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Perspectives on the Profession of Dance/Movement Therapy: Past, Present, and Future

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Abstract

Dance/movement therapy developed as a formal psychotherapy practice in the 1940s and has spread internationally. Dance/movement therapists address a great range of difficulties experienced by individuals of all ages in their work. This article offers an overview of the history, development, and current state of the profession of dance/movement therapy. Information is presented on educational training for dance/movement therapists, practice issues, and assessment tools. Reviews of some of the research, research applications, and resources for learning more information about dance/movement therapy are included.

Introduction

Dance/movement therapy (DMT) developed as a formal psychotherapy practice in the 1940s (Bartenieff, 1972), and although European and other international influences contributed to its development, the professional practice of DMT began in the United States. By 1966 a professional organization, the American Dance Therapy Association (ADTA), was started with 73 charter members. The membership of the ADTA included 955 professional and 255 nonprofessional members in 2000, with international members in Argentina, Australia, Canada, England, France, Germany, Hong Kong, Ireland, Israel, Italy, Japan, Korea, Mexico, Norway, Puerto Rico, Scotland, Spain, Sweden, Switzerland, and The Netherlands. In addition, there are currently national dance/movement therapy organizations in many international locals including Italy, Japan, Germany, and France.

Regardless of location, dance/movement therapists integrate the dancer's special knowledge of the body, movement, and expression with the skills of psychotherapy, counseling, and rehabilitation to help individuals with a wide array of treatment needs. Social, emotional, cognitive, and/or physical problems can be addressed through DMT via group and individual sessions in many different types of settings from hospitals and clinics to schools. The fact that dance/movement therapists are immersed in the language of the body, rather than focusing solely on the verbal, lends characteristics to their work that set it apart from other types of therapy. The bias of Western culture for cognitive, verbal processing and the proliferation of body-oriented therapies of recent years might cause some to think of DMT as an "alternative" therapy. But the origins and practice of DMT have more in common with psychodynamic psychotherapies than with alternative therapies, and although frequently classified as adjunct therapy, DMT was argued to be appropriate primary therapy some years ago (Zwerling, 1979).

Historical Development of DMT

Interestingly, the origin of DMT was directly related to changes in the dance art form that began at the end of the nineteenth century. The most notable characteristic of these changes was the introduction of the notion that dance, could be an expressive and communicative art form capable of moving people deeply and seriously, rather than a mere entertainment (McDonagh, 1976). The modern dance movement of the early twentieth century extended this idea and focused attention on the symbolic potential of the human body in motion free of the stylization that characterized classical ballet, the only serious theatrical

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dance recognized at the time. According to Bartenieff (1972), early modern dancers sought to reestablish the human communicative element in dance that existed when dance ritual was an integral spiritual and social element of societies. In Europe and the United States, dancers such as Isadora Duncan, Ruth St. Dennis, Ted Shawn, and Mary Wigman paved the way for a generation of modern dancers including Martha Graham and Hanya Holm (McDonagh, 1976). The first modern dancers produced three students, Marian Chace, Mary Whitehouse, and Trudi Schoop, who would independently take key elements of modern dance and pioneer the use of dance and movement with special populations -- creating the area of clinical practice known today as DMT (Chodorow, 1991).

It is important to note that modern dance could not simply be applied directly to clinical populations. Chace, Whitehouse, and Schoop each spent many years of contemplative teaching and performing to develop the skills necessary for DMT to coalesce. Familiarity with elements of modern dance forms such as the importance of expression, communication, and the dancer as part of a community, allowed Chace, Whitehouse, and Schoop to develop skills such as observation, interpretation, and the manipulation of dance elements such as rhythm and space to serve patients' needs. In June of 1942, Chace was invited to work with patients at St. Elizabeth's Hospital in Washington, DC, and she described her process of arriving at that point.

"Dance therapy, as a discipline, did not move into the mental hospital full blown and as a bright idea to be sold. Its roots were in work that had been going on for many years prior to this in the community...At the moment that I became interested in the reasons for seeking dance as an outlet by the non-dancers coming to the school, I added another dimension to my interest and teaching. I began to use my training as a means of communication and body awareness rather than as a teacher of art forms. As pupils in this group made application and then participated in the first class, I observed and empathized with the needs being expressed" (Chace, 1975, p. 9, 10).

