DANCE THERAPY

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Dance Therapy

Dance therapy is a form of psychotherapy that focuses on the use of movement as the medium of change. While the complex relationships between mind and body have long been recognized and studied, there has been limited exploration in modern western cultures on using the body as a healing force for emotional distress. Eastern cultures have more extensively examined this relationship. Many movement forms such as T'ai Chi are meant for meditation and self growth. The mind-body is seen as a system that must function in ease and harmony. Disruptions of the flow and unity may indicate the presence of psychological and physical stress and conflict. Dance therapy is based upon such assumptions, built upon psychological and physiological concepts with the strong belief in the psychic-physical relationship.

Historical Development

Dance has long been fundamental to man's existence as an expression of life itself. To be alive is to move, to function harmoniously with the rhythms of one's own body and the surrounding universe. In all cultures, man's earliest attempts at communication, historically and developmentally, occurred on the preverbal level. Gesture and body expression were clearly the vehicle to any attempt to share experience. As language and tribal structures developed, religion gave shape to life, and dance was inextricably part of the worship and

prayer that attempted to both structure and explain life. It was a powerful and unifying expression of the solemn movements of man's life: birth, puberty, marriage, and death. Dance was part of the means to control life by propitiating the forces which controlled the rain, the sun, and the fertility of earth and man. The rhythms and movements of tribal members provided group strength and unity during war, and solace during mourning. Its structures provided a means to pass tribal learning on to younger members. Dance is a language which uses the totality of body-mind-spirit to relate to the most profound experiences, painful and joyous, to those who would observe or share in the experience. Its deeply primitive aspects foster empathic understanding.

Dance Therapy as a Profession

The impetus for professionalizing dance as a therapeutic modality occurred after World War II, as the need for new therapeutic forms arose to meet the demands of the many psychological sufferers. Various group modalities were used experimentally and evolved as valid techniques. At this time, Marian Chace was teaching and performing in Washington, D.C. She was a member of the Denishawn dance group that experimented with new forms and had alliance to Eastern spiritualism and religious expression. She observed in her teaching that students who had no intention of becoming professional dancers, kept returning for dance classes. She carefully took note

of their individual movement communications and began to heed their separate motivations and psychological needs. It led to further understanding of why dance was a fulfillment of some of these needs. With her focus shifting to individual needs through movement, or client-centered dance rather than technique oriented, several psychiatrists became aware of her skills and began to send patients. With the recognition of her special skills, she was invited to work at St. Elizabeth's Hospital in Washington, D.C., using dance as therapy. Similarly during these same years, other individuals developed their art to use in a new and meaningful way to aid in the reintegration of body and mind. Trudi Schoop, working in California, developed her own techniques for working with psychotics (1974). Mary Whitehouse, Blanche Evan, Liljan Espenak, and others specialized in the relationship of movement to the neurotic process. Each came to the field after a rich background of performance and teaching in dance. They took what was basic to their art and purposefully made use of movement concepts to aid others in finding new ways of understanding and coping with emotions. Dance therapy now has several hundred practitioners in a great variety of settings. The power of dance itself was the force that drew each of them toward the realization of the therapeutic possibilities of dance therapy as a profession.

Presently there are two terms, "dance" and "movement" therapy, to describe the profession. *Dance* was modified to *movement* by those who wished to detach themselves from dance as a performing art. The word

"dance" in our culture has a narrow definition. The term is often misunderstood when used within therapy because of such stereotyping. There is also variation by dance therapists in the use of music in treatment. Those who make little use of music but rather rely on the internal rhythms developed by the patient more frequently use the term "movement." However, the rhythmic quality of movement, particularly as related to groups, and concepts of space, time, force, and balance have roots in dance itself. Many believe it important to maintain identification with dance as an art form, for it is that balance between art and science that makes the creative and therapeutic use of dance so valid and successful. There have been other attempts to find a descriptive term, such as Schoop and Salkin's "body-ego technique." However, all lead back to dance and movement therapy as generic terms. As in all disciplines, understanding the concepts proves more helpful than depending upon the name.

Psychiatric Theory and Dance Therapy

Because the use of movement in therapy has to do with the most basic and primitive concepts of human behavior and expression, it is possible to use it within the theoretical structure of existing psychiatric theories. All systems take cognizance of preverbal levels of development, of primary processes and of the many causes and difficulties leading to blockage of verbal communication, and yet the tools of psychiatry for direct intervention

on these levels have been very limited. The work of Wilhelm Reich (1942; 1949) is very useful as a base of understanding. He did extensive work to show that physiological behavior is functionally identical with psychic behavior; "character armor" appears not only as psychological defenses, but also as muscular defenses. Reich analyzed the muscular patterns and rigidities of his patients and believed them to be essential to the inhibition of primitive feelings. He therefore worked simultaneously to dissolve resistance in both the somatic and psychic realms. Lowen (1967; 1967, 1970, 1971) continued to develop Reich's theories into a system of "bioenergetics." A useful concept he developed is the relationship of improper breathing to the blockage of feeling. He states, "Moving with feeling is only possible when the respiratory movements are harmonized with the expressive movement" (Lowen, 1970). When crying is inhibited, the muscles related to eyes, jaw, and throat control and prohibit deep breathing. In dance therapy, many of the bioenergetic theories are useful in aiding in the release of body tension related to emotion. The application should be in the context of on-going therapy rather than merely offering exercises to deliberately elicit emotion.

In psychomotor therapy, Pesso (1969) makes use of Freudian analytic concepts. He realizes it is not only the emotion that is repressed, but the movement behavior it calls forth. He carefully structures therapy to allow for the impulses and resultant movement behavior after helping patients to not accede to inhibiting movement defenses. Pesso develops an interactional

model to permit the patient to follow through with appropriate movement behavior.

It is possible through dance therapy methodology to work on those basic levels that psychiatric theory has long taken account of but which has not been available. The framework that the dance therapist works within may differ. Chace primarily was conceptually Freudian and Sullivanian while Whitehouse was trained in the Jungian tradition. Differences in theoretical conceptualization may alter the style or technique, but the underlying movement theories are inclusive. Dance therapy offers an alternative method for working within the context of any systematized theory of human behavior.

Psychological and Physiological Concepts

The body itself is a source of memory, response, and learning. Learning about the self is closely allied with the understanding of how our body responds to the many conflicts and stresses in daily life. Dance therapy provides a structure which allows development of a sense of the body and through movement, makes use of the muscular and visceral responses related to emotion and emotional memory. This process allows an opportunity for cathartic release and expression of feelings which perhaps have been blocked or disguised. Lowen states:

> Every emotional illness is characterized by a degree of paralysis of body

> movement, specifically those movements of the body that express feeling. These movements which come from within as opposed to voluntary movements directed by the conscious mind are summed up in the expression, the motility of the body. The reduction of body motility is a measure of the severity of emotional illness. You only have to see a person in a catatonic state to realize the significance of this relationship between motility and health. There are also sick people who are hyperkinetic, hyperactive or hysterical. In these cases the motility is not so much reduced as it is fragmented, chaotic, frenzied or frantic (1970, p. 3).

Movement change and psychological change are integrally connected. Cognition and intellectual awareness are of course necessary for change. In dance therapy, the body and its movement are the prime tools that work toward that awareness and the unity of self.

Dance and movement therapists are clarifying the importance of the body, not only in its relationship to emotions and learning, but also its accuracy as a communicative force. To unravel the myriad of movement patterns of an individual becomes an intriguing and therapeutically rewarding task. Movement style is a language which speaks of how an individual has adapted to the life forces around him and his system of coping with those forces. By recognizing the language of movement, the dance therapist enables an individual to reach the source of emotional constriction and explore new and more satisfying systems of behavior.

Theories delineating the connections between emotions, the body and the mind are most important to dance therapy but would require a separate

treatise to do the subject justice. However, it is appropriate to briefly discuss a few of these hypotheses and their implications for dance therapy.

All life is made up of movement. Our very existence is made up of both voluntary and involuntary sensory-motor responses to inner sensations and the environment without. We are continually acting upon these impressions. Even when we are "still," experimental evidence suggests that muscular tension can be localized to particular muscle groups so that energy is released in sufficient amounts to be measured, even in the thinking processes.

