannon, 1994). Examples of DMT with these objectives will be discussed to further inform the
use of DMT for the target population in this project, pertinent objectives, and applicable approaches.

**DMT and Emotional Regulation**

Children with parents with SUD are at high risk for neglect and abuse. Maltreated children who have suffered neglect and abuse can lead to emotional dysregulation in children (Shipman & Zeman, 2001). Positive emotional development and the ability for children to modulate emotions are compromised when parents are unable to provide soothing and responsive caretaking, which is common among parents with SUD (Shipman & Zeman, 2001). Behaviors and symptoms displayed by these children include aggression and self-destructive tendencies. An array of literature has examined the use of DMT interventions and approaches to promote emotional regulation.

The concept of regulation in the DMT literature was defined by Kestenberg in terms of tension flow attributes, which reflect an individual’s core temperament by expressing attributes or qualities of emotions (Amighi, Loman, Lewis, & Sossin, 1999, pg. 60). Through individual preferences of tension flow attributes, an individual “develops a small measure of control or regulation over the expression of needs (tension flow rhythms).” The *Ways of Seeing* approach uses principles of dance/movement therapy and Laban Movement Analysis as intervention and assessment for responding to physiological and emotional dysregulation in children (Tortora, 2006). The approach focuses on helping children with emotional regulation on multisensory/physiological levels by teaching them how to attune to their emotional and physical states through dance/movement and play activities (Tortora, 2006).
Baudino (2010) utilized DMT in her work with a child who suffered from abuse and neglect, focusing on increasing emotional regulation. The importance of trust and safety when working toward emotional regulation is also emphasized in the literature. In order to promote safety and trust, she provided consistency in schedule and transitions, incorporated recurring activities, spoke in a soothing voice, and afforded the client ample personal space. Mirroring—the process of embodying the exact shape, quality, and movement of an individual—was also incorporated to reflect the child’s internal state (Baudino, 2010). Awareness to the child’s emotional expressions was strengthened through a technique called amplification, in which the client’s nonverbal movements were exaggerated by the therapist (Baudino, 2010).

Betty (2013) proposes a theoretical framework DMT application in residential treatment centers with the objective of increasing emotional regulation in maltreated children. This framework proposes four progressive and overlapping phases: creating safety, cultivating emotional awareness, strengthening internal emotional coping, and promoting external expression management. Betty (2010) proposes a training to promote these four processes for children and direct-care professionals for use in residential treatment facilities. The training covers each phase through four, 2 hour modules. Each module follows the following process: body-based check-in, instruction, experiential, observation reports, and self-care planning. The core DMT components include attunement, Tension Flow Effort System of the Kestenberg Movement Profile (KMP), and KMP’s Shape Flow Shaping System.

A common theme present in the literature regarding the benefit of DMT for emotional regulation is increasing body-awareness, and the fostering of safety. DMT utilizes mirroring and the tracking of body responses such as internal sensations, breath, and body position to increase
body awareness, which in turn increases emotional awareness (Homann, 2010). When children become aware of their body sensations and connect them to their emotional states, they become capable of using the body as a resource for emotional regulation (Homann, 2010).

These children may view the world as unsafe due to having endured dangerous situations and their needs consistently being unmet, thus fostering safety is beneficial. The use of DMT enables access of information that may not be readily available through verbal processing for these children and reveals information about social, emotional, physical, cognitive, and communicative development (Tortora, 2005). Safety is largely communicated nonverbally thus, DMT offers an effective approach to fostering the feeling of safety (Dales & Jerry, 2008). Through the use of DMT for movement observation and assessment, the therapist is able to assess nonverbal expressions and use this information to tailor interventions to fit the child’s needs.

**DMT and Self-esteem**

Research on the relationship between self-esteem and DMT suggests that DMT increases self-esteem. This relationship has been examined in several studies across different populations (Corteville, 2009; Bannon, 1994; Ingram 2013). Though research on the relationship between DMT and self-esteem with elementary school aged children is limited, there are many studies that focus on adolescents—these studies will be considered in the following paragraphs.

DMT has the potential to increase communication and interpersonal relationships, which in turn may increases one’s self esteem (Corteville, 2009). Corteville (2009) utilized DMT in a school setting to examine the effect of DMT on self-esteem, body image, and communication skills. Results on body image will not be discussed, as they are not pertinent to this program.
development project. The study included eight DMT sessions and participants included three, 15 year-old adolescent girls. The study found a strong association between high self-esteem, effective communication skills, and increased interpersonal skills (Corteville, 2009).

Another study also found DMT to have positive influences on self-esteem, communication, and interpersonal skills (Bannon, 1994). DMT services were provided to emotionally disturbed adolescents in a therapeutic day school with low self-esteem, poor self-control, interpersonal relating skills, as well as difficulty identifying and expressing feelings (Bannon, 1994). Within weekly DMT sessions, students addressed behavioral, relational, and identity issues through movement interventions. Acceptance by the therapist through the therapeutic relationship was suggested as an important component to fostering self-esteem (Bannon, 1994).

Ingram (2013) explored self-esteem through the DMT interventions of improvisation and planned movement formation. The study was a mixed methods, single-subject case study pilot implemented in a school setting with four adolescent Latina girls for six sessions. The DMT intervention of improvisation and the incorporation of salient movement qualities from movement responses into their planned movement formations showed an increase in self-esteem. Ingram (2013) suggests that the incorporation of movement responses from the therapist provided an empathetic reflection of their experiences. Mirroring is used as a way to develop empathy between client and therapist, thereby strengthening the therapeutic movement relationship (Levy, 1998). The use of empathetic reflection served to increase self-understanding, which contributed to greater self-esteem.
These studies presented similar findings—DMT is a valuable approach for increasing self esteem. Children of individuals with SUD oftentimes suffer from low self-esteem, which has been found to operate as a risk factor for depression and SUD (Orth, Robins, Trzesniewski, Maes, & Schmitt, 2009; Kim & Lee, 2011). In contrast, high self-esteem in these children can serve as a protective factor. Thus, DMT may serve as an effective approach to meeting the program objective of increasing self-esteem.

**Conclusion**

Parental SUD poses many detrimental effects on children. Children’s functioning on emotional, behavioral, educational, social, and physical levels may be negatively affected. Dysfunction within the family, poor parenting, and lack of structure within the home environment is common in families with SUD. Additionally, children are at risk for child abuse, neglect, externalizing behaviors, poor emotional regulation, and low academic achievement.

Effective prevention programming reduces risk factors and fosters protective factors. Existing prevention programming examined in this literature review address the issues of increasing coping skills, academic functioning, and increasing social-emotional learning. Creative arts prevention programs have been effective in increasing body awareness, promoting prosocial skills, and increasing self-expression. Most programs have been implemented in school or community settings.

Existing programming lacks an emphasis on increasing self-esteem as an objective, as well as a strengths-based approach that views the children as inherently resilient and builds upon those strengths. Also lacking in existing literature and prevention programming is a body-based prevention program for children of individuals with SUD. In other therapeutic settings, DMT has
been effective in meeting pertinent objectives such as increasing emotional regulation, fostering a sense of trust and safety, and increasing self-esteem. Therefore, DMT can be considered as an additional intervention with this population.

In review of the literature, considerations include more research on the use of DMT in preventative programs for children of individuals with SUD. Specifically, the use of dance/movement therapy and body-based programming needs to be addressed. A research question that emerged from this literature was the following: how can DMT help in preventing SUD in children of individuals with SUD to stop the cycle of generational continuity?
Chapter 3: Model and Process

The purpose of this project was to develop a DMT strengths-based resilience promotion program for children of individuals with SUD. The question this program aims to answer is: how would a DMT strengths-based resilience promotion program for this population be designed? Program design and development was approached using a theory approach logic model. Information gathering was facilitated using the Delphi method, which involved three rounds of interviews with collaborators. This model and process of information gathering is further elaborated in the following section.

Logic Model

This program development project was created using a theory approach logic model. A logic model is a structured visual representation of how one believes their program will work (W.K. Foundation, 2004). The purpose of logic models is to provide stakeholders a roadmap that describes the connection between the needs of the program, the desired results, and the actions expected to lead to these results (W.K. Kellogg Foundation, 2004). There are many useful ways to utilize logic models and many benefits that may be obtained from their employment. Program logic models are effective tools in facilitating the stages of planning, implementation, and evaluation of programs (W.K. Kellogg Foundation, 2004). Potential obstacles to the program’s operation can be identified and addressed early on through the use of a logic model. This approach also helps communicate ideas, purpose, and results clearly for stakeholders and funders (W.K. Kellogg Foundation, 2004). There are different approaches to logic models with different emphases, strengths, and uses (W.K. Kellogg Foundation, 2004).
For the development of this program, the theory approach logic model was utilized as it is considered to be most useful for program planning and design (see Appendix B; W.K. Kellogg Foundation, 2004). A theory approach logic model explains program assumptions by linking theoretical ideas together (W.K. Kellogg Foundation, 2004). Through this logic model, I focused on the problems my program wished to address and my reasons for wanting to explore these issues. This model illustrated my thoughts about whether, how, and why my program will work. Components of the logic model included: the problem or issue, community needs, desired results, influential factors, strategies, and assumptions. Each of these components is discussed in full in this section.

Problem. This program addresses the issue of the generational continuity of SUD. According to the Substance Abuse and Mental Health Services Administration’s (2015) 2014 National Survey on Drug Use and Health, SUD is a widespread issue affecting 20.3 million adults. Furthermore, there are more than 28 million children of individuals with SUD in the United States (SAMHSA, 2002). These children are at risk for a number of issues including child abuse, neglect, externalizing behaviors, social issues, emotional issues, low academic achievement, and future SUD (SAMHSA, 2002). DMT has the potential to enhance social, emotional, and cognitive competence through the use of nonverbal communication and the mind/body connection. Studies have found DMT to increase self-esteem as well as increase emotional regulation in children with a history of abuse and neglect (Baudino, 2010; Betty, 2013; Corteville, 2009; Bannon, 1994). Therefore, DMT may be a suitable modality for SUD prevention.
Community needs. The needs that led me to address the issue of generational SUD include problems related to crime, lost work productivity, and health care for tobacco, alcohol, and illicit drug use cost the United States over $600 billion annually (Robertson et al., 2003). In 2011, 20.6 million people ages 12 or older were classified with substance dependence or abuse in the past year (Robertson et al., 2003). It also costs $460.18 per day to care for drug-exposed infants who are abandoned or kept at hospitals (SAMHSA, 2002). Prevention for SUD would save our nation billions of dollars annually. Most importantly, prevention may save children at risk for SUD from lives of hardship, pain and suffering.

