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FINDING THE RHYTHM IN DANCE/MOVEMENT THERAPY: THE USE OF TAP
DANCE IN RESIDENTIAL TREATMENT

Alexandria D'Aurio

Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Dance/Movement Therapy and Counseling Department

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Abstract

This thesis project was inspired by this researcher's passion and interest in rhythm and more specifically tap dance. There is currently no literature on the use of tap dance in dance/movement therapy. The project was guided by the research question: How can tap dance be used as a dance/movement therapy (DMT) technique? By combining tap dance and dance/movement therapy the purpose of this thesis is to provide the DMT community (clients and dance therapists) with more knowledge and tools to use for facilitation and to further deepen the process in DMT sessions. The research will be presented in a clinical case study, with data collected from 10 weeks of sessions with two participants. The data takes the form of clinical notes and personal journal entries. Results show that the tap dance based DMT group helped to create group cohesion, a strong therapeutic relationship between therapist and clients, courage and self-expression. The clinical work was presented in a tap dance performance at an annual residential talent showcase.

Acknowledgements

I would like to thank my clients for being a part of this group. They allowed me to share the gift of tap dance with them and they were a part of making my dream of using tap dance in DMT come to life. I am also grateful for their permission to write about our journey together, as therapist and clients, as my thesis project.

I would also like to thank my advisor, Laura Allen, for her work and dedication to my project. As well as thank Andrea Brown for being my reader. Without the two of you my thesis would not be what it is today. Thank You.

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Chapter One: Introduction

When I began the dance/movement therapy and counseling (DMT&C) program at Columbia College Chicago (CCC), I entered the program as a student, dancer, and dance teacher. The terms, concepts, ideas, theories, and practices that I learned during my time in the program allowed me to leave CCC a novice dance/movement therapist who wants to work in the field of trauma. Prior to the program, I identified myself as a student who loved to learn; a tap dancer and teacher who enjoyed teaching tap to children and other individuals; and as a person interested in human movement, behavior, relationships and interactions. Through the program and my internship at a residential treatment facility I was able to put all of these interests and talents to use by creating a tap dance based dance/movement therapy group to lead and write about as my thesis project.

As a graduate student in dance/movement therapy (DMT), I learned that the technical definition of dance therapy “is the psychotherapeutic use of movement to promote emotional, cognitive, physical, and social integration of individuals” (ADTA, 2009). In her unpublished master’s thesis, Pavelka (2007) further explains that “DMT utilizes movement and the physical experience to integrate body, mind, and spirit” (p.1). Both of these definitions resonated with me and my work as a DMT intern during my second year of the program. See Appendix A for a full definition of dance/movement therapy.

As a student in the program I learned about DMT and its foundation in modern dance. In addition, I studied Laban Movement Analysis (LMA), including Laban’s approach of analyzing movement through the categories of Body, Effort, Shape, and Space. Included in Appendix A is a complete definition of LMA. Throughout my studies,

we practiced applying these concepts to DMT interventions and observations of clients, counseling skills, using performance as therapy, and many other DMT based concepts. The key counseling and DMT concepts that I focused on in my clinical work, and which are essential to this research, include: (a) grounding, (b) modulating, (c) self-regulation, (d) mindfulness, (e) organic movement, (f) body knowledge, (g) kinesthetic empathy, (h) kinesthetic (body) memory, (i) movement affinities and dis-affinities, (j) movement patterns, and (k) body part usage (See Appendix A which includes a complete list of the afore-mentioned terms and their definitions).

When it came time to choose an internship placement, I knew that I was interested in working with adolescents and trauma. I interviewed at a residential treatment center with a dance/movement therapist who would be my on-site supervisor. During the interview, I told her about my interest in movement, wanting to work with the adolescent population, and how much I would like to be able to somehow incorporate tap dance into my experience as an intern.

At my internship site, dance/movement therapy was called movement therapy. During sessions I often explained the difference between movement therapy and dance group (which also took place at the treatment center). I explained to the clients that movement therapy was a way for them to freely express their thoughts, ideas, feelings and emotions without having to put them in words. I would further explain, that while we would be dancing, moving, and choreographing in sessions, it would be different than dance group. The difference was that verbal processing was included both during the session and at its conclusion.

The field of DMT recognizes a few women as its founders. One of these founders is Marian Chace. I chose to use Chace's concepts as my theoretical orientation because I felt the most comfortable with it. Chace's work was organized into four main classifications: (a) body action, (b) symbolism, (c) therapeutic movement relationship and (d) rhythmic activity (Chaiklin & Schmais, 1979; Levy, 2005). Her concepts regarding interpersonal relationships can be attributed to her mentor, Harry Stack Sullivan, a prominent social psychologist. These concepts can be found in much of Chace's theoretical work.

Similar to Chace and Stack Sullivan, my clinical orientation was based on ideas of interpersonal connection. I found this through Carl Rogers' concept of client-centered therapy (Gatongi, 2007). I believe in giving choices, following the clients' lead and holding the space. I strive to guide the client to discover their own pathways and find the key to their treatment and healing. My practice works well with Rogers' approach to therapy because as Barnard (1984) stated "the client is empowered to take control over his own healing" through an open and accepting relationship with their therapist (p. 27). Furthermore, in client-centered therapy, healing is seen as something that originates from the client (Barnard, 1984). The therapist is there to accompany the client through their journey and their process. For this reason, the therapist must choose what techniques are appropriate and useful for the client as an individual (Clarke, 1994).

In each session I led, I kept in mind my own therapeutic concepts (as mentioned above) as well as Rogers' core concepts. These consisted of empathy, (the therapist's attempt to enter the clients' world, learn and know that world), congruence (genuineness), and unconditional positive regard (non-judgmental, warmth, acceptance)

(Gatongi, 2007). Leading from a pure and genuine place of openness and acceptance of the client is why client-centered therapy is my clinical theoretical framework.

Throughout my life, dance and movement have always been my outlet for expressing my feelings, thoughts, and ideas. It has been my passion and my comfort for as long as I can remember, and it continues to be today. As a dancer, tap dance has always been my passion. From being in the DMT program, I have come to learn that I use tap dance as a way to stay grounded in my body, to self-regulate, to express my feelings, to access effort qualities and body connectivities, to engage in movement and dance, and to have fun.

Throughout my study of DMT, I learned how much dance and movement affect everyday life, including one's choices, mood, feelings, thoughts, ideas, and creativity. I became curious if the positive influence tap dance had on my life would have the same effect on the lives of others as well. When it came time for the thesis process I decided to use the tap dance group I had recently begun at my internship for my study. I made this decision because I was curious about how tap dance can be used in DMT as a technique for interventions in sessions.

For my on-site movement group I focused on Chace's concept of group rhythmic activity which occurred throughout the session in the form of tap dance. This was because "the power of group rhythmic action was used by Chace to facilitate and support the expression of thoughts and feelings in an organized and controlled manner" (Levy, 2005, p. 22). Chace (1993) continued to say "our real lives are lived in rhythm and movement" (p. 326).

In the realm of non-verbal behavior, children who have experienced abuse and trauma can be overly intrusive on others' space or be very withdrawn. They do not allow others into their personal space easily because they feel they have been violated and there is the threat that it will happen again if another person gets too close. These children also often experience tension through their bodies and facial expressions. (Goodill, 1987).

“Any student who moves rhythmically can release tension, both physically and psychologically, and thus derive therapeutic benefit” (Boswell, 2005, p. 416). Rhythm is used often in therapeutic settings, usually consisting of drumming, clapping, stamping, in music and other ways. However, there is no current research in the field of DMT that mentions using tap dance to facilitate rhythm, as an intervention in therapy sessions.

“Rhythm not only organizes the expression of thoughts and feelings into meaningful dance action, but also helps to modify extreme behaviors, such as hyperactivity/hypoactivity or a tendency toward the use of bizarre gestures and mannerisms” (Levy, 2005, p. 22-23). For this reason further study and research on the use of rhythm in DMT groups is beneficial to the field itself and the dance/movement therapists who are working with clients.

Rhythm is the basis for human interaction and group activity (Goodridge, 1999, p. 39). Through rhythmic activities there is the freedom and safety in therapy where “...patients may freely express their basic emotions through rhythmic action” (Chace, 1993, p. 219).

The clients at the residential treatment facility have experienced traumatic events which can be defined as physical abuse, sexual abuse, and neglect. The behaviors that are exhibited by children who have experienced trauma are reflective of their experiences.

Most children who have experienced abuse and trauma are categorized as aggressive, withdrawn, immature or overly mature, defensive, hypersensitive to touch, mistrustful, and depressed (Goodill, 1987).

Many of the clients at my internship site struggled with the ability to self-regulate. I hypothesized that tap dance maybe a beneficial intervention for such clients. I had this idea because tap dance is organizing, through rhythm and grounding through weight (definitions of these concepts can be found in Appendix A). Tap dance can also be an outlet for self-expression, group cohesion, and the opportunity to learn a new dance style. I decided upon the research question: how can tap dance be used as a dance/movement therapy technique? The research question I have developed to guide this research is valuable to the field of DMT because to my knowledge tap dance has not been used in DMT. Exploring tap dance as an intervention with clients will be beneficial to the field of DMT for use in assisting clients to experience rhythm state, stable state, grounding, connectivities and self-regulation (See Appendix A). It is unclear to me why tap dance has not been used in DMT to date. I can only guess that because DMT is based in modern dance that is the movement form that most dance therapists use to facilitate sessions. I also wonder if tap dance is not widely used because there are not many dance therapists who are trained in tap dance.

As my internship site was a residential treatment center for children and adolescents who were diagnosed with posttraumatic stress disorder (PTSD) and behavioral and emotional difficulties due to severe abuse and neglect, I chose to focus my literature review on the areas of trauma, dance/movement therapy with trauma, and the use of rhythm in the treatment of trauma.

Chapter Two: Literature Review

Trauma

What is trauma?

Concretely defining trauma has been a difficult task. Something that may be considered traumatic for one person may not be for another. Aposhyan (2004) stated “trauma can be defined as anything that overwhelms the organism, physically, mentally, or emotionally” (p. 252). Levine (1997) stated that among mental health professionals a trauma diagnosis may be caused by a “stressful occurrence that is outside the range of usual human experience, and that would be markedly distressing to almost anyone” (p. 24). People who have experienced trauma have been subjected to damage to the basic structures of their self (Herman, 1992). Experiences are not innately labeled as traumatic or non-traumatic; it is how the individual reacts toward them that define things as traumatic (Aposhyan, 2004).

Components of trauma.

For a person who has experienced trauma, there are four components that are present to some degree. These include (a) hyper-arousal, (b) constriction, (c) dissociation, and (d) freezing (immobility), often associated with a feeling of helplessness. When these components appear together they form the core of a traumatic reaction. These components are the first to appear in the body when a traumatic event occurs (Levine, 1997).

As the nervous system’s response to threat, hyper-arousal (American Psychiatric Association, 2000) occurs when one experiences an increased heart rate, agitation, tension, difficulty sleeping, racing thoughts, jitters, and even an anxiety attack. During

hyper-arousal, when the above sensations occur, it is usually a signal from the body that its energetic resources are preparing to mobilize against a potential threat that might present. Furthermore, hyper-arousal usually cannot be controlled voluntarily and is the accelerator for the nervous system (Levine, 1997).

Constriction will alter breathing, muscle tone, and posture as to ensure that every effort has been made on behalf of the nervous system to allow complete focus on the threat. During this process, blood vessels in the skin will often constrict to ensure the maximum amount needed can be sent to tensed muscles to prepare for defensive actions (Levine, 1997).

Dissociation protects the person from the impact of the traumatic event and from any escalating arousal. In a traumatic event, dissociation appears to be the key component for the person to endure the experiences that are happening in the moment. Experiences which otherwise would be unbearable for a person. During dissociation, there are numerous possible splits that may occur. These can be between the consciousness and the body, one part of the body from the rest of the body, the self from emotions, thoughts, or sensations, or the self from the memory of the event (Levine, 1997).

The last component, freezing, is also known as a state of helplessness. “Helplessness is closely related to the primitive, universal, biological response to overwhelming threat – the freezing response” (Levine, 1997, p. 142). When a person is feeling extreme helplessness, the body cannot move, scream, or feel. It may seem as if paralysis has set in. (Levine, 1997). While components of traumas often occur during the traumatic event as a response; symptoms of trauma occur after it.

Symptoms of trauma.

The first symptoms from a trauma will usually appear shortly after the event and can recreate or even mimic the actual traumatic event. “Trauma symptoms are energetic phenomena that serve the organism by providing an organized way to manage and bind the tremendous energy contained in both the original and the self-perpetuated response to threat” (Levine, 1997, p. 147).

Levine listed some of the symptoms of trauma, that may include but are not limited to: (a) flashbacks, (b) anxiety, (c) panic attacks, (d) insomnia, (e) depression, (f) psychosomatic complaints, (g) lack of openness, (h) violent unprovoked rage, (i) attacks, (j) repetitive destructive behaviors, (k) extreme sensitivity to light and sound, (l) abrupt mood swings, and (m) reduced ability to deal with stress (1997, p. 41 & 147).

Dissociation is often the most common symptom of trauma. While some symptoms may suggest the type of trauma that occurred, there is no one symptom that is only related to a specific trauma.

“In trauma the organism often reverts back to more primitive patterns of accommodation and adjustment” (Hackney, 2000, p. 22). If this occurs it could be a sign of trauma. There is no one symptom that is exclusive of a particular type of trauma. All symptoms can be present (or not) for any type of occurrence of trauma.

Different kinds of trauma.

To further understand trauma, it is important to identify the different types of traumas that are possible and that a person can experience in his/her life. They include: (a) natural disasters (such as earthquakes, tornadoes, floods, and fires), (b) exposure to violence, (c) abuse, (d) neglect, (e) accidents, (f) falls, (g) serious illness, (h) sudden loss

(of a loved one), (i) surgical and other necessary medical and dental procedures, (j) difficult births, and (k) high levels of stress during gestation (Levine, 1997, p. 19). Knowing and understanding all of the different types of trauma that can occur is imperative to help and assist the person who has experienced trauma. Every person reacts differently to an event that could be considered traumatic and it is the person's reaction to the event that classifies it as traumatic or not (van der Kolk, 1996).

Post-traumatic stress disorder (PTSD).

Schiraldi (2000) stated PTSD often results from an overwhelmingly stressful occurrence. These can include war, rape, or abuse. The Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2000) classifies PTSD as an anxiety disorder. According to the DSM the essential feature in identifying and diagnosing PTSD is "the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury" (p. 463).

A person can also experience trauma if actual or threatened death or serious injury is not directed towards them but to someone they are close to, such as a loved one or child. Trauma can also occur if a person is a witness to someone being physically injured, death, another's integrity threatened, and learning about an unexpected death or violent act against another (American Psychiatric Association, 2000).

Schiraldi (2000) breaks down the DSM criteria for a PTSD diagnosis into the following three categories: (a) intentional human (man-made, deliberate, malicious), (b) unintentional human (accidents, technological disasters), and (c) acts of nature/natural disasters (p. 5). An intentional human stressor would encompass civil war, abuse

(physical, sexual, emotional), rape, torture, hostage, bombing, robbery, family violence, and violent crimes. Unintentional human stressors include fires, explosions, nuclear disaster, and transportation accidents. Lastly, acts of nature/natural disaster stressors are elements such as hurricane, earthquake, tornado, avalanche, animal attack, heart-attack, and loss of an unborn child (Schiraldi, 2000, p. 5).

PTSD can occur at any age and symptoms usually present within the first three months after the traumatic event. Severity, duration, and proximity of the person's exposure to the event are the most important key factors to take into consideration when diagnosing a client with PTSD. Furthermore, the person's response to the traumatic event must include feeling intense fear, helplessness, or horror (American Psychiatric Association, 2000).

Children with trauma.

During childhood abuse, attachment bonds have been severed between the child and his or her caregiver. When this occurs, healthy emotional growth becomes nearly impossible (Hugill, n.d.). A child who is trapped in an abusive environment must discover ways to adapt. To adapt, the child must look for ways that he can trust those who are untrustworthy. He must also find a way to establish safety in unsafe situations and maintain a sense of control in circumstances that are unpredictable and terrifying. Lastly, the child must learn a way to keep his power in situations of helplessness (Herman, 1992).

Children who have been in long-term abusive situations develop a state of alertness; they are constantly watching out for and scanning for any warning signs of attack (Herman, 1992). Children who have been in these types of abusive situations have

an incredible ability to read people's non-verbal movements. They become experts in any subtle movement shifts or changes in people; such as shifts in facial expressions and voice (Herman).

If a person has experienced ongoing abuse during their childhood they are at risk to suffer from "developmental trauma" (Levine, 1997, p. 10). This specific type of trauma refers to issues that are psychologically based. They may have resulted from inadequate nurturing and guidance from care-takers during critical developmental periods of childhood (Levine).