Life initially is represented by tactile, thermal, and pain impressions which are acted upon by motor activity. Movement begins as random and uncoordinated. As a child matures, he is better able to control his gross motor activities. Adults heed and respond to the body communications of the infant. With the development of language as communication, less significance is placed upon his physical responses. The intellectual processes receive the recognition for learning and communication. Language is a translation of primary processes.

Very relevant to dance therapy theory, are learning theories, defining the physiological changes of the body in relation to emotion, the development of the kinesthetic sense and empathic muscular response, and concepts related to the development of body-image. Theories of emotion examine the

relationship between physiological and muscular change, awareness and response. To experience an emotion such as anger, is a physical experience. Darwin's (1955) work 100 years ago described the innate nature of facial and bodily expressions in emotion. More recently, Ekman and Friesen (1971), in their cross-cultural studies support the hypothesis that certain facial expressions are universally associated with the same emotions. Similar muscular tensions and impulses in emotion are experienced by all; it is the translation to expressive movement which can be controlled, inhibited, censored, or diversely communicated according to the cultural and personality dynamics of the individual. Various theories of the origin of emotion and thought (Carl Lange, William James, Nina Bull) point to the experience of bodily sensations and movements which are the immediate response to perceptions of stimuli. Since dance is body movement, the emotions as expressed and communicated can be experienced and used directly in therapy. There is no need to translate those emotional experiences into the symbolism of words.

The central nervous system is organized into *movement patterns.* It is believed by kinesiologists that certain patterns are innate in our biological heritage, such as throwing and locomotive patterns. Others must be learned and perhaps modified for specific situations. Kinesthetic perception and memory are the base of the learning of voluntary movement. Such memory enables the performer to initiate a whole pattern of movement or to modify a

part of the whole. Only through experience and experimentation with movement are such patterns firmly established. In most sports activities, one is concerned only with specific skills and the body's relation to these. Little effort, except in dance and theater, has been made to consciously develop kinesthetic memory of the entire body and its parts.

Our relationships to the world around us are dependent upon our sense of body image. If knowledge of the body is incomplete or faulty, all actions for which this particular knowledge is necessary will be faulty too. Directional concepts such as *up, backwards,* and *sideways,* all relate to an internal sense of self. Spatial relationships develop by first using our own bodies as a point of reference. Many children have difficulty with this learning process and thus their learning is incomplete. They are not sufficiently aware of body parts, how to move them, or what they can do. As Schilder explains:

> . . . movement leads to a better orientation in relation to our own body. We do not know very much about our body unless we move it. Movement is a great uniting factor between the different parts of our body. By movement we come into a definite relation to the outside world and to objects, and only in contact with this outside world are we able to correlate the diverse impressions concerning our own body. The knowledge of our own body is to a great extent dependent upon our action . . . The postural model of the body has to be built up. It is a creation and a construction and not a gift (1950, p. 112-113).

Posture is one aspect of body image. A dynamically changing posture is the core out of which motor behavior flows. Controlled by the cerebellum, it is

maintained by nerves and muscles in reaction to the shifting location of the body's center of gravity. It is through posture that we are able to maintain an orientation to the earth's gravitational force and the environment around us. All learned movement patterns and learned responses result from the elaboration and reorganization of the basic posturing adjustments. The gravitational axis of the body is the zero point from which we establish direction and concepts of space. The implications for dance therapy would suggest that as an individual is able to increase his range of movement and develop a more flexible posture, he is more likely to have increased choices of behavioral responses.

While a kinesthetic sense aids in the muscular remembrance of coordination, weight, shape, and spatial factors, it also is an element in the empathic emotional perception of the muscular tensions of another person. Berger states:

> Kinesthesis, then, is important not only in the perception and control of the movement, position and balance of the body, but in the emotional experience and expression of the entire individual. Proprioceptive impulses arising from within our musculature enable us to regulate the force and coordination of all the motor activity required of us in the function of living and contribute to our experience of our own postural and emotional condition. And proprioceptive impulses which are activated by the external stimulation of the movement of others enables us to understand their emotional condition in terms of our own experience, and to receive cues which are important in our total reaction to those around us (1972, p. 210).

Dance therapy works to heighten kinesthetic experiences and thereby aids in expressive movement. Body posture, as a dynamic element, and gesture relate to emotional states. These become a form of communication as movements become expressions of feeling. Particular physical activities may carry with them specific feelings, such as the rocking of a baby, or shaking a stick. Schilder's treatise (1950) relates the concept of body-image to movement, kinesthesis, and postural reactions within a psychoanalytic framework. He states:

> Motion [thus] influences the body-image and leads from a change in the body-image to a change in the psychic attitude . . . Tension and relaxation are the elementary components in the dynamic sequence. There is so close an interrelation between the muscular sequence and the psychic attitude that not only does the psychic attitude connect up with the muscular states but also every sequence of tensions and relaxations provokes a specific attitude . . . every emotion expresses itself in the postural model of the body, and (that) every expressive attitude is connected with characteristic changes in the postural model of the body . . . The body contracts when we hate . . . this is connected with the beginning of actions in the voluntary muscles . . . We expand the body when we feel friendly and loving. We open our arms . . . We expand, and the borderlines of the body-image lose their distinct character (1950, pp. 208-210).

Dance therapy makes use of this interwoven relationship between emotions, the body and muscular patterning. Individuals express sorrow, joy, anger, and other strong feelings in their body movements. These are universal experiences in response to external stimuli. However, as a reverse process, by working with the muscular patternings related to an emotion, the feeling

itself can be experienced cognitively merely from the muscular memory of such relationships. By developing strong, sharp, quick movements in the arms and legs, involving the torso and quickened breathing, the sensation of anger can begin to be felt because of the movement itself. The process builds upon itself in that as one begins to experience such a sensation there is a further muscular discharge of energy that reflects awareness of this expressive quality. Ritualized movement, as used by various cultures, is based on this phenomena. In early tribal war dances, the rhythmic use of strong movements as a group experience helped develop for each individual a sense of strength, power, unity, and indestructibility. Similarly, the development of whirling dances, because of vestibular stimulation, were experienced ecstatically as losing a sense of the body and experiencing only the spiritual self. By structuring movement experiences and understanding the connections between muscular impulses and emotion, a dance therapist can help a patient comprehend and work through blocked emotions, or structure those emotions which are overwhelming.

Other studies are equally important to the understanding of movement. Condon (1968), a psychologist, has studied the synchrony of movement based on a film analysis of human interactions. He defined "self-synchrony" as movement in relation to one's own speech articulations, and "interactional synchrony" where the movement of a listener is synchronous with the speech and movements of the speaker.

> . . . there is a basic, dance-like sharing of movement on the part of the interactants during communication. This seems to be a general characteristic of normal interaction. Over 100 films of human interaction have been studied frame by frame (this included films of Kung Bushmen, Eskimos and Mayan Indians), and the phenomenon of interactional synchrony was found to occur consistently (1968, p. 33).

Relating the concept of synchrony to dance therapy, Condon states: "Moving together in harmony is communication. It is a relationship which is the message, 'I am with you.' Indeed, it resembles *heightened* interactional synchrony which . . . states closeness" (1968). This element of synchrony can be analyzed in dance terms. The rhythmic and empathic kinesthetic sense that brings about similar movement patterns in space and time is very meaningful to people. There seems to be a reaffirmation of self, and self in relation to another being. Synchrony of movement is normal in daily interactions. It can be dys-synchronous if people are not in harmony, or when an individual is not in harmony with himself. Synchrony with the therapist and with others is therefore a moment of awareness and closeness. This might evolve in a variety of therapeutic situations.

While dance therapy is primarily concerned with individual and personal experience, it is essential for us to maintain awareness of the larger scope of cultural learning that we each absorb. For instance, how individuals use touch and space may differ, due to their cultural heritage and not to their psychic problems. Scheflen (1964; 1972; 1974) and Birdwhistell (1952;

1970) among others, study movement within a cultural context. They maintain that body language is related to speech patterns, group processes, and the social order as a whole. "Kinesics," a term devised by Birdwhistell, denotes the behavior of touch, gesture, posture, eye contact, facial expression, and spatial territory in relation to social processes. If a dance therapist works in a multiethnic urban setting, it is vital for her to be sensitive to diversity in the use of body language and respect those differences.