Desired results (outputs, outcomes, and impacts). The goals I expect my program to achieve involve obtaining grants and other funding in order to implement the developed program in communities with high need. I also seek to provide a DMT program that is accessible to my target population. Short-term goals include increasing self-esteem, identifying strengths, increasing self-expression, and increasing body-awareness. The long-term goal of the program is to increase resiliency through the use of DMT interventions, which would help prevent the generational continuity of SUD.

Influential factors. There is a substantial need for preventative programming given the many risk factors and high number of individuals and families suffering from the disease of addiction (Robertson et al., 2003). The efficacy of a DMT program may be questioned because of the scarcity of quantitative research in the field of DMT. Working in favor of this approach, however, is that a program of this nature does not exist; a DMT program may offer a new, more holistic approach to drug prevention.
**Strategies.** There is no DMT or body-based programming aimed toward drug prevention for children. Research states prevention programs are most effective when they employ interactive techniques that allow for active involvement in learning about drug abuse (Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995). The use of DMT in this program promotes active involvement in learning through movement experientials.

Rena Kornblum (2002) created Disarming the Playground, a body-based violence and bullying prevention program geared toward children in school settings. Evaluation of the effectiveness of the program indicated significant positive changes including: increased emotional self-regulation, anger management, interpersonal communication, and self-confidence (Hervey & Kornblum, 2006). The evaluation provides recognition for body-based programming as valuable tools for violence prevention. The effectiveness of this program may also provide recognition for body-based programming for different types of prevention for children in other settings. Thus this program is a notable strategy currently being used in the field of DMT and prevention.

**Assumptions.** As exhibited in Kornblum’s body-based violence prevention program (2002), DMT has the potential to influence significant change when implemented in prevention programming. The Moving for Freedom program utilizes DMT to address skills such as coping and communicating feelings, as well as education on important topics such as addiction and safety. Exploring these concepts through a DMT approach offers children a more accessible way of expressing and processing thoughts and emotions. The program aims to promote resiliency among children and increase protective factors to prevent future drug use. By offering early
prevention and increasing protective factors, the program intends to interrupt the generational continuity of SUD, curbing the widespread issue of addictions that poses high costs for society.

**Participants**

Participants will include 3-8 children between the ages of 8-10. Participants will all be identified as having at least one parent with SUD. Elementary school aged children ages 8-10 are targeted in this program in order to increase protective factors before they enter middle school; they may be exposed to more opportunities to use drugs and social situations involving drugs during middle school. Studies show that early initiation of drug use can lead to greater drug use in the future. The National Survey on Drug Use and Health found that children are beginning to use drugs by ages 12 or 13 (Robertson, David & Rao, 2003). The goal is to provide services to children before they begin using substances in order to decrease their chances of using in the future.

Members may be of any gender or ethnicity. Participants will be recruited from outpatient services by providing parents with the option of entering their children in the program. Parents who have children who fit the criteria for the program will be given a referral form detailing the specifics of the program and requesting consent (see Appendix D).

**Proposed Implementation Site**

The proposed implementation site of this resilience promotion program is within an urban mental health center with a partial hospitalization program (PHP) and intensive outpatient program (IOP) for individuals with SUD. PHP is a daily program where clients come to treatment at the center for 6 hours during the day and return to home or work where they can practice learned skills. Clients attend PHP programs, on average, for 2-3 weeks. IOP at this
implementation site is less intensive than inpatient rehabilitation or PHP. Sessions are generally 4 days a week for 3 hours. There is no set timeframe for the duration of the program as this is tailored to each client and their needs; however, the average length that one participates in an IOP at this center is 4-5 weeks.

The Moving for Freedom program is designed to be implemented during weekend family nights that are offered to clients and their families. The purpose of the 2 hour family programming facilitated at this site is to educate families about how SUD affects the family, recovery and addiction, and skills for discontinuing unhealthy family patterns. Children will attend the Moving for Freedom program while adults attend their respective group.

An outpatient rehabilitation setting was chosen for ease of recruitment and the added benefits of providing child-care during treatment. Many of the programs reviewed in the literature implement programs in school settings. School settings would make it difficult to recruit these children given the nature of their situation. Secrecy surrounding the disease is common within these families because of the stigma and shame surrounding addictions. Therefore, disclosure of SUD in the family may be unlikely, which would make it difficult to know which children fit the criteria for this program in a school setting. Recruiting these children in an outpatient rehabilitation setting ensures that the program is targeting the intended population.

Additional benefits of this proposed implementation site include providing child-care for parents. One major barrier to women entering treatment is lack of childcare (Terplan, Longinaker, & Appel, 2015). This program would provide a safe space for children to go while
parents receive treatment. Decreasing barriers for parents facilitates their attendance to treatment while also increasing the likelihood of enrolling their children in the program.

**Delphi Method**

Information was gathered from collaborators by engaging in the Delphi method—an information gathering method used for the purpose of promoting structured group problem solving and planning (Hsu & Sandford, 2007). Although there is a standard Delphi process, the method is flexible (Skulmoski, Hartman, & Krahn, 2007). For this project, the method was roughly structured according to the standard Delphi process, but it was modified to better serve the purpose of this program development. Interviews were conducted and recorded to collect information in a three-round process. I will further explain the specifics of the information gathering process in the following paragraphs.

**Collaborators.** For this program development, collaborators were chosen based on their experience with the SUD population, DMT, and drug prevention. I collaborated with three experts in the field of addictions. Collaborators consisted of three therapists experienced in working with the substance use population. Two collaborators are dance/movement therapists, and the other with experience in drug prevention with children. I informally recruited collaborators by discussing my thesis question, ideas, and reasons for wanting to create this program with them. Additionally, each collaborator signed a consent form, which further explained my purpose and expectations (see Appendix C). The nature of this relationship was collaborative and interactive. Three rounds of interviews were conducted, each at least one hour long. The interviews were recorded and later reviewed in order to inform the next round of interviews and reach consensus. The structure and outcome of each interview is discussed below.
Round 1. This round consisted of an open-ended interview for the purpose of brainstorming and formulating broad ideas. Ideas about the structure of program, age of participants, implementation setting, session topics, and session activities were formulated in this round. Rationale behind each decision was also discussed, including pros and cons of different options that were being considered.

Round 2. Ideas formulated from the first round were reviewed, prioritized, and rationalized to begin forming consensus among collaborators. A rough draft of the program was brought forth to collaborators and each session was discussed, along with other components of the program. Ideas about the structure of the sessions, movement interventions, movement goals, session topics, psychoeducation, facilitation styles, program flow, and developmental appropriateness were themes that emerged in this round.

Round 3. The ideas summarized in the previous round were shared with collaborators for final revisions, opinions, and ideas. A final draft of the program was created from the consensus that was formulated.

Round 4. After further revisions, issues arose regarding congruence between the structure of the curriculum and the structure of the proposed implementation site. An extra round of interviews was conducted. This issue was time sensitive and needed to be resolved quickly, thus I was only able to gather data from two collaborators, as opposed to all three. These interviews were shorter in duration- 30 minutes- and conducted over the phone.

Session format was discussed, including the shift from closed group to open groups. Implementation site was also discussed, along with ways to better align the Moving for Freedom
program with the proposed implementation site. Alternate program topics and activities were considered as well.

**Conclusion**

A theory approach logic model was used in this program development project in order to organize rationale for the proposal of this program. This model illustrated the problem of the generational continuity of SUD, community needs, desired results, influential factors, strategies, and assumptions. This model is beneficial for future implementation of this program by providing stakeholders with a visual of the ideas, purpose, and desired results. The model may also be a useful tool for future evaluation of the program as well.

Ideas for the ultimate design of this program were formulated using the Delphi method through four rounds of individual interviews with collaborators. This process allowed for idea formulation, brainstorming, and decision making. I also found this method proved useful for problem solving when issues with the program curriculum arose. Through these methods, the vision for the Moving for Freedom was able to come to fruition.
Chapter 4: Program and Program Evaluation Plan

The Moving for Freedom program is a DMT strengths-based resilience promotion program for children of individuals with SUD created by this researcher for the purposes of this thesis project. The program was designed using a theory approach logic model. Information that guided the creation and structure of this program was gathered through the Delphi method and in collaboration with three clinicians with related experience. This chapter will provide an overview of the program including program organization, session format, and the program curriculum. This thesis project has not yet been put into effect; it is solely a program development created for the purpose of future implementation.

Moving for Freedom Program Overview

This program is a DMT strengths-based resilience promotion program for children of individuals with SUD aimed at addressing the issue of generational continuity of SUD. The program was titled Moving for Freedom to highlight the use of movement as the foundational approach, and also to embody the mission of the program: to assist children in realizing that their futures are not predetermined; that they have the strength, power, and freedom to move in whatever direction they choose. The program utilizes a strengths-based approach in order to empower them, help them realize their inherent strengths, and build self-esteem in the hopes of breaking this generational cycle of substance abuse. The metaphors of superheroes and superpowers were used in order to help children access their inherent strengths in a developmentally accessible manner.

Facilitators for this program must be registered dance/movement therapists with experience working with children, prevention, and SUD. Facilitators must also be trained to
facilitate this program. Interventions through movement, art, and verbal discussion are utilized to meet the objectives of the program, which include increasing body awareness, self-expression, and self-esteem through identification of strengths. This curriculum covers eight topics related to addiction and program objectives. Sessions are open, allowing children to join the program at any point. The program is also meant to help children realize they are not alone; many families struggle with addiction. The program seeks to provide a space where children feel safe and free to express feelings surrounding their experiences.

**Curriculum Organization**

The program curriculum is organized by eight topic areas including: superpowers, addictions, safety, feelings, anger, play, problem solving, and self expression through performance. These topics may be implemented sequentially or non-sequentially, as the facilitator sees fit. Sessions may be extended or repeated to be covered across multiple weeks if more time is needed to fully explore topic. There is value in reinforcing concepts if children are in groups past eight weeks and must repeat sessions. Under these circumstances, the facilitator may find it useful to have that child take on the role of leader or demonstrator, provided the child feels comfortable. They may also encourage participants to respond differently than in previous sessions while prompting the children to pay closer attention to something new they have learned or have noticed.

A consent/referral form is included and used for enrollment purposes (see Appendix C). A facilitator planning sheet is also included to provide the facilitator with an outline of sessions and to guide and assist the facilitator in preparing for individual sessions (see Appendix G). The facilitator may also use this sheet to take notes and evaluate the effectiveness of the session. A
list of body warm-up exercises (see Appendix H) and closing activities (see Appendix I) are included in order to provide the facilitator with options. The purpose of providing an open format for opening and closing exercises is to allow the facilitator to tailor the exercises to the group depending on the children’s energy level, mood, and affect.

**Session Format**

The following section outlines the format of the sessions and each session component. This section also contains guidance and useful tips for the facilitator to keep in mind when running each session. While there is a set curriculum, this program encourages and is designed to allow for individual style and creative adjustments in order to better tailor the sessions to various groups. Each session is planned to run for approximately 120 minutes including a break with a snack in order to align with the other family programming.

