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Michelle J Walsh
Challenges Faced by
Movement Therapists in
Terms of Recognition of
Their Profession

ABSTRACT

This empirical qualitative study was conducted to determine what movement therapists do and how their services interact with traditional psychotherapy. The purpose of this project was to provide information about dance/movement therapy as a way to promote the practice and move towards bridging the gap between this alternative therapy and mainstream psychotherapies.

This exploratory and descriptive study was carried out through semi-structured interviews. The sample (N=9) was made of up dance/movement therapists who were certified by the American Dance Therapy Association. Questions were designed to gather information about participant demographics, training and certification processes, methods and significance of dance/movement therapy, client characteristics and building clientele and report.

A content analysis of the findings indicated that dance/movement therapists do experience difficulties in developing a rapport within the mental health field. It was also discovered that most people have a poor understanding of what dance/movement therapy is and how it works as psychotherapeutic treatment. Cultural and spiritual implications are examined as well, as they relate to the alternative practice of dance/movement therapy.

CHALLENGES FACED BY MOVEMENT THERAPISTS IN TERMS OF
RECOGNITION OF THEIR PROFESSION

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2010

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CHAPTER I

INTRODUCTION

Movement therapy, sometimes known as dance therapy, is an alternative to talk therapy. The root of psychotherapy, developed within a Western and European culture, is in narrative or talk therapy. However, dance and movement have been used for centuries as a way to express, manage and experience emotion as well. As clinicians in Western culture begin to incorporate movement into their psychotherapy practice and more specifically, practice as a movement therapist, one may wonder about potential challenges faced by these professionals in a clinical world based on narrative interventions. To date, there have been challenges faced by certified movement therapists in becoming established, respected and recognized within the clinical profession.

Movement therapy is an “approach to facilitating therapeutic change [which] uses psychomotor expression as its major mode of intervention” (Mills & Daniluk, 2002, p. 77). As defined by the American Dance Therapy Association, movement or dance therapy is “the psychotherapeutic use of movement as a process which furthers the emotional, cognitive and physical integration of the individual” (Mills & Daniluk, 2002, p. 78). *Movement* is a modality that “is based on the premise that mind and body are inseparable, that what is experienced in the mind is also experienced in the body...the premise that self-expression facilitates growth and change and that verbalization alone,

unaccompanied by affect, creativity, or motor action, cannot touch the full range of human feeling” (Levy, 1995, p. 1-2).

Movement may look like a dance or simple motion of a body part – swinging arms at sides, tapping feet on floor while sitting in a chair. This expanded and also strategic use of movement complements what people tend to think of as dance that is, specific movements based on rhythm and method to promote emotional and physical healing.

The purpose of this study is to answer the following research question: What do movement therapists do and, how can their service interact with traditional psychotherapy? There is some available information on movement therapy. However, this information is usually accessed only by those who are curious to learn more about movement therapy. Psychodynamic training programs rarely mention movement therapy as an effective alternate technique to traditional talk therapy. In this study, information will be gathered from movement therapists in order to educate and advise mental health clinicians and others who potentially could use or refer clients to movement therapy.

Previous research (Berrol, 2006; Christie, Hood & Griffin, 2006; and Mills & Daniluk, 2002) has been done focusing on the effectiveness of movement therapy. However, little attention has been given on how to promote movement therapy as another form of clinical intervention - especially by those who are already mental health providers. The “how” in how to use the information found in previous research within traditional psychotherapy is left unanswered, and thus a gap between movement therapists and mental health clinicians providing services to clients who could benefit from movement therapy continues to exist. The findings of this study will hopefully

provide information which can be used by mental health providers and promote the use of movement therapy.

Movement therapy is aligned with social work ethics and values because all clients do not have the same style of processing, learning and sharing of their stories. It is a mental health provider's responsibility to be able to offer a treatment modality that suits each individual client's way of moving through and resolving presenting issues.

As movement therapy offers other avenues for clients to move through the therapeutic process as it best fits him/her, the objective of this study is to begin to bridge the existing gap between traditional "talk therapy" and movement therapeutic techniques. The findings of this study may inform movement therapists about ways in which they may expand their practice and for movement therapy to be a more accepted as an adjunct form of therapy within the traditional psychotherapy network. Thus, the purpose of this study is supportive of the ethical obligation clinicians have to keep the client's best interest first and foremost by offering a broader menu of effective treatment techniques.

As social workers, it is our obligation to bring new evidence based best practices to our clients. Specifically, methods of intervention that serve the client's way of being and adjustment/processing style best should be used. Movement therapy and the application of this intervention in a psychotherapy setting exemplify the values of social work as it involves the community and explores therapeutic resources. These resources may prove to be new interventions and alternative methods by which to best serve certain clients.

The intended audience for data collected in this study is primarily clinical social workers and social work students. Other interested readers may be consumers seeking

alternative therapeutic methods to narrative therapy and human service professionals, such as physicians who might refer a client for services.

CHAPTER II

LITERATURE REVIEW

In order to answer the question about what movement therapists do and how their services might interact with traditional psychotherapy, previous research on movement therapy must be reviewed. Also, there must be an examination of the effectiveness of movement therapy and its relation to the social work profession. The literature discussed here provides the framework for the current study.

In this chapter the emergence and types of expressive therapy, specifically movement therapy, are described. Beginning with various forms of expressive therapy and leading to an in-depth examination of movement therapy, I present and critique the previous literature that examines the effectiveness of these techniques. I then describe in detail the training and licensing requirements needed to practice as a certified movement therapist, along with current issues raised in the conducted research.

The Historical Foundation of Dance/Movement Therapy

Dance has been around for an extensive period of time. Dating back to early civilizations, dance has been a critical component in healing “long before contemporary medicine discovered the body/mind connection” (Wennerstrand, 2008, para. 9). Throughout time dance has been a vibrant cultural component and at times also restricted, depending on political and/or religious state of affairs and also by geographic location.

For example, in 12th century Europe dance was banned by the Catholic Church, limiting its emotional and powerful presence in many cultures for some time. It was not until the 20th century, when the phenomenon of modern dance came about, that Dance/Movement Therapy had a niche in which to cultivate. There are many individuals who have become famous for their work using dance with populations in need. Carl Jung was a Swiss psychiatrist, who founded Jungian psychotherapy based his work on “archetypal movement” and how this provides “direct access to the unconscious” (Payne, 1992, p. 167). These archetypes are “the inborn tendency to form conscious images and as psychic correspondents to the instincts on a psychological level” (Payne, 1992, p. 183). Archetypal movement and the collective unconscious are,

...a very valuable background and valid framework for understanding the underlying patterns in movement. Jung himself had patients who used dance as one of the techniques in the analytical work...he treated the dance as any other form of active imagination (Payne, 1992, p. 182).

Jung’s psychoanalytic technique uses emotional exchange; transference and countertransference, tools used in D/MT (Bright, 2000). Jung promoted the importance of becoming emotionally aware through assessing the transference and countertransference process, much like dance/movement therapists.

Marian Chace, founder and first president of American Dance Therapy Association (ADTA), worked in a hospital with a psychiatrist who encouraged self-expression. In D/MT, the body is seen as a container that holds memory and experience. In regards to containing, Chace considered the circle a significant structure within dance and applicable to therapy as circular movement is “encouraging both synchrony and safety” (Payne, 1992, p. 254). Others including Trudi Schoop and Mary Whitehouse used D/MT in treatment with schizophrenic, individuals with learning difficulties and hospitalized

psychiatric patients with varying degrees of illness (Dance to Health, n.d.) Rudolph Steiner, of England, developed *eurythmy*, a technique that connected modern dance principles – movements paired with color and music – to specific emotions.

Significance of Expressive Therapies

Previous research has been done since the 1980's on expressive therapeutic techniques (Kalish-Weiss, 1989). "Expressive therapy is a form of psychotherapy using all of the arts: visual art, dance, drama, music and poetry. Expressive therapists specialize in *intermodality*, that is, the switch from one medium to another, in order to further the process or gain depth" (L. Thompson, personal communication, October 21, 2009). In any therapy there is an emotional component for clients. These emotions can be accessed and expressed via these art forms that best suit the individual client's need. For each client, the different forms allow the "opportunity to connect affect and cognition with their bodies in a way that is non-analytical and bypasses the defenses of intellectualization and rationalization" (Antinori & Moore, 1997, p 174).

Music Therapy

Music therapy is "the systematic application of music to aid in treatment of physiological and psychological aspects of an illness or disability" (Chang & Chen, 2005, p. 454). A study in South Korea using movement therapy with 26 inpatients aimed at increasing self awareness, and establishing rapport. The goal of Choi, Lee and Lim's (2008) study was to reduce symptoms of depression and anxiety in order to improve self-esteem and self-expression, leading to better cooperation with others and increased

confidence and positive thinking. Unpaired t-tests were used to analyze data, articulating positive findings of music therapy and the improvement of depression, anxiety and relationships.

Findings of a second study that evaluated the effectiveness of music therapy showed increased learning in individuals with Rett Syndrome, a “severe learning disability” seen across all cultures, affecting mostly females (Elefant & Wigram, 2005, p. p.98). In this study seven females aged four to ten had individual music therapy sessions for 20-30 minutes at 3 times a week. Findings showed that children with Rett’s Syndrome can experience sustained learning – learning with consistent and reliable results – in direct correlation with music therapy treatment. It was noted that music is a natural motivating force for individuals within this population, so if movement had been the modality results may not have been significant (Elefant & Wigram, 2005).

Another experimental study investigated the efficacy of music therapy with pregnant Taiwanese women. Findings showed that the experimental group (where music therapy was introduced) had lowered anxiety and greater satisfaction with the cesarean birth experience (Chang and Chen, 2005).

Art Therapy

Before moving on to the examination of movement therapy, therapy involving the visual arts will be considered in order to provide a context within which to understand the differences between different creative forms of therapy. Two studies examined process and reflection as the instruments by which the research is conducted and results are examined.

Mahler's theory of Separation-Individuation was selected as the theoretical framework in the Somer and Somer's (1997) study. The purpose of the study was to uncover the subjective meanings given by an incest survivor struggling with DID, to her own spontaneous art work. The participant was a female, 27 year old incest survivor, diagnosed with Dissociative Identity Disorder (DID) with 31 alters.. During the course of the study she produced 250 pieces of art work. Her art work was created as she moved through four identified stages of her treatment process: autistic, symbiotic, differentiation and separation-individuation. A "phenomenological method of art therapy based on Betensky" was used by the participant to analyze her own art work, created during the span of treatment at her own home (Somer & Somer, 1997, p. 421). The five phases of the Betensky method are: 1) visual display of art expression, 2) physical distancing to gain perspective, 3) intentional looking at the art expression with therapist encouragement for the client to become the receiver of the deposited messages in the artwork, what-do-you-see procedure, 4) an invitation to the client to share the results of the earlier steps and to phenomenologically describe what the client sees in the picture and finally 5) assisting the client to unfold the private meaning contained on various levels in the visual product (Somer & Somer, 1997). The Betensky steps are similar to the process of many therapeutic treatments, as there is the expression, whether it be visual art, movement, verbal or just affect and then the process of perspective being offered by the therapist and assisting the client to describe and work through what has been raised.

Once the participant had analyzed her work the researchers, one of which was her clinical psychologist, analyzed her art work. Although the client's analysis was a bit more fragmented compared to the researchers' analysis (each piece of art work was seen

by the client as its own entity). The researchers saw the work as a compilation of her treatment and healing process and - the outcome of their analysis was of the same nature and supported by Mahler's theoretical framework. Reported in the discussion, the participant experienced a healing of "her injured child self" similar to Mahler's theory about "the psychological rebirth of a human infant" (Somer & Somer, 1997, p. 429).

The findings of Somer and Somer's (1997) study may be similar to the effects of movement therapy for clients with preverbal trauma and repressed trauma experiences. Somer and Somer stressed that important elements for clients to participate in this type of treatment are talent, a supportive environment, and a demonstrated need for alternative means of self-expression (Somer & Somer, 1997). It will be interesting to discover what further evidence there is to support this claim as not all clients possess artistic talent but they may benefit from art therapy. As with all therapeutic treatment, a supportive environment is crucial and the most effective treatment strategies are supportive to each individual's needs may include alternative self-expression. One major limitation of Somer and Somer's (1997) study was that there was only one participant; results may have been different if more individuals had participated.

The second study involving visual art is again based on one female (Kaufman, 1996). The researcher created her own visual art and analyzed data produced through the art process. The purpose of this research was to discover the nature and meaning of *containers*; implications of using boxes in art therapy. As boxes equal containers, this is synonymous with containment, beyond just a frame for one's emotions. Much like Winnicott's theory of a "*holding environment*, where a physical and psychic space within which the infant is protected without knowing he is protected, so that very

obliviousness can set the stage for the next spontaneously arising experience” (Mitchell & Black, 1995, p. 126). The method of data collection was done via open-ended reaction, recorded by journaling to analyze the meaning of containers being used in art therapy. Seven major themes and some sub-themes were identified. The results illustrated an emphasis on the relationship of art and suffering in this particular study. However, the researcher was able to create the “goal of ultimate healing” with “tacit understanding” via the experience of process – art making – and reflection of the creation (Kaufman, 1996). Kaufman kept a journal as she moved through the art making and reflecting process and her findings emerged from coding her own recorded qualitative data. This was a heuristic approach, using the art elements of form, process and content. Kaufman then systematically extracted data from the journal and concluded that art can be a form of transference and transformation of one’s own experiences (Kaufman, 1996) As with Winnicott’s holding environment Kaufman symbolically applied the idea of the container/space to mother and child and later on to the relationship between therapist and client, to the art in boxes.

One strength of Kaufman’s study was that her conclusion clearly articulates the relationship between Winnicott’s psychodynamic theory and art therapy. The use of open-ended journaling may be useful in recording future data as this method allowed for personal choice and an accurate representation of the individual’s personal journey.

Another aspect of Kaufman’s study had to do with the demonstrated connection of body and mind. Kaufman articulated an overarching theme of human development and the journey of life, referencing specifically the body, psyche and the soul (Kaufman, 1996).