Related to these concepts, Bartenieff and Paulay (1970; 1968) did a study of cross-cultural differences of dance styles called "choreometrics." They found that "styles of movement were learned, like other communication systems in culture, and that they varied by culture; that there were important categories of movement shaping all behavior in a culture and serving to identify the individual as a member of his group." Furthermore, dance style is the crystallization of that culture's everyday movement style which is socially, economically, and culturally determined.

Basic Goals and Structure

The basic goals of dance therapy are both similar and yet different from any other psychotherapy. Self-awareness, comfort with the self, clearer perceptions of others, development of satisfying relationships and an ability to acknowledge and develop choices for oneself are basically a result of the

therapeutic process. Simultaneously, the dance therapist works with her client toward achieving a "healthy" body; a body not frozen with conflicts, tensions, distortions, and unable to act as an openly expressive part of the self. The body should be free to work out those stresses and strong emotions which are part of man's existence, to acknowledge the moment and then restore itself to a relaxed balance and underlying unity of flow to perceive and radiate life. Therefore, recognizing that the mind and body are part of the same expression, dance therapy focuses upon movement change. Change is better understanding of the body and its messages, enabling an individual to extend the range of his movement so that there is opportunity to make choices and have options in how he copes with life. One should appropriately perceive and respond to one's own feelings and to others, enabling a person the freedom to spontaneously use the body and its movement as an expressive medium clearly related to ongoing thoughts and feelings.

Although one seeks to allow people to find their own movement and develop spontaneous responses, the dance therapist must provide the structure. This structure is similar in any psychotherapeutic modality. There must be defined limits of expected behavior, wide enough to allow narrow boundaries to broaden but clearly present should control be needed. The structure established in a dance therapy session should be primarily nonthreatening and supportive. Movement is seen as a joyful experience; there is even joy in experiencing sorrow and anger if these have been too

tightly contained. Movement is never seen as right or wrong. At times it may be inappropriate or limited, but it is always an individual's expression of how he must respond at that time. Whitehouse says:

> It is the *feeling* of dancing that counts: not the discovery of what their bodies cannot do but of what they *can* do, of what is naturally available to them, of the joy and rhythm and energy that is their rightful heritage ... I saw that the deeper I could get into the sensation of how movement felt *to the person doing it* the more expressive it became and the more clarity emerged (1969-70, p. 63).

The individual is the focus, and movement or dance is the tool. The therapist works with the existing patterns of the individual rather than using a stylized form of dance such as ballet or social dance (although sometimes special forms are used purposefully). Techniques may vary but there are underlying goals which are similar to all dance therapists. The dance therapist uses her skills, creativity, and spontaneity to enable others to experience themselves on the level of body sensations and impulses and allow communication through body action. Not only must a therapist have a rich vocabulary of movement but she must also be aware of her own responses and the messages she relates through her own body. Communication must be direct and simple, for movement is an honest reflection of the self, one that cannot be hidden by words. Appropriate and sensitively responsive to any communication, the therapist must be prepared to confront anger and hostility as well as withdrawal or apathy. While one's

role is often active, there is need to take care that it arises from the needs of the group or individual rather than from those of the therapist. The experience becomes one of co-workers making discoveries about the patient, their relationship to each other, and to their surroundings.

There is a range of techniques that makes one therapist's style different from another's. Some therapists work using pure dance and others work on a continuum that ends close to psychodrama and encounter techniques. Some work only with individuals, while others are more attuned to group processes. Those who stress the dance aspects tend to use much synchrony of movement and fluid movement transitions, and participate on a more equal basis. The amount of verbalization and interpretation will vary. There are times a therapist will not participate but will rather be an observer. Movement then often becomes a vehicle to make a conflict more immediate and at that time the therapist may be more directive. The use of music will also vary. Those working with groups, particularly institutionalized groups, tend to make greater use of structured rhythms. There are many levels of directed movement experiences. These are dependent upon the goals, age, handicap, or disability of a patient and the setting of treatment.

Description of Dance-Therapy Group Session

The following is a generalized description of a dance therapy session

with a small group. The dance therapist might have a large room to work in so that patients come to her area, or in the case of large institutions, she may at times go directly to a day room on a ward and work with those present. After greetings and a quick preliminary assessment by the therapist as to the overall tenor of the group, there generally is a warm-up period, both of bodies and relationships. The beginning of a session might look very much like a dance class with stretching, shaking out of limbs, exploring the use of isolated body parts, changing rhythms, and priming energy levels. The therapist initiates contact with each patient by responding qualitatively to his movement patterns, adapting her own movement style to that of the patient. The beginning simple rhythmic movement of hands, feet, the head or a shoulder, works not only on coordination but toward the direct expression of emotion. Whether it is shame, defeat, anger, or fear that a person experiences, related muscular tensions are reflected in the posture and the gestures. The therapist uses the warm-up to carefully observe and pick up cues as to the communications and needs of individuals and the group as a whole.

Using movement as the focus, themes can be developed which literally parallel any psychological or psychiatric concept. By relating to and responding to constantly changing patterns, expanding the use of the involved musculature and verbalizing about these body representations, foremost concerns begin to evolve. Our language descriptively amalgamates these feelings in body terms. We have feelings of falling apart, being out of

step, not being able to stand on one's own feet, needing a shoulder to lean on, keeping someone at arm's length, wanting to curl up, maintaining a stiff upper lip, and so it goes. Picking up movements and verbal signals, themes can be explored, developed, and expanded using the dynamics of movement. For example, the dynamics of foot-tapping might begin to change by moving with more energy, strength, and quickness. Shouts may be added and pushing-pulling sequences may be devised, or a gentle touch may lead to a shared slow-rocking movement.

Movement, because of its association with feeling, tends to draw people together. The sharing of an expression of anger communicates that *all* people feel anger at some time and that it can be expressed without being totally destructive to others or self. According to Freud (1955), there is an emotional contagion in a group that brings it together. ". . . men's emotions are stirred in a group to a pitch that they seldom or never attain under other conditions; and it is a pleasurable experience for those who are concerned, to surrender themselves so unreservedly to their passions and thus to become merged in the group and to lose the sense of the limits of their individuality." Just as early tribal dances used rhythmic action for cohesion, so the group can provide the same support. The use of the group releases the isolation of emotional feeling and one is able to go beyond usual individual limitations.

The flow of the session develops intensity as the leader connects one

spontaneous expression to another. The ideas for the movement actions flow from those participating in the group, whether from the direct leadership of one of the group members, or through the observational skills of the therapist. Each derives private meanings from the same moment in time and the experience comes from the movement.

A time for closure, a pulling together, a lowering of intensity serves the function of clarifying boundaries, sensing the integrity of one's own body, and recognizing the warmth and support of a shared experience.

Dance Therapy for the Mentally Ill

The Psychotic Patient

Perhaps most work in dance therapy has been with the institutionalized psychotic patient. These people have many needs which are symbolized through their movement expression. When using dance therapy within a psychiatric facility, it is important to be open to the unique communications of each individual and to respond to these directly. Yet, we can also make some basic assumptions.

One of the most striking characteristics of the hospitalized patient are the many differences in the quality and quantity of movement. Movement behavior clearly indicates those patients who have been there for long

periods, those most acutely disturbed, and those who are closest to leaving. The more disturbed an individual, the more dys-synchronous and fragmented are his movement patterns. There is a lack of connection between mind and body, an irregular and sporadic flow of effort, a lack of gestural or postural change or unity, or gestures which are random, ritualized or distorted. Davis shows:

> 1. That there are movement characteristics which are unique to schizophrenia, and more specifically, that there are movement patterns which correspond to various behavior—disorganization, stereotyping, regression and so on—in the illness.
>
> 2. That these movement features increase (i.e., appear or develop from less pathological characteristics) as the patient becomes seriously ill and decrease as he improves (1970, p. 26).