**Opening/check-in.** Each group begins with the administration of the pre-test. The children should be informed that this is neither a test of their intelligence nor is there a right or wrong answer. It is used for the facilitators to better understand what the children learned in session and will be used to improve future groups. The children will fill out a similar sheet at the end of the session as well.

Each session opening will include an introductory overview, body check-in, and a review of the rules and agenda. Sessions will begin with participants sitting in a circle. The introductory overview guide (see Appendix E) should be followed to introduce the purpose of the session, give context to why the children are there, and allow the children to introduce themselves. This will be particularly important if there are new children in the session. If there are returning members, they may be encouraged to give the introduction and explain the purpose of the
session. Introductions will involve children introducing themselves as superheroes, as well as their superpowers, and a representative movement.

A list of body warm-ups are included for the facilitator to choose from, however, they may implement a warm-up of their choosing (see Appendix H). The facilitator should assess the energy, mood, and movement qualities of the participants when deciding which body warm-up to implement.

Next, group rules will be reviewed and any clarifying questions answered if they arise (see Appendix F). Reviewing of the agenda includes introducing the topic being covered and the structure of the session. The agenda provides structure, which is important to maintain within this group given the lack of structure and unpredictability commonly experienced within the family (Lander et al., 2013). It may be helpful to post a copy of the agenda in the room where the children can see and follow along. Openings should last about 20 minutes.

**Movement activity.** There is an assigned movement activity for each session. 45 minutes should be allotted for this portion of the session, including discussion. It is helpful to prepare any materials ahead of time and make adjustments to allow space for movement. Facilitators should anticipate some participants feeling apprehensive about participating or unable to initiate self-expression through movement. It is important for the facilitator to validate the children’s feelings and explain that it is acceptable for them to not know how to express themselves, either verbally or through movement. Increasing self-expression is one of the goals in this program; it may take time and practice for the children to feel comfortable and able to express themselves. It will also be helpful for facilitators to model tasks, provide movement observations or suggestions, and invite the group to offer observations and suggestions.
**Discussion.** The discussion portion of the session serves as verbal processing and may be facilitated after the movement activity or throughout. Some guiding questions to consider are included in the session outlines, but facilitators may utilize this list as they see fit or ask other questions deemed relevant or beneficial. It is important, however, to initiate questions that foster body awareness during each discussion. Questions surrounding body-felt sensations should be posed in order to foster body awareness; examples of which are included in the session outlines.

**Break/Snack Time.** The group will receive a short 10-minute break with a snack. This will allow for the participants to recuperate, as well as provide an opportunity for socialization.

**Art processing.** Providing different forms of communication and processing through movement, verbalization, and art allow children many options for expression and provides a comprehensive treatment approach. Each session contains a corresponding art processing component. Art processing components may be adjusted and tailored to the children’s interests. For example, the facilitator may offer the option to write poetry or journal about their experiences if the child prefers to write. Age, attention span, reading skills, and writing skills of participants should be taken into consideration when making these adjustments. This section should last about 35 minutes. Time allowing, individuals may be invited to briefly share their artwork with the group.

**Toolbox.** When members first attend the session, boxes should be provided for each member. Participants will be learning about valuable tools throughout the group, those they already possess and those they will soon learn. The toolbox is meant to be a visual and physical representation and culmination of all of the tools learned throughout the program. Children should be encouraged to add to their toolboxes whenever they discover a new tool they have
used or can use. The toolbox also serves to foster the independence they are working on
developmentally, as well as fostering a sense of self.

**Closing.** For the group closing, a list of closing activities is provided. Similar to the
opening, the closing can be tailored to meet the group where they are at in terms of energy,
movement qualities, and mood. If the facilitator would like the closing to serve as a ritual, one
closing activity may be chosen to do throughout the entire program. The closing may last up to
10 minutes. Utilizing the superhero concept, the facilitator will also ask the participants to decide
what superpower they will utilize in the next week. Allowing the children to create their own
goals gives them a sense of autonomy and accountability.
Topic: Superpowers (Strengths and Resilience)

Group Member Goals:

- Look at how addictions has affected them and their families
- Identify a strength
- Gain understanding of dance/movement therapy and the mind-body connection

Movement Goals:

- Expressive movement: Use movement to express and increase awareness of a strength
- Body awareness: Notice and explore movement qualities associated with expressed strengths

Key Concepts:

- Many families are affected by addiction. Addiction is a disease that can affect everyone in a family, not just the person who is using drugs. Addiction can be thought of as a villain that causes problems for families.
- Everyone has superpowers that helps when the addiction villain causes problems for families. Superpowers can help people feel better or safe when the villain comes around. Superpowers also help to keep the villain from creating issues for you when you get older.
- It is important to note that the addiction/villain is not the person who has the addiction. The villain and the person who has the addiction are separate. This person, who might be a parent or family member, are still who they are but may act differently because the villain is affecting them.
• Having a place to talk about feelings with others can help people feel supported and feel like they are not alone in their problems.

• Dance/movement therapy provides another way to express one’s feelings and thoughts. What we think and feel is expressed through how we move, and how we move can also affect how we feel—this is the mind-body connection.

Agenda:

Group Opening/Check In:

1. Administer Pretest (see Appendix J)
2. Introductions/Overview (see Appendix E)
3. Body check-in (see Appendix H)
4. Review Rules (see Appendix F)
5. Review agenda

Curriculum Activity:

Movement:

• Identifying strengths:

  ○ Invite the group to recall their superheroes and superpowers. You may have the group revisit this by having each participant share their superhero name, powers, and movement with the group once more.

  ○ “We talked a little bit about addiction before in our opening. Who can tell me again what addiction is?” Let the group respond then validate and clarify responses: “Addiction is disease that some people live with that makes them get stuck on drugs. Even though their brain tells them ‘no’, addiction makes it hard
for people to stop using drugs. Sometimes addictions and drugs make people act differently.” Allow for questions or comments and clarify if necessary.

○ “Now we are going to imagine that this disease affecting your family is a villain. Think about what it would look like, what shape or form it would take on, and what color it might be. Maybe you decide to give it a name. It is important to remember that the villain is not your parent. Your parent is still who they are, but they are being affected by the villain and sometimes it makes them act differently.” Give the group paper to draw on and writing/coloring utensils (crayons, markers, colored pencils, etc.) and instruct them to draw the villain.

When the group has finished up their drawings, have the group share their villain drawings with the group, if they feel comfortable. If the group feels comfortable, they may have a discussion about their drawings. Use this time to help the participants differentiate the villain from the family members themselves and discuss how it affects them and/or their family.

○ “Now, think of how the villain may have made you feel in the past. Maybe it has made you feel sad, mad, scared, lonely, confused, or any other emotion. As a kid, it is not your job to control or cure your family from the villain but you do have powers that help you to feel better or deal with your situation. Now, we are going to think about what superpower you have been using to help you take care of yourself or to help you deal with any emotions that come up.” Give the group a moment to think about their superpowers.
- Once the group is ready, they may take turns one by one (they may go in the center of the circle if they are comfortable), name their superpower, and perform a movement, pose, or gesture that represents that trait for them. Facilitators may go first to model for the group if the group is feeling hesitant. The group then mirrors the movement back.

- Super Heroes Unite!:

  - Next, explain that the group will join forces and create a superhero group. The participants will figure out one superpower that they all share and come up with a joint group superhero movement.

  - The facilitator may assist the participants in figuring out a group superpower by initiating a conversation about what similarities they noticed when everyone was sharing their powers and experiences. The facilitator may also guide the participants to think about the shared purpose everyone has for being in the session in order to guide a discussion about their shared experiences and shared superpowers.

  - The participants will also come to consensus about the shared group superhero movement. The following is a list of suggested activities if the group is unsure of how to proceed:
    - Each participant shows their movement to the group once more. The group will discuss salient movement qualities in everyone's superhero movement and use them to create a group movement.
■ The group decides on a group superpower and creates a corresponding
group sculpture to represent it.

■ The group creates one movement sequence that incorporates each
participant’s original superhero movement.

Discussion:

● You may have an open discussion about the activity using the following questions as
a guide:

○ Why is it important to know our superpowers? How do our
superpowers help us?

○ Do we get to choose what the villains do? Do we get to choose how the
villains impact us or how we respond to it?

○ What did you notice about your superpower movement? Did you notice
anything about anyone else’s? Were there any similarities? How do you
feel when you do your superhero movement?

○ How did it feel to share your superpower with the group?

○ How can we use our superpowers in the future?

○ Can you think of any other superpowers you or your family might
have?

Break/Snack Time

Art Processing:

● Draw your superhero:
○ Give the group a selection of art tools (markers, crayons, paint, oil pastels, etc.) and instruct the group to draw themselves in superhero form.

○ Have the group share their drawings with the group when they finish. Allow time for thoughts and observations. You may also offer a movement response to each child, or allow the participants to give movement responses to one another.

Group Closing:

● Administer Posttest (See Appendix J)

● Choose group closing/goodbye exercise (see Appendix I)

● Maintenance: What strength/super power will your superhero use this week?
Topic: Addiction

Group Member Goals:

- Gain understanding about the disease of addiction and how it may affect people and their families
- Gain understanding of dance/movement therapy and the mind-body connection

Movement Goals:

- Expressive movement: Explore concepts of addiction through the creation and manipulation of movement sculptures
- Body awareness: Explore movement qualities and kinesthetic senses associated with concepts of addiction

Key Concepts:

- Sometimes when people have uncomfortable feelings, they use drugs to help them feel better. This is usually because they do not have any other coping skills to help them deal with those emotions.
- Healthy ways to deal with uncomfortable emotions and situations can be learned so that one does not have to turn to drugs.
- Children did not cause, cannot cure, and cannot control their parent’s addiction. It is not their fault.

Agenda:

Group Opening/Check In:

1. Administer Pretest (see Appendix K)
2. Introductions/Overview (see Appendix E)
3. Body check-in (see Appendix H)
4. Review Rules (see Appendix F)
5. Review agenda

Curriculum Activity:

Movement:

- Sculptures:

  1. Have the group form a circle and explain that they will be creating sculptures together using their bodies and movement. These sculptures will be used to further explore concepts of addiction.

  2. Present the following words to the group to which they will create movement sculptures:

     - Drugs
     - Addiction
     - Love
     - Safety

  3. Participants will create sculptures in the form of a pose or movement that represents the word. This activity may take many forms. The facilitator may allow the process to happen organically by allowing the group to create the sculptures as they please or provide more guidance for the group, if necessary.

  4. After the group creates sculptures for each word, you may decide to have the group manipulate sculptures and have them interact with one another. For
example: Have the group start with a love sculpture, add drugs to the structure and see how it changes or shifts.