Due to the symptoms of the patients, the "dance for communication" (Chace, 1975, p. 12) sessions Chace began at St. Elizabeth's were not classes with prescribed movement, but rather groups that used the spontaneous movement expressions of the patients and group rhythms to meet individual and group goals. She observed her patients closely and extracted dance elements that could be used to make contact with and communicate with them. The practice of DMT remains rather similar today. Movement is regarded as complex, individual, and expressive communication; prescribing particular movements would disrupt the process of assessing individual expression similarly to telling clients in verbal therapy what to say. The body and movement become the language of therapy through which assessment and intervention take place in DMT.

By the mid 1960s, a second generation of dance therapists had begun working. In addition to establishing the ADTA as a regulating body for the new profession, they began to formalize DMT training standards and develop graduate degree training programs at several universities. A master's degree is required of all dance/movement therapists and educational programs approved by the ADTA include studies in psychopathology, human development, movement observation, research methods, and DMT foundations and practice. A supervised internship in a clinical setting is also required, and students must have had extensive experience with multiple dance forms prior to their graduate work. Currently, there are ADTA approved DMT graduate programs in the United States at MCP Hahnemann University (Philadelphia, PA), Antioch/New England Graduate School (Keene, NH), Columbia College (Chicago, IL), and the Naropa Institute (Boulder, CO), and the program at Pratt Institute (Brooklyn, NY) has candidacy status. Eight other universities offer graduate work in DMT, five institutions offer post graduate courses, and eleven colleges and universities offer undergraduate coursework in dance/movement therapy. Internationally, there are 13 programs: two each in Australia, Israel, Austria, and Germany, and single graduate programs in Sweden, The Netherlands, London, Argentina, and Italy. In the US, a credentialing process with two levels distinguishes between dance/movement therapists who are prepared to work in professional settings within a team or under supervision (DTR) and those who are qualified to teach, provide supervision, and work in

private practice (ADTR). Continuing education units are necessary to keep a credential active.

During its early development, the practice of DMT was influenced by the prevailing theories of psychodynamic psychotherapy of the 1940s, 1950s, and 1960s (Chodorow, 1991). In addition, the resurgence of research on nonverbal communication of the early 1960s and 1970s (Schmais, 1980) and the growing awareness of the importance of the body in mental disorders in the 1960s (Silberstein, 1987) offered other influences on DMT practice. Developments in the knowledge base concerning disturbed mental states and behavior were not lost on first- and second-generation dance/movement therapists. They strove to understand and integrate the available information on conceptualization and treatment of mental disabilities with their nonverbal approach. Indeed this tradition continues as dance/movement therapists, like other professionals in behavioral health, strive to keep abreast of the influx of new information in the field.

Early on, the psychiatric community expressed interest in and fostered DMT and this may have been due in part, to the fact that movement disturbances and abnormal movement patterns had long been recognized as symptomatic of mental illnesses (Davis, 1972). With particular regard to schizophrenia, movement abnormalities had been regarded as an integral aspect and important symptom of illness since the early part of the century, and by the 1940s movement patterns in schizophrenics had begun to be studied empirically (Silberstein, 1987). Although today we have a more complete understanding of movement abnormalities in severe mental illnesses that give full recognition to the role of neurology (see Cruz, 1995/1996 for a more complete description), when DMT was in its inception, psychoanalysts considered movement symptomatology to be communicative of psychodynamic concerns (Deutsch, 1947). Psychoanalytic influences on the field continue to be visible in the psychodynamic orientation of many dance therapists and particularly in the work of Chodorow (1986).

In the 19th century, Darwin's work established facial and body movement patterns as a subject worthy of scientific investigation and had a significant impact on psychology (Dixon & Lerner, 1988). In the 1940s anthropologists and ethnologists began describing movement as a traditional code regulating and maintaining human relationships, and this line of research became a body of nonverbal communication information extensive enough for an annotated bibliography that was relevant for DMT (Davis, 1972). Birdwhistell (1970) developed a method of analyzing body movement that accompanied speech, while other researchers investigated postural movements, facial expression and eye contact as part of the interaction process. Posture and movement as communicative elements in the therapeutic interaction were studied (Schefflen, 1964), and while using evaluation of nonverbal communication, as part of the clinical assessment of psychological states was not new, a new emphasis on using this information to serve therapeutic goals did emerge (Davis & Hadicks, 1990). The nonverbal communication research literature both supported and expanded the understanding and interpretation of movement expression and observation with regard to interaction, and was central to the development and acceptance of the DMT profession.

Today, dance/movement therapists use various theories of psychodynamic and growth-oriented psychotherapy as frames of reference for their work, and integrate these with an informed and specifically trained understanding of nonverbal communication. However, there is not a centrally established and accepted theory or rationale regarding the efficacy of movement in psychotherapy that serves the profession; the diversity of populations and applications of dance therapy beyond traditional psychotherapy may have contributed to this fact. Bartenieff and Lewis (1980) proposed a general theory about the function of movement, theorizing that the body and its movement mediate between internal processes and the external environment, serving a coping function for satisfying and coordinating demands in either sphere. Most dance/movement therapists use this theory as a working model and add to it the idea that all movement, including posture and body structure (as the body develops according to its use), reflects states of psychological health and illness. Chace (1975) described a rationale for DMT, "since muscular activity expressing emotion is the substratum of dance, and since dance is a means of structuring and organizing such activity, it might be supposed that dance could be a potent means of communication and reintegration of the seriously ill

mental patient" (p. 71). DMT provides a therapy environment in which various aspects of relationship to self and others can be explored and experienced. But what is more, there is no requirement to verbalize the material of the therapy, so material can be discovered and addressed even if it is not verbally accessible to the individual. Similarly to other arts therapies, it is this symbolic, nonverbal access to therapeutic material that distinguishes DMT from verbal therapies.

In recent years, dance/movement therapists have been engaged by the wealth of new neuropsychological research that has theoretical implications for DMT. Interdisciplinary approaches such as that of Schore (1994) integrating research from the areas of child development, neurobiology, and psychoanalysis on affect regulation support the efficacy of nonverbal interventions. Such work is gaining notice by dance/movement therapists and will hopefully be explored further for its potential to help establish a scientific foundation for DMT.

Assessment in DMT

A great contribution to DMT was the introduction of a system of observing, analyzing, and describing movement behavior devised by Rudolf Laban. Laban was both a dancer and architect and his elaborate theory of movement, techniques of movement observation, and system of movement notation spread through Europe after World War II. His system of movement notation to preserve choreography is known as Labanotation, and he had many students who carried his work to England and America where his theories had a profound effect on dance and dance education (Thornton, 1971). His system of observation and notation describes the spatial and dynamic aspects of movement rather than only the actions performed, seeking to convey the qualities of the movements. The distinction between the action of movement and the qualities with which movement is performed is a key concept. This distinction allows analysis of movement behavior apart from action that can be used to describe functional and expressive movement as well as posture and the body at rest. Bartenieff, Lamb, and others adapted Laban's concepts into a system of movement assessment known as Effort/Shape (Dell, 1977).

The basic concepts of the Effort/Shape system including effort, shape, space, and body context proved to be essential to DMT. They served as a basis for the development of diverse movement observation scales, and essentially provided a movement language that is shared by dance/movement therapists. The Movement Psychodiagnostic Inventory (MPI, Davis, 1970; Davis, 1991) is a Laban-based scale originally designed for observing and noting the movement patterns of hospitalized psychiatric patients and used today to investigate involuntary movement disorder associated with severe psychopathology (Cruz, 1995/1996; Berger, 2000). Kalish (1975) developed and normed a body movement scale for autistic and atypical children that was influenced in part by the Laban descriptive language. North (1972) also used the Laban system to develop an assessment of personality for children, and the Kestenberg Movement Profile (KMP, Kestenberg, 1979) noting developmental movement patterns and using a Laban base, has been applied to a variety of assessment populations with a focus on clarifying treatment issues (Kestenberg-Amighi, Loman, Lewis, & Sossin, 1999). The variability of these applications demonstrates the usefulness of Laban's system.

Because DMT developed as an applied practice based on the assumption that movement reflects aspects of inter- and intra-personal functioning that include pathological conditions, Laban's work provided a key component of DMT by offering a systematic method of observing and describing the visible dynamic of movement devoid of particular movement tasks. This has proved useful in training, clinical practice, and research. DMT training programs teach movement observation using Effort/Shape and many dance/movement therapists obtain further training and certification in Effort/Shape at the Laban Institute in London and the Laban/Bartenieff Institute in the US.

Practice and Professional Issues

The populations with which dance therapists work have become wide-ranging and include such groups as medically ill children (Goodill & Morningstar, 1993; Mendelsohn, 1999) women with breast cancer (Dibbell-Hope, 2000; Serlin, Classen, Frances, & Angell, 2000), individuals with eating disorders (Krantz, 1999), and individuals with Parkinson's disease (Westbrook & McKibben,

1989). While dance/movement therapists report working in the areas of wellness and personal growth, palliative care, medical illness, developmental disabilities, and addictions, 60% of dance/movement therapists recently surveyed still classified their work as psychiatric (Cruz & Hervey, in review). Work with other populations such as infants and parents, children with autism and developmental disabilities, and the elderly has been ongoing since the 1970s.

While dance/movement therapists have expanded the populations with which they work, there has not been a corresponding increase in the amount of research on DMT. The early DMT literature was largely composed of theoretical formulations and practice descriptions (see for example, Chase, 1953) and as the profession evolved, research oriented publications were added to the literature. Although results of studies on the effectiveness of DMT using a variety of methods can be found, the case study has been noted to be the most popular DMT research method (Ritter & Low, 1996). And while no efficacy studies have been published, effectiveness studies with multiple populations have been published. While research reflecting development and expansion of knowledge related to practice is available and some of this will be reviewed a little later in this article, the troubling fact remains that this is not a large body of literature. An issue of some concern to dance/movement therapists is that DMT research may not be keeping up with the demands of practice and healthcare policy, (Cruz & Hervey, in review). Some of the explanation for this state of affairs is that DMT training programs focus on preparation for clinical practice rather than on research or the combination of the two, and remain limited to master's degree training programs. Master's theses abstracted in two volumes (Fisher & Stark, 1992; Chaiklin, 1998) create a large group of DMT literature, but with all of the attendant problems of design and execution that one might imagine when research is not a focus of training. Dance/movement therapists who desire doctoral degrees must take these degrees in other specialty areas and while some who do so remain in and contribute to the profession, others do not. For the maturity of the profession, it is vital that more dance/movement therapists obtain doctoral degrees with the attendant exposure to and experience with the spectrum of research methods that this implies. It is also hoped that the option of taking a doctorate in DMT will be available in the near future.

DMT Research

While the following discussion on DMT research is brief and far from comprehensive, it is hoped that a flavor for the range and potential of research from dance/movement therapists is conveyed. Although a greater proportion of the extant research is practice oriented, examining the effectiveness of DMT and describing interventions with particular cases, some of the research has focused on investigating the potential of the movement-based assessment tools unique to DMT for diagnostic and other purposes.

Aggregated evidence for the effectiveness of DMT, although based on a relatively small number of studies, has demonstrated treatment effects of DMT that are comparable to other psychotherapies (Cruz & Sabers, 1998). In fact, when effect sizes were examined among meta-analyses for DMT, verbal psychotherapies, cognitive behavioral therapies, meditation techniques, and exercise for psychological problems DMT fared rather favorably. Effects of DMT on anxiety, self-concept, body awareness, were included in the studies. Based on this evidence, which included studies from as early as 1974, DMT can be argued to be an effective treatment for individuals with a wide array of symptoms. Cruz and Sabers recommended that this information be used to lobby for the introduction and continuation of DMT positions in different clinical settings.

A study of DMT with older adults diagnosed with neurological trauma helps to demonstrate some of the flexibility in application of DMT, particularly, as neurological rehabilitation and interventions that are appropriate with older adults are increasingly important topics. In a study of older adults with neurological injury (non-progressive neurotrauma), Berrol, Ooi, and Katz (1997) used experimental and wait-listed control groups in five centers across the country. Participants received DMT two times per week and the researchers documented gains in measures related to quality of life for the experimental group in excess of those measured for the control group. Individuals who received DMT made significant gains in physiological measures such as walking, and had significantly improved cognitive performance over the control participants. In addition there were changes in the frequency of social

interaction with peers and involvement in social activities for the experimental group in spite of the fact that all participants had severe limitations due to the nature of their neuropathology.

Several studies have been conducted examining the potential of DMT based movement indicators for diagnostic purposes. Lausberg (1998) studied the movement behavior of individuals with bulimia nervosa and anorexia nervosa using inflammatory bowel disease patients and healthy individuals as controls. Participants completed a movement assessment and although no significant differences were found among the patient groups, the healthy control participants were distinguished from the patient groups on several movement indicators including motor tasks and use of weight, space, and body involvement. Lausberg concluded that severity rather than type of psychopathology might have been a factor. However she also proposed that univariate analyses were not effective in uncovering differences among patient groups and that multivariate analyses might be more effective. Indeed, due to the complex character of movement Cruz (1995/1996) proposed that expecting a single movement indicator to differentiate pathology was unrealistic.

Using the MPI (Davis, 1991) with raters blind to diagnosis, Cruz (1995/1996) found that patterns of involuntary movement indicators, distinguished using multivariate techniques, discriminated between patients with schizophrenia and those with personality disorders. While it may seem that distinguishing between these groups based on motor behavior might not be that difficult for untrained raters, interestingly, it was not degree or severity of motor disorder but pattern across indicators that proved to be important. Evidence for the validity of the MPI as a measure of motor disorder was found in the patterning of MPI items along the hyperkinesia – hypokinesia continuum traditionally used to classify motor disorder. However, a group of MPI items could not be ordered along this continuum and the MPI may represent a finer level of distinction of motor disorder than has been traditionally defined. In a related study based on movement characteristics in individuals with borderline and narcissistic personality disorders, Berger (2000) found that these two groups could be distinguished with 86% correct classification using the MPI and again using a multivariate statistical technique. It is fairly easy to argue that untrained observers would not distinguish between these diagnostic groups based only on motor behavior. The surprising finding across these two studies is that a level of diagnostic specificity was obtained based purely on motor behavior indicators for diagnoses that are typically made based on extensive interview and history taking.

A final study for discussion offers another interesting application of the observational and assessment tools that have emerged from Laban's work. Lotan and Yirmiya (in press) used elements of the KMP (Kestenberg, 1979) to investigate the role of body movements during the process of falling asleep. In order to help explicate sleep problems in toddlers, their movements were analyzed as they were falling asleep. The movement variables predicted the length of the falling asleep phase significantly better than other variables associated with the falling asleep phase including duration of pacifier or thumb sucking and presence of objects in the bed. In addition, there was a relationship between the presence of parents in the room and the type of movement exhibited by the children. Parents who spent more time in the room had toddlers who exhibited fewer soothing movements than those whose parents were not in the room. What is most outstanding about this study is that advanced technology was used in the filming and computer analysis of the toddlers' movements. The KMP, which was developed for and is still largely used by highly skilled observers (Koch, Cruz, & Goodill, in press), was combined with technology capable of exactly measuring amplitudes of qualitative changes. The use of technology to improve on observer ratings represents a true advance that will eventually have an impact on DMT research. While the movement language used in DMT assessments and instruments is unique and can make a real contribution to research of many types, the fact that these instruments must still be coded by trained raters cause their use to be costly and time consuming. Introducing technology that mimics and even improves upon human raters would certainly push research in DMT forward. Further, the application of DMT instruments to research in areas such as developmental psychology and psycholinguistics could make real contributions in these areas.

The possibilities for research collaboration between dance/movement

therapists and psychologists in various specialty areas are particularly exciting. Productive collaborations have already proven useful in developmental psychology, especially in the areas of motor development and parent-child interaction (see Kestenberg-Amighi, Loman, Lewis, & Sossin, 1999), and neuropsychology (see Lausberg, Davis, & Rothenhaeusler, 2000). However, the true potential of such research partnerships has yet to be tapped. A simple review of the specialty areas in psychology reveals a broad range from forensic and engineering psychology to rehabilitation and school psychology. The language of the body and movement provide a rich source of data that is seldom used in to inform research outside DMT. Introducing the DMT vantage point to research in other areas would allow cross-fertilization of ideas and information. Indeed, exploiting movement data in collaborative research can enhance our understanding of questions related to many interactive, expressive, and intrapersonal elements of human experience.

Summary

The growing international presence of DMT is heartening to those of us with a passion for the profession. But the fact remains that DMT is a small and specialized area of clinical practice and the intimacy with the dance form that is required for entry into the profession, although necessary, may contribute to slow growth of the profession. While the field of psychology can accept students from all walks of life, traditionally, dance/movement therapists must first be dancers. DMT offers a rewarding professional option to dancers who are attracted by psychology and human service, and in addition there is still much work to be done to extend the profession. Research and scholarship are needed to improve clinical practice, to explore theoretical underpinnings, and to extend DMT observational tools into mainstream science. Since the 1940s, the profession has flexibly accommodated trends in healthcare and changes in the understanding and treatment of different disabling conditions. The richness of DMT with its unique focus on the language of movement and the body has much to offer mainstream research and healthcare, and I hope that in the future, DMT makes its own impact through contributions to research and clinical practice.

Resources

Web Sites

<http://www.adta.org> American Dance Therapy Association

<http://www.ncata.com> National Coalition of Arts Therapies Associations

Books

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