A prime goal of a dance therapist working with hospitalized patients is, therefore, to aid in body integration and awareness, strengthen a realistic sense of body-image and either enlarge the vocabulary of movement or help control impulsive, random behavior. Bernstein (1972) outlines five levels of body-image organization and specific techniques for aiding these and various other "developmental constellations." She divides body-image levels into (1) investment of positive affect, or the capacity to perceive and accept the body and its functions; (2) differentiation of the body from the environment; (3) recognition of body parts and their interrelationships; (4) movement of the body through space; and (5) sexual identity. There perhaps should be another

level before sexual identity pertaining to the body in relation to others.

In schizophrenia, there seems to be a need to relearn developmental patterns associated with body organization. Dance therapists work directly on elements related to gravitational pull, the growing or shrinking related to breathing, the flow of energy, the isolated movements of body parts using varied efforts and spatial concepts as well as total body movement, small and gross locomotive patterns, spatial patterns relating to others in space, and various tactile, kinesthetic, optic, and vestibular stimulations to aid in physical integration. One must first have a perception of oneself, some sense of control and choice before one is able to perceive clearly and relate to others. Fears and other strong feelings lead to a profound sense of isolation. Words are used as barriers rather than as attempts to communicate. The depth and scope of feeling is too intense to speak about easily and therefore creates further loneliness. Basic movement and dance is an effective way to cut through this isolation.

In psychosis, internal stimuli determine most behavior; there is a lessened relationship to the reality of the environment. Because it is so difficult for psychotic patients to interact with others, group rhythmic movement becomes a way of responding, first to the structure of the music, then to the therapist and to each other. Music is useful in initiating and focusing on rhythmic action. The circular structure of a movement group is

supportive to building relationships and the movement becomes a satisfying experience in itself.

Chace (n.d.) wrote:

> A positive quality of aliveness is present in the group of dancers which is in strong contrast to the patients who are sitting listlessly absorbed in no activity, withdrawn from all others in loneliness. It is exciting to see one of these passively still people rise as though drawn by a magnet and move toward this living group. One must subscribe to the belief that rhythm and a shared emotional experience is important to a feeling of well being. Basic dance is the externalization of these inner feelings which cannot be expressed in rational speech but can only be shared in rhythmic symbolic action.

Activation of the withdrawn and depressed is an important function of dance therapy. It is particularly advantageous with the catatonic. Movement, no matter how small or subtle, is the one useable form of communication for those so withdrawn. There is great sensitivity to the movement communications of the therapist on the part of a catatonic patient. Hence, a relationship can be established that requires no use of speech on the patient's part. One begins on whatever level the patient is functioning. With catatonics, it is possible to start with what *can* be done, which may be to focus on breathing rhythms. To *take* a breath becomes an active role.

For those who exhibit ritualized movement patterns, perhaps associated with anxiety or compulsiveness, the opportunity to change the use

of muscular patterns eases tension, at least temporarily. This is more difficult for the manic patient as his strong, quick gestures seem to afford little relaxation. The therapist must meet the patient's movement on his own level, which says to the patient, "I understand what you are saying," and gives the therapist an opportunity to modify and restructure patterns. Symbolic movement battles tend to be shared experiences that may lead into the beginning of mutual understanding while verbal exchanges may tend to further isolate. Chace describes a scene:

> An assaultive patient, when moving forward with threatening gestures, will invoke fright in the therapist, no matter how transient. This fright usually provokes aggressive, retaliative action. If, however, the fright is put into dance movement, such as shrinking to the floor, and then quickly developed into a very broad welcoming, friendly gesture, the expected retaliation is forestalled. If the patient continues to come toward the therapist with a threatening movement, the next response is usually one of steadfastness, carried out by wide, firmly placed feet and erectness of the torso . . . again developed into a friendly movement. I often suggest putting hands on each other's shoulders and pushing back and forth, setting up a swinging motion . . . this action is in essence, a substitute or sublimation of the assaultive action, which for some reason had seemed necessary to the patient (1953, p. 222).

There are times when an individual session may be more appropriate than a group experience for a psychotic patient. An individual may be too anxious to work in a group. At times there is a need for more prolonged personal exploration in creative movement. Those who are more acutely disturbed may make good use of such sessions to focus on immediate intense

feelings.

With a group that has been institutionalized, the therapist must fight against the passiveness and dependency which often pervades a group. As in all therapy, the development of spontaneous movement is a goal to be achieved. Lowen writes:

> Spontaneity is an expression of the unconscious. Coordination is a function of consciousness. When the unconscious and the conscious arc integrated in any person you have grace, the physical expression of emotional health. Spontaneity is a manifestation of the aliveness of the so-called id, the feeling aspect of the person. Coordination reflects the strength of the ego. In a unified personality id and ego, or body and mind are fused with the result that every movement of the body is graceful. Movements that are coordinated but not spontaneous are mechanical. Movements that are spontaneous but uncoordinated are infantile or impulsive (1970, p. 8).

According to J. L. Moreno, spontaneity is the vital element related to catharsis. It is through spontaneous interaction that doors are opened to new behaviors.

While movement is the prime tool, verbalization should not be ignored. There is a need to develop cognitive and thought processes in relation to movement in order to maximize its potential. Imagery and verbalization in response to movement patterns involve individuals further. The depth of discussion is dependent upon the abilities of the group to deal with insight and language.

The changes that occur in a movement group can be clearly observed during a session. The feeling tone will have changed from one of silence and fear to a more open awareness of each other shown by relaxed laughter and conversation, comfortable touching and spatial closeness.

The Neurotic Patient

With neurotic groups, basic goals are similar to those followed when working with the psychotic, in that body awareness, extension and integration of movement, and spontaneous expression and interaction are fundamental. Techniques to achieve these vary somewhat. The emphasis shifts to better awareness of inner sensations and being free to respond to these, rather than structuring the experience to be more in touch with external reality as needed for psychotic patients. In neuroses, there are frequently many inhibitors and censors so that the body is restricted, composed of "dead" areas, and tension ridden.

Dance therapists work to develop awareness of tension areas, breathing patterns, and expressive movement. Relaxation techniques, improvisational movement built upon specific themes, shared group improvisation and task-solving exercises are some techniques which may be used. By analyzing and linking these patterns to one's experiences, related cognitive and emotional experiences occur. Such experiences may lead to new understanding and

possible alternatives in behavior. In describing her experiences with Whitehouse, Cheney writes:

> These experiences are not only deeply meaningful . . . but provide increased sensitivity, insight, perspective and material . . . 'Movement in depth' is considered primarily as therapy. Therapy in the concept of Whitehouse is cathartic and creative; resolving the past while constructing a new pre-ent, getting rid of excess tension while realizing new uses for energy. It has phases of unconscious and conscious work, occurring in movement and then brought into conscious awareness. One not only gets rid of symptoms hut makes an effort to understand the causes (1969-70, p. 67).

Such work is done individually or through group experiences where interactional opportunities add an additional dimension.

The Autistic Child

Dance therapy with autistic children is proving to be a particularly rewarding use of this therapeutic modality. As Kalish notes in her description of working with an autistic child:

> The initial aim of movement therapy is to reach the autistic child at the level where he seems to be functioning—a primitive sensory-motor level; and to explore with him rhythms, vocalizations and body actions, in an attempt first to gain his attention and hopefully lead to an emotional relationship, and second, and equally important, to help him form a body image. This is the ingredient I sensed was missing in these children. While the schizophrenic may have a distorted image or lost what he once had, the autistic child has never formed an intrapsychic representation of his own body. Therefore the therapist must keep this in mind, as she works to

help the child build new psychic structures and concepts (1968, p. 51).

Janet Adler depicts her techniques in working with autistic children most movingly in her film *Looking For Me.* She begins by entering into the child's world of movement. There is first a period where she will ". . . speak her language by moving with her as she moves in space. In the beginning there is much direct imitation, which by definition means delayed responses on my part. However, as she permits my presence and as the trust develops, I find the one-sidedness falls away and a more mutual dialogue begins to creep into being; we become synchronous" (1968). There seems to develop two main concepts in the work of both of these therapists, influenced somewhat by different perspectives. Kalish focuses more on a developmental view of autism, relating it to a movement scale based on a system of movement observation. Adler is more descriptive of the interactional processes leading to communication. Yet, both of them are concerned with body image and a therapeutic relationship. Both describe the child's initial lack of a sense of self and the reenactment of developmental stages that had never been completed satisfactorily. The first stage seems to be a fusion or symbiotic relationship between therapist and child; then evolves a thorough exploration of the therapist's body and finally the child's discovery of himself as a separate being, relating to another. It is at this stage that synchronous movement may develop.

Dance therapy is being used with children and adolescents in many settings. The concepts are essentially the same and again the structure is altered to provide the controls and limitations within which a child is free to grow. Special education schools make good use of dance therapists, for dance provides many sources of learning simultaneously. In addition to emotional problems, movement aids the developmental processes that serve as an aid to learning because of increased abilities in sensory-motor development and perception. Use of a great variety of props becomes particularly useful with children in order to organize movement more efficiently. The use of images helps in kinesthetic learning. Dance makes use of a child's natural interest in play and movement. When the activity is one of joy rather than ritual, when spontaneity is encouraged, motivation is not a problem in learning.

Varied Settings

There are several other areas where dance therapy is supportive of rehabilitation. Many therapists work with the retarded in order to give positive structure to emotions and develop improved body awareness and coordination. People with limitations such as blindness, deafness, and speech disorder always exhibit additional physical manifestations in the use of the body in space and as a form of communication. Dance-therapy concepts are most valid in working in any area where there is stress upon normal communication or where there are body-image difficulties.

With the development of gerontology as a mental-health field, dance therapy can also serve a very important function. Aside from the assistance it provides in maintaining physical health through use of the physiological and muscular systems, it is particularly helpful in developing and maintaining self-esteem and social interaction. Loneliness is dispelled as people move rhythmically together, no matter how limited they are in physical movement due to illness or age. The goals most probably would be more supportive rather than seeking basic personality change.

Dance therapists also work in the field of corrections as the problems related to self and others are basically the same. Half-way houses, community mental-health centers, and referred private practice are all settings for dance therapy. Within a multi-disciplined agency, a dance therapist functions as a team member contributing her skills as a clinician to the treatment plan set forth by the staff.

Contraindications

At present there seems to be no condition when dance therapy is contraindicated. The structure changes to serve the purpose. If someone is brittle, has superficial controls, and the intensity of feeling may be too frightening, movement should be closely structured to non-emotional patterns such as working with ballet technique. In a group, where at some

point in time an expressive display of anger would be too frightening for that particular group to handle, it is possible to structure energetic movement that has the same muscular release but eliminates conscious emotional overtones. One such group used a small foam ball to throw and kick in a wild and exuberant "soccer game." When necessary to the development of physical and psychic controls, creative forms give way to formal patterns and safe structure.

Research and Movement Observation

In the process of developing a profession, we have need to establish typologies of diagnoses and methods used in dance therapy. There is a need to examine for whom dance therapy is most useful, at what stages, if there are contraindications, and varied methods within the scope of dance therapy. No diagnostic system is perfect or considered definitive. We can only use the level of knowledge on which it is based. If we can facilitate the examination of the information we have and create the possibility of communication, we can then advance our knowledge. Because dance therapists are just beginning to be involved in writing and research, theoretical concepts are generalized and described in global terms rather than in terms specific to diagnostic categories. There are some beginning attempts to become specific. As a new profession, there is need for research to establish and validate theoretical structures.

A troublesome problem in the use of movement has been the difficulty in accurately observing, analyzing, and describing what is seen other than in subjective language descriptions. Also, it is so ephemeral, lasting briefly, and then gone. While the use of video and films have been a useful device, movement description must be a language equally shared by the observer. One person's stylized walk might be simultaneously described as "sloppy, carefree, strolling, sassy, not caring, or sexy," depending upon the eye and the interpretation of the various observers. The development of a system of observation founded upon movement terms is invaluable for dance therapy. It allows for an objective description of movement behavior. The context and theoretical foundations of the therapist can lead to interpretation of that behavior.

While it is not part of dance therapy procedure, one such system of observation is *Laban analysis,* or "effort-shape," as it is still more commonly called. It provides a theoretical structure from which movement can be observed objectively and analytically. Rudolf Laban (1956; 1960; 1963; 1966; 1947), a multifaceted and talented dancer and choreographer, developed a system of observation based upon the natural affinities of movement. Later elaborated upon by Lamb (1965; 1969), a replicable system was devised which could be used for describing, measuring, and classifying movement. Every individual has patterns of movement which are fairly constant for himself. An analysis of these patterns suggests observable behavior related to

neurophysiological and psychological processes within a cultural framework. How he adapts to inward strivings and copes with outer stimuli is accurately reflected by his movement behavior.

Bartenieff and Davis state:

> Ultimately behavior must be understood in relation to neurophysiology and total organic functioning. The effort-shape theory of movement is based on an organic model of behavior. The major hypothesis of this presentation is that neural processes, adaptation and expression are integrated in movement. Every movement in any part of the body is at once adaptive and expressive; it functions as a coping mechanism while at the same time it reflects something about the individual. The alpha-gamma system and the reticular formation, as the major integrative mechanisms of sensorimotor activity, are considered the physiological basis of this unity of expression and function. Movement perceived through effort-shape appears to reflect the functioning of the alpha-gamma system itself, from the stirs of effort flow in the newborn to the mature movement repertoires of the adult. There is a great deal of evidence that effort-shape can be used to trace each stage of development and contribute significantly to the understanding of mature functioning (1965, p. 51).

Effort-shape is a system which requires much study and practice in observation. The meanings and implications of its terms cannot be presented here in detail. However, a few words will be defined and used with the context of describing its use in dance therapy. Basic concepts include: (1) the use of the body's flow of muscular tension between bound and free (effort-flow); (2) movement that flows toward or away from the body (shape-flow); (3) the use of body planes (horizontal for widening and narrowing, vertical

for rising and sinking, sagittal for advancing and retreating); (4) exertions related to an active attitude toward space (direct vs. indirect), time (quickness vs. sustained), and force (strength vs. lightness) called *efforts;* (5) moving into space (directional, shaping qualities); and (6) the relationship between gesture (use of an isolated body part) and posture (activation of many parts in relation to each other).

The myriad of reciprocal relationships, combinations, proportions of frequency, range of use, phrasing, body parts used, and spatial relationships are some of the aspects related to the immense variety and complexity of human movement. Because this system of observation is applicable to all human movement it is, at present, being used in psychology, anthropology, cross-cultural and child development studies, dance education, business personnel assessments, and, of course, dance therapy.

Laban analysis, as a technique of observation, provides a tool for research in dance therapy. As Bartenieff, the leading proponent and teacher of effort-shape wrote:

> Those of us in the dance therapy field using Effort-Shape see in it not a method of therapy but a tool of increasing sensitivity to movement responses and direct communication. Its usage has convinced us that we do not yet fully understand the entire range of nonverbal behavior; nor could we claim that Effort Shape is the panacea in specialized methods of therapy. But a theory of movement that is not merely a borrowing from the verbally oriented psychological and psychiatric vocabulary seems a vital factor in establishing methods and in enabling the therapist to make

> specific contributions to research, while maintaining his intermediate position between the arts and science (1972-73, p. 15).

With a standard nomenclature to describe movement in addition to a theoretical model based on movement itself, dance therapists have the means to diagnose through movement and to develop treatment plans. Since one can fairly accurately notate the movement patterns of an individual at varied periods, it becomes possible to assess movement change both in quantity and quality, keeping in mind that movement change is synonymous with psychological change. For example, an effort-shape analysis is made of a patient within a psychiatric hospital. The therapist observes that there is reduced mobility, range of tension-flow is minimal, the torso is set, head and shoulders are still, flow is bound, movement is somewhat fragmented in that weight shifts are disorganized, movement is limited to the vertical plane, there is no use of gesture or shaping of space and effort qualities are not observable, i.e., no use of strength *or* lightness. For clarity, not all possible variables are described. In psychiatric terms the diagnosis might be schizophrenic, catatonic reaction. This movement is fairly clear and simple to observe. It is possible to assess much more complex movement behavior where individuals are active but show conflicting use of the body or are limited in specific areas of the body in effort and/or shape and space qualities. The dance therapist very clearly has specific movement goals based upon the movement analysis. The underlying assumption is that the larger

the movement repertoire a person has to choose from, and the better integrated these patterns are, the better able he will be to cope with the environment and with his own emotions in a flexible and more satisfying manner. Davis (1970) developed a Movement Diagnostic Scale describing the movement characteristics of hospitalized patients. She was able to establish those characteristics which were indices of change. The grouping of patients by movement profile also indicated the possible relationship of movement characteristics to clinical diagnoses.

The use of movement observation is also of real value in child development studies. Kestenberg (1965; 1965; 1966; 1967; 1967; in press), a child analyst, sees dance therapy as an aid to her own work. She has done several studies using movement assessment to observe infants and children. Her findings are correlated with a classification of diagnostic criteria devised by Anna Freud. The rhythms and attributes of tension flow, "a basic alteration of free and bound discharge of changing levels of intensity, high and low, building up steeply or gradually, held on even keel or modulated" (Kestenberg, 1967), are distinguishable and correlate with the psychosexual development of the child. Rhythmic tension-flow patterns reflect the oral, anal, urethal, inner genital, and phallic stages. Kestenberg also concludes that rhythms in infants are congenitally determined. While there may be changes in the complexity of movements, because of maturity and interaction with the environment, preferences for certain rhythms influence character formation

and drive discharge. Her theories have led her to examine the movement patterns of infants and those of mothers to determine possible conflicting rhythmic patterns and to help mothers adjust their own rhythms to those of her child. Her assessments give indications of the areas needed to be experienced and enlarged upon by a child so that the dance therapist can extend and retrain movement to complement the psychotherapy.

Similarly, Kalish (1971), a dance therapist who has done much work with autistic children, has devised a movement scale for observation that she hopes will prove useful in early assessment of dysfunctional movement patterns of children and thereby serve as a means for early preventative treatment.

Training

Partly due to new interest in nonverbal techniques by other disciplines, there has been a rapid growth in the use of dance and movement therapy. There are differences in the use of the nonverbal. Dance therapists view movement behavior as the prime area for change while other disciplines often see it as a preliminary to verbal interaction. While other professional disciplines add to the understanding of movement and human behavior, it is above all the theoretical concepts of dance itself and the experience of movement which have meaning and satisfaction of their own. It is hoped that

other disciplines will make use of movement within their methodology; however, because of the patient's need for the profound understanding and comfort when using movement, a dance therapist must be well trained in her art. The American Dance Therapy Association, formed in 1966, is continually working to define the meanings of dance therapy and thereby clarify the kind of education and training needed to practice. An intensive and extensive dance background is basic, as well as the understanding of human growth and behavior and the structures of the body. These can then be woven into a theoretical base useful to understanding the unique concepts of dance therapy. The application of these concepts into treatment must be carefully supervised before a trainee is ready to practice.

Conclusion

Dance therapy is a new profession that is still in the process of defining itself. Research and study will further establish it as a distinct therapeutic discipline. The significance of dance therapy is that it uses and develops the strengths of people by starting with what they *can* do and working toward the total integration of the body and the mind. It is a creative experience and often a joyful one. Movement is the gift we all share.

Bibliography

Adler, J. "The Study of an Autistic Child," Proc. Am. Dance Ther. Assoc. 3rd Annu. Conf., Madison,

Wis., 1968, pp. 43-48.

Allport, G. W. and P. E. Vernon. *Studies in Expressive Movement.* New York: Macmillan, 1933.

Ardrey, R. *The Territorial Imperative: A Personal Inquiry into the Animal Origins of Property and Nations.* New York: Atheneum, 1966.

Aubert, C. (1927) *The Art of Pantomime.* Translated by E. Sears. New York: Benjamin Blom, 1970.

Bartenieff, I. "Dance Therapy: A New Profession or a Rediscovery of an Ancient Role of the Dance?" *Dance Scope,* 7, Fall-Winter (1972-1973), 6-18.

Bartenieff, I. and M. Davis. *Effort-Shape Analysis of Movement: The Unity of Expression and Function.* New York: Albert Einstein College of Medicine, 1965. Unpublished monograph.

Bartenieff, I., M. Davis, and F. Paulay. *Four Adaptations of Effort Theory in Research and Teaching.* New York: Dance Notation Bureau, 1970.

Bartenieff, I. and F. Paulay. "Choreometrics Profiles," in Alan Lomax ed., *Folk Song Style and Culture,* AAAS Publ. no. 88, pp. 248-261. Washington: Am. Assoc. Adv. Sci., 1968.

Bender, L. and F. Boas. "Creative Dance in Therapy," *Am. J. Orthopsychiatry,* 11 (1940, 235-244.

Berger, M. M. "Nonverbal Communications in Group Psychotherapy," *Int. J. Group Psychother.,* 8 (1958), 161-178.

Berger, M. R. *Bodily Experience and Expression of Emotion. Monogr.* no. 2, pp. 191-230. Columbia, Md.: Am. Dance Ther. Assoc., 1972.

Bernstein, P. L. *Theory and Methods in Dance-Movement Therapy.* Dubuque, Iowa: Kendall-Hunt Publ., 1972.

Birdwhistell, R. L. *Introduction to Kinesics.* Louisville: University of Louisville Press, 1952.

----. *Kinesics and Context.* Philadelphia: University of Pennsylvania Press, 1970.

Boas, F. "Origins of Dance," Proc. Am. Dance Ther. Assoc. 6th Annu. Conf., Washington: 1971.

Bull, N. *The Attitude Theory of Emotion.* Nerv. Ment. Dis. Monogr. no. 81. Baltimore: Williams & Wilkins, 1951.

Campbell, D. G. "Posture: A Gesture Toward Life," in *Impulse* (1951), 25-30.

Canner, N. . . . *And a Time to Dance.* Boston: Beacon, 1968.

----. *Stimulating Sounds and Vocalization Through Body Movement and Rhythm with Hospitalized Children.* Monogr. no. 2, pp. 1-12. Columbia, Md.: Am. Dance Ther. Assoc., 1972.

Chace, M. "Dance as an Adjunctive Therapy with Hospitalized Mental Patients," *Bull. Menninger Clin.,* 17 (1953), 219-225.

----. "Common Principles in Music Therapy," *Music Ther.,* 4 (1954), 87-90.

----. "Development of Group Interaction through Dance," in J. H. Masserman and J. L. Moreno, eds., *Progress in Psychotherapy,* Vol. 3. Technique of Psychotherapy, pp. 143-15.3. New York: Grune & Stratton, 1958.

----. "Dance Alone Is Not Enough," *Dance Mag.,* 38 (1964), 46-47, 58.

----. "The Power of Movement with Others," *Dance Mag.,* 38 (1964), 42-45, 68-69.

----. "Dance Therapy for Adults," Paper presented at the Natl. Educ. Assoc. Conf., Atlantic City, N.J.

Chaiklin, S. "Dance Therapy," Proc. Am. Dance Ther. Assoc. 4th Annu. Conf., Philadelphia, 1969, pp. 25-31.

Cheney, G. "It Is a Gift," *Impulse* (1969).

Condon, W. S. "Linguistic-Kinesic Research and Dance Therapy," Proc. Am. Dance Ther. Assoc. 3rd Annu. Conf., Madison, Wis., 1968, pp. 21-42.

Cornyetz, P. "Movement Therapy and Total Health," Proc. Am. Dance Ther. Assoc. 6th Annu. Conf.,

Washington, 1971, PP-1-12.

Cratty, B. J. *Movement, Perception and Thought.* Palo Alto: Peek Publ., 1969.

Darwin, C. *The Expression of the Emotions in Man and Animals.* New York: Philosophical Library, 1955.

Davis, F. *Beyond Words: The Science of Nonverbal Communication.* New York: McGraw-Hill, forthcoming.

Davis, M. "An Effort-Shape Movement Analysis of a Family Therapy Session." Yeshiva University, 1966. Unpublished paper.

----. "Movement Characteristics of Hospitalized Psychiatric Patients," Proc. Am. Dance Ther. Assoc. 5th Annu. Conf., New York, 1970, pp. 25-45.

----. *Understanding Movement Behavior: An Annotated Bibliography.* New York: Arno, 1972.

Dell, C. A *Primer for Movement Description: Using Effort-Shape and Supplementary Concepts.* New York: Dance Notation Bureau, 1970.

De Mille, A. *The Book of the Dance.* New York: Golden, 1963.

Denby, E. (1949) *Looking at the Dance.* New York: Horizon, 1968.

Deutsch, F. "Some Principles of Correlating Verbal and Non-verbal Communication," in L. A. Gottschalk and H. A. Auerbach, eds., *Methods of Research in Psychotherapy,* pp. 166-184. New York: Appleton-Century-Crofts, 1966.

Dratman, M. L. "Reorganization of Psychic Structures in Autism: A Study Using Body Movement Therapy," in Proc. Am. Dance Ther. Assoc. 2nd Annu. Conf. Washington, 1967, pp. 39-45.

Dunbar, F. "Interpretation of Body Behavior during Psychotherapy," in J. H. Masserman, ed., *Science and Psychoanalysis,* Vol. 3. Psychoanalysis and Human Values, pp. 223-230. New York: Grune & Stratton, 1960.

Dyer-Bennett, M. "Some Thoughts about Change—Our Most Deceptive Therapeutic Goal," Proc. Am. Dance Ther. Assoc. 5th Annu. Conf., New York, 1970, PP-51-57.

Dyrud, J. and M. Chace. "Movement and Personality," Proc. Am. Dance Ther. Assoc. 3rd Annu. Conf., Madison, Wis., 1968, pp. 16-20.

Ekman, P. "Communication through Non verbal Behavior: A Source of Information about an Interpersonal Relationship," in S. S. Tomkins and C. E. Izard, eds., *Affect, Cognition, and Personality,* pp. 390-442. New York: Springer, 1965.

Ekman, P. and W. V. Friesen. "The Repertoire of Nonverbal Behavior: Categories, Origins, Usage and Coding." *Semiotica,* 1 (1969), 49-98.

-----. "Constants across Cultures in the Face and Emotion," *J. Pers. Soc. Psychol.,* 17 (1971). 124-129.

Ellis, H. (1923) "The Art of Dancing." In *The Dance of Life,* pp. 34-63. New York: Modern Library, 1929.

Escalona, S. and G. M. Heider. *Prediction and Outcome: A Study in Child Development.* New York: Basic Books, 1959.

Espenak, L. *Body Dynamics and Dance in Individual Psychotherapy.* Monogr. no. 2, pp. 111-127. Columbia, Md.: Am. Dance Ther. Assoc. 1972.

Fisher, S. and S. E. Cleveland. (1958) *Body Image and Personality.* New York: Dover, 1968.

Freud, S. (1921) "Group Psychology and the Analysis of the Ego," in J. Strachey, ed., *Standard Edition,* Vol. 18, pp. 69-143. London: Hogarth, 1955.

Gates, A. *A New Look at Movement: A Dancers View.* Minneapolis: Burgess Publ., 1968.

Gesell, A. and C. S. Amatruda. *Developmental Diagnosis: Normal and Abnormal Child Development Clinical Methods and Pediatric Applications,* 2nd rev. ed. New York: Hoeber, 1947.

Goffman, E. *The Presentation of Self in Everyday Life.* Garden City, N.Y.: Doubleday, 1959.

----. *Encounters: Two Studies in the Sociology of Interaction.* Indianapolis: Bobbs-Merrill, 1961.

----. *Behavior in Public Places: Notes on the Social Organization of Gatherings.* New York: Free Press, 1963.

Goodenough, F. L. "Expression of the Emotions in a Blind-Deaf Child," *J. Abnorm. Soc. Psychol.,* 27 (1932), 328-333.

Govine, B. *The Use of Movement as Adjunctive Therapy in the Rehabilitation of Psychiatric Day Patients.* Monogr. no. 1, pp. 12-15. Columbia, Md.: Am. Dance Ther. Assoc., 1971.

Hall, E. T. *The Silent Language. Garden* City, N.Y.: Doubleday, 1959.

----. *The Hidden Dimension.* Garden City, N.Y.: 1966.

H'Doubler, M. A. *Dance: A Creative Art Experience.* New York: Appleton-Century-Crofts, 1940.

Horst, L. *Modern Dance Forms in Relation to the Other Modern Arts.* New York: Dance Horizons (not dated).

Huang, A. C.-L. *Embrace Tiger, Return to Mountain—The Essence of T'ai Chi.* Lafayette, Calif.: Real People Press, 1973.

Hunt, V. "The Biological Organization of Man to Move," in *Impulse* (1968), 51-62.

----. "Neuromuscular Structuring of Human Energy." Paper presented at the 45th Conf. Progr. and in the Annu. Rep. of the Western Society for Physical Education of College Women, 1970. Unpublished.

Irwin, K. *Dance as Prevention of, Therapy for, and Recreation from the Crisis of Old Age.* Monogr. no. 2, pp. 151-190. Columbia, Md.: Am. Dance Ther. Assoc. 1972.

Jacobson, E. *Progressive Relaxation: A Physiological and Clinical Investigation of Muscular States and Their Significance in Psychology and Medical Practice,* 2nd rev. ed. Chicago: University of Chicago Press, 1938.

----. *Biology of Emotions: New under standing Derived from Biological Multidisciplinary Investigation: First Electro-physiological Measurements.* Springfield, Ill.: Charles C. Thomas, 1967.

Kalish, B. "Body Movement Therapy for Autistic Children," Proc. Am. Dance Ther. Assoc. 3rd Annu. Conf., Madison, Wis., 1968, pp. 49-59.

----. *A Study of Nonverbal Interaction in the Classroom,* Monogr. no. 1, pp. 16.-37. Columbia, Md.: Am. Dance Ther. Assoc., 1971.

Kamin, D. *Thoughts on Therapy. Monogr.* no. 1, pp. 50-68. Columbia, Md.: Am. Dance Ther. Assoc., 1971.

Kendon, A. "Movement Coordination in Social Interaction: Some Examples Described," *Acta Psychol.* (*Amst.),* 32 (1970), 100-125.

Kephart, N. C. *The Slow Learner in the Classroom.* Columbus, Ohio: Merrill, 1960.

Kestenberg, J. S. "The Role of Movement Patterns in Development: I. Rhythms of Movement," *Psychoanal. Q.,* 34 (1965), 1-36.

----. "The Role of Movement Patterns in Development: II. Flow of Tension and Effort," *Psychoanal. Q.,* 34 (1965), 517-563-

----. "Rhythm and Organization in Obsessive-Compulsive Development," *Int. J. Psycho-Anal.,* 47 (1966), 151-159.

----. "Suggestions for Diagnostic and Therapeutic Procedures in Movement Therapy," Proc. Am. Dance Ther. Assoc. 2nd Annu. Conf., Washington, 1967, pp. 5-16.

----. "The Role of Movement Patterns in Development: III. The Control of Shape," *Psychoanal.* Q., 36 (1967), 356-409.

Kestenberg, J. S., H. Marcus, E. Robbins et al. "Development of the Young Child as Expressed through Bodily Movement: 1," *J. Am. Psychoanal. Assoc.,* in press.

Kubie, L. S. "Body Symbolization and the Development of Language," *Psychoanal.* Q., 3, 1934.

Laban, R. *Principles of Dance and Movement Notation.* London: MacDonald & Evans, 1956.

----. *The Mastery of Movement,* 2nd rev. ed., L. Ullmann, ed. London: MacDonald & Evans, 1960.

----. *Modern Educational Dance,* 2nd rev. ed., revised by L. Ullmann. London: MacDonald & Evans, 1963.

----. *Choreutics.* Annotated and edited by L. Ullman. London: MacDonald & Evans, 1966.