Discussion:

- Once the group feels that the sculptures are complete, have the group discuss their observations. You may ask some of the following questions:
  - What do you notice about this sculpture? What movement qualities do you notice?
  - What kind of bodily sensations or feelings do you notice as you participate in, or witness, this sculpture, if any?
  - What words would you use to describe this sculpture?
  - How did you notice the sculptures shift or change?

Break/Snack Time

Art Processing:

- Sculpture Drawing:
  - Give the group a selection of art tools (markers, crayons, paint, oil pastels, etc.). Instruct participants to create an art form of the sculpture that stood out to them most during the exercise.

Group Closing:

- Administer posttest (see Appendix K)
- Choose group closing/goodbye exercise (see Appendix I)
- Maintenance: What strength/super power will your superhero use this week?
Topic: Safety

Group Member Goals:

- Understand the need for and importance of staying safe
- Understand what traits make individuals “safe people”
- Identify safe people in their lives
- Understand it is okay to ask safe people for help and learn how to ask for help
- Understand boundaries and what healthy boundaries are
- Gain understanding of dance/movement therapy and the mind-body connection

Movement Goals:

- Body awareness: Develop an awareness of one’s own and others’ space; gain awareness of one’s own spatial preference
- Boundaries: Exploring boundaries through the use of space

Key Concepts:

- If children are in an unsafe situation, which includes being at risk for, or being harmed physically, mentally, or emotionally, there are people who can help. Being safe includes feeling protected and not being harmed physically, mentally, or emotionally. It is important to know who can help in an unsafe situation and how to contact those people if help is needed.
- It is important to set up healthy boundaries with people. People are in charge of who comes into their personal space bubble and who stays out. It is important to know which people are safe to have in one’s space bubble and what kind of people are unsafe to have in one’s space bubble.
● Everyone has problems and stress. They cannot always fix them on their own. It is okay to ask for help when needed.

● It is important to identify safe people to ask for help and learn how to handle problems in safe ways.

Agenda:

Group Opening/Check In:

1. Administer Pretest (see Appendix L)
2. Introductions/Overview (see Appendix E)
3. Body check-in (see Appendix H)
4. Review Rules (see Appendix F)
5. Review agenda

Curriculum Activity:

Movement:

● Identifying characteristics of safe and unsafe people:
  1. Have two large sheets of flipchart paper on the wall. One sheet will be labeled “safe” and the other “unsafe”. Brainstorm with the class to compile a list of characteristics that make a person safe or unsafe.
  2. Pass out the worksheet and have children fill it out with people that fit the characteristics of safe people. Explain that they should keep this list in a safe and accessible place as reference if an unsafe situation arises.

● Exploring space bubbles (Kornblum, 2002):
1. Have children spread out so that they have enough space to extend their arms without touching anyone else. Next, have the children walk around the room while maintaining space as large as their hands can reach, without touching anyone else. You may instruct them to move in different directions (forward, backward, sideways) as well as different speeds (slow, medium, fast), and in more complex ways (dance, gallop, skip).

2. Next, set up boundaries to make the space smaller.

3. Before allowing them to explore moving through this smaller space, have a discussion to identify potential strategies for moving without intruding upon others space while maintaining their own space and comfort. You may have the children brainstorm some strategies then introduce the following if not yet touched upon:
   - Staying close to the outer part of the space if you feel uncomfortable with the closeness
   - Instead of pushing, use your words to ask for more space in a way that is respectful but firm
   - Respect one another’s space and agree to give someone more space if they ask for it
   - Move slower, and make your body smaller by making it more narrow
   - Ask the facilitator for help if at any time you feel too uncomfortable or unsafe to continue the activity
4. The children may practice these strategies through role-play or more discussion about possible uncomfortable situations that may arise and how they would go about handling the situation in a healthy, positive way.

5. Children will then move around the smaller space while not touching. Ask children to notice what they must change about their movements and bodies in order to maintain their space. Also, invite them to pay attention to how they feel in this smaller space. If children are noticeably agitated or uncomfortable, you may stop the activity to review the suggestions listed above.

Discussion:

- You may have an open discussion about the activity using the following questions as a guide:
  - How do you feel when someone gets close to your space bubble? What is that feeling in your body and where is that feeling?
  - What can you say or do if someone is too close, in your space, or making you feel uncomfortable?
  - What is a safe distance to give ourselves with someone who feels unsafe? What should we do if we cannot give ourselves that distance?

Break/Snack Time

Art Processing:

- Drawing my space bubble:
  - Give the group a selection of art tools (markers, crayons, paint, oil pastels, etc.)
1. Explain that boundaries are made to help us have control over how close we want people to be to us, how much we allow other people to touch us, how much we decide to tell people, or how much we decide to trust people.

2. In the space bubble activity they set up boundaries by how close they decided to be to others or how close they allowed others to be to them. Explain that they are now going to draw their space bubbles, keeping in mind their spatial preferences or boundaries.

3. Ask them to draw themselves and imagine now that their space bubble is a real bubble that they live in. Ask them to consider the following when drawing their space bubbles:
   - How big or small is your bubble?
   - Think about how much you let others in or try to keep them out. Can people come in and out? If so, how do they enter or leave? Is there a door?
   - What is your bubble made out of? How much can people see in?

4. The group can share their space bubble drawings when finished. Allow time for thoughts and observations. You may have a discussion about the images using the questions listed above or the following:
   - Are there certain people you let in your bubble?
○ What kind of people do you want to keep away from your bubble?
○ What are healthy boundaries?

Group Closing:

- Administer posttest (see Appendix L)
- Choose group closing/goodbye exercise (see Appendix I)
- Maintenance: What strength/super power will your superhero use this week?
Topic: Feelings

Group Member Goals:

- Identify and express comfortable and uncomfortable feelings
- Understand how feelings affect them and how to handle feelings in safe ways
- Understand there are safe people they can share feelings with and get support from

Movement Goals:

- Expressive movement: Use movement to explore and express different feelings
- Body Awareness: Notice and explore movement qualities associated with different feelings

Key Concepts:

- All feelings are okay; they are neither good or bad, they just are.
- Expressing uncomfortable feelings can be difficult.
- Feelings are signals that should be paid attention to. When uncomfortable feelings come up, it is a signal that we should take care of ourselves.
- Using alcohol or drugs can be a way for people to manage their feelings. Sometimes people use drugs to relieve uncomfortable feelings to make them go away temporarily.
- There are healthy ways to deal with uncomfortable feelings that do not involve using drugs.

Agenda:

Group Opening/Check In:

1. Administer Pretest (see Appendix M)
2. Introductions/Overview (see AppendixE)
3. Body check-in (see Appendix H)

4. Review Rules (see Appendix F)

5. Review agenda

Curriculum Activity:

Movement:

● Feelings charades:

1. Fill a bag with an assortment of index cards, each with a feeling written on it.

2. Have the group form a circle. Participants take turns picking a feeling out of the bag. Without telling the group which emotion they chose, they will then express that emotion through movement.

3. The group guesses the emotion and the mover shares a situation when they experienced that emotion. If they cannot think of a specific situation, they may come up with a hypothetical situation that might make them feel that emotion.

4. Invite others in the group to share situations when they have experienced that emotion as well. You may ask if anyone’s feeling movement may have looked different and invite them to share.

Discussion:

● You may have an open discussion about the activity using the following questions as a guide:
What were some examples of uncomfortable emotions? What were examples of comfortable emotions?

Are some emotions more comfortable for some than others? Why?

What movement qualities were associated with uncomfortable emotions?

One person’s movement for a certain feeling may look very different than someone else’s, why do you think that is?

What was it like sharing your emotional experiences with the group? Was it easy for you to do or hard? Why?

What was it like to hear other people’s emotional experiences?

What are some healthy ways to deal with uncomfortable emotions?

Break/Snack Time

Art Processing:

- Body Scan
  - Give the group a selection of art tools (markers, crayons, paint, oil pastels, paper, pens etc.). Distribute a sheet of paper with the outline of a body printed on it (or you may allow the children to create their own silhouette). Ask participants to think about different emotions that they can identify (you may want to give them a list of emotions to consider or ask them to do a feeling they felt in the past week). They can consider the following questions:
    - Where does that emotion live in your body?
    - What sensations do you feel in your body when you feel this emotion?
- Are there any images, shapes, or colors that can represent this emotion?

- They will use the art materials to draw their emotions within the silhouette.

- Have the group share their drawings with the group when they finish. Allow time for thoughts and observations.

**Group Closing:**

- Administer post-test (see Appendix M)

- Choose group closing/goodbye exercise (see Appendix I)

- Maintenance: What strength/super power will your superhero use this week?
Topic: Anger

Group Member Goals:

- Discriminate between healthy and unhealthy ways of coping with and expressing anger
- Learn that anger is a normal and healthy emotion
- Learn ways to cope with anger

Movement Goals:

- Body awareness: Notice body sensations associated with anger and relaxation.
- Relaxation techniques: Increase breath connectivity and/or use of bound and free flow via progressive muscle relaxation to learn relaxation techniques that can be used to cope with feelings of anger.

Key Concepts:

- Everybody feels angry sometimes; it is normal and okay.
- There are different levels of anger and everyone experiences and expresses anger differently. Anger can be a very uncomfortable emotion.
- Some people turn to drugs when they get angry to help them momentarily relax and feel better.
- How we handle situations when we are angry is very important. If we do not handle situations in safe and healthy ways, our anger may take control of us. It is important to know safe ways of dealing with anger to prevent us from turning to other unhealthy ways of dealing with anger, such as drugs.

Agenda:

Group Opening/Check In:
1. Administer Pretest (see Appendix N)

2. Introductions/Overview (see Appendix E)

3. Body check-in (see Appendix H)

4. Review Rules (see Appendix F)

5. Review agenda

Curriculum Activity:

Movement:

- **Angry bottle shake up:** The following activity will use glitter bottles to represent and explore anger and how your brain and/or body might feel when you become angry. Children will create angry bottles and then use them for the movement experiential (crazyblessedlife, 2011). The following materials are needed:

  - Three clear, plastic water bottles with lids
  - Hot water
  - 3 bottles glitter glue (3 different colors)
  - 3 small tubes superfine glitter (3 different colors)
  - Whisk
  - One medium-sized bowl

- Steps:

  1. In a bowl, pour enough hot water to fill up one bottle.

  2. Add one small bottle of glitter glue (or about ¾ of a bottle, or ½ a bottle, depending on how long you want it to take to settle). More glitter glue will mean it takes longer to settle after shaking.
3. Add one or two teaspoons of superfine glitter.
4. Whisk until there are no more clumps of glitter glue.
5. Use a funnel to pour the glitter and water mixture into the plastic bottle.
6. There may be foam at the top. If there is, squeeze the bottom of the plastic bottle to get the foam to rise and spill over the top of the bottle (hold over a sink while doing this). Then top off with more water to fill.
7. Place on the cap. Super Glue the cap if you feel like the recipients of the glitter jar may want to uncap it and drink the mixture or might spill it.
8. Shake and watch glitter swirl and then settle.
9. Repeat with other two bottles and the other glitter colors.