Three ways a child could adapt during times of trauma include dissociation, fragmented identity, and regulation of emotional states (Herman, 1992). During dissociation the child will wall off the abuse from conscious memory, as if to trick the mind into thinking it did not exist. Also, children learn to ignore severe pain, hide their memories, and alter their sense of time, place, or person. Creating a fragmented identity of oneself includes developing personalities with their own names, functions, and even memories. Altering their personalities allow the child to cope during times of abuse. Emotional states of children who have been abused can range from unease, anxiety, dysphoria, panic, fury, and despair (Herman). In any of these emotional states, emotional dis-regulation can occur. These states can often evoke a response of perceived threat and/or abandonment in a child who had been abused (Herman). The "three major forms of adaptation – the elaboration of dissociative defenses, the development of a fragmented identity, and the pathological regulation of emotional states – permit the child to survive in an environment of chronic abuse" (Herman, p. 110).

Children who have experienced physical, sexual, and emotional abuse often have trouble developing a healthy embodiment of their self and difficulty experiencing safety in their bodies. Lasting effects of these particular traumas may leave the child feeling helpless, hopeless, and filled with shame. The child's ability to self-soothe and self-regulate is also in jeopardy, as well as his/her ability to ground himself (Hugill, n.d.).

How trauma can affect the body.

The central nervous system is biologically conditioned to either fight, flight, or freeze when a trauma has occurred (van der Kolk, 1996). Once the trauma, or crisis, is over the autonomic nervous system can regulate itself by adapting bodily responses. These responses may include breathing, shivering, or crying. Often, adults can control or repress their adaptive defensive reactions to a trauma that has occurred. They may do this by not fighting back or fleeing. Physiological responses can also be repressed or controlled by not shaking or breathing freely. When bodily reactions and responses have not been fully expressed, the autonomic nervous system is unable to complete its own physiological process. This results in posttraumatic stress and the nervous system continuously repeating the cycle of trauma over and over until it is resolved (Aposhyan, 2004).

To study how trauma affects the body, we must first understand how the body is affected during a traumatic event. This is a key component in healing the aftermath of a traumatic event. Levine (1997) reports "the body reacts profoundly in trauma. It tenses in readiness, braces in fear, and freezes and collapses in helpless terror" (p. 6). Furthermore, any subtle sensations, rhythms, and movements are key elements and important in the

recognition of symptoms and they are just as important as large obvious movements (Levine, 1997).

From her research in the field of sensorimotor therapy, Pat Ogden (Ogden, Minton, & Pain, 2006) recognized that the body is profoundly affected by trauma. These effects are manifested in the body as a whole and in the nervous system. Therefore, many symptoms from trauma are somatic. “For traumatized individuals, the debilitating, receptive cycle of interaction between mind and body keeps past trauma ‘alive,’ disrupting the sense of self and maintaining trauma-related disorders” (Ogden et. al., 2006, p. 3).

After clients have suffered a traumatic event they are often left with trauma that has been unresolved. When this has happened, clients will often report an un-regulated body experience, and uncontrollable emotions and physical sensations (Ogden et. al., 2006, p. xxviii). Through therapeutic work, clients are able to regain a sense of control over their life, mental state, emotional state, and self. They begin to learn how to self-regulate and re-organize their nervous system (Levine, 1997).

Treatment and recovery of trauma.

Before treatment for trauma can occur, its symptoms must be recognized. Traumatic symptoms can be difficult to recognize because they are often the result of primitive responses to the occurrence (Levine, 1997). Some symptoms that have been caused by a traumatic event can mimic or recreate the event that originally caused them. Therefore, the healing process includes the ability for the client to recognize their response to the trauma and the symptoms that accompany it (Levine, 1997). For a client to begin to heal from his or her trauma, he must get in touch with any bodily sensations,

thoughts or actions that may be from the traumatic event. The client must develop the ability to identify any symptoms he might have that are trauma related. Once this has occurred, the client can begin the healing process.

Recovery from trauma unfolds in three stages: the establishment of safety, remembering and mourning, and reconnection with ordinary life (Herman, 1992, p. 155). While these stages are merely a guided path for clients to perhaps follow; no recovery moves linearly from stage to stage nor does recovery absolutely happen according to these stages. “Establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment” (Herman, 1992, p. 160).

Defining personal space is important in the treatment and recovery of trauma. Empowering the client to say who is allowed into their personal space is important for recovery. This will support clients in regaining control of their bodies and communicate to others when they feel uncomfortable. It is important for clients to become assertive, speak out, and say no (Goodill, 1987).

While working in psychotherapy with clients who have experienced trauma and have posttraumatic stress, the main tasks of therapy include: (a) creating basic coping skills, (b) supporting healing and development without reactivating the trauma, and (c) allowing the trauma to be slowly and safely renegotiated once sufficient healing and development have occurred (Aposhyan, 2004, p. 71).

Dance/Movement Therapy

Movement is a natural form of human expression and can be utilized to express feelings, thoughts, emotions, ideas, passions and any other element of life. Chace (1993)

provides a succinct definition of dance therapy: “dance therapy is making use of the most basic movements expressive of emotion” (p. 263).

“Man has made use of art forms...dance – as a means of communicating his inner feelings about himself and his environment” (Chace, 1993, p. 199). Dance/movement therapy guides clients to utilize the power of movement. Movement gives clients opportunities to open channels of expression and communication. This is accomplished through rhythms, music, improvisation and other techniques that create stimulation. Movement and the expression of feelings through movement is the raw material that makes up the clients’ past and personal experiences (Espenak, 1981).

Most DMT sessions begin in a circle and end in a circle. This shape is important to the therapeutic process and use of movement in therapy because it provides stability to the clients. The circle also allows for the opportunity for clients to feel equally connected to one another. The therapist leads the clients to engage in spontaneous self – expression and interaction with each other (Hugill, n.d.)

Many art forms can be used to express feelings. However, dancing and movement include the activation of the body, which is an essential part of our selves; where art is offered from inside out the body out to the world. Furthermore, non-verbal communication is the baseline for human relating (Chace, 1993). Within the therapeutic setting, clients have the opportunity to express thoughts and feelings without the added worry of how they may sound. Their movements are open to interpretation by themselves and the therapist. Clients have the opportunity to explain their movements if they choose to do so.

“Unconscious muscle contractions throughout the body are constantly expressing feeling. Dance therapy is making use of the communication that is constantly occurring between all people” (Chace, 1993, p. 262). This allows for relating to each other and for relationships to be formed, both are key aspects of successful therapy. “The majority of human communication is not through verbal language but rather through the body language: facial expression, eye contact, movement, behavior, posture, autonomic arousal, gestures, muscular tension, and so forth” (Ogden, 2006, p. xxxiii).

The role of the therapist in a DMT session is active. Therefore, through movement the therapist is able to: (a) influence the content of the movement toward therapeutic goals, (b) model the many movement possibilities that are available to the client, (c) open the communication pathways on a pre-verbal level, and (d) engage the client by modeling how desirable and important movement and the expression of feelings through movement is (Payne, 1992, p. 64). Interventions facilitated by the dance therapist facilitate expression of the experience in session and the overall experience that the client is presenting with. From here, themes arise and are worked on based on therapeutic objectives.

DMT with Trauma

“Most trauma therapies address the mind through talk...however, trauma is not, will not, and can never be fully healed until we also address the essential role played by the body” (Levine, 1997, p. 3). DMT work with people who have experienced trauma is beneficial because it provides clients with the tools they need for reconnection to their body and to their self. Many traumatized people will relive the moment of trauma over again. This does not occur only in thoughts and dream, but in behaviors as well (Herman,

1992). When beginning treatment, clients must first learn and understand exactly how the body has been affected by the trauma and that the body is the key component to healing the aftermath of trauma (Levine, 1997).

Addressing trauma on a body level includes restoring feelings of safety in the body. To create this safety, the client must identify areas in the body that feel connected and safe. Then those areas can literally provide protection and support to other areas of the body that do not feel as safe. The client will also need to identify where fear lives in their body. Then, the client can begin to start listening to those areas, allow them to express themselves instead of being repressed and reassure those fears that there is no longer any threat (Aposhyan, 2004). Helping the client to identify areas of safety as well as fear in the body can be key interventions for treating trauma through DMT.

Three important goals of therapy when working with a person who has survived trauma should include: helping the person to feel safe and stable in their self and with others, working through and integrating the traumatic memories, and fully re-engaging in life activities and relationships. Establishing safety includes increasing body awareness in a safe environment that will allow the client to notice any support that has been given to parts of the body that have not been traumatized. The client must also accept their body as a whole and develop trust in it so that information can be gathered and wisdom to be shared. Safety is also gained through the ability to connect the body and ground to the support the earth provides. To integrate traumatic memories, the client must renegotiate and integrate information and memories. This is done through dreams, images, fantasies, and feelings that are transmitted through the body in DMT sessions. Integrating traumatic memories is also accomplished by relieving tension and any anxiety of hyper – arousal,

and combining traumatic material with creative play and expression. Lastly, through the use of movement, sound, and imagination the client is able to integrate the memory of the trauma into symbols and stories and begin to discover how the meaning of the trauma is important in their lives (Hugill, n.d.).

Trauma can leave a person lost, confused, and disconnected. Through DMT there is the ability to re-connect the body and mind. “All the information that we need to begin renegotiating trauma is available to us. Our bodies (instincts) will tell us where the blockages are and when we are moving too fast” (Levine, 1997, p. 188).

Using DMT with trauma and children.

Dance/movement therapy “serves to involve the young people in a creative, relationship-building experience with the aim of definition of self” (Payne, 1992, p. 42). The use of DMT with children who have experienced trauma will assist the children in working through the traumatic event(s) on a bodily level. DMT will also allow children to express aspects of his trauma, any feelings about the trauma, and other thoughts, feelings, or actions in a way that the children may be more comfortable with using non-verbal movement. Often, children who have experienced a traumatic event will repeatedly re-create the scenario in their play (Levine, 1997).

Even if a child has been able to rationalize his abuse or remove it from his mind, the effects of the trauma continue to be registered within the body. “The normal regulation of bodily states is disrupted by chronic hyper-arousal. Bodily self-regulation is further complicated in the abusive environment because the child’s body is at the disposal of the abuser” (Herman, 1992, p. 108). When this has happened, the child’s regular cycles of sleep and awake, eating and elimination can be severely disrupted.

Payne (1992) discusses different strategies for DMT work with this specialized population. These include: (a) joining, (b) the idea of the moving therapist, (c) space, (d) the implementation of ground rules, and (e) the use of combined treatment approaches and assessment and evaluation (p. 62). Joining occurs when the client is actively joined by the therapist in the session. This is done through many different ways. One way is moving with the client and reflecting their movements by shadowing, echoing, or mirroring. Another way the therapist joins the client is to verbalize the movements she is seeing. By doing this, the movements begin to take on special meaning and are made important (Payne, 1992).

With the therapist being active and moving in the session with the client, she is able to model many of the possibilities of movement that are available to the client and create a path for non – verbal communication between herself and the client. When the therapist is moving in the session she can engage with the client by showing him that movement can be inviting and important; while influencing the content of the movement and the form that it takes. This can allow for the movement to become more creative and reach the therapeutic objectives that have been set (Payne, 1992).

Having a consistent space is a critical element to DMT sessions. Using a space that is not used for other activities so that the clients will not have any other associations with the space is important. While this can be a difficult task to accomplish, as space is often limited in treatment centers, it is one that is of great importance (Payne). A frequently agreed upon ground rule is about boundaries. Having strong boundaries is an essential aspect of any therapy with children and adolescents. Rules assist the clients in feeling safe and secure. These rules must be agreed upon by everyone participating in the

group (Payne). Using a combined approach includes the client seeing the same therapist for individual and group DMT sessions. This is useful because the group session can bring out problems that would not come out in an individual session, such as adjustment issues (Payne, 1992).

The therapeutic treatment of trauma can also be approached on a body level. Current research in the field of trauma (van der Kolk, et al., 1996) recognizes the importance of treating the body in trauma work. First the autonomic nervous system has to re-gain its regulatory balance. Then, the body's muscles and fluids can begin to let go of the shock they experienced and toward fully participating in life again (Aposhyan, 2004). It has been surmised then, that "body sensation, rather than emotion, is the key to healing trauma" (Levine, p. 12).

The therapeutic relationship.

Traumatic events can shatter a person's connection between self and world, thus creating distrustful relationships. Furthermore, in the aftermath of a traumatic event, individuals may withdraw from any close relationships they have had, while simultaneously desperately yearning for them (Herman, 1992). Therefore, rebuilding some trust with others is a primary task in the aftermath of a traumatic event. A strong and mutual therapeutic relationship between therapist and client is the necessary foundation for healing to take place so that the client may re-build their self-esteem and trust in others.

Interventions.

DMT interventions with trauma clients can assist clients with learning about and becoming aware of the different levels at which information processing occurs (cognitive,

sensorimotor, and emotional). By combining cognitive, psychodynamic, and somatic interventions the client will gain the ability to “engage the frontal lobes in mindful self-witnessing and in practicing new actions that promote empowerment and success” (Ogden et al., 2006, p. 188).

Mindfulness is another useful intervention to assist in the treatment of trauma. Through this technique, clients may become aware of how their own self-representations and emotions related to the trauma can affect their physical organization (Ogden et al., 2006). During sessions, the client and therapist work together using mindfulness to notice thoughts, sensations, emotions, and movements that are related to a traumatic experience and other experiences as well.

“With sufficient mindfulness, resources, time, interactive support of the therapist, and interactions of the movement, the client begins to manifest more adaptive movements that emanate from the core, or center, of the body and are carried out by gross motor movements, expanding the client’s capacity to fulfill his or her desires” (Ogden et al, 2006, p. 282)

Another intervention that can be used in the treatment of trauma is bringing movement to the consciousness of the client. This can be done through the use of contact statements. Contact statements are when the therapist states what she is noticing that is occurring in the client. They derive from information the therapist gathers through body-reading and tracking and occur on a bodily, cognitive, and emotional level. To accomplish this, the therapist tracks and contacts the physical process that is being communicated by the client’s body. The therapist further assists the client to make meaning out of any emotional content that was evoked from the physical content (Ogden

et al., 2006). An example of contact statements are reflecting back to the client that you notice their shoulders rising and their torso sinking as they are speaking. Bringing these movements to the clients' awareness is useful because it assists in keeping the client in the present moment (Ogden et al.). Bringing sensory stimuli into the consciousness of actions that are occurring in the moment are the main link to the here and now and to emotions (Rothschild, 2000).

Other interventions include but are not limited to: (a) grounding, (b) reconnecting body connectivities and patterns, (c) the therapeutic use of touch, (d) breath work, (e) creativity, and (f) self-expression.

Rhythm

Rhythm is fundamental of life. It is present in our selves and between people. It lives in our heartbeats, pulse, breathing, and movements. Through the use of rhythmic and dance activities, clients are provided with the tools to improve their motor skills as well as having fun and gaining valuable experiences in problem solving and creative expression.

What is rhythm?

The word rhythm means "a particular way of flowing" (Barba & Savarese, 1991, p. 211). "In dance, rhythm is usually heightened and exerts power as a motivating force which generates action and form" (Goodridge, 1999, p. 57). Rhythm has been viewed as the basis of dance. Some of the most commonly known movements which create a distinctive rhythmic pattern are swaying, swinging, bouncing, punching, and skipping (Goodridge).

Rhythmic movement is a “balancing of contracting and expanding movements that are connected and repeated...when two movements are connected and repeatedly performed, a rhythm is created” (Boswell, 2005, p. 417). When the body’s center of gravity is held directly above the hips, it promotes a steady and regular rhythm. However, when the opposite occurs and the center of gravity is tilted, it allows for a more variable rhythmic pattern (Goodridge, 1999).

In music the pulse, tempo, accent, and patterns make up a rhythm. The pulse is the underlying beat of the rhythm. It continuously repeats with each beat and takes an equal amount of time. That is unless the tempo slows down or speeds up. The pulse allows for the exploration of internal rhythms before moving to exploring external rhythms that are in sync with others (Boswell, 2005). The tempo is the speed of the rhythm. Accents are an element of rhythm that can further be used to attract attention to a specific movement. While accents can range from small movements in an isolated body part to large movements expressed by the whole body, they are important for both expressive and stylistic purposes (Goodridge, 1999). An accent occurs when there is emphasis placed on certain beats and they are responsible for the structure of the rhythm (Boswell, 2005). Rhythmic patterns create a variety in rhythm and present complexity that is not already found in pulse, tempo, or accent. A rhythmic pattern is comprised of recurring groups of beats (or movements) and each group has different tempos.

Rhythm in human interaction.

According to Chace’s work with inpatient psychiatric clients at St. Elizabeth’s hospital, rhythm and rhythmic sound are elements, when actively felt, that all clients respond to (Chace, 1993). Espenak (1981) recognized that rhythm is key in human

response and interaction. “Rhythmic patterns may turn out to be one of the most important personality traits that differentiates one individual from the next” (Hall, 1983, p. 180). Rhythm has been said to be an aspect of characterizing the quality of movement. Through rhythm, movements are given meaning and provide interactions between one another. Rhythm that occurs in human movement can be described as the arrangement of many different components into a series of patterns or into sequential patterns (Goodridge, 1999, p. 25).

“Somatic awareness is a natural dimension of human functioning...” (Bakal, 1999, p. 199). The most commonly known body rhythms are walking and the human heartbeat. Other body rhythms can include voice, breathing and pulse rate, the rate at which one performs tasks, flow between movements (smooth or choppy), and flow between interactions. “Experience of one’s own rhythms is an experience of integration of movement and emotion” (Espenak, 1981, p. 22).

Rhythm in movement.

“Of all the ingredients in...dance, rhythm is the most persuasive and most powerful element...” (Humphrey, 1980, p. 104). Dance has the ability to provide sensory-oriented and motor experiences. The first may stem from auditory stimuli in response to rhythm and the second from feelings that have been evoked by freedom of movement and a release of inner tensions (Espenak, 1981).

To begin teaching rhythmic activities, it is best to progress developmentally. Most clients and people in general need to feel rhythmic patterns while stationary before moving them through space (Boswell, 2005). First, focus on an internal rhythmic awareness, then shift the awareness to external. Next, listen to the pulse of the music

before moving to it and with it. Then, begin with movements that do not locomote before progressing to movements that do. While exploring non-locomotive movements, begin small with hand gestures before moving to other body parts and larger movements. Next, gradually increase the difficulty of concepts and directions. Lastly, allow clients to move individually, then with a partner, and finally progressing to movement with a small group (Boswell, 2005).

Rhythm in DMT.

Rhythm is often a component that is used in DMT as an intervention for organizing thoughts and movements. Using rhythm in DMT allows for the expression of body states, and the release of emotions into kinesthetically felt experiences. This can then lead to an ability to communicate emotions (Espenak, 1981). “Rhythmic and dance activities offer opportunities not only to improve motor skills but also to have fun and gain valuable learning experiences in problem solving and creative expression” (Boswell, 2005, p. 416). Thus, using rhythm in DMT allows clients to work through problems by creatively expressing the problems and trying out different avenues that can lead to solving them. This can all be achieved through using rhythmic actions and activities.

During DMT groups, rhythm is commonly used. While the clients of the group may not be consciously aware that their movements, steps, and actions have a rhythm or are being performed in a rhythm the therapist recognizes this and will bring the clients’ awareness to it. Once aware of group rhythmic action, it is used as a therapeutic tool that facilitates communication and body awareness in the clients (Chace, 1993). “The most profound catalyst in dance therapy is rhythm” (Espenak, 1981, p. 11).

The use of rhythm in DMT sessions can take many forms, such as drumming and through carefully selected music. The following sections will review such forms.

Drumming and drum therapy.

“Therapeutic drumming is a holistic activity using drumming and purposefully undertaken for the benefits which it gives. These benefits may manifest themselves physically, physiologically, emotionally, developmentally, psychologically, socially and spiritually” (Therapeutic Drumming Foundation, n.d.). Drumming is becoming a more commonly used intervention in music therapy. Group drumming has been found to promote feelings of openness, togetherness, closeness, sharing, connectedness, and intimacy (Bensimon, Amir, & Wolf, 2008).

“Drum therapy is an ancient approach that uses rhythm to promote healing and self-expression” (Drum circles, n.d.). The benefits of drumming include: (a) physical and mental relaxation, (b) stress release, (c) feeling of well-being, (d) temporarily alleviates pain and muscular stiffness, (e) clarity of thought, (f) spiritual experience, (g) social networking, (h) strengthening personal relationships, and (i) teamwork (Benefits of Drum therapy, n.d.). Using drumming has been shown to reduce tension, anxiety, and stress, help control chronic pain, produce a deeper self-awareness, access the entire brain, and create a sense of connectedness with others (Drake, n.d.).

Drum circles.

Drum circles can also promote group cohesion and interactions between participants (Bensimon et al., 2008). Drum circles require teamwork from the participants to create a synchronized rhythm (Drum circles, n.d.). Group Drumming can break down social barriers and promote freedom of expression (Alternative Depression Therapy,

n.d.). In drum circles, the drums do the talking for the participants. They are the way for feelings to be expressed, problems to be worked out, and relationships to be formed.

Music.

“Usually music follows a regular rhythmic pattern which is easy to move to. Sometimes the music speeds up or slows down but the rhythm is still metrical” (Newlove & Dalby, 2004, p. 116). Chace’s musical selection was influenced by the rhythmic aspects of it and its effects on the clients. She carefully chose music that varied in speed, rhythm, tempo, and other factors to meet clients where they were in the session emotionally and physically. She often began with waltzes and progressed based on what she saw occurring in the group between the participants. Taking note of movement qualities and interactions, Chace would choose the musical selections she thought would be best for the group in that moment (Chace, 1993).

Tap Dance as a DMT Intervention

According to the research that was available, tap dance has not been used in dance/movement therapy. Tap dance is an art form that utilizes the lower extremities of the body as percussion instruments and its intent is to create percussive sound (Mayers, Bronner, Agraharasamakulam, & Ojofeitimi, 2010). By using tap dance as a DMT technique, dance therapists are open and available to new and creative ways of facilitating interventions and creating group rhythmic activities. Some of the benefits of using tap dance in DMT sessions include: (a) accessing rhythm state, (b) accessing stable state, (c) connection to the head/tail connectivity, (d), connection to the upper/lower connectivity, and (e) promoting stability/ mobility. These goals are valuable for clients because they are essential components of rhythmic movement. They will also allow

clients to further expand their movement repertoire to create effective movement change in the therapeutic session. This change can then eventually be brought to their lives outside of the therapy room, thus promoting change in mood, relationships, and view of self.

Rhythm state is comprised of the effort elements weight and time. Stable state consists of weight and space. It is important that children who have experienced trauma have the ability to access these states for healing, body awareness, and self-regulation. Rhythm state and stable state provide clients with the increased ability to become aware of bodily sensations when they are occurring in the moment, and for self-regulation to happen on a body level through awareness and movement.

The head/tail connectivity promotes an aliveness through the spine and the core. Psychological aspects of this connectivity include differentiation, individuality, following one's curiosity and imagination, and the feeling that all things are possible and within reach. Both the head and tail (coccyx) are connected and in relationship with each other. When there is a small change that takes place in any part of the spine, it promotes the opportunity for fuller movements at the distal ends (Hackney, 2000).

In the upper/lower connectivity, whole body action is organized from either the upper body or the lower body. Generally, the lower body is used for locomotion and support while the upper body is used for connecting and creating relationships in the world. Psychological implications are at times struggling to claim one's own power and how to use it, the ability to push away from and make space for one's self, reaching out toward a goal, standing on one's own two feet, and confidence while moving in the world (Hackney, 2000). This connectivity assists with locating the center of gravity in the body

and therefore, promotes grounding. The upper/lower connectivity also promotes support, creating, setting, and pushing away boundaries, activating the lower body for forward movement, and activating the upper body for connection and relationships without losing the connection to the earth (Hackney).

For both the head/tail and upper/lower connectivities, the patterns of yield/push and reach/pull are critical interventions and phases to accomplish. The yield/push pattern is related to grounding, and the reach/pull pattern gives the ability to reach out into the world and in relation to the world (Hackney, 2000).

Stability is the stabilizing and supporting body part, while mobility is the moving body part. Movements that are executed in any of the dimensional directions promote stability, while the ones conducted in diagonal directions promote mobility (Goodridge, 1999).

Tap dance can also allow for freedom of expression and feelings by the client. The therapist can glean clues about his emotional state just by having the client walk around the room. Observing the way the client uses his weight in his tap shoes provides multitudes of information for the dance therapist. There is also opportunity to identify body parts with held tension in them while using tap dance in treatment. If a client is having difficulty executing a step it may be due to bound flow or tension in the moving body part (or the opposite may be occurring and there could be too much free flow).

One of the most important aspects of tap dance is that it allows the client to access his weight, connect to his center, and ground himself. Thus tap dance interventions can promote self-regulation, self-expression, a fuller and more expressive body, and connection to one's self.

Benefits of Rhythm in Therapy

Tap dance is rhythm. Rhythm is organization of body and ideas. The first and most common forms of rhythm are walking and the heartbeat (Newlove & Dalby, 2004). Tap dance has the potential to link people to these basic and fundamental rhythms of life. Walking and the heartbeat are our pulse to the world and can be connected through tap dance. Through rhythm, pathways can be formed to foster the ability to ground the self, self-regulate, and form a new coping skill.

The act of group rhythmic activity can develop a sense of well-being among group members as well as relaxation. “Even primitive man understood that a group of people moving together gained a feeling of more strength and security than any one individual could feel alone” (Chace, 1993, p. 196). Thus group rhythm promotes cohesion and oneness among group members. “The group participation gives him a feeling of confidence in himself that he seems unable to find alone” (Chace, p. 200). Simply picking up and moving rhythmically with another person can establish a connection between the two (or group of) people (Kendon & Ferber, 1971).

Rhythm has the capability of providing participatory and self-expressive behavior. It allows clients to take participation in the social aspect of joining a group and taking part in a shared experience with others (Espenak, 1981). Rhythmic action has such a profound effect on the people who experience it; there is no wonder that primitive tribes called this effect magical (Chace, 1993). Furthermore, the use of rhythmic action in unison assists clients in feeling the rhythms in their bodies.

It is important to note that even the clients who are not actively participating in the session benefit from the use of rhythm. This is because clients respond to the

rhythmic action they are seeing and hearing in their own bodies. “Spectators are feeling the rhythm in their own musculatures and by so doing feel a part of the group” (Chace, 1993, p. 201). Chace describes a clear and powerful example of this happening in one of her groups from St. Elizabeth’s:

Group dancing is satisfying, not only to those taking part in the dance, but also as a passive recreation. Rhythmic action when watched is felt by the onlookers in their own musculatures. Eyes lift toward the dancers, bodies noticeably relax, and smiles appear. Suddenly another patient leaves her chair at the back of the room to join the circle of people stretching their bodies and then relaxing in time to the music. It is not the urging of the leader. It is the contagion of rhythmic body action which draws her into the circle. She has made a beginning toward living and the enjoyment with others of this living (1993, p. 218).

While all children possess a sense of rhythm, not all have the same degree of rhythmic sense. This can be due to various reasons, such as poor concentration, lack of any appropriate rhythmic experience, and physical differences. Experiencing a difficulty in rhythm is often accompanied by trouble moving in time. These movements often look choppy or awkward. However, one’s sense of rhythm can be restored, developed, or refined. This is done through carefully selected rhythmic activities that offer fun and challenging opportunities, thus resulting in feelings of accomplishment. There is visible proof when a client has refined their sense of rhythm. The proof is in their movements (Boswell, 2005, p. 417). They are no longer awkward or choppy, but fluid and in time. Anyone “who learns movement rhythmically discovers how to trust in kinesthetic and emotional assessments of what they are doing” (Siegenfeld, 2009, p. 118).

Perhaps the greatest benefits of all are that in groups that use rhythm, clients may “freely express their basic emotions through rhythmic action” (Chace, 1993, p. 219) and rhythm is “a key element in human communication and interaction” (Goodridge, 1999, p. 109).

The question that guided this research was how can tap dance be used as a dance/movement therapy technique? This researcher hypothesized that tap dance can be used as a method to facilitate interventions from a rhythmic perspective, for modulation between states, for sensory awareness, and for grounding.

The purpose of the study is learning if and how tap dance can be used in dance/movement therapy. It will be beneficial to dance therapists worldwide who are interested in more options for rhythmic interventions in their sessions. Since there is currently no research that this researcher was able to identify on the use of tap dance in DMT, this study will begin that process.

Chapter Three: Methods

Participants

The participants of this group were two African-American boys, both 10 years old. They were both residents at the treatment facility and had been there for longer than one year. Both clients have guardians that are not their biological parents because parents' rights have been revoked. Both clients were diagnosed with post-traumatic stress disorder (PTSD), attention deficit disorder (ADD), decreased ability to control impulses, and had self-injurious behaviors (among other diagnoses). The source of their PTSD diagnosis is from physical abuse.

It should be noted that this researcher had both of these clients in groups previous to the beginning of this tap dance based DMT group. One client was seen in a DMT group with one other peer (male) that eventually turned into an individual session (due to the peer being discharged back to his family). The other client was part of a larger DMT group that consisted of eight of his peers (male and female). That group ended when the schedule was over for the semester.

All groups in which data was collected were held at an Illinois residential treatment center where both boys were currently living.

Methodology

This study took the form of a clinical case study (Chaiklin & Chaiklin, 2004), and as pointed out by Gilgun (1994) the overall defining characteristic of the case study is “its focus on an individual unit” (p. 372). The study was grounded in the development and implementation of a treatment plan (see Appendix B).

In the field of research, case studies are not directly linked to any specific type of data collection or data as results (Yin, 1989). Therefore, clinical case study was chosen as the methodology of this study because this researcher was not interested in manipulating any interventions of the group; but rather to lead, observe, and document the group and the participants as sessions organically occurred. The main focus of the group was to learn how tap dance can be used as a dance/movement therapy technique. This group was made part of the clients' treatment and interventions were made for the sake of the clients and their treatment and not for research purposes. For this reason this researcher chose clinical case study as the best possible methodology for the research project. Tucket (1999) stated, "the case study is the method of choice for studying on-going life situations" (as cited in Chaiklin & Chaiklin, 2004, p. 72).

As a dance therapy intern, the clients' treatment was top priority; and although this researcher was conducting research she was also the clients' movement therapist for these sessions. Keeping treatment as the main focus, this researcher also felt clinical case study was the best methodology for this research because:

a dance/movement therapist doing clinical diagnosis by assessing movement can report an overall diagnostic impression and the specific movement characteristics that went into making that diagnosis. During the diagnostic process different movement interventions can be tried as the therapist moves toward forming an estimate (Chaiklin & Chaiklin, 2004, p. 73).

This group began as a new program for the treatment facility. The purpose was to offer new experiences and introduce the clients to a form of dance and movement that they had never come in contact with before. This case study did not begin as a thesis

project but as a new form of treatment that this therapist/researcher could bring to the facility. For this reason, this type of case study is a grounded theory study (Gilgun, 1994), in that it did not begin with any hypotheses that this researcher was looking to test.

The most important elements of case study research were captured by Fonagy and Moran (1993) when they stated “it is a powerful way to communicate and to help the public understand therapeutic ideas” (as cited in Chaiklin & Chaiklin, 2004, p. 73). Furthermore, “case study research can make a contribution to helping people, professional learning, and furthering dance therapy as a profession” (Chaiklin & Chaiklin, p. 85).

Procedures

To begin creating this group, this researcher had to gain permission from the internship supervisor to add another group into an already full expressive therapies schedule. Once permission was granted, this researcher had to decide which age group to work with, if the group was going to be only male, only female or both; where the group was going to be held, when the group would meet and how often, if tap shoes could be purchased for the participants, what the purpose and goals of the group would be, and if the group was going to be conducted as a dance group or as dance/movement therapy sessions.

The first task to tackle was deciding with which age group to work. To assist with this decision this researcher took a look at the client list she was currently seeing and decided to choose the age group she was working with the least for the tap dance group. This was the youngest boys unit (6-10 years old).

Next, this researcher spent time conducting observation on the unit. Milieu observations were conducted by this researcher. Forty-five minute observations each day over five days were spent on the youngest boys unit. During this time this researcher observed behavior, movement patterns, movement affinities and dis-affinities, peer interactions, resident-staff interactions, and time alone. No notes or journal entries were taken during this time period because this researcher was observing all the clients residing in the unit to just notice what she noticed.

After three days in the unit, attention was placed on four boys who were in the milieu consistently over the past three days and who would be there for the next two days. This allowed this researcher to narrow down the potential clients from 10 to four. Next, this researcher looked at each of those four boys' schedules to see how full they were. She then spoke to the unit's primary verbal therapist about all four of the boys to get her input and recommendations. From there this researcher spoke to the four boys and out of those four only two were interested in joining the group. This researcher then went back to the primary verbal therapist to speak more specifically about these two boys.

Once the primary verbal therapist gave her recommendation for the boys to participate in the tap dance group this researcher began to figure out the logistics of the group. After looking at the clients' daily schedule and checking with the unit team leader about any scheduling conflicts this researcher was able to set Monday evenings from 6:00 pm to 6:30 pm for the group. The recreational arts office was chosen as the location for the group. This room was selected because it was the only space that was available that did not have carpet, the floor could get tap marks on it and no one was using the office for other sessions or paperwork.

The next large task to tackle was finding out if purchasing tap shoes for the boys to use during group was going to be something that was possible. The first person this researcher contacted to ask for budget money (each person in the expressive therapies department is given budget money every month to purchase supplies that they need; however this did not include interns) was this researcher's internship supervisor. She suggested this researcher speak to the head of the expressive therapies department to see if extra budget money was available. This researcher set up an appointment with the head of the department to tell him about the tap group, who would be participating in it and that she would like to be able to give them the full experience of learning tap dance, and purchase shoes for them. Prices of shoes were already known and the head of the department was given an exact amount of how much the purchase would cost, including shipping fees. The head of the department said he would check the budget and get back to this researcher about any extra money that might be available. Within a week this researcher was informed that there would be money available for her to use to purchase the shoes (she had to purchase the shoes and then submit a receipt for reimbursement).

The next step was to verify with the clients if they were still going to be participating in the group. Both clients said yes and this researcher wrote a memo to the clients' primary verbal therapist to inform her that the boys were going to be a part of the group. The memo further detailed location and time. This researcher also informed the unit team leader so that the change could be made to the boys' individual schedules as well as the unit schedule.

This researcher also decided that the group was going to be dance/movement therapy based and not a traditional dance class. This researcher made this decision

because she was an intern at the treatment center, was interested in group process as it pertains to tap dance, and as a potential thesis topic. From here, this researcher went on to create a treatment plan for the clients (see Appendix B) which she gave to their verbal therapist.

To prepare for the beginning of this new group, this researcher/therapist took the following steps: (a) wrote out a list of tap dance steps she hoped to teach the clients, (b) found a video of tap dancer Savion Glover to show to the clients, (c) saved a picture of the tap shoes the clients were going to receive to show them, and (d) listened to different kinds of music to create a play-list for the group. However, this therapist decided that having music in the group might distract the clients from the learning process and did not want music to influence their mood, effort level or any other qualities of their movement. Therefore, these sessions were conducted without the use of music.

Before beginning the first group (and the groups that would follow) this researcher set up the recreational arts office to fit the group as best as possible. She pushed the extra tables and chairs off to the side of the room, pulled out a medium sized rug for the clients to sit on, turned off all computers, closed the doors to the game closet and turned off the lights in the office. At this particular treatment center it was the therapists' responsibility to get their clients and bring them to their session. When this researcher left the recreational arts office she closed the door behind her.

To get the clients for session this researcher went to each of their rooms and told the clients that it was time for tap dance group (she had also reminded them and their staff about group earlier in the day. This reminder for the clients and staff was because this group was added to the schedule in the middle of the season). Only one client was

attending group on the first day, however for the other groups this therapist greeted both clients at their rooms and all three walked to group together.

Outside the door to the recreational arts office this researcher reminded the client(s) that this was an office and to respect all of the items that are in it. She directed the client(s) to immediately sit on the rug when he (they) entered the room. Then, as a group, they would go over rules of the office and create their own for their tap group (this occurred during the second group when both clients were present). This researcher opened the door and turned on the lights and reminded the client(s) to sit on the rug (she sat down there with him).

Each session began with a verbal check-in. During this time each client was given two minutes to share anything he wanted to about his day. While listening to the client this researcher was taking this time to observe body attitude, movements that were occurring (swinging feet, sitting on hands etc.), shaping, reach space, and effort life.

After the check-in, this researcher led the clients in a body-part warm-up, rhythmic combinations that often consisted of clapping, stamping, patting knees and arms, and going through the steps the clients learned in previous sessions by incorporating them into the rhythmic combinations (during the first session, since no steps had been taught yet the warm-up consisted of a traditional body part warm-up beginning with the head and working down to the feet and rhythms created using clapping and stomping). Often, the timing of the rhythm that this researcher created to begin the group was dependent upon what the clients were presenting during the verbal check-in. For example, if the clients' energy appeared to be high the group would start

with a rhythm that was fast paced (to meet them where they were) then modulate them down to a medium speed thus prompting a medium energy level.

After the rhythmic warm-up, the session moved into theme development. This part of the group looked different than a typical dance/movement therapy group because it was during this section of the group that teaching/learning took place. This therapist used this part of the group to teach the clients new tap dance steps and vocabulary, set-up tap dance challenges for them, and allow them to practice their improvisational skills by creating short tap dance phrases to show the rest of the group (these phrases were usually between four and 12 counts). Therapist chose tap dance steps for each session based on what the clients were exhibiting in their movements during the warm-up, developmental progression of steps, and steps that would address goals outlined in the movement therapy treatment plan (Appendix B).

The conclusion of the group consisted of verbally processing any difficulties, complaints, worries, excitement and anything else that came up during the group. As their therapist, this researcher often reflected back statements she heard the clients make during the group; specifically regarding the learning process. Such statements consisted of “I can’t do this,” “this is hard,” “I like this one!” and “hey look I got it!” This therapist would then often ask the clients questions about these statements; such as client “M when you said this one was hard (showed step) what was hard about it?” and client “R when you said you liked this one (showed step) what was it that you liked about the step?”

After verbal processing the clients were led through a cool down that often consisted of breath work (either standing up or sitting down in a chair) to officially end the session.

After the first session this researcher decided to present this group in the upcoming thesis seminar class as an idea for her thesis project. The project was accepted by the thesis seminar instructor and this researcher was required to gain informed consent for the clients to be a part of the thesis project.

Informed consent was obtained by each of the clients' case-workers. This researcher created an informed consent form (see Appendix C) for each of the case-workers which she faxed to them with the help of the unit outreach worker (social worker) who had the case-workers' names and phone numbers. First, this researcher tried calling each of the case-workers to inform them she would be faxing over an informed consent form requesting their signatures along with a brief proposal of the thesis project for them to look over and consider before signing. One case-worker responded via fax, the other had to be contacted and have a brief face-to-face meeting with this researcher for him to voice his concerns about the client's anonymity. After this meeting he was satisfied that his client would not be identified and he signed the consent form. This researcher also collected verbal assent from both of the clients during the last session. She explained to the clients how the group was going to be used in a thesis project and that their names would not be used.

The final consent that was needed was from the treatment center. The facility required a letter from Columbia College Chicago stating this researcher was in fact a student there and this was thesis research. The letter also had to state that informed consent from the clients' case-workers was obtained, client assent was obtained and that the facility and the clients would remain completely anonymous. Once this final consent

was granted this researcher was given full permission to write about the tap dance based dance/movement therapy group for her thesis project.

Data Analysis

Data was collected during and after the sessions through clinical notes, this researcher's journaling, kinesthetic memory, and embodiment of the clients during the sessions as well as after the session during the journaling process.

The data was analyzed by this researcher reading through her clinical notes and highlighting any time there was an expression of feeling or an affect shift, any behavior that was noted, when clients appeared grounded and regulated during the group (especially the learning process), tap steps that were taught and/or used during the session, other movements that occurred, and any important statements that the clients made during the sessions.

The data that was included in this study in the results and discussion chapters included the highlighted material listed above. This included common movement patterns that appeared throughout the duration of the group, client interactions, statements made by the clients when frustrated or excited, when tap dance was used as a coping skill and a form of self-expression, and rhythmic patterns that were created or appeared. Further descriptions of when this researcher embodied the clients and their movement qualities and states were also included. This is used when movements, gestures, postures, and effort life are described in the next chapters.

Chapter Four: Results

After analyzing the data that was collected from 10 weeks of sessions, the clinical themes that emerged from the tap dance DMT group appeared to be: (a) a therapeutic relationship between therapist and clients, (b) group cohesion, (c) self-expression, (d) creativity, (e) body and mind organization, and (f) courage.

Each session consisted of the following components: (a) introduction which consisted of a verbal check-in, (also the time where this therapist conducted observations and assessed each of the clients before beginning each session), (b) body-part warm-up that began with the head and progressed down the body to the feet. During this time, therapist focused on the clients' movement qualities that they were beginning the group in, (c) theme development/intervention section that included this therapist teaching the clients new steps and reviewing steps from previous sessions, as well as tap dance challenges (d) group rhythmic activity part of session consisted of rhythmic combinations, created by therapist and/or clients, and (e) cool down/ closure where verbal processing occurred as well as breath work. The order of theme development/intervention and group rhythmic activity often switched, depending on the clients' needs and how the session was going.

Bringing the clients into rhythm state was the most frequently used intervention. It was established through tap dance. Clients entered group in their respective effort states. This therapist facilitated tap dance movements and rhythmic combinations and patterns to modulate the clients into rhythm state. The session then concluded with another modulation from rhythm state to stable state. This last modulation occurred during the conclusion of any tap rhythms that were occurring and during the cool down

section of the group. To be sure the clients were continuing to access their weight, the breath work was conducted standing up or sitting in a chair with both feet firmly on the floor (to continue grounding). To drop out the element of time and bring in the element of space, while the clients were breathing therapist led the clients through short sentences that re-capped the activities of the group. The goal of this was to have the clients remain in the present moment and bring in their thinking side of remembering what occurred during the group and how they could bring those movement qualities back to the milieu.

It should be noted that the phrases this therapist and therapist are used interchangeably in this and the following chapters. Also, all sessions began the same way. The therapist greeted each client at his room and all walked together to the recreational therapy room. The room was set-up the same way each week to the best of the therapist's ability.

Session 1: March 16, 2009
Number of Clients in Session: 1

This was the first time this group met. There was only one client in attendance for this group; as the other client was asleep due to a change in medications.

This group began with this therapist preparing the recreational therapy room where the session was to take place. Preparations were conducted prior to the session beginning and included this therapist clearing any balls, games, and other miscellaneous props and activities, pushing chairs out of the space, and checking to be sure all drawers of desks were closed. This therapist then placed a rug on the floor of one side of the room (this was for the clients to sit on upon entering the room). Before leaving the room to get the clients for group, this therapist turned off the lights and closed the door to give the idea to the clients that they were entering a new space for this group.

This therapist then went to client M's room to tell him it was time for group, while he was getting his shoes on she went to client R's room (he was asleep, she checked with staff about the situation and learned it was due to his medication being changed earlier that day). During this time, M was patiently waiting for this therapist in the hallway outside his room.

This therapist walked over to M and informed him that R was asleep and would not be coming to group. While walking to the recreational therapy room, this therapist explained to M the rules of the group (see Procedures section in Chapter Three: Methods).

Introduction.

Once in the room, the client was directed by this therapist to sit on the rug and she sat with him, diagonally across from him. This therapist then took a few minutes at the start of this session to introduce this specific and special movement therapy group to the client. The introduction consisted of explaining to the client that while this was a movement therapy group, which he was familiar with, it would be somewhat different from other movement therapy groups he had participated in. In this moment, this therapist noticed there was a shift in the client's affect. His face changed from relaxed to tense, as seen by his eyebrows narrowing and his mouth closing to create a straight line. His expression appeared to be one of questioning and curiosity. The client's reaction was noted, and this therapist chose to continue with the group. This therapist informed the client that the group would focus on tap dance. The client nodded his head yes, and his affect shifted back to look more relaxed, as he had been when he entered group. His eyes were also widening as he was listening. This look appeared to be one of excitement.

This therapist explained to M that rather than the movement therapy groups he was accustomed to, where improvisational movement was the main focus, this group's focus would be on learning tap dance technique.

Warm-up.

The group began with this therapist explaining to the client Laban's elements of weight and time. To experience these elements, this therapist asked the client to stomp and march around the room. These movements exemplified the fighting quality of the element of weight, identified by the term: increasing pressure.

After moving the fighting quality of increasing pressure, the group began exploring the indulging quality of weight: decreasing pressure. In order for the client to experience decreasing pressure, this therapist suggested tip-toeing around the room.

The movement element of time was explored next. This was executed by walking around the space. To experience the fighting and indulging qualities of time, accelerating and decelerating, this therapist invited the client to walk around the room; directing him to go faster and/or slower.

Theme development/group rhythmic activity.

Next, this therapist led the client in an activity that combined the elements of weight and time, thus creating rhythm state. The activity consisted of clapping, stamping, stomping, exploring the various combinations of rhythm state. The client was then provided the opportunity to lead this therapist in a rhythmic combination he created.

To end the session, this therapist chose to engage the client in rhythm state by playing a game. She gave him the option to choose the game and he picked tic-tac-toe. This was an active version of tic-tac-toe that engaged the full body. The game was played

by having the client throw a ball at blocks to turn them over to make an X or an O. The game allowed the client to control how much force he threw the ball with. Force is the result of one's conscious decision to either increase or decrease his pressure. The client was able to win the game. He did so by learning to modulate his weight by throwing the ball both strongly and gently.

Cool down/closure.

To cool down and end the group, this therapist transitioned the client from the game to breathing exercises. These consisted of deep breathing for 30 seconds. Once the client was calm and quiet this therapist ended the session and escorted the client back to his room.

Client's response.

The client appeared to be taking in what he was learning in this session. Learning was evidenced by: (a) his eagerness and willingness to try new things, (b) participating without protest or hesitation, and (c) staying fully engaged during the 30 minute session. Furthermore, he did not appear to have any trouble executing the steps he was learning with his sneakers on instead of tap shoes. The client exhibited further interest in the group and what he was learning by asking when he would receive his tap shoes.

From this therapist's observations of how well the client was able to pick up the rhythms and steps he was taught, this therapist decided to teach more elaborate rhythms, integrating more body parts, and progression to toe-drops, heel-drops, and air shuffles for the next session.

Clinical implications.

During this first session, therapist focused on building the therapeutic relationship and on goal four from the movement therapy treatment plan (see Appendix B) and explored rhythm state and stable state with client M. Therapist took note that the client appeared to engage in the fighting qualities of both elements easier than the indulging qualities. She also took note that while he was able to modulate between the different qualities, it was often not a smooth transition.

Goals one, two, and eight from the movement therapy treatment plan (Appendix B) were also addressed in this session and in the sessions to follow. These goals were worked on through teaching tap dance steps, creating rhythms, and engaging in tap dance challenges.

Session 2: March 23, 2009

Number of Clients in Session: 2

Session two began the same as session one. This was client R's first time attending, thus there were two clients in this session. Therapist asked client R if he was feeling better after his medication change the week before. Client R responded "yes and ready to do some tap dance!" Then, he performed some movements with his feet that he called tap dance and client M gave him a high-five.

While walking down the hall to the recreational therapy room, this therapist asked client M if he remembered the rules of the room that they had gone over the week before. Client M said that he did and this therapist asked him to tell client R what they were. This therapist asked M to tell R the rules so she could be sure that client M remembered the rules, and so that she could hear how client M interpreted and understood them.

Once reaching the recreational therapy room, this therapist opened the door, turned on the lights, and asked the clients to sit on the rug (the room was set-up the same as session one). She sat down with them, diagonally across from them, as she had with client M the week before.

Introduction.

To begin the session, this therapist asked the clients to think of a few rules they would like to have for their group. Client R responded first. Raising his hand to place high in the vertical dimension, and engaging his head/tail connection to sit-up straight he said “no touching anything in the room.” This therapist nodded her head and asked client M if he had a rule, he said “yes, come to group.” Therapist acknowledged the rule by nodding her head again and asked the clients if either of them had any other rules they would like to contribute. Client R said “keep hands to self,” and this therapist again nodded her head to acknowledge the rule. She then asked the clients if hands were the only body part to be kept to their selves, and client M said “legs too.” This therapist also added arms, feet, heads and all other body parts should be kept to oneself. The exception would be if somebody asked permission to touch another and permission was granted. Both clients nodded in agreement.

Therapist asked if there were any other rules that should be added for the group. Client M raised his hand, retreating backward, enclosing his shoulders, and in a very low voice said “no making fun of someone or laughing.” Client R agreed by saying “oh yeah that’s a good one.” This therapist also agreed with the rule by nodding and saying “yes that is a good rule and an important one to remember. Everyone needs to remember that this is a tap dance group and tap dance is something new that you are both learning.

While learning something new, it can be difficult to do a step right away or one person may be able to do the step sooner than the other person. That is okay, everyone is here to learn about tap dance and movement therapy. There is no competition and it's okay to make mistakes. Just keep trying and have fun!" Both clients started to move and roll around on the mat.

Warm-up.

With the rules complete and the clients already moving around the space, this therapist asked the clients to stand so they could begin a body-part warm-up. This therapist led the clients in a warm-up that began with their head and progressed down the body to the feet.

Theme development/intervention.

While warming up their feet, this therapist introduced toe-drops to the clients as the first tap dance step. Both clients had trouble grasping this step and this therapist noticed it was due to their weight being on the front of their feet. To be able to execute toe-drops the weight must be towards the back of the feet so the toes can lift off the floor. Noticing the clients' weight towards the front of their feet, this therapist decided to introduce the clients to heel-drops. She thought this step would meet the clients were they were at with more weight in their heels, and allow them to start in a familiar place.

The clients were able to learn heel-drops quickly, and they appeared easier for them than toe-drops. Next, this therapist asked the clients to make their sounds louder and the clients responded well. At this point in the session, therapist took the opportunity to teach the clients about weight shifting. She explained that they may have had trouble lifting their toes because they were holding their weight in the front of their feet. She told

them that lifting their heels is easier with their weight in the front of their feet and lifting their toes is easier with their weight on the back of their feet.

Now that the clients had a better idea of how to lift their toes off the floor, this therapist suggested they try toe-drops. Client M was able to shift his weight and execute toe-drops. Client R still had some trouble and was only able to lift his toes slightly off the floor.

Group rhythmic activity.

This therapist then led the clients in a rhythmic combination that included clapping, stamping, toe-drops and heel-drops. Client R had some trouble keeping with the timing of the rhythm, as he would continuously speed up stating he wanted to be the fastest. This therapist explained to him that it was not a contest or a race. The goal of the activity was to keep in time and create the rhythm with the group. He slowed down, but appeared to disengage from the group. This was seen by a change in affect and loss of concentration. His expression changed from a smile to a slight frown, and he began gazing around the room.

Both clients were given the opportunity to be leaders in the group. They created their own rhythms and taught them to this therapist and their peer. Client M went first, creating a rhythm that began with clapping and ended with toe-drops. The timing did not vary and was executed at medium speed. Client R's rhythm began very quickly and continued to speed up while he was leading. His rhythm was so quick that this therapist and client M could not learn the rhythm. Both clients began laughing at how fast the rhythm progressed, and began creating incoherent rhythms. Sensing she was losing the clients' engagement this therapist began to bring the group to a close.

Cool down/closure.

To cool down, this therapist led the clients in deep breathing exercises for 30 seconds. Once the clients appeared to be calmer and quieter, she asked them if they would like to see a picture of the tap shoes she was going to order. They both said “yes!” She asked them to sit in chairs while she turned the computer on. This therapist showed them the picture and asked if they liked the shoes. Both clients said yes and client R asked when they would get the shoes and if they were going to have to share a pair. Therapist told them she would order the shoes after group and they did not have to share, she was going to order them each their own pair of shoes. She then checked their sneakers for sizes. After looking at the picture of the tap shoes, this therapist led both clients back to their rooms.

Clients’ response.

Both clients were engaged in the session. Though they needed to be re-directed during the introduction of the group while making rules, the clients were able to keep their focus. This was seen by their participation in the creation of rules. During the time that the clients were learning toe-drops they both appeared to get frustrated when they could not do the step, client M more than client R. However, both clients remained regulated and continued to try the step. Switching to heel-drops appeared to assist the clients in learning and kept them focused.

This therapist was not able to address her plan of teaching the clients air-shuffles. For the next session, this therapist planned to review toe-drops and heel-drops, teach the clients air-shuffles, tapping on top of their toe, and the combination toe-toe-heel-heel.

During the week, anytime this therapist saw client R he asked if he was having tap group that day, if she ordered the shoes, if the shoes had come in yet, and if he was really getting his own pair of tap shoes. Client R would also show her his moves that he called his tap dance any time he saw this therapist. Thus showing this therapist he was interested in and excited about the tap group.

Clinical implications.

One goal of this group was to create rules that each group member agreed upon and followed. Therapist asked the clients to come up with rules they wanted for the group so they could be a part of the process. It was beneficial for the clients to create rules that were important to them in the group.

Other aspects of this session focused on the first goal on the movement therapy treatment plan (Appendix B). The clinical significance of the body part warm-up beginning with the head and progressing down the body to the feet was for stability, grounding, and connection to the body. Also, ending with the feet as the last body part to warm-up and move allowed for a smoother transition into tap dance steps.

Continuing to focus on the first goal of the treatment plan, weight-shifting was a key movement pattern that was present in both clients during this session. Shifting weight from the front of the feet (for heel drops) to the back of the feet (for toe drops) was an intervention facilitated by this therapist to allow the clients the experience of moving their weight to the back of their bodies. Therapist observed a common movement pattern among the clients at her internship site. This was that their weight is held in the front of their bodies. Therapist wondered if this is in preparation for the defense responses of fight, flight, or freeze.

While creating rules in this session, improving the clients' impulse control issues was a focus. Clients had to figure out when to contribute a rule so that it would be heard (i.e. not talking over each other). Also, focusing rules on respecting all the group members and therapist was important for these clients. Respecting, noticing, and asking permission to come into another's space was a key component in these rules. Respecting and not touching another group member was also an important rule for these clients as they often have boundary issues and invade each others' space and touch each other, either intentionally or not.

Client R's need to execute his rhythms in quick time may have perhaps been due to his nervousness of performing in the group. His natural movement affinity for quick time may have also contributed to this rhythm and that he has yet to learn to take control over this aspect of his movements and his body.

Goal three was also worked on in this session through the use of breath. Breath work is important for these clients because it allows them to experience stillness and safety within their bodies. It was also utilized as a closing ritual for each session to allow clients to begin to access their free flow. This was important for them to leave the session with so that they may transfer what they learned in session back to the milieu and interactions with their peers.

Session 3: March 30, 2009
Number of Clients in Session: 2

Session three began with this therapist greeting each client at his room. While walking to the recreational therapy room, client R asked if their tap shoes had come in yet. This therapist told him no but that they had been shipped and should arrive soon. He said "I hope so cause I'm tired of my sneakers and I want to make a lot of noise."

Introduction.

To begin the group, this therapist checked in with each of the clients. Neither client had anything he wanted to share about the day, so this therapist began the warm-up.

Warm-up.

The warm-up was conducted at a faster pace than usual, as both clients came to session with high energy levels. Beginning with their heads and working down to their feet, this therapist led the clients through a body-part warm-up that concluded with toe-drops and heel-drops. Both clients still had some difficulty with toe-drops. However, this therapist saw an improvement from the previous session when toe-drops were first introduced.

Theme development/intervention.

After concluding the warm-up, this therapist introduced air-shuffles to the clients. They appeared to have some difficulty holding their balance, and this therapist took this time to teach the clients about their core. She explained to them that their core was the center of their body and by engaging their core muscles they would be able to hold their balance. Client R asked if it was like squeezing your muscles when you do sit-ups. Therapist replied it was similar to that, in that engaging your muscles means to wake them up and work them. She further told the clients that trying to do the step with their hands on their hips might also help them with their balance. Clients attempted the step with their hands on their hips and engaging their core muscles and were able to hold their balance to execute the step. Client R exclaimed “this is fun!” as he was swinging his foot back and forth.

Next, this therapist asked the clients to create a short rhythm that included air-shuffles, toe-drops and heel-drops. Client M showed his combination first, putting air-shuffles at the beginning and toe-drops at the end. Client R then showed his rhythm which consisted of clapping and heel-drops.

Then, this therapist introduced the tap combination toe-toe-heel-heel to the clients. Keeping in mind this might be difficult for them, she still wanted to teach them the combination and allow them to work their way through it if needed. However, before she could teach the combination the clients needed to be grounded and regulated as they were becoming dis-engaged from the group. Why the clients were dis-engaged at this point is unknown. However, therapist can guess that perhaps the clients were becoming frustrated learning the new combination or that because the timing of the group was shifting from quick time into slow time the clients' began to loose interest as their energy levels were high to begin the group. To gain back their attention, therapist led the clients in a pick-up rhythm. She began the rhythm combination and went around the circle with each client adding a movement or sound to the combination. This continued around the circle three times.

Once the clients were grounded through the pick-up rhythm, therapist showed them the combination toe-toe-heel-heel. Both clients tried the step, as this therapist slowly talked them through it. During the learning process she reminded them about weight shifting and engaging their core. These interventions appeared to help the clients because they were able to shift their weight back and forth to execute the step properly. This therapist noticed the clients appeared to be cautious and careful while performing the step. She wondered if they were concentrating on the weight shift and asked the

clients. Client R did not respond and client M shrugged his shoulders as if to say I don't know.

Client R then asked when they would be getting their tap shoes. Therapist told him she was still waiting for them to come in. Client R sat down on the floor, resting his head on his hands, and looked down. Therapist sat down with him and asked client M to also sit down. She asked client R what was wrong. He replied that he wanted tap shoes. Therapist told him she understood that and they were probably on their way. Client R then asked if they were going to have to share their shoes. Therapist told him no, she ordered a pair for each of them. R then said that he meant would they have to share them with the other kids. Therapist told him no, the shoes were only for them and this group.

Therapist then told both clients that they had done an excellent job in group. Their rhythms were clear and everyone could follow them and that they had learned a pretty difficult footwork combination. Client R stood-up and said "that wasn't hard. You mean this one?" and he performed toe-toe-heel-heel. Therapist said "yes that one. And look how well you are doing it." Client M then stood up and also executed the step. Both boys did the step together three times before client R asked to see the picture of their tap shoes again. Therapist pulled up the picture of the tap shoes on the computer.

Cool down/closure.

To end the group, therapist led the clients through deep breathing exercises for 30 seconds. She also asked them if they were enjoying their new movement therapy group. Both clients nodded their heads yes.

Clients' response.

Both clients appear to be progressing in the tap dance group. Their rhythms during this group were clear and easy to follow, and they are remembering steps from week to week. The clients also appear to be enjoying the group, as seen by their affect during the group. Both clients appeared to be excited about teaching their rhythms and liked the pick-up rhythm intervention.

There seems to be a common theme developing with their tap shoes, even though they have not received them yet. Client R is especially worried about the shoes and having to share them. Therapist can hypothesize that client R does not want to share his shoes because this is his chance to have something that is only his. Often in the treatment center and specifically on his milieu the children have to share their possessions. These shoes would only be client R's and therapist thinks he may not believe that they are his and is questioning her on the issue.

Clinical implications.

For this session, clients' energy level was high and they were having difficulty decreasing their impulsive behaviors. This promoted quicker movements, fluctuations between free and bound flow, and movements that were uncontrolled. Therapist did not want to modulate the clients down to slower movements at the onset of the session. She wanted to allow them the space they needed to have high energy levels. Meeting them in their high energy and flow fluctuations, the warm-up was conducted in a quicker time than in the last session.

Difficulty holding their balance and engaging their core were movement themes that developed during the session. Through psycho-education and movement examples,

clients were able to engage their core muscles and hold their balance to execute air shuffles.

Possible reasons for the clients disengaging during the session are that the pace and flow of the group may not have been meeting their movement needs at the time, or they could have been having trouble being in their bodies and staying in the present moment. Therapist noticed that when she was showing the clients movements where weight was the dominant effort element the clients would disengage. Therapist wondered if this happened because the clients were in an unfamiliar place in their bodies when they accessed their weight through these movements.

Creating their own rhythmic combinations allowed the clients to each have a turn being the leader of the group. This allowed each to be in charge for a few moments and be seen positively. Creating their own rhythms also allowed for creativity and self-expression (goal seven on the treatment plan).

Session 4: April 6, 2009

Number of Clients in Session: 2

While walking with the clients to the recreational therapy room, therapist told them she had a surprise for them and to sit on the rug as soon as they entered the room. Client R asked if it was their tap shoes. Client M looked at her with wide-eyes as he awaited her answer. She told the clients they would have to see when they got into the room. Upon entering the room, both clients ran over to the rug and immediately sat down.

Introduction.

Therapist checked in with each of the clients on how things were going that day, neither said anything. Client M was sitting on the rug, while client R was moving all around the space. Therapist told client R she could not show them their surprise if he was

not sitting down. He came running over to the rug and sat down next to client M. With both clients seated, this therapist opened her desk drawer and pulled out two boxes containing the clients' tap shoes. Both clients reached out for the boxes with excitement. Therapist told the clients they needed to try on their shoes to be sure they fit. To do this, she gave each client a chair to sit in on the rug. Therapist instructed the clients to remain on the rug until told they can step off. This was so she could check to be sure the shoes fit properly, and if they had to be returned they could not have scuff marks on them.

Therapist then handed each client a box, which had their name on it. Inside was a pair of black, tie-up tap shoes. She asked the clients to be careful while taking the shoes out of the boxes and trying them on. Client R asked why: she explained to them about not getting scratches in case they had to be returned. Client R said his fit perfectly and did not have to be returned (he only had one tap shoe on when he made this statement). Therapist told both clients once they had both tap shoes on and tied, she would check their sizing.

Once both clients had their shoes on and therapist determined the shoes fit properly and did not have to be returned clients were allowed to step off the rug and hear their taps for the first time. Both clients stepped off the rug carefully, using extreme bound flow and decelerating time. They looked as if they were walking on ice and did not want to fall. Therapist allowed the clients a few minutes of free time to test out their tap shoes and the sounds they can make. She reminded them that running was not an option while in tap shoes.

Therapist offered suggestions of tap steps to the clients to try with their shoes on. Marching around the room was the first one. While marching around the room, client M asked if he could show his tap shoes to staff. Client R also asked if he could show his

shoes to staff. Both clients began jumping up and down chanting “please, please, pleeeeeeease!!” Therapist allowed the clients to walk down the hallway showing their staff their tap shoes, reminding them not to run and to try to walk quietly.

Once coming back into the room, client M asked for a few more minutes of free time with their tap shoes. Therapist observed clients jumping, stamping, clapping, and hopping. While the clients were exploring movement with their tap shoes on, therapist was observing how the clients’ movements changed with tap shoes on. After about three minutes she asked the clients to come make a circle to begin the warm-up.

Warm-up.

The warm-up began the same way as previous ones, however, clients had to be re-directed not to move their feet around. Once reaching the feet, therapist led the clients through toe-drops and heel-drops. She noticed the problem of weight-shifting had returned and both clients were having difficulty lifting their toes. Therapist reminded the clients about weight-shifting and engaging their core. This time, this intervention did not appear to help the clients as it had in the past. Therapist took a mental note of this.

Theme development/intervention.

Therapist chose not to introduce any new steps to the clients during the remainder of this session. They had limited time left after trying on the tap shoes, exploring, and showing their staff. She did not want to introduce any new steps to the clients and have to rush through the teaching process because the group would end. Instead, she wanted to give the clients the opportunity to hear the steps they had already learned. Hearing steps in tap shoes is very different than hearing them in sneakers and this therapist wanted to give the clients that opportunity.

Therefore, this session consisted of therapist leading the clients through a rhythm combination, the clients creating their own rhythm combinations, toe-drops, heel-drops, and the combination toe-toe-heel-heel.

Cool down/closure.

To end the session, therapist asked each client to remove his tap shoes and place them back in their boxes. She told the clients the shoes were going to stay in her office in a safe place. Client R asked if other kids would be using his shoes. Therapist told him no they were his shoes and he would be the only one to use them.

Once the clients' shoes were in their boxes, therapist led them through deep breathing exercises for 35 seconds. When both clients were calmer, therapist escorted each back to their rooms.

Clients' response.

Both clients appeared to be extremely excited to receive their tap shoes. Their excitement was visible from their affect shifts, continuously asking the therapist to show their shoes to their staff, and what appeared to be a sense of pride they were displaying while walking down the hallway. The pride of the clients took form in their bodies, creating a strong head-tail connection in both clients, one this therapist had not seen prior to this session.

There seems to be a recurring theme with client R about his tap shoes. He appears to be quite worried about having to share his tap shoes or that others will be using his tap shoes. Therapist saw client R multiple times in between this session and the next and each time she saw him he asked if he could have his tap shoes. She told him no and briefly explained (if able to) that for right now the tap shoes were used only in tap group.

Therapist wonders if R kept asking about his tap shoes to see if any one else was using them or had access to them. She also wonders if he asked about the shoes because he wanted (what seems to be) one of the only items that are his or perhaps he wanted his shoes because he was feeling the need to regulate himself and wanted to use his tap shoes and tap dance to do so.

Clinical implications.

Goals seven and eight from the treatment plan (Appendix B) were addressed during this session. Clients appeared excited about receiving their shoes and proud of them as well. This was evidenced by their affect and eagerness to show their staff their shoes.

Clients' creativity and exploration of movement was clearly visible during this session. Both clients took the time to explore movements they had previously learned (shuffles, toe-drops, and heel-drops) and others that they knew (jumping, hopping, marching, and walking) with their tap shoes on. During this movement exploration, therapist noticed clients accessing bound flow in their upper bodies and free flow in their lower. Impulse control did not appear to be an issue during this time. Neither client had any movement outbursts and both appeared to have control over their lower body movements.

Frustrations over not making proper sounds began to become evident. While being able to recognize what this feels like in their body is a goal (number nine), therapist did not address it at this time. She felt it was important for the clients to have the exploration time.

Session 5: April 13, 2009

Number of Clients in Session: 2

Introduction.

To begin this session, this therapist gave each client their tap shoes and asked about their day. Client R asked if she was sure these were his shoes and not client M's. Therapist told him she was sure and showed him his name written on the box. She also told him they wore different shoe sizes so once his shoes were on he would be able to tell if he had the wrong shoes by the way they felt. Client R shrugged in response to this and asked to see where his name was written on the box.

Warm-up.

Once both clients had their shoes on, therapist began the session with the usual body-part warm-up. Clients required re-direction during this time. When therapist asked what was going on today client M asked if he could sit in a chair. Therapist told him that he may use a chair and asked client R if he would like a chair also. He said yes, and then pulled out a chair from one of the desks. Therapist created a circle with three chairs and each sat in a chair. Client M began swinging his feet above the ground, noticing this movement; client R also began swinging his feet. Therapist mirrored both clients and began swinging her feet as well. She did not disturb the silence and fun that was occurring in the group, just observed it. After about one minute, client M asked "what are we doing today?" Therapist asked what he would like to do. Client M replied that he liked making up rhythms to teach. Therapist asked him to create a rhythm to teach to the group. Client said he would and then created a seated rhythmic combination which he led the group in executing.

Next, therapist asked client R if he would like to create a rhythm to lead the group. Client declined and said he would like to learn something new. Therapist decided to teach the clients toe-taps to the side and back. Tapping to the side requires a flexible ankle to lift the foot up and down. Tapping to the back is done on top of the toe on the top part of the shoe.

Theme development/intervention.

Therapist began with tapping to the back. She stood up from her chair to show the clients how the step was done. However, she told them they can remain in their chairs if they wanted to. Client M remained seated, client R stood. R then sat back down, saying he did not want to mess up his shoes tapping on his toe. Both clients began swinging their legs again. Therapist gave the intervention to try swinging their legs in different directions. Clients began laughing as they were accessing their free flow in their lower bodies to allow their legs to swing, while using their binding flow in their upper bodies to stabilize in the chairs.

Therapist then gave the intervention for the clients to try dropping their foot to the side to make a tap sound when they swing their legs to the side. After watching this therapist execute the movement a few times, clients were able to mirror her. She asked the clients what changes they made in their bodies to accomplish this step. Client R looked at client M. Client M said he slowed down the swinging, client R nodded and looked at therapist. She nodded, acknowledging his self-observation.

She then tried to use the same intervention to get the clients to tap on the top of their toe to the back. Both clients avoided this step, even after watching therapist execute it. She asked the clients if they were going to try, they both said no. They stated the same

reason as above for not wanting to do the step. Therapist took note of this, and did not push the issue as it was the first time it was coming up.

Next, she asked the clients to try toe-drops sitting in their chairs. Client M responded that he could not reach the floor sitting in the chair. Therapist took this opportunity to try to engage the clients' head/tail and upper/lower connectivities. She did this by asking the clients to move to the edge of their chairs, sitting up straight, putting their feet flat on the floor, and placing their hands either on the tops of their thighs or holding onto the sides of their chairs. Both clients shifted and therapist asked how it felt sitting this way. Client R said it hurt, client M shrugged his shoulders. Therapist then led the clients through toe-drops, heel-drops, toe-toe-heel-heel combination and began to introduce shuffles.

Cool down/closure.

To end the session, therapist led the clients in a rhythmic combination. She kept the timing slow, the weight light and began to bring in spatial awareness by varying the level in which some movements took place. Before taking off their tap shoes, therapist led the clients through deep breathing for 30 seconds. As clients were putting their tap shoes back in the boxes, therapist asked them if they had heard of the talent show that would be occurring in a few weeks. Both clients said yes and began to discuss things their peers were saying about the show.

Clients' response.

During his time to lead, client M was very vocal in giving directions to this therapist and his peer on how his rhythm should be executed. He gave client R the directive that he was going too fast and told this therapist to be louder when she stamped.

Both clients appeared to have lower energy levels during this session and conducting the session while seated in chairs appeared to work well for the clients. While both stated that they did not want to tap on top of their toe because they did not want their shoes scratched or dirty they did not become dis-regulated or frustrated during the session when this therapist suggested the intervention. Both clients, client R more than client M, were adamant about not even trying the step for fear of their shoes being ruined.

Therapist thinks that clients do not want to ruin their shoes because they have been given something that is brand new and they want to keep them that way. While therapist has told them that it is okay to get tap shoes marked up, the clients refuse to do anything that would put marks on their shoes. Therapist thinks this is because in their lives the clients are not used to receiving items that are new and not already ruined and since they have been given this opportunity they are going to try to keep the shoes as new looking as possible. Therapist also wonders if the shoes are the boys' link to the tap dance group, which is a group that only the two of them are a part of. Therefore, this sets them apart from the other boys on their unit in a different way.

Therapist introduced the idea of the talent show during this session. In the next session, she will ask the clients if they want to participate.

Clinical implications.

Significant themes in this session were low energy levels exhibited by both clients, participating in chairs, and not getting their tap shoes messed up or dirty. While a low energy level was not common among these boys until this session, therapist did not focus too much on this aspect of the group. The significant aspect of this group was the clients' strong desire to not have their tap shoes ruined by executing certain tap steps that required them to tap on top of their shoes. Clients were also against bending their shoes, which made weight-shifting difficult. It appeared that the clients may have been working on goal 10 of the treatment plan (Appendix B). However, instead of building a relationship with each other or this therapist, the relationship was with their shoes. Therapist began to wonder about the significance of the shoes and what they meant to the clients, as it appeared to her that their desire about the shoes ran deep. She further wondered if the tap shoes were becoming a transitional object for the clients between their selves and the group.

Session 6: April 20, 2009

Number of Clients in Session: 2

To begin session six, therapist asked each client how they were doing while walking to the recreational therapy room. Both clients said they were good and client R burst through the door and picked up his tap shoes off therapist's desk. She asked him to put the box down, as he knows the rule about coming into group and being ready for group before getting his shoes. Client R required three directives to put the shoes down before he could follow through. Therapist asked again if there was anything going on that either client wanted to discuss—as something seemed off with the clients. They both shrugged, while looking around the room.

Introduction.

Therapist gave each client their tap shoes and began group. Clients pulled out chairs. Therapist asked if they would like to have group in chairs again and both clients said yes. She assisted them in getting the chairs into a circle. Both clients sat in their chairs and began swinging their legs, as they had been during the previous session.

Warm-up.

This was the first session where the warm-up was conducted while seated. To accommodate the clients, who were already swinging their legs, therapist began the warm-up with leg swings. The warm-up then progressed to lateral pelvic shifts, fluidity in the torso through the spine and neck, and allowing the head and arms to react naturally.

Both clients appeared to still have low energy and while they were executing the warm-up, did not appear fully engaged.

Theme development/intervention.

Therapist asked if clients would like to continue learning shuffles, as they had begun during the last session. Both clients shrugged. She asked if they would like to create a rhythmic combination to lead and then challenge each other. Client M asked what challenge was and therapist explained (see Appendix B for definition). Both clients nodded their heads yes and there was an affect change apparent in both clients. Their energy levels began to shift as well and therapist asked which client would like to create a rhythm first. Client M went first, incorporating steps from previous sessions, including attempting shuffles. Client R's rhythm was next, and there was an improvement evident from the first time he created his own combination to this combination. It was clear, made sense, and had a steady beat.

Client M then asked if they could challenge each other. Therapist asked client R if he wanted to give this activity a try: he said yes. Therapist led the clients through their first tap dance challenge. Client M created his tap steps first. His turn lasted two counts of eight. Client R then took his turn, creating a combination that was 12 counts. They each took one more turn, this time laughing and having fun with their challenge.

Therapist asked clients to incorporate tapping on top of their toe to the back in their challenge steps. Client R said no and client M did not respond. Both clients sat in their chairs.

Therapist asked the clients if they could have a discussion about why they did not want to tap on top of the shoe. Client R said he did not want his shoes to “get all messed up like yours (pointed to therapist’s shoes).” Client M agreed by nodding his head. Therapist assured the clients that getting their shoes messed up was part of becoming a tap dancer. Clients shrugged their shoulders. Therapist asked if they wanted to try shuffles again and learn a new step. Clients said yes.

Therapist led the clients to learning shuffles by first going through air shuffles then leading them to strike the floor with their shoes. While their sounds were not a clear one-two count, the action of the foot swinging and striking the floor was correct. After about three minutes, client R asked what the new step was. Therapist introduced flaps to the clients.

Cool down/closure.

To end the session, therapist led the clients through deep breathing exercises for 45 seconds. She told them next week the goal would be one minute. Then, therapist asked the clients if they were interested in being in the talent show. Client M jumped up and

said yes; client R was hesitant and shook his head no. Client M began prompting R to say yes that it would be fun and cool. Client R asked therapist if they would be tap dancing; therapist said yes. Client M continued with his prompting; therapist asked him to allow client R to decide on his own. Therapist told Client R she would check-in with his decision about it on Wednesday.

Clients' response.

Client R's rhythms in this session were clear. He appeared pleased with himself and the rhythm he created while leading the group. It appeared that he noticed that therapist and his peer were able to follow the rhythm easier than they had in the past.

Both clients appeared to enjoy the tap dance challenge intervention and were able to engage in friendly conversation. Neither client was declared a winner, but both were acknowledged and praised for their improvisational skills and creativity.

For the next session, therapist decided to show the clients a video of Savion Glover tap dancing.

Clinical implications.

Clients asked to have session in chairs again. Once seated, they began swinging their legs and appeared to be disengaged from the group. Therapist took note of this and decided to try to raise the clients' energy level by introducing tap dance challenges for them. Clients took to the challenges right away and appeared to engage more in the session during this intervention. Tap dance challenges provided the clients with the opportunity for self-expression and creativity (goal seven). They also provided the clients with the opportunity to be witnessed in a positive way by therapist and the other client. Exploration of weight and time, including fluctuations between the fighting and indulging

qualities of each were also invited (goal one). The steps taught during this session helped to facilitate weight-shifting, this time from back to front, as well as focus on balance and engaging the core.

The theme of not wanting their tap shoes to be ruined seems to be a reoccurring one. When asked about it, clients could not give concrete reasons for not wanting them ruined but only that they just did not. Perhaps this is due to their histories of trauma and diagnoses of PTSD. The clients may be unable to link their feelings of not wanting to ruin their shoes to the emotional attachment they are creating between themselves and their shoes and the group. Also, the clients may not yet have the tools they need to identify their feelings about their shoes. At this point, all they know is that they do not want them ruined. They can not yet describe their feeling about why or how they feel to have something that is new and only for them. Traumatic experiences take away the clients ability to create emotional attachments to people so they are creating them with objects (the tap shoes).

Session 7: April 27, 2009

Number of Clients in Session: 1

For this session, only client M was in attendance because client R was asleep. It was not clear why he was sleeping. When therapist asked staff, they did not know and guessed that it may have been from medications. While walking to group, client M was telling this therapist about a peer who had run away shortly before their group had started (therapist was aware of the run, but wanted M to have the place to talk about it). M was clearly affected by this client being out on run. His affect displayed sadness; his shoulders were rising while his torso was sinking and he was enclosing. Also, his energy level was extremely low and his eyes were often looking down at the floor.

When client and therapist entered the room for session, client M immediately walked over to the window and was looking outside. Therapist got them both chairs and placed them facing each other, she asked M if he would like to sit. Client M asked if he could put his tap shoes on, but told therapist he did not want to do any tap dance. Therapist gave him his tap shoes and they both sat in the chairs. M carefully placed his tap shoes on his feet. Once they were on, he placed his elbows on his knees and rested his head inside his hands. Therapist put on her tap shoes and mirrored the client's posture. She asked him if he was sad. Client said yes and that he was worried about his friend. He continued to tell therapist that he was nervous because it was dark out and his friend was really small. The client told her that he was wondering where his friend was, what he was going to do, if he would go to the hide-out spot and stay there or if he would come back. Therapist asked the client where the hide-out spot was but client denied knowing where it was, just that it existed.

Therapist noticed client M tapping his toes as he was speaking. Therapist mirrored this movement as well; careful to be sure her taps were not louder than his. She did not want to distract the client with her sounds. Client and therapist sat in silence for one minute, tapping their toes together.

Client M then asked if they could create combinations to show each other, but wanted to remain sitting down. Therapist nodded and asked the client if he wanted to go first. He nodded his head yes. The rhythm client M created was slow and light. This was the first time during this group that this client's movements were executed using decreasing time and lightness. During his own rhythm he continued to look down, during this therapist's rhythm he watched her but never made eye contact. Each made up two

rhythms before M got up from his chair, walked over to the window and looked out again.

He commented that it was getting late and he wondered if his friend had taken any clothes with him. Therapist joined client M at the window and tried to reassure him that staff was out looking for his friend and he would be back soon. Therapist also pointed out to M how nice it was for him to be so concerned. M looked at her, shrugged his shoulders and said “he’s my friend.”

Client M then began walking around the room, therapist walked with him. He would occasionally stop and look out the window then look at this therapist. He would not say anything and then continue walking around the room. He asked therapist if she would check with staff if his friend had come back yet, she did and he had not. Client M sat back down in his chair. Therapist sat too and asked if he wanted to talk about anything. M said no but could they end group a little early so he could go back to his room. Therapist looked at the clock, there was seven minutes left in the session. She told him they could end early, but first he had to do his cool down breathing. Therapist asked client M to put his feet firmly on the floor and sit-up straight during the breathing exercises to help ground him. Client M engaged in deep breaths for 30 seconds, took off his tap shoes put them away and began walking out of the room.

Therapist walked with client M back to his room, and then informed his team leader of the session and that he was in his room. She did this because M has self-injurious behavior and she wanted staff to be aware of how he was feeling so that they would keep an eye on him for the remainder of the night.

Clinical implications.

This was the first group where it seemed apparent to this therapist that client M was using tap dance as a coping skill (goal six) and observed evidence of the therapeutic relationship that was being developed between M and therapist (goal 10). Tap dance being used as a coping skill was evident in this session when client M asked for his shoes and appeared to be regulating himself through tap dance, and more specifically weight and time (goal four), as he was walking around the room. Client M has a history of self-injurious behaviors and acting out aggressively and therapist was concerned that he might engage in those behaviors because he was so upset about his friend being on run. Client M was able to use rhythm state and tap dance to regulate himself so that these behaviors did not occur (during session or afterwards).

Building the therapeutic relationship was seen in this session when the client opened up and was talking about how worried he was about his friend and wanted to engage with this therapist even though he was upset.

Upon leaving group, client M appeared to be in stable state (goal five) as he was very clear on what was going on and his emotions on the situation. He was not engaging in any of his other known mechanisms for coping (self-injuring or acting out aggressively) and appeared to be grounded in his body and in his thoughts. He was able to physically and verbally express his emotions, further showing that he used rhythm state to modulate himself through the state he entered the group in and into stable state to leave the group (goal five).

Session 8: May 4, 2009

Number of Clients in Session: 2

Session began with both clients entering the room in an upbeat and excited stated. They were jumping and speaking loudly, client R more than client M. Therapist reminded both clients that they needed to bring their energy levels down a little before they got their shoes. Clients then took out chairs, placed them in the center of the space and sat down.

Warm-up.

Client M began creating a rhythmic combination and told client R to follow him. Therapist joined the clients in the circle and also followed along. Client R then told client M it was his turn to follow as he led a rhythm. Both clients then decided they wanted to have another tap dance challenge. They stood up, moved their chairs and began their battle.

Theme development/intervention.

After a few rounds of the challenge, client M asked what else they would be doing in session today. Therapist responded she was going to go over flaps and flap heels with them. Client M suggested the group get started on that; client R laughed. Therapist said agreed and the session got started with flaps and flap heels.

Next, therapist told the clients she had a video to show them. The video was a short clip of Savion Glover dancing. Therapist thought this would give the clients some insight into what professional tap dance looked like, as well as a tap dance performance. Both clients were extremely intrigued by the video. They requested to watch it over and over again, a total of six viewings. During the first viewing, therapist just let the clients watch the video and experience the sounds and rhythms that were created. During the

next viewings she attempted to point out steps that Savion was doing that they also had learned. These included: (a) toe-drops, (b) heel-drops, (c) shuffles, (d) flaps, and (e) flap heels. He also used clapping and stamping in his movements.

While watching the video client M remained seated, watching in awe, pointing to steps and either asking what the step was or exclaiming “we can do that!” Client R could not sit still, he would attempt steps like Savion’s and was especially fascinated at the speed in which Glover tapped.

In between viewings four and five, therapist asked the clients if they would like to participate in the talent show. They both said yes! She told them they would have to start creating their dance during that session because the preview was in a few days. They agreed, but asked to watch the video one more time. Therapist said yes as she began thinking of steps to use.

The clients decided that they wanted to use chairs in their dance and that it should have music (therapist had asked their opinion on these topics). She told them she would choose their music and bring it for them to listen to. She also told them they would have to meet a few times for a short period during non-session times to create the dance. Both clients agreed.

Cool down/closure.

To end the session, clients requested to watch the Savion video again. They did and then therapist led them through one minute of deep breathing before bringing them back to their rooms (this session ran ten minutes extra).

Clients' response.

Both clients were able to execute the motion of flaps and flap heels. Client M was able to make more sound than client R, however both sounded like the tap was only grazing the floor instead of striking it.

Both of the clients clearly enjoyed viewing the tap dance video. It appeared to be motivation to perform in the show and also reassurance for the steps they were learning. Clients will have to be focused and committed to creating and learning a dance if they do want to be a part of the talent show.

Clinical implications.

During this session, both clients seemed to be taking in the information they were seeing and hearing differently. While watching the tap dance video and therapist was pointing out the steps that they knew, client R was outwardly excited. This was seen by him pointing to the screen and asking if he knew how to do that. He also jumped out of his chair a few times to try to tap as fast as Savion. Client M's response was more inward; quietly asking about the steps and shifting his affect from a stern face to one that was much softer.

Showing the clients the video appeared to help them connect more to the steps they were learning and provide them with confidence for the talent show. Clients appeared to be proud to be learning and executing the same steps as someone who is famous.

Session 9: May 11, 2009

There was no session today. The clients were at rehearsal for the talent showcase that was to occur on May 13th.

Time in between sessions consisted of therapist meeting with the clients to create their dance. Client R missed a few of the meeting times, but client M said he would show the parts he missed to him. When both clients were present they worked well together. They allowed each other to express ideas and were completely part of the creative process of creating their dance. They were each given the freedom to use the improvisational skills they had been fine-tuning over the previous sessions in their dance. Both clients looked to each other when one forgot a step. They appeared to be a good support system for each other.

During the show, client R became nervous. He told this therapist and client M that he was not going on stage. Then would change his mind and say he was going on stage. He continued back and forth during the first half of the show. Client M talked to him and told him it was their dance and he had to go on stage with him. M told R that he did not want to go on stage by himself. Therapist assisted, saying they were partners and tap dancers don't leave their partners during a performance. Client M told client R that he was just as nervous and if they went up together it would be fun. Client R agreed to go on stage, telling this therapist and client M he wanted to have fun and for everyone to see him.

The performance went well. The tap sounds were not very loud but both clients worked with each other. Client R looked to client M for every step, but was smiling the whole time. Client M appeared nervous in his affect but also looked comfortable being on a stage. Both clients did excellent with their performance.

Clinical implications.

The clinical importance of the clients performing in the talent show was for therapeutic benefits and met goal seven on the movement therapy treatment plan. The clients performing allowed them to be seen by their staff and peers, showcase their creativity, and have the opportunity to perform things they were learning in their therapy. Further, the talent show provided another way for the clients to create group cohesion between the two of them and work together toward a common goal together, performing.

Client M was given the opportunity to truly take a leadership position and assist R in becoming grounded and confident so that he could go on stage. M did this through encouragement and reassuring R that he would be on the stage with him and help him with the steps if he needed.

Session 10: May 18, 2009

Number of Clients in Session: 2

This was the last session of this group. It started off with difficulty. When this therapist went to client R's room to bring him to group, he said he was tired. She told him that he had to come to group for two reasons; it was part of treatment and the last group. When he heard it was the last group he became extremely upset. He became adamant about not going to the group and sat in the hallway outside his room with his arms folded across his chest.

Therapist knelt down next to the client and asked him if he was okay and why he was not coming to group. Client M had also walked over by this time and was standing in front of client R. Client M asked R what was wrong. Client R said he was not coming to group. Client M asked him why and he just shook his head. Therapist asked him to please come to the group. Client M also asked him to come to the group; he further told him that

it was the last group and they had to end it together. Client R thought about this statement for a moment before standing up to walk to the group.

Upon entering the room, client R asked to watch the dance video again, client M agreed. Therapist said they could watch the video after they had some fun tap dance challenges. Both clients said yes and gave each other a high-five. Then both clients and this therapist participated in tap dance challenges that included all the steps they had learned over the course of the 10 sessions.

Client M asked if they could do their dance a last time. Therapist set up the area as a stage for them and turned on their music. Both clients performed their dance and were smiling and laughing during the whole dance.

Then, therapist turned on the tap video and both clients watched. Client M asked her to point out the steps that he knows and client R was up dancing saying he was Michael Jackson. They watched the video twice.

To end the group, therapist and clients sat at a table and had a discussion about the group. She asked them how they liked the group, if they enjoyed being in the talent show, and what their favorite part of group was. She then asked the clients if it would be okay with them to use the group as her thesis project. She assured both clients that their names would not be used and that she just enjoyed the group so much and had learned a lot that she wanted to write about it. Both clients said yes and gave each other nicknames that the therapist could use (though they are not used in this project).

Therapist then gave each client a letter she had written for them as part of the termination process. Both clients asked her to read their letter to them and each wanted to hear what the other's letter said. Therapist read both letters out loud to the group and

client R said he did not want to come to group today because he did not want it to be over. She asked him if he was glad that he decided to come and he said yes. Client M also said he did not want the group to end.

Lastly, to officially close the group, therapist gave each client his tap shoes. She told them she had checked with their team leader and their shoes would be kept in the cottage office with their other personal items. She then walked with the clients to the cottage office where they gave their tap shoes to their team leader. Client R asked if he could use them outside sometimes and client M asked when he could use his. Team leader told the clients they could discuss it at another time. Therapist thanked both clients for being in the group and each one hugged her. She then walked with them back to their rooms.

Clinical implications.

This session was the termination of the group. It was important for the clients to have closure from the group since it was ending permanently and not just for a short amount of time. Closure is important for clients so that they have the opportunity to have some control over the termination.

Clients were excited to receive their tap shoes and wanted to be sure they would not have to share them. The tap shoes appeared to be a transitional object for the clients, R especially. They wanted them to be their own and not have to share with anyone else. The shoes could also have been a connection to this special group of which they were a part.

Through all sessions, therapist focused on creating a safe environment for the clients where they felt comfortable and felt they had the space to express themselves and

work on goals. While these clients were often known for running away, acting out aggressively, injuring their selves, and having trouble controlling their impulses tap dance appeared to assist the clients in regulating their bodies and emotions so that these behaviors were not acted upon during the group.

This therapist noticed many themes during the 10 week group which will be discussed in the following chapter. Examples from this chapter will be used to highlight such themes.

Chapter Five: Discussion

Rhythm used in dance/movement therapy sessions promotes group involvement, group cohesion, clients interacting with each other, organization of body and thoughts, and the freedom to express oneself through movement.

Exploring new forms of movement can allow clients the outlet for trying things outside of their regular comfort zone. It also encourages the engagement of neuroplasticity, in which clients are laying down the pathways for new options of coping in stressful or traumatic situations. They are also learning new ways to use their bodies and movement to ground themselves to prevent physical and emotional escalation, such as violence, from occurring.

The process of learning something new can increase possibilities in altering movements and thinking patterns. This can then translate from the therapeutic setting to life. Trauma survivors can often be stuck in their same way of coping with their environment, thoughts, and behaviors. Learning tap dance can provide clients with more opportunities for new patterns and movement options to be laid out and explored. This further allows for the exploration of the person in relation to self, others, and the environment.

In tap dance weight-shifting occurs. During this process the body is changing, often sending the client off their vertical axis. This promotes a change in balance; as seen in session two when clients were learning toe-drops and heel-drops. Moving off the vertical axis can elicit a sense of losing control over one's body and movements. During this group, therapist made the conscious choice to keep the clients stable on their vertical axis to allow them to feel in control of their movements and their bodies.

However, there are therapeutic benefits for facilitating movement interventions where clients will move off of their vertical axis. One of these is that clients have the opportunity to expand their bodies and movements outward into their kinesphere and ultimately out into the world. Exploring the space from near reach space to mid-reach space can allow for the clients to take risks within the safety of their movements and their established personal space within their kinesphere. This provides the opportunity to face fears and learn new ways of moving and reacting to fears and concerns.

The use of tap dance in dance/movement therapy as a technique for interventions allowed the clients and this therapist to develop a strong therapeutic relationship. Clients were able to open up and talk to therapist about things that were bothering them (when the other client was on run) and also felt safe enough to tell the truth about not wanting to ruin their tap shoes. Clients also engaged with therapist and asked about the group every time they saw her outside of group. This was not only through the therapist/client relationship, but also through the teacher/student relationship.

While this therapist led and initiated the sessions and the interventions, the clients also participated in leading rhythmic combinations. This allowed the clients the opportunity to be leaders and witnessed by their peer and therapist in a positive way. “While there is great dependence here on the leader to sustain the rhythm...leadership does not remain entirely with her in this formation but can shift to various members of the group for short periods” (Chace, 1993, p. 200).

Rhythm promoted group cohesion and involvement because “the melody and rhythm in the music, together with the rhythmic action of the people about him, draw him in almost before he is aware that he is participating with the group” (Chace, 1993, p.

207). When group cohesion exists, there is a sense of we-ness and trust among the group participants (Plach, 1996).

At the beginning of the group cohesion stage, group participants are usually unwilling to share private information or be supportive of their fellow group members. To assist in the creation of group cohesion it is helpful for all the group members to focus on accomplishing a specific goal. While the participants are working toward this goal, they are no longer individuals working toward the same goal, but a group of people wanting to accomplish a goal together (Plach, 1996). In this group, the goal was the performance. Both clients worked toward the goal of performing by contributing ideas for choreography. When one group member was not present the other was there to catch him up. Both clients also learned to rely on each other and work together and not to compete against each other. This was seen during their performance when they looked to each other before moving on to the next movement.

Group cohesion was built in this group from the beginning of the sessions through its termination. Rhythm helped to build the cohesion of the group, through tap dance, because “by simply picking up the rhythm of another person’s movements one can establish a connection with him” (Kendon & Ferber, 1971, p. 122). Also, M encouraged R to perform and was a positive supporter for R while he was nervous just before going on the stage.

Tap dance proved to be organizing for the clients on a body level. Using tap dance to facilitate rhythm state assisted in modulating the clients from the state they entered group in, through rhythm state, to then leaving group in stable state. It was evident that the clients left group in stable state by the way they ended the group and exited the room.

They were able to engage in a slow and quiet cool down where stable state was beginning to modulate. Then when leaving the group, the clients' thoughts seemed to be more organized; this was evident through verbal statements. Stable state could also be seen in the clients' movement qualities. They appeared to be more organized and connected, as evidenced by their increased ability to end the group in a constructive way. Clients also appeared to be more aware of their space and surroundings. They were thinking clearer than they were when first entering the group. This was seen by their sentence structure and organization of movement to take off tap shoes and walk back to their rooms.

Clients were able to express their selves creatively in the tap dance group. They created movements for their dance, learned about improvisation and structure, and tap dance challenges. These were all ways for the clients to use movement and tap dance to express their thoughts and feelings at the present moment.

During the creation of individual rhythms to teach to the group, this therapist was joining in with one rhythmic creation by one client and then another rhythmic creation by another client. While it all may have seemed like a "spontaneous flow of movement" (Chace, 1993, p. 328) without any clear direction or reasoning behind it, the movements were just the opposite of that. Embodying both clients' rhythms gave this therapist the opportunity to take a closer step into the clients' world of feelings, emotions, and body sensations. "It is an exciting and stimulating experience for a leader to share the feeling of rapport with patients who respond to music with the rhythm of their own bodies" (Chace, 1993, p. 219).

Clients knew they would not receive their tap shoes for group until they were in group and ready to begin. This included not jumping around the room, touching things in

the room, walking in and out of the room, talking to other peers who were not a part of the group, and being dis-regulated or aggressive. This appeared to assist the clients to come into group. Not much re-direction was necessary. Clients knew there was a possibility of not receiving tap shoes until the end of the session if their behavior was not proper according to the group rules they helped to create. Therapist never withheld the tap shoes. They were not being used as a means of punishment or control over the clients, but as an incentive for good behavior and for being a part of the group.

Client R continuously asked therapist if he could have his shoes anytime he saw her in between their sessions. Therapist thought this showed his interest in tap dance, how he appreciated the group, and his tap shoes. This also showed that he was beginning to seek tap dance as a new coping skill because he asked to have them in his room for times that he needed them. Upon receiving his tap shoes at the termination of the group, client R stated “I love my tap shoes and I wanna use them all the time.” This was most evident in client M during the session when his friend was on run. He used his tap shoes to walk around and regulate himself and also to assist in the verbal expression of his feelings (tap his toes while talking).

There is a large difference between teaching and therapy. When teaching, “the focus is on specific learning outcomes whereas in therapy it is on inward processes” (Payne, 1992, p. 54). These sessions were an attempt to bridge these two outcomes together. The hope was that through the use of learning tap dance the clients were able to discover different aspects of their selves that they would not have had the opportunity to do had they not been in a tap dance based DMT group and gone through the process of learning a specific dance type. Therapist used the sessions to observe and address

movement qualities and affinities. She then facilitated tap dance steps to assist clients in changing and/or altering their movement qualities and affinities to assist in benefiting them in their everyday lives.

This study asked the question: how can tap dance be used as a dance/movement therapy technique? While there was no previous research on the specific use of tap dance in treatment there were previous studies on the use of general rhythm.

The field of dance/movement therapy will benefit from this research in the use of rhythmic interventions. The study shines a light on how important the use of rhythm as a form of treatment in therapeutic groups is. Dance/movement therapists can focus on the therapeutic benefits rhythmic combinations, patterns, and movements create for their clients. Using tap dance to facilitate these interventions allows dance therapists to meet their clients on a level that had not yet been explored prior to this study. Tap dance can also allow for freedom of expression and feelings by the client which can give the therapist clues to their emotional state just by having the client walk around the room.

The ability of this therapist to be able to get tap shoes for both clients assisted in the outcome of this group. While the group could have been conducted without tap shoes, having them allowed the clients the full tap dance experience. The shoes also allowed for movement explorations of weight and time that perhaps would not have occurred if tap shoes were not available. The shoes also provided the biggest limitation and difficulty to this study, because neither client (R more than M) wanted their shoes ruined. They thought that by bending them or tapping on top of them as is required in some steps would ruin the shoes and then they would be less valuable. Therapist could only guess what the shoes truly meant to the clients because when asked about this or when their

behaviors were pointed out by this therapist, clients were unable to answer and usually shrugged their shoulders. Therapist thinks the clients did not want their shoes ruined because they were valuable to them. She thinks the shoes' value to the clients included connecting them to the group, each other, this therapist, tap dance, DMT, and performing.

The tap shoes became transitional objects for the clients in this group. Transitional objects are items that children use for comfort and security as they are moving through developmental stages; they are “the area of experience to which inner reality and external life both contribute” (Winnicott, 2004, 73). A well known example of a transitional object is a child's blanket. The blanket is often a substitute for the mother's breast. With a transitional object, the child can create an illusion about a situation that is part subjective and partly based in reality. The child can see and control the blanket while they can not see or control their mother. The tap shoes served the clients as an item that they could objectively perceive, be comforted by, and have control over. The shoes took the place of the blanket in the above example; they were the boys' connection to the group, this therapist, each other, and their therapy. The tap shoes provided the boys with comfort and knowing that they had an object that they could possess that was only theirs. The shoes were also an example of their therapy. They were the tools that assisted the boys with what they were working on in terms of their therapeutic goals.

Sessions for this group were guided by a movement therapy treatment plan that listed goals. This assisted in making the group a therapy group and not a tap dance group as well as clearly laying out how tap dance in therapy can benefit these clients. The therapist created the goals of this group specifically for these clients based off of their

movement patterns she had observed previously as well as their interactions between each other, other peers and staff, and their environment.

Tap dance and DMT provided corrective experiences for the clients. One of the ways this was done was through the relationships that were built between this therapist and the clients. The therapeutic relationship that was created during this group was one of respect between the clients and between the clients and this therapist. It was also a grounded relationship in the sense could be open with therapist about their feelings. This was clearly evidenced by client M during session seven when he conveyed to therapist that he was worried about his friend who had run away; and by client R during the last session when he expressed his sadness about the group ending. Using tap dance in these DMT sessions set up an environment where learning could take place, and the therapeutic relationship that was created allowed for successful accomplishments for the clients. They were able to successfully learn and execute many tap dance steps (see Appendix D) and allow their creativity to be expressed and witnessed by others in their performance during the talent show (Appendix E).

Another way tap dance and DMT provided the clients with a corrective experience were through allowing the clients to learn ways of having control over their bodies. They were provided with the tools they needed to begin to establish their connectivities, ground to the earth, access their breath, and regulate their movements and emotions. This was all done through tap dance steps, rhythmic combinations, and breath work in the DMT sessions.

While this research was guided by a specific research question, new research questions can include: How can the benefits of rhythm differ culturally? Is there a

difference in rhythmic patterns between genders? How does rhythm affect brain waves and other physiological responses? While researching the use of rhythm as a means to decrease aggression and sexualized behavior, this researcher also wondered if the opposite can happen. Can the use of rhythm ever increase aggressive and/or sexualized behavior?

Study Summary

To summarize the study, tap dance was used to facilitate rhythmic interventions in a dance/movement therapy group. The group, consisting of two 10 year old boys, met for 10 weeks. During each of the sessions, the clients were taught tap dance steps and terminology. This therapist used tap dance and the steps she was teaching the clients to assist them in grounding, accessing rhythm state and stable state, providing opportunities for creativity and self-expression, and group cohesion.

It is important to mention that both clients come from a background where they experienced trauma. While their trauma was not directly addressed in the sessions, their behaviors from the trauma were. These behaviors include aggressive actions, self-injurious behaviors, running away, decreased impulse control, and the decreased ability to build and maintain healthy relationships.

Research has shown that trauma can be healed and the use of rhythm in therapy is extremely beneficial to clients. While some traumatic events can leave clients feeling debilitated and at a loss of self; as humans we are fortunate “because we are instinctual beings with the ability to feel, respond, and reflect, we possess the innate potential to heal even the most debilitating traumatic injuries” (Levine, 1997, p. 19).

When trauma has been resolved, clients have been given a gift. It is the return of their lives. They have the tools to resolve problems, express themselves, build healthy and meaningful relationships, and have a deeper understanding and connection to their self. They are returned to “the natural world of ebb and flow, harmony, love, and compassion” (Levine, 1997, p. 21).

“Man uses many forms of rhythm and dancing to reveal himself” (Meerlo, 1960, p. 17). With the use of rhythm, movement qualities can be changed, feelings and thoughts can be expressed, and clients can feel a sense of community, joining, and cohesion with their fellow group members. “The rhythm of life brings the dance” (Meerlo, 1960, p. 40).

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Appendix A: Definitions of Terms

Many of these definitions have been operationalized for this study. This researcher recognizes that these definitions may not fully encompass the use of or meaning of all the words. Definitions that do not include a citation were created by this researcher based on how she used them throughout the research process and/or how she understands them and uses them in her work.

Body Awareness: “The precise, subjective consciousness of body sensations arising from stimuli that originate both outside of and inside the body” (Rothschild, 2000, p. 101).

Body Knowledge: The therapist’s ability to receive information through movement.

Breathwork: “Literally any work involving conscious breathing” (Aposhyan, 2004, p. 265).

Dance/Movement Therapy: “The psychotherapeutic use of movement to promote emotional, cognitive, physical, and social integration of individuals” (ADTA, 2009). DMT uses the body and movement as expressions of thoughts, ideas, and feelings. The body is the main tool used in this form of therapy and the therapist receives more information from the non-verbal cues the body is giving than from the verbal words from the client. The body is used to create interventions and treatment. DMT is practiced in hospitals, schools, residential treatment centers, in rehabilitation, medical centers, mental health treatment, and in disease prevention.

Embodiment: “The moment to moment process by which human beings may allow their awareness to enhance the flow of thoughts, feelings, sensations, and energies through their bodily selves” (Aposhyan, 2004, p. 266).

Grounding: “Allowing physical weight of the body to pass down into gravity;”
“grounding brings one’s attention back to the body;” “bring the mind back to the body,
focus on the lower body” (Aposhyan, 2004, p. 267 & 132).

Group Cohesion: “Members of a cohesive group feel warmth and comfort in the group
and a sense of belongingness; they value the group and feel in turn that they are valued,
accepted, and supported by other members” (Yalom, 2005, p. 55).

Kinesthetic Empathy: Empathizing with a client through the use of body and
movement. Therapist takes on the client’s movements to further understand his world.

Kinesthetic Memory: Embodying a client until the therapist is able to access the
movement in her body. This is utilized to remember sessions and experiences with
clients.

Laban Movement Analysis: “Laban Movement Analysis provides a comprehensive
vocabulary and analytic framework for the description of human movement. Using LMA,
one can systematically look at a unit or phrase of movement in terms of the four major
movement components: Body, Effort, Shape and Space. These basic components can be
identified and examined alone and in relationship to each other” (Laban/Bartenieff
Institute, 2009).

Mindfulness: “A clear, lucid quality of awareness regarding to the cognitive and
emotional experiences of everyday life” (Bakal, 1999, p. 13).

Modulating: The therapist suggests movement interventions to the client for them to
move through states. Assisting the client to move from one state to another by changing
one element of the state at a time provides a change in movement quality. This further
assists in changing effort life and mood. Modulation is related to self-regulation because

when clients are able to modulate they can shift from a non-regulated state to one that provides grounding and regulation for them. This can ultimately be achieved with assistance from the therapist or not.

Movement Affinities: A client's preference for certain movement qualities. Affinities can also occur when movement qualities are affined with each other. For example, rising with decreasing pressure is an affinity.

Movement Dis-affinities: A client's dis-like for particular movements and effort qualities. Dis-affinities can also occur when movement qualities are not affined with each other. For example, rising with increasing pressure.

Movement Patterns: "We make connections in our own bodies through patterns or plans which our neuromuscular system develops for executing movement sequences." "There are basic patterns and principles of movement, but there is no one pathway for all persons to achieve full functioning. Human beings pattern their movement responses in ways in which they originally perceive will enable them to function in their environment, and each individual history is unique" (Hackney, 2000, p. 13 & 48).

Organic Movement: Occurs when movement begins from an impulse to move and not from instruction. Neither the client nor the therapist force any movement or intervention. The session unfolds in the moment.

Residential Treatment: A residential treatment center specializes in the treatment of children and adolescents who have been diagnosed with severe behavioral and emotional difficulties. Often these are a result of neglect and abuse (physical, sexual, emotional, verbal, and cognitive). Forms of therapy include individual, group, and family (when possible).

Rhythm: “Rhythm is the lawless law which governs us all without exception... Time and rhythm are inseparable. Rhythm consists of accented and unaccented moments in time.”

(Newlove & Dalby, 2004, p. 117). The most common known rhythm is the heartbeat.

Self-Expression: The opportunity and ability to express one’s thoughts, ideas, feelings, emotions, and self through the use of movement.

Self-Regulation: Remaining calm, cool, and collected in high stress or provoking situations.

Space: (As in where) is related to attention (Newlove & Dalby, 2004, p. 193). The fighting quality is directing and the indulging quality is indirecting.

Staying in Your Body: When a person is “aware of a significant portion of one’s bodily sensations from moment to moment” (Aposhyan, 2004, p. 92).

Tap Dance: “A form of dance in which wooden or tap shoes are used to create rhythmic sounds and patterns by striking the tap or sole against the floor” (Fletcher, 1997, p. 142).

Time: (As in when) is related to decision (Newlove & Dalby, 2004, p. 192). The fighting quality is accelerating and the indulging quality is decelerating.

Traditional Tap Dance: Is executed while “dancing flatfooted, passing work down from one to another, experimenting with the art of improvisation, working with live musicians” (Fletcher, 1997, p. 30-31).

Weight: (As in what) is related to intention (Newlove & Dalby, 2004, p. 192). The fighting quality is increasing pressure and the indulging quality is decreasing pressure.

Appendix B: Movement Therapy Treatment Plan

I. Reason for Referral

Clients were referred to movement therapy to assist in achieving the goals on their individual treatment plans (ITP). These goals include learning to express feelings without aggression, hurting others or running away and having a creative outlet for self-expression, among others. In addition to assisting the client to meet their specific ITP goals; this movement therapy group can also assist the clients in increasing their ability to remain grounded and in their body, increase ability to self-regulate in stressful and/or provoking situations, and increase their outlet for and further foster their self-expression.

II. Services Provided

Clients will attend one movement therapy group a week that lasts 30 minutes. This movement therapy's group primary focus is rhythm. During the group clients will learn to execute rhythm, including Laban's rhythm state and stable state through the use of tap dance. Clients will also learn tap dance steps and vocabulary, engage in tap dance "challenges" using their tap dance repertoire, and create a short dance.

III. Movement Therapy Goals

1. Clients will increase their awareness and use of weight through their upper/lower connectivity so that they may fully access their ability to remain grounded.
2. Clients will increase their awareness and use of their head/tail connection to fully access their verticality.

3. Clients will increase their awareness of and use of free flow.
4. Clients will learn what Laban's rhythm state and stable state are.
5. Clients will modulate from current state, through rhythm state, to leave group in stable state.
6. Clients will increase their ability to use tap dance as a coping skill to increase self-regulation.
7. Clients will increase their creative self-expression through the use of tap dance and a performance in the annual residential talent show.
8. Clients will learn about tap dance: what it is, how it can be used, proper terminology and correct ways to execute steps.
9. Clients will increase their awareness of somatic sensations when they become frustrated, angry, aggressive, and proud.
10. Clients will develop a therapeutic relationship with each other and this therapist.

Appendix C: Informed Consent

To Whom It May Concern:

I am currently a student at Columbia College Chicago completing my Master's Degree in Dance/Movement Therapy and Counseling. Currently, I am a Dance/Movement Therapy intern at the residential treatment center and have been working with client R since I began my internship in August. I currently see client M and R in a dance/movement therapy group that uses tap dance and for my thesis project I would like to write about the tap group; tracking the group from beginning to end. This would take the form of a case study in which M and R's names and place of residence will be changed so that there will be no way for them to be identified. Their identity will remain confidential throughout the process. My data will take the form of clinical notes (where their names will also be changed) as well as my own personal journal entries about the group. Attached you will find a consent form for your signature, allowing me to write about the group in which M and R are a part of and not about the clients personally. If you provide your consent, please sign this form and fax it back to me immediately. If you have any questions you may contact me or my thesis advisor (contact numbers are on the consent form).

Thank you,
Alexandria D'Aurio

Appendix D: Tap Dance Terminology

All definitions were retrieved from: Fletcher, B. (1997). *Tapworks: A tap dance dictionary and reference manual*, (2nd ed.). Highstown, NJ: Princeton Book Company.

Across the floor: To practice or perform tap steps or combinations from one side of the room to the other side of the room, or from one corner to the other corner (p. 37).

Ad-lib: To improvise or to create on the spot with no previous planning (p. 37).

Air Shuffles: A movement that imitates shuffles, but the dancer does not strike the floor. Therefore, the correct action is present, but no sounds are made (p. 39).

Air Taps: When a step is executed but the taps never hit the floor; the action is present, but there are no sounds created (p. 39).

Alignment: The relationship of the body segments to each other. Correct vertical alignment occurs when the head is centered over the shoulders, the shoulders over the hips, and the rib cage and the pelvis are held in a neutral position. Finding and maintaining the proper alignment is not only a conscientious and constant procedure, but also a must for good technique and proper execution (p. 39).

Alternating (changing): A term, not a step. It means the act of changing from one foot, hand, etc. position to the other. Those steps that normally transfer weight are not usually labeled as alternating (e.g. shuffle step, toe heel, flap ball change, etc.). Those steps originally meant for repetition on one foot only, but that are now changing from foot to foot, are called alternating or changing (e.g., alternating wings, alternating pickups, etc.). The term alternating shuffles is misleading as it is not really referring to shuffles but to shuffle steps (p. 39).

Alternating Heel Drops: (2 or more sounds). Standing feet flat on floor, usually in a parallel position, weight forward, in plié, lift first the right heel and forcibly lower, then lift left heel and forcibly lower. Continue in alternate fashion. When done in a continuous even rhythm, a rolling sound is produced. If the same level is to be maintained, remain in plié. If a bouncy effect is desired, legs may straighten and then bend with each sound. Alternating heel drops may be done parallel, inverted, turned out, from side to side, etc (p. 40).

Alternating Heel-Toe Drops: (2-4 sounds). Standing feet flat on floor, usually in a parallel position, weight centered. To execute: raise right heel and lower, then raise right toe and lower. Or raise right heel and lower, raise left heel and lower; raise right toe and lower, raise left toe and lower (p. 40).

Alternating Shuffles: (6 sounds). Walking: the transfer of weight from shuffle to shuffle is done by stepping. Therefore, shuffle step right and left. Running: the transfer of weight from shuffle to shuffle is done by leaping. Therefore, shuffle right leap right, shuffle left, leap left. Alternating shuffles can be done in place, forward, backward, sideways, turning, etc (p. 40).

Alternating Toe Drops: Stand with feet flat on floor, parallel usually in plié, weight centered. Lift and flex right toe, right heel remaining on floor (weight on left foot and/or right heel), forcibly lower right toe. Repeat action on left. To maintain a level, remain in plié, or if a bouncy effect is desired, legs may be straightened and bent with each toe drop (p. 40).

Alternating Toe-Heel Drops: (2-4 sounds). Standing with the feet flat on floor, usually in parallel position, weight centered. This step has the same components as a cramroll.

To execute: lift right toe and lower, lift left toe and lower, lift right heel and lower, lift left heel and lower. Or lift right toe and lower, lift right heel and lower and reverse (p. 41).

Alternating Toe Rolls: Drop right toe, then left toe in rapid succession and in a steady rhythm, thus creating a rolling sound (p. 41).

Arched: A term, position, or movement; not a step. Literally means bent over. Arched could refer to the back, feet, the total curve of the body, etc (p. 42).

Ball: The part of the foot and the shoe upon which the tap is placed. Ball is executed by: placing the ball of the foot on the floor, the heel of that foot is raised, with/without weight, with/without sound; striking the ball of the foot on the floor, with/without weight, with/without sound; ball may be done in any direction or position, with/without weight, with/without sound (p. 46).

Ball Change: (2 sounds). Implies a quick transfer of weight, with accent on the last foot. May be done in any position of the feet: opened, crossed, parallel, turned out, in relevé, plié, in place or traveling front, sideways, backward, or turning. Many times it is combined with other steps (such as shuffle ball change, step ball change, etc.). To execute: step right backward; on ball of right. Step forward left, either flat or on the ball of the left (p. 46).

Beat: In music; is a steady rhythmic pulsation much like the beating of a heart or the ticking of a clock that in music is a unit of measure (p. 50).

Challenge: The challenge, usually friendly, takes place between two dancers to see who can produce the most intricate and exciting footwork, rhythms and flash steps. It involves improvisation and creativity (p. 61).

Drop Toe or Toe Drop: Starting with feet in parallel position, flex toes of one foot, using the heel in contact with the floor as a pivot point. Weight is on the supporting leg. With a firm action, lower the toes; weight is transferred (p. 75).

Drop Heel or Heel Drop: Starting with feet in parallel position, lift the heel of one foot. Using the ball of the foot in contact with the floor, firmly lower the heel. Weight is transferred (p. 76).

Flap: (2 sounds). A very early step in tap. to execute: raise right foot in a backward position; swing right foot in a forward and downward direction making a brush sound, then step forward right, usually on the ball of the foot. This step can be done traveling in any direction, turning or in place. Flaps alternate from foot to foot. Knees are relaxed and bent (p. 82).

Flap Heel: (3 sounds). The heel usually receives the accent. To execute: flap right high on ball of foot and forcibly lower the heel. Reverse. It may be executed in any direction and performed to many rhythms (p. 83).

Heel Toe: (2 sounds). To execute: stand left, place right foot forward, backward edge of right heel on floor, toes flexed. Drop right toes, keeping right heel on floor. May be done with or without weight (p. 92).

Hop: (1 sound). A movement executed by standing in plié on one foot, springing into air, and landing on the same foot. The free leg should be controlled and the landing is usually in plié (p. 93).

Improvisation: To sing, dance, act, choreograph, or perform without a set plan in mind. To work from inspiration and impulse rather than from a previously thought-out plan (p. 94).

Individual Rhythm: The individual's ability to feel a beat, timing, and tempo with or without music being present. More advanced types of rhythm must be practiced, but much natural rhythm seems to be present in certain individuals either because of inherent qualities or environmental exposure (p. 117).

Parallel: A position of the arms, body, head, or feet in relationship to each other or to a surface. Literally, "side by side," "having the same course" (p. 107).

Relevé (Rise): Present in all forms of dance. It literally means to rise on the points or the balls of the feet (p. 115).

Rhythm: In Music—the regular occurrence of the beat. It is the framework upon which all other principles, such as accent, syncopation, etc., are based. Rhythm is intricately tied to its time signature and is involved with tempo. It includes such things as double time, 3 against 4, etc (p. 117).

Rolling Rhythm: Any rhythm that is continuous and has a repetitive count (p. 123).

Shoes (taps): Tap shoes began as clog shoes. Later, they progressed to a split clog shoe, in which the sole was split into three sections with hollow heels of honeycomb wood. By the 1800s, leather was available and with the popularity of sand dancing and the essence, it became the shoe of choice. Its name, the soft shoe, and the dance became synonymous. Most clog dancers, however, continued to wear wooden shoes for performing. By 1915, metal taps had been placed on the toes and heels, and the tap shoe as we know it was born (p. 128).

Shuffle: (2 sounds). With right foot in a backward position, brush the foot forward striking the ball of the foot on the floor, then spank right backward. (The shuffle is one of the most fundamental and most frequently used steps in tap) (p. 129).

Shuffle Ball Change: (4 sounds). While standing on the left, execute a shuffle right, then ball change right back left. The shuffle and the ball change may be done in any position or direction (p. 130).

Shuffle Toe-Heel: (4 sounds). Stand on left, shuffle right, toe heel right, reverse. May be done in any position or direction. Feet remain side by side or crossed (p. 131).

Single Shuffle: (2 sounds). Stand left, right bent and back, execute brush forward and spank backward. Can be done in any position or direction, using whole leg, lower leg, or ankle only. Supporting leg can be straight or bent, feet can be oblique, parallel, turned-out, etc (p. 129).

Spank: (1 sound). Stand left, raise right in forward position, swing back striking ball of foot on floor (brush back right), right ends in back in air. (Spank is the backward version of brush and is classified as a movement whose normal action is toward the body, whereas brush moves away from the body) (p. 134).

Stamp: (1 sound). A forcefully executed step using the whole foot. Reverse with weight. May be done in any direction or position. To execute: raise right (right knee usually bent), lower entire right foot to floor with weight. Reverse (p. 137).

Step: (1 sound). In movement: to place a raised foot on the floor, usually on the ball with weight, without sound (p. 138).

Stomp: (1 sound). A stamp carrying no weight (p. 139).

Tap: (1 sound). A sound created by striking the tap on the floor, usually using the ball of the foot or the tip of the toe (p. 142).

Tap Dancing: A form of dance in which wooden or tap shoes are used to create rhythmic sounds and patterns by striking the tap or sole against the floor (p. 142).

Traditional Tap: Also known as hoofers and jazz tappers, includes such people as Savion Glover, Gregory Hines, Buster Brown, Leon Collins, Cookie Cook, and Diane Walker. They are from the original school of tap; dancing flatfooted, passing work down from one to another, experimenting with the art of improvisation, working with live musicians. They are the keepers of the flame and turn their attention and talents totally to the art of tap, refusing to be influenced or changed by other forms such as ballet, modern dance, or jazz. They have different motivations and goals from the contemporary dancer. Unfortunately, there are only a few of them left and with their passing goes their knowledge, for it has been little documented or recorded. The film *Tap* best explains their philosophy (p. 30-31).

Toe-Drop: (1 sound). With right heel on floor, toes raised and flexed, using heel as pivot point, forcibly lower toes. Inferred to carry weight; if not then it should be stated as no weight (p. 153).

Appendix E: Dance from Talent Showcase

Walk 4x

Head nod

Walk 3x clap...repeat 4x

Look at each other...head nod

Sit in chairs

Client M begins rhythm

Client R joins in

Stand up

Look at each other...head nod

Shuffle 4x

Toe toe heel heel toe toe clap

Look at each other...head nod

Walk to back

Look at each other... head nod

Walk off to sides