Laban, R. and F. C. Lawrence. *Effort.* London: MacDonald & Evans, 1947.

Lamb, W. *Posture and Gesture: An Introduction to the Study of Physical Behaviour.* London: Gerald Duckworth, 1965.

Lamb, W. and D. Turner. *Management Behaviour.* New York: International Universities Press, 1969.

Langar, S. K. *Feeling and Form: A Theory of Art.* New York: Scribners, 1953.

Lefco, H. *Dance Therapy: Narrative Case Histories of Therapy with Six Patients.* Chicago: Nelson-Hall, 1974.

Lomax, A., I. Bartenieff, and F. Paulay. "Dance Style and Culture," in A. Lomax, ed., *Folk Song Style and Culture,* AAAS Publ. no. 88, pp. 222-247. Washington: Am. Assoc. Adv. Sci., 1968.

Lowen, A. (1965) *Love and Orgasm.* New York: New American Library, 1967.

----. *Betrayal of the Body.* New York: Macmillan, 1967.

----. "The Body in Therapy," Proc. Am. Dance Ther. Assoc. 5th Annu. Conf., New York: 1970, pp. 1-9.

----. *(1958) The Language of the Body.* New York: Macmillan, 1971.

Luce, G. G. *Biological Rhythms in Psychiatry and Medicine,* Public Health Service Pub. no. 2088. Washington: U.S. Govt. Print. Off., 1970.

Luria, A. R. *The Nature of Human Conflicts: An Objective Study of Disorganization and Control of Human Behaviour.* Translated and edited by W. H. Gantt. New York: Liveright Publ., 1932.

Mason, K., ed. *Focus on Dance. 7: Dance Therapy.* Washington: Am. Assoc. Health, Physical Education, and Recreation, 1974.

May, P. R. A., M. Wexler, J. Salkin et al. "Non-verbal Techniques in the Re-establishment of Body Image and Self Identity: A Preliminary Report." *Psychiatr. Res. Rep.,* 16 (1963), 68-82.

Meerloo, J. A. M. *Dance Craze and Sacred Dance.* London: Peter Owen, 1961.

----. "Rhythm in Babies and Adults: Its Implications for Mental Contagion," *Arch. Gen. Psychiatry,* 5 (1961), 169-175.

----. *Unobtrusive Communication: Essays in Psycholinguistics.* Assen, The Netherlands: Van Gorcum, 1964.

Mehrabian, A. "Methods and Designs: Some Referents and Measures of Nonverbal Behavior." *Behav. Res. Meth. Instrument.,* 1 (1969), 203-207.

Montagu, A. *Touching: The Human Significance of the Skin.* New York: Columbia University Press, 1971.

Nadel, M. H. and C. G. Nadel. *The Dance Experience: Readings in Dance Appreciation*. New York: Praeger, 1970.

North, M. *Personality Assessment through Movement.* London: Macdonald & Evans, 1972.

Ostrander, S. and L. Schroeder. *Psychic Discoveries Behind the Iron Curtain.* Englewood Cliffs, N.J.: Prentice-Hall, 1970.

Pennington, J. *The Importance of Being Rhythmic.* New York: Putnam, 1925.

Pesso, A. *Movement in Psychotherapy: Psychomotor Techniques and Training.* New York: New York University Press, 1969.

Preston, V. A *Handbook for Modern Educational Dance.* London: MacDonald & Evans, 1963.

Reich, W. *The Function of the Orgasm.* Translated by T. P. Wolfe. New York: Noonday, 1942.

----. *Character-Analysis,* 3rd ed. Translated by T. P. Wolfe. New York: Noonday, 1949.

Robins, F. and J. Robins. *Educational Rhythmics for Mentally and Physically Handicapped Children.* New York: Association Press, 1968.

Rolf, I. P. "Structural Integration: Gravity, an Unexplored Factor in a More Human Use of Human Beings," *Systematics,* 1 (1963), 66-83.

Rosen, E. *Dance in Psychotherapy.* New York: Teachers College Press, Columbia University, 1957.

Rowen, B. *Learning through Movement.* New York: Teachers College Press, Columbia University, 1963.

Ruesch, J. *Disturbed Communication: The Clinical Assessment of Normal and Pathological Communicative Behavior.* New York: Norton, 1957.

----. *Therapeutic Communication. New* York: Norton, 1961.

Ruesch, J. and W. Kees. *Nonverbal Communication: Notes on the Visual Perception of Human Relations.* Berkeley: University of California Press, 1956.

Russell, R. W. "The Wisconsin Dance Idea-Tribute from a Movement Therapist," *Impulse* (1969-70).

Sachs, C. *World History of the Dance.* Translated by B. Schonberg. New York: Crown Publ., 1937.

Samuels, A. *Movement Change through Dance Therapy-A Study.* Monogr. no. 2, pp. 50-70.

Columbia, Md.: Am. Dance Ther. Assoc., 1972.

Schachtel, E. G. *Metamorphosis: On the Development of Affect Perception, Attention and Memory,* 4th ed. New York: Basic Books, 1959.

Scheflen, A. E. "The Significance of Posture in Communication Systems," *Psychiatry,* 27 (1964), 316-331.

----. *Body Language and the Social Order.* Englewood Cliffs, N.J.: Prentice-Hall, 1972.

----. *How Behavior Means.* Garden City, N.Y.: Doubleday Anchor, 1974.

Schilder, P. *The Image and Appearance of the Human Body.* New York: International Universities Press, 1950.

Schlichter, J. "Movement Therapy," in O. Pursglove, ed., *Recognitions in Gestalt Therapy.* New York: Funk & Wagnall's, 1968.

Schmais, C. and E. White. "Introduction to Dance Therapy, Workshop in Dance Therapy: Its Research Potentials," pp. 1-6. Proc. Joint Conf. Am. Dance Ther. Assoc., C.O.R.D., and Postgraduate Center for Mental Health, New York, 1968.

----. "Movement Analysis: A Must for Dance Therapists," Proc. Am. Dance Ther. Assoc. 4th Annu. Conf., New York, (1969), pp. 52-59.

Schoop, T. *Won't You Join the Dance? A Dancer's Essay into the Treatment of Psychosis.* Palo Alto: National Press Book, 1974.

Selver, C. "Sensory Awareness and Total Functioning," *Gen. Semant. Bull.,* 20-21 (1957), 5-16.

Sheets, M. *The Phenomenology of Dance.* Madison, Wis.: University of Wisconsin Press, 1966.

Smallwood, J. C. "Dance-Movement Therapy," in J. H. Masserman, ed., *Current Psychiatric Therapies,* Vol. 14, pp. 115-New York: Grune & Stratton, 1974-

Sorell, W. *The Dance through the Ages.* New York: Grosset & Dunlap, 1967.

Spitz, R. A. *No and Yes: On the Genesis of Human Communication.* New York: International Universities Press, 1957.

Stanislavski, C. *An Actor Prepares.* Translated by E. R. Hapgood. New York: Theatre Arts Books, 1936.

Stern, E. M. "She Breaks through Invisible Walls," *Ment. Hyg.,* 41 (1957), 361-371.

Siegel, E. V. *The Phantasy Life of a Mongoloid-, Movement Therapy as a Developmental Tool.* Monogr. no. 2. Columbia, Md.: Am. Dance Ther. Assoc., 1972.

Todd, M. E. (1937) *The Thinking Body: A Study of the Balancing Forces of Dynamic Man.* New York: Dance Horizons, 1968.

Wachtel, P. L. "An Approach to the Study of Body Language in Psychotherapy," *Psychother. Theory, Res. Pract.,* 4 (1967), 97-100.

White, E. Q. "Child Development Move ment Studies (Part 1)," unpublished paper, Goddard College, Plainfield, Vt., 1968.

Whitehouse, M. "Reflections on a Metamorphosis," *Impulse* (1969-70).

Wigman, M. *The Language of Dance.* Translated by W. Sorell. Middletown, Conn.: Wesleyan University Press, 1966.

Wolff, W. *The Expression of Personality: Experimental Depth Psychology.* New York: Harper & Brothers, 1943.