- Begin the activity by having the group shake up their bottles and mindfully watch the bottle as you lead them through the activity:
  
  ○ “When we get angry, our mind gets like this bottle; everything is fuzzy, and cloudy. It can be hard to think or talk about how you are feeling. It can take time for us to calm down too, just like it takes time for the glitter to settle at the bottom of this bottle. Some people may get angrier than others about certain things and may take a longer time to calm down. As you watch the glitter settle to the bottom of the bottle, I will guide you through a relaxation activity that you can use when you feel angry to help you calm down.”
  
  ○ The facilitator may guide the group through a relaxation technique of their choosing some options include:
- **Mindful breathing**: Guide children through a breathing exercise. You can use imagery (a balloon, a light, etc.) to guide them through the process. It may help to count as they breathe (5 seconds inhale, 5 second exhale) in order to ensure that they are breathing deeply enough.

- **Progressive muscle relaxation**: Children will tense each muscle, progressively, having them contract for a count of 5 and then release and relax for 15-20 seconds. Invite them observe and notice the differences between contraction and relaxation during the release phase. You can explain that the contractions may represent how they may feel when they are angry and the release is the letting go of the anger.

- **Body scan**: Pay attention to each body part, one by one, starting from the head and moving to the toes. Instruct them to notice any tension or body sensations; try to use their breath to relax or calm any tension they may be feeling.

**Discussion**:

- You may have an open discussion about the activity using the following questions as a guide:
  - What kind of body sensations did you notice during this exercise?
  - How can we use this (either the bottle, the relaxation activity, or both) as a way to help us when we are feeling angry?
○ What makes you angry?
○ What does your body feel when you are angry?
○ What do you do when you get mad?
○ Is it okay to get angry sometimes?
○ How do you know when your anger has taken control of you?
○ What are ways to take control of your anger and calm yourself down?

Break/Snack Time

Art Processing:

● Draw your anger:
  ○ Give the group a selection of art tools (markers, crayons, paint, oil pastels, paper, pens etc.)
  ○ Guiding questions to help facilitate artwork:
    ▪ What does it look like? Does it take on a specific image?
    ▪ How big or small is it?
    ▪ What color is it?
    ▪ Is it out for everyone to see or does it stay hidden?
  ○ Add artwork to toolbox

Group Closing:

● Administer post-test (see Appendix N)
● Choose group closing/goodbye exercise (Appendix I)
● Maintenance: What strength/super power will your superhero use this week?
Topic: Play

Group Member Goals:

- Learn about self-care and what it means
- Understand the importance of play
- Identify fun recreational activities

Movement Goals:

- Creative movement: Using movement and role-play to engage in creative and imaginative play

Key Concepts:

- Many times when kids have parents with addictions, they end up having to take care of themselves, parents, or siblings. This causes them to have to grow up too quickly and does not allow them the time to be a kid.
- The only jobs a kid should have is to play and learn. It is important to take the time to do this.
- Sometimes people turn to drugs because they are bored and do not have anything else to do. Having fun hobbies can be a way to protect you from turning to drugs. Fun activities can also be a good way to de-stress, which can also serve as a coping skill.
- Self-care is just that-- taking care of ourselves. It is when we do healthy things to focus on ourselves and make ourselves feel better. When we do not do this we may get exhausted, not be able to be the best we can be, and our superpowers may not work.

Agenda:

Group Opening/Check In:
1. Administer Pretest (see Appendix O)
2. Introductions/Overview (see Appendix E)
3. Body check-in (see Appendix H)
4. Review Rules (see Appendix F)
5. Review agenda

Curriculum Activity/Experiential:

Movement:

● Superhero Vacation:

1. The group will embody their superhero, and get into character. You may find it useful to invite them to recall their superpower and their superhero pose/movement that they came up with in the introduction so they can get into character.

2. “Imagine that your superhero has the day off from saving the world. Today, your only job is to focus on yourself, and do things that you have fun doing. So let’s pretend we are all going on a superhero vacation! Where should we go?” Continue the role-play and follow the children’s lead throughout the imaginative play. Here are some questions to help guide the activity:

Discussion:

● You may have an open discussion about the activity using the following questions as a guide:

  ○ Why is it important for us to play?
What kind of things get in the way of us being a kid?

What does self-care mean?

What do you like to do for fun?

What kinds of fun activities might you be able to do with your family?

Break/Snack Time

Art Processing:

● Free-art:
  ○ Give the group a selection of art tools (markers, crayons, paint, oil pastels, paper, pens etc.).
  ○ Explain that this art exercise will be open, meaning that they can create whatever kind of art they please. Though this is an open activity, the art they create should be respectful. Review the rules before they begin the activity.
  ○ Have the group share their artwork with the group when they finish. Allow time for thoughts and observations. You may also offer a movement response to each child or open the floor to have them give one another movement responses.

Group Closing:

● Administer post-test (see Appendix O)

● Choose group closing/goodbye exercise (see Appendix I)

● Maintenance: What strength/super power will your superhero use this week?
Topic: Problem Solving

Group Member Goals:

● Work together to problem solve and accomplish a team building activity
● Understand they have many choices when trying to solve a problem

Movement Goals:

● Explore use of direct or indirect space dependent on group decisions
● Explore use of accelerating or decelerating time dependent on group decisions

Key Concepts:

● Feelings of powerlessness are sometimes seen with these children as a result of not being able to solve their family’s problems. This can make it difficult for them to engage in effective problem solving.
● It is important to understand that there are many options when solving problems and ways to make healthy and smart choices. The choices that we make may have important consequences.

Agenda:

Group Opening/Check In:

1. Administer Pretest (see Appendix P)
2. Introductions/Overview (see Appendix E)
3. Body check-in (see Appendix H)
4. Review Rules (see Appendix F)
5. Review agenda

Curriculum Activity/Experiential:
Movement:

- Team Building Activity:
  - Explain to the group that they will be playing a game that involves completing a common goal. The group will start on one side of the room. The facilitator will be on the opposite side of the room with a ball on the floor. You may set up a start/finish line on their side of the room. The goal of the game is for the participants to get the ball to their side of the room, past the finish line. Explain the following rules to the group:
    - The facilitator will turn around and count to 10 (as fast as she/he pleases). Once they reach 10, they will turn around and the participants must freeze. If anyone is caught moving, the whole group must return back to the starting line.
    - Participants approach the facilitator and retrieve the ball when they get close enough.
    - When the facilitator turns around, they will have 3 chances to guess who has the ball (if the group is smaller, consider giving the facilitator 1 or 2 guesses). If the facilitator correctly guesses who is in possession of the ball, the group must return to the start line.
    - This process continues over until the group has completed the task.
    - Everyone must touch the ball at least once by the time it gets back to the other side of the room.
  - Some things to consider:
- Set the group up for success. Give them time to brainstorm together to come up with a strategy. If they are struggling, ask questions that will guide and facilitate problem solving, such as: “what has/hasn’t worked for you?”, “how can we work together as a team?” etc.

- You may find it beneficial to have a reward for them (candy or prizes) to keep them motivated and give positive reinforcement for their hard work.

**Discussion:**

- You may have an open discussion about the activity using the following questions as a guide:

  - How did we decide what we were going to do?
  - Were there any problems that came up? How did we deal with them? If not, how did we avoid those problems coming up?
  - Why are the decisions we make important? How do we make healthy and smart decisions? What happens when we make bad decisions or do not fully think things through?

**Break/Snack Time**

**Art Processing:**

- **Endless possibilities:**

  - Give the group a selection of art tools (markers, crayons, paint, oil pastels, paper, pens etc.).
○ Instruct the group to draw an object. Make it a simple object (dog, cat, car, tree, flower, etc). Once they have drawn their object, tell them to draw that same object 5 more times, but each time they draw it they must make it different in some way.

○ Once the group has finished, have them find a partner and share all of their creations. Have them explain to one another how they made each one different and what characteristics they changed for each drawing.

○ After discussion with partners, instruct participants to draw that object once more but this time they must incorporate something they observed from their partner’s drawings. Once the drawings are finished, they may show their partner once more and have a discussion about what aspects they incorporated into their drawings.

○ Have a group discussion about the process. You may use the following as a guide:
  ■ What was it like having to come up with different ways to draw something? Was it easy or hard? Why was it easy or hard?
  ■ What changes did you make to your drawing?
  ■ What did you notice about how your partner changed their picture? How were their changes the same or different from yours?
  ■ What ideas did you use from your partner’s drawings to change your own?
  ■ Ask what the group thinks the point of the project was. Validate thoughts and explain the following:
    ● “Sometimes, when situations come up, we only think there is one way to solve the problem. If we do not know of any other ways to deal with a situation, we keep doing what we always have always
done in the past. This activity was meant to show you that there are many ways to solve a problem. The same way you can draw a cat 7 different ways, you have many different options and ways to go about handling a situation. When you are feeling stuck, you can ask someone for help, or get ideas from other people, the same way you got ideas from your partners today.”

Group Closing:

- Administer post-test (see Appendix P)
- Choose group closing/goodbye exercise (see Appendix I)
- Maintenance: What strength/super power will your superhero use this week?
Topic: Superhero Performance (Self-Expression)

Group Member Goals:

- Collaborate to put together and present a dance/movement performance

Movement Goals:

- Expressive Movement: Perform an expressive dance/movement piece created by the group/individual

Key Concepts:

- Dance/movement therapy provides another way to express one’s feelings and thoughts. What we think and feel is expressed through how we move; how we move can also affect how we feel—this is the mind-body connection.

- Performing in front of other people can make us feel a lot of different emotions (nervous, excited, scared, proud, happy, etc), all of which are normal. Getting out of our comfort zone and trying new things is good for us because we might learn something new, meet new people, and have a good time.

Agenda:

Group Opening/Check In:

1. Administer Pretest (see Appendix Q)
2. Introductions/Overview (see Appendix E)
3. Body check-in (see Appendix H)
4. Review Rules (see Appendix F)
5. Review agenda

Curriculum Activity/Experiential:
Movement:

- Explain to the group that today they will be creating a performance that will showcase their superheroes and superpowers. Give them a moment to remind themselves of their superhero name, movement, and superpowers. You may find it useful to have them repeat the introduction as a reminder.

- The group will collaborate to create a dance together to perform at the end of group.

Some things to consider:

  ○ Let the group decide whether they would like to perform in front of an audience. Who will the audience be? Will they invite parents, family members, or staff?