Dance/Movement Therapy

Included in the repertoire of expressive therapies is Dance/Movement Therapy. I focus on Dance/Movement Therapy (D/MT) for two reasons. First, dance and movement is “less culture-bound than more traditional psychotherapies” and could be a more effective therapeutic approach across various cultures (Kalish-Weiss, 1989, p. 4). Secondly, I found through personal experience that movement can be a useful tool in bringing to client’s attention behaviors, thoughts and emotions they might not consciously be aware of. “Movement therapy is a term used by somatic therapists, and those who use developmental movement. Dance/movement therapy is the form of psychotherapy that the ADTA [American Dance Therapy Association] oversees. We use a creative process to utilize dance in treatment” (L. Thompson, personal communication, October 21, 2009).

Examining D/MT from the Clients’ Point of View

The findings noted in many previous studies (Mills & Daniluk, 2002) were based on what the observer saw, thought and felt as the client moved. Findings of these studies might be questioned given that bystanders were making observations rather than the client’s firsthand report of his/her own experience. However, recent research linking neurobiology and movement therapy supports that experienced feelings of the observer/therapist are actually most often an accurate expression of the client’s own experience (Berrol, 2006).

Motivation for Mills and Daniluk’s (2002) study was based on the fact that there was little research having to do with the client’s experience as previous research focused on

the dance therapist' intuition and judgment rather than the client's reported experience. Additionally, previous research frequently focused on single study cases or participants were assessed based on a single session intervention. Thus, the purpose of Mills & Daniluk's (2002) study was to explore how D/MT brings about healing for clients, in order to answer the question, "What is the lived experience and meaning of dance therapy for individuals who found it to be facilitative of their personal growth and healing?" (p.78).

Participants in Mills and Daniluk's (2002) study were required to have already had a D/MT experience and to have considered their treatment facilitative to their personal growth or healing or both. It could be considered that their participant population was skewed toward getting positive results before even conducting the study, as participants already had a positive view of D/MT. Participants were recruited via snowball method and posted notices at social service agencies and D/MT studios. All participants were Caucasian of European-American decent, educated beyond high school and had all participated in D/MT group experiences. The participants' experiences of the D/MT intervention were captured via unstructured interviews. Identifiable themes from interviews with participants were spontaneity, permission to play, struggle, freedom, intimate connection and bodily reaction. The body-mind connection was a major factor in the analysis of these 6 themes in relation to this psychomotor intervention, as they related to emotional reaction and experiences. Positive reactions were reported for spontaneity, permission to play, freedom and intimate connection, via an open-ended interviewing process. Profound experiences were reported in relation to bodily reactions.

And the theme of struggle was often centered on the notion of being self conscious around other group members.

“Implications of the findings are discussed in terms of the therapeutic nature of dance therapy and how this therapeutic modality facilitates change and healing in clients’ lives” (Mills & Daniluk, 2002, p. 77). It was noted that trauma can be stored in the body especially for pre-verbal trauma; these experiences are often more easily expressed through physical movement.

Significant phrases were highlighted, but there did not seem to be a clear definition of what the researcher thought was significant. Additionally, meaning was extracted by using “‘creative insight,’ while taking care to remain faithful to the data,” which seems to be very subjective and could have again catered to the desired results of the researcher (Mills & Daniluk, 2002, p. 79). It would have also been useful to know how the participants came about to use D/MT to begin with in an effort to determine the extent of mainstream use D/MT. It would be useful to include participants who did not have a history of child sexual abuse.

Other useful components to this study, which may prove as a useful model for the study at hand, is the way in which data was analyzed; the use of common themes and subthemes identified by coding for common thematic content. Thematic descriptions were returned to participants for validation, which credits the researchers work, but may not be applicable to the current study due to the limited time in which the study must be completed (Mills & Daniluk, 2002).

Despite the limitations, the findings of Mills and Daniluk’s study strongly support the use of movement therapy. The results describe the deep healing which took place for

these women and is inclusive of their comparison to previous experiences in narrative therapy, that were less successful (Mills & Daniluk, 2002).

Investigating the “inflexible partition”

Age, gender, developmental level, previous experiences of pain and situational and psychological factors were variables in this next movement therapy treatment study, in which it was noted that, historically, there has been an *inflexible partition that is*, “a firm divide between the mind and the body.” (Christie, Hood & Griffin, 2006, p. 570). This study used a multidisciplinary team made up of a medical doctor, psychotherapist, occupational therapist, social worker, psychologist, and pharmacological services and acupuncture. The team was a key factor in engaging the participants and their families. Two teenage female participants, both whom experienced chronic pain with no medical evidence as to the cause made up the sample for this study. An examination of physical versus psychological problems was the basis for this research as the participants experienced chronic pain with no identified organic causes. (Christie et al. 2006). With only two participants it may not be realistic to make a generalization for D/MT effectiveness on somatic pain. However, both participants had been treated using traditional psychotherapy and experienced little relief from their pain. The results of this study gives rise to the notion that D/MT may not be appropriate for everyone as one participant had extremely positive results – was able to become a mainstream student and excel – while the other participant did not experience positive results and continued to experience somatic symptoms (Christie et al, 2006).

Touch was a component in this study, as “physical contact has the potential to make an individual aware of basic instincts, highlighting thoughts and feelings (both emotional and physical) through the senses” (Christie et al. 2006, p. 572). It was noted that touch is essential at the early stages of development and can raise awareness to areas which are in need of containment or release of tension (Christie et al. 2006). The use of touch must be strategically considered as this intervention treads a fine line of invading personal space and at times has been a reason for malpractice. On the other hand, it may be that touch is critical in bridging the body-mind gap for some individuals, as it can draw attention to the somatic symptom in direct connection with the psychological, right in the moment (Christi et al. 2006). The use of touch in D/MT is not directly related to the goal of the current study and may be a question for further research as to how touch plays a role in most D/MT and if that has impacted a therapists’ work.

Mirroring and Observation

Research and subsequent data has supported the effectiveness of D/MT from a neurological standpoint. In exploration of the mirror neurons – “a class of neurons said to be actively engaged in the process of simulation” within the pre-motor cortex (Berrol, 2006, p. 4) – there is explanation of how “D/MT embodies empathic forms” (Berrol, 2006, p. 2). Findings show that empathy is experienced in witnessing human interactions, not only in an emotional sense, but in a cognitive sense as well. Two studies are referenced in Berrol’s article showing how even those who witness the movement experience can react and draw from the one being observed, “Like a mirror image, the same sets of neurons are activated in an observer as in the individuals actually engaged in

the action or the expression of some emotion or behavior” (Berrol, 2006, p. 2). “These inherent mirroring properties help explain the mechanisms of social, kinesthetic and emotional cognition or understanding” (Berrol, 2006, p. 2). This concept of mirroring offers a screen from which to watch what is being experienced or felt by the client or participant of D/MT and suggests powerful evidence of the effectiveness of the practice.

Brauninger’s (2006) article shows how mirroring and observation were a key factor in researching and drawing conclusion about both the therapist’s and the client’s experience accurately (Brauninger, 2006). Brauninger (2006) used mirroring and observation to investigate the following: How should dance/movement therapists act with ambulant clients? Is there such a thing as a ‘better’ treatment modality that therapists should choose? And should therapists guide more into active or receptive roles during D/MT sessions? Additionally exploration of what dance/movement therapists feel and expect of themselves during session and how clients perceive their self-efficacy was explored. How imaginative clients are prior to and after 10 session D/MT intervention was also considered in this multifaceted study.

Empirical data was gathered by actively moving, observing and witnessing the clients’ experience of D/MT. This randomly selected the sample was made up of a control group (N= 65) and a treatment group (N=97) from 11 German cities. A questionnaire that gathered quantitative and qualitative data on: 1) treatment modalities and self expectancy of therapists, 2) participants’ active or receptive modes and 3) their self-efficacy and imagination. Findings showed that neither active nor receptive modalities influenced the efficacy of D/MT. Clients showed heightened self-efficacy and increased imagination (Brauninger, 2006). Confusing variables were modality and self-

efficacy; both could have been more clearly defined. Findings supported therapists trusting their intuitive choice or aesthetic consciousness, which again is a concept that could have been more clearly defined.

As this study pertains to the self-efficacy and self expectancy of clients and therapists, respectively it was a bit confusing. More in depth explanation of the variables would have been more useful. Another limitation was that there were only 15 male participants and 147 female participants, a highly skewed ratio, leaving any gender inferences to be inconclusive. The rationale for conducting this study was not clearly articulated. Lastly, the therapists were asked to measure their client's receptive or active mode. As noted in previous research having the therapist report the client's use of this treatment is devoid of the clients report and self-experience (Brauninger, 2006).

It may also be possible that the body-mind integration may have caused challenges in engagement within particular Western cultures; the cultural backgrounds of the participants were not mentioned and perhaps that may have had an influence on the somatic pain. As movement therapy becomes more widely used in Western culture it is most likely that the breakdown of a mind/body division must occur. As mentioned Christie, et al's (2006) study, Cognitive Behavioral Therapy (CBT) connects behavior with thought processes. CBT may be a way of attributing connectedness of cognition to the body through an evidence based practice, in direct relationship to D/MT.

Theoretical Framework for Movement/Dance Therapy

Theoretical frameworks identified in the previous literature include that of Winnicott (Somer & Somer, 1997). Winnicott's emphasis on play and experience versus

interpretation allows clients to maintain the “original notion of transitional objects, more as a process and less as an object” (Somer & Somer, 1997, p. 420). Going along with this theory in D/MT the client is literally moving through this process of change and experiencing the provided space as this transitional object.

In addition to Winnicott, Mahler’s “separation-individuation process,” Betensky’s phenomenological approach using reflection and paraphrasing (Somer & Somer, 1997). Webster’s notion of our bodies as containers (Kaufman, 1996), and the Pessio Boyden System Psychomotor (PBSP) therapy (Antinori & Moore, 1997) are all frameworks that assessment can be made involving the body and support movement therapy. It is also found to be that many theories in psychology, such as “Reichan, psychoanalytic, Gestalt, object relations, humanistic, family systems, and Adlerian” have been influential in the field of dance therapy (Mills & Daniluk, 2002, p. 78).

There are obviously several theoretical frameworks by which D/MT can be examined. Considering psychoanalysis as the foundation for psychotherapy, D.W. Winnicott’s – psychoanalyst and psychodynamic theorist – theoretical framework will be applied more deeply to D/MT. Three main elements of Winnicott’s theory can be applied to D/MT.

Transitions

Beginning with transitional experience, Winnicott did not defined change from dependence to independence, but rather “the transition between two different modes of organizing experiences, two different patterns of positioning the self in relation to others” (Mitchell & Black, 1995, p. 128). This transition is often a goal in therapy, to gain perspective and adjust one’s way of being to better themselves in relationships and

behavior patterns. However, specific to movement therapy Winnicott's use of the transitional object and the transitional experience" expanded into his vision of mental health and creativity" (Mitchell & Black, 1995, p. 128). As Winnicott saw it the therapeutic space became

the protected realm within which the creative self could operate and play; it was the area of experience from which art and culture were generated...it was precisely the ambiguity of the transitional realm that rooted experience in deep and spontaneous sources within the self and, at the same time, connected self-expression with a world of other subjectivities (Mitchell & Black, 1995, p. 128).

Spontaneity

Secondly, the use of spontaneity in movement therapy is also important, giving room for the creative inner self to speak without inhibition and limiting the use of ego defenses (Mills & Daniluk, 2002). Spontaneity and play from Winnicott's view allows for an exploration and regenerating of the client's subjective personal needs and wants.

According to Winnicott there is no perfect parent, rather the "good enough mother" is the term for the caregiver that tends to the child's needs effectively, understanding that no parent can provide everything a child needs at the exact instance he or she needs/wants, but a caregiver who offers a healthy sense of self for their child is good enough (Mitchell & Black, 1995).

The analyst, like the good-enough mother, tries to grasp the deeply personal dimensions of the patient's experience, the patient's spontaneously arising desires. The patient is offered refuge from the demands of the outside world; nothing is expected except to "be" in the analytic situation, to connect with and express what one is experiencing (Mitchell & Black, 1995, p. 133).

This idea of being in the experience is one very subjective to D/MT as the client is participating in an active movement, whether it's as subtle as breath or as large as full body dancing. The artistic component of D/MT, as an expressive/creative therapy also is

in line with this notion of play, as it does not require definitive structure and is open to possibilities that may arise during session.

True Self and False Self

Thirdly, Winnicott's false-self, also seems to be in line with a functionality of D/MT. That is, D/MT provides a modality through which a client is able to by-pass the ego defenses and avoid the cognitive component that is ever so present in talk therapy, "False self disorder was the term Winnicott began to use to characterize this form of psychopathology in which subjectivity itself, the quality of personhood, is somehow disordered" (Mitchell & Black, 1995, p.124). For a client who is offered, via D/MT, an environment that is "genuinely attuned" to the client's "uniqueness" the true-self will be able to emerge (Berzoff, Flanagan & Hertz, 2008, p. 133). The idea is that the false-self develops when a child is not given the proper space for his or her own personal way of being to be prominent. That is a client may learn to become more neurotic and compliant in order to maintain a learned posture within their family system, because their own wants are unsatisfactory to caregivers; thus giving life to the false-self (Berzoff, et al. 2008). Dance/Movement Therapy offers a clinical and safe medium through which a client can explore the true-self, bypass the defenses and experiencing what their inner-self/voice may desire without needing to go through intensive cognitive processing, all while making use of the safe holding environment as a transitional experience.

Training Programs for Movement Therapy

Currently there are two educational routes which lead to certification as a Dance/Movement Therapist. Graduates from a recognized D/MT program must meet established requirements in order to obtain a certificate as a Registered-Dance Movement Therapist (R-DMT).

R-DMT represents attainment of a basic level of competence, achieved through the completion of dance/movement therapy education and training. The R-DMT signifies both the first level of entry into the profession and the individual's preparedness for employment as a dance/movement therapist within a clinical and/or educational setting (ADTA Dance/Movement Therapy Certification Board, Inc. (DMTCB), 2009, para. 6).

Requirements of R-DMT are outlined in the ADTA Standards for Graduate Dance/Movement Therapy Programs (ADTA Education & Training, 2009). Included in these requirements is a supervised clinical internship of 700 hours (ADTA Dance/Movement Therapy Brief Fact Sheet, 2009). These requirements are set in place by the Standards and Ethics Committee of ADTA, organized to maintain compliancy with the ADTA Code of Ethics and Standards of Ethical Practice (ADTA Standards and Ethics, 2009).

