Spring 5-19-2018

Dance Movement Therapy with Adolescents in a Partial Hospital Program: A Method for Engagement

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Capstone Thesis

Lesley University

May 19, 2018

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Specialization: Dance Movement Therapy

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Abstract

Therapeutic engagement during adolescence can be a major challenge in adolescent mental health. Research has indicated therapeutic techniques designed for engaging clients are often ineffective for adolescents because adolescents bring distinctive qualities to the therapy process that differentiate them from other therapy populations. There is also limited research showing effectiveness of Dance/Movement Therapy (DMT) with the adolescent population. This capstone will present an adaptable method utilizing dance/movement therapy interventions with participants ages 12-17 in a Partial Hospital Program. The objective of this project was to examine how DMT can improve engagement in treatment with adolescents in a partial hospital program through movement experiences and emotional content. The participants were asked to engage in a series of interventions such as movement exercises, body awareness, improvisation, writing, and processing emotions. The goal of the method was to bring awareness to dance movement therapy's value, benefits, strength and creativity. To develop a better understanding of this topic, this writer designed and adapted four dance/movement therapy sessions for the adolescents. Based on pre and post emotional responses, motivation to attend group, positive engagement and positive responses, the DMT interventions had a positive effect and can benefit adolescents and younger populations.

Keywords: adolescence, depression, anxiety, Dance/Movement Therapy, emotions, engagement, treatment

Dance/Movement Therapy with Adolescents in a Partial Hospital Program: A Method for Engagement

"Dancing is not just getting up painlessly, like a leaf blown on the wind; dancing is when you tear your heart out and rise out of your body to hang suspended between the worlds."

— Rumi

Dance/Movement Therapy (DMT) can be defined as a psychotherapeutic or healing tool rooted in the awareness that the body and the mind are one (Levy, 2005). It is an inspiring journey relating to creative movement and therapy that uses the relationship between motion and emotion as an outlet for engagement (Payne, 1992). The current Capstone suggests the effectiveness of dance/movement therapy interventions to improve engagement with adolescents in treatment.

There is growing neurological evidence in favor of using creative arts therapies such as art, music, dance, drama, and poetry therapies due to their importance and countenance of group involvement (van Westrhenen & Fritz, 2014). "Engaging adolescents in psychotherapy and establishing a strong therapeutic alliance with adolescents require that therapists express empathy and genuineness, utilize developmentally appropriate interventions, address the stigma, and increase choice in therapy" (Bolton Oetzel, & Scherer, 2003, p.215). Dance/movement therapy can provide an experiential process through which teenagers can express themselves, discharge feelings in a creative and safe way, release tension, reduce stress, establish trust, and develop meaningful relationships (Malchiodi, 2007). A combination of talk therapy and DMT can possibly improve a client's ability to engage and strengthen their therapeutic experience, decrease the symptoms of depression and anxiety as well as support the therapeutic process.

When discussing adolescence, factors such as physical, cognitive, and social and emotional growth between childhood and adulthood plays an important role. Based on that awareness, this facilitator developed a method which incorporated dance/movement therapy for adolescents between the ages of 12-17 in a Partial Hospital Program. The purpose of this method is to investigate the ways in which Dance/movement therapy (DMT) can improve engagement in treatment with adolescents, (specifically those who struggle with depression, anxiety and expressing emotions). When working with the adolescent population at the Partial Hospital Program, the predominant approach implemented is talk therapy. This facilitator's goal was to apply a body centered approach and assess client's engagement. In speaking about the body centered approach, Malchiodi (2007) emphasized that "dance/movement therapy is an action oriented, creative, and spontaneous therapy leading to growth and change and facilitating people's natural ability to express themselves and communicate more fully through their own bodies" (p.87). This emphasis will highlight the implementation of dance/movement therapy, determine the effectiveness of the approach and possibly improve engagement in treatment with adolescents.

Literature Review

The following review will discuss literature pertaining to dance/movement therapy, adolescent development, anxiety, depression, and how DMT can improve engagement in treatment with adolescents in a Partial Hospital Program.

Defining Adolescence

Throughout history, the term adolescence has been defined in numerous ways. G. Stanley Hall, an early developmental researcher coined the term adolescence and described it as a "storm and stress" (Hall, 1904). He referred to adolescence as a period of inescapable chaos and

inevitable turmoil that takes place during the transition from childhood to adulthood. In his book, he identified conflict with parents, mood disruptions, and risky behavior as the three main causes of storm and stress. According to Hall (1904), adolescents are more inclined to be rebellious and resistant, they tend to be emotionally unstable in which they experience mood disruption, and they contain a higher rate of dangerous, devious and introverted behavior. Furthermore, adolescents cause disruptions of the social order and engage in behavior that carries the potential to harm themselves and others (Hall, 1904).

In recent definitions, Mosby's Medical Dictionary (2013) saw adolescence as "the period in development between the onset of puberty and adulthood. It usually begins between 11 and 13 years of age with the appearance of secondary sex characteristics and spans the teenage years, terminating at 18 to 20 years of age with the completion of the development of the adult form" (p.44). Lerner & Steinberg (2004) note adolescence is characterized by an increase in the complexity of group interactions and social behavior. Steinberg (2014) later described adolescence as a dynamically developing theoretical concept informed through physiologic, psychosocial, temporal and cultural view. Anna Freud saw adolescence as a biologically based and universal developmental disturbance and Erik Erikson viewed the period as an inherited maturational ground plan resulting in the inescapable psychosocial crisis of identity versus role confusion (as cited in Lerner & Steinberg, 2004). Much of the literature on adolescence focuses on different aspects of behaviors essentially because the manifestations of a temperament dimension may change over time and behavior is highly pertinent to the developing adolescent.

Common Clinical Issues

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or DSM–5 (American Psychiatric Association, 2013), states "a mental disorder is a syndrome characterized

by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities" (p. 20). Mental disorders like as depression can be a struggle and burden for adolescents in all aspects. The DSM-5's criteria of Major Depressive Disorder provides a combination of symptoms including depressive mood, loss of interest or failure, weight loss or weight gain, insomnia, or hypersomnia, psychomotor agitation, fatigue, feelings of worthlessness, incisiveness, and suicidal ideation (American Psychiatric Association 2013). According to Akandere and Demir (2011), when those symptoms are presented, it can be perceived as oppositional, negative, uneasy, inadaptable, behavior-attitude, alienation from society and school, failure in school success, carelessness in clothing, sensitivity to being rejected, and a predisposition to substance. Furthermore, "depression is twice more prevalent in females than males and the risk of a recurrence can be as high as 50–90%" (Akandere & Demir, 2011, p.651).

Another common clinical concern within adolescents is Anxiety. Anxiety disorders are one of the most prevalent mental health disorders with a 12 month prevalence rate of 0.9% in generalized anxiety disorder among adolescents (American Psychiatric Association, 2013). Unfortunately, detecting anxiety before adolescence is difficult because the occurrence of the diagnosis appears in middle age and declines later in life. Anxiety is defined as "a state of intense apprehension, uncertainty, and fear resulting from the anticipation of a threatening event or situation, often to a degree that normal physical and psychological functioning is disrupted" (American Heritage Medical, 2007, p. 38). The DSM-5 mentioned that Generalized Anxiety Disorder is comprised of extreme anxiety and worry, and difficulty controlling fear. In addition,

the physiological and emotional symptoms associated with Generalized Anxiety Disorder include restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and sleep disturbance. In relation to adolescents, the DSM-5's criteria for Generalized Anxiety Disorder highlight that anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013).

Emotional experiences are pivotal responses to every individual's experience. Ford, Lwi, Gentzler, Hankin, & Mauss (2018), defined emotions as "ubiquitous and powerful experiences that are central to how we relate to our environment and each other" (p. 2). Often, emotions are described as complex feelings that are internalized. While studying emotions, Ford et al. (2018) propose that each individual is an emotion theorist, deciding for her or himself whether emotions are controllable. The idea behind this study focused on youths' beliefs about emotion and how those beliefs can predict emotion regulation and depressive symptoms. Results from the Ford et al. (2018) study found emotions to be uncontrollable when thoughts are connected with low self-efficacy, pessimism, stressors, and negative emotional reactivity in response to stressors. The most important element from this study is the emphasis on having motivation and strength to find emotional regulation.

When analyzing emotions, an important factor is to understand the source of the expression. According to Lee (2014), movements activate an interactive process between one's outward expression and inner feelings/thoughts, and serve as a gateway between one's inner and outer world. Through expressive movements, one becomes aware of oneself and opens the self to the outer world. Lee (2014) examined three phases of treatment. Phase one focused on relationship building, phase two concentrated on awareness of the body and verbal

interpretations in relation to movements, and phase three was tailored towards embodiment of internal imagination, connecting inward and revealing traumatic experience. This study concludes that releasing the body from habituated movements comes from nonverbal contact and some verbal exchange. Expressing emotions through voice and body can be a helpful tool for treatment and progress (Lee, 2014).

Another study exploring emotions by Tamir and Bigman (2017) found that emotions and behavior are inextricably linked and individuals have expectations regarding personal achievement. In speaking of their study on emotions, Tamir and Bigman (2017) proclaim that "what emotions do is a function of what people expect emotions to do (p.23). Consequently, what some adolescents are expecting emotions to do may determine what they actually do. Emotions are central to our lives and behavior can be influenced by certain emotions.

Engagement

Engagement is imperative to therapy as it requires interaction and effective rapport. Therefore, finding and maintaining creative ways to foster engagement is important to the therapeutic relationship. Schaufeli (2012) proclaims that engagement requires participation, commitment, passion, enthusiasm, concentration, motivation, effort, dedication, and energy. Thus therapeutic engagement of adolescents is critical to maximizing the success of any psychotherapy intervention (Bolton Oetzel & Scherer, 2003). It is also important to be mindful of cognitive, physical and social maturation, as well as attachment considerations.

Bolton Oetzel and Scherer (2003) explored the need to enhance therapeutic engagement with adolescents and found that "many adolescents are very suspicious about the psychotherapeutic enterprise because they are in a time of transition and identity consolidation that leaves them feeling vulnerable and unsure of themselves, particularly in a novel

psychotherapy setting" (p. 221). Furthermore, they discovered that adolescents frequently fail to see the purpose in treatment and doubt that it will have any meaningful impact on them because they lack motivation and understanding of treatment. As a result of these thought processes, engagement becomes more difficult and has negative influences on the therapeutic process such as resistance and therapeutic outcome (Bolton Oetzel & Scherer, 2003). In investigating adolescent engagement in treatment, Holdsworth, Bowen, Brown and Douglas (2014) conducted research studying client engagement and treatment outcomes and discovered that how clients are referred to treatment is likely to impact their engagement. Holdsworth et al. (2014) also learned that the synthesis of the findings is related to the source of the referral.

Lenz, Del Conte, Lancaster, Bailey and Vanderpool (2014) evaluated the treatment effect associated with a Partial Hospitalization Program (PHP) for Adolescents. Lenz et al. (2014) conducted the study with 35 female and 16 male adolescents who were diagnosed with mood, major depressive and substance abuse disorders. Findings suggested that "participants completing the PHP tended to report a decrease in severity or frequency of the symptoms representing these constructs such as tension and apprehension or dysphoric mood" (Lenz et al., 2014, p. 9). The overall findings indicated that "participants in a PHP demonstrated positive, desired change over time and that PHP programs may provide the structure and support that are required to promote adjustment and resilience" (Lenz et al., 2014, p.12). While providing treatment in the Partial Hospitalization Program, Lenz et al. (2014) reported increased awareness of relational health with peers and mentors. Upon completion, participants demonstrated positive desired change over time. Nonetheless, the presence of resistance expressed by a lack of motivation does not necessarily mean the adolescent has no desire to change. The need to be accepted by and belong to society may be represented by a significant adult; the therapist

therefore needs to be able to be idealized as a significant other in order for a working alliance to develop (Payne, 1992).

Partial Hospital Program

Kettlewell, Jones and Jones (1985) stressed that partial hospitalization programs have been used to represent a variety of treatment approaches. In order to analyze the outcomes and explore further research, Durbin, Preddy, Stewart and Walters (2017) confirmed that "child partial hospitalization programs (CPHPs) provide specialized, intensive, interdisciplinary day treatment for children with significant social, emotional, and behavioral needs that warrant a higher level of care than outpatient therapy, but a less intensive care setting than admission to an inpatient unit" (p. 3). In regards to adolescence, Kettlewell et al. (1985) asserts that over the past 20 years, the stresses placed on adolescents have increased. This awareness increases the need for partial hospital programs for adolescents.

Kettlewell et al. (1985) emphasize the purpose and objective of PHP groups are for clients to be vulnerable, gain new skills and generalize all skills learned upon transition. The duration for treatment in PHP usually varies between 8 to 12 weeks. A typical routine in a PHP program consists of psychoeducational groups, skills practice and activities where each group contains elements and goals that encourage structure and predictability throughout the time of enrollment. Given the scarce information on partial hospitalization, more research was needed. Consequently, Kettlewell et al. (1985) conducted research on adolescent partial hospitalization by evaluating variables such as Child and Adolescent Behavior Problem Checklist, Assessment of Current Functioning Scale and Goal Attainment Scaling. Results confirmed improvement in problem areas like friendships, school, and emotional control over anxiety and depression. Those results support adolescent partial hospitalization as treatment (Kettlewell, Jones & Jones, 1985).

According to Durbin et al. (2017) several studies demonstrate significant emotional, social, and behavioral improvement for children from admission to discharge, but only a few studies have analyzed the long-term impact of partial hospitalization programs. A case study was completed on a 12 year old female struggling with challenging behaviors at home and school referred to as Josie (Durbin et al. 2017). Over the course of treatment, Josie participated in milieu, individual, group, and family therapies. In the milieu, Josie appeared to be immature and struggled with age-appropriate social behavior, including giving peers space. In individual therapy, Durbin et al. (2017) confirmed that Josie was highly motivated to learn and use coping skills including deep breathing and muscle relaxation. She also was receptive to cognitive restructuring techniques for anxiety and practiced challenging anxious thoughts. Results of this study provided understanding that some families and children stay involved in follow-up treatment and are satisfied with their providers, which in turn may reduce recidivism for both partial and inpatient levels of care as well as enabling families to maintain treatment gains. "This is important information since partial level of care is not widely available in this age range and yet clearly appears to be an effective alternative to more restrictive interventions" (Durbin et al., 2017, p. 3).

Dance/Movement Therapy

According to the American Dance Therapy Association website (https://adta.org, 2014), dance/movement therapy (DMT) is defined as "the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual, for the purpose of improving health and well-being". Payne (1992) speaks of dance movement therapy as the "the use of expressive movement and dance as a vehicle through which an individual can engage in the process of personal integration and growth. It is founded on the principle that there is a

relationship between motion and emotion and that by exploring a more varied vocabulary of movement people experience the possibility of becoming more securely balanced yet increasingly spontaneous and adaptable. Through movement and dance each person's inner world becomes tangible, individuals share much of their personal symbolism and in dancing together relationships become visible. The dance movement therapist creates a holding environment in which such feelings can be safely expressed, acknowledged and communicated" (Payne, 1992, p. 4). Dance/Movement Therapy focuses on the "basic premise that body movement reflects inner emotional states and that changes in movement behavior can lead to changes in the psyche, thus promoting health and growth" (Levy, 2005, p. 1).

Dance/Movement Therapy is used in a variety of settings with clients struggling with an array of stressors. It has been utilized in different settings like residential homes, private practices, psychiatric hospitals, rehabilitation centers and schools. In addition, the method is an efficient tool for individuals with physical, developmental, emotional, social, and cognitive difficulties. DMT can also assist individuals create and implement interventions that targets emotional, social, physical, and cognitive integration using verbal and nonverbal communication (American Dance Therapy Association, 2014). Backdating to the 1900's, the roots of dance/movement therapy can be traced to modern dance. DMT originated from a reaction to the social and intellectual climate as well as a revolt against other art forms (Levy, 2005). Despite the accessibility of current art forms, there was a growing interest in the nonverbal and expressive parts of behavior in the area of psychotherapy. There was a need for expressive movements that accentuated spontaneity and creativity. Overall, dance therapy is rooted in the idea that the body and the mind are inseparable; it cultivates healing through the body and builds the bridge between the mental and the physical. Furthermore, the basis of dance/movement

therapy is that body movement reflects inner emotional states. Therefore, the goal of DMT supports an individual in regaining a sense of wholeness by experiencing the fundamental unity of the body, mind and spirit (Levy, 2005).

Dance/Movement Therapy is growing and interventions arebeing implemented in many areas. Bräuninger (2014) examined the correlation between specific DMT interventions and the improvement in quality of life, stress management, and stress reduction. Results of the study appear to be successful in improving quality of life. The results emphasized that the techniques used are essential dance/movement therapy interventions that enhances clients' daily life and decrease somatization symptoms. The findings of this current study support this method as it demonstrates the connection between improvement shown and the DMT techniques used. Koch, Morlinghaus, and Fuchs (2007) adds on by stating that stimulating circle dances can have a positive effect on patients with depression and may be recommended for use in dance/movement therapy and other complementary therapies.

Punkanen, Saarikallio and Luck (2014) published an article focusing on the effectiveness of DMT intervention for depressed participants ages 18-20. Their results confirmed that a short term DMT group intervention had a positive effect on patients with depression and anxiety. Anderson, Kennedy, DeWitt, Anderson and Wamboldt (2014) conducted a study which concluded that dance/movement therapy may serve as a potential coping strategy for modulating particular emotions and assist all different backgrounds. Anderson et al. (2014) found that regardless of age, gender, ethnicity, primary diagnosis, insurance status, psychiatric medications, length of stay, and treatment unit, DMT can stimulate mood changes in adolescents with psychiatric problems.

According to Kim, Kim and Ki (2014), depressed and anxious adolescents demonstrate low self-esteem. In addition, the depression experienced by many adolescents causes problems such as suicide, smoking, alcohol use, and drug addiction. Kim et al. (2014) found that group art therapy combined with breath meditation was an effective way to improve the subjective well-being of depressed and anxious adolescents.

Jeong, Hong, Lee, Park, Kim, and Suh (2004) state dance/movement therapy has been used as a form of art therapy in the Western world since the 1950s. This proves that movement has been used to improve communication and modify emotions for centuries. The study evaluated the profiles of psychological health and changes in neurohormones of adolescent females with mild depression after 12 weeks of dance/movement therapy. Results of the study found that after 12 weeks of DMT, the negative psychological symptoms were improved as well as showed significant improvements in negative psychological symptoms such as somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (Jeong et al. 2004).

Engelhard (2014) conducted a study with the intention of learning about adolescence and the experience of the body and movement in adolescence utilizing the phenomenological-qualitative method. Upon completion of the study, Engelhard (2014) suggested therapist relate to how adolescents experience their body, the expression of feelings and emotions related to the body, thoughts or fantasies about the body, body language and movement language. Engelhard (2014) also stated “because adolescence is a time when changes in the body and mind take place, it is very important that the environment be sensitive to signals conveyed by the adolescent’s body” (Engelhard, 2014, pp. 502-503).Furthermore, the dance/movement therapist should “pay attention to gaps between what the patient says about their body and the movement to enable

discussion about the experience of the body" (Engelhard, 2014, p. 503). Overall, DMT provides a restorative framework for adolescents to express their struggles in a dynamic and interactive form that is often easier for to communicate.

Dance/movement therapist Blanche Evan began her career working with children and subsequently her approach moved from educational to psychotherapeutic. Levy (2005) stated "Evan believed that children could express in movement and metaphor what they were unable to express in words" (p. 30). Evan's overall method focused on the physical warm up, functional technique, improvisation and projective technique (language & vocalization). This structure assists in building relationship between emotions and engagement (Levy, 2005). The warm up is intended to bring individuals into contact with the reality of their psychophysical selves and release tension. The essence of the warm up will help participants gain concentration that is receptive to expressive movements, feelings, and emotions. The functional technique is designed to retrain muscles to move in relation to nature's design in a rhythmic expansion and contraction. Improvisation is the spontaneous creation of form. Lastly, projection technique (language & vocalization) is used to facilitate projection through body movement. It uses statements in the context of movement where Evan would call out incomplete sentences and encouraged clients to complete them through movement (Levy, 2005).

Moore (2009) states, "Laban Movement Analysis (LMA) is a tool that can be used to refine awareness of movement, to describe actions objectively, and to encourage conscious reflection on the meaning of this dynamic dimension of human behavior" (p. 35). Laban Movement Analysis (LMA) provides a wide range of movement possibilities for individuals to improve their expressive repertoire. LMA provides a rich overview of the scope of movement possibilities where the basic elements can be used for generating movement or for describing

movement. Laban Movement Analysis was developed in the 1950s by the scientist, teacher, artist, social activist, visionary, and a creator named Rudolf Laban. Laban created LMA to provide movement analysis for the witness as well as the mover. With the exploration of movement analysis, dance/movement therapy benefits from the application of movement observation and effort analysis on various levels. The therapist is able to notate and assess the movement patterns occurring, as well as develop insight into the inner experience of the mover (Goodill, 2005). Laban Movement Analysis is broken into four major categories: Body, Effort, Space, and Shape, also known as (BESS). The eight basic effort actions are punch, press, slash, wring, dab, glide, flick and float. In a context that captures movement dynamics, Laban focused on the awareness that human effort is a choice. In awareness of the body, Moore (2014) quoted Laban as he stated "the astonishing structure of the body and the amazing actions it can perform are some of the greatest miracles of existence. Each phase of a movement, every small transference of weight, every single gesture of any part of the body reveals some feature of our inner life" (p. 29).

Methods

The interventions used in this Capstone were implemented with the adolescent Population in a Partial Hospital program in an urban setting through the following methods.

Participants

Participants in this capstone presented with a history of major depression, anxiety, difficulty staying engaged, decreases in academic performance, aggressive or threatening behavior at school or home, substance use, withdrawal and suicidal ideation. Adolescents ranged between the ages of 12-17 years and varied with each session due to PHP's continuing enrollment and discharges.

Interventions

The Dance/Movement therapy interventions took place in the large group room in the partial hospital program. Each session lasted 90 minutes and consisted of five parts that included a warm up, release, theme development, centering, and closure. During the warm up, participants got acquainted with one another engaging in movement activities and stretching. The release allowed participants freedom to have fun and release tension. Throughout the theme development, participants processed with props, engaged in partnering, and explored the space through body awareness. The facilitator used music to assist Participants in centering back to the group. Closure included wrapping up and transitioning. Each session utilized the five part DMT session with adapted methods from Blanche Evan's projective technique, Marian Chace's mirroring and Rudolf Laban's basic effort actions.

Materials

The interventions incorporated age appropriate developmental activities for adolescents to apply and generalize in different settings. The components consisted of music, a white board, writing utensils, a clipboard, and handouts.

Procedure

The goals of the interventions were 1. Describe emotions and those around them. 2. Stay engaged and actionize words and feelings observed. 3. Observe movement patterns. 4. Discover positive and alternative ways to express and stay engaged.

Session one began with the five part DMT session which included the warm up, release, theme, centering and closure. Participants began by taking part in breath meditation, rhythm and the Laban Effort Actions (see Appendix A) activity. During the warm up, participants engaged in the shake down of the body parts counting backwards from 8 to 1. Participants proceeded to the

release section and incorporated different walks such as fast, slow, light, heavy, direct and indirect. During the theme development, the facilitator introduced effort shapes through movement and participants moved through the eight basic effort actions across the floor. Upon completion, the facilitator instructed participants to process their own experiences as well as create and share their process using three or more of the effort actions. Upon completion, participants discussed their process and demonstrated their story utilizing the efforts. Session ended with breaths and participants stating a feeling/emotion.

Session two began with a warm up led by the facilitator in which the adolescents stood in a circle, engaged in breath meditations and body awareness of each body part starting from head leading down to the toes. The duration of the warm up was 3-5 minutes each session. The warm up assisted participants in preparing for the activities, which incorporated two different methods each session. Participants were also asked to state an emotion in the beginning and the end of each session. In the release section of the session, participants embodied a tension and release exercise where each muscle experienced tightness and release of the muscles. This was repeated four times. The facilitator introduced a rhythm activity in which each participant provided a rhythm; the next participant mirrored the movement and incorporated a rhythm of their own. This continued until the entire circle had a chance to participate and the whole group completed the rhythm cohesively. Information was discussed with participants during the theme development regarding dance/movement therapy and emotions. The facilitator passed out index cards to each participant and instructed them to write two emotions that reflected what they were experiencing or feeling. The cards were later collected, shuffled and re-distributed to the participants. Each participant took turns describing the emotion nonverbally and the rest of the members named the emotion. The duration of the theme development persisted over a 20 minute

period and usually integrated two DMT interventions during the process. Upon completion of the emotions card game, participants transitioned to the centering and engaged in a creative movement exploration where the facilitator called out incomplete sentences for participants to finish with movement. The facilitator called out sentences such as “I feel sad when_____, “My mood shifts when my body feels_____, “I believe I am_____”. "My body can_____", “I'm going to ___”, "I want to be _____" and “I feel ____.” Participants ended the session by getting into the circle and engaged in deep breaths. Each participant stated a feeling/emotion and positive affirmation to express their current emotion.

Session three began with a continuation the five part DMT session as participants took part in breath meditation and awakening from the body. For the release, the facilitator introduced a mirroring activity. The purpose of this activity was to provide empathy, engagement and enhancement of emotional intentions. The mirroring continued until all participants participated and the group embodied everyone’s movement phrase to ensure connection and validation. Theme development consisted of participants filling out a “Name Game” and “I Am” worksheet (see Appendix B). Upon completion of the worksheets, participants moved “I am” statements with their bodies utilizing Evan’s projective technique.

Session four begin with breath mediations and stretching out the body from head to toe. Subsequently to the stretches, participants stated an emotion to describe how they were feeling. Afterwards, a name wave activity took place. During the Name Wave, all participants stood in a circle and the facilitator introduced her name to the group along with a gesture. Everyone repeated the facilitator’s name accompanied by her gesture. Participants discussed the “Purpose of Emotions” (see Appendix C) and “The Experience of Emotions in The Body” worksheet (see Appendix D) and were asked to complete an inspired poem based on their emotions. Upon

completion of the poems, facilitator embodied participants' inspired poems. Participants were also asked to describe how they felt while they observed their words come to life. The session ended with the facilitator playing "I Will Survive" by Gloria Gaynor. Participants moved freely, engaged in body exploration, and processed emotions to release and make external. All participants ended the session by sharing a positive word or phrase of affirmation.

Data Analysis

Unstructured data was collected and recorded to document the adolescents' pre and post intervention emotions. The facilitator's observations, adolescents' body attitudes, engagement and responses were also documented. This writer utilized the Body Attitude Coding Sheet to address these observations (see Appendix E). Upon completion of each session, the participants were asked to state an emotion and later encouraged to share some highlights from their experience.

Results

The Dance/Movement therapy interventions were completed in an effort to improve engagement with adolescents. The results were gathered after each session in which a body attitude and an emotion sheet was used to keep track of participants' body assessment and emotions from the beginning to the end of the sessions (see Appendix E). Observations and client comments were also written and collected.

Observations

This facilitator's observations of each adolescent's behavior throughout the different sections were closely analyzed using LMA. Some of the comments expressed during the session were "This is fun, let's do it again," Are we doing the rhythm activity today?" "I actually feel better," and "I feel lighter." The participants that were more engaged used movements in a

medium reach kinesphere, the spatial stress was vertical with some horizontal flares, and all body parts were active. Some of the less engaged clients presented with more bound and sustained movements. They sporadically stated comments like "Do I have to do this? "My body has the same emotion all of the time," "I don't know what that would look like," and "This is silly." Body attitude of the less engaged demonstrated retreating, enclosing and bound movements. The kinesphere was near reach.

Movement Responses

Not all of the adolescents in the Partial Hospital Program are inclined to movement. Therefore, this facilitator gradually implemented DMT interventions while meeting the participants where they were. Consequently, the adolescent's movement responses to their engagement with the interventions appeared appropriate and applicable to the impact of dance/movement therapy interventions used. Using Laban Movement Analysis, clients were observed using recurring gesture, posture, merger as well as frequent upper body movements. Most of the Participants demonstrated a vertical posture during the session. During the projection intervention, some of the clients presented with arc like movements and some moved through the space with lightness using direct and indirect movements. All participants were in the awake, rhythm, stable, and mobile state in each session. The drives shifted from action in which movements were practical, to vision in which movements were out of body.

Many of the clients resonated with each other's stories and offered feedback and encouragement. The facilitator prompted participants' to engage and interact and one of the experiences shared was "I never get to be silly and just dance." Another participant stated "This is actually fun, I'm going to take the sheet home." During the Laban Efforts activity, one participant stated "This is me punching and fighting with my anger, I came to terms with my

situation and pressed and pushed away my depression. I used the flick to free me from my anxious moments and I slashed to keep negativity out of my way." Not all participants stayed fully engaged however, utilizing dance movement therapy as emotional expression and engagement gave participants' new patterns and a new awareness to their emotional state.

Closing Session

At the end of each session, the participants were asked about their overall experience. They were asked to state a positive affirmation and they were asked if their emotion improved from the first session to the last. All 8 of the participants described the sessions as informative; another participant stated "I love doing therapy outside of the box." Some participants mentioned they were reluctant in the beginning but were less anxious and more willing towards the end. Overall, all participants referred to the interventions as different. The clients really enjoyed the Laban effort actions and asked questions pertaining to generalization. Many walked in the room the last session and asked "Are we moving?"

Emotional Change Results

Of the eight participants, three adolescents indicated feeling different, better and wanting to be more engaged. One shifted from apathy to okay, another moved from sad to content, reluctant to willing, tired to good, and one participant stated feeling no change from the beginning of the session until the end. One participant reported feeling anxious and overwhelmed and ended session still feeling anxious. Overall, the majority of the adolescents classified their emotions as different from before engaging in the dance/movement therapy interventions sessions.

Discussion

In agreement with the literature (Bolton Oetzel & Scherer, 2003), this writer's results show that while adolescents in a Partial Hospitalization Program may experience difficulties with depression, and anxiety, the use of creative arts and dance/movement therapy is important as it leads to the expression of creativity in healthy and actualizing ways. An important factor is that movement allows adolescents to express their conflicts in an active, behavioral form that is often easier for them to communicate (Bolton Oetzel & Scherer, 2003). The results provided effective evidence of the use of dance/movement therapy interventions and structured activities, adolescents are more likely to be engaged in treatment. Among the eight adolescents who participated in the study, only one indicated no change.

Results showed that Laban efforts actions can enlighten engage and inform on a perceptual level of processing. The LMA elements were used effectively during sessions as indicated by the efforts used. The heavy, bound, slow and direct elements were used to demonstrate experiences such as depression, trauma, scars, anger, and anxiety. Elements like light, quick, free and indirect were used to demonstrate freedom and the desire to change. This method demonstrated the use of dance/movement therapy in a PHP where clients had the opportunity to acknowledge and express their emotions properly, as well as gain alternative ways to stay engaged in treatment. This finding supports the research that states "Movements activate an interactive process between one's outward expression and inner feelings/thoughts, and serve as a gateway between one's inner and outer world" (Lee, 2014, p.400).

Further study with dance/movement therapy interventions has demonstrated its effectiveness with engaging adolescents. The outcome of utilizing dance/movement therapy interventions with adolescents at the Partial Hospital Program further supports research with

adolescents such as the finding of Lentz et al. (2014) that participants in a PHP demonstrated positive, desired change over time. For individuals whose symptom severity and level of functioning have created an overall low sense of well-being, PHP programs may provide the structure and support that are required to promote adjustment and resilience. Engelhard (2014) affirmed that "movement in a safe and nurturing environment can, in therapy, be a transformative psychosomatic experience allowing the adolescent to dream feelings, emotions and thoughts, to express them and to know their significance" (p. 502).

There are articles, books and research that underline the effectiveness of dance/movement therapy with adolescents. However, research pertaining to adolescent engagement should expand and develop. In upcoming research, there is space to explore this study in different settings with individual sessions and with participants of all ages. Further findings may provide practical and effective research for healthcare providers, school, and mental health workers with creative engagement methods valuable for adolescents.

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Appendix A

Laban Basic Effort Actions

LABAN

Laban's Eight Efforts

THE EIGHT EFFORTS:

Punch, Slash, Dab, Flick, Press, Wring, Glide, Float

THE FOUR COMPONENTS:

Direction: Direct or Indirect

Speed: Quick or Sustained

Weight: Heavy or Light:

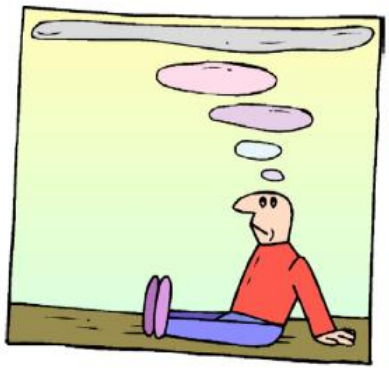
Flow: Bound or Free

	DIRECTION	SPEED	WEIGHT	FLOW
PUNCH	Direct	Quick	Heavy	Bound
SLASH	Indirect	Quick	Heavy	Free
DAB	Direct	Quick	Light	Bound
FLICK	Indirect	Quick	Light	Free
PRESS	Direct	Sustained	Heavy	Bound
WRING	Indirect	Sustained	Heavy	Bound
GLIDE	Direct	Sustained	Light	Free
FLOAT	Indirect	Sustained	Light	Free

Appendix B

I Am

I Am...



Emotional self-awareness is the ability to recognize one's feelings. In the spaces below complete each statement based on how you feel. Use the blanks to add your own feeling words.

Example:
I am most happy when _____.
I feel embarrassed when _____.
I think negative thoughts about myself when _____.

I am _____ when _____.
I feel _____ when _____.
I think _____ about _____ when _____.

I am _____ when _____.
I feel _____ when _____.
I think _____ about _____ when _____.

I am _____ when _____.
I feel _____ when _____.
I think _____ about _____ when _____.

I am _____ when _____.
I feel _____ when _____.
I think _____ about _____ when _____.

Finish this statement: I think the world needs...

Appendix C

Purpose of Emotions

Purpose of Emotions

What is the purpose of emotions? What do they do for us? They certainly have a significant effect on us, but what is it all for?

Motivation

First of all, motivations are 'e-motions'. They act to motivate us. Without emotions we would probably not do very much and hence would not survive - at least in the evolved form we are in now.

Motivations are felt in the body. Our muscles tense or relax. Our blood vessels dilate or contract. When we feel emotionally, we also feel physically. Our emotions can thus make us feel uncomfortable or comfortable, sending us signals to do something urgently or to stay in our comfortable state.

Internal signals

Internally, for example when we are trying to make understand something or make a decision, we use our emotions to deduce whether what we have concluded is a good idea. Self-Perception Theory and the Cognitive Appraisal Theories of Emotion explain how we deduce our emotions by watching ourselves.

When we think about something that contradicts our values, our emotions will tell us that it is bad. When we think about something that could hurt us, our emotions will tell us that this is not a good idea. Just by imagining what might happen, our emotions are still triggered and hence let us make better decisions.

Social signals

We generally wear our hearts on our sleeves as our inner emotions are displayed on our outer bodies. Our faces, in particular, have around 90 muscles, 30 of which have the sole purpose of signaling emotion to other people.

Signals are generally very useful, as they help others decide how to behave towards us. If someone is looking angry, then attacking them is probably not a good idea. If they are looking afraid then you could attack them or you could help them and thus earn their gratitude.

So what?

You can use emotions to motivate people. Connect good emotions with what you want them to do, and bad emotions with what is not wanted.

Respond to the signals you see in other people. Also notice how what you do affects those emotions, thus connecting what you do with a real inner effect on them.

Also watch your own emotions. They are signals that tell you something about what is happening in the inner you. This can be very useful as we often do not realize what is going on in that deep, dark subconscious inside of us.

Positive and negative emotions

There are more negative emotions than positive emotions. We can feel fear, anger, shame, hate, and yet beyond a basic happiness and joy, there are few other positive feelings. A reason for this is because most emotions are designed to keep us alive. They signal warnings and prompt us to act, from running away to avoiding others to fighting back.

Appendix D

The Experience of Emotions in the Body

The Experience of Emotion in the Body

How do you know you are happy, sad or feeling any other emotion? A particular way we know is how we feel, physically, within the body. So what are those feelings and where do we experience them?

Nummenmaa et al (2012) produced an innovative 'heat map', showing where emotions are experienced and the intensity of the feeling. This was done by offering subjects emotional words, stories, movies and facial expressions and then asking them to identify the emotion and bodily sensations they experienced.

Emotion	Location and intensity
Anger	Fairly evenly across upper torso, head and arms. Hottest in heart, hands, face. A little sensation in lower legs.
Fear	Warm across upper torso with some in lower torso. A little in arms and less in legs. Some in head, but not lower face.
Disgust	Lightly warm upper body, head and hands. Hottest in lower face and lower abdomen.
Happiness	Warm all over body. Hottest in heart and head and some down the arms.
Sadness	Cold arms and legs, especially lower legs. A little heat in heart, neck and eyes.
Surprise	Slightly cool legs. Warm chest and head. Warmest around eyes.
Neutral	Just a little coolness around armpits.
Anxiety	Hot torso with hottest around heart. Some warmth in head. Some coolness in legs.
Love	Hot upper body, especially around heart, face and groin. Warm arms with a little warmth running down legs.
Depression	Cold legs and arms, with some coolness in head and lower abdomen.
Contempt	Heat only in central upper torso, hot only in face. Some coolness around groin.
Pride	Hot upper body with most heat around whole upper torso and face. Some warmth in arms
Shame	Some warmth through torso. Warm head and hot cheeks. Coolness in arms and legs.
Envy	Some warmth in upper torso. Greatest warmth in head. A little coolness in legs.

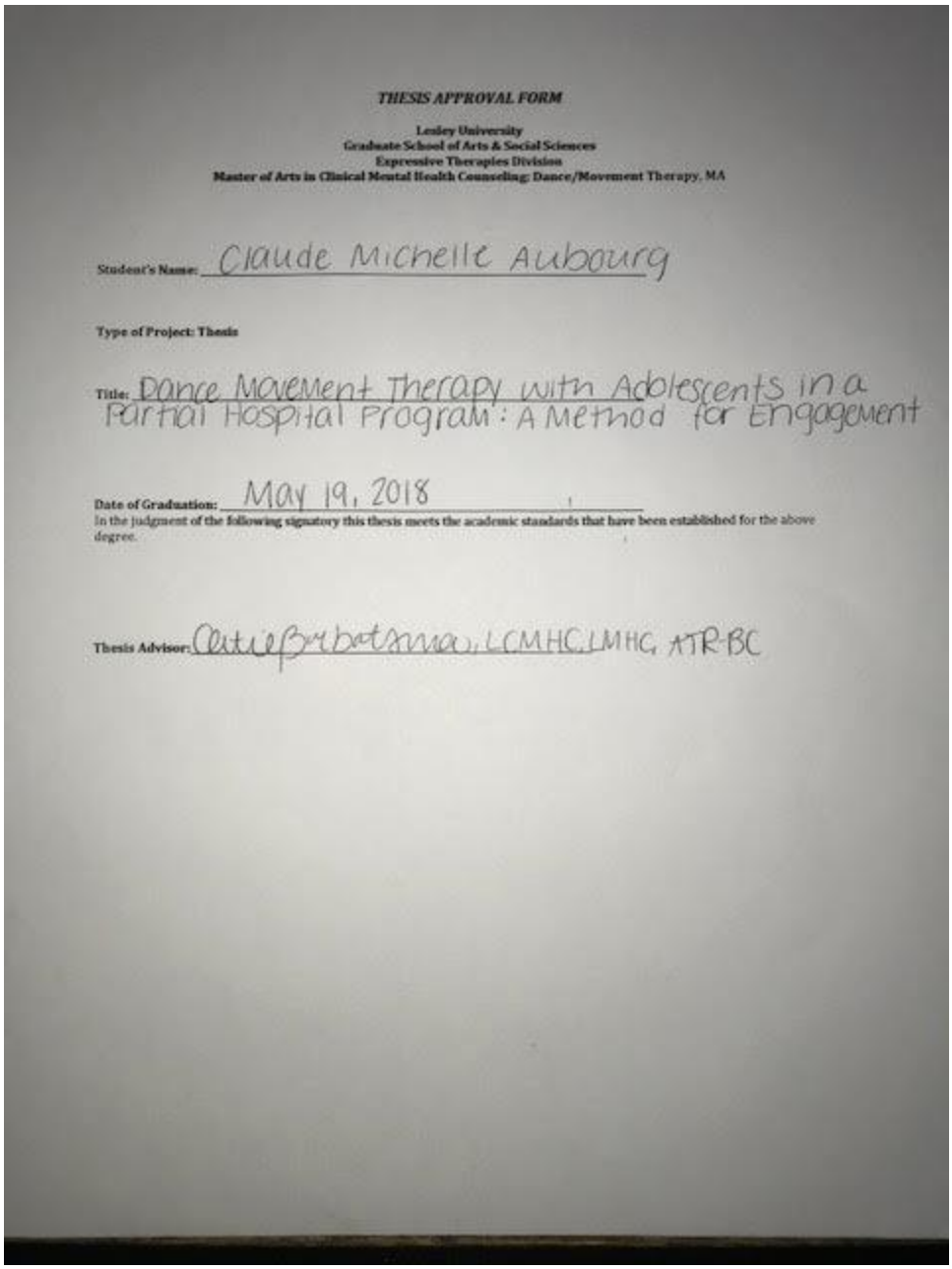
Appendix E

Body Attitude Coding Sheet

Body Attitude Coding Sheet

Name:_____ Date:_____ Context:_____

Body	Tally	Notes
Breath		
Kinesphere		
Far Reach		
Near Reach		
Medium Reach		
Posture/Gesture		
Gesture (distal)		
Posture (torso)		
P/G Merger		
Spatial Stress		
Vertical		
Horizontal		
Sagittal		
Active/Held		
Body Parts Held		
Body Parts Active		
Fundamentals		
Head/Tail		
Heel/Coccyx		
Scapula/Arm		
Thigh/Pelvis		
Diagonal (upper-lower)		
Body Half		



THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Dance/Movement Therapy, MA

Student's Name: Claude Michelle Aubourg

Type of Project: Thesis

Title: Dance Movement Therapy with Adolescents in a Partial Hospital Program: A Method for Engagement

Date of Graduation: May 19, 2018

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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