  ○ Allow the group to take the lead and make decisions. Support them in the decision-making process and offer ideas if the group gets stuck. You may find it useful to provide them with ideas and have the group vote on what they want to do. Here are some suggestions:

    ■ Put together a superhero skit. Determine who the villains are and how you use your superpowers to protect yourself. You may reference past groups if you have returning participants and have them showcase some of the skills and information they learned.

    ■ Each person individually showcases their own superhero, introducing their superhero, their movement, and their superpowers. Or, they may write down their preferred introduction and have the facilitator introduce each person. Each person may want to also pick a song they would like to enter with.
Come up with a group dance that incorporates each person’s superpower movement. The group can pick a song that they feel best represents the group.

- Be sure to give the group time to rehearse before they perform.

Break/Snack Time

Performance:

- The group will perform their piece. Some things to consider:
  - If there is an audience, consider how you will introduce the group and give some background information.

Discussion:

- After the performance, you may ask the audience (if there was one) to offer any reactions, thoughts, or words they would like to share. You may invite them to offer a movement response to the group, or to their child.
- Have an open discussion with the group (without audience present) about the performance using the following questions as a guide:
  - What was it like to perform? What feelings came up for you?
  - Performing in front of others takes a lot of courage. What other super power(s) did you discover about yourself after this performance?

Group Closing:

- Administer post-test (see Appendix Q)
- Choose group closing/goodbye exercise (See Appendix Q)
- Maintenance: What strength/super power will your superhero use this week?
Evaluation Plan

Though this program was not implemented for the purposes of this thesis, an evaluation plan is included. Program evaluation is intended to provide information about the progress of a program or its participants (Newcomer, Hatry, & Wholey, 2015). Outcomes and goal achievement are also measured through program evaluation (Newcomer et al., 2015). In order for potential program funders to decide if they are interested in contributing to the program or continuing to fund the program, they will want to know if the program can deliver results (Newcomer et al., 2015). Data collected from evaluative measures can provide potential funders with information needed to make these decisions. This data can also be used when seeking funding and writing grant proposals in order to provide evidence and build a stronger case for the program (Newcomer et al., 2015). Evaluation can also be used to inform program developers. By monitoring the progress of the program, developers can be made aware of any modifications that need to be made. Evaluation is necessary to promote changes and enhancements to the program to better fit the needs of the population they serve (Newcomer et al., 2015).

For this program, assessment of participant changes and understanding of the material will be evaluated through administration of a pre-test and post-test. A pre-test will be administered at the start of each session and a post-test will be administered at the end of each session during closing. This format of evaluation measures any changes that occurred in the children by providing and comparing information about what they knew before and after the each session.

This pre-test and post-test were modeled from the tests provided in the Children’s Program Kit (SAMHSA, 2002). Some modifications were made to better fit the format of this
program. Questions on the tests are phrased so that children’s answers are opinion-based by titling the test “What do you think?” This format is used to avoid provoking the anxiety and pressure of having to submit a correct answer. With this format, there is no “right” or “wrong” answer. Tests will be kept confidential and children should not write down their names. Open-ended questions are also included in order to obtain more detailed information about the children’s perception of the program. Open-ended questions may provide rich information about what was most valuable to the participant, which may aid in the process of improving the program to better serve its population. The facilitator will also contribute to evaluative measures through their own data collection. Included in the facilitator planning sheet (see Appendix G) is a section for facilitators to record information about the effectiveness of particular aspects of the session, ideas for adaptation, and any other evaluative information.
Chapter 5: Discussion

This program development project was started in an effort to answer the following question: how can a DMT strengths-based resilience promotion program be designed for children of individuals with SUD? Through a review of the literature and the collaboration process through use of the Delphi method, a DMT strengths-based resilience promotion program was created. Movement, art, and performance are used to promote self-awareness of inherent strengths and resilience, therefore promoting self-esteem. Topics and activities included in the program curriculum were chosen in an effort to increase protective factors that are identified in the literature and existing programs. Creating this program proved to be an insightful experience with its share of difficulties along the way. The following section will discuss the program development process, limitations, suggested adaptations, and implications for the field of DMT.

Collaboration Process

The collaboration process was a valuable asset to this program development process. The use of the Delphi method for information gathering assisted in formulating ideas that ultimately culminated into the program that is presented in this thesis. Considerations for the Delphi method design in regards to this project include expertise criteria, number of participants, number of rounds, and mode of interaction.

According to Adler and Ziglio (1996), the Delphi participants should meet the following four “expertise” criteria: knowledge and experience with the issues under investigation, willingness and capacity to participate, sufficient time to participate; and effective communication skills. All of these considerations were made when choosing participants for this project and the collaborators involved met all requirements. Experts in the field are oftentimes
very busy and this may become an impediment to full participation. With this in mind, a consent form was sent to them prior to interviews, which outlined the expectations and the time commitment involved. Giving my collaborators ample amount of time to schedule a meeting was another strategy that contributed to full participation.

Future evaluation of this program might include a more comprehensive group of collaborators who may impart different perspectives. For example, including adult children of individuals with addictions as collaborators may be of value. They may provide information and ideas about the needs of this population through their own lived experiences and deep understanding of the effect of SUD on the family. Parents of these children may also have an understanding of this effect on a personal level and may be able to provide information on how to incorporate a more family-based approach. However, consideration of their current stage of change in their recovery would be necessary because this may influence their capacity to participate.

There are a number of factors to consider when deciding how many participants to include. One must consider whether the group is homogeneous or heterogeneous. Research involving a homogeneous group, as is the case in this project, may yield sufficient results with a smaller sample of between ten to fifteen people (Skulmoski et al., 2007). However, there are no set rules to how many participants are needed and there is a diverse range in the sample size used in Delphi studies (Skulmoski et al., 2007). Originally, I planned to meet with five to ten collaborators. When I got deeper into the process, I realized having so many collaborators would slow down the writing process. Logistically, it was difficult to find enough time in my schedule to meet with numerous people and coordinating around everyone else’s schedule would have
proven difficult as well. Throughout my writing process, I found that I struggled with deciding and committing to one idea. I decided it would be in my best interest to narrow down the amount of collaborators, providing enough perspective, but not too many ideas that would make it difficult to come to a decision. With this decision, I was taking into account the consideration of decision quality/Delphi manageability tradeoff. This idea holds that managing the Delphi process and analyzing the data becomes cumbersome in return for marginal benefits above a certain threshold (Skulmoski et al., 2007). In the end, the amount of collaborators proved suitable in terms of manageability.

Though the number of rounds is variable and tailored to the purpose of the research being conducted, it is suggested that two or three Delphi rounds are sufficient for most research (Delbecq, Van de Ven, & Gustafson, 1975). For my project, I followed this guideline and conducted three Delphi rounds. Originally I planned to conduct one of those rounds as a focus group but decided against that to avoid any difficulties with scheduling. There are many modes of Delphi interaction available to researchers including pen and paper, electronic mail, or online surveys, which are most often used in qualitative Delphi research. Since the purpose of this research was to gather qualitative data, I decided to conduct individual in-person recorded interviews.

Using the Delphi method was useful for providing a structure for the interview and collaboration process. Meeting with collaborators helped consolidate my thoughts. They also brought up meaningful questions about aspects of the program that I had not previously considered. Each collaborator brought a different approach and perspective that coalesced to inform the development of the program.
**Structure of Curriculum**

Creating the structure of each session was a process that involved a great deal of change. When I was first creating the structure of the session, I wanted to create a program with an open format allowing the facilitator to tailor the sessions to the group and the facilitator’s individual style, but also wanted to maintain structure and format. Creating a program with a balance of flexibility and structure proved difficult for me. One way I was able to allow for an open format was based off of the structure of the Children’s Program Kit (SAMHSA, 2002). I created a list of opening and closing activities the facilitator could choose from. This allowed the facilitators to choose an activity they felt was best suited for the group, rather than having to facilitate a particular activity that may not meet the needs of the group in that moment. This program was also created based on my own facilitation style and theoretical framework. My hope is that this program can and will be adapted to fit the facilitator’s creative style and theoretical framework. The design of the curriculum was tailored to encourage individual style and creative adaptations.

For my first draft of the program, I included many sections to the sessions. For the activity section of the program, I included psychoeducation, movement, and discussion. When reviewing with my collaborators, they quickly helped me realize there were too many parts; all of these sections were not necessary because time would not allow for each section to be covered. Additionally, the sessions would be more cognitively based rather than body-oriented, which conflicted the purpose of this program. When one of my collaborators suggested eliminating the psychoeducation piece as a separate section, the structure and program better aligned with the goals of the program—building awareness of resilience through a DMT approach. The psychoeducation would happen throughout the experiential, through exploration
of the concepts through movement and discussion, which would bring the implicit kinesthetic felt experience to the explicit.

**Implementing a strengths-based approach.**

Another issue I encountered when creating the structure was incorporating a strengths-based approach throughout the program. Many of the ideas that were included in the program were generated through the collaboration process. Initially, I included a question in the opening of the session that asked the participants how they utilized their strength in the past week. For the closing of the group, I wanted to include maintenance work that would encourage the children to utilize the skills they learned in group. I found difficulty in determining how to get children to identify their strengths.

In order to facilitate a developmentally appropriate way of communicating and fostering expression with these children, I utilized the metaphor of superheroes and superpowers to aid in eliciting strengths. This idea was adapted from Dennis McCarthy’s (2007) body-based approach to play therapy where he asks children to draw themselves as a monster. In his work, he uses the monster as the central theme that is used to help children communicate and explore the self in an imaginative way. He explains “children are usually looked at and listened to in a detached and overly intellectualized manner by the many adults who attempt to help them. But to know and help the child we must speak their language or at least know they are speaking it” (McCarthy, 2007, p. 18). A body-based approach to imagination utilizing themes such as monsters or superheroes allows children to go on a journey of self-exploration and express themselves in a way most familiar and natural to them.
I use the imaginative theme of superheroes and superpowers to help children draw out their strengths and to build self-esteem. I decided to change the opening and closing of the sessions to utilize this theme through superhero introductions and superpower goal setting. The superhero theme added an element of fun and excitement that I felt was an essential revision to the program compared to earlier drafts.

Limitations

Lack of focus on families. One shortcoming of the Moving for Freedom program is that it does not address familial or parental level factors. Focus and education on parental monitoring and supervision are critical for drug abuse prevention because SUD issues exist on a familial level (Kosterman, Hawkins, Haggerty, Spoth, & Redmond, 2001). Additionally, research shows that community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone (Battistich, Solomon, Watson, & Schaps, 1997).