One may also become a Dance/Movement Therapist via recognition from the Dance/Movement Therapy Certification Board (DMTCB), via the Alternate Route.

The Alternate Route requires a master's or doctoral degree in a *human services-related* field (i.e., counseling, psychology, social work, special education, dance education, a creative arts therapy, family therapy, occupational therapy, psychiatric nursing, or medicine) from an accredited school in combination with specific dance/movement therapy coursework, and extensive dance/movement background. Once Alternate Route education is completed, one can apply for the R-DMT (ADTA Education & Training, 2009, para. 2).

Additionally, there is an advanced level of dance/movement therapy practice known as Board Certified Dance/Movement Therapist (BC-DMT). This signifies the second

level of competence for the profession and an individual's preparedness to provide training and supervision in dance/movement therapy as well as engage in private practice (ADTA, Dance/Movement Therapy Certification Board, Inc. (DMTCB), 2009, para. 7). BC-DMT "indicates a clinician who has additionally completed 3,640 hours of supervised clinical work, and passed a rigorous examination" (ADTA Dance/Movement Therapy Brief Fact Sheet, 2009, para. 2). Both R-DMT and BC-DMT are awarded by the Dance/Movement Therapy Certification Board, within the United States (ADTA Dance/Movement Therapy Brief Fact Sheet, 2009).

There are set requirements for pursuing a career as a D/MT. Included in these requirements are prerequisites for educational and dance experience. It is recommended by the ADTA to contact each specific D/MT institution for their prerequisites, but generally "extensive dance experience and a liberal arts background with coursework in psychology are recommended" (ADTA Prerequisites for Graduate Training in Dance/Movement Therapy, 2009). Additionally "experience working with people in a variety of human service settings, and teaching dance and creative movement to children and adults, will also be helpful" (ADTA Prerequisites for Graduate Training in Dance/Movement Therapy, 2009).

Some examples of coursework required for R-DMT were taken from the D/MT curriculum at Lesley University located in Cambridge, Massachusetts.. Courses include: Movement Observation, Principles and Practices of Expressive Therapies, Psychopathology, Developmental Psychology, Theories of Counseling and Psychotherapy, Assessment and Power, Privilege and Oppression in Clinical Practice

(Lesley University, Master of Arts in Expressive Therapies: Dance Therapy with a Specialization in Mental Health Counseling (60 Credits), 2009).

The ADTA Board of Directors has specific requirements for therapists who will be working with children. These requirements are: 1) the therapist must hold a master's degree in D/MT or a related field, 2) have knowledge and understanding and demonstrated competencies acquired through education, supervised internship, or work experience in applications of D/MT with children, 3) understand and apply cognitive social and psychological development, movement behavior and nonverbal communication, family systems theory, development through the lifespan, and 4) have training in multiculturalism and diversity (ADTA Education & Training, 2009).

The ADTA has approved specific programs for their D/MT education. These programs qualify individuals to obtain R-DMT status. A program's approval is based on the standards and professional requirements outlined by ADTA. There are six national programs, at the following institutions: Antioch University New England, in New Hampshire, Columbia College Chicago, Drexel University in Pennsylvania, Lesley University in Massachusetts, Naropa University in Colorado and Pratt Institute in New York. In addition there are sixteen approved international programs (ADTA Approved Graduate Degree Programs in Dance/Movement Therapy, 2009).

Current Issues

In the 12th Century dance was highly influenced by the Catholic Church clergy who believed that dance was an inappropriate form of expression. Today, there continues to be a worldwide struggle for dance and where and when it is used. Certain cultures are

very movement oriented, while others do not incorporate dance into their traditions at all. This trend of cross cultural non-acceptance has also affected D/MT and in several countries.

For dance teachers who have strong movement and technique background, it is the psychotherapy theory and methodology that is missing. Conversely, the psychotherapists, counselors, and physical therapists need to learn dance and body movements along with dance therapy theory and practice (Capello, 2006, p. 32).

This divide contributes to the international dilemma in putting effort forth to promote D/MT as there is no universal standardized training or certification to practice D/MT worldwide. D/MT programs differ even within the United States. Another factor in the difficulty of promoting D/MT treatment is the “failure of government to recognize dance/movement therapy as a valid profession” (Capello, 2006, p. 32-33).

There have been accomplishments within the field apart from the current dilemmas. Accomplishments toward bringing professional recognition and inclusion of D/MT have occurred in countries from Taiwan to Egypt, to Spain, to Mexico and the USA. These efforts were recognized at the 11th International Panel, at the (ADTA) annual national conference (Capello, 2006).

Cross Cultural Considerations

Movement and dance are recognized as a universal language throughout the world (Hearn, Levy, & Ranjbar, 2006). “In virtually all known cultures, dance has existed as a form of communication, ritual, and celebration” and thus is an effective means by which to provide therapy, to diverse populations (Mills & Daniluk, 2002, p. 77). The required integration of body and mind in movement therapy can present challenges in engagement within particular Western cultures. As previously stated, in order for movement therapy

to become more widely used in Western culture the breakdown of a mind/body division must occur. Thus, gathering data from movement therapists may shed more light on how this separation continues to affect their practice.

Kalish-Weiss conducted a study in 1989 in which movement therapy was included as an intervention. In this study, treatment with inner-city children was provided by a team that consisted of a licensed clinical psychologist, a licensed social worker, two child psychiatrists, an art therapist and a dance/movement therapist. The school's population was diverse – including ethnic demographics of, in order of largest population to smallest, Hispanic, Asian, Black and Caucasian. For bilingual children and their parents in the sample, it was suspected that pressure was lessened because they were not required to speak English. This study supported previous research that a strong therapeutic alliance was critical (Kalish-Weiss, 1989).

A questionable component of credentialing was raised at the 11th International Panel of D/MT as the practice differs between cultures. Although dance is universal, the concept of “standardized training” (Capello, 2006, p. 38) is complicated. Even among the panel members the “variety of learning styles and cultural differences” raised questions about “how a systemized training experience may *not* be a valid goal. The idea of respect for each countries cultural identity and customs as it relates to dance, body movement, use of space and touch, and eye contact” was scrutinized (Capello, 2006, p. 38-39). The end result from this panel was the notion that comprehensive standard education needed to be built on the “core elements essential to good practice” while also honoring individual cultural identities (Capello, 2006, p. 39). The proposed study is influenced by this balance of standardized training in the context of various cultures;

some questions will be devoted to exploring participants' training and their experience with credentialing as they practice.

Summary

In this literature review, expressive therapy as a whole was introduced and, the different modalities were described, specifically visual art, music, and dance/movement. Previous studies on music therapy were more easily found and very few studies were found that focused on D/MT. These studies illustrated the effectiveness of D/MT as a viable practice. Then information regarding the education of such therapists and their credentials was presented..

D/MT is a way of healing and engaging with the emotional self that has historical and cultural roots, worldwide. As noted by the neuroscience of mirror neurons D/MT is effective in exercising and expressing empathy and emotional states of being via transference and countertransference.

Jane Wilson Cathcart's movement therapy "treatment helps the young become aware of their resources for building self-esteem" (Hearn, Levy, & Ranjbar, 2006, p. 6). In addition to Cathcart, creative therapists are serving clients in a variety of settings that truly promote their healing and growth processes. Research has shown that music, art and movement therapy are all effective modes of expressive techniques. However, movement therapy emphasizes a direct relationship between the body and mind, and is less culture bound (Levy et al. 2006).

D/MT supports social work values and ethics as it is part of a broader repertoire of resources that provide clients more options to experience a greater sense of living. This

provision is not limited to talk therapy, but must cater to the individual and the means and modalities through which each person's growth is best facilitated. Providing knowledge to clinical social workers on alternative evidenced based practice inherently involves offering information on D/MT.

As mentioned in at least one study and in early practice of D/MT as with Marian Chace and Trudi Schoop (Dance to Health, n.d.), a multidisciplinary approach was key in their success. I hope to further provide evidence of the necessity of this versus independent function for D/MT in my proposed research.

There is evidence presented in this literature review which provides some initial support that D/MT is effective in psychotherapeutic treatment and thus, the research questions for the current study is warranted for investigation. The purpose of the current study is to further explore the struggle for D/MT to gain recognition within the clinical field of social workers and psychologists, as it is a unique technique with such specific credentialing and training. There is obvious evidence supporting the effectiveness of movement therapy, however, there is little I have come across examining the relationship R-DMT's and BC-DMT's have had in establishing themselves and providing therapeutic treatment to clients.

CHAPTER III

METHODOLOGY

An exploratory, descriptive qualitative study was conducted in order to answer the following research question: What do movement therapists do and how can their service interact with traditional psychotherapy? Based on the reviewed literature, the sample for this study targeted movement therapists in order to examine the extent of their practice within the field of mental health. One purpose of this study was to explore the difficulties certified movement therapists may have encountered in becoming a part the clinical community. The findings of this study may provide accessible information to traditional psychotherapists about D/MT.

The research design for this study was exploratory and descriptive. Exploration can “provide a beginning familiarity” of the topic to the social work field (Rubin & Babbie, 2007, p. 29). There is little, if any, information available on movement therapy within the field of social work; thus, using an exploratory method has provided more information and a greater understanding. As a descriptive study, information has emerged that might be useful in understanding how movement therapy could be useful as an adjunct to psychotherapy and the field of social work.

Qualitative research methods in the form of an interview guide with semi-structured, open-ended questions were used to gather narrative responses from clinicians who are certified as movement therapists. A qualitative method allowed participants to

speaking candidly about their personal experience that may have contained emotion and thought processes involved with the research question (Rubin & Babbie, 2007). Prior to meeting for the scheduled interview I emailed the informed consent letter, recruitment flyer and a copy of the interview questions to participants for their review and to help in preparation for the interview.

Sample

Participants were recruited based on their practice as certified movement therapists. In order to participate in this study, individuals must have been practicing for at least four years and hold either an R-DMT or BC-DMT certification. Retired certified movement therapists that fit the criteria were included in the sample. The desired sample was twelve participants; however, despite several recruitment efforts only nine were gathered (N=9). Recruitment efforts began by retrieving names and email addresses from the ADTA website. Emails were sent to thirty-eight movement therapists within Massachusetts with the Informed Consent (Appendix A) and recruitment flyer (Appendix B). Out of this thirty-eight four responded and were interviewed (n=4). A fifth participant (n=1) was recruited via email, her contact information obtained from reviewed literature. From this fifth participant a snowball sample of ten was gathered, out of which two responded and were interviewed (n=2). A second round of emails was sent to potential participants within New Hampshire, Rhode Island, and Maine, again using the ADTA's movement therapist listserve. This provided the final two movement therapists (n=2). Had more time been allotted for this study a full sample of twelve would most likely have been obtained.

It was intended that the demographic characteristics of the sample include a variety of racial and ethnic backgrounds in addition to ages, religious preference, and state of health. Recruitment was conducted in a way that allowed for no indication of demographic characteristics of participants until the interview actually began. Exclusion criteria for this sample were the following: 1) if an individual had been practicing for less than four years in a movement therapist capacity and 2) were not certified as a movement therapist, practicing with at least an R-DMT. This was a non-probability sample as participants were not chosen at random. Participants were recruited using listed movement therapists on the ADTA website in addition to snowball sampling and outreach with movement therapists found via reviewed literature. Sample recruitment began by contacting registered dance movement therapists listed on the ADTA database of certified movement therapists. The recruitment and informed consent letter were emailed to 55 movement therapists, between Maine, Massachusetts, New Hampshire, and Rhode Island listed on the ADTA website. These states were chosen in the hope that the majority of interviews could be conducted in-person.

After receipt of approval from the Smith College School for Social Work Human Subjects Review Committee, I contacted those movement therapists who had responded to my initial outreach. Individuals were contacted via telephone or email. When it was confirmed the movement therapist qualified for the study, a time and day to conduct the interview was scheduled. Interviews took place at a convenient and confidential location chosen by the participant, usually their office. For those participants who were not close enough to travel, interviews were conducted via speakerphone. Participants were asked if he/she had colleagues that might have been interested in the study. It was anticipated

that the sample may not have been representative of all movement therapists, as participants were expected to be localized to the Boston area; however, participants ended up representing a wider geographical area.

Data Collection

Interview Guide

In order to increase the validity of the interview guide and questions, I pilot tested the interview guide with two individuals who were not part of the sample in order to gain feedback on the logical flow, clarity and consistency as related to my research question.

Additionally feedback was given within the first few interviews by participants on questions on ways to make questions clearer and also to insert more appropriate language familiar to movement therapy population. Participants were informed that if they not wish to answer a question for any reason, they were at liberty to pass.

Information on the demographics of participants was gathered as this may have influenced experiences reflected in his/her personal accounts offered during the interview. Demographic information included race, ethnicity, name of D/MT training program attended, states in which participant holds certification, type of setting participant currently practices in, and how long participant has been in practice.

Qualitative data was gathered through semi-structured, open-ended interviews with movement therapists. Questions included: What is your racial and/or ethnic background? What was the name of your R-DMT/BC-DMT training program? In what states do you hold certification? What type of setting do you currently practice in? How long have you been in practice? Is there any additional demographic information you'd

like to provide? What led to your decision to become a movement therapist? Would you please describe the training and certification process you went through to become a R-DMT/BC-DMT? Why do you feel the D/MT modality is significant? How does D/MT differ from other therapeutic modalities? Studies mention the absence of body-mind therapeutic approaches in most clinical theories, how has this impacted your practice? Have you had difficulty building clientele as a movement therapist? If so, how have you dealt with these challenges? As a supporter of movement therapy, if applicable, how have you educated others about it? If you are aware of any, what ideas to people outside of the movement therapy community have about this particular form of clinical work? Do you have experience working on a multidisciplinary team as a R-DMT/BC-DMT? How would you say being on a multidisciplinary team compliments a movement therapist? How has client's insurance affected your practice as a movement therapist? Have you had problems with the mental health community and/or colleagues, that have been an issue because of your practice and theoretical orientation as a R-DMT/BC-DMT? What are, if any, the similar traits you might recognize in clients who seek out movement therapy? What are, if any, the stereotypical traits of movement therapy clients, in terms of symptomology and/or personal characteristics? How do you think culture, race, and ethnicity pertain to movement therapy?

There were some unplanned questions, probes, were added based on information offered during the interview as they elicited more detailed narrative responses. These unplanned questions did shape future interviews, as language and understanding of the interviewer became more specific to the movement therapy population. Clarifying

questions were asked during interviews to ensure accurate understanding and interpretation of information.

Interviews took place in a setting chosen by the participant, however for in-person interviews it was often suggested to meet at the participant's place of work. On average interviews lasted 45 minutes and were conducted at a time convenient for the participant. During the interview participants answered questions regarding their practice as either a R-DMT or BC-DMT. Questions asked were open ended allowing participants to share personal experience. Interviews were recorded using a digital audio recording device. This researcher completed transcription of the data.

Ethics and Safeguards

In order to ensure confidentiality and safeguard identifying information, participants' name, age, and demographic information were not reported in the findings. All identifying information was kept separate from the audio recordings and transcriptions. Numerical codes were assigned to each transcript. Demographic characteristics are reported in the aggregate and identifying information has been removed from descriptions and quotes. Participants were given the option to pass on any question should they not want to answer it, however, none did so.

All study materials have been stored in a safe, locked location and remain within such restraints for three years, as required by Federal regulations, after this time materials will then be destroyed. The research advisor assigned to this study will have access to the transcribed data after the removal of identifying information.

Data Analysis

A portable digital audio recorder was used to record interviews after receiving consent from the participant. Interview questions are structured in a way to obtain specific information, in anticipation of maintaining clarity.

Demographic Characteristics

A breakdown of demographic characteristics is presented in the form of descriptive frequencies. Qualitative data on movement therapist's clientele was gathered allowing for conclusions to be drawn regarding correlating or differing characteristics of each, movement therapist's practice.

Narrative Responses

The primary method for analyzing the narrative data was done according to the content/themes that emerged. The transcribed data was reviewed and organized in order to identify themes. By identifying patterns within the qualitative data meaning was given to the information, allowing for conclusions to be drawn about movement therapy. Patterns were identified by counting how many times a certain characteristic – such as a feeling or type of thought – or word was used or came up within all interviews. By picking out these patterns connections between interviews allowed for meaning to be made from the information gathered. For example, an examination might have begun by looking within the collected data, for the way in which movement therapists expect to be regarded by other mental health professionals, by types of words they used to describe

their experience. Looking for commonalities between these responses, or lack thereof provided meaning, leading to the following conclusion (Rubin & Babbie, 2007).

Discussion

Limitations and Bias

One limitation of this research was my bias on the topic. My support of movement therapy and belief in the potential and power of such treatment – as a useful and important tool and clinical method – needed to be taken into account. I developed and practiced an awareness of the way in which I asked questions and how and when I asked follow-up questions. It was anticipated that a second limitation would be the lack of generalizability, given that the movement therapists in the sample were expected to be solely from the Boston area, however, this did not prove to be so as several participants were not from the Boston area. Considering the fact that some participants were recruited via snowball sample safeguards had to be put in place to ensure each participant would not be able to recognize another's comments. However, as this issue was communicated to participants for the sake of transparency, the response was positive that others were also participating in the study.

Findings might have shed some light on which clients/subjects benefit from expressive therapy interventions. Variables such as depression, relationships and anxiety (Choi, Lee & Lim, 2008), “greater sense of self,” “becoming more physically conscious,” exploration of “ways of expressing thoughts, feelings and emotions,” and exploration of “how the mind and body relate,” (Christie, Hood, & Griffin, 2006, p. 573) are areas in which positive results have been found when creative therapy is the form of treatment.

Participants did believe that movement therapy should be promoted as a readily recognized therapeutic profession as it is grounded in theory and supports positive self esteem, constructive social interaction, and family involvement. “Dance is an excellent way for children to build self-esteem and to develop socialization skills” (Hearn, Levy & Ranjbar, 2006, p. 6). Additionally, movement therapy provides avenues for individuals managing trauma (Daniluk & Mills, 2002) and creative interventions can be symbolic and explorative, offering alternatives to narrative therapy for all ages (Kaufman, 1996).

The results of this study may offer some generalizability within the state of Massachusetts, the majority of which participants were representing. However, movement therapists worldwide may not be represented within the sample discussed here. Limitations were experienced due to my bias and support of movement therapy. However, these limitations did not inhibit the feasibility of the study. The study was feasible as this researcher had transportation means by which to travel to interviews with participants as well as a digital audio recorder to record interviews. Identifying certified movement therapists was not difficult, contributing to the feasibility of the study, however, scheduling interviews and gaining response from potential participants did present difficulties.

CHAPTER IV

FINDINGS

Introduction

This chapter contains findings gathered from semi-structured interviews. Movement therapists holding national certification of either R-DMT (Registered Dance Movement Therapist) or BC-DMT (Board Certified Dance Movement Therapist) from the American Dance Therapy Association (ADTA) were interviewed. Interviews satisfied curiosities of what movement therapists do and how their practice and theoretical orientation compares to traditional psychotherapies. Interviews were conducted with movement therapists either in-person or via phone.

Questions asked during interviews were designed to foster open-ended and candid responses. Two mock-interviews with professionals, not part of the sample, were conducted to ensure clarity of interview questions. Questions were altered in terms of language after the first interviews, as the Dance Movement Therapy (D/MT) verbiage became more familiar. Three interviews were conducted in-person while the remaining six were via phone. Years of practice as a movement therapist within the sample ranged from four years to forty years. Movement therapists who had been practicing the longest could speak to the transition of D/MT moving from a young profession into an evidence-based, informed clinical practice based on neuroscience. Seven of the interviewees either

reported having difficulty building clientele or would have anticipated challenges had they not possessed additional credentialing – such as a license in marriage and family therapy or psychodrama therapy (n=7). One individual reported for several years she did not even market herself as a BC-DMT because of fear of rejection, from the client.

Contrasting challenges faced all participants were eager to share their thoughts and knowledge of D/MT. Several stated that being involved in this study reminded them of their pride, love and passion for D/MT. One participant shared “I’m so lucky that I found a field that I always enjoy. In fact I’ve had so much fun working with people and they’ll say ‘it’s so nice of you to volunteer’ and [I say] I’m not a volunteer!”

Data will be reported in the same order as it was gathered from participants. Beginning with Demographic Characteristics, following with Training and Certification Processes, Methods and Significance, Client Characteristics and Building Clientele and Report as an R-DMT or BC-DMT.

Demographic Characteristics

Demographic information of *N* is reported below in the *Table 1*. Acronyms representing data within *Figure 1* are: R-DMT = Registered Dance Movement Therapist, BC-DMT = Board Certified Dance Movement Therapist, LMHC = License Mental Health Counselor, LMFT = Licensed Marriage and Family Therapist, SLP = Speech Language Pathologist and *NP* = *Not Provided*. All participants (n=9) identified as Caucasian and five (n=5) stated they were Jewish. The remaining four (n=4) did not share their religious preference or background. Six individuals previously or currently practice privately and are licensed as an LMHC (n=5) or an LMFT (n=1). Of the

remaining three (n=3) their setting of practice is either educational or outpatient, and two of these three (n=2) do not hold a state license. Eight interviewees were from the Northeast – Massachusetts and New Hampshire (n=8), and one person was from Louisiana (n=1).

Table 1 Demographic Characteristics

Participant	Race and Ethnicity	Origin of Graduate Matriculation for D/MT	Certification	State Licensure	Setting of Practice	# of years in Practice	Additional Demographic Information
1	Caucasian of Irish and German descent	Hahnemann University (now Drexel University)	BC-DMT	LMHC	Private	10	Age: 35 Geographic location: MA, USA
2	Caucasian of Irish, Swedish and Canadian descent	Antioch University New England	R-DMT	LMHC	Outpatient Mental Health	4	Age: <i>NP</i> Geographic location: MA, USA
3	Caucasian	Lesley University	BC-DMT	<i>None</i>	HIV Residential Facility	40	Age: 68 Geographic location: LA, USA
4	Caucasian of Jewish descent	Antioch University New England	BC-DMT	LMHC	Private	18	Age: <i>NP</i> Geographic location: MA, USA
5	Caucasian of Jewish descent	<i>Alternate route</i>	BC-DMT	LMHC	<i>Currently not in practice</i>	30	Age: 63 Geographic location: MA, USA
6	Caucasian of Eastern European Jewish descent	<i>Alternate route</i>	BC-DMT	LMHC SLP	Private	39	Age: 62 Geographic location: MA, USA
7	Caucasian of Jewish Descent	New York University	BC-DMT	LMFT	Private	23	Age: <i>NP</i> Geographic location: MA, USA
8	Caucasian	Antioch University New England	BC-DMT	LMHC	Private	14	Age: <i>NP</i> Geographic location: NH, USA
9	Caucasian of European Jewish Descent	Antioch University New England	R-DMT	<i>None</i>	Educational	13	Age: <i>NP</i> Geographic location: NH, USA

Training and Certification Process

The Decision to Become a Movement Therapist

All participants went through a certification process (n=9). Two of them (n=2) obtained their dance registry from the ADTA via the alternate route, which required an application process, illustrating their clinical experience. Occasionally some additional D/MT course work, was required for completing the alternate route. Most individuals had a formal dance background, prior to obtaining R-DMT status (n=6). All, however, spoke of having a passion for dance, or being naturally inclined as movers and having a body awareness that was prominent in their lives, prior to their D/MT training (n=9). For some people discovering D/MT was a natural progression as they sought a field incorporating dance and psychology. Each participant's process of going through D/MT training was based on an intuition and personal need to have the body and "inner-self" incorporated in their career.

As interviewees reflected on why they chose to pursue D/MT as a career, different forms and analysis of movement were talked about, such as Laban – a tool used by dancers and therapists alike, for analyzing and addressing movement. Additionally the work of Janet Adler, particularly her video *Looking for me*, and the works of Marian Chace and Mary Whitehouse were inspirational sources, leading to the pursuit of a degree in D/MT.

Training and Certification Processes to become R-DMT or BC-DMT

Two people (n=2) studied with individuals such as Janet Adler and Mary Whitehouse, two of the original proprietors in the professional development of D/MT. The development of the ADTA, was referenced as one participant (n=1) reflected on the alternate route requirements. Particularly, she spoke of and how she had to work harder to get approval for her accumulated hours of supervision from people like Janet Adler, to count toward her R-DMT, because Adler was practicing before ADTA was formed and didn't have her R-DMT.

I had to write an opera case study. I had verified my training in different areas... You couldn't just come in having any experience, but your own process, your own creative process and your own somatic process. And then they reviewed it. And what was really weird was, oh you had to be supervised, there are clinical supervision hours, and at the time people like Janet and all those people weren't certified because they were the beginning people, it was very strange. So I had to go through a little reframe of that. To say these are the women that started the profession before there was anything about supervision, I mean we're talking the very beginning, so how could they not count.

Participants described training experiences as “serious”, “strenuous” and “rigorous”. Most programs participants went through were 2 to 3 years long, some required a thesis, and all demanded two internships in a clinical setting, such as psychiatric hospitals like the Brattleboro Retreat in Vermont.

There are different philosophies and approaches for providing D/MT. One style is Chacian, which involves music and props; this was the training framework for some participants. A participant trained in the Chacian framework talked of how she comes “in with these props.” She also shared, “boxes are usually around my desk and my art supplies are underneath. My stretch band's usually sitting on my chair. I've got balls and my canopy and a bunch of other things.”

Other interviewees were trained from a Jungian perspective. It was stated that “Authentic Movement or Jungian dance therapy is primarily used with healthier clients, people who have an ego so they can sort of let it go and some people call it regressive. It’s like active imagination, but through movement.” Other frameworks mentioned were the Kestenberg Movement Profile – an assessment instrument for working nonverbally.

Several interviewees spoke of their supervisory experience for students going through D/MT training programs. It was stated that in order to be accepted into a program “you had to have a background in dance; you couldn’t just come in having any experience but your own process, your own creative process and your own somatic process.”

A few participants teach at the college level and described programs have become more clinical in recent years. “Lesley is more clinically based than it used to be. It used to be more of a personal process kind of thing. But over the past five, ten years it’s really changed. It’s gotten its ADTA accreditation over the past several years.” In the past, New York University and Hahnemann were the most clinical and research oriented, while others such as Lesley and Antioch were based more on a personal process experience. Whether an interviewee had more dance experience or more psychology experience the alternate component was harder to master, during their graduate career.

Most participants confirmed that having a state license made it possible to bill insurance companies. Many people often market themselves under this license, which increases career opportunity and clientele. To clarify, six out of the nine were licensed as Licensed Mental Health Counselors (n=6). Others were either not licensed – as it wasn’t required by their position of employment as remedial or special education teacher – or

were practicing under other licensure such as Licensed Marriage and Family Therapist or Speech Language Pathologist.

Most therapists interviewed had their BC-DMT (n=7). Only two (n=2) had an R-DM, because of years in practice or satisfaction with their employment and no requirement to obtain a BC-DMT. All participants had some dance experience – whether it was professional leisure or an appreciation for body movement. Additionally participants spoke of their interest in helping people identify the movement of within the inner-self.

D/MT: A Significant Modality

Participants offered evidence-based information along with personal opinions as to why D/MT is a significant modality. D/MT treatment combines expressive and cognitive qualities. “Dance therapy is very good for people who are very verbally acute because of the stories we create in our mind,” stated one interviewee. Also “dance therapy is good for the less verbal client who might have difficulty speaking.” An important point made by almost all participants was that trauma is stored in the body. The more that is learned about memory and traumatic experiences both preverbal and in utero, the more D/MT becomes an essential and effective treatment strategy. D/MT allows both the therapist and client to bypass the ego defenses, as the therapy becomes the experience, differing from verbal therapy in which the client talks about an experience.

Two main themes emerged. The first was that D/MT offers a medium for clients to connect with their true thoughts and desires and experience change within the

therapeutic moment. Secondly, D/MT provides a clinical, theoretically based palette for all nonverbal experiences and expressions, considering that our bodies hold a tremendous amount of unconscious information. The body provides information about what the client is dealing with in that moment.

Working with the body cuts through a lot of layers. There's an immediacy to it, which is very usable. I also obviously use words, but then, exactly that, you're in the experience and instead of talking about something that happened in the past, you can already be in that experience. And it's not so dependent on the client actually explaining anything, because it's already right there.

The following statements also support the significance of D/MT. "Ninety-eight percent of all communication for everyone is not verbal," "The head is a body part, the body is not part of the head," "Exercise elevates serotonin and changes the neurotransmitters...in order to feel better you have to move more," and "Our bodies don't lie." Additionally, points were made about how our culture within the USA is too "head oriented," meaning that we often think and rely on cognition and dismiss components that are not of the practical mind. Approaching treatment from a movement perspective can look like talking and/or moving, but there is a body sensation element, also known as transference and countertransference that becomes a critical component in D/MT.

The role of neurobiology was referenced frequently and with some excitement, because it provides scientific reasoning as to why D/MT is effective. As explained in the literature review mirror neurons create new pathways in the brain and scientific evidence that through empathic exchanges treatment can occur.

D/MT is effective across the developmental lifespan, as participants spoke of their treatment with infants to elders. D/MT is "about helping a person hold both – in their

own time – form a respectful relationship between what is known and what isn't known. What the body is bringing and how your cognitive mind relates to it.”

How D/MT Differs from Other Therapeutic Modalities

One movement therapist shared the way in which she explains D/MT to clients.

The way I describe it to clients is that it allows a person to discover new patterns and try them out in a safe environment; you've already sort of practiced the pattern and movement. Whereas in verbal therapy you might talk about a way you want to change, but you haven't tried it yet. The movement therapeutic environment is a very safe environment. It's already creating the neurological pathways in the mind, already established so it's easier to implement it when they're out in the world.

D/MT differs from other therapeutic modalities because of its artistic expression and experiential makeup. It offers a concrete medium for “people to understand what it means to listen to themselves in a different way and also experience an experience instead of think they're experiencing an experience with their therapist.” The idea of being in the experience was raised by several different participants as a process the client is involved in, rather than the client receiving something from the therapist. Also, because dance movement therapists are working with the body they have the client's whole history because clients cannot sensor as much as they can when just talking.

Our bodies hold a lot of our past, a lot of feelings that we've stored. So moving bodies and releasing those feelings, or even expressing the conflicts that a person has, it can't fake it. Verbally you could lie. They say dance therapy is very good for people who are very verbally acute and can, it's not like purposeful lying, but lying to themselves, like the stories we create in our minds.

Perhaps the way in which participants talked of therapy in general speaks to how D/MT differs from other therapeutic modalities. Most of the movement therapists differentiated D/MT from verbal therapy or art therapy, or hypnotherapy. Within

traditional psychotherapy seldom is there differentiation between the different types of therapeutic modality. Rather, among this community it is assumed that therapy *is* verbal therapy. Verbal therapy is a component in D/MT, but not necessary for treatment. Participants shared that some sessions are conducted entirely through verbal interaction – especially in the beginning of a new client therapist relationship. For most cases movement becomes integrated into the therapy. In a sense the movement piece is unavoidable as it is how dance movement therapists are trained to assess.

D/MT merges the polarity within individual's lives; allowing people to become whole. The true essence of the person and the Self – as the inner self is addressed in Jungian therapy – wants to be whole, moving toward an integration of the different aspects of a person's personality. This integration is accomplished through D/MT as it is experiential and an in-the-moment practice in which the client creates the therapy. Differing from verbal therapy, clients do not have to find words to talk about their feelings, but use this body-based approach to express what is bothering them. “You have the whole range of verbal/non-verbal and a whole lot of ways of working.” Also D/MT “is creative, so it focuses on and encourages the healthy creative side of the person.” Patients are given an opportunity to not just talk about their problems, but actually try out solutions right there in the safe space of their therapy session; the client creates the therapy and the therapist is just “the vessel.”

Although not talked about by all participants (n=6), the spiritual aspect of D/MT causes it to be actively different. Addressing the body, mind and spirit in the practice of D/MT was believed to be an important factor in promoting a client's happiness and overall well-being. A participant described D/MT stating, “I would say artistic and

spiritual in ways that standard therapies are not. And because of its artistic and spiritual, well artistic component that it touches, I think it touches clients at a spiritual and soulful level, which is frankly, I think where a lot of the pain is.”

One participant thought it necessary for information to be provided on how D/MT differs from other body psychotherapies. Specifically, how D/MT is based in clinical theory and frameworks of practical application, and also how it is founded in elements of dance. D/MT may be considered a body psychotherapy, but not all body psychotherapies use the language of a dance.

There’s body psychotherapy, but dance movement therapy has its roots in the expressive elements of dance and integrates movement, so that’s also one of the ways that it specifically differs from other forms of counseling, even body based psychotherapy; because it draws on the creative and expressive roots of dance, even though we might not be literally dancing with clients.

The Absence of Body-mind Duality in Therapeutic Approaches

One interview question: *Studies mention the absence of body-mind therapeutic approaches in most clinical theories, how has this impacted your practice*, frequently needed clarification as some participants were unaware of theories that did not include the body. Clarifying information was provided to explain the apparent divide between the body and the mind. Participants were told that minimal attention is paid to the body’s information in our Western culture which is so cognitively based. Thus, the impact of the body-mind divide on movement therapists’ practice could not be fully explored, leaving most of these conversations focused on theory instead of impact. Some therapists mentioned how the body-mind separation influenced them to spend decades educating those people who do not use movement in treatment.

The ensuing discussion provoked by the above interview question brought to light the fact that little attention is paid to the wealth of information provided through the body. However, it became apparent that the body was not necessarily left out of traditional psychodynamic theories. Freud and Jung both referenced the body. One participant noted that Jung and Wilhelm Reich studied under Freud.

Jung was a student of Freud and actually he took over the Freudian Institute during World War II, Freud had to flee. He used art therapy with some of his patients. And I think at least one client did movement with Carl Jung. Another student of Freud's was Wilhelm Reich and he did a lot of studies and writing and work on connecting the body and mind. Historically, he was a Freudian student, who broke away from the school and created his own, Reichian. ,

Another participant referred to Judith Kestenberg, also a Freudian, who developed the Kestenberg Movement Profile. Speaking of her dance experience this therapist stated "I knew a lot about the movement portion, I knew a lot about the Laban portion and the Kestenberg Movement Profile that they do at Antioch, or that Antioch focuses on I guess you should say."

The point is that many traditional, verbal psychotherapeutic schools of thought are based on Freudian theory. This beginning differs from the framework for D/MT which comes from theorists who broke away from Freud because of their use of the body in psychoanalysis. Another therapist noted that "the developer of Authentic Movement, Mary Whitehouse, studied Jungian psychology, so she brought in the Jungian aspect. People always talk about being in the box, and it helps people kind of be out of the box and come up with new solutions."

The importance of incorporating the body in treatment is even more supported by emerging neurobiological evidence. D/MT treatment allows the client to practice new thought patterns; "developing the new pathways right there in the session. As opposed to

just the expression of talking about all the things that are related to all the things the person is experiencing.” The way in which mirror neurons interpret information from the therapist’s and the client’s movements to one another become new avenues for implementing further treatment.

The elements missing or different from traditional clinical theories are dance and spirituality. Several dance movement therapists referred to spirituality as a recognition of the inner-self; as a story and/or wealth of information residing within the body. One participant stated that “my practice was called Moving Stories.” She said that, in session, she might ask the client “to stop talking for a minute and let that gesture grow and, boom, there’s a story. That’s what held the authenticity at the time.” Another therapist noted that the ADTA’s philosophy has “more of the medical model influence, that they don’t include the spirit in it;” “it straddles the medical world and the dance world.” Yet almost all interviewees mentioned the spirit in conjunction with the body and mind. The artistic and spiritual components of D/MT seem to be directly related to the body-mind partnership, often mentioned by participants.

The bridge between the body and mind become more strongly connected as further research is completed. Despite challenges faced by movement therapists, the professional development has an air of excitement as one participant noted, “because it’s like pulling out a little seed and bringing it to someone’s attention.”

Client Characteristics

The following section includes aspects of D/MT clients, identified by participants. Similar traits in people who seek out D/MT will be explored, followed by symptomology and personal characteristics of D/MT clients. Lastly the pertinence of culture, race and ethnicity to D/MT will be explained.

Similar Traits in Clients Who Seek out D/MT

There are three types of people who receive D/MT treatment. First there are those clients who *seek* out D/MT. Then there are clients receive D/MT because of where they reside. For example, clients who are on inpatient units in a hospital or some clients in prison. Thirdly, there are those clients who seek treatment and by chance happen upon a therapist who is certified as a dance movement therapist. Clients who purposefully seek out D/MT are described as having a heightened awareness of their body. Some have physical issues, *such as* somatic complaints. These clients often tend to be self expressive. They are “people who like to move, like to dance, like to draw, are artists” and are inherently creative and artistic. One participant stated “they’re motivated people who actively seek out D/MT and want to move out of the ways in which they are stuck.” Another interviewee said that “they have an interest in self expression. They might likely describe themselves as seekers in some way. They’re looking for a deeper understanding of the self.” These individuals who *seek* out D/MT were described as being “interested in bettering the world around them” and have “an awareness of how the personal and global are somehow connected.”

Many traditional psychotherapists may not be aware that dance movement therapists do talk therapy as well. Many interviewees mentioned that clients who come to them for therapy are frequently unaware of their credentials as a dance movement therapist. In these situations, the beginning work is verbal and D/MT is later incorporated. Most clients do end up moving in some way over time even if it is just recognizing one's use of breath. Many stressed that movement therapists need to be aware of which techniques to use with each client. For example, a free flowing approach may be "very ungrounding, because you're using imagery and maybe music that's not grounding at all. If a psychotic client comes into a group you make sure you have drumming on and your feet are stomping and it's much more concrete." One participant reported that at times "there's a profound appreciation for the power of movement therapy" but for all "people who participate in it, it's quite powerful. It's liberating, it's like medicine."

Symptomology and/or Personal Characteristics of Movement Therapy Clients

All participants (N=9) stated that there was no specific symptomology or personal characteristics pertaining to typical D/MT clients. Two movement therapists (n=2) noted that their clientele was mostly female. She added that the field of "dance as a profession is also heavily female" Thus, the gender of these participants' clients is a reflection of dance in general. The demographic characteristics and personality traits within D/MT client population was quite varied. Clients' presenting issues were usually "self harm", "self-esteem", "anxiety", "abuse history", "depression", "bipolar disorder" and "borderline personality disorder".

Clients with a trauma history – considering that traumatic memories are stored in the body – benefit from D/MT as do clients with eating disorders and body image issues. The following quote supports this fact., “Lots of trauma, I’d say 95% of my clients have a trauma history. From domestic violence to sexual abuse, physical abuse, in utero trauma, preverbal trauma, a lot of preverbal trauma gets sent to me.” The span of who makes up D/MT clientele is quite wide, including children having difficulty in school and non-verbal elderly.

Although no profile of personality traits was identified, participants note the following clientele descriptors: “artistic”, “kinesthetic learners” and “deep diggers,” and a “sense of success” in regards to their creative therapy treatment.

The setting where interviewees practiced influenced what was said about their clients. For instance, therapists who worked in a mental health clinic or school spoke about specific symptomology. “A lot of people have self harm and substance abuse” or “what’s common with all those children, is generally a lack of success in school, academic success or social success.” Practitioners in private practice offered a generalized description about their clients; “I have seen such a variety of people, I don’t see any” stereotypical traits; “dance movement therapists work with everyone from infants to substance abuse, eating disorder, every range of client you get within psychotherapy.” Private practice therapists also believed that their clients were higher functioning and had an artistic way of problem solving.

There was ultimately no similar set of characteristics noted by movement therapists’ clientele that differs from those seeking treatment over the broader spectrum of therapeutic intervention. One participant who had facilitated movement therapy

groups in a school setting stated she “would take the kids that were in wheelchairs or the kids that were blind or deaf.” Clients were male and female; verbally articulate and non-verbal; anxious, depressed and personality disordered. The spectrum of symptoms and personality characteristics can be summed up in the following statements, “I’m not sure that it differs at all from a therapist in town who’s doing verbal therapy, social work;” dance movement treats everyone “from people who have trouble expressing themselves to people who are very able to express themselves, so it’s a very big range.”

Pertinence of Culture, Race and Ethnicity to D/MT

Two themes surfaced when gathering data of culture, race and ethnicity in regards to D/MT. The theme was that historically “dance therapy is very white.” Many individuals remarked how the “field has been dominated by sort of middle class white females.” One individual talked about problems in her training program. The majority of the class was made up of White students and the students of Color faced challenges because of racial and cultural differences. Several therapists did note that change was slowly occurring as far as D/MT becoming less White, but Caucasian females still seem to make up the general population. One participant noted that because D/MT came out of the modern dance movement, D/MT, “was pretty insular and not very diversified and now I think that definitely is just different, because there’s more training programs there’s more of different ethnicities in the training programs. There are conferences that are internationally connected.”

Secondly, D/MT is a therapeutic avenue that can reach many cultures because of its non-verbal quality and its innate ability to breakdown cultural boundaries. For

example, a participant ran two groups in long-term care facilities that were separated by a parking lot. One group spoke Spanish and the other English. This therapist described how D/MT brought them together.

I mean I thought it was ridiculous to begin with, but the fact that there were two different separate programs. So I brought the two groups together and I led a group with groups from both senior centers together. And it brought them together. The highlight of that group was when I played a song that both people, who spoke Spanish and didn't could relate to and dance to when they were turning sixteen and everybody lit up and they were all dancing together and it was wonderful.

A second example of how dance and movement are universal had to do with one woman's experience in Johannesburg. She stated, "I went to one of their clinics and said I was going to introduce them to dance therapy. And I started to describe it and they said that's what we do, they said if anybody in our community has a problem, we dance with them." When someone had schizophrenia or was developmentally delayed, they were taught the tribal dances and they were able to be a part of the community.

A final point regarding the cultural exchange of dance and movement is the need to be aware that what is done in one culture may not be acceptable in another. Thus it is very important to educate oneself about that culture prior to introducing D/MT. "I don't think just because dance is universal and present in many cultures, I don't think that's the same as just taking what we do in one culture and applying it to another. A lot of differences that you have to educate yourself with first," stated an interviewee.

Clients from cultures differing from Western hemisphere, may feel a sense of control and validation when their ways of dancing and moving are incorporated into treatment. One participant mentioned that "if you go to indigenous cultures or you go to non Caucasian, non western cultures, especially African American, Latino, and some of

like aboriginal type indigenous cultures, there is a movement component, naturally in the culture that's more known than it is for White culture."

Work that is being done with so many different cultures and people was described. "The work that's being done around the world is just amazing, with torture survivors from Afghanistan" and "an organization that's helping the immigrants from Sudan to be integrated into America...dance therapists have travelled to various places in the world." "There are cultures that are definitely open to this, when it's part of their tradition" but other cultures find it quite uncomfortable. One participant reported "I've had some Japanese students at Endicott College and they were even less sort of comfortable expressing their feelings and express their feelings through movement. So it does depend on the culture and dance therapy can address those issues." People from different racial, ethnic or cultural backgrounds may really appreciate dance and movement while others may be more skeptical or uncomfortable. It is critical that the dance therapist recognize such circumstances and adjust treatment accordingly.

Another aspect of D/MT's universality lies in anthropology. In many ancient cultures, dance was a way in which people were treated when ill. "At one point arts were the medicine, literally. You know the community would gather and there would be a shaman or a medicine person. There are still cultures that do that. I'm not saying that that replaces antibiotics, but there's deep healing."

Lastly, a dance therapist and professor raised the importance of recognizing the aspect of D/MT involving touch.

The fact that this is a profession where we move and we move our bodies and the therapist moves and the therapist sometimes moves with the client and not always or witnesses. Just the fact that the body is moving, to me makes it kind of inherently have a lot of potential sensuality and even sexuality...the body is

exceptionally powerful, it brings up body memories, it might bring up abuse memories, so you form a relationship very quickly through shared movement or witnessing movement. There's potential for a lot of difficult things. You need to be extremely sensitive to using touch, separate from the whole issue of legal liability.

There are courses such as *Touch and Sensuality in Dance Movement Therapy*, which are designed to address this specific issue. There is great significance in the therapist's awareness of clients comfort levels. For example, "when you're working is with a group of adults, or even seniors and your kind of saying let's dance, let's move and as a group you're swaying your hips and to us that's just movement, but to them, that kind of movement may be in the context of courtship."

Building Clientele and Report

In this section challenges faced by movement therapists will be examined. Data will be reviewed in the following order: Difficulties Faced Building Clientele as a Movement Therapist, Dealing with the Challenges of Building Clientele and Report, Educating Others about D/MT, Ideas about D/MT from the Outside Community, Dance Movement Therapists and Their work on a Multidisciplinary Team, The Effects of Client's insurance on D/MT Practice, and Problems within the Mental Health Community for D/MT.

Difficulties Faced Building Clientele as a Movement Therapist

Three out of nine participants (n=3) confirmed that it is difficult to build clientele as a movement therapist. The remaining six (n=6) said they had no problems acquiring clients. Two (n=2) were employed in settings where their clients are assigned, such as a

mental health clinic or a school setting. One person (n=1) said she did not have difficulty, but her multiple certifications made it difficult to identify what is attracting clients; “I’ve been able to build a clientele, but it’s really difficult for me to separate out what’s attracting people to what.” The remaining three participants (n=3) also answered the question a bit ambiguously, knowing that getting clients was somewhat conditional on two factors.

One of these conditional factors is the benefits of having additional training and licensure, such as a BC-DMT paired with LMHC, or having both a BC-DMT and Cognitive Behavioral Therapy (CBT) training. The most experienced movement therapist interviewed stated “I usually advise people entering the field to get a dual degree,” for the purpose of having more mobility within the mental health field and less trouble getting clients.

The second factor is directly related to the setting in which one practices. Practicing privately seems to make it more difficult to build clientele, when compared to other settings such as some hospitals. Some state hospitals have dance movement therapy positions built into their treatment.

Dealing with the Challenges of Building Clientele and Report

Following up from the previous section, participants described how they sometimes had to create their own employment within positions were not specific to D/MT. Providing D/MT services under a recognized state mental health license such as an LMHC, offers this flexibility and increased marketability. Possessing a state license

allows R-DMT's or BC-DMT's to bill insurance companies and ensure their practice is within state regulations.

As stated by one movement therapist, “the challenge I would say is being too rigid, in having to only be seen as a dance therapist, the big challenge.” Dance movement therapists need to work within the system; marketing themselves for all the skills and credentialing they possess, not just the D/MT component. An alternative to self marketing is working as part of a team in an institutional setting.

Reflecting on client recruitment several interviewees remarked that “it’s hard, but it’s not hard to build rapport once people are there.” Building the therapeutic alliance is critical in maintaining a caseload. D/MT naturally fosters an efficient and effective development of the client therapist relationship.

Educating Others about D/MT

Every participant articulated the ways in which they educate others about their practice as dance movement therapists. Many conduct in-services and trainings at their place of work –hospitals, mental health clinics, day treatment programs and schools. Public speaking forums, workshops, community and private presentations and parent-teacher conferences are additional educational services offered by dance movement therapists. One interviewee stated, “It’s a requirement that most healthcare facilities have ongoing education for their staff and I volunteer, ‘Oh let me do it, let me do it this month, let me do it next month!’” One person mentioned that even if the presentation that she is giving is not on D/MT, she brings D/MT into it by physically moving while she is talking. There is often a great appreciation from the people receiving D/MT information;

“they love it! They’re blown away and they forget they’re learning it for the sake of their patients and they start using [it] for their own sake.” Not all participants have written about their work, but some have published articles.

Traditionally dance movement therapists aren’t writers, they’re movers. And when they say write about your work, which we say to one another all the time it’s like, ‘oh I can’t write well.’ And it’s painstaking to get these articles, especially the research that’s most valuable, to get that done. We’re body workers and it’s hard for us to get it into written word.

D/MT therapists generally encouraged one another to write about what they know and practice, as a way of sharing with other dance movement therapists and non-dance movement therapists alike.

Several people commented that their participation in this study was a way to indirectly educate others about D/MT. Several individuals reported that they supervise others who are working towards their BC-DMT. Also, “doing good clinical work” is a way to promote D/MT, as one participant said.

Interviewees on the faculty at Lesley University, Endicott College and Antioch University New England have built in forums for continuing education. Conducting presentations within local dance communities is another way to increase awareness about D/MT. D/MT programs strongly encourage their students to educate the public. One participant shared her experience stating, “That was the big thing in Hahnemann, trying to get the word out.”

When a movement therapist’s supervisor knows little of D/MT, it is another great opportunity to teach about the profession. A therapist described her relationship with supervisors saying, “Each of them has actually been open to me telling them how I do things. You know, and I feel supported in that respect. They’re like ‘wow, that’s

amazing.” One participant recalled celebrating “Dance Movement Therapy Day, [created by] Donna Newman-Bluestein in Boston, I think it’s actually April 28th...sometimes Donna will get the governor of Massachusetts to proclaim it’s Dance Therapy Day.”

Many therapists mentioned the power in just talking about D/MT at every opportunity “You know the art of translation and you know how to give examples and how to be, learn to be respectful and open minded and not just get frustrated. So I’ve done a lot of education, just by talking to people and giving examples and doing good work that was effective with people,” shared a participant.

Ideas about D/MT from the Outside Community

People outside of the D/MT community have a range of understanding about this clinical work. However, it is generally reported that most have a poor understanding of D/MT. Movement therapists reported that people frequently think they are psychotherapists who work only with dancers, or that D/MT is some form of physical therapy or occupational therapy. People are “clueless” and “ignorant” about D/MT, thinking that it involves dance performances or dance steps. People perceive them as dance teachers - leading movement activities just for fun. People’s misconception is that D/MT is a recreational, dance-around-with-scarves and play type of activity. One therapist addressed this misunderstanding saying “[it’s] like you’re there to make them feel good and happy, direct them in dancing activities, not meant to bring up hard feelings and problems.”

Dance movement therapists are indeed clinical psychotherapists, trained through rigorous programming in assessment, pathology and diagnosis using the DSM-IV TR. The public understanding of D/MT is limited. In recent years people are becoming more familiar with the concept of expressive and creative arts therapies. Participants often ask if a person has heard of music therapy or art therapy as a segway into what they do. Most people have heard of other alternative therapies and explanation can then be provided stating, “have you heard of art therapy and music therapy and they say yeah and I say well, it’s the same thing with dance.”

People outside of D/MT are becoming more aware of the practice. One participant recalled, “Thirty years ago, 40 years ago, when I said I was a dance movement therapist, people would say ‘is that like Jazzercise?’ I don’t get that nearly as much anymore.”

However, D/MT is still generally unknown. Secretary’s Day happens to be on the same as Dance Movement Therapy Day and that is, as one therapist noted, “sort of indicative, you know secretary’s get their day on a calendar...my husband would get his secretary flowers and not get me flowers, on Dance Movement Therapy Day!” The limited general knowledge about D/MT continues to provide arenas for constant education and outreach.

Dance Movement Therapists and Their Work on a Multidisciplinary Team

Eight participants (n=8) had some experience working on a multidisciplinary team. The remaining one (n=1) stated her team experience was based on her position as a teacher, not as a dance movement therapist. All participants believed that working on a

multidisciplinary team is valuable. Words that interviewees used to describe being a part of a multidisciplinary team were “collaboration”, “essential”, “wonderful”, and “opportunity”. Each movement therapist (n=9) articulated ways in which collaboration complements D/MT treatment. Multidisciplinary teams are also positive avenues for public relations and networking among various professions.

Dance movement therapists spoke of opportunity to educate peers when functioning within a team. One person said, “It’s always a way for me to get across what I do to them as well as I think helps the patient. Different things work for different people and also as a team we can support all the different parts that are in a person.” D/MT is “developmentally delayed” so “one team at a time, you’re educating the world about dance therapy” when working together on a team.

It was mentioned that when the teams are good, the experience is good. When team members have an open mind it benefits the client as well as D/MT, because dance movement therapists possess skills that mainstream therapists do not. Respect among team members also fosters support along with provision of best service. This was articulated by one participant, “Such respect is gained when they learn I write notes, we meet in meetings, we speak about the client, we speak about what I’m doing with that client and how they’re benefitting from dance therapy and people learn yeah this is helpful.”

The use of language is critical in fostering relationship across disciplines. All therapists “need to make things accessible and learn the language and become a translator. It’s very important to understand how the place you’re working looks at things, how they talk about it, how they have to notate. And then bring the

body/movement/creative process to their language.” A multidisciplinary setting compliments D/MT treatment greatly.

The Effects of Client’s Insurance on D/MT Practice

Participants did describe the challenges with health insurance. Dance movement therapists were limited by not being third party reimbursable or not being in an insurer’s network. For example, a BC-DMT practicing as an LMHC could not take Mass Health – Massachusetts state insurance for low and moderate income families. Several participants concurred with the following statement, “It’s limited to me, instead of taking insurance I do a sliding scale. So I treat people for anything from twenty dollars to eighty dollars a session.”

The setting in which a movement therapist is practicing creates an interesting dynamic between them and insurance companies. For instance, some day treatment programs cannot get reimbursed by certain insurances for D/MT services. Participants practicing in an outpatient setting face similar issues to that of all outpatient therapists. For example, one therapist said, “I’ve never had an insurance company question my treatment plan, I’ve had more issues with getting sessions from insurance companies, you know in the outpatient world I have that a lot, it’s a big piece of my job.” Dance movement therapists and non-dance movement therapists alike face barriers to obtaining additional authorization for more sessions once the initial authorization has ended.

One therapist stated that a D/MT treatment plan looks the same as for mainstream therapy.

In terms of the movement therapy portion, they don’t really know that I do that, because all they really need to know are the treatment goals. Okay we’re working

on anger or we're working on depression and coping skills. So I do that through movement, which [are] still the same treatment goals as another therapist.

Insurance companies reimburse participants based on licensure held. For many dance movement therapists this license is an LMHC. R-DMT and BC-DMT are national certifications and not state licenses, so dance movement therapists cannot bill through insurance companies unless they have a state license to deliver mental health services. Licensure varies from state to state. New York is one of the only states that offers a Creative Arts Therapy license. "New York got the good one, Creative Arts Therapy License, I think it may be the only state. New York City is a great place to work if you're a dance therapist." In the past, not all states offered a license under which one could practice as a dance movement therapist, but most states do now, "Most of them have a License in Mental Health Counseling, the ones that have licenses, I think California, it's Family and Marriage Therapy."

Another insurance issue that has affected dance therapists is the extensive paperwork required for each client. One participant who was in the process of joining an insurance network said, "You have to keep in correspondence with them and you get a few sessions at a time and you have to keep getting approval for continued work and it's a lot of paperwork for not a whole lot of money.", Also, long-term clients, are often not covered by insurance for the duration of treatment because many of them are higher functioning.

Insurance companies reimburse for 50 minute sessions; at least one participant stated that she works for a "full sixty minutes. I just need time. Something about talking and moving and processing, it just seems cheap to give them less than an hour."

Generally, insurance issues were not catastrophic, but as one movement therapist put it,

“When somebody’s looking for a service that I can or can’t give them it makes a difference.”

Problems within the Mental Health Community for D/MT

Participants articulated feelings about their interactions with mental health professionals outside of the D/MT community. One movement therapist felt lonely when she received a lack of external acknowledgement for other professionals. Others spoke about an underlying fear of not being taken seriously by non-body psychotherapists. Four participants (n=4) affirmed that dance movement therapists do face problems with mental health providers because of their theoretical orientation and dance movement practice. On the other hand, the remaining five (n=5) indicated they did not experience problems outside of the D/MT community.

Participants who experienced problems described attitudes of skepticism and lack of understanding and acceptance received from colleagues and coworkers. A BC-DMT talking about her supervisor said, “He was initially hesitant to hire me because of my degree in dance therapy.” A participant was also asked by her supervisor, if “people didn’t show up for sessions because of the type of therapy” she did; implying that D/MT was limiting her ability to develop relationships or pushed clients away from treatment. These misunderstandings have kept dance movement therapists separated from other practitioners. Some participants reported that D/MT practice has been undermined during treatment meetings. One interviewee stated that her colleagues,

...had problems with wanting to make sure they don’t have to do any of the dance therapy. And some people do not want to understand it, or continuously getting it wrong; how they talk about it in treatment meetings. Those are problems that would come up, that definitely keep us separated.

When talking about other mental health providers one participant said “They don’t like it, but they respect it.”

Other challenges included one therapist’s experience trying to find an office to sublet for her private practice.

Actually, one time when I was interviewing...places to have my private practice and sign a lease and a psychiatrist had never heard of dance therapy. But when I told her about the dance therapy piece, she had some questions [like] would I be using touch in the space, and I don’t think she wanted me there because of that.

Another challenge had to do with a therapist who was hired at an outpatient clinic, working in a position that paid less than her previous salary. This therapist said she accepted the job under the agreement that the agency would support her financially by contributing to D/MT conference and training costs. She stated, “I don’t ask for much from my job, but I was promised that I would have my trainings covered and I’ve seen them [give] one hundred eighty-five dollars for one clinician to go to a training so they could keep their CEU’s for their license, and for me to be denied my dance therapy training.” This participant reported there was no way to accurately know under what circumstances monies were allocated. However this experience did make her feel as if her specialization was “less than”, compared to the other therapists.

A third challenge had to do with one therapist’s experience treating a 60 year old client who had been institutionalized at 6 months of age only because of strabismus (explain what this is). At the time of treatment the client was nonverbal. This participant was co-treating the client with a psychiatrist. Dramatic results were seen as a result of her dance movement therapy treatment. The client began forming relationships and attaching to the therapist which had not happened before. The psychiatrist became aware

of the successful D/MT treatment and reacted by stopping the client's treatment by this participant, allowing no time for termination. Said participant remarked about the psychiatrist, "I think she was completely threatened that I had gotten to this place with this person, who had been closed off from every avenue before...she just cut it off and wouldn't take my calls. It was awful; it was so awful to me." The depth of this work left such devastation as it was completely unfinished and abruptly terminated, because gains had been made via alternative treatment.

It is important to also recognize the positive interactions movement therapists have experienced with other mental health professionals. One participant remarked that both the clients and staff "crave the arts in clinics." Additionally interactions with colleagues who are not dance movement therapists have provided opportunities for education and forum for showing, teaching, speaking up, and explaining the benefits of D/MT. Some participants were able to identify how their theoretical orientation may have been a problem, but through a positive attitude and seizing opportunity they did not face separation from non-movement practitioners.

Summary

D/MT is defined as a psychotherapeutic body-based therapy incorporating the fundamentals of dance. Nine participants (N=9) were interviewed. Demographic details about their backgrounds were discovered. All interviewees were Caucasian and female. This demographic reflects the general population of movement therapists. Each individual reflected on their knowledge of D/MT, along with their experience within the field. This included interactions with other mental health providers, client characteristics

and treatment of clients. No stereotypical traits were identified clients. However the generalization that D/MT benefits all peoples is accurate. Differing opinions, occurrences and ways of educating others about D/MT were discussed in terms of dance movement therapists' practice, theoretical framework, and promotion of the field.

Generally dance movement therapists experienced some challenges in developing themselves professionally and being recognized within mental health. However, not all participants' individual experiences were synonymous.

CHAPTER V

DISCUSSION

The purpose of this qualitative study was to explore what movement therapists do and how their work interacts with traditional psychotherapy. There was overlap in what participants said and the previous literature. In addition to providing a base for comparing what was previously written, the narrative data offered insight into what the experience has been for movement therapists in the traditional mental health profession.

What was discovered in this study confirmed previous research findings, mainly within the methods and significance of Dance Movement Therapy (D/MT). There was supporting evidence in this study that complemented what has previously been said about D/MT and neuroscience and why D/MT is an effective treatment. Additionally, data concerning client characteristics and cultural implications within D/MT were also confirmed. In previous research the rigid divide between the body and mind was mentioned frequently (Christie et al. 2006). Although what was addressed by participants did not disconfirm the body mind separation, there was less mention of it than expected.

This chapter presents these and other issues in the following order: 1) key findings in relationship with previous literature in terms of demographic characteristics, training and certification processes, methods and significance, client characteristics and building clientele and rapport as a R-DMT or BC-DMT; 2) implications for social work

as it relates to D/MT; and 3) recommendations for future research based on what went unrecognized and areas which are left to still be explored.

Demographic Characteristics

Demographic characteristics were relatively homogenous, as far as race and gender, raised the question that had the sample included non-White and/or male dance movement therapists would different data have been produced? Demographic representation in previous research was more varied racially and ethnically, but not as far as gender. Brauninger (2006) only had fifteen male participants and one hundred forty-seven females. The wide age range in that sample showed that those who had been in the field longer had more insight to offer, adding to data richness. It was interesting that the majority of participants were of Jewish descent. This will be discussed further in regards to culture.

Training and Certification Process

The Decision to Become a Movement Therapist

As participants shared of their experiences leading up to their certification as either R-DMT or BC-DMT it became apparent that the process they moved through were similar to D/MT itself. Dance and the creative process were already present in their lives, influencing a natural inclination toward this type of therapy. Whether what led participants to become dance movement therapist was having a dream of helping and working with others through dance or seeing the *Looking for Me* video, the experience

resonated on a body based spiritual level. No study was found that examined what lead people to become dance movement therapists.

Training and Certification Process to Become R-DMT or BC-DMT

Each of the dance movement therapists interviewed were able to describe their process to become certified. The older aged participants studied with people such as Janet Adler and Mary Whitehouse, both founders of D/MT as a profession. Those who took an alternate training and certification route and those who went through an actual D/MT masters training program reported that their training was rigorous and exacting. This is in line with how the programs are described in each school's literature. It was noted that reaching the BC-DMT level of certification "indicates a clinician who has additionally completed 3,640 hours of supervised clinical work, and passed a rigorous examination" (ADTA Dance/Movement Therapy Brief Fact Sheet, 2009, para. 2). Both R-DMT and BC-DMT certificates are awarded by the ADTA. Thus, comparable standards are set for all D/MT programs which may be why all participants reported going through strenuous training. This is also why all individuals completed two internships during their training, or had to submit an extensive application via the alternate route.

Program descriptions from training institutions did not clearly identify and describe their theoretical framework. The two main frameworks mentioned by the therapists were Jungian and Chacian, both mentioned in D/MT history (Payne, 1992). Both theoretical perspectives work with the active imagination which emerged from Jungian theory (Payne, 1992). Jungian theory may be more easily integrated into

traditional psychotherapy, as it emerged from a Freudian origin. Schools such as Drexel University or Pratt Institute that are more clinically based, could offer a stronger foundation for movement therapists looking to influence traditional psychotherapy.

Methods and Significance

Why D/MT is a Significant Modality

Neuroscience based evidence was mentioned by both participants and in the literature (Berrol, 2006). The biologically based transformation resulting from D/MT surfaced in several interviews, confirming what movement therapists have been witnessing for decades. This evidence is very much like what one participant stated about the recent mirror neuron research; “it’s catching up with something that was already true.”

D/MT techniques have ability to bypass the ego defenses was confirmed by interviewees and in the previous research. One participant stated that D/MT is

...a great way to bypass people’s defenses. The way we defend is with our brain, you know our mind trying to do its usual tricks and movement and dance go to that symbolic place, that symbolic creative world...helping people understand what it means to listen to themselves in a different way.

Participants supported what was quoted earlier, that D/MT “bypasses the defenses of intellectualization and rationalization” (Antinori & Moore, 1997, p. 174). Bypassing the defenses contributes to what was also mentioned about the immediacy of therapeutic results and being *in* the experience versus talking *about* an experience, supporting D/MT as a significant modality.

The fact that D/MT creates a space for non-verbal treatment was also mentioned by all participants. Each participant spoke of the non-verbal component of D/MT; “dance

therapy is good for the less verbal client who might have difficulty speaking.” It is also “good for people who are very verbally acute,” because it gets beyond words and reaches the deeper, emotional level. The benefit of a psychotherapeutic treatment, which incorporates talking, but does not require verbal interaction was noted as applicable for all clients.

There is a wealth of information available in the current literature that supports the effectiveness of D/MT. Winnicott (Somer & Somer, 1997) and Jungian theory – both psychodynamically based – are applicable frameworks that describe how D/MT bypasses defenses and accesses the unconscious (Payne, 1992). The fact that “D/MT embodies empathic forms” in regards how the brain registers information, offers the practice considerable weight (Berrol, 2006, p. 2). This form of treatment is indeed significant, based on people’s experiences, evidence based practice, and hard neurobiological evidence.

Ways in which D/MT Differs from other Therapeutic Modalities

The opportunity provided in a D/MT session that gives a client the chance to “discover new patterns and try them out in a safe environment” a participant stated, “is the difference from other modalities.” This notion of immediacy and trying out new solutions with the movement therapist was not specifically identified within literature reviewed for this study. However, there was no evidence found that disproved this phenomenon. The interviewees stated that D/MT fosters the creative self as did previous research. Bruaninger (2006) reported an increase in imagination as treatment progressed.

The notion that “everything we’ve learned and everything we know is encoded in our bodies” was supported by previous research and the findings of this study “Our bodies are how we learn and how we respond in situations and it holds the unconscious,” was stated by one movement therapist. This body memory is confirmed by previous research with trauma survivors; that trauma can be stored in the body especially pre-verbal trauma (Mills & Daniluk, 2002).

Movement is innovative, especially when expressed using elements of dance. Exploration in what could be considered a theatrical way can shed light on new ways of being for a person in life’s areas of struggle. D/MT offers a dynamic space for expressing conscious and unconscious traumatic experiences with or without verbal communication. Jung spoke of the “inborn tendency to form conscious images” corresponding with the unconscious (Payne, 1992, p. 183). Basically D/MT offers individuals an “opportunity to connect affect and cognition with their bodies” (Antinori & Moore, 1997, p. 174). Trauma can be stored in the body, especially preverbal trauma; movement offers an alternative way to accessing and expressing these experiences (Mills & Daniluk, 2002). Considering the number of clients seen in therapy who have a trauma history, D/MT should be integrated into all therapeutic training programs.

The Impact of the Absence of Body-Mind Duality in Therapeutic Approaches

One study noted the “firm divide between the mind and the body” (Christie et al. 2006). This theoretical disconnect of body and mind was found in previous literature (Christie et al. 2006), yet the therapists in this study described not a complete separation, but rather the elimination of the element of spirit. The majority of participants stressed

the inclusion of the spirit. One movement therapist stated that she “really includes the spirit and encourages people to connect to their higher power.” With regard to the ADTA, this therapist added that “the dance therapy association hasn’t added that to the definition of dance therapy. I’d like them to maybe someday I’ll get them to because I believe it’s a really important part of health.”

The participants agreed that D/MT is split between the medical world and the dance world. As an alternative therapy, D/MT is “outside the box” that does not always tap into the conscious. D/MT focuses directly on the unconscious part of the cognitive mind, as it offers “direct access to the unconscious” (Payne, 1992, p. 167). This alludes to the fact that D/MT addresses the “true-self” rather than the cognitive conscious composition of who we present to the world (Berzoff, et al. 2008). Following this thought one may consider that D/MT fosters a connection with the spirit in a way that traditional psychotherapies do not. And it may be spirituality that is left out, as third component to the body-mind partnership. Meditation and yoga are practices that are said to be spiritual and they are very new to the clinical realm. D/MT is an alternative practice, possibly involving spirituality, but can also be supported through clinical theories (Payne, 1992, and Berzoff et al. 2008). It may be this split that needs to be addressed, rather than breaking down the divide said to be between the body and mind.

Client Characteristics

Similar Traits in Clients Who Seek out D/MT

There are three identified categories of clients who receive D/MT. The first group included people who actively seek out dance therapy treatment. The second group were people who receive D/MT because it is part of the intensive treatment, program (eg: in a prison or residential treatment facility). The third group was comprised of clients receiving treatment by a dance movement therapist due to availability and/or location.

Research shows that dance movement therapists work in a variety of settings such as schools (Kalish-Weiss, 1989), or hospitals (Christie et al. 2006). These settings show that individuals who are not specifically seeking out D/MT can also benefit from the modality.

Previous research did not specifically examine the types of people who seek out D/MT treatment. It is known that individuals have experienced positive results from D/MT treatment, prior to their involvement in previous studies (Mills & Daniluk, 2002). The fact that these individuals had positive results the first time, may lend credence to the idea that these people may be inclined to pursue D/MT treatment a second time on their own accord, thus causing them to be seekers of the treatment.

Symptomology and/or Personal Characteristics of Movement Therapy Clients

According to the participants in the sample, there is no general symptomology or personal characteristics of movement therapy clients. D/MT can be effect for clients with self-esteem issues as well as clients with significant abuse histories. Characteristics that

did stand out were articulated by the following participant who stated, “Ninety-five percent of my clients have a trauma history.” Also some participants spoke of having a majority of females in their caseload. However, the therapists also stressed D/MT is effective not only with both genders but also across the developmental lifespan. Although D/MT is particularly effective in treating trauma, the participants generally agreed that there are no typical traits or presenting issues..

Previous studies have described the wide range of clients that benefit from D/MT. Some samples in studies were high school students (Kalish-Weiss, 1989), victims of child sexual abuse (Mills & Daniluk, 2002) and individuals with chronic pain (Christie et al. 2006). Also, both men and women clients have comprised samples of previous research (Bruaninger, 2006). Therapists in the sample for this study also noted that D/MT is effective with ambulatory clients as well as those who are wheelchair bound and with males and females of all ages.

Pertinence of Culture, Race and Ethnicity to D/MT

Two main themes surfaced in this study. One being D/MT is very White, as far as the clinician population and ADTA members. A second theme was that many cultures can be served within this context, as D/MT is reported to be less culture bound, than other modalities.

Research indicated that the ADTA is engaging more and more internationally, with other dance movement therapists and organizations (Capello, 2006). Considering this collaboration across cultures it may be concluded that D/MT might not be as White as it once was, but no such statements were made by participants.

Hearn et al. (2006) noted that movement and dance are recognized as a universal language. The therapists in this study and findings from previous studies confirm that dance is an ancient “form of communication, ritual and celebration” (Mills & Daniluk, 2002, p. 77). D/MT provides a space for incorporating a variety of cultural practices in the context of treatment. D/MT also cuts through the barriers caused by language and the need to be able to articulate and describe an experience. By dancing and moving, clients are can share their stories and feelings in the moment.

Both in findings of this study and the previous literature stress that the use of touch must be incorporated into treatment with great care. Touch is critical in drawing client’s attention to somatic symptoms in relation to psychological issues (Christie et al. 2006). The use of touch presents a sensitive challenge, yet one program description did not address this issue (Lesley University, Master of Arts in Expressive Therapies: Dance Therapy with a Specialization in Mental Health Counseling (60 Credits), 2009). Therapists noted that this topic should be addressed with care, but candidly.

Building Clientele and Report

Difficulties Faced Building Clientele and Report and Dealing with these Challenges

Ultimately participants either overtly experienced hardship in acquiring clientele or assumed that their success was based on practicing as a movement therapist in combination with another degree or marketable license. Most participants felt that dance movement therapist need dual licensure. .

The notion that dual training is best for developing a viable career as a dance movement therapist was not mentioned in the previous research. Building a substantial

clientele can be a challenge for the person with only a movement therapy certification. Thus, those movement therapists who wish to have a larger caseload, additional work need an additional license in order to receive insurance reimbursement and successfully recruit clients.

Ideas and Education of the Outside Community

There is a very poor understanding of what D/MT is and how it works outside of the D/MT community. In cultures that are less westernized, dance has been an essential component in healing rituals (Wennerstrand, 2008). For some, the idea of using dance and movement as a way of bettering one's life is not a foreign concept. The previous literature and the responses from this study's participants confirm that there is a need for education about D/MT in the United States and other westernized countries. All the movement therapists in the sample spoke of the importance of educating others about D/MT. Fostering this general knowledge was a common practice for participants. A variety of avenues for informing people of D/MT were noted, such as in-services, casual conversation, and classroom teaching. The nature of how D/MT is described to other is critical as well. There is value in "the art of translation;" being able to provide examples, in addition to being respectful of who you are educating by using tactful language that is specific to that particular setting or audience.

The way in which one educates others about D/MT needs to be focused on the "core elements essential to good practice," thus, educating through modeling of positive therapeutic work (Capello, 2006, p. 39). This study's findings and previous research

(Dance to Health, n.d.) affirm that work with multidisciplinary teams is of incredible value as an educational forum and to provide best service.

Participants described many opportunities for sharing the impressive impact and joy of D/MT. Utilizing these avenues with a humble approach and exercising an understanding of who the audience are effective ways to promote D/MT. It can be inferred that this does involve a certain level of self education on the part of the dance movement therapist because in order for him or her to know who they are talking to, they will need to spend some time listening first.

The Effects of Client's Insurance and Problems with the Mental Health Community

The necessity of providing therapy under a billable state license is critical to the livelihood of dance movement therapists according to participants. Many therapists who do not have a state mental health license cannot accept clients' insurance. These therapists require payment out-of-pocket and, according to some participants, treating "people for anything from twenty dollars to eighty dollars," on a sliding scale. "Failure of government to recognize dance/movement therapy as a valid profession" makes it complicated for therapists (Capello, 2006, p. 32-33). This lack of recognition forces D/MT therapists to obtain an additional insurable license. This situation continues despite the fact that D/MT is a psychotherapy based in theory and evidence based practice.

Problems within the mental health community are reflected in the governmental lack of recognition of D/MT. One participant stated that a lot of people outside of the field think of dance movement therapists as "a bunch of flakes." Hopefully the findings

that emerged from this study will serve as a source of support and information to those who are not equipped to make an accurate statement about D/MT

Implications for Clinical Practice

Social work values a systemic perspective that includes the environment, relationships, individual development and biological factors. Clinical social workers' privilege of providing best services includes incorporating these elements with psychodynamic theories. D/MT is inherently a creative treatment. D/MT addresses all treatment issues and can be ideal for a wide range of clients. Social work, in the form of traditional psychotherapy, and D/MT can complement one another. D/MT addresses all treatment issues and offers opportunity for client development and growth through the use of movement and dance in place of or as a complement to traditional treatment.

This study emerged from a place of personal interest. This study was initiated as a way to promote D/MT and raise awareness of a professional therapeutic treatment, that is struggling to be perceived as valid and legitimate psychotherapy among mental health professionals. This study was conducted with respect and passion for the possibilities posed by D/MT and a firm belief in the power of dance and movement. Thus, in accordance with social work values, there is an obligation to share new or little known treatment strategies with other mental health providers. Grounded in theory and neuroscience, D/MT is a creative modality that can help mental health professional best serve some clients as it offers avenues for working non-verbally and deepens trauma work.

Recommendations for Future Research

Much research needs to be conducted on the use and effectiveness of D/MT. This study was based on the narrative testimony of D/MT clinicians. Future research from the client's perspective may further ground D/MT as evidence based treatment. Continued research with larger samples may also help in validating the process of D/MT with specific clients and presenting issues either as a sole treatment method or in conjunction with traditional psychotherapy.

More research is needed that addresses the cultural universality of D/MT, specifically when used with varying cultures. Conducting cross-cultural studies comparing different racial and or ethnic groups may also be beneficial as many studies explicitly focus on homogeneous samples as far as race and ethnicity. This study was conducted primarily within the Northeast area of the US. Further research across the entire nation in addition to cross-national studies will provide a greater span of information. Surveying D/MT therapists from a larger pool of D/MT institutions may be increase the generalizability of the findings from this study. Lastly, looking deeper into the spiritual component of D/MT may provide a better understanding of what this means for both therapists and clients.

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Appendix A

Informed Consent Form

March 23, 2010

Dear Potential Participant,

My name is Michelle Walsh and I am a graduate student at Smith College School for Social Work. I am conducting a research project for my MSW thesis, and possible presentation and publication. The objective of my study is to explore the process of movement therapy, training and certification requirements and potential challenges faced by providers, in their establishment of practice and recognition as a movement therapist, within the clinical profession.

In order to participate in this study, you will need to be certified as an R-DMT and have been practicing for at least five years in this capacity. I hope to interview you for approximately 45 minutes to an hour, and interview will be recorded and then transcribed. There is the possibility I may use a transcriber and if so said person will be required to sign a Volunteer or Professional Transcriber's Assurance of Research Confidentiality form. I will ask you about your training and practice as a R-DMT. I will explore possible difficulties that you may have encountered in becoming a part of the mental health community. I would like to find out more about what you do as a movement therapist and how your skills might interface with traditional psychotherapy. Questions will also be included regarding your demographic information and that of your clientele – for the purpose of drawing conclusions of individuals currently receiving movement therapy.

The risks of participating include potential emotional distress as you reflect on your experience of becoming and practicing as an R-DMT/BC-DMT.

The benefits of participating are: a) data gathered may contribute to the establishment of movement therapy as a viable and valuable service, used by those in psychology and social work; b) this information may help bridge the gap between body and mind in the context of clinical work with clients; and c) the opportunity to share your story, experiences and challenges. It should be noted there will no financial compensation for participating in the study.

Your participation in this study is confidential. The signed informed consent and other identifying information will be kept separate from the interview tapes and transcripts. Demographic findings will be reported in the aggregate. Quotations will be sufficiently disguised in any used narratives and a pseudonym instead of your real name will be used in my final report. All tapes and data will be secured in a locked location for a minimum of three years, as required by Federal guidelines. If there is need for the data beyond three years I will continue to keep them secure until no longer needed, at which time project materials will be destroyed. You have the right to not respond to a question

during the interview and/or withdraw from the study without penalty at anytime. Once a participant, if you wish to withdraw you must do so prior to May 10, 2010 when the final report will be written.

Thank you for participating and please retain a copy of this consent for your records.

If you have any questions please don't hesitate to contact me. If you have any concerns please contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant

Date

Researcher

Date

Appendix B

Recruitment Letter

April 1, 2010

Dear Potential Participant,

My name is Michelle Walsh and I am a graduate student at Smith College School for Social Work. I would like you to join me in my efforts to learn more about Dance/Movement Therapy (DMT).

I am looking to explore how recognized D/MT is within the clinical profession. Many clinical social workers and psychologists I have spoken with are unaware of D/MT; I'm looking to explore this phenomenon further.

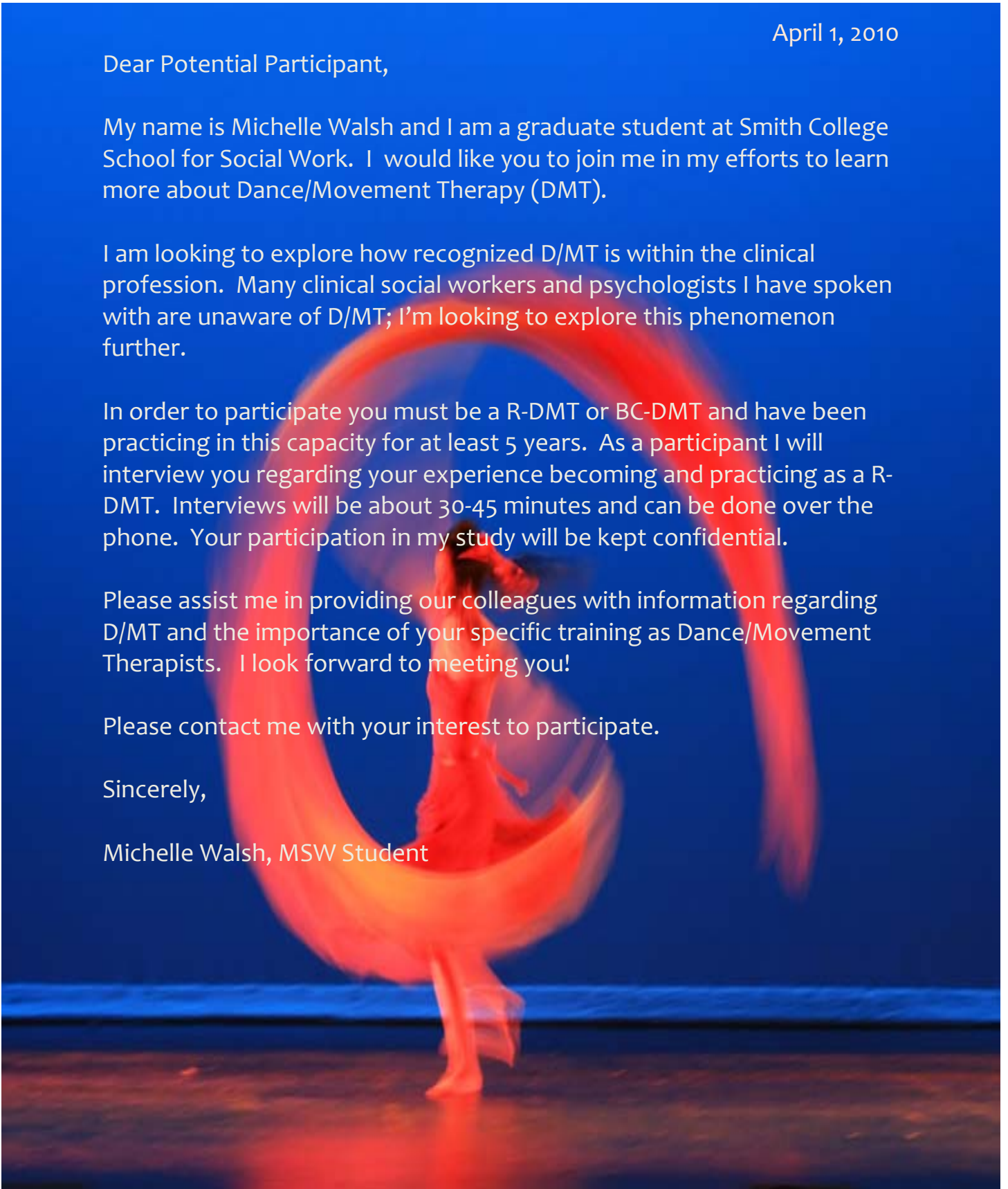
In order to participate you must be a R-DMT or BC-DMT and have been practicing in this capacity for at least 5 years. As a participant I will interview you regarding your experience becoming and practicing as a R-DMT. Interviews will be about 30-45 minutes and can be done over the phone. Your participation in my study will be kept confidential.

Please assist me in providing our colleagues with information regarding D/MT and the importance of your specific training as Dance/Movement Therapists. I look forward to meeting you!

Please contact me with your interest to participate.

Sincerely,

Michelle Walsh, MSW Student



Appendix C

HSR Approval Letter

March 24, 2010

Michelle Walsh

Dear Michelle,

Your revised materials have been reviewed and all is now in order. We are happy to give final approval to your study. You have done a good job of changing the tone to one of the researcher asking a question.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.

Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor

Appendix D

Interview Guide

Please be aware you can pass on any question you wish not to answer.

A. Demographic Characteristics

1. What is your racial and/or ethnic background?
2. What was the name of your R-DMT/BC-DMT training program?
3. In what states do you hold certification?
4. What type of setting do you currently practice in?
5. How long have you been in practice?
6. Is there any additional demographic information you'd like to provide?

B. Training and Certification Process

7. What led to your decision to become a movement therapist?
8. Would you please describe the training and certification process you went through to become a R-DMT/BC-DMT?

C. Methods and Significance

9. Why do you feel the D/MT modality is significant? How does D/MT differ from other therapeutic modalities?
10. Studies mention the absence of body-mind therapeutic approaches in most clinical theories, how has this impacted your practice?

D. Building Clientele and Report

11. A. Have you had difficulty building clientele as a movement therapist?
 - B. If so, how have you dealt with these challenges?
12. As a supporter of movement therapy, if applicable, how have you educated others about it?
13. If you are aware of any, what ideas do people outside of the movement therapy community have about this particular form of clinical work?
14. A. Do you have experience working on a multidisciplinary team as a R-DMT/BC-DMT?
 - B. How would you say being on a multidisciplinary team compliments a movement therapist?
15. How has client's insurance affected your practice as a movement therapist?
16. Have you had problems with the mental health community and/or colleagues, that have been an issue because of your practice and theoretical orientation as a R-DMT/BC-DMT?

E. Client Characteristics

17. A. What are, if any, the similar traits you might recognize in clients who seek out movement therapy?
 - B. What are, if any, the stereotypical traits of movement therapy clients, in terms of symptomology and/or personal characteristics?
18. How do you think culture, race, and ethnicity pertain to movement therapy?