The Moving for Freedom Program solely focuses on the child and does not touch upon these familial or parental level factors. Future adaptation of this program to enhance effectiveness may incorporate the addition of a family systems approach with a focus on parent training including: rule-setting, techniques for monitoring activities, praise for appropriate behavior, and moderate, consistent discipline that enforces defined family rules (Kosterman et al. 2001). Research has shown that a secure attachment with parents may also serve as a protective factor for these children, thus a focus on fostering positive parent-child attachments may also be of value (Molina et al., 2010).
Programs that utilize a family systems approach such as the Focus on Families (FOF) program and the Strengthening Families Program (SFP) may serve as a useful model for future program adaptation. Objectives of these programs include improving parenting skills, family communication, reducing risk factors for children, and increasing their protective factors. A notable feature of these programs is the structure of the sessions—parents and children have their own respective groups along with a joint group component, which is a feature that could be added to the Moving for Freedom program in the future. DMT has also shown to support positive parent-child attachments, which may substantiate the use of a DMT approach to a family systems DMT-based SUD prevention program (Tortora, 2010).

**Age group.** The program was tailored toward the specific age range of 8-10 year olds. Creating a program specifically for each developmental age was outside the scope of this project. Adjustments may be made if implementing the program with different age groups to achieve a developmentally appropriate curriculum. If facilitating groups with younger elementary school children, concepts can be made more simple and concrete. Less time should be spent on discussion and more time spent on the activity section. With older middle school children or high school aged adolescents, the facilitator should consider the developmental needs of the group and adjust the group accordingly. Depending on the presentation of the group, more time may be spent on processing, discussion, or artistic expression.

Future adaptation of this program may include a specific curriculum and planned activities tailoring to each age group. Research suggests the implementation of follow-up programs and long-term treatment to reinforce prevention goals (Scheier, Botvin, Diaz, & Griffin, 1999). The benefits from middle school prevention programs have been shown to
diminish without follow-up programs in high school (Scheier et al. 1999). Thus, programming that tailors to multiple developmental age groups may provide a more effective approach to SUD prevention.

Additionally, the age specificity of this program has limitations in regards to the proposed implementation site. If families have multiple children of different ages, this poses an issue for childcare when they attend services and their children do not fit the age criteria for the program. The Children’s Program Kit may serve as a useful model for the inclusion of curriculum tailored to multiple age groups. This program contains activities specific to elementary, middle, and high school aged groups, which provides an opportunity for long-term treatment that reinforces prevention goals.

**Open group format.** The Moving for Freedom program was originally designed as an eight-week program with a closed group format to be implemented in an outpatient rehabilitation setting. Children would attend groups while parents were in their outpatient treatment groups. Due to the incongruence between the structure of outpatient treatment groups and the Moving for Freedom program, this program design was modified. The final design for the program included open groups for implementation in an outpatient rehabilitation setting during weekly family groups.

This shift from closed to open groups changed the structure of my original program. Originally, the groups followed a weekly progression where groups would reference previous groups and topics. Also, the group had a designated introduction and goodbye group that involved a culminating performance. This design format would not work for open group sessions, as a result, the curriculum was adjusted to better fit the structure of the implementation
setting. Similar to the Children’s Program Kit (SAMHSA, 2002), I created a template for an introductory overview of the program to be used during each session that would provide useful context for children, whether they participated in the past or were new to the program.

Open and closed therapy sessions each have their advantages. An advantages for open group sessions include ease of implementation as waiting lists are avoided. Furthermore, open groups avoid sessions ending earlier than intended due to participant attrition. In contrast to open groups, closed groups may maximize the potential for each phase to be explored by allowing participants to live a common experience from start to finish. It also provides for a more defined and structured framework that is limited in time. The social environment of a closed group may foster a greater sense of stability, subsequently enhancing feelings of security and confidence bonds (Grotsky, Camerer, & Damiano, 2000).

Clinical research has not yet reached a consensus on which format—open or closed group—is the preferred method for group therapy (Tourigny, & Hébert, 2007). Tourigny and Hébert (2007) conducted a study examining the efficacy of open group therapy for sexually abused adolescent girls. Differential gains linked to open versus closed group sessions were also explored in this study (Tourigny, & Hébert, 2007). The study found that relative to participants in the control group, participants who participated in open group sessions showed significant improvements on a majority of the variables considered including posttraumatic stress symptoms, coping strategies, and behavioral problems. This study also found no significant differences between open and closed formats, which suggest that both formats of group intervention may be equally efficient for symptom reduction within this population.
Implementation site. The proposed implementation site of this resilience promotion program is a weekly family meeting within an urban mental health center with a partial hospitalization program (PHP) and intensive outpatient program (IOP) for individuals with SUD. Adjustments may be required if put into action in alternative settings. One area that may need to be adapted is the recruitment procedure. One rationale for choosing to implement in this particular setting was for ease of recruitment. Recruitment may be more difficult in school settings unless there is disclosure of SUD by the child or family.

This program is not tailored or well-suited for implementation in a school program because many issues with confidentiality may arise. Nonetheless, school is the most common setting for drug prevention programming because of the access and availability to children. Thus, adaptations for implementation in schools are of value. If implemented in a school, the target population of the program may have to be modified to include at-risk children in general, as opposed to the more specific population of children of individuals with SUD. If this change is made, content included in the program regarding how children are affected by SUD in the family will also need to be removed or adjusted.

One shortcoming of implementing this program in a rehabilitation setting would be attendance. The children’s attendance is dependent on parents coming to treatment. Early exit from substance abuse treatment is prevalent and research has found that 70% to 80% of clients return to using substances (Stevens, Radcliffe, Sanders, & Hunt, 2008). High dropout rates and relapse during the recovery process may affect children’s ability to regularly attend groups and receive the full benefit of the curriculum.
Conclusion

This thesis project culminated into the Moving for Freedom program—a DMT strengths-based resilience promotion program for children of individuals with SUD. Methods included the use of the Delphi method to collect information from collaborators and a theory approach logic model. Program objectives included increasing self-esteem, enhancing self-expression, identifying strengths, and learning of the effects of addiction.

Future evaluation and adaptation of this program may include curriculum for a wider range of age groups and implementation settings. As in the case of Rena Kornblum’s Disarming the Playground (2002), prevention programming utilizing a DMT approach has proven successful. It is my hope that the Moving for Freedom program will offer some insight to promote further research and prevention program development for other populations in the field of DMT, including children of parents with SUD.

It was interesting to find that writing this strengths-based program helped me discover my inner strengths in direct relation to this topic. Through this project I was able to recognize my resilience that allowed the interruption of the generation cycle of SUD within my family tree. I have gained considerable insight and personal growth throughout the creation of the Moving for Freedom program. I hope to have shed some light on the need for a focus on children of individuals with SUD and the importance and need for substance use prevention.
References


doi:10.1007/s00406-005-0624-4


111


Appendix A

Definition of Terms

Substance Use Disorder

“Substance Use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (American Psychiatric Association, 2013, p. 483).

Parentified Children

“This occurs when the caretaker is unable to meet the developmental needs of the child, and the child begins to parent themselves and perhaps younger siblings earlier than developmentally appropriate” (Lander, Howsare, & Byrne, 2013).

Protective factors

Factors that promote resilience and act as buffers against stressful life events that threaten one’s development (Vellemen & Templton, 2007).

Selective programs

“Target groups at risk, or subsets of the general population such as children of drug abusers or poor school achievers” (Robertson, David, & Rao, 2003)
Appendix B

Logic Model

(W.K. Kellogg Foundation, 2004, p. 57)
Appendix C

Informed Consent

I ____________________, agree to collaborate with Maria Torres on her program development which seeks to answer the following question: How would a dance/movement therapy prevention program be designed for children of individuals with substance use disorder? I understand that my involvement in this project will consist of the following expectations:

- Attending and participating in three rounds of recorded interviews, with the possibility of one focus group. It is preferred that these interviews be conducted in person, if possible. If meeting in person is not possible, a Skype or phone session will also be an acceptable means of communication
- Each interview will last approximately 45 minutes to an hour, although this time is flexible
- The three rounds of interview will follow this format:
  - Round 1: Open-ended interview for the purpose of brainstorming and formulating broad ideas.
  - Round 2: Summarized ideas formulated in first round are reviewed, prioritized, and rationalized via individual interviews to begin forming consensus among collaborators.
  - Round 3: Draft of logic model is created from consensus and ideas summarized in previous round and shared with collaborators for final revisions, opinions, and ideas.

I understand that I have the option of remaining anonymous if I so choose and that I have the option of rescinding my involvement in this project at any time.

Signature_________________________________ Date________________

NOTE: In exchange for your time, effort, and contributions, you will have the option of receiving a copy of the completed thesis as well as an acknowledgement in the written thesis.
Appendix D

Referral Form

Dear Parent(s),

As part of your family recovery plan, we recommend that you enroll your child(ren) in our
dance/movement therapy resilience promotion program. A board certified dance/movement
therapist will facilitate this program. The program aims to empower, build self-esteem, increase
resilience, and educate children on topics surrounding addictions. Topics that will be covered
include: addiction, safety, feelings, coping, self-care, and problem solving. This program utilizes
dance, movement, and art to offer a fun and creative way to explore and learn these topics. We
look forward to welcoming your children.

Enrollment Criteria:
- Children 8-10 years old
- Must be children of individuals with addictions in outpatient program

Parent/Guardian Name___________________________________________________________

Mailing Address __________________________City__________________Zip Code_________

Phone Number _________________________________________________________________

May we send information to your mailing address?    YES       NO   (Circle one)

Please list the names of all the children you are enrolling:

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note: These forms will be kept confidential and only shared with program personnel
who will work with your child’s group
Appendix E

Introductory Overview

The following introductory overview is used for the opening of each session. This overview is used as a reinforcement of the purpose of the program for returning children and as context and introduction for those joining the program for the first time.

Overview and purpose of the program:

- Ask participants what they think the purpose of the program is, and why they think they are all here. You may initiate a conversation by stating a version of the following:

  ○ “We are all here today because even though all of our experiences can be very different from one another, there is something that connects us. This program is meant to be a space where you have the opportunity to share anything you want, and to be as open as you are willing to be. I want to give you the chance to talk about your experiences, because they matter. Sometimes we do not always get the chance to speak about how we are feeling or what we think, but you deserve to be heard, and this is a place where you can do that. So, who would like to share what they think brings us here together today?”

  ○ After thoughts are shared validate and clarify their understanding by stating a version of the following: “You are all in this program because addiction, or drugs, has affected your family in one way or another. Can anyone tell me what addiction is?” Allow the group to share their thoughts. You may encourage children who have previously attended to state the purpose of the group.
“Sometimes, people use drugs to help them feel better. Addiction is a disease that makes people get stuck and hooked on drugs. When they use drugs too much, it might start to become a problem and affect how they act and their relationships with people they love. When using drugs becomes a big problem in someone’s life, the drugs start to control that person and their life. Your mom and dad are here in treatment getting help to control their drug problems. We want you to understand that their problem is not your fault. You did not cause it, you cannot control it, and you cannot cure it. While your mom or dad is here getting help, you are here to explore the strengths and superpowers you have that will help you to not be controlled by drugs in the future. In this program we will be learning in a fun and creative way! We will use dance, movement, and art to help us express ourselves. That may sound like a lot of fun to some of you, and may make some of you a little nervous. All of these feelings are okay and normal, but I encourage you to give it a try, there is no right or wrong way to move or make art.”

**Introductions**

- Welcome everyone to group and instruct participants to think about themselves as a superhero. Give them a moment to think about their superhero, including their superhero names and super powers. Once the group is ready, ask participants to briefly introduce themselves. Invite them to share a movement, gesture, or expression that represents them as a superhero, explain what their super hero strengths are, and give their real name and superhero name. The group will then mirror the movement back to the individual. Group facilitators should introduce themselves first.
Appendix F

Group Rules

In order to create a safe space where participants feel comfortable sharing their thoughts, feelings, and questions, basic ground rules should be established. Guidelines for expectations and confidentiality should be discussed.

**Suggested Ground Rules:**

1. **What is said in group stays in group**
   - Explain that what is said in group will not be shared with parents or anyone outside of the group. However, let children know that if they do express something that makes you think their safety might be in danger then you will have to tell someone in order to help keep them safe.

2. **Be respectful and nice to each other**
   - Treat others how you would like to be treated. This group is meant to be a safe space where people can share their feelings and thoughts. Put-downs, name calling, etc. will not be tolerated.

3. **Share time and give everyone a chance to speak**
   - Make sure everyone has a chance to share. No talking over each other-- one person talks at a time.

4. **Be safe**
   - Be aware of the space around you when moving, make sure to give everyone enough space to move

5. **Have Fun!**
Appendix G

Facilitator Planning Sheet

Date: _______________

Session Title: ________________________________________________________________

Group Facilitator: _____________________________________________________________

Materials Needed: _____________________________________________________________

Group Opening/Check In (20 min):
- Pre-test
- Introductory overview
- Body check-in
- Review rules
- Review agenda

Curriculum Activity/Experiential (45 min):
  a. Movement:

  __________________________________________________________________________

  b. Discussion:

  __________________________________________________________________________

Break/Snack (10 min)

Art Processing (35 min):

___________________________________________________________________________

___________________________________________________________________________

Group Closing (10 min):
- Post-test
- Group closing/goodbye exercise
- Remind of next session
- Maintenance
  - What strength/super power will your superhero use this week?

Notes on Session: (response, effectiveness, suggestions to improve, etc.)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

121
Appendix H

Body Warm-ups

Listed below are some activities that you can use for group openings. You should become familiar with the openings before the program begins so that you may tailor the opening to the group. The facilitator should assess the energy, mood, and movement qualities of the group when deciding which body warm-up to implement. All exercises are done in a circle formation.

- **Feeling Move**: Invite participants to reflect how they feel by sharing a movement, gesture, or expression with the group. They may also include a word if they so choose. Have the group mirror the movement and repeat the individual’s name back, in unison.

- **Follow the Leader**: Have each participant take a turn at leading the group through a movement or dance. The group mirrors the movement, and may decide to add their own style to the movement if they choose.

- **Body part warm-up**: Begin from the head and move down to the feet (or begin at the feet moving to the head). Progressively move through each body part and allow the group to move that body part as they please.

- **Dimensional scale**: Guide the group through the dimensional scale. You may decide to add music. You may also do this activity at different speeds.

- **Body-Connectivities**: Structure a body warm-up to follow the sequence of body connectivities (Breath, core-distal, head-tail, upper-lower, body-half, cross-lateral).

- **Intention**: Have the group set an intention/goal for the group and then express that goal through a movement.
Appendix I

Group Closings/Goodbyes

Listed below are some activities that you can use for group closings/goodbyes. You may choose which activity to do ahead of time or become familiar with the options and decide which closing is most appropriate and fitting for the group. You may also decide to choose one group closing and perform it each week as a ritual.

- **Feeling Move:** Invite participants to reflect how they feel at the end of the group by sharing a movement, gesture, or expression with the group. They may also include a word if they so choose. Have the group mirror the movement and repeat the individual’s name back, in unison.

- **Group Breath:** Have the group stand, and form a circle. Ask the group what they gained from the group that day and have them imagine they are breathing this on the inhale, and exhaling anything that does not serve them. You may bend knees then lift arms up while straightening knees out on the inhale, then bring arms down and bend knees again on the exhale to promote grounding.

- **Energy Ball Pass:** The group stands in a circle, and passes around an imaginary energy ball. When the ball gets passed to them, participants share a word that represents what they gained from group that day. When each person has held the ball, it is placed in the center and everyone extends their arms out and imagine that they are receiving the energy from the ball to take with them when they leave session.

- **A Gift For You:** While in a circle, each person gives a special “gift” to the person next to them in the form of a movement and a word (example: The gift of love, happiness, friendship, etc.)

- **Group Hug:** The group stands in a circle, places arms on the shoulders of the people standing on either side and give a gentle squeeze on the shoulders.

- **The Serenity Prayer:** “God grant me the serenity to accept the things I cannot change, the courage to change that things I can, and the wisdom to know the difference. You may have to pass out handouts or have the prayer written on a piece of paper for everyone to be able to follow along.
Appendix J

Pre/Post-test

Superpowers

WHAT DO YOU THINK?

Date: ____________________

Age: ____________________

Circle one: MALE      FEMALE

Place a checkmark in the column you agree with:

YES      NO

___  ____  1. I am good at something.

___  ____  2. Many families are affected by drugs.

___  ____  3. Drugs only affect the person who uses them.

___  ____  4. I have strengths that help me in hard situations.

___  ____  5. It’s not important to know what your strengths are.

Post-questions only

6. How I felt about this group:

   1  2  3  4  5  
   Didn’t enjoy In the middle Really Enjoyed

7. Things I really liked about this group:

8. Things I didn’t really like about this group:
Appendix K

Pre/Post-Questionnaire

Addiction Session

WHAT DO YOU THINK?

Date: ____________________

Age: ________________

Circle one: MALE FEMALE

Place a checkmark in the column you agree with:

YES NO

___ ___ 1. Is addiction a disease?

___ ___ 2. Will you have problems with drugs if you start using when you’re young?

___ ___ 3. Addiction only affects the person using the drugs. It does not affect anyone else.

___ ___ 4. Children should be able to solve their parents’ problems.

___ ___ 5. Your parents’ problems are not your fault.

___ ___ 6. Recovery from addiction happens very fast.

Post-questions only

7. How I felt about this group:

1 2 3 4 5
Didn’t enjoy In the middle Really Enjoyed

8. Things I really liked about this group:

9. Things I didn’t really like about this group:
Appendix L

Pre/Post-Questionnaire

Safety Session

WHAT DO YOU THINK?

Date: ____________________

Age: ____________________

Circle one: MALE          FEMALE

Place a checkmark in the column you agree with:

YES   NO

___ ___ 1. Most people do not have problems.

___ ___ 2. Asking for help is a sign of weakness.

___ ___ 3. It is okay to ask for help even if your parent doesn’t get help.

___ ___ 4. It’s okay to ask for help with problems.

___ ___ 5. It’s important to identify safe people in your life.

Post-questions only:

6. How I felt about this group:

1       2       3       4       5
Didn’t enjoy                        In the middle                        Really Enjoyed

7. Things I really liked about this group:


8. Things I didn’t really like about this group:
Appendix M

Pre/Post-Questionnaire

Feelings Session

WHAT DO YOU THINK?

Date: ____________________

Age: ____________________

Circle one: MALE FEMALE

Place a checkmark in the column you agree with:

YES  NO

___  ____  1. Feelings are mainly good or bad.

___  ____  2. Expressing uncomfortable feelings is sometimes hard.

___  ____  3. I can express myself through movement, dance, or art.

___  ____  4. There are only three feelings in life.

Post-questions only:

5. How I felt about this group:

1 2 3 4 5
Didn’t enjoy In the middle Really Enjoyed

6. Things I really liked about this group:

7. Things I didn’t really like about this group:
Appendix N

Pre/Post-Questionnaire

Anger

WHAT DO YOU THINK?

Date: ____________________
Age: ____________________

Circle one: MALE FEMALE

Place a checkmark in the column you agree with:

YES NO

___ ___ 1. Anger is a bad feeling to have.
___ ___ 2. I know of healthy ways to deal with anger.
___ ___ 3. I can use my body and movement to help me deal with my anger.
___ ___ 4. Everyone shows their anger in the same way.

Post-questions only:

5. How I felt about this group:

1 2 3 4 5
Didn’t enjoy In the middle Really Enjoyed

6. Things I really liked about this group:

7. Things I didn’t really like about this group:
Appendix O

Pre/Post-Questionnaire

Play Session

WHAT DO YOU THINK?

Date: ___________________

Age: ___________________

Circle one: MALE FEMALE

Place a checkmark in the column you agree with:

YES NO

____ ____ 1. It is my job to take care of everyone.
____ ____ 2. Having fun and playing is not important.
____ ____ 3. I can name at least 3 things I can do for fun.
____ ____ 4. If I do not do self-care then I might get exhausted and not be the best I can be.
____ ____ 5. I cannot control my parent’s drug use.

Post-questions only:

6. How I felt about this group:

1 2 3 4 5
Didn’t enjoy In the middle Really Enjoyed

7. Things I really liked about this group:

8. Things I didn’t really like about this group:
Appendix P

Pre/Post-Questionnaire

Problem Solving Session

WHAT DO YOU THINK?

Date: ____________________

Age: ____________________

Circle one: MALE FEMALE

Place a checkmark in the column you agree with:

YES NO

____ ____ 1. There is a right and wrong way to solve problems.

____ ____ 2. I need to figure out everything on my own.

____ ____ 3. Most people do not have problems.

____ ____ 4. Working as a team can help solve problems.

Post-questions only:

5. How I felt about this group:

1 2 3 4 5
Didn’t enjoy In the middle Really Enjoyed

6. Things I really liked about this group:


7. Things I didn’t really like about this group:
Appendix Q

Pre/Post-Questionnaire

Superhero Performance Session

WHAT DO YOU THINK?

Date: ____________________

Age: ____________________

Circle one: MALE FEMALE

Place a checkmark in the column you agree with:

YES NO

___ ___ 1. Art, movement, or dance can help me to express myself.

___ ___ 2. I shouldn’t try new things because it is scary.

___ ___ 3. Dance/movement therapy is about the mind-body connection

___ ___ 4. I have strengths that have helped me deal with things in the past

Post-questions only:

5. How I felt about this group:

1 2 3 4 5
Didn’t enjoy In the middle Really Enjoyed

6. Things I really liked about this group:

7. Things I didn’t really like about this group: