

**The Effect of Dance/Movement Therapy on Incidences of Aggression and Levels of
Empathy in a Private School for Children with Emotional and Behavioral Problems**

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DEDICATION

This work is dedicated to all the people in my life who have continually encouraged me through everything I have been through, and who told me to always reach for the stars and never settle for anything less.

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~ I can do all things through Christ which strengthens me.

Philippians 4:13

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ABSTRACT

The Effect of Dance/Movement Therapy on Incidences of Aggression and Levels of Empathy in a Private School for Children with Emotional and Behavioral Problems

The hypothesis for this thesis is: The Dance/Movement Therapy program “Disarming the Playground, Violence Prevention through Movement and ProSocial Skills” will reduce aggression and increase empathy in children ages 8-12 years among children enrolled at an approved private school for children with emotional and behavioral problems. The effectiveness of this curriculum had not previously been examined in a school for children with emotional and behavioral disturbances.

The research design was a quasi-experimental single subject design with 2 children, with an ABA design (Mertens, 2004). Both children were African American males, ages 8 and 9, diagnosed with Attention Deficit Hyperactive Disorder. Child 1 carried a co-morbid diagnosis of Learning Disorder NOS, and Child 2, with Oppositional Defiant Disorder. This study included a two week initial baseline, four week intervention phase, and two one week post-intervention baselines. Quantitative data were collected six times using the Teacher Forms of the Child Behavior Checklist and the Social Skills Rating System. Qualitative data were collected through Green Tree Lower School progress notes.

Major quantitative findings showed a decrease in Total Problem Behaviors for both children on both assessments. Total Social Skills scores on the SSRS decreased in

both children. Common themes in qualitative data included engaging in positive, trusting relationships, self-awareness, and group cohesion.

Disarming the Playground is a curriculum designed for “normal” and “at-risk” children in public schools, as a preventative measure for violence and aggression. The participants were not able to appropriately function in a public school. As the *Disarming the Playground* curriculum is designed to be used in total, and sequential order, choosing only specific activities to utilize proved to be a challenge for the participants. If the entire curriculum was to be implemented, there may have been an increase in social skills and empathy levels, and a lasting impact on both variables of aggression and empathy.

Chapter I: Introduction

The overall purpose of this study is to examine the effectiveness of Rena Kornblum's Dance/Movement Therapy (DMT) program (Kornblum, 2002) in decreasing incidences of aggression and increasing levels of empathy among children ages 8-12 years enrolled at an approved private school for children with emotional and behavioral problems. The design of this study was quasi-experimental: a single subject design with 2 children using an ABA format (Mertens, 2004). The dependent variables, aggression and empathy, were measured six times throughout the eight week study. The measurements occurred at weeks 1, 3, 5, 6, 7, and 8. Four one-hour group DMT sessions were given over the intervention timeframe. Scores on each dependent variable were compared pre- and post- intervention for each participant. The group DMT sessions will follow the Kornblum "Disarming the Playground, Violence Prevention through Movement and ProSocial Skills" program.

The problem to address in this study is the high incidence of aggression related behavior problems among children enrolled at a special education school for emotionally disturbed and behaviorally challenged children. One such school is the Green Tree Lower School, where this study will be conducted. If the findings show that the DMT program "Disarming the Playground, Violence Prevention through Movement and ProSocial Skills" can effectively decrease aggression and increase levels of empathy, therapists will have evidence, and the schools where they work, will have evidence and methods for working effectively to address these two areas. The findings from this

proposed study will be applied to the practice of DMT by aiding therapists to confidently implement Kornblum's method in other private schools for children with emotional and behavioral problems with children of this age range.

Researchers de Castro, Bosch, Veerman, & Koops (2003) studied the effects of emotion regulation, attribution, and delay prompts on aggressive boys' social problem solving. The participants were 31 boys with behavioral problems, whose scores were compared to a normal comparison group of 32 boys in regular education. Each of the children were placed in a variety of provocative situations and were then asked to become more aware of their own feelings, the feelings of others, and delay their aggressive behavioral responses, or questions about the vignette that were not connected to the boy's emotional responses. The children were randomly assigned to one of four groups: SELF, OTHER, DELAY, or FACTUAL. The results showed the aggressive boys responded more aggressively to the vignettes than did the boys in regular education. However, the aggressive boys' responses on the *Socially Desirable Answers* measure were more socially desirable than were those of the boys in regular education. The aggressive boys in the DELAY condition showed an increase in aggressive responses.

Shennum (1987) conducted a six week study on the effect of Art and Dance/Movement Therapy (DMT) on the behavior of children living in a residential treatment facility. The children were randomly assigned to one of into three different treatment conditions: 0, 1, or 2 hours of art and/or Dance/Movement Therapy per week. At the end of the study, assessments of the children's functioning levels were made using the Devereux Child Behavior (DCB) Rating Scale by staff members who were familiar

with each child (i.e. case workers or child care supervisors). The children were scored in two areas; emotional unresponsiveness, comprised of emotional detachment and a low “need for adult contact” (p. 85), and behavioral acting out, in “social aggression and unethical behaviors” (p.85). The results showed that the children who received more art therapy and/or DMT had lower levels of emotional unresponsiveness and negative acting out behaviors.

In 2005, Hanrahan studied the use of psychological skills training to enhance life satisfaction and self-worth in a group of adolescent Mexican orphans in residential care. Each of 15 sessions used team-oriented games and focused on concentration, attention, imagery, self-talk, time management, and self-confidence. The team-oriented games also built communication and trust. Pre and Post-test scores were recorded on the Satisfaction with Life Scale (SWLS) and Self-Perception Profile for Adolescents (SPPA). The results showed an overall increase in the areas of: life satisfaction, global self-worth, physical appearance, social acceptance, close friendship, scholastic competence, as well as behavioral conduct.

Koshland & Wittaker (2004) evaluated the PEACE Through Dance/Movement program, created by Lynn Koshland. The program, designed to enhance peer interactions, is a 12 week Dance/Movement Therapy (DMT) program for violence prevention with multi-cultural elementary schools students. The group DMT sessions focused on increasing communication and social skills, of children while working together to problem solve. Observational results reported by teachers indicated a

decrease in aggression and disruptive behaviors, and an increase in self control among the children who received DMT, when compared to children who did not.

Robin, Schneider & Dolnick (1976) examined the effectiveness *Turtle Technique*, a three-phase program that aids children in learning to control their impulsive and aggressive behaviors. Eleven children in two elementary classrooms from a school for children, who suffer from emotional problems, were chosen to participate in this study. Results for every child showed there was a decrease in disruptive behavior of at least 30% from baseline scores. The results of this study suggested that “young emotionally disturbed children can learn to control their own aggressive behavior” (p. 452).

Vernberg, Jacobs, Nyre, Puddy, & Roberts (2004) explained the development, implementation, and preliminary outcome results of a school-based intensive mental health program (IMHP) with a group of 50 children, ages 5-13, with severe, early-onset, serious emotional disturbances. The participants in IMHP were given specialized daily academic instruction, group therapy four times each week, individual therapy sessions at least twice each week, and an individualized behavior program. Their study found more than $\frac{3}{4}$ of the participants with severe emotional disturbances showed significant improvements in overall functioning and adaptation from the time of intake to discharge. Scores on role performance and psychological symptoms also significantly improved.

Hervey & Kornblum (2006) used a mixed-method approach to evaluate the effectiveness of Kornblum’s “Disarming the Playground” program, among second grade students. The body-based program was utilized in public schools and is designed to reduce violence and increase peaceful problem solving among elementary school

children. There was no control group used and nearly half the sample was children with special needs or at-risk students. The Behavior Rating Index for Children (BRIC) completed by the classroom teachers found positive results in six areas: more effective emotional self-regulation such as self-soothing and anger management; increased non-verbal attunement and empathy; more effective interpersonal communication, such as making “I” statements; increased use of cognitive skills such as self-talk, ignoring and focusing, Increased positive risk taking, assertiveness, and self-confidence; and Greater interpersonal spatial awareness (p. 127).

The research question for the present study is: Can the DMT program “Disarming the Playground, Violence Prevention through Movement and ProSocial Skills” reduce aggression and increase empathy in children ages 8-12 years among children enrolled at the Green Tree Lower School? The hypothesis for this thesis is: The DMT program “Disarming the Playground, Violence Prevention through Movement and ProSocial Skills” will reduce aggression and increase empathy in children ages 8-12 years among children enrolled at an approved private school for children with emotional and behavioral problems. The research design for this study was quasi-experimental single subject design 2 children, with an ABA design (Mertens, 2004). The dependent variables, aggression and empathy, will be measured six times throughout the nine week study. The measurements will occur at weeks 1, 3, 5, 6, 7, and 8. There will be a total of six assessment periods. Four one-hour group DMT sessions will be given over the intervention timeframe. Scores on each dependent variable will be compared pre- and post- intervention for each participant. The group DMT sessions will follow the

Kornblum “Disarming the Playground, Violence Prevention through Movement and ProSocial Skills” program.

This study is delimited by the small sample size; the study utilized 2 children. The child participants in this study were ages 8-12, and therefore, the results of the study can not be generalized to children younger than 8, or older than 12. A limitation to this study is the therapist conducting the intervention was a graduate student still developing her clinical skills. However, a Professional Dance/Movement Therapist on staff at Green Tree School was present in all the sessions and will assist the student researcher in guiding the children to follow the curriculum correctly. The presence and guidance of the Professional Dance/Movement Therapist mitigates the limitation to some extent.

If the findings show the DMT program “Disarming the Playground, Violence Prevention through Movement and ProSocial Skills” effectively decreases aggression and increases levels empathy, therapists will have evidence and methods for working effectively in private schools which focus on emotional and behavioral problems, to address these two areas. The findings from this proposed study will be applied to the practice of DMT by aiding therapists to confidently implement Kornblum’s method in private school settings for children in this age range with emotional and behavioral problems.

For purposes of this study, Dance/Movement Therapy will be defined as the “psychotherapeutic use of movement as a process that furthers the individual's emotional, cognitive, social, and physical integration” (American Dance Therapy Association, 2008). The dependent variable of aggression was defined as an offensive unprovoked

physical attack against one's self, other people, or property (Webster's Dictionary Electronic Version, 2008a). Empathy was defined as having the ability to recognize or experience another person's state of mind or emotion within oneself (Webster's Dictionary Electronic Version, 2008b). Pro-social skills were defined as: classroom skills, peer interaction skills, conflict resolution/problem solving, and anger management (Kornblum, 2002).

Chapter II: Literature Review

Developmental Challenges and Co-Occurring Disorders Among Children ages 8-12 Years Old

A great deal of research has been done to examine the psychological and social development of children and adolescents, and the numerous factors that can be influential in the process. Much of the research has been prospective in nature, which allowed observation of possible changes over time. It has been found levels self-esteem observed in childhood and adolescence have an immense impact on outcomes later in life in terms of mental illness, substance dependence, relationships, and overall satisfaction with the quality of life.

The relationship between self-esteem in adolescence and mental health, substance abuse, life and relationship outcomes later in life was examined by Boden, Fergusson, and Horwood (2008). The data gathered were used as a part of the Christchurch Health and Development study, a longitudinal study of a birth cohort of 1265 children, who participated from birth to age 25. The data were collected periodically through interviews, numerous self-reported published inventory scales, and custom written surveys about multiple aspects the researchers identified as possibly predicting levels of self-esteem. The results of this study were that self-esteem was shown to have a weak causal role in later mental health, substance use, and life and relationship outcomes. However, the researchers found a positive link between self-esteem and life satisfaction

at ages 15, 18, 21, and 25. One of the biggest, but unmeasured factors in this study was the context in which people are raised.

DuBois et al (2002) conducted a two-year, four-wave longitudinal study to examine how social support (peer and adult oriented) and self-esteem influenced adjustment during early adolescence in the internalizing or externalizing of problems. Data were collected through questionnaires four times in group or individual sessions, from both from the children and their parents. Results were consistent in showing that children will better adjust to adolescence with greater the social support both from peers and adults, as well as high self-esteem levels. The researchers also found the lack of peer social support may lead to greater behavioral problems in adolescence.

Children who carry more than one mental health diagnosis usually include Attention Deficit Hyperactive Disorder (ADHD) and Oppositional Defiant Disorder (ODD). There have been multiple studies conducted throughout the world, most of which found the same results; children who have these common co-morbid disorders tend to do poorly in school, have more serious behavioral problems, and have greater difficulty forming and keeping relationships with family members and teachers in school. There has been limited research of the co-morbidity of ADHD and Learning Disabilities, and their impact on academic and behavioral outcomes. Future research should continue to explore this area for the benefit of the children who carry this combination of mental health diagnoses.

Adewuya and Famuyiwa (2007) conducted a two stage study to examine the prevalence of Attention Deficit Hyperactive Disorder (ADHD) and co-morbid disorders

in 1,112 Nigerian children, ages 7-12 in multiple primary community schools. The children were from families, varying in socioeconomic statuses, ethnicities, and religious groups. The first stage assessed each child using *The Vanderbilt ADHD Teacher Rating Scale* (Wolraich, Hannah, Baumgaerta, & Feurer, 1998 as cited in as cited in Adewuya and Famuyiwa, 2007). It was completed by 187 teachers; the teachers rated 35 symptoms of ADHD and common co-morbid disorders, along with eight school performance questions. The 35 items are grouped into four categories, two of which measure ADHD symptoms, and two of which measure other co-morbid disorders. The ADHD categories include ratings on: all 9 symptoms listed in the DSM-IV behaviors for inattention and all 9 symptoms listed in the DSM-IV behaviors for hyperactivity/impulsivity. The co-morbid categories include: a modified scale (10 items) with symptoms of Oppositional Defiant Disorder (ODD) and Conduct Disorder, and a modified scale (7 items) for symptoms of anxiety and depression from the Pediatrics Behaviour Scale (Lindgren & Koepl, 1987). A 5-point Likert scale evaluated the eight school performance items. The *Vanderbilt Attention-Deficit Hyperactive Disorder Diagnostic Parent Rating Scale* (Wolraich, Hannah, Baumgaerta, & Feurer, 1998 as cited in Adewuya and Famuyiwa, 2007) was used in the second stage of this study. The children who scored positive on at least three or more symptoms of ADHD on the teacher scale, in addition to scores on co-morbid categories were included in the second stage of the study and scored on the parental rating scale. The parental rating scale includes 18 items to evaluate if children meet all the DSM-IV criteria for Attention Deficit Hyperactive Disorder (ADHD), 8 items for Oppositional Defiant Disorder (ODD), 15 items for Conduct Disorder, and 7

items from the *Pediatrics Behaviour Scale* (Lindgren & Koepl, 1987 as cited in Adewuya and Famuyiwa, 2007) for anxiety and depression. Of the 1,122 children assessed in the first stage of the study using the teacher's rating scale, only 382 were eligible to be included in the second stage of the study. The results showed the most common sub-type of ADHD was inattentive, which was seen in more than half of the children. The most prevalent co-morbid disorder was ODD, seen mostly with children with the ADHD sub-type of hyperactivity / impulsivity. Children who were diagnosed with ADHD combined subtype, anxiety and depression were the most common co-occurring disorders found among this group.

Michanie, Kunst, Margulies, and Yakhkind (2007) used the DSM-III-R to assess the prevalence of ADHD and ODD symptoms in 300 Argentinean children ages 6-12 years. The children included were patients from three outpatient pediatric clinics in private hospitals. The researchers gathered information about the prevalence of ADHD symptoms, and problems associated with the diagnosis. The parents of the children completed the DuPaul Scale to evaluate their child's ADHD symptoms in the waiting rooms of the outpatient pediatric clinics. The DuPaul Scale has a Likert scoring system to measure the 14 characteristics of ADHD according to the DSM-III-R. Positive scores on the DuPaul Scale suggest the presence of ADHD symptoms, but is not a way to make a clinical diagnosis. To assess the prevalence of ODD symptoms, the researchers developed a questionnaire using the nine characteristics listed in the DSM-III-R, which followed the same format as the DuPaul Scale, and it was completed by the parents. As both assessments were completed by the parents, it was unknown if these symptoms were

also prevalent in school. Scores 1.5 standard deviations above the mean on both scales indicated a positive score for ADHD and/or ODD. The means and standard deviations differed for boys and girls, and the child's individual scores were compared respectively. To test the reliability of the positive ADHD scores, the subject data were compared to the mean scores on the DuPaul Scale of 30 boys and 30 girls, ages 6-12 in an outpatient psychiatric population with a confirmed diagnosis of ADHD. The results indicated 27 children had positive scores on the DuPaul Scale for ADHD, and 24 had positive ODD scores. No gender differences were found between boys and girls for either disorder. In the non-ADHD group, 5.5% of children were found with positive ODD scores, whereas 33.3% of children with positive ODD scores were found in the positive ADHD group. It was also found that among 151 girls, only 2 repeated school grades, whereas of the 149 boys, 14 had repeated grades. Children in this study who scored positively for ADHD symptoms also had a high percentage of co-occurring symptoms of ODD and had repeated grades, which were also seen in children with confirmed diagnoses of ADHD and ODD.

Harada, Yamazaki, and Saitoh (2002) researched the psychosocial problems in children with co-morbid disorders of Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) and compared the data to children who carry diagnoses of only ADHD or ODD. This study included 31 patients with co-morbid ADHD and ODD, 23 children with ADHD alone, and 10 children who carry a diagnosis of solely ODD. All the participants ranged in ages 7-14, met the DSM-IV criteria for ADHD and ODD simultaneously, or ADHD or ODD alone, and were patients at the

National Center of Neurology and Psychiatry in Nagano, Japan. Each of the subjects and their mothers were interviewed by child psychiatrists. Each child's records of DSM-IV axes I and II, present illnesses, and home and school adaptation scores were also provided for the researchers. School refusal, operationally defined as missing 30 or more days of school per year, not due to illness, was then examined by the researchers. The Wechsler Intelligence Scale for Children-Revised and the Illinois Test of Psycholinguistic Abilities was administered by clinical child psychologists to measure intelligence. Each child was also assessed by using the Japanese version of the Children Depression Inventory (CDI) and the State-Trait Anxiety Inventory for Children (STAIC). The mothers were interviewed about their child's coping abilities in school and at home. If the mothers voiced the children had experienced problems in either environment, they notated the problems in great detail. The results of this study found no significant differences in IQ scores between the co-morbid group, and those with only ADHD. This comparison could not be made for the ODD only group due to minimal data collected on this variable. When comparing the number of symptoms of ADHD, there were no significant differences between the co-morbid group, and the group with only ADHD, or for the ODD only group. The presence of anxiety disorders, mood disorders, learning disorders, tic disorders, or somatoform disorders was found to be the same among all the groups. Results collected from the CDI showed significantly higher rates of depression in the co-morbid group, than in the ADHD and the ODD group. The co-morbid group also displayed significantly higher rates of anxiety than the ADHD or ODD groups on the STAIC. However, there were no significant differences on the Trait-Anxiety scores

among the groups. The problems found in school may be due to the relationship problems with teachers and friends. School refusal in the co-morbid group was found to be significantly higher than the ADHD group, but significantly lower than the ODD group. Other school problems included relationships with teachers, which were found to occur most often in the co-morbid group. Relationships with friends was also assessed, and found to be the most troublesome for children in the co-morbid group, followed by the ADHD group, then the ODD group. When determining school performance, no significant differences were found among the three groups. Familial relationships were also measured for each child; this category was broken down into problems with mothers, fathers, and sibling. No significant differences were found among all the groups in terms of the occurrence of relationship problems with the children's fathers. However, the co-morbid group was found to have significantly higher occurrences of problems with their mothers than the ADHD group, but significantly lower occurrences of problems when compared to the ODD group. These findings may be associated with the Japanese cultural norm of the mother as the primary caretaker, and the father having limited involvement with their children. Problems with siblings included fighting and bullying in all the participants; problems with sibling relationships were found in all groups, however the results were not significantly different from one another.

The National Household Education Survey (NHES, 2001), developed by the National Center for Educational Statistics (NCES, 2003a, 2003b), was used by Smith and Adams (2006) to examine the effect of co-morbidity of ADHD and Learning Disabilities through parental reports and the impact of co-morbidity on behavioral and academic

variables. Data were collected through random dialing of 9,583 parents of children ages 5-15, enrolled in public or private schools, in Kindergarten through eighth grade. The researchers interviewed the parents on the phone to assess the variables of behavioral and academic outcomes. Interview questions included inquires about their child's mental health diagnoses, specifically learning disabilities and/or Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD), their child's grades in school this year, if anyone from the school has contacted any adult in the household about the child's behavior or school problems, if the child has had an out-of school suspension or expulsion this year, if the child has repeated any grades since Kindergarten, and if the child was receiving special education services under the Individuals with Disabilities Act. Based on the parental responses to the interview questions, the data placed children in one of four groups: ADHD + Learning Disability (LD), ADHD only, Learning Disability only, or neither ADHD or Learning Disability. The total number of children with a disorder based on the data collected from parents was 1,167. A working sample of 970 was created by the researchers by randomly selecting one child per household; data from a single, randomly selected case were used from each household. Results on the behavioral outcome variable showed parents of children with ADHD + LD had significantly more frequent behavioral problems, when compared to those with ADHD or LD alone. Children with ADHD only also showed more frequent behavioral problems than those with LD alone. There were no significant differences among the three groups in terms of suspension and expulsion from school. Academic outcomes were found to be significantly poorer among children with ADHD + LD, than ADHD alone. Children in

the LD alone group were found to have a significantly higher frequency of poorer academic grades (C's or lower) and the repetition of grades when compared to the ADHD only group, but not when compared to the co-morbid group. Neither gender, ethnicity, nor grade level had a significant impact on any interaction effects in this study. Children with ADHD only had significantly lower frequencies than of receiving special education services when compared to the LD only group, however, there were no significant differences between the co-morbid and LD group in the prevalence of receiving special education services. This had had been found in other research studies (DHHD-CDCP, 2002 as cited by Smith and Adams, 2006). This study was limited by the fact that it was the first research study of a large magnitude to examine the co-morbidity of ADHD and LD on specific behavioral and academic variables, that all the data were gained through parental reports, and that the subtypes of ADHD were not specified. This study is considered preliminary in its findings, and more research must be done to confirm or disprove the outcome results.

Other Intervention Programs Used in Specialized Schools

Children who are unable to thrive in a public school tend to improve when enrolled in a specialized school. At specialized schools, there are multiple special programs that are implemented to allow the children to get the most of their education. Most specialized schools have a variety of specially designed programs to address the negative behaviors and/or emotional problems due to past experiences. The specialized schools and interventions have been shown to be greatly beneficial to the children.

Dutch researchers de Castro, Bosch, Veerman & Koops (2003), looked at 31 boys in special education with severe behavioral problems, ages 8-12. The scores of the 31 boys with behavioral problems were compared to a normal comparison group of 32 boys in regular education. The participants were placed in a variety of provocative situations and asked to become more aware of their own feelings, the feelings of others, and to delay their aggressive behavioral responses. Measurements were taken by the researchers in the areas of behavioral problems, social information processing, verbal intelligence, and socially desirable answers. To measure the children's behavioral problems, the teachers filled out the Dutch version of the Teacher's Report Form ("TRF," Achenbach, 1991; for the Dutch version, see Verhulst, van der Ende, & Koot, 1997). Participants were tested individually; they were told stories of situations that could happen on a daily basis, and asked to imagine they were involved in the situation, and were asked how they would respond. The children were randomly assigned to one of four groups: SELF, OTHER, DELAY, or FACTUAL. Each group had two modes, spontaneous, and prompted. In the spontaneous mode, the children were asked how they would respond after being read a scripted vignette. In the prompted mode, the children listened to four other vignettes, and again were asked how they would respond. In the SELF condition, the children were asked to be aware of their own emotions and think of a way to regulate their emotions when they experienced the vignettes, and if they became upset, they strategized as to how they could make themselves feel better. In the OTHER condition, the children were asked to consider the emotions and the intentions of the person in the vignette who was the provoker. In the DELAY condition, the children listened to the

vignette, but were asked to wait 10 seconds to provide an answer as to how they would respond to it. In the FACTUAL condition, the children were asked factual questions about the vignette they had just heard, which were irrelevant to the emotional responses of themselves or others, or the intentions of the others in the vignette. The results showed the aggressive boys responded more aggressively than did the boys in regular education. However, the aggressive boys' responses on the *Socially Desirable Answers* measure were more socially desirable than the boys in regular education. As hypothesized, the boys in special education overall showed a decrease in aggressive responses to questions regarding their own emotions and emotional regulation. Nonetheless, those aggressive boys in the DELAY condition showed an increase in aggressive responses.

The *Turtle Technique*, a three-phase program that aids children in learning to control their impulsive and aggressive behaviors was examined by Robin, Schneider, & Dolnick (1976). This technique teaches children they can control their own impulses to become aggressive through three steps: imagining they are turtles retreating into their shells, relaxing their muscles to settle their heightened emotions, and use problem-solving skills to think of an alternative way to positively express how they feel. A total of eleven children from two elementary classrooms in a school for children, who suffer from emotional problems, were chosen to participate in this study. The researchers presented four scenarios in which the children were to emit the *Turtle Response*, including: a perceived situation where aggressive behavior with a peer was about to occur, when a child became frustrated or angry at himself and about to have an aggressive outburst, when the teacher yelled "turtle", and when a classmate yelled

“turtle”. “Turtle” signaled the children to freeze, relax, and problem solve together to work through the given scenario. Results for every child showed there was a decrease in disruptive behavior of at least 30% from baseline scores. “The results of the present study suggest that young emotionally disturbed children can learn to control their own aggressive behavior” (p. 452). The researchers concluded the results of this study were preliminary and are not definitive.

Vernberg, Jacobs, Nyre, Puddy, & Roberts (2004) studied the development, implementation, and preliminary outcome results of a school-based intensive mental health program with a group of 50 children, ages 5-13, with severe, early-onset, serious emotional disturbances. Children were enrolled in this program from 1-48 months, with a mean length of enrollment at 12.06 months. The Intensive Mental Health Program (IMHP) was made up of multiple components: a structured behavior management program, a collection of evidence-based psychosocial and bio-medical interventions personalized for each child, frequent meetings with parents, school personnel, and other caregivers, the use of clinical assessments and continuous use of objective data to inform and guide treatment decisions, and coordination with parents/guardians, and all others people involved with the child. The participants in IMHP were given specialized daily academic instruction, group therapy four times each week, individual therapy sessions at least twice each week, and an individualized behavior program. Results of the IMHP showed 84% of the participants with severe emotional disturbances showed significant improvements in overall functioning and adaptation from the time of intake to the time of discharge. Scores on role performance and psychological symptoms also significantly

improved. Because there was no comparison group, these results can not be generalized, nor can a cause-effect relationship be determined.

The impact of a psychological skills training program which taught a variety of tools that could be used improve people's abilities in sports, work, music, or any other area of achievement was examined (Hanrahan, 2005). The participants in this study were orphans living at an institutional home outside of Mexico City, ranging in ages 15 – 20 years. Each participant completed two self-reported questionnaires (translated into Spanish and slightly modified) about self perception among adolescents and overall satisfaction with life during the first and final session of the study. Although variables of life satisfaction, self-worth, and physical appearance self concept were never directly measured, the results showed great improvement in all these areas upon the completion of the study.

Dance/Movement Therapy with Children

There are a variety of techniques and activities used in individual or group Dance/Movement Therapy (DMT) sessions, including: role playing, the use of imaginative play, and structured and improvisational movement experiential exercises, with and without the use of props. As will be seen in the works summarized below, the activities used in DMT sessions can support the development of the child, improve positive coping skills, improve impulse control, self-esteem, facilitate appropriate social interactions, self awareness, body boundaries, building of empathy, and the ability to form healthy relationships with others. The therapist assesses the child/children current

level of functioning on a non-verbal level, then creates interventions activities that are congruent with assessment. The overall goal of DMT is for the child/children to take the skills they learn in a session and apply them in everyday situations.

The purpose of this section is to describe the state of the field of DMT with children using available research and case literature, commentary, cross-cultural work, and examples of professional related applications of DMT, dance, and movement education in child mental health are covered for their relevance to the research question.

Leventhal (1980) discussed movement therapy for the special child. One goal of movement therapy is to expand a child's movement repertoire and increase their movement expressivity. If these goals are reached, it is believed there will also be a change in a child's behaviors. Dance/Movement therapy does not directly teach children new skills, but if children participate in dance/movement therapy activities, their defenses lower, and they are more receptive to learning new skills and modifying their patterned behaviors.

Erfer & Ziv (2006) worked for a number of years with children ages 5-12 years old on a short-term inpatient psychiatric unit. The authors examined and describe a dance/movement therapy (DMT) session designed to increase group cohesion with seven children ages 5-8 years old. The children in the session had a variety of diagnoses, including: depression, attention deficit hyperactive disorder (ADHD), conduct disorder, as well as psychosis, anxiety, and post-traumatic stress resulting from physical or sexual abuse. The session the authors described of numerous DMT activities that focused on: development of body image, self-awareness, and awareness of other people. During as

well as after the DMT sessions, it was observed the children demonstrated better impulse control, frustration tolerance, delay of gratification, and more positive peer interactions.

In school dance/movement therapy with traumatized children was examined by Kornblum & Halsten (2006). When working within a school setting, it is beneficial to work with the team of school staff, as well as any other professionals involved with the identified clients and their families. Typically, groups to address trauma are with 2-8 children and are held weekly for 60-90 minutes. One therapist is in charge of the group; however, it is beneficial for there to be more professionals as aids in the group when the groups are larger. The longer group time is used to allow for emotionally sensitive material to emerge and having adequate time to process it with the group. Consistency, safety, and trust is established through holding closed groups; once the group of children is created, no new members will be allowed to join. Prior to group sessions being held, each child meets with the therapist individually to orient the child to the purpose and location of the group. In the early stages of the group, the children's strengths are identified and utilized as a starting point. The ritualistic nature of the group process aids in establishing continuity, decreasing anxiety, and increasing safety. The group structure described by the authors was made up of five parts, including an opening ritual, a verbal/non-verbal check in, a movement warm up, theme development and creating stories through movement, and ending with a snack and verbal processing. The opening ritual assesses and meets the needs of the group at that time; interventions are based on the needs of the group that day, and ranged from engaging in intense gross motor movements to gradually bringing them down to a more manageable energy and intensity

level, to quiet relaxing meditation to create a serene, peaceful environment to prepare the group to move later in the group. The verbal and non-verbal check in allows each participant to share their feelings and thoughts for the day, as well as improving listening skills, and building of empathy. The movement warm up used structured as well as unstructured movements to facilitate group cohesion, body boundaries, and self awareness. If within the warm up, the group demonstrated poor impulse control and spatial boundaries, they were instructed to sit on the ground, lowering their sense of gravity, and allowing them to become grounded and re-organized. Themes developed within the warm up extend into the creation of stories through movement. Using movement to tell a story provided a safe way to explain an event in someone's life; it acts as a metaphor, and can provide support for the story teller, as well as the group. The movement, verbalization, and creative process allowed the children to work through the concern that may have initially been unresolved.

A pilot study by Gronlund, Renck, & Weibull (2005) examined dance/movement therapy (DMT) as an alternative treatment for young boys diagnosed as ADHD according to the DSM-IV. The study used a mixed methods case study design, which allowed for the collection and analysis of data simultaneous with the ongoing intervention phase. Data were analyzed through triangulation, interpreting the data from various theoretical perspectives. The researchers looked at DMT as an alternative treatment for ADHD in two six year old boys referred by a clinical department of child and adolescent psychiatry. The participants began the 10 week DMT sessions the same time they began school. Neither child was given medication, nor any other intervention through the

course of the 10 week period. The groups were held one time each week for 40 minutes, spanning 3 months, co-led by two Dance/Movement Therapists. Due to the nature of the short term groups, each session included goal-directed interventions and the enforcing of group rules and boundaries. The initial phase of the intervention focused creating a safe space and utilized the child's strengths. In the middle phase, both children became more comfortable with the DMT sessions, and allowed the dance therapists to give the boys more freedom to use their creativity and express themselves with less structured activities. The middle phase also focused on improving the boys' body boundaries and self awareness. The final phase emphasized the growth the boys showed over the duration of the DMT sessions. It also focused on cooperation between the boys and finding comfort in the sharing of conflicts and fears. Data were collected in multiple ways before and after the intervention phase, including a questionnaire, designed by the researchers and completed by the parents to obtain socio-demographic data. The parent version of the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997 as cited by Gronlund, Renck, & Weibull, 2005) was used in this study. The SDQ is comprised of five subscales: hyperactivity, emotional symptoms, conduct problems, peer problems, and prosocial. The ABC Motor test (Henderson & Sugden, 1992, as cited by Gronlund, Renck, & Weibull, 2005) was also completed by a trained psychotherapist. This assessment was chosen to measure the capacity for improvement after the DMT sessions. The tasks and level of difficulty vary with age; tasks include the use of manual dexterity, ball skills, and balance. The boy's parents also engaged in pre- and post- interview, administered and recorded by a trained psychotherapist. Parents were also interviewed a

third time, 2 years after the DMT sessions ended. Each DMT session was videotaped for movement observation and supervision purposes. Observations of the videotapes looked for attention, activity, impulsivity, movement changes, socio-emotional changes, interactions, motor development, and self-esteem. The first child, Tom, (a pseudonym) was a 6 year old only child diagnosed as ADHD/DCD (developmental coordination disorder). Tom presented with hyperactivity, inability to sit still, and aggressive outbursts. Tom liked to be in control of his environment and did not tolerate change well. He displayed poor gross motor ability, balance, and coordination. He did not move with a clear purpose; he moved wildly about with impulsive movements. Tom showed no change on the SDQ Total Score; his score remained in the abnormal range pre- and post- DMT interventions. His presenting behaviors continued to impact his daily life, at school and home. His score on the prosocial subscale showed no change over the 10 weeks; his score places him at the borderline range, suggesting he has some social competence. Tom's scores on the Movement ABC's showed positive improvement after the DMT intervention. The post-DMT interview with Tom's mother found he still had aggressive outbursts, but they were less frequent and intense. Tom was better able to interact with other children as well as adults, with less conflict. His mother also commented on his ability to positively interact with the other child participant. She also noted overall, Tom was more relaxed and less hyperactive. In the final interview, two years after the intervention, Tom's mother reported although he still had school problems, he has an understanding teacher, who is willing to help him. His teacher commented Tom had better concentration and peer relationships. Tom still had occasional outbursts

at home, and his mother wanted him to receive more DMT. The second child, Peter (a pseudonym) is a 6 ½ year old child, diagnosed as ADHD, without DCD (developmental coordination disorder). He presented with panic anxiety, problems coping with change, and the need to control his environment, especially his mother. Peter appeared to have good gross motor abilities, balance, and the ability to do organize himself to do multiple summersaults in a row. He also presented with high tension, mostly in the neck and shoulders. Peter had difficulty controlling his hyperactivity and the intensity of his movements, as well as modulation of time. Peter struggled with new activities, and did not like to lose; his affect oscillated between believing he is a complete failure to acting omnipotent. Peter's score on the SDQ Total Difficulties decreased after the DMT sessions. His scores on the subscales of hyperactivity, emotional, and conduct also decreased. His score on the prosocial scale remained at a constant, normal range score throughout the study. The SDQ also indicated a decline in the impact of the problem behaviors on his everyday life; however, his mother reported she feels burdened as his parent. Although Peter did not score poorly on the Movement ABC assessment, there were improvements found on the total score after the 10 week DMT sessions. Qualitative data suggested an overall improvement; however, there were still some problems he can continue to work on. The interview with Peter's mother after the 10 weeks revealed she saw positive interactions with peers, and a greater sense of relaxation in her son. Peter still felt the need to control his environment and his struggles with change. It was also reported that prior to the DMT intervention, Peter could not sit still in school and was very hyperactive, but after, he was able to concentrate and listen for a full hour, was more

able to control his impulses, displayed greater frustration tolerance, and patience. Two years after the intervention, Peter's mother reported a gradual decline in his level of functioning at school and home. He reportedly became confused, depressed, and self-destructive with suicidal thoughts. He was placed on an anti-depressant medication. His mother took him back to the clinic who referred them to the DMT sessions two years prior, but learned there were no current resources available. One year later, Peter was no longer taking medication and his parents felt better able to cope with him and his behaviors. Because this study only used two participants, the findings of short-term dance/movement therapy treatment in a paired group setting produces positive results for children with ADHD can be used as a hypothesis.

The following summary of a research study does not include the use of Dance/Movement Therapy as a specific modality to meet the needs of the child participants. However, the techniques used in the following research study used creative movement in group sessions, and incorporated interventions also typically seen in Dance/Movement Therapy groups.

Caf, Krofkić & Tancig (1997) examined the use of creative movement and dance on the activation of hypoactive children in a primary school. Children who are labeled as "hypoactive" do not have behavior problems; however, they struggle with communication and motorics. The researchers included the techniques of breathing, movement in space, movement formation, playing with movement, improvisation with movement, and expressive and creative movement when working with the children in the study. The children attended the same primary school, and were divided in two groups, 8

in the experimental and 8 in the control group. All the participants were ages 7-10 years and had been referred for the study by their teachers. The children also carried diagnoses of various learning disabilities, including problems with reading, writing, speech and communication. The children were placed in the experimental group as their teachers reported they suffered from greater hypoactive behaviors and more passivity, than those in the control group. The experimental group participated in optional creative movement groups for one hour week, spanning a total of 4 months. The control group did not attend creative movement groups. Both groups were assessed at the beginning and the end of the experiment using multiple assessments, including the Thinking Creatively in Action and Movement (TCAM), Activities 1, 3, 4 (Torrance, 1981 as cited by Caf, Kroflic & Tancig, 1997). The teachers also completed a non-standardized questionnaire about the child's creativity within the classroom (Kroflic, 1992 as cited by as cited by Caf, Kroflic & Tancig, 1997). The children were also assessed with the Body Image Evaluating Scale (Cratty, 1979 as cited by Caf, Kroflic & Tancig, 1997) and a non-standardized version of the Behavior Evaluating Scale for Hypoactive Children. The dance teacher conducting the creative movement and dance groups also kept notes and observations about the experimental group. The results of the test and retest of the control group on the TCAM showed no significant differences, however, there were significant increases in the experimental group in terms of creative thinking in all three activities. There were expansions in the experimental group's movement repertoire and an increase in the children's imaginary play. The teacher's completion of the Child's Creative Behavior questionnaire found the experimental group had a significant increase on the final

assessment in curiosity, originality, imagination, activity, inventiveness, fluency, skills, and flexibility. There were no significant differences in the experimental group on the sub-scale of intrinsic motivation; scores within the control group remained the same on the first and final assessment. There were significant improvements on the Body Image Evaluating Scale in the experimental group. The Behavior Scale for Hypoactive Children found the children showed a decrease in hypoactive behavior in both the experimental and control group, however, the differences were not significant. Verbal behavior levels remained consistent throughout the experiment. Passivity and the fear of performing significantly decreased in the experimental group. The creative movement and dance found to improve relaxation and communication with peers among children. The classroom teachers assessed those who received the creative movement and dance as more active, having a positive effect, and more expressive of their feelings after the four month intervention.

The following paragraphs discuss dance/movement therapy education for clinical staff working with children in a mental health facility, impactful elements and dynamics within a dance/movement therapy group session, and cross-cultural aspects of dance/movement therapy.

The use of dance/movement therapy (DMT) techniques to augment the effectiveness of therapeutic holding with children was studied by Lundy & McGuffin (2005). The study had a pre- and post-test design with quantitative and qualitative measures at a residential treatment center (RTC) and day program. Participants included ten RTC staff and ten boys, ages 3-12 years with diagnoses of Attention Deficit

Hyperactive Disorder (ADHD), learning disabilities, Oppositional Defiant Disorder (ODD), and Explosive Disorder who had received at least one therapeutic hold prior to the commencement of the study. There were three phases of this study. The first phase included interviews with each of the children to discuss their experience in the therapeutic holds. In the second phase, the researcher interviewed the staff participants to obtain their perspectives and empathy levels for the child when they had administered the therapeutic holds. The participating staff was also given the Interpersonal Reactivity Index (IRI) (Davis, 1983 as cited by Lundy & McGuffin, 2005) to measure empathy levels before the DMT workshop. In the third and final phase of the study, the researchers provided the staff participants with four, one-hour DMT training sessions which addressed the results of the pre-tests. Two weeks after the workshop, the IRI was administered to staff again to observe any changes in post-test empathy levels. The children's interviews illustrated their anger and fear for their own safety while being held. The anger the children feel toward the staff occurs in the moment, but there were no reports of lasting animosity towards their holders. The staff reported sharing the fear of injury during the therapeutic holds prior to the DMT workshop, and there was no change in their concern with safety post DMT sessions. The adult's IRI scores showed no significant change in empathy levels overall. However, within the "perspective taking" subscale of the IRI, the scores showed a significant increase from the pre-test scores. After the DMT workshop, the number of therapeutic holds in the residential treatment center decreased overall. The DMT workshop sessions increased the adult's awareness, sensitivity, and having the ability to shift perspectives. There was also an increase in

confidence, interest, and awareness of positive outcomes of DMT workshops to address issues of therapeutic holding of children. The findings of this study suggest DMT can be beneficial for all when working with children; it may enable the staff to become more of how their actions and verbalizations when administering a therapeutic hold may have an impact on the child. DMT may also benefit staff needing to therapeutically hold a child by increasing their understanding what the holding and containment of the child can provide for the child, a sense of safety and nurturance they need to calm down in their heightened state of arousal.

Schmais (1985) looked at factors within group dance therapy sessions that elicit positive change, growth, and health in its participants. Factors that can be seen in typical group dance therapy sessions include: synchrony, expression, rhythm, vitalization, integration, group cohesion, education, and symbolism. There are multiple types of synchrony, rhythmic, spatial, and effort. Rhythmic synchrony is seen in people moving together in time, however not necessarily moving in the same way or with the same body parts. Spatial synchrony is the group moving around the space in the same spatial pathways, or making the same spatial patterns with various body parts. Moving with the same effort qualities, regardless of what body part is being used, is referred to as effort synchrony. Synchrony requires a sense of communication and social awareness among group members. Expression is a way for participants in group dance therapy sessions to express experiences they went through in the pre-verbal stages of development or those emotions that are more complex and can not be expressed by the participant verbally. Expression is only able to occur when the group provides a send of trust and acceptance.

Rhythms provide a connection for the person to themselves or others, especially in times of trouble, both internally and externally. Rhythms provide structure, integration, inspiration, and regulation for a dance therapy session. Breath is an internal rhythm everyone can experience and connect to as a way to gain a better sense of themselves. Vitalization is "...investing people with the power to live" (p. 25). Some people have suppressed their emotions for such a long time they can no longer feel their emotions. Through group dance therapy, one's inhibitions gradually lower, and people become more able to tap into those emotions that had been suppressed for so long, and now people feel more comfortable to express how they are feeling. "The flow of motion connects limbs to torso and feelings to actions" (p. 25). Integration in dance therapy sessions can be seen within one's own body, as well as a person's internal and external reality. The dance therapist's goals are to re-integrate the group member's body actions, facial expressions, and verbalization. Memories can be stored somatically, which can lead to muscular rigidity, which limits one's range of movements. Dance therapy can expand people's movement repertoire, which can enable people to revisit those experiences stored in the body, and give people an opportunity to deal with them in a more positive, healthy way. Cohesion refers to people getting along and interacting with others in a group. It can also refer to people becoming tolerant of physical proximity. Physical closeness is a precursor for allowing touch. Education in dance therapy can teach participants about themselves, others, relationships to other people and to the external environment. People learn about these aspects of themselves through watching and modeling the movements of others, and through the therapist providing imagery,

statements, and questions about the movement process. Symbolism provides a bridge between people's inner and outer worlds, and aids people in linking what happens within the group process to everyday life. "The identification of nonverbal processes which heal and the subsequent confirmation by research are essential ingredients in confirming dance therapy as a 'healing method'" (p. 34). Common themes of groups, based on clinical experience and group therapy theory (group, synchrony, expression, rhythm, vitalization, integration, group cohesion, education, and symbolism) (p. 18) can emerge and be beneficial for participants at any age or stage of life.

The group themes are universal; however, the methods and therapeutic interventions to address the themes vary with the ages of group members. When addressing these themes with children, is it helpful to use props and movement games and activities. When the children are engaging in the activity, they are not always aware of the goal, but through the therapist's verbal processing during the activity or at the end of the group, it helps the children make connections from what emerged in a group session and apply them to everyday life.

At the 2007 American Dance Therapy Association conference, "Bridging Cultures" in Brooklyn, NY, representatives of multiple countries from around world held a panel discussion about cross-cultural dance/movement therapy with children (Capello, 2008). There were a total of four panels; the first group was comprised of representatives from countries in which Dance/Movement Therapists had abundant opportunities for education and support for their work from other professionals. The second panel examined the effect of cultural differences in raising children and how dance/movement

therapy had benefited children's development in these varying cultures. A third group explained prominent issues in research that have emerged within the dance/movement therapy (DMT) realm, as well as in other clinically related fields. The final panel discussed the benefit of dance/movement therapy for children who have been survivors of war and torture.

The first panel included representatives of Israel, Spain, Canada, and Germany. In Israel, the Dance/Movement Therapists have the opportunity to work with children as a part of their school's treatment staff; the Dance/Movement Therapists work alongside educational psychologists, other expressive arts therapists and counselors. Although Dance/Movement Therapy (DMT) is not universally recognized by the clinical professional world in Spain, Dance/Movement Therapists continue to advocate for the benefits of their work. Spain has a greatly established and recognized field of psychomotricity, which carries components of Dance/Movement Therapy. Most Dance/Movement Therapists practicing in Spain find employment at the same facility where they had done internships, create their own private practice, or seek grants from the government for special programs and projects for children. Canada claims to have a multitude of opportunities for DMT, but not enough experienced clinicians to fill the open positions. The focus of DMT in Canada is with children surrounding attachment and trauma issues. Most of the children were born in to families who had been separated due to government politics. German Dance/Movement Therapists dominantly work with the tension/flow rhythms from the Kestenberk Movement Profile (KMP), as well as Laban Movement Analysis (LMA). Dance/Movement Therapists in Germany work

with children and adolescents in institutions with psychiatric illnesses, personality and eating disorders (including obesity), psychosomatic problems, and trauma. Those Dance/Movement Therapists in private practice work with children who carry developmental disorders, physical disabilities, sensory deficits, obsessive compulsive issues, emotional problems and neglect, as well as enuresis and encopresis (Capello, 2008).

The panel to examine the effect of cultural differences in raising children and how dance/movement therapy (DMT) has benefited children's development in these varying cultures was made up of representatives from Japan, Korea, Greece, and Argentina. Due to the decline in birth rate in Japan, the way children are being raised has changed. Gender roles have remained consistent, with men working and the women, whether they are working or not, are the primary caregiver. In Japan, there is "movement education" available to those children diagnosed with a developmental delay in early childhood and enrolled in a therapeutic education center; Dance/Movement Therapists are not employed at these centers. Mothers are encouraged to join their children in the movement experience to avoid isolation, accept their child's disability, and build relationships with their special needs child. Within most psychiatric facilities in Japan do not offer DMT, however, physical education is a part of a "special support education". In special educational settings, Japan is striving for the integration of all special needs children, despite their differing disabilities. In Korea, education and developing cognitive abilities are valued, but because engaging in physical experiences is not as important in Korean culture, developmental motor disabilities have become more prevalent. As a result of the

constant pressure for superior intellect, Korean children spend most of their time in isolation and studying and lack peer relationship development, are under constant stress, display attention deficit disorder, and aggressive behaviors. Dance/Movement Therapists in Korea work with children to express their feelings and needs through movement, improve peer relationships, develop physically, and integrate the whole self. DMT has greatly grown in Greek health care and educational settings. DMT is typically done in inpatient hospitals or private practice. Special education is a part of the regular school system and children can attend regular classes with special support if needed. Not all children with special needs are able to attend regular school, and attend a special school, or receive education at home. The panelist representing Greece believes Dance/Movement Therapists can benefit the educational environment by educating teachers, using early diagnostic and evaluation tools, developing interventions unique to each child, and being an active participant on the therapeutic team. Within a special school in Argentina, DMT is the first method of intervention for children with emotional disturbances, cognitive problems, who struggle with relationship formation, and slack of social development. Foreign language teachers have received DMT to increase their awareness and non-verbal skills development to utilize while instructing children. The teacher's increased awareness facilitated their understanding of their student's needs, self-esteem, body language, and social identity (Capello, 2008).

Prominent issues in research that have emerged within the dance/movement therapy (DMT) realm, as well as in other clinically related fields were presented by representatives of France, Finland, and Egypt. French Dance/Movement Therapists

collaborate with psychologists and psychiatrists on “dance-psychotherapy” practice with children and adolescents in the public healthcare system. Psychomotricity, which the panelist described as a pre-cursor to DMT in Europe, is used with children with Autism. This method believes the view of the connection of the mind and body; clinicians work with the client to integrate all aspects of the body, mind, emotions, social interactions, and the client’s ability to adapt behavior to the psychosocial context. Psychomotorics uses imitation with some structure striving to achieve the goals of increased body awareness and boundaries, as well as increased self-esteem. In Finland, DMT is classified as an adjunctive therapy. It is not referred to as Dance/Movement Therapy, but as “therapeutic dance education”. The “therapeutic dance education” combines movement with various multi-media tools and activities when working in groups to work with a child on all sensory levels. In Egypt, research has been done with children and adolescents with emotional and behavioral problems, and/or nocturnal enuresis. In a pilot randomized control study, 30 participants were placed into 15 pairs, and then randomly assigned to one of two groups. One group received DMT, and the other served as the control group; the control group received no medication or other forms of therapy. The 90 minute DMT groups occurred two times each week for a total of seven weeks. The group moved for 60 minutes each session, and ended with a 30 minute verbal processing phase. The DMT interventions used props, such as ropes, sheets, balls, and blankets. Other interventions implemented without the use of props, focused on building empathy, molding to another’s movements, the therapeutic use of touch, and synchrony. Both groups were assessed pre- and post- intervention using the Standford-Binet Intelligence

Quotient Assessment, the parent and self administered version of the Strength and Difficulties Questionnaire, the Child Personality Assessment Questionnaire, and the Body Image Assessment. Although no significant differences were found between the groups pre- and post- intervention in the control group, there were significant differences within the DMT group on the parameters examining emotional symptoms, emotional responsiveness, peer problems, and self-adequacy in the post- DMT assessments. Six months after the intervention, improvement continued in the group who received the DMT sessions (Capello, 2008).

The use and benefit of dance/movement therapy for children who have been survivors of war and torture was shared by panelists representing Sierra Leone, India, Norway, and Haiti. An American Dance/Movement Therapist (DMT) worked with former child soldiers in Sierra Leone to address the horrific effects of war through group and individual therapy sessions. Although virtually none of the participants had received any previous psychological counseling, all were very enthusiastic about DMT. A key to the DMT sessions being beneficial was there needed to be a safe space established, which allowed the participants to build trust for one another. The sessions utilized familiar music and used creative and improvisational movements to promote relaxation, decrease aggression, reduce sleep disturbances, increase body organization and stability, and accept and cope with their extensive trauma history. All of the participants shared the group DMT sessions improved their overall well-being, lessened their depression and post-traumatic stress. In 2003, a new organization in India was established to use DMT to work with victims of violence and human trafficking, as well as those who were

underprivileged and marginalized. The organization has extended its services to children in Bangladesh, Nepal, and Thailand. They have also worked extensively with those with traumatized, vulnerable, and suffering children, as well as those who have been diagnosed with HIV/AIDS. Dance/Movement Therapists hold weekly sessions, provide workshops to others, and continue to expand the program to other areas in need.

Dance/Movement Therapists work with a “curriculum called “Sampoornata”, which stands for recovery, healing, expression, and rehabilitation (p. 33).” Within the DMT sessions, children work on increasing their self esteem and using their creativity to openly express themselves in a space free from a fear of being judged. Norway has become one of many areas children or unaccompanied minors run to for refuge from their war-stricken homeland. The theoretically based clinical environment, which stressed psychodynamic and cognitive-behavioral theories of Norway, has welcomed DMT and other arts and body-based, expressive forms of therapy. The Norwegian government has established treatment programs to address the needs of these refugees and survivors, which now includes the use of DMT interventions. Haiti, the poorest country in the western hemisphere believes in using the body in many ways, including healing, prayer, transformation, and at the center of life for individuals as well as communities.

Dance/Movement Therapists in Haiti work with children who were soldiers, gang members, tortured, and victims of human trafficking and violence. As violence is viewed as a means of survival in Haiti, their treatment programs are unique in they work with the victims, as well as their perpetrators. Dance/Movement Therapy also assists children in learning how to re-enter their community to be successful (Capello, 2008).

The above summaries of Dance/Movement Therapy literature provide a broad overview of just some of the work done throughout the world in the field of children's mental health. The following section will provide a more in-depth view of literature pertaining to the dependent variables addressed in this research study.

Dance/Movement Therapy to Increase Empathy and Decrease Aggression

“Dance/movement therapy (DMT) is effective in helping youth deal with highly charged social issues and emotional complexities; assisting in the treatment and prevention of conflict, peer violence, and abuse” (American Dance Therapy Association, 2008, DMT Fact sheet, p. 5). DMT can provide a safe outlet of expression of feelings, especially anger and/or frustration. It is a way for children to learn that having these negative feelings is okay, but acting out the negative behaviors is not. When children learn to identify these feelings, they are better able to learn how to control the impulse to act on them. “Developing of a repertoire of behaviors that allow safe expression or distraction from these intense feelings is...a big part of anger management” (Kornblum, 2002, p. 216).

Hervey & Kornblum (2006) used a mixed-method approach to evaluate the effectiveness of Kornblum's *Disarming the Playground* program, among 56 second grade students. The purpose of this evaluation was to find ways to continue to develop and improve the program, as well as find better ways to assess how effective it is. There was no control group and 50% of the sample was children with special needs or at-risk students. In addition to the Kornblum program, some children also volunteered to be

interviewed and take part in drawing and writing activities. All the classes were class participated in a weekly 45 minute session; one class for one semester, another for three-quarters of the academic year, and one for the entire year. At the end of the academic year, all the classes received a three hour intensive session to reinforce what they had worked on earlier in the year. A Likert-type scale, the Behavior Rating Index for Children (BRIC) was completed pre- and post- intervention by the classroom teachers. The students and teacher were also asked to write about what they had learned from the sessions, and to describe one main skill they learned and how it helped them. Results of the BRIC assessment illustrated a statistically significant decrease in behavioral problems; however, because there was no control group, results were not causal. The qualitative results showed the students had indeed learned from the *Disarming the Playground* program, however, they did not report always using what they had learned.

The PEACE Through Dance/Movement program, created by Lynn Koshland, was designed to enhance peer interactions and improve problem solving. It is a 12 week Dance/Movement Therapy (DMT) program for violence prevention, and was evaluated in a study with 54 multi-cultural elementary schools students. Koshland & Wittaker (2004) studied a total five classes of students in first, second, or third grade; each class received 50 minute sessions weekly. Each session followed a specific sequence, beginning with group focus, reading a story, personal space, followed by social space, movement problem, and ending with closure and discussion. The sessions incorporated skill-building activities focused on self-control, emotional regulation, and problem solving. Data were collected from the students, teachers, an independent classroom observer, and

incident reports given to the principal. The children were assessed using the Student Response Form (modified from Goldstein). This assessment used pictures, so it did not require reading ability; the participants reading comprehension was poor due to their young age. The pictures depicted where problems occurred, what happened, the child's feelings about the problem, and their feelings being witness to an incident. The classroom observed the children in 10 minute intervals using the Behavior Incident Report form B during weeks 1, 6, and one week after the program ended. Results from teacher's observations were there was a decrease in disruptive, acting out behaviors, and increase frustration tolerance, and the ability to control their emotions. Overall, there were significant decreases in aggression and disruptive behavior. However, there was not an increase in positive or pro-social behaviors.

Shennum (1987) conducted a six week study to examine the effects of art and dance/movement therapy on children's behavior among 42 children ages 6-13 years old. All of the participants resided in a residential treatment program for emotionally and behaviorally disturbed children resulting from histories of abuse, neglect, or both. The children randomized into three different treatment conditions: 0, 1, or 2 hours of art and/or Dance/Movement Therapy per week. The sessions took place in a building separate from the residential cottages, usually done in small groups of four. However there were occasions when only one child was present for a session. Upon the conclusion of the six weeks, assessments of the children's functioning levels were done using the Devereux Child Behavior (DCB) Rating Scale by staff members who were familiar with each child (i.e. case workers or child care supervisors). The creative arts therapists did

not assess the children to prevent bias, as they knew the activities program was being done for research purposes. The children were scored in two areas; emotional unresponsiveness, comprised of emotional detachment and a low “need for adult contact” (p. 85), and behavioral acting out, in “social aggression and unethical behaviors” (p.85). Devereux Child Behavior (DCB) Rating Scale (Spivack & Spotts, 1966, as cited by Shennum, 1987) data were statistically analyzed using one-way analysis of variance (ANOVA). The researchers concluded the more children participated in the art and/or dance movement therapy, the more they were willing to interact with adults, were less emotionally detached, and showed less acting out of negative behaviors, than those who received less.

Synopsis of Literature

Self-esteem and peer support in early adolescence was found to have an impact on the internalizing or externalizing of problems, mental health, relationship outcomes, and substance abuse later in life (Boden, Fergusson, and Horwood, 2008; DuBois et al, 2002).

Literature in this review also supports children who carry a diagnoses of Attention Deficit Hyperactive Disorder with another co-morbid disorder, such as Oppositional Defiant Disorder or Learning Disorders are more likely to have higher rates of depression, anxiety, behavioral problems, aggression, conduct disorders, poorer academic scores, increased social problems with peers, family, and other adults (Adewuya and Famuyiwa, 2007; Harada, Yamazaki, and Saitoh, 2002; Smith and Adams, 2006).

Other interventions have been created and implemented for children, usually with emotional and/or behavioral disturbances in school. The programs created to use in the specialized schools have provide a structured curriculum to address negative behaviors, impulsivity, group cohesion, and positive coping skills (de Castro, Bosch, Veerman & Koops, 2003; Robin, Schneider, & Dolnick, 1976; Vernberg, Jacobs, Nyre, Puddy, & Roberts, 2004; Hanrahan, 2005). The literature in this review also discussed the curriculum used had an impact on other areas of children's functioning, not directly intended to address.

Throughout this literature review there have been implications that Dance/Movement Therapy (DMT) has an impact on the mental health of children who present with various issues, including severe trauma (Kornblum & Halsten, 2006), depression, attention deficit hyperactive disorder (ADHD), conduct disorder, as well as psychosis, anxiety, and post-traumatic stress resulting from physical or sexual abuse (Erfer & Ziv, 2006). DMT was also found to have an impact on children in a pilot study as an alternative treatment for Attention Deficit Hyperactive Disorder (Gronlund, Renck, & Weibull, 2005).

Dance/Movement Therapy education for clinical staff was examined by Lundy & McGuffin (2005) was shown to have a positive impact on therapeutic holding with children in an in-patient setting. Theme of synchrony, expression, rhythm, vitalization, integration, group cohesion, education, and symbolism are seen in typical dance/movement therapy adult and child groups, and can elicit positive change, growth, and health among the group members (Schmais, 1985).

Cross-cultural dance/movement therapy has been examined in the literature; the literature implies it has impacted children's development issues surrounding differences in child rearing and children who have been survivors of war and torture (Capello, 2008).

Dance/Movement Therapy has been used as a tool to address aggression and empathy; as noted in the literature, the curriculums have been utilized in public schools as a preventative measure (Hervey & Kornblum, 2006), in a multi-cultural school setting (Koshland & Wittaker, 2004), and in a residential treatment program for emotionally and behaviorally disturbed children with histories of abuse and/or neglect (Shennum, 1987)

There is no current literature to address the effect of dance/movement therapy in private schools for emotionally and behaviorally disturbed children utilizing a specific curriculum to address incidences of aggression and levels of empathy, which was done in the current study.

Chapter III: Methods

Design of the Study

The design of this study was a quasi-experimental: a single subject design with 2 children using an ABA format (Mertens, 2004). The hypothesis for this thesis is: The DMT program “Disarming the Playground, Violence Prevention through Movement and ProSocial Skills” will reduce aggression and increase empathy in children ages 8-12 years enrolled at an approved private school for children with emotional and behavioral problems. The dependent variables, aggression and empathy, were measured using the Child Behavior Checklist (CBCL) Teacher Form and the Social Skills Rating System (SSRS) Teacher Form.

Location of the Study

The location for this study was the Green Tree Lower School, located at 146 West Walnut Lane, in Philadelphia, Pennsylvania. Green Tree School is a non-profit state-licensed, approved private school serving children diagnosed with Autism Spectrum Disorders, serious emotional disturbances and preschool developmental delays.

Time Period of the Study

The commencement date of this study was March 30, 2009 and extended through May 18, 2009.

Enrollment Information

The number of participants included in this study was 2 ranging from age 8 – 12 years of age. Children of all genders, racial backgrounds, religions, and ethnicities were considered for this study.

Subject Type

All participants were enrolled at the Green Tree Lower School. There were 2 children in this study, ranging in ages 8-12. The results of the study can not be generalized due to the case study design and the small number of participants. All participants have social, emotional, and behavioral problems. The participant's diagnoses included at least one of the following: Attention Deficit Hyperactive Disorder (ADHD), Oppositional Defiant Disorder (ODD), Anxiety Disorder, or Learning Disorder NOS.

Subject Source

The participants were enrolled in the identified classroom at the Green Tree Lower School. The classroom chosen included children who fell within the age range, and suffered from the most severe behavioral problems in the school. At the time of recruitment five children met all the inclusion criteria, however not all parents provided parental permission for all children, and so only two children were included in the study.

Green Tree Lower School is a non-profit state-licensed, approved private school serving children diagnosed with Autism Spectrum Disorder, serious emotional disturbances and preschool developmental delays. Green Tree School is dedicated to improving the quality of life for students with special needs and their families. The school connects students to effective academic, therapeutic, personal and vocational services that enable success throughout the lifespan. More specifically, the Green Tree Lower School provides services for elementary aged children with social, emotional, and behavioral problems. There are numerous programs in the Lower School available to the students at the lower school, including: educational, enrichment (i.e. Music therapy, Dance/Movement therapy, physical education, reading, and art), and access to the on-site psychiatric clinic. The psychiatric clinic offers numerous services: case management, psychiatric testing and evaluations, individual psychotherapy sessions, crisis intervention, group psychotherapy sessions, movement therapy, monitoring of medication (if required), family support services, and consultation with inter-disciplinary team.

Recruitment

The participants for this study were recruited with the assistance of the professional Dance/Movement Therapists at the Green Tree Lower School. Children who met all the inclusion criteria were identified through a review of records of children in the identified classroom of the Green Tree Lower School. The Professional Dance/Movement Therapist's on the clinical staff, who already have routine access to the children's files, conducted the record review.

The professional Dance/Movement Therapists contacted the parents of the identified children to give them initial information about the *Disarming the Playground* program and the student researcher's thesis project.

The student researcher then sent a recruitment letter (Appendix A) home describing the proposed study. The letter provided assurance to the parents that permission for their child's participation in, or refusal to participate in the proposed study will have no bearing on the child being able to continue receiving the same services already in place at Green Tree Lower School. The letter also invited the parents of the children in the identified classroom to attend an optional meeting to learn more about the *Disarming the Playground* program.

Following the letter being sent home to the parents of the children in the designated classroom, an optional meeting with the student researcher was scheduled at the Green Tree Lower School to discuss Rena Kornblum's *Disarming the Playground* program. The plan was to give parents in attendance a handout of the recruitment flyer (Appendix B) discussing the proposed study at the same time of the scripted announcement. As none of the parents attended the optional meeting, the recruitment flyer was sent to their home. After two school days, the clinical staff followed up with a phone call to make sure the flyer was received.

There was no incentive offered for the participants in the study, nor remuneration given to the participants.

Subject Inclusion Criteria

Children who were eligible for this study must

- 1) Have been between the ages of 8-12 years old
- 2) Have been identified by their primary therapist to address continuous serious aggressive behaviors and notable deficits in pro-social skills
- 3) Have been sent to the LRC (Learning Resource Center) on at least one occasion, due to a physical altercation or verbal confrontation.
- 4) Carry a diagnosis of at least one of the following: Attention Deficit Hyperactive Disorder (ADHD), Oppositional Defiant Disorder (ODD), Anxiety Disorder, or Learning Disorder NOS
- 5) Assigned to the Green Tree Lower School classroom designed for children with the characteristics named in items 1-4 above

Subject Exclusion Criteria

Children may not be enrolled in this study if they

- 1) Were not enrolled at the Green Tree Lower School
- 2) Were not assigned to the designated classroom
- 3) Were younger than 8 years old or older than 12 years old at any time from the onset of the study to the end of data collection.
- 4) Carried a diagnosis on the Autism spectrum, Pervasive Developmental Disorder (Asperger's Syndrome, Childhood Disintegrative Disorder, or Rett's Syndrome), or Mental Retardation may not participate in the study.

Investigational Methods and Procedures

Informed consent.

- A. In a scripted meeting with the participant's parents and Mr. John Madden Lower School Program Coordinator or Dance/Movement Therapist, Ms. Amy Ruzic Hunter, MA, ADTR, the researcher explained the parental permission form. The parents were asked to explain each of the forms back to the researcher in their own words to verify that they understand the research study. If the parents showed they understood, and were willing to, they were asked to sign two copies of the permission form. The parents were also informed that one copy of the form would be given to them, and the other will be stored in a locked, secure file in the Drexel University Creative Arts Therapies office.
- B. To inform the child participants about the details of this study, the researcher described the purpose and procedures of the study, as well as the rights the participants would have throughout the study by using an Assent form (Appendix D). Because the participants were under the age of 18, the child participant's were given an assent form (Appendix D) explaining the research study, as well as all adults who were informed about their participation in the study (i.e. parents, therapists, teachers, etc.). The assent form also affirmed that the child had the right to drop out of the study at any time, without having to face repercussions. If the child

chose to drop out of the study, they were still permitted to participate in the DMT group. The child subject read the assent form in a face-to-face meeting at the Green Tree Lower School, and then was asked to explain this form in their own words. If the child was able to understand what was being asked of them, and if they choose to, they were asked to sign the assent form. During the face-to-face meeting and signature, Mr. John Madden, Lower School Program Coordinator or Ms. Amy Ruzic Hunter, MA, ADTR, were also present. Each of the parents/guardians was asked to sign two parental permission forms and the children, two assent forms. The parents/guardians and participants were told one copy of each form will be given to them, and the other will be stored in a locked, secure file in the Drexel University Creative Arts Therapies office.

Instrumentation

The dependent variables in this study are aggression and empathy.

Child Behavior Checklist – Teacher Report Form (CBCL-TRF).

The instrument to be used to quantitatively measure aggression was the Child Behavior Checklist (CBCL), the teacher report form (TRF). The CBCL is the most current version of the Achenbach rating form (Achenbach, 1991a, 1991b, 1991c, 1992). The CBCL uses a 3-point Likert scale to assess areas of competency (sports, hobbies, clubs, jobs, chores, friends, peer relationships, and academic performance), and open

ended questions about illnesses, overall concerns, and things the child likes the most about themselves. The CBCL can be completed by the child participant, the parent, or the child's teacher to examine the level of emotional and behavioral functioning and competency. The teacher report form was chosen over the self-report by the child because the CBCL is formatted at a fifth grade reading level, which might have proven to be troublesome to the younger participants in the study. The directions of the CBCL-TRF were to assess each child over the last two weeks, up to the assessment day. The most recent version of the TRF was normed with children ages 6-18. The CBCL TRF is normally administered every two months to monitor changes; for purposes of this study, the time between assessments was modified so it was administered to assess for change every two weeks.

The TRF complements the other measures in this group. It can be used to describe student's functioning to make referrals, compare students' functioning in different classes, determine eligibility for special education services, and reevaluate students after intervention (Achenbach 1991b on p. 300 Rush, First & Blacker, 2008).

Reliability of item scores on the CBCL was assessed using the intraclass correlation coefficient (ICC) from one way analysis of variance (Bartko, 1976). "The ICC can be affected by both differences in the rank ordering of the correlated scores and the differences in their magnitude" (Achenbach & Rescorla, 2001, p. 99). Inter-interviewer reliability of the item scores compared data from 241 triads of children to children matching in age, gender, ethnicity, and SES assessed by two other interviewers. The total number of children assessed was 723. The ICC was 0.93 for the competence

items and 0.96 for the specific problem items. The statistics for inter-interviewer reliability of the item scores were found to be very high.

Test-retest reliability of item scores were assessed through data gathered by one interviewer from the mothers of 72 non-referred children at one week intervals. Non-referred children were assessed due to them having a lower chance of regression than the referenced children may have. The ICC for the competence items was 1.00, and 0.95 for the specific problem items. The statistics for test-retest reliability of the item scores were found to be very high (Achenbach & Rescorla, 2001).

Internal consistency of scale scores is also known as, split-half reliability. Each of the adaptive characteristics and the academic performance scale on the TRF has single scores, alpha for the Total Adaptive Score on the TRF was found to be 0.90. Scores on the empirically based problem scales on the TRF were found to range from 0.72 to 0.95. Scores on the DSM-oriented scales on the TRF were found to range from 0.73 to 0.94 (Achenbach & Rescorla, 2001).

Pearson correlations (r_s) and t tests were used to compute test-retest reliability of scale scores by comparing ratings on the CBCL from parents, the youth self report (YSR), and the TRF completed by teachers. Data were collected in mean intervals of 8 to 16 days. Children included in this reliability test sample were non-referred, as well as children who were actively participating in special education classes and/or mental health services. Overall, test-retest reliability was found to be very high with most scores ranging from the 0.80s to the 0.90s. The r_s for Total Competence, Total Adaptive Functioning, and Total Problems from the CBCL and the TRF ranged from 0.91 – 0.95.

The mean rs for the CBCL competence and empirically based problem scales, and the TRF adaptive and problem scales were found to be 0.90. The DSM oriented scales were found to have lower mean rs scores (Achenbach & Rescorla, 2001).

Test-retest attenuation found significant ($p < .05$) decreases on multiple problem scales; four of the significant changes can be explained by chance when using a $p < 0.05$ (Sakoda, Cohen, & Beall, 1954). The decreases on Problem Scores on the TRF did not go beyond the expectations. There were more significant differences in Problem Scores due to chance on the CBCL and the YSR (Achenbach & Rescorla, 2001).

Cross-Informant agreement was tested using the Pearson rs by comparing CBCL's completed by the referred children's mothers and fathers; all the referred children were receiving multiple mental health services at the time of the administration of the assessments. The TRF's completed by teachers of the referred children in special education or receiving mental health services was also used. Finally, the combination of CBCLs, YSRs, and TRFs for children in the researcher's national survey and in mental health settings was also included. With $p < .05$, all cross-informant rs were significant, with the exception of the DSM-oriented Somatic Problems Scale on the TRF, and the correlation of the Somatic Complaints syndrome on between the YSR and the TRF. Overall, the mothers tended to score their children higher than the fathers on the empirically based problem scales, as well as the DSM-oriented scales. Parents also tended to score their children than the child scored themselves using the YSR (Achenbach & Rescorla, 2001).

The stability of scale scores was also assessed; each form of the CBCL was given twice over a specific time period. The CBCL was completed two times, at 12 and 24 months by the mothers of 7-9 year olds who were participants in a longitudinal study which was studying children with low and normal birth weight. The YSR was completed two times in a 7 month period by children aged 11-14 years old from a general population sample. The TRF was administered in two month increments by teachers of children in special education for emotional/behavioral problems. Results found scores were stable on the YSR and the CBCL. Scores on the TRF were also found to be highly correlated at 2 and 4 months. However, more declines in scores were by chance were seen on the TRF, but not on the YSR or the CBCL. The researcher's hypothesized this phenomenon could be the results of special educational services or behavior scores that regressed, and became closer to the mean by the emotionally/behaviorally disturbed boys (Achenbach & Rescorla, 2001).

Validity was tested by comparing the CBCL to other assessments measuring similar instruments. The Conners Scale was correlated with the data collected on the DSM-oriented scale. Pearson correlations were used for the CBCL and the TRF with the corresponding scales on the Conners (1997a as cited by Achenbach & Rescorla, 2001) Parent Rating Scale Revised (CPRS-R), and the Conners (1997b as cited by Achenbach & Rescorla, 2001) Teacher Rating Scale Revised (CTRS-R). Correlations of 0.88 and 0.89 were found when comparing the scores of Attention Problems on the TRF and the DSM-oriented Attention Deficit hyperactive scale; nearly identical results were found on the CTRS-R ADHD index. Very high correlations were also found in all other areas of

the CBCL and the TRF with the Conners Scales. The researchers concluded although the Conners Scale has significantly fewer items scored than the CBCL, most children will produce similar results (Achenbach & Rescorla, 2001).

Validity was also assessed by comparing the CBCL TRF with the Behavior Assessment System for Children (BASC) (Reynolds & Kamphaus, 1992 as cited by Achenbach & Rescorla, 2001). Validity was tested with a sample of children and adolescents who were had been seen for psychological evaluations or therapy at the Bryn Mawr College Child Study Institute. 82 children were assessed by their mothers, 68 by their fathers, and 51 by their teachers. Overall, scores ranged from 0.38 to 0.89 ($p < 0.01$). Correlations on the scales of Somatic Complaints, Attention Problems, and Rule Breaking Behavior Syndromes were all higher than 0.70. Thought Problems and Aggressive Behavior syndrome correlations ranged from 0.60 to 0.85. Correlations on the DSM-oriented scales and the equivalent scale on the BASC were found to 0.52 to 0.85. Results in Internalizing, Externalizing, and Total Problems scales were found to be the highest correlations, ranging from 0.74 to 0.89 (Achenbach & Rescorla, 2001).

Overall, the content validity of the CBCL, YSR, and TRF was found to be highly supported. All items were also found to have significant differences ($p < .01$) among demographically matched referred and non-referred children. The Criterion-related validity of the CBCL, YSR, and TRF was also found to be highly supported. Significant discrimination ($p < .01$) between referred and non-referred children was also found. The researchers concluded the results can provide clinical information for various purposes. Construct validity was also supported in multiple ways, including replications of cross-

cultural syndromes, genetic biochemical results, and the predicting of long term outcomes (Achenbach & Rescorla, 2001).

Social Skills Rating System - Teacher Report Form.

Empathy was measured using the Social Skills Rating System (SSRS) created by Gresham & Elliott (1990). This assessment is a self-report instrument, and can be completed by the student participant, parent, or the child's teacher to look at social skills, problem behaviors, and academic competence. The SSRS was standardized in 1998 on a national sample of 4,170 children in grades 3-10, in both special and regular education. 17% of the total sample was determined to be handicapped (i.e. learning disability, behavior disorder, mild mental retardation) and in special education classes. Children included in special education spent at least 75% of their school day in a special education classroom, and were assessed by their special education teacher. Each special education teacher also determined if their students were capable of completing the self-rating form. The standardization sample also included 1,027 parental assessments and 259 teacher reports of 1,335 students. Some teachers independently assessed children in grades 11 and 12.

The median reliability coefficient of all forms of the SSRS was found to be 0.90 on the Social Skills Scale, 0.84 on the Problem Behaviors Scale, and 0.95 on the Academic Confidence Scale. Overall, the reliability coefficients indicate a high level of scale homogeneity.

Validity was examined by comparing multiple assessments to the SSRS Teacher Form. The first validity test used the Social Behavior Assessment (SBA) (Stephens, 1978 as cited by Gresham & Elliott (1990). with 79 elementary aged students. The SBA Teacher Form includes 136 questions to assess social skill behaviors, grouped into four subscales, environmental behaviors, interpersonal behaviors, self-related behaviors, and task-related behaviors. Correlations were found to be -0.68 for the Social Skills subscale, 0.55 on the Problem Behaviors subscale, and -0.67 on the Academic Competence subscale. These findings demonstrate a moderate to high correlation of the SSRS Teacher Form and the SBA. Validity was also tested with the Child Behavior Checklist Teacher Report Form (CBCL-TRF) (Achenbach & Edelbrock, 1983 as cited by Gresham & Elliott (1990). Validity testing focused on the correlation between the Problem Behavior Scale on the teacher form of the SSRS and the CBCL. High correlation was found in scores of Externalizing Behaviors on the SSRS and CBCL ($r = 0.75$), Total Problem Behavior Scores on the SSRS and CBCL ($r = 0.81$), and Hyperactivity scores on the SSRS and Externalizing Behaviors on the CBCL ($r = 0.77$). Moderate correlation was found on the Internalizing Behaviors of the SSRS and CBCL, at 0.59. Validity was also tested using the SSRS Elementary Teacher Form and the Harter Teacher Rating Scale (TRS) (Harter, 1985 as cited by Gresham & Elliott (1990). The Harter Teacher Rating scale does not assess social skills, but it examines self-perception. 269 cases from the standardized sample of the SSRS teacher form were found to have a moderate to high correlation with the Harter Teacher Rating Scale. The median correlation of the total scores was found to be 0.57. The SSRS Problem Behavior Scale was negatively

correlated with the Harter total score at -0.66 . The SSRS Social Skills Scale and the Academic Competence Scale were correlated with the Harter total score at 0.70 and 0.63 respectively (Gresham & Elliott, 1990).

For this study, the teacher form for children in grades K-6 was used. The teacher form assesses the student's behaviors at schools, where as the parent form assesses the child's behaviors in the home. The SSRS illustrates the perceived frequency and importance of behaviors of children which can impact their performance in school and adaptive functioning at home. The SSRS looks for positive behaviors and social skills of those being assessed, and academic competence and areas which can be a cause for concern about forthcoming problem behaviors. Results of the SSRS can aid in identifying students with problem behavior and problems in academia, help to make a distinction between those who carry a mild handicap (i.e. learning disability, behavior disorder, mild mental retardation) than non-handicapped students. The SSRS also assists in determining proper interventions in school and at home, as well as classifying problem behaviors as performance related or problems with the acquisition of information. The SSRS improves communication to parents and teachers about the student's perceived problem behaviors; it also impacts the writing and implementing of a student's Individualized Educational Plan (IEP) with creating goals and selecting the most beneficial interventions to address social skills. The Social Skills Scale within the SSRS is divided into 5 subscales, including cooperation, assertion, responsibility, empathy, and self control. Responses on the Problem Behaviors scale fall into the externalizing of problems, the internalizing of problems, and hyperactivity (Gresham & Elliott, 1990).

Green Tree Lower School Progress Note.

To collect qualitative data for each participant, the researcher completed the Green Tree Lower School Progress Note (Appendix E). The researcher completed the notes for each child participant by using field notes and input from clinical supervision with her onsite supervisor, Gayle Gates, a professional Dance/Movement Therapist, who was also present in each of the sessions. The progress note form examined the *data*, *assessment*, and *plan* for each participant. The *data* included presenting behaviors, information gained, and interventions used in the session. The *assessment* of the client focused on the effectiveness of treatment and the participant's responses to interventions. The *plan* section included what aspects of therapy for this participant should be continued, or should be altered. At the Green Tree Lower School, individual progress notes are completed by clinical staff, only after individual or group therapy sessions.

Data Collection

Data for this research study were collected utilizing three instruments, the CBCL Teacher Report Form, the Social Skills Rating System Teacher Form, and the Green Tree Lower School Progress Note (Appendix E). The student researcher wrote the progress notes for each participant after each Dance/Movement Therapy (DMT) session. Upon the conclusion of this study, there were a total of four progress notes for each participant. For this study, the SSRS and CBCL were completed at weeks 1, 3, 5, 6, 7, and 8. There was a total of 6 assessment periods.

The teacher of the designated classroom completed the CBCL and the SSRS at approximately 10:00 am on Mondays, for both children 4 of the 6 assessment points. The initial plan was for the classroom teacher to complete both assessments for both children throughout the entire study. Unfortunately, three assessments were completed by the teaching assistant, two for one child, and one assessment for the other child participant. The teaching assistant completed the assessment for both participants at week 6. The teaching assistant also completed assessment for Child 1 in week 8. The teaching assistant spends the same length of time with each child as does the classroom teacher, and has known them for as long as the classroom teacher has. Assessments for the fifth week were taken one week after the date of the final intervention phase session. The student researcher assessed each child using qualitative data through the use of the Green Tree School Progress Note.

Intervention Program

The program that was followed for this research was created by Rena Kornblum (2002), *Disarming the Playground: Violence Prevention through Pro-Social Skills*. The program is body-based and was utilized in public schools and is designed to reduce violence and increase peaceful problem solving among elementary school children. This program focused on the following areas: Spatial awareness, safe distancing between self and others, self-control, stress management, modulation of energy, awareness and responses to dangerous situations, coping skills for aggression, anger management, and building empathy. These activities were selected based on the common and salient

challenges for the boys in the designated classroom. In preparation for the study, the student researcher secured customized tutorial training in the *Disarming the Playground* curriculum from Karen DeHaven, MA, ADTR, LPC, who had studied the curriculum directly with Kornblum. Thus the intervention program was designed to help the children apply what was learned in the Dance/Movement Therapy sessions to everyday life.

The current study utilized the program with a group of 5 children, including 2 research participants, ages 8-12 enrolled in a designated classroom at the Green Tree Lower School. The sessions took place on Mondays at 1:45 pm at the Green Tree Lower School. The children that participated in this study carry at least one of the following diagnoses: Attention Deficit Hyperactive Disorder (ADHD), Oppositional Defiant Disorder (ODD), Anxiety Disorder, or Learning Disorder NOS.

Description of the Intervention

Session #1: Intervention phase week 1 – Tuesday.

	Child 2	Boy X	
Child 1			Boy Y
	P.DMT	S. DMT	

This was the first meeting of the group for the study. The day and time of the group had to be changed for this week only, due to Child 2 being absent on the regularly scheduled day. There were four boys present; one was absent today. Prior to entering the

space, the boys were instructed to go in and sit in a circle on the floor. The group began with going over the rules and expectations of the group members. A verbal check in was initiated by the Student Dance/Movement Therapist; a “feelings ball” was passed to each member to say their names and how they were feeling that day. While sitting on the floor, a body warm up began with the feet and traveled up the body, moving to standing and incorporating the whole body. The first activity was “Approach and Stop”. The boys were divided into two lines facing one another, and listened to the instructions. Child 1 was paired with Child 2, Boy X with Boy Y. Due to Boy Y struggling to engage in a face-to-face peer interaction, he was paired with the Professional Dance/Movement Therapists. Child 2, Boy Y, and Boy X were “the bosses first” and Child 1, the Professional Dance/Movement Therapists, and the Student Dance/Movement Therapist were “the movers”. This activity was first done with “the movers” walking slowly, and was repeated several times. The roles were reversed and the activity was repeated with walking slowly. When the group appeared to have mastered this part of the activity, “the movers” were instructed to run towards their partners; each child had a turn to be “the boss” and “the mover” with the running directives. When the directions were to walk slowly towards their partners, the distance between the two was closer than when the directions were to run. The group was able to verbalize how it felt to them when their partner was walking versus running to their partner. Common themes verbalized when “the mover” ran, were feelings of fear when approaching “the bosses” quickly and the greater distance between the two was more comfortable when running. A prevalent theme when someone was walking slowly towards you was a feeling of safety. The next

activity was “Grounding While Standing in the Stretch Cloth”. The stretch cloth was introduced to the group while sitting on the floor. Ground rules were set for using this prop and the Student Dance/Movement Therapist facilitated various activities to familiarize the children with the prop. After an emerging physical confrontation was stopped by the Professional and Student Dance/Movement Therapist the group returned to sitting on the floor. The stretch cloth was placed behind the backs of all group members and the group leaned back together in synchrony, then one at a time. The stretch cloth provided a physical container for the group. It aided the children in being aware of how it felt to be connected to one another, and provided a visual image of how their movements had an effect on all the others. The group stood with the stretch cloth behind their backs, all leaning back together and working together to maintain balance as a group. Without using hands on the cloth, the group swayed in synchrony side to side, and bent and straightened their knees. The activity ended prematurely as Boy Y was demonstrating unsafe behaviors with the stretch cloth. A verbal processing occurred about the session around working together, following directions, being aware of personal limits to one’s own space. The Student Dance/Movement Therapist verbalized sometimes it is hard to follow directions and pay attention, especially when participating in a new activity with people who may be unfamiliar to you. Boy Y continued to engage in negative attention-seeking behaviors during the group closure. The other boys were able to ignore this boy and to engage in the discussion. Before returning to class, the group stood to take deep breaths and was reminded the group would be at the original time next week. Both therapists walked the boys back to class.

Session #2: Intervention phase week 2 – Monday.

	Child 2	Boy Z	
P.DMT			Boy Y
	Child 1	S. DMT	

Today was the second week of the intervention phase. Boy X was absent today, and Boy Z was present today. He was absent during the last session. Prior to the boys entering the room, they were reminded to go in and have a seat in a circle on the floor. The Student Dance/Movement Therapist reviewed the purpose and time frame of the group. A verbal check in was done with a “feelings ball”; each child said their name, how they were feeling today, and something they like to do when it is sunny outside. The body warm up was led by the Student Dance/Movement Therapist, beginning on the floor, with the feet and sequentially moving up the body. The warm up ended standing up to use the whole body and incorporate the use of breath with the movements. Breathing and balancing was initiated by Boy Y, which the group followed. The concept of “space bubbles” was introduced by the Student Dance/Movement Therapist as a precursor to the activity “Maintaining Space While Traveling”. The Student Dance/Movement Therapist verbally and physically explained and demonstrated small, medium, and large space bubbles. Due to Child 1’s attention-seeking behaviors, Boy Y asked for a time out, rather than choosing to feed into the negative behaviors. The Student Dance/Movement Therapist created a large area with visible physical boundaries

to begin the “Maintaining Space While Traveling” activity. The Student Dance/Movement Therapist instructed the group to move through the space using a large “space bubble”, while remaining within the boundaries set up and without running into someone else’s “space bubble”. Initially, quick rhythmic music was playing in the background, and the group was struggling to remain in control of their bodies to not run into one another and stay within the confines of the space created. This Student Dance/Movement Therapist changed the music to a slower tempo and with less percussive intensity, which aided the boys in moving in a safe, more controlled manor. The Student Dance/Movement Therapist adjusted the space to a medium space, then a small space. The Student Dance/Movement Therapist repeatedly redirected Child 1, as he was struggling to maintain his “space bubble”, and testing limits. He chose to sit in the corner and refuse to participate. The Professional Dance/Movement Therapist connected and moved with Boy Y to encourage his active participation; the Student Dance/Movement Therapist attempted to connect and move with the others which facilitated them moving through the space more freely, in different spatial pathway and less bound Flow. The next activity introduced by the Student Dance/Movement Therapist was “We All Stop Together”. The directions were for the group to walk slowly through the space, while constantly watching others to see when someone stops. When they saw someone freeze, they must also; there was no designated order of who was to stop when. When the group was frozen, they were asked who stopped the movements. Initially, the Student and Professional Dance/Movement Therapist were the only people who could stop the movements. Child 1 continued his regressed behaviors by hanging on

to the Dance/Movement Therapists, using passive weight. The Student Dance/Movement Therapist chose 2 group members as the stoppers”; Child 1 responded to his peers stopping the group, rather than the Professional or Student Dance/Movement Therapist. When the group appeared to have mastered two people at a time, all 4 boys were stoppers; therefore they all were required to be more aware of others. A verbal processing was done at the end of the session, and the group was able to verbalize which “space bubble” was easier or harder, why it was harder, and what they needed to do to not run into each other. The Dance/Movement Therapists also shared their observation of the group able to take turns without discussion of an order of when someone going to stop, and how they became very good at watching other’s cues to stop during “We All Stop Together”. Two deep breaths were done together while standing in a circle to re-focus and organized the group. The group smoothly transitioned back to class.

Session #3: Intervention phase week 3 – Monday.

	P. DMT	Child 2	
Boy Z			Boy Y
	Child 1	S. DMT	

Prior to entering the therapy space, the group was instructed to go in and sit in a circle on the floor. A verbal check in was done using a “feelings ball” and each child saying their name, how they were feeling today, and their favorite sport. The warm up,

lead by the Student Dance/Movement Therapist, began sitting on the floor, with the feet stretched into the center of the circle. The warm up included activities focusing on following directions, and impulse control. While still sitting, the group reached for and pressed against one another's hands. Because the circle was large and spread out, each boy stretched as far as they could, while maintaining control and balance in the body. To physically connect the entire group, the circle became smaller, and everyone pressed against one another's flat palms equally. All the group members needed to modulate how much or how little to press against one another as to not overpower someone else, or be pushed off balance. The warm up moved to standing and a novel "high 5" was introduced by Boy Y, and picked up on by the rest of the group. This high 5 made connections to people on either sides, and became more interactional and people connected with people all around the circle. Boy Z was willing to participate in the novel high 5 when initiated by the professional and Student Dance/Movement Therapist on a one-on-one interaction. Within the transition into the first activity, Child 1 disengaged from the group, and began to engage in disruptive behaviors. Although the other group members were able to ignore him, he continued to engage in the negative attention seeking behaviors. The Student Dance/Movement Therapist introduced the "4 B's" to the group. As the Student Dance/Movement Therapist explained the B's and demonstrated the movements, Child C, who was still lying on his side against the wall, began to engage in the movements as well. The Student Dance/Movement Therapist continued to explain the "4 B's"; when discussing the "brains", the power of self talk was brought up. When doing the movement for "brains", one should also tell themselves "I

can calm down” and this will help them calm down from a heightened state of arousal. If a person tells themselves something enough times, they will begin to believe it. To demonstrate the power of self talk, each child was asked to stand up and place one arm out to the side. The Student Dance/Movement Therapist used two fingers to press down on their wrist, while the Student Dance/Movement Therapist resisted her and said “I’m weak” and “I’m strong”. Each of the boys took a turn; when they repeated “I’m weak”, they were unable to resist the pressure being applied to their wrist. However, when they repeated “I’m strong”, all were able to resist the pressure and maintain their arm out to the side. The next activity was “Put on the Brakes”. Each Student Dance/Movement Therapist was to sprint to a line laid on the floor, and they must stop before touching or crossing the line. The Student Dance/Movement Therapist asked the boys what it felt like and how were they able to stop so quickly to encourage self-awareness and acknowledge each of them had the power to control themselves while moving quickly. The final activity was “Who’s the Mirror?” The group was divided into pairs facing one another; Child 2 with Boy Z, Child 1 with the Student Dance/Movement Therapist, and Boy Y with the Professional Dance/Movement Therapist. One person in the dyad was “the mover” and the other was “the mirror”. “The Mover” was instructed to move slowly and with simple movements, while “the mirror” was watching and imitating the movement they were seeing by their partner. Child 2 was initially asked to be “the mirror”, however his partner became anxious and told Child 2 he needed to be “the mover” first; Child 2 was agreeable to that. Boy Y and the Professional Dance/Movement Therapist shared a positive interaction. As Child 1 moved into a closet

and shut the door for a longer period of time, the Student Dance/Movement Therapist observed Child 2 and Boy Z. Child 1 peered out of the closet sporadically, and yelled that no one wanted him in the group and the Student Dance/Movement Therapist wasn't paying attention to him. After Child 2 and Boy Z each had a turn in both roles, the Student Dance/Movement Therapist was "the mover" and they were both "the mirrors". Both boys were attentive and focused on her movements, and they both displayed a bright affect throughout the interaction. After much encouragement from the Student Dance/Movement Therapist and his peers, Child 1 came out of the closet, and was "the mirror" while the Student Dance/Movement Therapist was "the mover". He refused to switch roles. To end the group, the Student Dance/Movement Therapist reviewed the "4 B's" gave each boy a hand out for the group to remember and practice them. Before leaving, two deep breaths were taken as a group. The boys transitioned back to class with no problems; 2 stopped to get a drink of water.

Session #4: Intervention phase week 4 – Monday.

	P. DMT	Child 2	
Child 1			Boy Y
	S. DMT		

The boys were in their language arts class when the Student Dance/Movement Therapist arrived. The group began by the Student Dance/Movement Therapist

acknowledging it was the final group, and as per the group's request for the past three sessions, she may allow them to use the parachute pending their following directions throughout the group. A "feelings ball" was passed to each person for a verbal check in; each person said their name, how they were feeling today, and one thing they liked the most about the groups. Due to rising tension between Child 1 and Boy Y, the Professional Dance/Movement Therapist and Child 1 traded places in the circle. The warm up, led by the Student Dance/Movement Therapist, began with the feet outstretched into the center of the circle. The warm up traveled up through the body, and allowed for each child to show the group 1 "trick" they were good at (i.e. headstands or summersaults). The warm up moved to standing in a circle and reaching for the people on either side of them. If the person did not want to connect, others had to respect their wishes. Pressing against each other's palms was initiated by another group member, which was joined in by the rest of the group. As a result of aggressive pressing between Children 1 and 2, the group was told to sit on the floor and "restart". Once calm, the group stood up and held hands, moving in and out of the circle together in synchrony; moving in synchrony also helps to promote group cohesion. Due to Child 1's oppositional behaviors, his movements of weaving in and outside of the circle were incorporated into the group activity, allowing each child to have a turn. The Student Dance/Movement Therapist asked the boys to sit down and review the 4 B's introduced in last week's session. The next activity was "Giving Our Weight to the Stretch Cloth". Ground rules were set for using this prop and the Student Dance/Movement Therapist facilitated various activities re-familiarize the children with the prop. As the intensity of

the group was high, the group began using the stretch cloth sitting on the floor. The group was “showing their muscles” as they pulled on the stretch cloth and leaned back in synchrony. Multiple images began to emerge while sitting and giving our weight to the stretch cloth. Each boy lay down in the cloth and covered themselves up. While sitting in and being supportive of one another in the stretch cloth, the activity “Guessing Games” was introduced. Each child had the opportunity to make a facial expression to display an emotion, and the group was to guess what it was. The boys earned the opportunity to use the parachute. Multiple structured therapeutic activities were done with the parachute and a small ball to focus on group movement synchrony, cooperation, turn taking, following directions, and impulse control. Possibly due to the stopping of the parachute activity, as well as this session being the final group and the boys’ not wanting to it to be over, Child 1 and Boy Y began to wrestle over the ball. Due to the anxiety level in the room rising, Child 2 ran to hide in the closet. To calm the entire group, the boys were separated and the 4 B’s boys were practiced to calm down. Child 1 was told to leave the room as he was unable to control his behaviors and was being unsafe towards the others. The group ended with two deep breaths and verbalization about things the boys had learned in the groups, and some things that were more difficult and should continue to be worked on. The remaining boys returned to class with no problems.

Data Analysis

Data were analyzed in the following ways:

1. Green Tree Lower School Progress notes, which included narrative data, were analyzed using qualitative data analysis techniques, including pattern coding. A priori themes of the participant's progress notes stemmed from purposes of each activity used in the current study from the *Disarming the Playground* curriculum. Other emerging themes were from the coding of the data from the progress notes written by the student researcher. The student researcher was also the student therapist in the current study, allowing for dual perspectives. Emerging themes of the Green Tree Lower School Progress Notes were determined from the student researcher's knowledge of dance/movement therapy theory and practice. The coded data were clustered into related groups, and then the clusters of themes were named based on their commonalities.
2. CBCL teacher report forms were hand scored by the researcher using the Teacher Report Form Hand Scoring Profiles
3. SSRS teacher forms were scored by the researcher. The scores were interpreted by trained professionals by following the instructions found in the SSRS manual. The interpretation aided in assessing and planning interventions for children who were found to have deficits in social skills.

Operational Definitions of Terms, Concepts, Variables

For purposes of this study, Dance/Movement Therapy was defined as the “psychotherapeutic use of movement as a process that furthers the individual's emotional,

cognitive, social, and physical integration” (American Dance Therapy Association, 2008). The dependent variable of aggression was defined as an offensive unprovoked physical attack against one’s self, other people, or property (Webster’s Dictionary Electronic Version, 2008a). Empathy was defined as having the ability to recognize or experience another person’s state of mind or emotion within oneself (Webster’s Dictionary Electronic Version, 2008b). Pro-social skills were defined as: classroom skills, peer interaction skills, conflict resolution/problem solving, and anger management (Kornblum, 2002).

Possible Risks and Discomforts to Subjects

The potential for physical harm to the participants in this study were minimal; participants were asked to participate in mild to moderate exercise. There was a slim risk of minor injuries or bruises, as with any everyday physical activity.

Special Precautions to Minimize Risks or Hazards

One safety procedure to minimize potential risks, the researcher would have referred the participants to their primary therapist, if necessary, to discuss any issue that arose during the study. The researcher also reassured the participants they were free to leave the study at any time without fear of facing repercussions. The children also had access to the school nurse throughout the study.

Chapter IV: Results

In this chapter, the hypothesis for the current study will be restated. Each child participant will be explained in further detail, including family history, and details about their medications, as well as notations of any changes in their the medication(s). A written description of each child's results on the Child Behavior Checklist & Social Skills Rating System will be followed by graphs illustrating their scores throughout the course of the study, including raw data and linear trend lines. The Green Tree Lower School Progress notes will be discussed, followed by any instances of the participants needing to be removed from their classrooms and taken to the Learning Resource Center (LRC).

Hypothesis

The hypothesis for this study was: The Dance/Movement Therapy program “Disarming the Playground, Violence Prevention through Movement and ProSocial Skills” will reduce aggression and increase empathy in children ages 8-12 years among children enrolled at an approved private school for children with emotional and behavioral problems.

Major Findings

Major quantitative findings showed a decrease in Total Problem Behaviors for both children on the Child Behavior Checklist and the Social Skills Rating System. Total Social Skills scores on the SSRS decreased in both children. Common clusters of themes

found through the analysis of the qualitative data included engaging in positive, trusting relationships, self-awareness, and group cohesion.

Participants

Child 1.

Child 1 was an 8 year old African American Male with diagnoses of Attention Deficit Hyperactive Disorder (ADHD) Combined type and Learning Disorder NOS (not otherwise specified). At the time of the study, Child 1 lived at home with his biological mother and step father. He is an only child; however his father has had other children which Child 1 has no contact with. Child 1's maternal grandmother, uncle, and 16 year old male cousin live in the home as well. A 3 year old female cousin stays in the home on weekends. The family psychological history includes Child 1's father is diagnosed with Bipolar Disorder, and a half sibling is also diagnosis with Attention Deficit Hyperactive Disorder. Child 1 came to Green Tree School presenting with behavioral and learning problems. He has a history of making noises and moving around the classroom, distracting the other students. His history also included refusal to do or complete school work. He displays problems with reading and oral language. He has displayed signs of depression and a negative self regard, claiming he hates himself; he has been positive for suicidal ideations. At the time of the study, Child 1 was taking Ritalin 5mg two times a day, the first dosage was taken at home before coming to school and the second dosage at lunchtime. During week six, the week of the final intervention phase, there was a change in Child 1's medications. He continued to take Ritalin 5mg in

the morning, and if needed, the second dosage at lunchtime. He also began to take Concerta 18mg with the Ritalin in the morning before going to school.

Child 2.

Child 2 was a 9 year old African American Male with diagnoses of Attention Deficit Hyperactive Disorder (ADHD) and Oppositional Defiant Disorder (ODD). At the time of the study, Child 2 lived with his biological mother and step father. His biological father lived out of state and has no custody rights. There were other children in the home, including two teenage brothers, a younger brother, and Child 2's twin brother. His maternal great aunt and uncle also live in the home. When Child 2 came in Green Tree School, he presented with difficulty following directions, listening, obeying rules, verbal and physical aggression. Child 2 has a history of becoming easily frustrated, with little to no patience. He also displayed perfectionist qualities and symptoms of anxiety, resulting in him "shutting down" when frustrated, and having a negative self concept and extremely low self esteem. His mother reported having a "high risk" pregnancy due to her carrying twins; Child 2 was born at nearly 40 weeks by a vaginal birth. There were no delivery complications reported. The family psychological history includes Child 2's mother having a history of anxiety, depression, and a recent diagnosis of Bipolar Disorder. His maternal grandmother carries a diagnosis of depression, and an older brother with Attention Deficit Hyperactive Disorder. At the time of the study, Child 2 was taking 1 tab of Adderall 20mg in the morning either at home or when he came to school. Child 2 also was given ½ tab of Adderall 10mg one hour before lunchtime if he

took the morning dosage at home; if the morning dosage was taken at school, he was given the afternoon dose at lunchtime.

Child 1 Findings

Child Behavior Checklist – Teacher Report Form.

Figure 1 illustrates Child 1's scores on individual syndrome scales. Child 1's scores on all the Syndrome Scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems (Inattention), Attention Problems (Hyperactivity/Impulsivity), Attention Problems (I + H/I), Rule Breaking Behavior, and Aggressive Behavior fell within the normal range for most of the study. The acceptance was found in the first assessment point, week 1, the start of the initial two week pre-intervention baseline. Child 1's scores on Attention Problems (Inattention), Attention Problems (Hyperactivity / Impulsivity), Attention Problems (I + H/I) fell in the Borderline range. It is suggested the Dance/Movement Therapy (DMT) groups using activities from the *Disarming the Playground* curriculum was effective for Child 1 in decreasing the number of total problem behaviors, specifically with externalizing problem behaviors. These results were found on the Child Behavior Checklist (CBCL) Syndrome Scale scores. Child 1 also displayed a decrease in internalizing problem behaviors; the number of initial internalizing problem behaviors was less than externalizing. There was a slight decrease in internalizing, followed by a leveling off as the study progressed. The total number of problem behaviors was at the

lowest point during the intervention phase of the study, suggesting Child 1 benefited from the interventions.

Figure 2 illustrates Syndrome Scale Totals for Child 1. Child 1 was found to have an overall decrease in Total Syndrome Scale, External, and Internal Total scores. There was a greater decrease seen on Total Syndrome Scale and External Scores. Internal scores were found to have a slight initial decrease from week 1, and then leveled off as the study continued. The T scores for Internal Totals, External Totals, and Total Syndrome Scales fell within 1.5 standard deviations above or below the mean of 50 throughout the study.

Figure 3 illustrates Child 1's Adaptive Functioning scores. Learning and Happy scores were found to have a slight, gradual decrease from the initial assessment point in week 1, through the completion of the study. Scores on Working Hard and Behaving Appropriately slightly increased during the study. Overall, Child 1's Adaptive Functioning Scores demonstrated an increase throughout the course of the study. All of Child 1's scores fell within the normal range during the intervention phase. However, the week 1 assessment revealed scores in the Borderline and Clinical range for the areas of Working Hard and Behaving Properly, respectively. Scores on Learning at weeks 6 and 7 were at the cutoff point between the Normal and Borderline range. All four areas of Adaptive Functioning scales on the Child Behavior Checklist increased during the study. The two of the four areas which increased were those most relevant to the nature of the study. Working Hard and Behaving Appropriately both increased, with Behaving

Appropriately beginning at the lowest point of all four areas, and showing the greatest improvement.

Figure 1: CBCL Assessment TRF – Syndrome Scales - Child 1

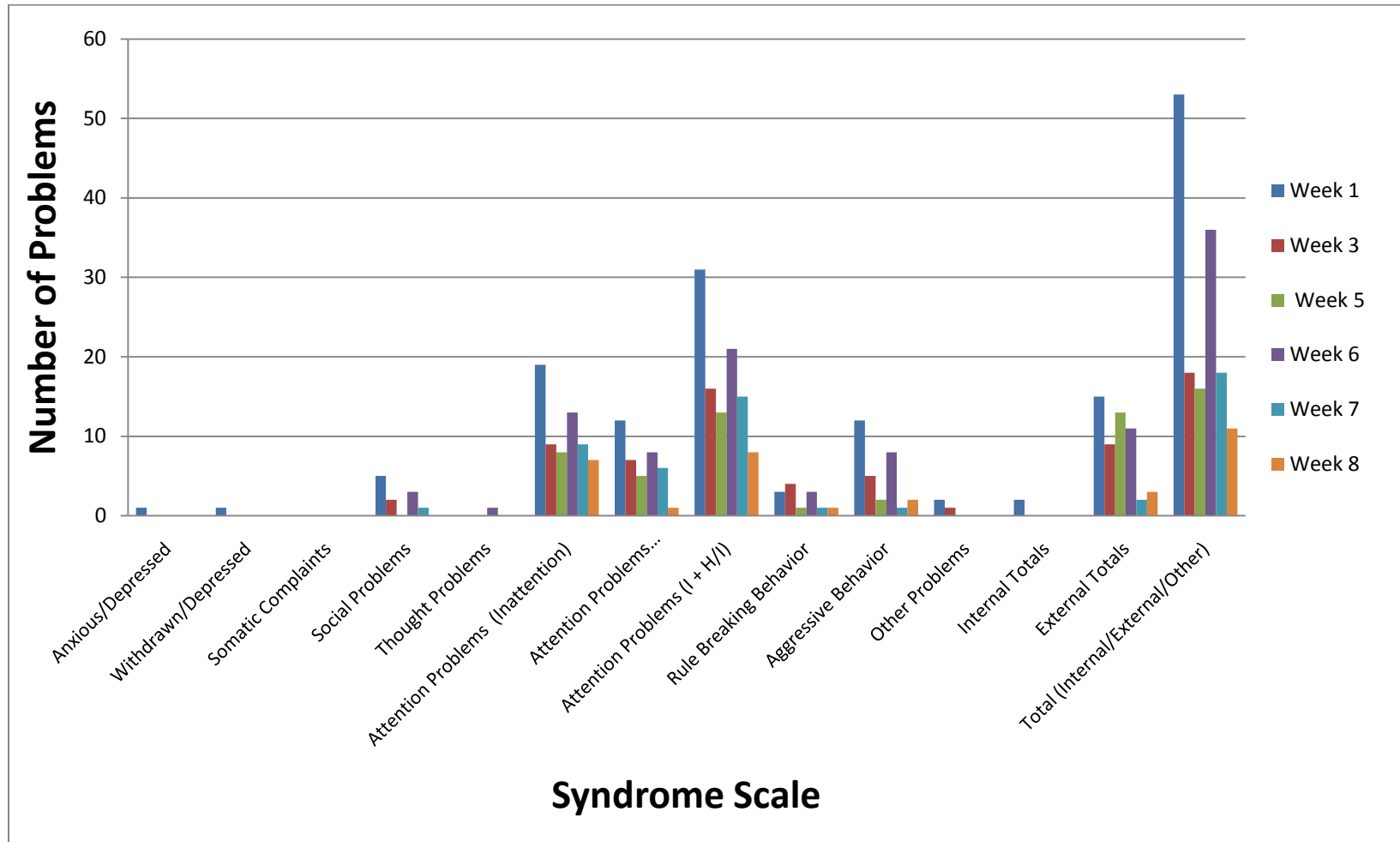


Figure 2: CBCL Assessment TRF - Syndrome Scale Totals - Child 1

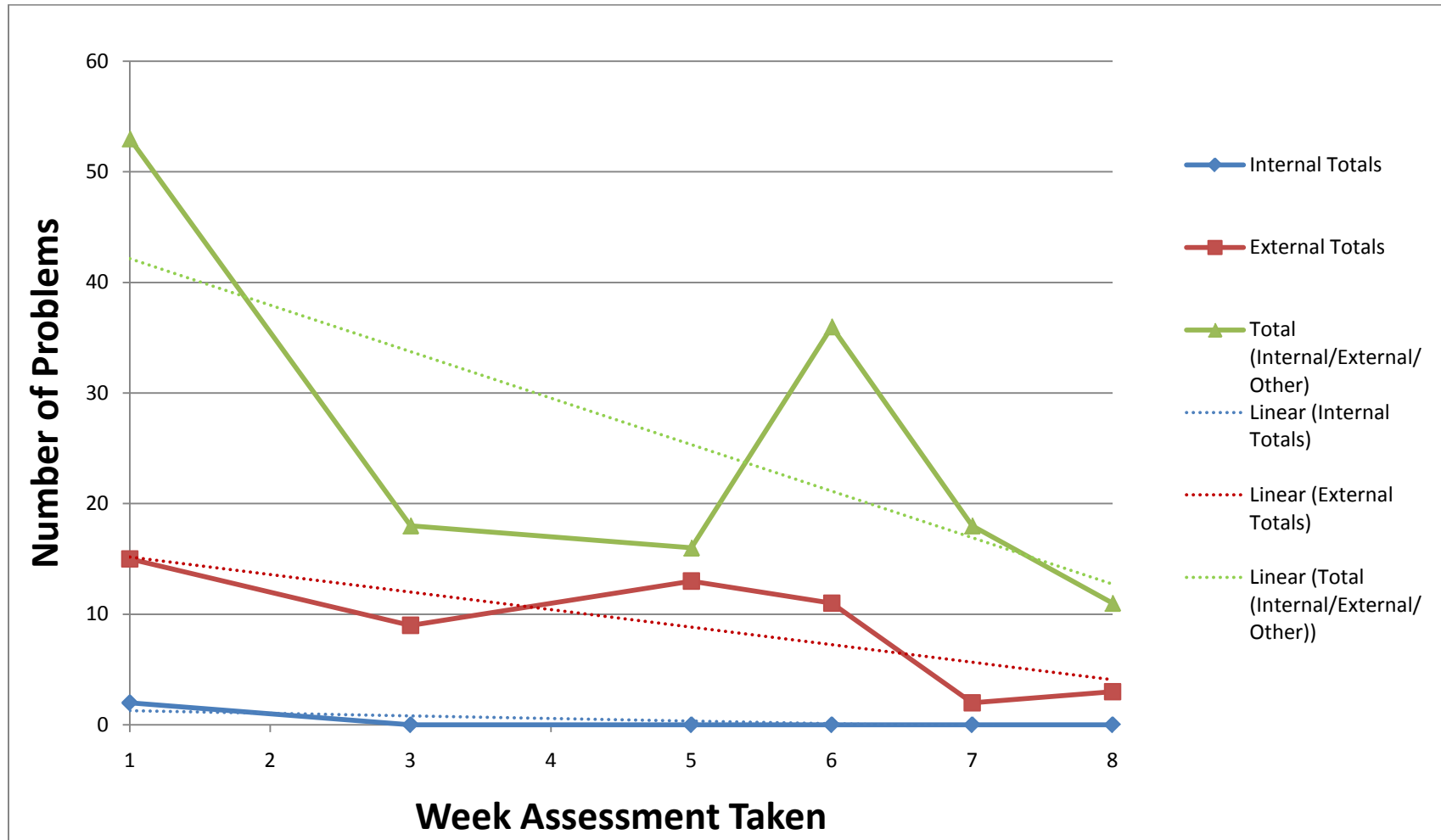
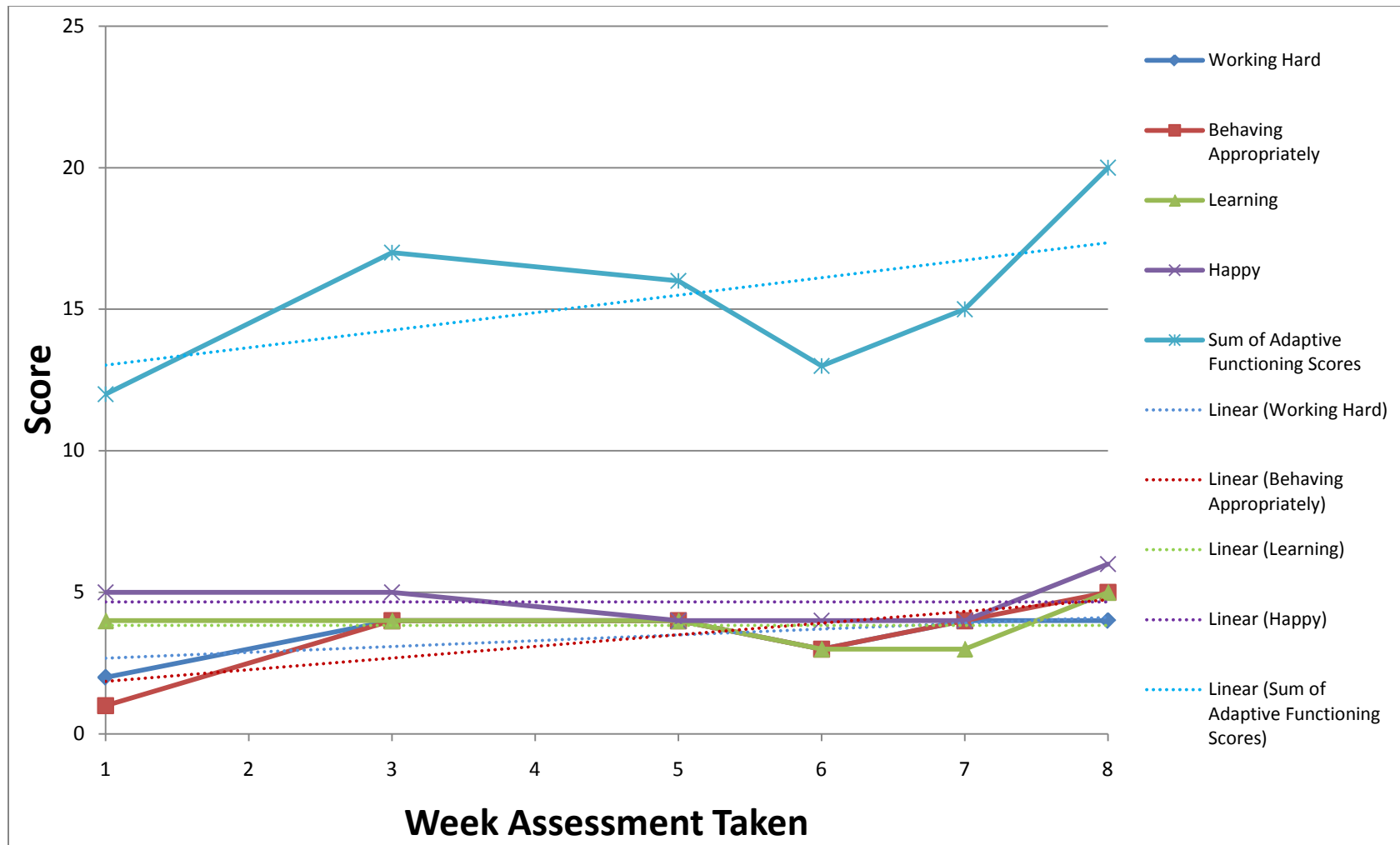


Figure 3: CBCL Assessment TRF - Adaptive Functioning - Child 1



Social Skills Rating System – Teacher Report Form.

All scores on the Social Skills Rating System were analyzed using a 95% confidence interval. Child 1's total scores in the scales of Problem Behaviors, and Academic Competence remained at the average behavioral level. Social Skills total scores were found to be below the average behavioral level at week 6. This drop in scores may be due to the assessor being the teaching assistant, rather than the classroom teacher, who had completed all the other assessments.

Figure 4 illustrates Child 1's scores on the Social Skills Scale. Trends for the subscale scores on Cooperation remained fairly consistent throughout the study. Child 1 demonstrates a slight increase in scores of Self Control, and slight decrease in Assertion. Overall scores for Social Skills slightly decreased during the study. In the middle of the intervention phase of the study, at week 5, Child 1's scores on self control were much higher than in weeks 1 and 3, as well as the assessment point in week 6, after the completion of the four week Dance/Movement Therapy Groups. His score of self control at the assessment point in week 5 is consistent with the common themes observed by the student researcher in the progress note for that week.

Problem Behaviors scales can be found in Figure 5. Child 1 demonstrated a decrease in Internalizing and Externalizing Behaviors from the initial assessment point in week 1, throughout the study. His scores on Hyperactivity slightly decreased during the study. Child 1's decreasing score on Hyperactivity began to increase again at the sixth week; this was the same time he began taking Concerta and he was no longer taking the afternoon 5 mg dosage of Ritalin on a regular basis.

The trend of Child 1's Academic Competence scores (Figure 6) remained constant during the study. No part of the intervention focused on improving these scores, so it is not surprising these scores did not show notable change.

Figure 4: SSRS - Assessment Social Skills – Child 1

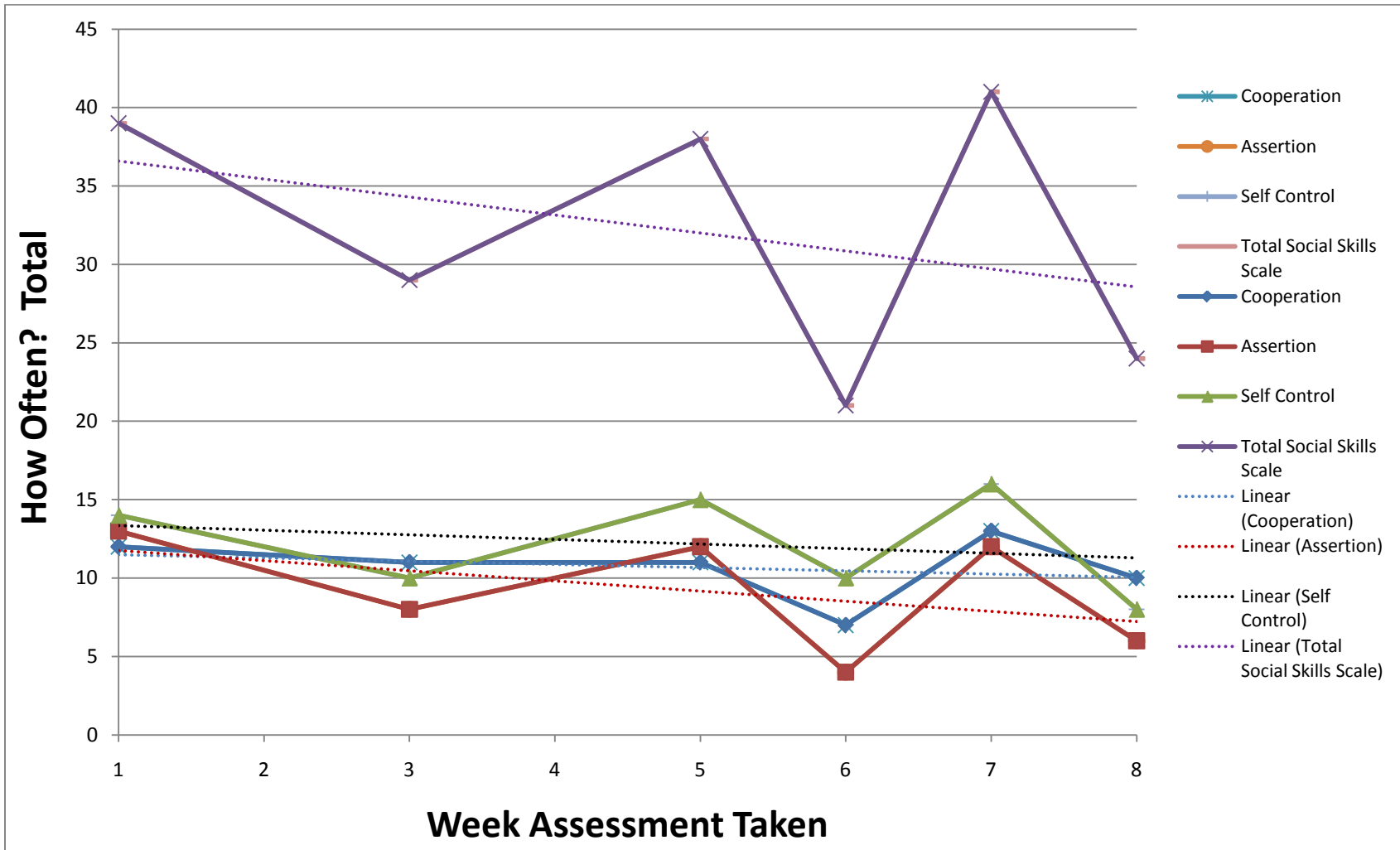


Figure 5: SSRS Assessment - Problem Behaviors - Child 1

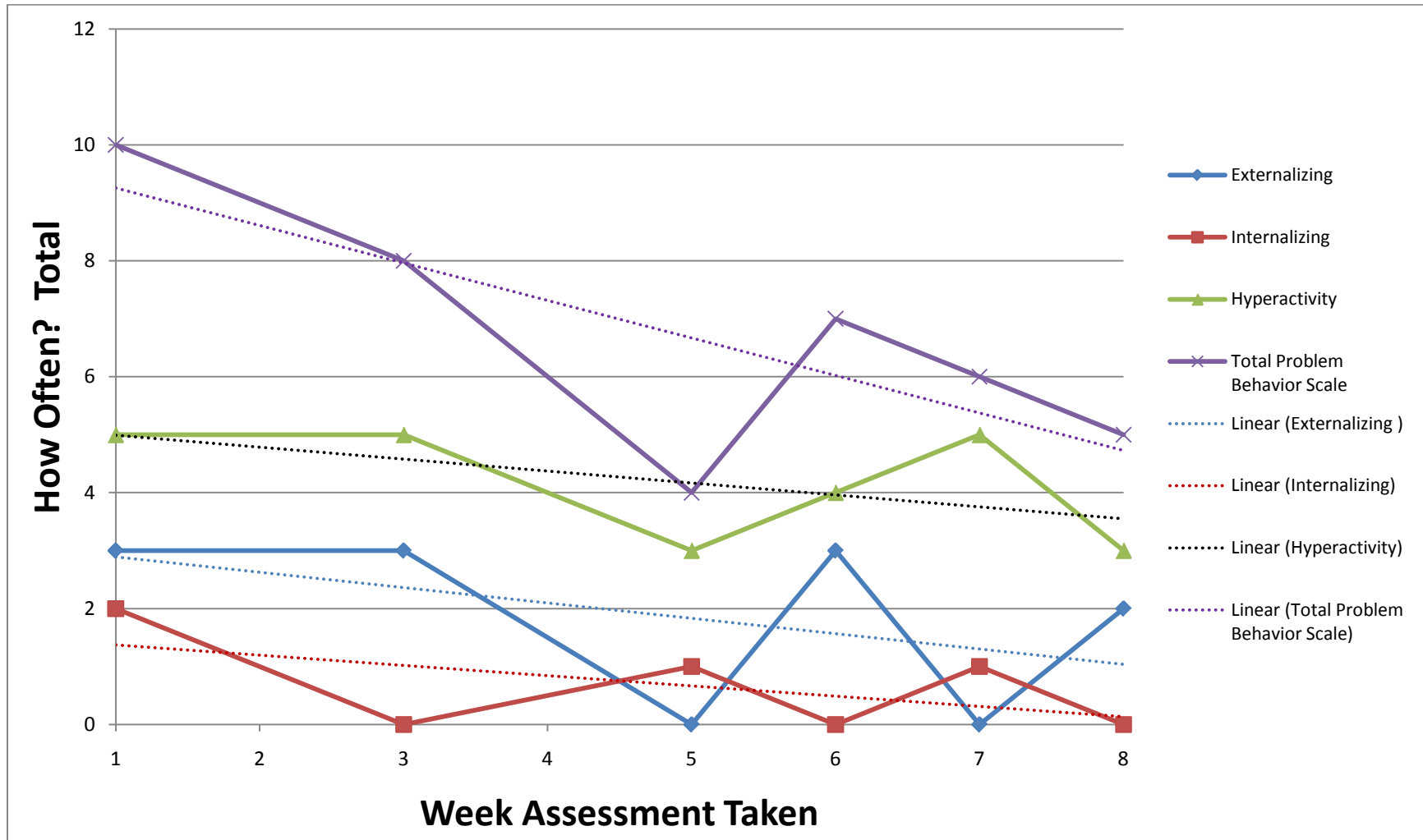
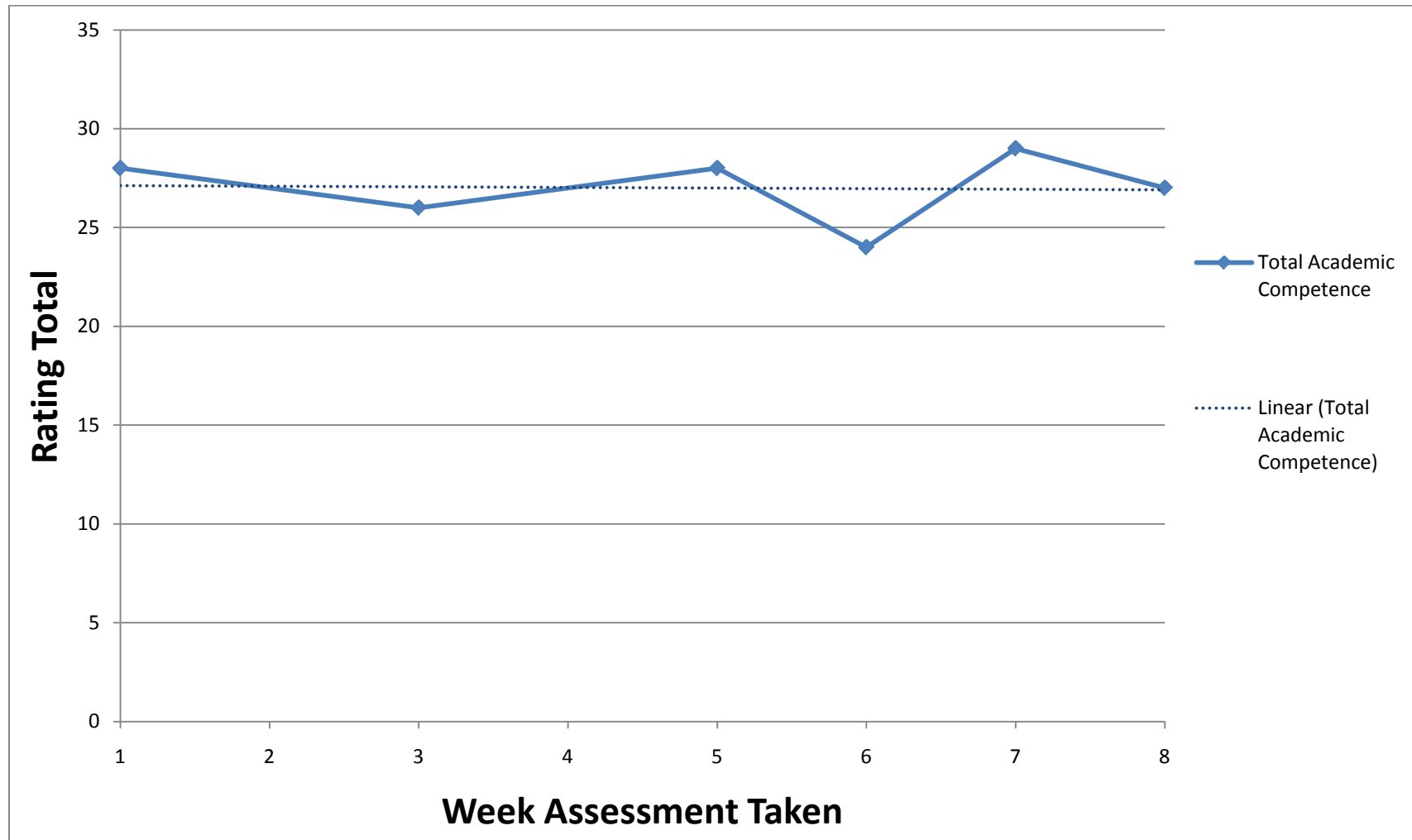


Figure 6: SSRS Assessment - Total Academic Competence - Child 1



Green Tree Lower School Progress Notes.

Pattern Coding was used to analyze Child 1's progress notes and discern common themes for each session. Common themes seen in Child 1's experience of the first intervention group (Appendix J) were, following directions/compliance, his ability to work within a group/cooperation, creating positive relationships with others, and relationship with/awareness of self. In week 2 (Appendix L), Child 1 focused on relating to others, self-awareness while moving in a space, seeking nurturance and acceptance from therapists and other group members, the connection/integration of body parts and movements, and sustainment of attention and focus. The two major themes seen in week 3 of the intervention phase (Appendix N) were seeking relationships with others and self control. In the final group session, themes seen in Child 1's experience were cooperation/ability to be part of a group, body organization and integration, and reflection and expression of the self (Appendix P). Although progress note data suggest Child 1 struggled to maintain his attention and positive behavior and interactions throughout each intervention group, he was still able to benefit from the activities occurring, whether he directly participated or not. Common themes observed in Child 1 throughout the intervention phase of the study were self-control, cooperation/group cohesion, and seeking nurturance and relationships with others. The theme of self-control was observed in the quantitative data collected on the SSRS; his self-control score was elevated at the assessment point in week 5.

Child 1 also placed a lot of transference onto the professional and student Dance/Movement Therapist with regard to acceptance. Throughout the intervention

phase of the study, Child 1 engaged in regressed behaviors (i.e. using passive weight hanging off the therapist's arms, when asked to stand up, he fell to the ground) and made comments such as "Why did you let me get hurt?" Child 1 may have put the therapists in the maternal role, and what he may actually have been saying is "Why don't you care if I get hurt?" When the topic of the power of "self talk" was brought up, Child 1 said he did not believe the power of self talk, even after he observed the other boys engage in the activity to demonstrate the power. When he was asked if he believed he could change how he feels based on what he continually tells himself, he said no. Although Child 1 agreed to engage in the activity as well, he commented that he is "stupid, 'cause my mom tells me I'm stupid, so I must be stupid". Child 1's lack of self-esteem possibly due to believing and repeating negative self talk was seen when using a stretch cloth as a group. All the participants were "showing off their muscles", and the therapists were commenting on how strong everyone was, Child 1 said "4 of us are strong", when he was the fifth person in the group. The therapists encouraged him and affirmed he was strong, but he continued to deny it. Child 1 tends to seek approval and acceptance from anyone who will give it to him; however, when only the therapists displayed their acceptance of him, that was not good enough. He repeatedly sought acceptance from all child group members individually.

As indicated by the Child Behavior Checklist (CBCL) and Social Skills Rating System (SSRS), scores on scales of problem behaviors decreased during the study. The trend seen in his problem behavior scores on both assessments remained unchanged throughout the study. Child 1 displayed a decrease in overall expression of problem

behaviors, more specifically, the externalizing of problems on both quantitative assessments.

According to the Green Tree Lower School behavioral specialists, Child 1 had one incident of being taken to the Learning Resource Center (LRC) for 20 minutes due to non-compliance with a teacher during the initial 2 week base line of the study.

Child 2 Findings

Child Behavior Checklist – Teacher Report Form.

Figure 7 illustrates Child 2's scores on the individual Syndrome Scales. His scores on all the Syndrome Scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems (Inattention), Attention Problems (Hyperactivity/Impulsivity), Attention Problems (I + H/I), Rule Breaking Behavior, and Aggressive Behavior fell within the normal range for much of the study. During the intervention phase of the study, Child 2 scored a 0 on Aggressive Behaviors. His scores on Withdrawn/Depressed display a slight increase from the initial assessment in week 1, to the next assessment point in week 3, just prior to the intervention phase. For the remainder of the study, his scores on Withdrawn/Depressed decreased. The T scores for Internal and External Totals, as well as Total Syndrome Scale scores fell within 1.5 standard deviations above or below the mean T score of 50. Trends seen in Figure 8, Syndrome Scale Totals, illustrate a great decrease in Internal and Overall Total scores. External Total Scores displayed a gradual increase during the study. It is suggested the Dance/Movement Therapy (DMT) groups using activities from

the *Disarming the Playground* curriculum was effective for Child 2 in decreasing the number of total problem behaviors, specifically with internalizing problem behaviors, as assessed on the Child Behavior Checklist (CBCL). Although his scores of internalizing behaviors decreased greatly during the study, his externalizing behaviors increased slightly. On the individual Syndrome Scales, Child 2 displayed very few attention or hyperactivity problems, although he carries a diagnosis and takes medications for attention deficit hyperactive disorder (ADHD). These Syndrome Scales fall under the externalizing problem behaviors, of which he had very few. He did, however, show more problem behaviors during the course of the study associated with anxiety, withdrawal, and depression; these behaviors fall under the internalizing problem behavior scale.

Child 2's score on the Adaptive Functioning Scales (Figure 9) including areas of Working Hard, Behaving Appropriately, Learning, and Happy, all fell within the normal range for the duration of the study. The trend found in Child 2's overall Adaptive Functioning level decreased during the study. His score on "Happy" was at its highest points at week 3, the start and end of the intervention phase; however it consistently remained the lowest of the adaptive functioning areas.

Figure 7: CBCL Assessment TRF - Syndrome Scales - Child 2

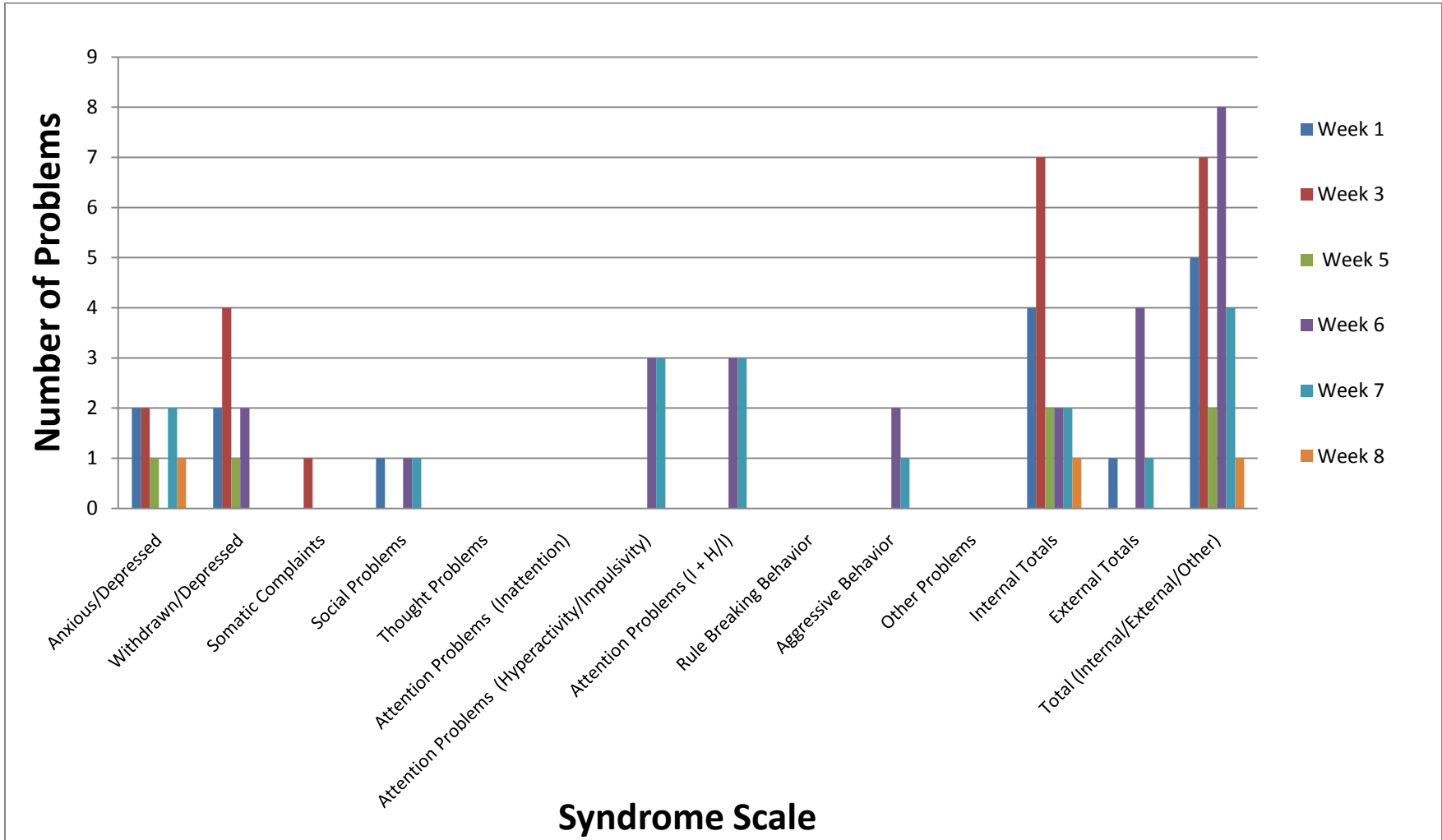


Figure 8: CBCL Assessment TRF - Syndrome Scale Totals – Child 2

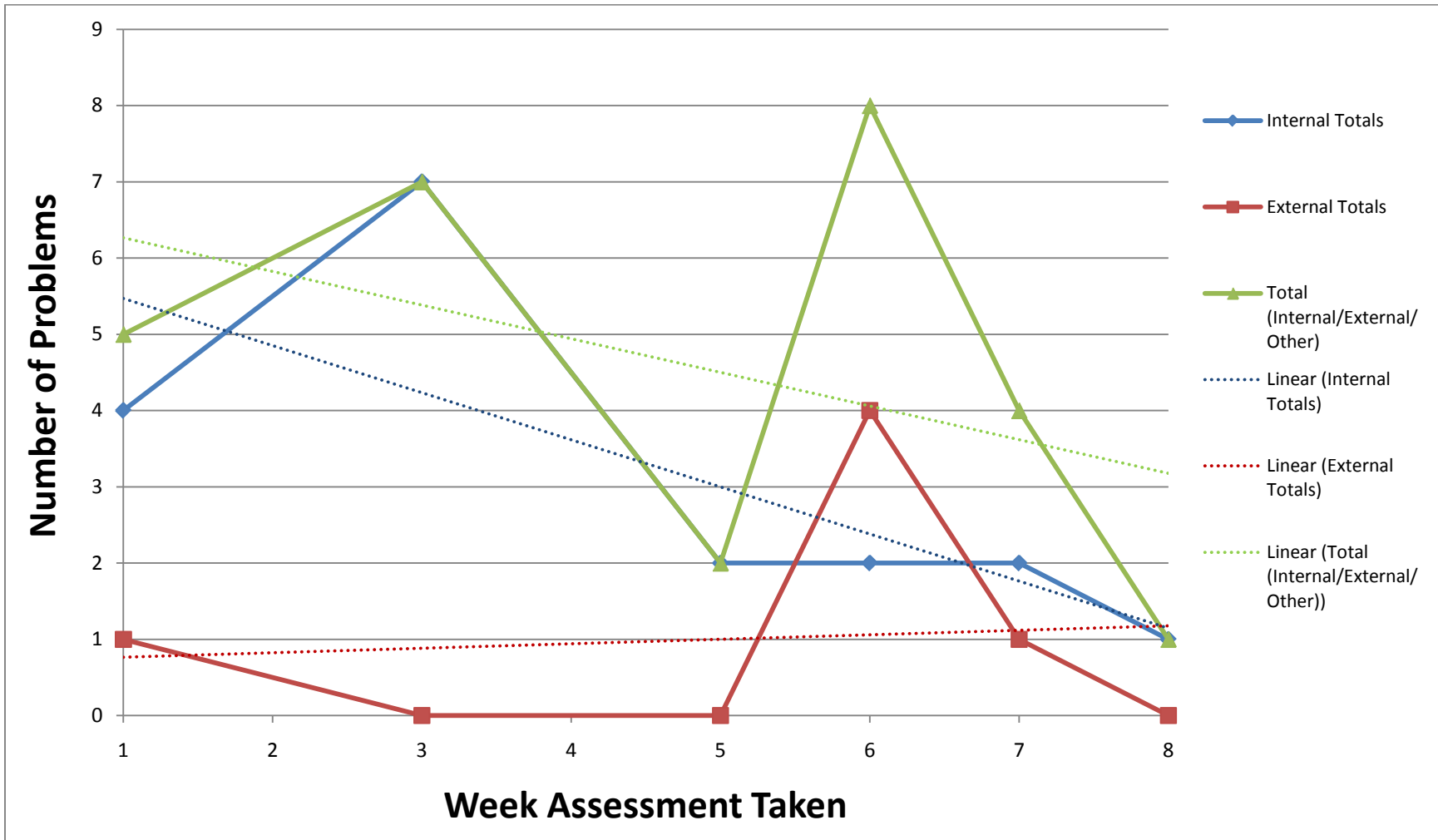


Figure 9: CBCL Assessment TRF - Adaptive Functioning - Child 2



Social Skills Rating System – Teacher Report Form.

All scores on the Social Skills Rating System were analyzed using a 95% confidence interval. Child 2 scored at the average behavioral level for the scales of Problem Behaviors, and Academic Competence. At the assessment points in weeks 1 and 3, Child 2 scored in the above average behavioral level on the subscale of Cooperation on the Social Skills scale. Child 2 scored below average on Assertion subscale of the Social Skills scale at the final assessment point, in week 8.

Figure 10 illustrates Child 2's scores on the Social Skills scale. The trends show Child 2's scores slightly decreased during the study. The Total Social Skills score increased the most at the assessment point after the completion of the intervention, in week 6. This increase in scores may be due to the assessor being the teaching assistant, rather than the classroom teacher, who had completed all the other assessments.

Scores on Problem Behaviors for Child 2 all fell within the average behavioral level throughout the study. Figure 11 demonstrates the numerical scores for each intervention point, as well as the overall trends. Child 2 was found to have a decrease in Problem Behaviors overall. Child 2's internalizing behaviors decreased, while his Externalizing behaviors and level of Hyperactivity increased during the study. All Child 2's Problem Behavior scores were at the lowest point at the assessment taken at the midpoint of the intervention phase, in week 5.

Academic Competence Scores (Figure 12) were found to slightly decrease during the course of the study. When Child 2 was compared to other children in his classroom, he consistently fell in the middle to upper 20% of his class on his academic performance

in specific subjects, classroom behavior, intellectual functioning, parental encouragement to succeed, and self motivation to succeed

Figure 10: SSRS Assessment - Social Skills – Child 2

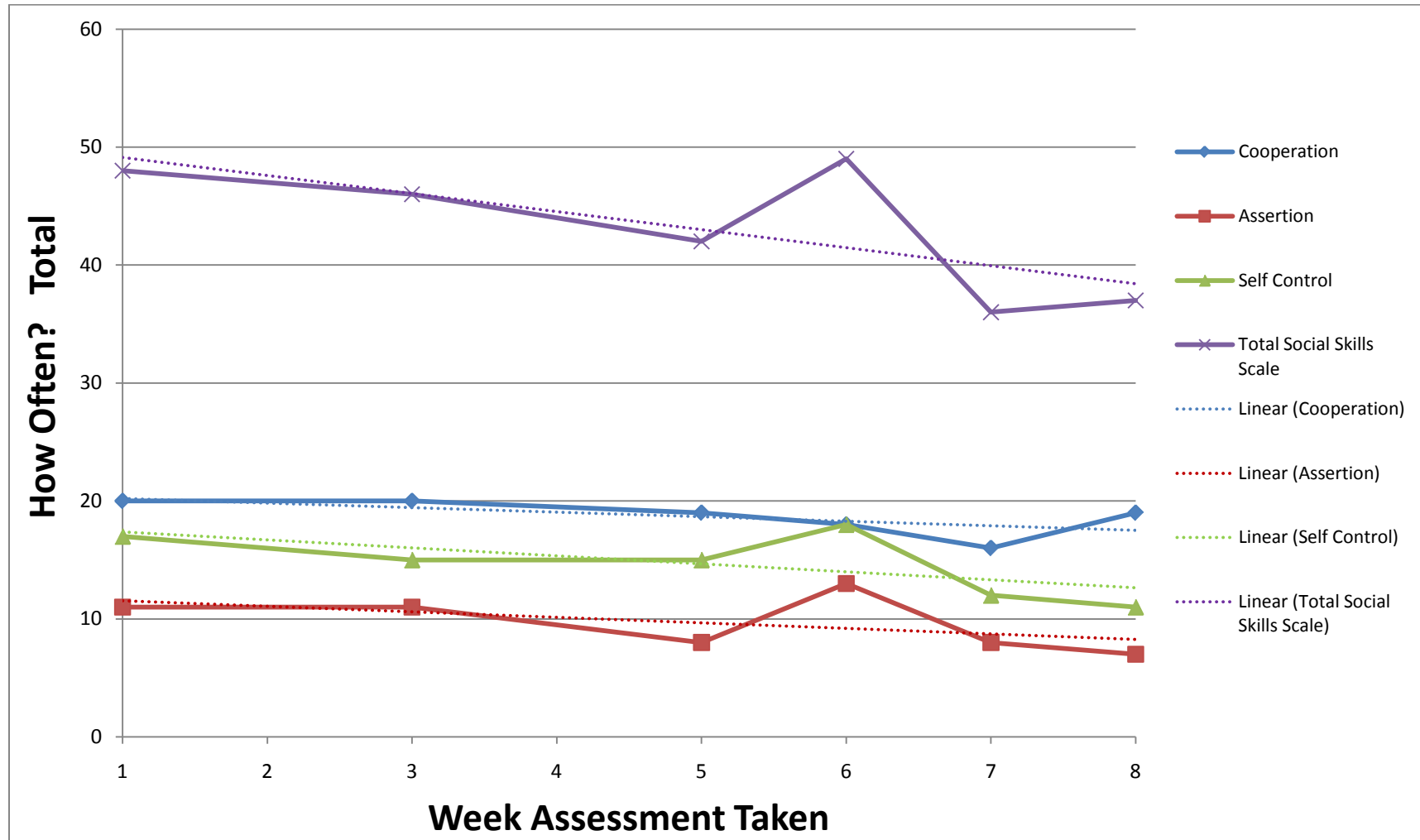


Figure 11: SSRS Assessment - Problem Behaviors - Child 2

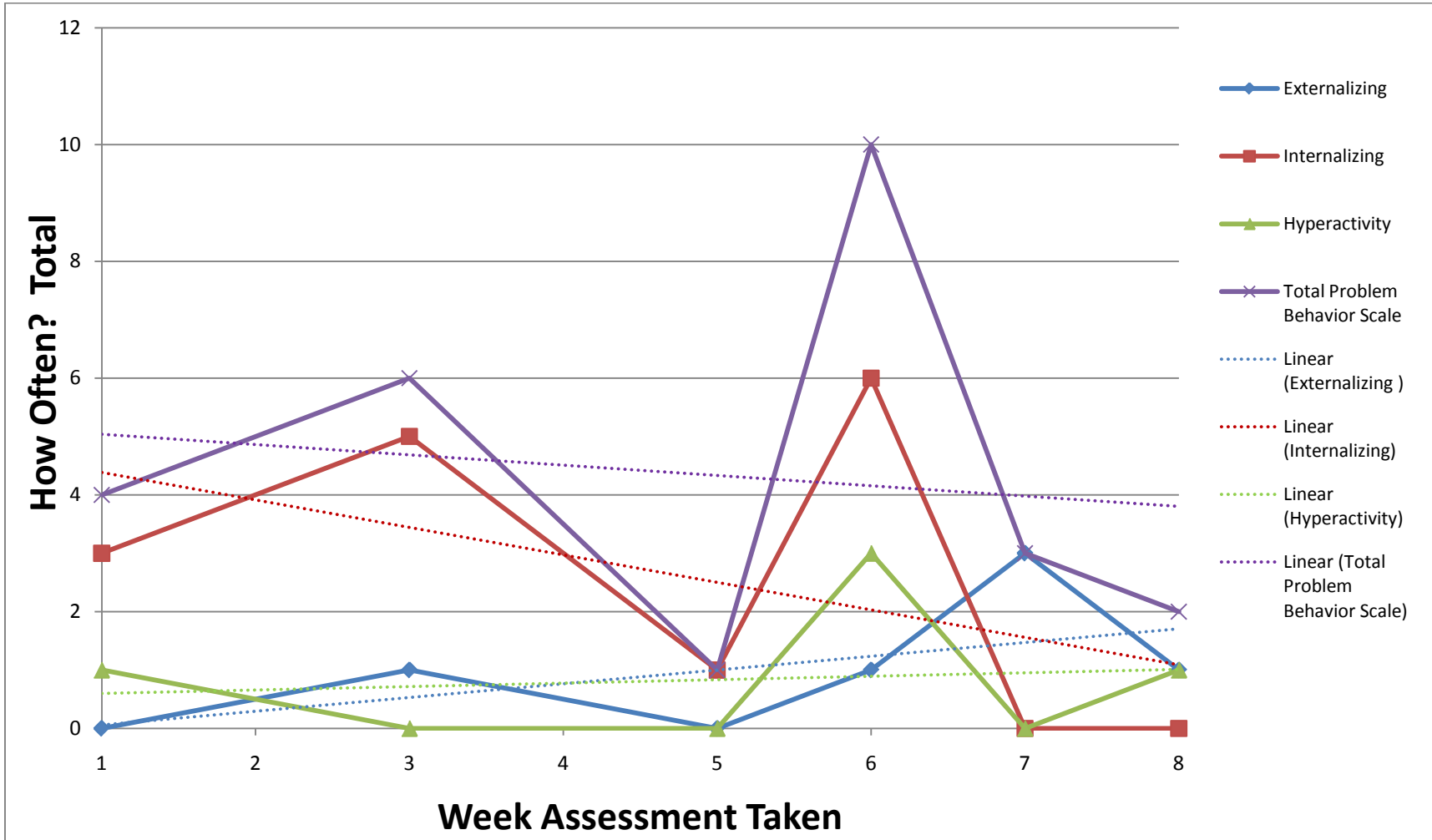
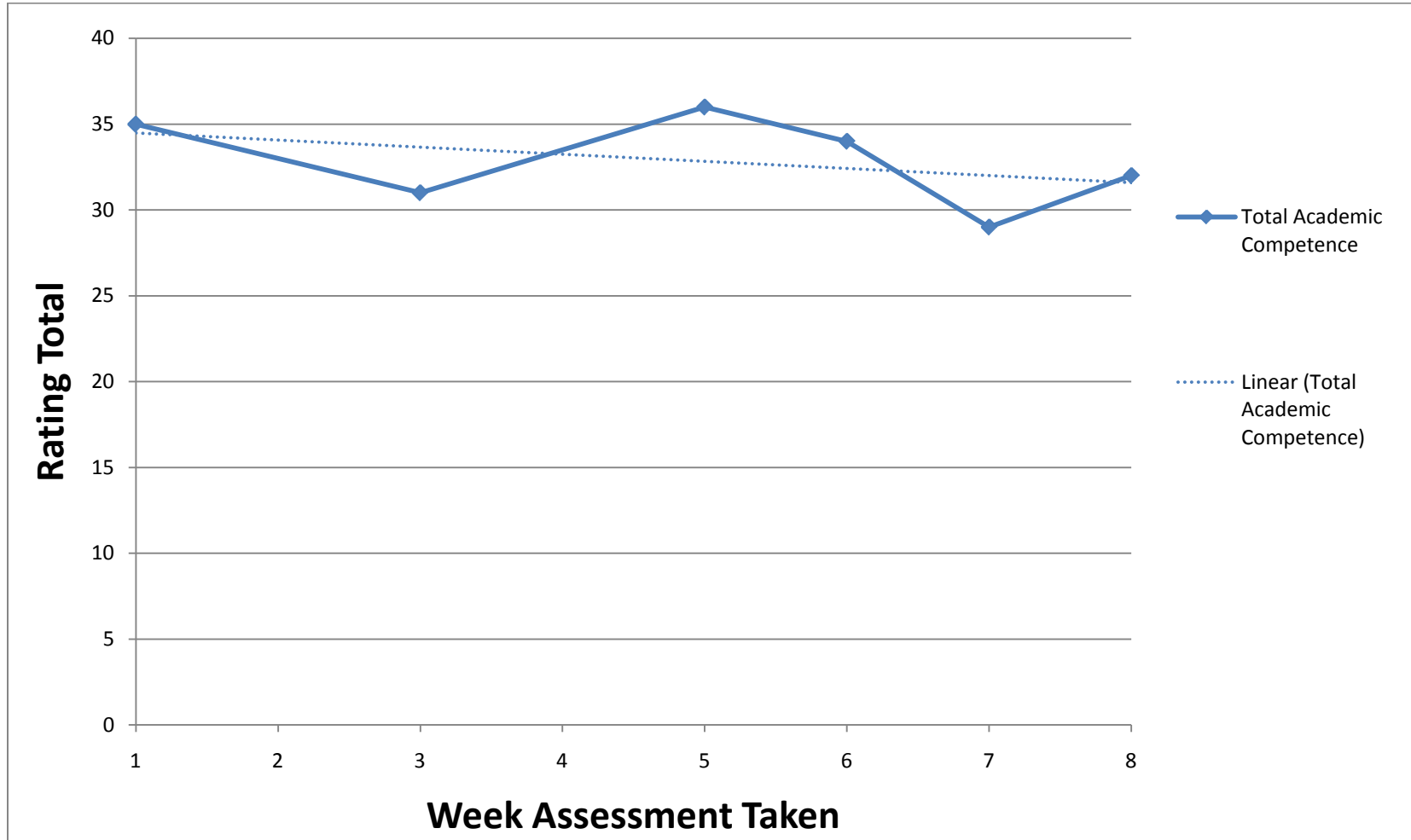


Figure 12: SSRS Assessment - Total Academic Competence – Child 2



Green Tree Lower School Progress Notes.

Pattern Coding was used to analyze Child 2's progress notes and discern common themes for each session. Child 2's experience in the first group session of the intervention phase (Appendix K) demonstrated themes of following directions/compliance, relationships to others, self control, and self-awareness. In the second week of the intervention phase (Appendix M), common themes found were relationships to others, making adjustments in one's self to meet the needs of the environment, connection/integration of body parts and movements, as well as self-awareness, which was also seen in intervention week 1. Major themes in intervention week three (Appendix O) were connecting the movement activities to the self and, connections/relationships to others. In the final intervention group, Child 2 experienced common themes of self-expression, group cohesion/trust, and awareness of self in relationship to the changing environment (Appendix Q). Throughout the intervention phase, Child 2 experienced prominent themes of positive relationships with others, cooperation, flexibility within himself, and group cohesion. Although he spends the entire school day with the others in the group, and has been with them for the duration of the school year, Child 2 appears not to trust them. When Child 2 worked one on one with another peer or with the therapist, he appeared to be more comfortable. This may be his way of feeling safe and in control; with only one other person interacting with him, he does not need to be as aware of all that is going on in his environment. There were multiple occurrences of Child 2 placing himself against a wall or in a corner, so he could be observant of his environment, and feel a sense of protection and containment. He only

moved away from the wall or the corner when prompted by one of the therapists; he may have chosen to remain against the wall or the corner until someone “gave him permission” to come off; making that decision for himself may have been too anxiety provoking for him. The sense of containment was also provided with the group using a stretch cloth. When Child 2 used the stretch cloth, it was in a group setting, and every member had to trust and depend on others; Child 2 consistently appeared to become more rigid in his body and anxious in his affect. There were other incidences (i.e. when other group members began to engage in a physical altercation and the therapists needed to intervene) Child 2 became extremely anxious.

As indicated by the Child Behavior Checklist (CBCL) and the Social Skills Rating System (SSRS), Child 2 tended to internalize most problem behaviors at the time of the current study, but there were also indications of externalizing of negative behavior. These instances of externalizing negative, and at times, aggressive behavior was seen in the CBCL, as well as the progress note for intervention week 4 (Appendix Q).

According to the Green Tree Lower School behavioral specialists, Child 2 was taken to the Learning Resource Center (LRC) two times, at 30 minutes each time during the course of the study. The first time he was taken to the LRC was during the seventh week of the study for noncompliance with his teacher. He was asked to take a brief time out from class, and was unable to pull himself together and return to class. The second time Child 2 was taken to the LRC during the study was in the eighth week of the study. He was taken to the LRC due to a verbal confrontation and abuse towards a peer after

Child 2 claimed the other child called him a negative name. Child 2 also verbalized disrespect for multiple staff members.

Case Comparison

Child Behavior Checklist scores compared.

When comparing these two cases using the scores on the Child Behavior Checklist (CBCL), similarities and difference emerge. Although both children scored within the normal range on all individual Syndrome Scales for most assessment points, overall, Child 1 had much higher scores to begin with than did Child 2, especially on the subscales related to their diagnoses, including Attention Problems Inattention and Attention Problems Hyperactivity. As Child 2 showed less problem behaviors in the areas of Attention, he displayed many more problems in areas related to Anxious / Withdrawn and Depressed/Withdrawn than did Child 1.

In terms of total scores on problem behaviors, Child 1 began with more than 10 times the number of total problem behaviors than Child 2. However, both participants showed nearly a 50% decrease in Total Problem Behavior scores during the course of the study. Child 1 tended to have more externalizing behaviors, while Child 2 showed more internalizing problem behaviors.

Scores on the scale of Adaptive Functioning differed greatly between the participants. Child 1 began with a lower score on adaptive functioning than Child 2, however, Child 1's score on Overall Adaptive Functioning increased throughout the study. During the intervention phase, Child 1's score remained high for him, and then

dropped at the conclusion of the intervention phase. Child 2's score on Overall Adaptive Functioning went up and down, the overall linear trend showed a decrease at the end of the study. Child 1's increase in Adaptive Functioning Scores at the end of the study was slightly less than Child 2's Adaptive Functioning Scores at the beginning of the study.

Social Skills Rating System - Teacher Report Form compared.

When comparing these two cases using the scores on the Social Skills Rating System (SSRS), there were many similarities between the two boys. Both participant's scores on Total Social Skills decreased slightly throughout the study. In contrast from the Total Problem Behavior scores on the CBCL, Child 1 and 2's scores on Total Social Skills began nearly equal. Child 1 showed a greater percentage decrease than did Child 2 during the study. Child 2's score remained at a more constant level, whereas Child 1's score jumped up and down.

Scores on the Problem Behavior Scale decrease for Child 1 overall, as well as all the subscales, Externalizing, Internalizing, and Hyperactivity problem behavior. Child 2 also had a decrease in Overall Problem Behaviors and Internalizing. However, Child 2 was found to have an increase in Externalizing and Hyperactivity.

Academic Competence Scores remained fairly constant for Child 1 throughout the study. Again, Child 2's initial scores began higher than did Child 1's, but Child 2 showed a greater decrease in Academic Competence by the end of the eight week study.

Green Tree Lower School Progress Notes compared.

When comparing the two participants based on the progress notes, there were many common themes, however, they may not have occurred in the same week of the intervention.

In the first week of the intervention phase, Child 1's themes included: following directions/compliance, ability to work within a group/cooperation, creating positive relationships with others, and relationship with/awareness of self. Child 2 shared the themes of following directions/compliance and relationships to others. Child 2 had additional independent themes, including self-control and self-awareness. These additional themes observed in Child 2 may be associated with his higher initial scores on both quantitative assessments, and overall level of ego functioning.

The second week of the intervention phase, common themes between the participants included relating to others, and the connection/integration of body parts and movements. Child 1 also focused on self-awareness while moving in a space, seeking nurturance and acceptance from therapists and other group members, as well as sustainment of attention and focus. Making adjustments in one's self to meet the needs of the environment was also seen in Child 2, as was a theme seen in week 1 also, self-awareness.

Intervention week 3 appeared to be about relationship with others for both participants. Child 1's additional themes were to seek relationships with others, as well as maintaining his self control. Child 2 also focused on connecting the movement activities to himself, as seen in week 2.

In the final intervention week, group cooperation and trust were prevalent themes for both boys. Self expression was a new theme, and also seen in both participants. Child 1 also focused on body organization and integration, while Child 2 became more flexible and aware of himself in relationship to the changing environment.

Chapter V: Discussion

The overall purpose of this study is to examine the effectiveness of Rena Kornblum's Dance/Movement Therapy (DMT) program (Kornblum, 2002) in decreasing incidences of aggression and increasing levels of empathy among children ages 8-12 years enrolled at an approved private school for children with emotional and behavioral problems. The problem to address in this study is the high incidence of aggression related behavior problems among children enrolled at a special education school for emotionally disturbed and behaviorally challenged children. There were a total of four one hour Dance/Movement Therapy group sessions, using previously selected activities from the *Disarming the Playground* curriculum. Quantitative and qualitative tools were used to assess two child participants were enrolled in this 8 week study. One quantitative assessment examined behavior and aggression levels. The other quantitative assessment was used to measure levels of empathy, social skills, problem behaviors, and academic competence. The qualitative data were collected through progress notes written by the student Dance/Movement Therapist. Major findings, themes, and outcomes will be discussed. Clinical applications to the field of Dance/Movement Therapy, limitations, and implications for future research will also be discussed.

A review of the progress notes suggests that during the intervention phase of the study, the Dance/Movement Therapy groups typically moved in waves. There were times of positive interactions and a lot of beautiful material emerging from the activities chosen. However, there were also times of negative interactions and relationships with

others, along with a few incidents of the beginning stages of a physical altercation between two group members. This “wave effect” of the groups is similar to one of the diagnoses carried by each child, Attention Deficit Hyperactive Disorder. The group was constantly struggling to sustain their focus and organization. The therapy space was cleared of all objects, creating a wide open, empty space prior to the group entering before each session. All other objects were removed in an attempt to prevent the group members from being distracted by the objects; on the other hand, it provided an open, unstructured space. Not all of the group members had the ego strength to contain themselves and their impulsiveness when presented with this space with no physical structure or boundaries to help provide a sense of containment. Typically, the times of disorganization were initially when the group entered the space, and during the transitions from one activity to another, where there was less structure.

For this thesis, the *Disarming the Playground* curriculum was presented not as a strict step by step “cookie cutter” curriculum. As the Student and Professional Dance/Movement Therapists are just that, therapists, they agreed to enter the intervention phase of the thesis by observing and working with the presented material from the boys in the group. At the beginning of each of the intervention sessions, the Student and Professional Dance/Movement Therapists presented materials and tools through the activities the boys could use to control their aggression and increase their empathy for others. Although the activities were chosen prior to the group beginning, the Student and Professional Dance/Movement Therapists allowed the emerging material to be developed further by utilizing the therapy process and verbal processing. The Student and

Professional Dance/Movement Therapists remained true to the activities within the *Disarming the Playground* curriculum; however, there was a shift from the educational goals of the activity, to goals which would develop material to a deeper psychotherapeutic level. For example, an educational goal of one *Disarming the Playground* activity is to maintain one's own personal space, and respect that of others. When developing the activity and material more in the Dance/Movement Therapy (DMT) session, the goal may shift. The new therapeutic goals may be:

- a) attuning to others and becoming more aware of one's own physical and emotional reactions when people are uncomfortably close to you, or
- b) what it feels like in one's own body when moving towards someone else and they tell you to stop.

All the boys in the group had engaged in individual and/or group Dance/Movement Therapy (DMT) sessions prior to this study. Because of their previous experiences, they may have had a pre-conceived idea as to what would happen in the groups during the intervention phase of the study. In their prior experiences, the DMT sessions had less structure, i.e., there were no pre-planned activities for each session, but there was a goal that was to be addressed in the session. Reflecting on the field notes, it seems that the boys may have struggled to adjust to the greater structure used in this study. For example, many times in each of the sessions, the boys requested to use props or to engage in activities they preferred and likely had experienced in past DMT sessions. They actually became frustrated when they were not allowed to do so in that moment. Because they were not permitted to engage in a preferred DMT activity in the moment, it

may have impacted their willingness to engage in the planned activities, and their willingness to learn and retain material presented by the Student Dance/Movement Therapist. In general, if children are not willing to learn and experience the materials and tools presented, it becomes difficult for a Student and/or Professional Dance/Movement Therapist, or educator to teach (R. Kornblum, personal communication, 06/04/09).

Child 1

The decrease in the number of problem behaviors for Child 1 was consistent with the results of the study by Hervey & Kornblum (2006), when evaluating the *Disarming the Playground* curriculum among a group of second grade students. Child 1 displayed great difficulty in the dance/movement therapy groups, struggling to maintain focus and appropriate behavior; however, it appeared he still gained something from this study.

Children with Attention Deficit Hyperactive Disorder + Learning Disabilities were shown to have significantly more frequent behavioral problems, than those with ADHD or LD alone according to a preliminary study by Smith and Adams (2006). The results of the current study suggest Child 1 received benefits from the Dance/Movement Therapy groups. Although Dance/Movement therapy does not directly teach children new skills, if children participate in dance/movement therapy activities, their defenses lower, and they are more receptive to learning new skills and modifying their patterned behaviors (Leventhal, 1980), which was observed in Child 1.

Child 1 did not always sit and participate in the group activities, but he was always present in the room, with a few incidences of brief time outs during the one hour

sessions. It appeared as if he was not paying attention or listening to what was happening in the group, as he was seemingly trying to sabotage the group process, or gain the attention, usually through negative ways, from peers or the therapists.

Overall, Child 1 was found to have a decrease in Total Social Skills on the Social Skills Rating System, with a increase on the individual subscale of self control.

Koshland & Wittaker (2004) evaluated a violence prevention program, finding an increase in Self Control.

While participating in Dance/Movement Therapy groups, Child 1's seeking nurturance and relationship with others was done in both positive and negative ways. When Child 1 was seeking a relational interaction with a peer, he typically targeted another group member whom Child 1 knew would respond to his behaviors. He would instigate a negative interaction with the other boys, but when the others would react to him, and give Child 1 exactly what he wanted, he played the victim role and began to seek nurturance from the therapists. Child 1 appeared to want the attention and relationships with others, but he was unsure as to an appropriate way of doing it. DuBois et al (2002) found children with a lack of social support (peer and adult) and self esteem may lead to greater internalizing and/or externalizing of behavioral problems in adolescence. Upon the completion of the current study, Child 1 was found to have a great decrease in Total Problem Behavior of both quantitative assessments. At the time of the study, Child 1 appears to externalize problem behavior more so that internalize it. As Child 1 tended to relate to peers in a negative manor, he may benefit from continued group Dance/Movement Therapy sessions, as his experience of the groups placed a lot of

emphasis on relationships with others, and group cohesion/trusting of others. Child 1 tended to externalize his negative problem behavior; that may be his way of attempting to connect with someone else, and seek that social support and interaction he wants, and acting out negatively is the only way he knows how. He tends to be the child who provokes the others to get them to react to him; when the other children react to Child 1, it is usually in a negative, aggressive way.

Boden, Fergusson, & Horwood (2008) discussed the relationship between self-esteem in adolescence and mental health, substance abuse, life, and relationship outcomes later in life. Boden, Fergusson, & Horwood did not measure the context in which people are raised and for Child 1, that would appear to play a large part. Child 1 displayed his lack of self-esteem multiple times during the intervention phase of the study; he commented he was stupid or weak, and those things will never change because “mom says so”. Despite the self talk techniques taught in the intervention groups, and Child 1 experiencing the power of self talk, he remained feeling negative about himself. Although Child 1 is not yet in adolescence, it is likely he may still feel the same negative ways about himself when he is an adolescent.

Child 2

Child 2 demonstrated more problem behaviors during the course of the study associated with anxiety, withdrawal, and depression; these behaviors fall under the internalizing problem behavior scale on the Child Behavior Checklist. Harada, Yamazaki, & Saitoh (2002) found similar results when they examined the psychosocial

problems in children with attention-deficit hyperactivity disorder (ADHD) with oppositional defiant disorder (ODD). Results collected from the Japanese version of the Children Depression Inventory (CDI) showed significantly higher rates of depression in the group of children who carried co-morbid diagnoses of ADHD and ODD, than among the children who only carried the diagnosis ADHD or ODD alone. The co-morbid group also displayed significantly higher rates of anxiety than the ADHD or ODD groups on the State-Trait Anxiety Inventory for Children (STAIC).

Child 2's scores on the SSRS Social Skills Scale decreased slightly throughout the study. Similar results were seen as in the Child Behavior Checklist; his scores were high at the assessment point at the end of the intervention, in week 6. This may be attributed to Child 2 knowing he was close to attaining his behavioral accomplishment ceremony; however, it may also be attributed to the teacher's assistant completing the assessment forms, rather than the teacher, who completed all others. During the seventh week, his total social skills scores dropped to their overall lowest point, as well as the individual subscales, including assertion, cooperation, and self control.

Coincident with the end of the intervention phase of the study (Week 6), Child 2 had earned the privilege to engage in a ceremony at Green Tree Lower School for maintaining his good behavior, following all the school, rules and completing all his homework. This "honors ceremony" was a celebration of Child 2 maintaining positive behaviors accumulated in the Green Tree Lower School behavioral points system for a consecutive 60 school days. Child 2's parents were in attendance, as well as all other children and staff at the Green Tree Lower School. All of those in attendance had the

opportunity to give Child 2 compliments; most included his being a good friend, a hard worker, able to cooperate with others, and how much he had improved behaviorally and how much his affect had brightened since his first day at Green Tree. Child 2 was able to choose colors to paint his hands and to place his handprints on the wall. Those in attendance then sang “For He’s a Jolly Good Fellow” and clapped for him. Child 2 chose two people to write on the wall: one to write his name, and one to write the date he had reached this “honors day 60”. His hand prints on the wall joined those of other students who had previously earned the privilege of this special ceremony.

At the assessment point in week 7 his social skills scores on both assessments began to drop, and the externalizing problem behaviors on the SSRS increased. According to Harada, Yamazaki, & Saitoh (2002), school problems among children with co-morbid ADHD and ODD included relationships with teachers and peers. At the same time as the drop in social skills scores, and increase in externalizing of problem behaviors on the SSRS, Child 2 was sent to the Learning Response Center (LRC) two times due to non-compliance with a teacher, and a verbal confrontation/abuse towards a peer, as well as verbalizing disrespect towards multiple staff members. It appears as if Child 2 maintained what he needed to do to participate in the special ceremony, and when it was over, he may have felt as if there was nothing else to achieve, so why should he continue to maintain his positive behaviors, when he knew there would be no reward. Typically when a child earned the privilege to participate in the special ceremony, their daily behaviors are no longer tracked, but they are still able to reap all the benefits of being on the highest behavior level. However, due to his negative behavior which escalated to the

point where he needed to be removed from class after the special ceremony, the tracking sheet to record his daily behaviors was reinstated. His negative problem behaviors briefly increased then decreased, as he again had an incentive to behave appropriately.

While working with the group as whole, especially when the stretch cloth was used, Child 2 becomes most anxious; he is in a situation he can not control directly. DuBois et al (2002) examined how social support (peer and adult oriented) and self-esteem influenced adjustment during early adolescence in the internalizing or externalizing of problems. The results were consistent in showing children will better adjust to adolescence with greater the social support both from peers and adults, as well as high self-esteem levels. The researchers also found the lack of peer social support may lead to greater behavioral problems in adolescence. If Child 2 felt he was unable to be supported (physically or metaphorically) by his peers, it may have been a cause of concern for him as he enters into adolescence. As Child 2 carried a diagnosis of Oppositional Defiant Disorder (ODD) at the time of the study, he may have continued struggles with behavior and conduct as he gets older, which could cause him many problems in his future. If Child 2 would continue to address his limited ability to trust his peers and feel supported by others while he is still young, it may have a great impact on his future and the possibility of continuing to internalize or externalize problems.

Clinical Implication for Dance/Movement Therapy

“Dance/movement therapy (DMT) is effective in helping youth deal with highly charged social issues and emotional complexities; assisting in the treatment and

prevention of conflict, peer violence, and abuse” (American Dance Therapy Association, 2008, DMT Fact sheet, p. 5).

The *Disarming the Playground* is a curriculum designed for “normal” and “at-risk” children in the public schools, as a preventative measure for violence and aggression. The children in this study were enrolled at the Green Tree Lower School due to the inability to appropriately function in a public school due to their aggression and behaviors. The *Disarming the Playground* was designed to be implemented over a greatly extended intervention phase, and done sequentially, as the activities build on top of aspects learned in earlier activities. By significantly shortening the time frame of the intervention phase of this study, it did not allow to implement the entire curriculum. Due to the variables being examined within this study, activities specifically pertaining to focus on them were chosen. As the *Disarming the Playground* curriculum is designed to be used as a whole, in sequential order, choosing only specific activities to use in the Dance/Movement Therapy groups proved to be a challenge for the participants. Because they did not have the foundational knowledge, they struggled with “jumping into” the curriculum at various places. If this study were to be replicated in future Dance/Movement Therapy research, choosing only one element to examine should be done. When the one element is chosen, use only those activities focusing on the specified area. If future research was to be done using both of the variables used in this study, a greatly extended intervention phase should be used, allowing for the entire curriculum to be implemented.

The Dance/Movement Therapy (DMT) groups using the *Disarming the Playground* curriculum were shown to have an impact on total problem scores and increased self awareness for both participants seen in all assessment forms. The trend in the results for Problem Behaviors continually decreased throughout the study. Because of these results, it can be hypothesized the interventions used in the DMT groups were impactful on the participants; they had learned new skills to use to better control their problem behaviors. By becoming more self aware, it allowed the participants to experience what they were feeling in their bodies; by increasing one's self awareness, a person is able to identify feelings within themselves, and have a longer time to process them. The participants may have become more aware of themselves and how they feel when they become agitated or frustrated, and learned methods to calm themselves down, and manifest their feelings in positive ways. "Developing of a repertoire of behaviors that allow safe expression or distraction from these intense feelings is...a big part of anger management" (Kornblum, 2002, p. 216).

A pilot study by Gronlund, Renck, & Weibull (2005) examined dance/movement therapy (DMT) as an alternative treatment for young boys diagnosed as ADHD. A post-intervention interview with a participant's mother reported her 6 year old son with Attention Deficit Hyperactive Disorder / Developmental Coordination Disorder (ADHD/DCD) was more relaxed and less hyperactive. Re-assessment using the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) of another 6 year old boy with a diagnosis of ADHD found an overall decrease in difficulties after the DMT sessions. The scores on the subscales of hyperactivity, emotional, and conduct also

decreased. The SDQ also indicated a decline in the impact of the problem behaviors on the participant's everyday life. These results are consistent with the decrease in Total Problem Behaviors found in the current study. Although the participants in the current study also took medication to help control their symptoms of their diagnoses of ADHD, it can be hypothesized Dance/Movement Therapy, specifically the *Disarming the Playground* study is an effective treatment tool to help control and manage manifested symptom behaviors of ADHD.

Limitations of the Study

One limitation was the recruitment process proved to be a problem for the parents of the participants, and prospective participants. One requirement to the consenting process was that the parents needed to come to the Green Tree Lower School to sit with the student researcher and witness to go over the permission form. Many of the students live up to one hour travel time from the school, either in the city of Philadelphia, or just outside the city limits, and many do not have reliable transportation. Also, many of the children's parents are working all day and/or have other young children at home. Thus, traveling to Green Tree Lower School to sign permission forms proved to be almost impossible.

This study was also limited by the children in this study were between ages 8-12 years old, and therefore, the results of the study can not be generalized to children younger than 8, or older than 12.

Some of the participants in the group had been involved in previous individual Dance/Movement Therapy (DMT) sessions. As the boys have had experience with DMT in the past, the study may have been limited in they may had been expecting the group to be run as others were in the past, where they had more freedom to suggest activities and props to incorporate into the group. However, this study did not allow for as much input from the participants, as there had been specific activities chosen to address the variables studied, and it was necessary for the sake of the study to follow the *Disarming the Playground* curriculum.

As the student Dance/Movement Therapist conducting the interventions was a graduate student still developing her clinical skills also limits the study. However, a Professional Dance/Movement Therapist on staff at Green Tree School was present in all DMT sessions and assisted the student researcher in guiding the children to follow the curriculum correctly. The presence and guidance of the Professional Dance/Movement Therapist mitigates the limitation to some extent.

Due to the nature of the school setting, students are not reliable to be present every day. Students who were research participants or other group members were not all consistently present for each sessions. Absences were due to a multitude of reasons; this limitation impacted the group dynamics of the group Dance/Movement Therapy sessions.

This study was also limited by having a four week intervention phase, rather than a much longer intervention phase, which would allow the *Disarming the Playground* curriculum to be embellished and the activities to be developed to a deeper level. Because of the shortened time frame, only specific activities were chosen, rather than

implementing the entire curriculum. By significantly shortening the time frame of the intervention phase of this study, it did not allow to implement the entire curriculum. Due to the variables being examined within this study, activities specific pertaining to them were chosen.

Because only specific activities from the *Disarming the Playground* curriculum were chosen and implemented, it limited the study. The curriculum was designed to be presented in sequential order as the activities presented later in the curriculum utilize building blocks, skills, and concepts learned in activities presented early.

Multiple tools were used to collect quantitative data, including two assessments. The teacher or teacher's assistant of the designated classroom completed the Child Behavior Checklist – Teacher Report Form (Achenbach, 1991a, 1991b, 1991c, 1992) to assess aggression levels, and the Social Skills Rating System – Teacher Report Form (Gresham & Elliott, 1990) to measure levels of empathy throughout the study. A limitation of these assessment tools could be a desire to please the student researcher with their responses. Another limitation may also have been a hurry to complete the assessments, as the teacher and teaching assistant had other responsibilities and job requirements they must fulfill as well.

Another limitation in regards to the quantitative assessments for each child include a measurement error. Initially, the primary teacher in the designated classroom was the only person designated to complete the assessments for each of the participants. However, due to circumstances beyond the researcher's control, and without the researcher's knowledge, the teaching assistant in that classroom was asked by the

primary teacher to aid her by completing the assessments in the second half of the study. This limitation may have impacted the overall results of the quantitative data; although the teaching assistant spends equal time with the children, her perspective of the children may have differed from the primary teacher's.

In addition, the Green Tree Lower School uses a behavioral point system, and this system provides some consistency amongst the educational team members for recording disruptive and disrespectful behaviors. However, it was not clear whether the primary teacher and her assistant referenced the children's daily points sheets when completing the quantitative assessments for this study. This too constitutes a limitation in the data collection.

Due to the time constraints of the study, the student researcher modified the time between assessment points for the Child Behavior Checklist – Teacher Report Form (Appendix H) so it was administered to assess for change every two weeks, rather than every two months.

For the purposes of this study, the student researcher eliminated irrelevant child identifying items and on the Sample of Social Skills Rating System (SSRS) Teacher Report Form (Appendix G) and the Child Behavior Checklist Teacher Report Form (Appendix H) with the assistance of Dr. Sherry W. Goodill, the primary faculty advisor in this study. These items were removed to reduce assessor fatigue, prevent a breach of confidentiality, and they were not necessary to include for the purposes of this study. The items eliminated on the SSRS included any identifying information, if the student was handicapped, and if the student was handicapped, the classification (learning

disabled, behaviorally disordered, mentally handicapped, or other handicapped). The handicapped items were considered irrelevant due to the nature of the Green Tree Lower School. Items removed from the CBCL included all identifying information and irrelevant items for the purposes of this study. The irrelevant items included: mother and fathers type of work, how much time the child spends in the teacher's class/service each week, the type of class/service it is, if the student had been referred for special class placement, services, or tutoring, if the student repeated any grades, academic performance in individual subjects, most recent achievement scores, IQ/Readiness/Aptitude test scores, and mental and/or physical illness or disability.

The progress notes for each child were completed by the student researcher, who was also the leader of all the Dance/Movement Therapy groups. This may have limited the study, as she was playing two different roles at the same time. The student researcher needed to be fully present and aware of the happenings in the group at all times, in addition to noting important facts and themes for each child participant. As there was no videotaping of the sessions, the student researcher had to rely on memory and clinical supervision experiences to write the progress notes.

Recommendations for Future Research

Two ways to decrease the limitations of this study would be to increase the number of participants, and expanding the age range. By dramatically increasing the number of participants and expanding the age range, the results could be generalized to a larger population, with a greater age range. In an attempt to rectify the limitation of

parents not having reliable transportation to come in to the Green Tree Lower School to sign the paperwork, future researchers could provide transportation for the parents, or agree to meet them, with a witness, in a neutral setting, more convenient for the parents to sign the parental permission forms.

Future research could be conducted by a professional Dance/Movement Therapist (DMT) who is finished with their education. A Professional Dance/Movement Therapist would have had more clinical experience and greater time to develop their clinical skills to facilitate the Dance/Movement Therapy group intervention sessions.

To ensure all participants would be present for all sessions, the setting of the study would need to be altered. For example, if this study were to be replicated at a residential treatment facility for children with emotional and behavioral problems who typically stay for months at a time. If the Dance/Movement Therapy group sessions were a part of their regularly scheduled day, there would be a better possibility all participants would be present to attend all group sessions.

A way to decrease the limitation of this study of only specific activities were chosen, rather than implementing the entire *Disarming the Playground* curriculum would be to increase the length of the intervention phase of the study. If the intervention phase spanned a much longer time frame, it would allow for enough time to implement the entire curriculum. As the *Disarming the Playground* curriculum is designed to be used as a whole, in sequential order, choosing only specific activities to use in the Dance/Movement Therapy groups proved to be a challenge for the participants. Because the participants may have entered the intervention sessions expecting one kind of group,

and received another, as well as the children not having the foundational knowledge, they struggled with “jumping into” the curriculum at various places. If this study were to be replicated in future Dance/Movement Therapy research, choosing only one element to examine should be done. When the one element is chosen, activities focusing on the specified area should be presented and elaborated on; this may provide show greater improvements in the specified area by the participants. If future research was to be done using both of the variables used in this study, a greatly extended intervention phase should be used, allowing for the entire curriculum to be implemented.

Assessors, who do not know the student researcher, may decrease the limitation of the assessors wanting to please the student researcher with their responses. With the teacher and teacher’s assistant having multiple responsibilities and job requirements to fulfill during the study, an assessor who does not have other job responsibilities and obligations may lessen the limitation of the teacher and teacher’s assistant possibly hurrying to complete the assessments.

As it is standard practice for the teachers and teaching assistants to complete daily behavioral points sheets. It was unknown if the teacher and teacher assistant in the designated classroom used the points sheet while completing the quantitative assessment forms.

Future research should also include the data from the daily points sheets as a way to obtain continuous behavioral data on each of the child participants. As this data would be collected from multiple teachers and teaching assistants who interact with the children throughout the day, it would provide multiple perspectives of the children’s behaviors. It

would also allow the researcher to observe if the findings on the quantitative assessments taken at various points throughout the study were consistent with the findings on the daily points sheets.

If the student Dance/Movement Therapist had been responsible for only running the groups and if the progress notes had been completed by another trained Dance/Movement Therapist, this may have decreased the limitation of the student researcher needing to fulfill two different roles simultaneously. Videotaping each of the Dance/Movement Therapy group sessions, in addition to clinical supervision may also be beneficial in future research to better observe notable movements and interactions among the group members. This would allow whoever is writing the progress notes to see aspects of the group and individual movements and dynamics which may have been overlooked.

Chapter VI: Summary

The overall purpose of this study was to examine the effectiveness of Rena Kornblum's Dance/Movement Therapy (DMT) program, *Disarming the Playground* (Kornblum, 2002) in decreasing incidences of aggression and increasing levels of empathy among children ages 8-12 years enrolled at an approved private school for children with emotional and behavioral problems. The eight week study was quasi-experimental: a single subject design with 2 children using an ABA format (Mertens, 2004). Two quantitative assessments, the Child Behavior Checklist – Teacher Report Form (Achenbach, 1991a, 1991b, 1991c, 1992) and the teachers form of the Social Skills Rating System (Gresham & Elliott, 1990). The dependent variables, aggression and empathy, were measured six times throughout the eight week study. The measurements were completed in weeks 1, 3, 5, 6, 7, and 8. Four one-hour group DMT sessions were given over the intervention timeframe. Scores on each dependent variable were compared pre- and post- intervention for each participant.

There were two participants in this study. Child 1 was an 8 year old African American Male with diagnoses of Attention Deficit Hyperactive Disorder (ADHD) Combined type and Learning Disorder NOS (not otherwise specified). At the time of the study, Child 1 was taking Ritalin 5mg two times a day, the first dosage was taken at home before coming to school and the second dosage at lunchtime. During the fourth intervention week, there was a change in Child 1's medications. He continued to take

Ritalin 5mg in the morning, and if needed, the second dosage at lunchtime. He also began to take Concerta 18mg with the Ritalin in the morning before going to school.

The results showed overall, Child 1 had a great decrease in Total Problem Behaviors and Externalizing Problem Behaviors on the Child Behavior Checklist based on individual Syndrome Scale Scores. He also showed a slight decrease in internalizing problem behaviors initially, before leveling off. Child 1 had an increase in Overall Adaptive Functioning, with the greatest increase on the subscale of Behaving Appropriately. According to the Social Skills Rating System, Child 1 showed a slight decrease in Overall Social Skills, including cooperation, assertion, and self control. There was also a decrease in Overall Problem Behaviors, including subscales of Internalizing, Externalizing, and Hyperactive Behaviors. The trend found in Child 1's Academic Competence remained constant throughout the study.

Child 2 was a 9 year old African American Male with diagnoses of Attention Deficit Hyperactive Disorder (ADHD) and Oppositional Defiant Disorder (ODD). At the time of the study, Child 2 was taking 1 tab of Adderall 20mg in the morning either at home or when he came to school. Child 2 also was given ½ tab of Adderall 10mg one hour before lunchtime if he took his morning dosage at home; if the morning dosage was taken at school, he was given the afternoon dose at lunchtime.

Child 2's scores on the Child Behavior Checklist for Total Problem Behavior, as well as Internalizing Problem Behaviors decreased throughout the course of the study. He showed a slight increase in the Externalizing of Problem Behaviors. Child 2's Total Score on the Adaptive Functioning scale, including items such as "Happy", "Behaving

Appropriately”, “Learning” and “Working Hard” oscillated between high and low scores, with a trend result of an overall slight decrease. According to the Social Skills Rating System, Child 2 showed a slight overall decrease on the Social Skills Subscales. His scores on the subscale of Problem Behaviors were consistent with the CBCL; he showed a decrease on Total Problem Behaviors and Internalizing Problem Behaviors. However, Child 2 score for Externalizing Problem Behaviors increased on the SSRS. Child 2’s academic competence also showed a slight decrease during the course of the 8 week study.

The Dance/Movement Therapy (DMT) groups using the *Disarming the Playground* curriculum were shown to have an impact on decreasing total problem scores and increased self awareness for both participants seen in all assessment forms. The trend in the results for Problem Behaviors continually decreased throughout the study. “Developing of a repertoire of behaviors that allow safe expression or distraction from these intense feelings is...a big part of anger management” (Kornblum, 2002, p. 216).

The *Disarming the Playground* is a curriculum designed for “normal” and “at-risk” children in the public schools, as a preventative measure for violence and aggression. The children in this study were enrolled at the Green Tree Lower School due to the inability to appropriately function in a public school due to their aggression and behaviors. By significantly shortening the time frame of the intervention phase of this study, it did not allow to implement the entire curriculum. Due to the variables being examined within this study, activities specifically pertaining to focus on them were chosen. As the *Disarming the Playground* curriculum is designed to be used as a whole,

in sequential order, and continually building on previously learned concepts, choosing only specific activities to use in the Dance/Movement Therapy groups proved to be a challenge for the participants.

Despite the challenge to the participant's ego strength and attention span, there was a continual decrease in the trend scores for Problem Behaviors throughout the study. Because of these results, it can be hypothesized the interventions used in the DMT groups were impactful on the participants; they had learned new skills to use to better control their problem behaviors. "Dance/movement therapy (DMT) is effective in helping youth deal with highly charged social issues and emotional complexities; assisting in the treatment and prevention of conflict, peer violence, and abuse" (American Dance Therapy Association, 2008, DMT Fact sheet, p. 5).

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Appendices

Appendix A. Letter to parents

Appendix B. Recruitment Flyer

Appendix C. Parental Permission Form

Appendix D. Assent form

Appendix E. Green Tree Lower School Progress Note

Appendix F. Sample of Green Tree Lower School Progress Note

Appendix G. Sample of Social Skills Rating System (SSRS) Teacher Report Form

Appendix H. Sample of Child Behavior Checklist (CBCL) Teacher Report Form

Appendix I. Script for initial phone call to parents by primary therapist at Green Tree

Lower School

Appendix J. Progress Note for Child 1 – Intervention Week 1

Appendix K. Progress Note for Child 2 – Intervention Week 1

Appendix L. Progress Note for Child 1 – Intervention Week 2

Appendix M. Progress Note for Child 2 – Intervention Week 2

Appendix N. Progress Note for Child 1 – Intervention Week 3

Appendix O. Progress Note for Child 2 – Intervention Week 3

Appendix P. Progress Note for Child 1 – Intervention Week 4

Appendix Q. Progress Note for Child 2 – Intervention Week 4

Appendix A. Letter to parents

Alexis Lanzillo
146 W. Walnut Lane
Philadelphia, PA 19144
January 21, 2009

Dear Parents/Guardians:

I am a second year Dance/Movement Therapy student at Drexel University in Philadelphia, Pennsylvania. Currently, I am an intern at the Green Tree Lower School. Beginning in the early months of 2009 I will be conducting a short-term special Dance/Movement Therapy group to address aggressive behaviors and the building of empathy. The group will utilize a specific program to address these issues. In addition, I am also in the process of writing my thesis to meet the requirements for graduation. I am writing to you because I am interested in using the data provided by your child's participation in this special group as a part of my Master's thesis research. Your child has been recommended for this group by the Dance/Movement Therapists on staff at Green Tree.

Dance/Movement Therapy can be defined as the psychotherapeutic use of movement as a process that furthers the individual's emotional, cognitive, social, and physical integration. The overall purpose of this study is to examine the effectiveness of Rena Kornblum's Dance/Movement Therapy program "Disarming the Playground, Violence Prevention through Movement and ProSocial Skills" in decreasing incidences of aggression and increasing levels of empathy among children ages 8-12 years enrolled at the Green Tree Lower School.

If you are willing to let your child participate in this research project, or have any questions, please contact me as soon as possible. You can reach me by phone at 814-558-5174 or by e-mail at greentreeproject@yahoo.com. You can also call my thesis advisor, Dr. Sherry W. Goodill, Ph.D., ADTR, NCC, LPC at 215-762-6926 or e-mail her at sg35@drexel.edu if you have any further questions. There will also be a meeting to discuss in greater detail the *Disarming the Playground* program you are invited to attend on Tuesday February __, 2009 at 2 pm. Your child will still be permitted to participate in the special Dance/Movement Therapy group even if you are not interested in allowing them to be in the study.

Thank you for your time. I look forward to hearing from you.

Sincerely,

Alexis A. Lanzillo, BA
Green Tree Lower School DMT Intern

Appendix B: Recruitment Flyer



Drexel University Recruiting Volunteers for a Research Study

Research Title

The Effect of Dance/Movement Therapy on Incidences of Aggression and Levels of Empathy in a Private School for Children with Emotional and Behavioral Problems

Research Objectives

The overall purpose of this study is to examine the effectiveness of Rena Kornblum's Dance/Movement Therapy (DMT) program, "*Disarming the Playground: Violence Prevention through Movement and Prosocial Skills*" for decreasing incidences of aggression and increasing levels of empathy among children ages 8-12 years enrolled in the Green Tree Lower School in Philadelphia, Pennsylvania. The study will span a total of 8 weeks, with a 4 week intervention period. Four one-hour DMT sessions will take place Mondays at 1:45 pm at the Green Tree Lower School. Scores on aggression and empathy levels will be measured by the children's classroom teacher five times throughout the eight week study.

Information for Research Subjects Eligibility

Children who meet all of the following criteria are eligible to participate in the study. Children must be:

- between the ages of 8-12 years old
- have been identified by their primary therapist to address continuous serious aggressive behaviors and notable deficits in pro-social skills
- have been sent to the LRC (Learning Resource Center) on at least one occasion, due to a physical altercation or verbal confrontation
- carry a diagnosis of at least one of the following: Attention Deficit Hyperactive Disorder (ADHD), Oppositional Defiant Disorder (ODD), Anxiety Disorder, or Learning Disorder NOS
- are assigned to the Green Tree Lower School classroom designed for children with the characteristics named in above items.

Location of the research and person to contact for further information:

Green Tree Lower School, 146 W. Walnut Lane, Philadelphia, PA

This research is approved by the Institutional review board.

If you are interested in participating in this study, please contact

Alexis Lanzillo
814-558-5174

This research is conducted by a researcher who is a member of Drexel University.

Drexel University

Parental Permission to Take Part in a Research Study

1. **Child's Name:** _____

2. **Title of Research:**
The Effect of Dance/Movement Therapy on the Incidences of Aggression and Levels of Empathy in a Private School for Children with Emotional and Behavioral Problems.

3. **Investigator's Name:**
Principal Investigator: Sherry W. Goodill, Ph.D., ADTR, NCC, LPC
Co-Investigator: Alexis A. Lanzillo, BA

4. **Consenting for the Research Study:**
This is a long and an important document. If you sign it, you will be authorizing Drexel University and its researchers to perform research studies on your child. You should take your time and carefully read it. You can also take a copy of this consent form to discuss it with your family member, physician, attorney or any one else you would like before you sign it. Do not sign it unless you are comfortable with your child participating in this study.

5. **Purpose of Research:**
Your child is being asked to participate in a research study. The purpose of this study is to find out if the Dance/Movement Therapy program *Disarming the Playground* is an effective way to decrease the number of aggressive behaviors (fighting with others, throwing objects, damaging other's property, yelling at other people) and increase children's empathy, or the ability to see things the way other people may see them.

Parent/Guardian Initials _____

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The researcher, Ms. Alexis A. Lanzillo, is a graduate student doing this research project as a partial fulfillment to obtain her Master's Degree in Dance/Movement Therapy at Drexel University.

There will be up to 5 children in this study; however, there may be more than 5 children in this special Dance/Movement Therapy group. Not all the children who are in the group will also be in the study with your child. All of the children in the study will be students in the designated classroom at the Green Tree Lower School.

Your child's participation in the group may end if one of the following happens: a change in your child's mental health diagnosis to include one of those within the exclusion criteria (diagnosis on the Autism Spectrum or any Pervasive Developmental Disorder, such as Asperger's Syndrome, Childhood Disintegrative Disorder, or Rett's Syndrome), being hospitalized, or leaving Green Tree Lower School to attend another school or program.

Your child may not participate in this study if he/she is not a student enrolled in the designated classroom at Green Tree Lower School, is are younger than 8 years old, or older than 12 years old, carries a diagnosis on the Autism Spectrum, Pervasive Developmental Disorder (Asperger's Syndrome, Childhood Disintegrative Disorder, or Rett's Syndrome), or Mental Retardation.

Your child does not have to participate in this research study if he/she does not want to. He/she is allowed to quit the study at any time if he/she chooses to. If he/she does choose to quit the study, he/she will still be allowed to continue his/her participation in the special Dance/Movement Therapy group.

6. PROCEDURES AND DURATION:

Version 02-14-09

Parent/Guardian Initials _____

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You understand that the following things will be done to your child.

- Your child will be participating in a special Dance/Movement therapy group using the Disarming the Playground program. The sessions will happen one time each week, for one hour, spanning 4 weeks. Your child will be taken out of class for all of these sessions. The total number of hours your child will be missing class is 4 hours over 4 weeks.
- During the study, your child will participate in some exercise in the Dance/Movement therapy group. The group sessions will help him/her to: learn ways to calm down when he/she is really angry, prevent getting into fights, learning to trust others, learning to deal with situations that make your child mad, and learning to look at things the way someone else might.
- Your child's homeroom teacher will also be filling out forms 5 times throughout the study about your child's behaviors while he/she is in school.

7. **RISKS, DISCOMFORTS/CONSTRAINTS:**

- The potential for physical harm to your child's participation in this study is minimal. Your child will be asked to participate in mild to moderate exercise. There is a slim risk of minor injuries or bruises, as with any everyday physical activity.
- Your child will have access to the school's nurse at all times during this study. All possible precautions will be taken to protect your child's privacy as a participant in this study.

Parent/Guardian Initials _____

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8. UNFORESEEN RISKS:

Participation in the study may involve unforeseen risks. If unforeseen risks are seen, they will be reported to the Office of Regulatory Research Compliance.

9. BENEFITS:

There is a chance your child may be not receive any benefit from participating in this study. Your child may have an increase in: controlling their aggressive impulses, feeling empathy towards others, learning positive coping skills, increasing positive social interactions, realizing how their actions directly affect others, and becoming more trusting of others. Your child may also have fun during the Dance/Movement Therapy activities that will occur throughout this study.

10. ALTERNATIVE PROCEDURES/TREATMENT:

There are no alternative procedures for participation in this study. You understand if you do not allow your child to participate in this research, your child is still able to participate in the special Dance/Movement Therapy group, without being in the study.

11. REASONS FOR REMOVAL FROM STUDY:

Your child may be required to stop the study before the end for any of the following reasons:

- a) Your child's grades are negatively impacted by the missing of classes
- b) Your child's mental health diagnosis changes to include one those listed in the exclusion criteria (diagnosis on the Autism Spectrum or any Pervasive Developmental Disorder, such as Asperger's Syndrome, Childhood Disintegrative Disorder, or Rett's Syndrome).

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- c) **Your child leaving Green Tree Lower School due to a hospitalization or to attend another school or program.**

12. VOLUNTARY PARTICIPATION:

You understand your child's participation in this study is voluntary, and you can refuse permission for your child to be in the study or to stop at any time.

There will

be no negative consequences if you decide not to permit your child to participate in the study or to stop.

You understand if you do not allow your child to participate in this research, your child is still able to participate in the special Dance/Movement Therapy group, without being in the study.

13. STIPEND/REIMBURSEMENT:

You or your child will not be given any reimbursement for your child's participation in this study. There is no requirement of you or your child to pay anything to participate in this study.

14. RESPONSIBILITY FOR COST:

You or your insurance company will not be charged separately for any activities related to the research aspect of this study.

15. IN CASE OF INJURY:

If you have any questions or believe your child has been injured in any way by being in this research study, you should contact Dr. Sherry W. Goodill at telephone number (215) 762-6926. However, neither the investigator nor Drexel University will make payment for injury, illness, or other loss resulting

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from your child being in this research project. If your child is injured by this research activity, medical care including hospitalization is available, but may result in costs to you or your insurance company because the University does not agree to pay for such costs. If your child is injured or has an adverse reaction, you should also contact the Office of Regulatory Research Compliance at 215-255-7857.

16. CONFIDENTIALITY:

All steps will be taken to assure the confidentiality of your child's identity and responses to all activities done within this research study by replacing your child's name with a numeric code known only to the student researcher and the child's homeroom teacher.

Any publication or presentation of research results, your child's identity will be kept confidential, but there is a possibility that records which identify your child may be inspected by authorized individuals such as representatives of the institutional review board (IRB), or employees conducting peer review activities. You give permission to such inspections and to the copying of excerpts of your child's records, if required by any of these representatives.

17. OTHER CONSIDERATIONS:

If you would like further information regarding your child's rights as a research participant or if your child has problems with an injury named in section 5, sustained as a result of the study, please contact the Drexel University of Regulatory Research Compliance at 215-255-7857.

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18. CONSENT:

- I have been informed of the reasons for this study.
- I have had the study explained to me.
- I have had all of my questions answered.
- I have carefully read this permission form, have initialed each page, and have received a signed copy.
- I give permission voluntarily.

Subject or Legally Authorized Representative_____
Date_____
Investigator or Individual Obtaining this Permission_____
Date_____
Witness to Signature_____
Date

List of Individuals Authorized to Obtain Permission

<u>Name</u>	<u>Title</u>	<u>Day Phone #</u>	<u>24 Hr Phone #</u>
Alexis Lanzillo	Student Researcher/Therapist	814-558-5174	814-558-5174
Sherry W. Goodill	Primary Investigator/Faculty	215-762-6926	215-762-6926

Drexel University

ASSENT FORM FOR CHILDREN/MINORS IN A RESEARCH STUDY

You are being asked to participate in a research study. This study will take place in the early months of 2009. This study will part of a special Dance/Movement program group therapy group for 5 children at the Green Tree Lower School. The Dance/Movement Therapy sessions will help with violence prevention.

All administrative, teaching, and therapeutic staff at the Green Tree Lower School will know about your participation in the study. Your classroom teacher will be asked to fill out forms about your behavior five times during the study. We will not put any of your names or any other ways to identify you on these forms; you will be given a random number and only your classroom teacher and Ms. Alexis will know that number.

Child's Assent: I have been told about the study and know why it is being done and what to do. I also know that I do not have to be in this study if I do not want to. I understand that even if I choose not to be in Ms. Alexis' research study that I can still be in the special Dance/Movement Therapy groups. If I have questions, I can ask Ms. Alexis. I can stop at any time.

My parents/guardians know that I am being asked to be in this study.

 Child's Signature

 Date
List of Individuals Authorized to Obtain Assent

<u>Name</u>	<u>Title</u>	<u>Day Phone #</u>	<u>24 Hr. Phone #</u>
Alexis Lanzillo	Student Researcher/Therapist	814-558-5174	814-558-5174
Sherry W. Goodill	Primary Investigator/Faculty	215-762-6926	215-762-6926



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: _____

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

Data (what happened, i.e. presenting behavior, information, interventions):
Assessment (effectiveness of treatment, client response to interventions):
Plan (what aspects of therapy should be continued, changed, etc):
Clinician Signature:
Date:

Clinician Name:



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: "Sara"

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #
	30 min		11:00-11:30	X			

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>Today was the first session in two weeks due to therapist's illness and holiday vacations. When the therapist took "Sara" from class, her affect appeared to be angry, but she was willing to go to her session with no problems. As soon as she entered the therapy space, her affect brightened. "Sara" talked with the therapist to discuss what has been occurring in the last two weeks because they had not met. She cut off that conversation by asking "Aren't we supposed to be doing a warm up first?" "Sara" led the body warm up, which the therapist mirrored. The warm up included the head, shoulders, arms, and feet; she skipped the torso, hips, and knees. "Sara" then suggested a therapeutic activity that focused on turn taking, being aware of how one's actions will effect other's, and frustration tolerance. However, if "Sara" felt the activity was becoming unfair to the therapist, she would have to "reshuffle" the cards, and she placed the necessary card on top; she attempted to do this without the therapist seeing her. The therapist asked "Sara" about the placing the handprints on the wall ceremony as some of her classmates were going to do it today. She explained what students need to do in order to be allowed to do that, but when she was asked about what level she was on, she said "I don't know", and that she did not want to put her hands on the wall again because there are "too many people and it's scary". The session ended abruptly as the honors ceremony began.</p>	
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>"Sara's" affect became happier when she saw the therapist come get her for the session. She appears to like coming to sessions and building the relationship with the therapist. "Sara" seemed to like leading the warm up; however her warm-up only used the peripheral parts of the body, which suggests she is still working on trusting others and not willing to let people get too close to her. During the therapeutic activity, "Sara" did not like it when she felt the activity was unfair to the therapist, and would have to "fix it", so she could then finish her turn. "Sara" appears to like manipulating her environment to meet her standards and her expectations as to what she wants to happen. When the therapist questioned "Sara" about the handprints on the wall ceremony, she was able to explain the process of being able to take part in it, as she has done it before. However, she firmly stated she did not want to do it again, and was not able to tell the therapist what level she was on. These comments infer she believes it is good for other people to be able to have this honor, but she doesn't feel she deserve to do it again.</p>	
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>"Sara" should continue individual therapy to focus on continuing to build a trusting relationship with the therapist, and trust issues she may have with other people. Therapy should also focus on building up her self-esteem and self-confidence. Other areas to be worked on include being able and willing to tolerate situations she may not enjoy, even if it is not directly impacting her, and she does not need to "fix" things to make other people happy.</p>	
<p>Clinician Signature:</p>	<p>Date:</p>

Clinician Name

Appendix I: Script for initial phone call to parents by primary therapist at Green Tree Lower School

Hello Ms. _____. This is _____, the Dance/Movement Therapist at the Green Tree Lower School. How are you today? Do you have a moment to talk?

I would like to talk about a special Dance /Movement Therapy group that that will be offered to your child starting in the early months of this year. The group will be led by Ms. Alexis Lanzillo, a Drexel University graduate student intern here at Green Tree. Ms. Lanzillo will be conducting this special group as a part of her thesis research, a requirement for graduation. Ms. Gayle Gates, a professional Dance/Movement therapist also on staff at Green Tree will also be in the group. (OR IF MS. GATES IS MAKING THE CALL, “I, as a professional Dance/Movement Therapist on staff at Green Tree, will also be in the group.”)

The special group will follow a program designed to reduce violence and increase empathy among school-age children. The special group will begin in the early months of this year and will extend over a period of eight weeks. The four movement therapy groups will be one hour each Monday at 1:45 pm. During the eight weeks, your child’s classroom teacher will be completing two assessments about your child’s behaviors five times during the study.

Ms. Lanzillo will be sending a letter home with more information about her study. The letter will also invite you to attend an optional meeting at Green Tree in February to learn more about her study and the program she will follow.

Thank you for your time. Please be on the look out for the letter from Ms. Lanzillo.



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 1

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #				
Week 1											

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>Today was the first group of the study. The day and time had to be changed for today only due to Child 2 not being in school on the regularly scheduled day. Child 1 appeared to be very excited about the group, as he had told the therapists throughout the day he would see them later. He and one other group member came in to the therapy space before the group and asked "is it time yet?" They were told the therapists would come get them when it was time. After the therapists took the boys from class and prior to entering the space, the student Dance/Movement Therapist instructed them to go in and sit in a circle on the floor. The group began with the student Dance/Movement Therapist explaining the purpose of the group, and having each child read some of the group rules listed on the wall. A verbal check in was done using a "feelings ball", the ball was passed to each child, who said their name and how they were feeling today. One group member was hesitant to participate in the group, but after watching the others, he was willing to engage in the check in. The body warm up began with the feet while sitting on the floor, and traveled up the body, and ended standing up. The same child who was hesitant early in the group began to constantly tease Child 1, despite multiple prompts by the therapists to stop and remember the rules that were stated at the beginning of group. Child 1 did not respond to the teasing, but asked if he could take a "time out", and step out of the room for a moment. The professional Dance/Movement therapist accompanied Child 1 out of the room. They returned within 2 minutes. The first activity was "Approach and Stop". The student Dance/Movement Therapist placed the boys in two lines facing one another; Child 1 was paired with Child 2. This activity was first done with walking slowly, and was repeated several times. The roles were reversed and the activity was repeated with walking. The activity continued with "the movers" running towards their partner. Child 1 was "the mover" first, and walked slowly toward Child 2, "the boss" until Child 2 said to stop. When instructed to walk slowly toward "the boss", Child 1 walked quickly and did not stop when the boss" instructed him to. Child 1 claimed he did not hear the instruction to stop. Child 2 asserted himself more when the activity was repeated, and Child 1 still did not stop as soon as he heard the directions. The boy who was teasing Child 1 throughout the session continued to make comments under his breath; however Child 1 was able to restrain himself from reacting to him. The next activity was "Grounding While Standing in the Stretch Cloth". This activity began sitting on the floor and the therapists setting ground rules when using this prop. The student Dance/Movement Therapist facilitated activities with the stretch cloth to familiarize the boys to it. The same boy who was teasing Child 1 throughout the session continued to disrupt the group and tease Child 1. Child 1 displayed agitation and anger in affect when this boy continued to tease and confronted Child 1 in a face-to-face confrontation. Both of the therapists positioned themselves in between the two boys, while the other group members were still and patiently waiting. With multiple redirections, the boy could pull himself together and rejoin the group activities. While still sitting on the floor, the stretch cloth was placed behind the backs of the group, and all leaned back together and one at a time. The rest of the group had to support the individual who was leaning back by maintaining their own weight in the stretch cloth. The group stood with the stretch cloth behind their backs, all leaning back together and working together to maintain balance as a group. Without using hands on the cloth, the group swayed in synchrony side to side, and bent and straightened their knees. The same boy who was disruptive throughout the group continued to be troublesome and he stretch cloth was put away. A verbal processing occurred about the session around working together, following directions, being aware of personal limits to one's own space. As the processing continued, the child who was disruptive throughout the group began to play "Duck Duck Goose" and ran around the circle. The others were able to ignore this boy and to engage in the discussion. Before returning to class, the group stood to take deep breaths and was reminded the group would be at the original time next week.</p>
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>Movement/Behavioral Assessment</p> <p>When Child 1 entered the therapy space, he appeared to be happy and excited, as he displayed a bright affect and sat next to the professional Dance/Movement Therapist and oriented himself to the speaker. When the student Dance/Movement Therapist was speaking about the purpose of the group and addressing the rules, Child 1 struggled to sit still, but with redirection, was able to stop moving and focus his attention. When Child 1 was being teased early in the group, he was able to feel himself getting upset and frustrated, and dealt with these feelings by asking for a time out, rather than acting on those feelings through negative behaviors. During the "Approach and Stop" activity, Child 1 needed to multi-task and ignore the negative comments from his teaser, and attend to the directions of his partner; he struggled to do this. Child 1 appeared to be distracted by his teaser, as he continued to make comments under his breath, which may have distracted Child 1 from fully engaging in the activity, and being able to hear the directions of his partner to stop. This inability to follow directions of his partner and multi-task may also be due to Child 1's diagnosis of Attention Deficit Hyperactive Disorder. The stretch cloth provided a physical container for the group. It aided the children in being aware of how it felt to be connected to one another, and provided a visual image of how their movements had an effect on all the others. During the "Giving Your Weight to the Stretch Cloth", Child 1 was able to modify how far he was able to lean back so the rest of the group could still support him. His feet were close together and he leaned back from his upper back, whereas the therapists modeled leaning from the waist. His leaning from his upper back and his narrowing in his feet being close together is indicative of Child 1's distrust of the group members, if they would support him. It may also be his anxiety about using a novel prop and his hesitancy in engaging fully in a new activity.</p>
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>Child 1 should continue to attend the special group therapy sessions to work on controlling his impulsivity in his movements. Future sessions should also encourage Child 1 to use multiple foci and continue to ignore teasing from others. Therapy should also support Child 1's awareness of himself when he becomes agitated, and encourage him to stand up for himself in a positive way, and not give into engaging in negative behavior.</p>
<p>Clinician Signature:</p>
<p>Date:</p>

Clinician Name:



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 2

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #
Week 1							

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>This was the first meeting of the group for the study. The day and time of the group had to be changed for this week only, due to child 2 being absent on the regularly scheduled day. There were four boys present; one was absent today. Prior to entering the space, the boys were instructed to go in and sit in a circle on the floor. The group began with going over the rules and expectations of the group members. A verbal check in was initiated by the student Dance/Movement Therapist; a "feelings ball" was passed to each member to say their names and how they were feeling today. One group member was resistant to initially participate in the check in, but eventually complied. While sitting on the floor, a body warm up began with the feet and traveled up the body, moving to standing and incorporating the whole body. The same group member who was initially resistant began to tease another boy in the group, disrupting the process of the group, with redirection, he stopped. The first activity was "Approach and Stop". The boys were divided into two lines facing one another, and listened to the instructions. Child 2 was paired with Child 1. Child 2 was "the boss" first, while Child 1 was "the mover". Child 2 complied with the directions, although "the mover" didn't listen when Child 2 said "stop". This activity was first done with walking slowly, and was repeated several times. The roles were reversed and the activity was repeated with walking. The activity continued with "the movers" running towards their partner. The next activity was "Grounding While Standing in the Stretch Cloth". The stretch cloth was introduced to the group while sitting on the floor. Ground rules were set for using this prop and the student Dance/Movement Therapist facilitated various activities familiarize the children with the prop. The same group member who was struggling throughout the group began to disrupt the group and attempted to physically confront the group member he was teasing earlier. While the student Dance/Movement Therapist and the co-therapist redirected him multiple times and physically placed themselves between the two boys, child stopped and pulled himself together and rejoined the activity. The other boys patiently waited and were silent during this intervention. While sitting on the floor, the stretch cloth was placed behind the backs of all group members and the group leaned back together, then one at a time. The group then stood with the stretch cloth behind their backs and leaned back together, being aware of and supporting one another. The group then swayed in synchrony side to side, bent and straightened their knees together. The group member who was acting out throughout the session began to disrupt the group, therefore, the stretch cloth was put away. A verbal processing occurred about the session around working together, following directions, being aware of personal limits to one's own space. As the processing continued, the child who was disruptive throughout the group began to play "Duck Duck Goose" and ran around the circle. The others were able to ignore this boy and to engage in the discussion. Before returning to class, the group stood to take deep breaths and was reminded the group would be at the original time next week.</p>
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>Movement/Behavioral Assessment</p> <p>When Child 2 entered the space, he displayed a flat affect. He was very attentive while the therapist spoke in the beginning of the session. He was also compliant with following all directions; however, he appeared to be hesitant initially to engage in the movement warm up and activities. This may be due to being with a new therapist and in a new therapy space. It may have also been amplified due to him usually being seen in individual sessions, and this was the first group of this year he had been a part of. When Child 2 was "the boss" during the "Approach and Stop" activity, initially he was very soft spoken and Child 1 said he did not hear Child 2 say "stop". Child 2 asserted himself, and became louder with the vocalizations and clearer in his gesture of "stop". When Child 2 was "the boss", he was able to verbalize he knew "the mover" was close enough, without invading his personal space, by observing the empty space between him and "the mover". When Child 2 was "the mover", he appeared to be hesitant in a direct, face-to-face approach, and was not able to sustain eye contact with "the boss". When both of the therapists attempted to redirect the group member who was acting out, Child 2 was able to ignore the negative behaviors, and maintain his own self control. At times, he also encouraged the boy who was acting out to "get it together" so the group could continue. The stretch cloth provided a physical container for the group. It aided the children in being aware of how it felt to be connected to one another, and provided a visual image of how their movements had an effect on all the others. Child 2 appeared to be anxious while standing in the stretch cloth, as he kept his feet close together and became very rigid throughout his body. These movements may be indicative of his lack of comfort with and trust for the other group members. Due to the distrust, he inhibited his movements.</p>
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>Child 2 should continue to attend these special group therapy sessions to assert himself using his voice, and setting clear limits with others. Child 2 should also continue to work on maintaining self control and his ability to ignore others if they are engaging in negative behaviors. Future sessions should also help Child 2 focus on building positive and trusting relationships with others.</p>
<p>Clinician Signature:</p>
<p>Date:</p>

Clinician Name:



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 1

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #
Week 2							

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>Within the last week, there have been discussions among the school psychiatrist, the play therapist, and Child 1's mother to possible increase his medication to control his ADHD symptoms. Today was the second week of the intervention phase. One boy was absent today, and one group member present today who was absent during the last session. Prior to the boys entering the room, they were reminded to go in and have a seat in a circle on the floor. Child 1 initially placed himself directly across from the boy who was teasing him in the previous session, however, he complied with sitting between the professional and the student DMT. The student DMT reviewed the purpose and time frame of the group. After reviewing the rules posted on the wall, the student DMT said 1-2 verbal warnings will be given before the child would be asked to leave if they could not follow the rules. Child 1 struggled to control his impulses to move, and engaged in attention-seeking negative behaviors. A verbal check in was done using a "feelings ball" passed around the circle; each child said their name, how they were feeling today, and something fun they like to do when it is sunny outside. The body warm up was led by the student DMT, beginning with the feet while sitting on the floor. The group members added suggestions of body parts they felt were not warmed up. The warm up ended standing up to use the whole body and incorporate the use of breath with the movements. Breathing and balancing was initiated by one group member. The student DMT introduced "space bubble" concept, and demonstrated what they looked like on the body, and asked for examples of when a small, medium, or large "space bubbles" would be necessary. Child 1 struggled to sit and listen to the student DMT, and continuing to struggle to control his impulses to move and was disrupting the group, most other group members were able to ignore these negative behaviors and remain engaged in the group. Child 1 was the same boy being teased in the previous session; the boy who was the teaser in last week's session asked if he could take a time out. The professional DMT accompanied this child on his brief time out. The activity of "Maintaining Space While Traveling" began with the student DMT creating a large space, with clear boundaries, and quick, percussive music playing in the background. The boys were instructed to move through the space using their large "space bubbles". They were to stay within the confines of the boundaries in place, move while remaining in control, and not run into someone else's "space bubble". The group as a whole was struggling to maintain their own "space bubbles" and not run into one another, therefore the student DMT changed the music to a slower tempo and with less percussive intensity, which helped most of the group maintain more control over their movements. The student DMT adjusted the space to a medium space, then a small space; the boys needed to modify the size of their movements and their spatial pathways to remain within the confines of the space, and the directives to use a medium or small "space bubble". The next activity was "We All Stop Together". It was said the group could walk slowly through the entire space, while constantly watching others to see when someone stops. When they see someone freeze, they must also; there was no designated order of who was to stop when. When the group was frozen, they were asked who stopped the movements. Initially, the student and professional DMT's were the only people who could stop the movements. Child 1 continued his regressed behaviors and consistently ran into others and during the freeze would hang on to the DMT's, using passive weight. With redirection, Child 1 was able to participate correctly when two of his peers were the stoppers". Child 1 and the boy who was teasing him in the previous session were paired as the "stoppers" at the same time, and they were able to work together, and take turns who was going to stop the group, without needed to discuss the order in which they would go. Eventually all 4 boys were the "stoppers" of the group. A verbal processing was done at the end of the session, and the group was able to verbalize which "space bubble" was easier or harder, why it was harder, and what they needed to do to not run into each other. It was also shared by the DMT's how the group was able to take turns without discussion of an order of when someone going to stop, and how they became very good at watching other's cues to stop during "We All Stop Together". Two deep breaths were done together while standing in a circle. Child 1 became oppositional and turned away from the group, but was able to re-join with redirection. The group smoothly transitioned back to class. Later, Child 1 sought out the student DMT to tell her he's "not coming to movement class next Monday."</p>
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>Movement/Behavioral Assessment</p> <p>Despite the verbal warning policy for negative behaviors and the inability to follow directions, the student DMT chose not to ask Child 1 to leave due to his involvement in the research study. As soon as Child 1 entered the space, he placed himself directly across from his teaser from last week's session. This may be indicative of the continuing tension between the two and his desire to confront him. When he was asked to move between the DMT's, he complied, but initially invaded the space of the professional DMT who was now sitting directly across from his teaser. Child 1 may have desired to return to his original seat, or wanted to be close to and align with the professional DMT. When she asked him to move over, out of her space, he became agitated and began to regress. During the verbal check in, he said he was "happy" and began to rock forward and backwards, laying his back, and resisting redirection by the student DMT. When he was told he was not participating and following the rules, he sat up and re-oriented himself to the group. "Maintaining Space While Traveling" proved to be difficult for Child 1. He continued his negative behaviors and moved through the space quickly. He was also intentionally running into other group members; the others were again able to ignore his negative behaviors and modify their own movements to move out of his way. He was also testing limits through moving just inside the boundaries set up, and placing one arm or one leg on the other side of the boundaries. As the space became smaller, he struggled to modify his movements to follow the directions as well as keep everyone safe; when redirected, he sat in the corner and refused to participate. With encouragement and redirection, he rejoined the group in the small space, but remained in the corner, facing the wall at times. During the activity "We All Stop Together" when the DMT's were the "stoppers", Child 1 consistently reached out for and would hang on their arms when everyone was to freeze. The DMTs asked him to stand up and support himself, because they did not want him to fall and get hurt. However he did not comply; he became more passive and intentionally fell to the floor, and over-dramatized a bump to his knee to seek the nurturance and attention he wanted. He then asked the DMTs why they "pushed him on the floor". Although the DMT's said they did not want him to get hurt, there may be some transference and underlying attachment issues. Throughout the group, he placed the DMT's in a nurturer position, and by the DMT's saying they do not want to see him get hurt, he may have translated that as mom doesn't care if he gets hurt. He was silent during the verbal processing; although he sat in the circle with the group, he did not participate. His oppositional behavior of turning outside of the circle was his final attempt to gain the DMT's attention. Child 1's attention seeking behaviors may also be due to a transference sibling-like rivalry with the other boys in the group. They are all in the same class, and have known each other for at least one year. Child 1 observed the positive attention and reinforcement the DMT's would say to the other's and desired that attention, as one sibling may due when a caregiver is giving their attention to another sibling.</p>
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>Discussions of an increase in medication will continue to be discussed among the psychiatrist, the play therapist, and Child 1's mother. Child 1 should continue to attend the special Dance/Movement Therapy groups to work on sustaining his appropriate participation in the group when there is no direct attention focused on him. Future goals for sessions will be to control his impulsive movements and modulate his movements to accommodate those of the other group members.</p>
<p>Clinician Signature:</p>
<p>Date:</p>

Clinician Name:



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 2

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #
Week 2							

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

Data (what happened, i.e. presenting behavior, information, interventions):	
<p>Today was the second week of the intervention phase. One boy was absent today, and one group member present today who was absent during the last session. Prior to the boys entering the room, they were reminded to go in and have a seat in a circle on the floor. The student DMT reviewed the purpose and time frame of the group. When requested, two group members volunteered to read the rules posted on the wall. The student DMT reminded the group 1-2 verbal warnings would be given before a child would be asked to leave the group for the remainder of the session. A verbal check in was done with a "feelings ball"; each child said their name, how they were feeling today, and something they like to do when it is sunny outside. The body warm up was led by the student DMT, beginning on the floor, with the feet and sequentially moving up the body. The group members added suggestions of body parts that had not been specifically warmed up. The warm up ended standing up to use the whole body and incorporate the use of breath with the movements. Breathing and balancing was initiated by one group member. The concept of "space bubbles" was introduced by the student DMT as a precursor to the activity "Maintaining Space While Traveling". The student DMT verbally and physically explained and demonstrated small, medium, and large space bubbles. The group was able to add scenarios when the various "space bubbles" are needed to be used. One group member was struggling to control his impulses to move and was disrupting the group, most other group members, including Child 2, was able to ignore these negative behaviors and remain engaged in the group. The group member acting out today was the same child who was being teased in last week's session. The group member who was the teaser in last week's session was struggling to stay in control, and requested a time out; he and the professional DMT took a brief time out. When the two returned to the group, the student DMT created a large area with visible physical boundaries to begin the "Maintaining Space While Traveling" activity. The student DMT instructed the group to move through the space using a large "space bubble", while remaining within the boundaries set up and without running into someone else's "space bubble". Initially, quick rhythmic music was playing in the background, and the boys were struggling to remain in control of their bodies to not run into one another and stay within the confines of the space created. This difficulty was observed by the student DMT, who then changed the music to a slower tempo and with less percussive intensity. The student DMT adjusted the space to a medium space, then a small; the group member who was struggling to control his quick impulses throughout the group was continuing his negative behaviors and moving through the space quickly. He was also intentionally running into other group members; the others were again able to ignore his negative behaviors and modify their own movements to move out of his way. To help one group member who was reluctant to participate, the professional DMT took him by the hand and they moved together. The other boys observed this connection, and they were willing to make connections with others, and move through the space more freely, in different spatial pathway and less bound flow. The next activity introduced by the student DMT was "We All Stop Together". It was said the group could walk slowly through the entire space, while constantly watching others to see when someone stops. When they see someone freeze, they must also; there was no designated order of who was to stop when. When the group was frozen, they were asked who stopped the movements. Initially, the student and professional DMT's were the only people who could stop the movements. When the group appeared to master this, 2 group members at a time were then the stoppers, and then all 4 boys were stoppers. A verbal processing was done at the end of the session, and the group was able to verbalize which "space bubble" was easier or harder, why it was harder, and what they needed to do to not run into each other. It was also shared by the DMT's how the group was able to take turns without discussion of an order of when someone going to stop, and how they became very good at watching other's cues to stop during "We All Stop Together". Two deep breaths were done together while standing in a circle. The boy who was acting out throughout the group became oppositional and turned away from the group, but was able to re-join with redirection. The group smoothly transitioned back to class.</p>	
Assessment (effectiveness of treatment, client response to interventions):	
<p>Movement/Behavioral Assessment</p> <p>When Child 2 entered the space, he had a flat affect and initially sat against the wall of the room, outside of the circle. With prompting, he rejoined the group. During the verbal check in, he demonstrated very low energy and passive weight. He verbalized he was "sad" today, and shrugged his shoulders when he was asked what he liked to do when it was sunny outside. During the warm up, Child 2 participated; however, he maintained a concave torso when there was movement directly focusing on using the torso. When the warm up moved to standing, he was able to integrate the use of his entire body, and used a lot of widening in the horizontal plane, attempting to reach for and connect with the group members on either side of him. He became more actively engaged in the movement group at that point. Throughout the group, when Child 1 was struggling to control his impulses to move, Child 2 remained still and quietly waited for him to calm down, or was able to ignore him completely. While using the large space in "Maintaining Space While Traveling", Child 2 appeared to become anxious; he used a lot of bound flow throughout his body and very small movements. He also stayed near a wall or the corner of the room, unless encouraged to explore the space by one of the therapists; he consistently returned to the corner or against the wall. The wall or the corner may have provided a feeling of safety for him; he was able to be aware of where everyone was at all times, especially Child 1, who was continuing to move quickly and running into others. When the student DMT put slower music on and created the small space to practice using the small "space bubbles", Child 2 observed a physical connection between the professional DMT and one group member, he appeared to become less anxious, and displayed a bright affect. He was willing to make a physical connection with the student DMT, as well as other group members. He explored new ways of moving through space, a various levels, spatial pathways, and widened in his own body. He extended his arms out in both directions, and others were moving under his arms; Child 2 also became willing to move under other's arms and around them. He needed less encouragement to use the full space available and may have felt it was safer for him to use the whole space now that it was much more confined. This may be associated with the nature of his diagnosis of ADHD; he clearly saw the boundaries of a small space, and everyone was forced to slow down their movements and make them smaller to be sure not to run into someone else. While processing this part of the group, Child 2 verbalized the large space was the easiest, and the small space was "really hard 'cause there were a lot of people really close". During the activity "We All Stop Together", Child 2 did extremely well. He followed directions to move slowly while using the whole space, and demonstrated his ability to be aware of all others in the room; he watched those who were the "stoppers" as well as the other group members and was observing where they were moving so he did not run into them. He identified who was the "stopper" correctly approximately 90% of the time. He verbalized when he did not see who stopped the group; he watched others around him to know when to stop. When Child 2 was a "stopper" with another boy, they took turns stopping the group, without discussing it first. He appeared to like stopping the group, as well as being a mover. He verbalized it was much harder when there were 4 "stoppers", rather than only 2. Throughout "We All Stop Together", his affect was bright, and he was laughing.</p>	
Plan (what aspects of therapy should be continued, changed, etc):	
<p>Child 2 should continue to attend the special Dance/Movement Therapy groups to continue his awareness of others moving within the group, without it hindering his own movements and participation level. Future groups should also continue to encourage him to verbalize his feelings and his reactions to the group activities.</p>	
Clinician Signature:	Date:
Clinician Name:	



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 1

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #
Week 3							

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>When the student DMT went to get the boys for the group, Child 1 had received a balloon from his teacher, and asked to take it to the group with him. The student DMT said she would hold it and give it back to him at the end of the group. Prior to entering the therapy space, the group was instructed to go in and sit in a circle on the floor. Upon entering the space, Child 1 sat in the circle, but struggled to sit still. A verbal check in was done using a "feelings ball" and each child saying their name, how they were feeling today, and their favorite sport. Child 1 appeared to be ready for the ball first, and he tested the student DMT saying his favorite color, rather than following instructions. After 3-4 prompts, he finally said his favorite sport before passing the ball to another group member. The warm up, lead by the student DMT, began sitting on the floor, with the feet stretched into the center of the circle. The warm up included activities focusing on following directions, and impulse control. Child 1 and another group member were struggling to maintain positive and safe behaviors during the warm up, and asked to take a time out. The professional DMT agreed they could take a 20 second time out separately, on which she accompanied them. While still sitting, the group reached for and pressed against one another's hands. Because the circle was large and spread out, to physically connecting the entire group, the circle became smaller. The warm up move to standing and a novel "high 5" was introduced by one group member, and picked up on by the rest of the group. This high 5 made connections to people on either sides, and became more interactional and people connected with people all around the circle. Within the transition into the first activity, Child 1 disengaged from the group, and began to engage in disruptive behaviors. Although the other group members were able to ignore him, he continued to engage in the negative attention seeking behaviors. The student DMT introduced the "4 B's" to the group. Child 1 instantly complained and verbalized they "already know this stuff". The student DMT acknowledged this comment, and said he should be an expert and asked him to show her. Child 1 became defensive and stated "the pictures are on the wall in my classroom". The student DMT continued to explain the "4 B's"; when discussing the "brains", the power of self talk was brought up. Child 1 did not believe the student DMT when she explained if people tell themselves something over and over, it becomes true. When asked if she could prove it to Child 1, he declined. Instead, the other boys were willing to experience the power of self talk; each child was asked to stand up and place one arm out to the side. The student DMT used two fingers to press down on their wrist, while the student resisted her and said "I'm weak" and "I'm strong". After observing the other group members be able to resist the pressing down when saying "I'm strong", Child 1 wanted a turn. He was also able to resist the pressing down when verbalizing "I'm strong", but claimed he did not believe the student DMT and the power of self talk. The next activity was "Put on the Brakes". Each student was to sprint to a line laid on the floor, and they must stop before touching or crossing the line. The student DMT asked the boys what it felt like and how were they able to stop so quickly. The final activity was "Who's the Mirror?" The group was divided into pairs facing each other; Child 1 was paired with the student DMT. While the directions of the activity were explained, Child 1 began to wonder around the room, in and out of the closets within the room. One person in the dyad was "the mover" and the other was "the mirror". "The Mover" was instructed to move slowly and with simple movements, while "the mirror" was watching and imitating the movement they were seeing by their partner. Child 1 moved into a closet and shut the door for a longer period of time, so the rest of the group continued, and the student DMT was observing one pair of boys. Child 1 peered out of the closet sporadically, and yelled that no one wanted him in the group and the student DMT wasn't paying attention to him. With encouragement from only the student DMT, he did not come out of the closet. He asked each group member individually, and they all said they wanted him in the group. He eventually came out of the closet, and was "the mirror" while the student DMT was "the mover". He refused to switch roles. To end the group, the student DMT reviewed the "4 B's" gave each boy a hand out for the group to remember and practice them. Before leaving, two deep breaths were taken as a group. The boys transitioned back to class with no problems; 2 stopped to get a drink of water.</p>
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>Movement/Behavioral Assessment</p> <p>Before entering the therapy space, Child 1 was challenging the leadership of the student DMT with wanting to bring the balloon to the session, and this continued throughout the session. During the verbal check in, he was asked to say his favorite sport and he responded by stating his favorite color, and required multiple prompts to answer the original question posed. When Child 1's asked for a time out, it was unclear if he really needed a time out, or it was his way of avoiding the group activities and interactions, which focus on positive relationships, awareness of the self, modulation of one's preferences for movements, and experiencing and sitting with emotions. Near the end of the body warm up, while engaging in the novel high 5, Child 1 demonstrated his lack of spatial awareness of himself and others, as he freely swung his arms and twisted his body from side to side. This was acknowledged by the professional and student DMT, and Child 1 reluctantly modulated his movement so he could safely participate in the group. When Child 1 acts out negatively and is seeking attention and is ignored by the other group members, this may cause him to continue in hopes to engage one of the other boys and join Child 1 in the negative behaviors. When the other boys do not join in, Child 1 turns his negative behaviors towards the therapist to attain their full attention. If the therapists give him the attention and tell him repeatedly to stop, he regresses and whines to gain more attention. His regressive behaviors appear to seek nurturance and acceptance by the therapists. When discussing the concept and the power of self talk, it appeared to elicit deeper issues for Child 1. He verbalized he must be stupid "cause mom says I'm stupid all the time". He asked the student DMT if he was stupid, she said no, and Child 1 continued to repeat and believe he is stupid "cause mom says I'm stupid all the time." During the "Putting on the Brakes" activity, Child 1 was unable or unwilling to control his movements, and stop before the line, rather than crossing over it. After multiple attempts, Child 1 was able to stop before the line, but he still struggled to firmly plant his feet on the floor and stop his momentum, as his upper body continued to lean forward and pull him off balance. This lack of control and grounding displays Child 1's disorganization of his own body. He struggles to control himself and organize his body while moving through space. Child 1 struggled to engage in the "Who's the Mirror?" activity; this may be due to the intimacy of the face to face interaction, and the possible anxiety of seeing one's own movements reflected by someone else. He was willing to be "the mirror" but not "the mover". Child 1 also demonstrated his low self esteem and desire for acceptance by his others as he needed the affirmation of each child they wanted him in the group before he would come out of the closet to participate in the group activity.</p>
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>Child 1 should continue to attend the special group Dance/Movement therapy sessions to work on his frustration tolerance; if things do not go as he wants them to, he should remain engaged in the activity, rather than negatively acting out or engaging in regressed behaviors. Future sessions should also aid Child 1 in building his ability to tolerate face to face, non-confrontational interactions. Another goal for Child 1 is to encourage his ego development, and increase his self esteem and confidence in himself.</p>
<p>Clinician Signature:</p>
<p>Date:</p>

Clinician Name:



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 2

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #
Week 3							

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>When the student therapist went to get the boys for the special DMT group, Child 2 had been asked to get cups for his classroom, as per his teacher's request. Prior to entering the therapy space, the group was instructed to go in and sit in a circle on the floor. When Child 2 entered, he sat against the wall across from the student DMT, with encouragement, he moved into the circle. The group began with a verbal check in by passing a "feelings" ball; each child said their name, how they were feeling today, and their favorite sport. The warm up, lead by the student DMT, began sitting on the floor, with the feet stretched into the center of the circle. The warm up traveled up the body, and included activities focusing on following directions, and impulse control. Two boys were struggling to maintain positive and safe behaviors during the warm up, and asked to take a time out. The professional DMT agreed they could take a 20 second time out separately, on which she accompanied them. While still sitting, the group reached for and pressed against one another's hands. Because the circle was large and spread out, to physically connecting the entire group, the circle became smaller. The warm up moved to standing and a novel "high 5" was introduced by one group member, and picked up on by the rest of the group. This high 5 made connections to people on either sides, and became more interactional and people connected with people all around the circle. The student DMT introduced the "4 B's" to the group. When discussing the "brains", the power of self talk was brought up. To illustrate the power of self talk, each child volunteered to stand up and place one arm out to the side. The student DMT used two fingers to press down on their wrist, while the student resisted her and said "I'm weak" and "I'm strong". The next activity was "Put on the Brakes". Each child sprinted up to a designated line on the floor and was required to stop before they crossed the line. The student DMT asked each boy what it felt like and what they needed to do to stop that quickly. The next activity was "Who's the Mirror?" The group was divided into pairs facing each other; Child 2 was paired with a peer. "The Mover" was instructed to move slowly and with simple movements, while "the mirror" was watching and imitating the movement they were seeing by their partner. Child 2 was initially asked to be "the mirror", however his partner became anxious and told Child 2 he needed to be "the mover" first; Child 2 was agreeable to that. One boy was disrupting the group, running in and out of the closets in the room, and throwing himself on the floor. The rest of the group was able to ignore his behaviors and concentrate on their partner. After Child 2 and his partner each had a turn in each role, the student DMT was "the mover" and they were both "the mirrors". The child who was acting out continued to run in and out of the closet, saying no one wanted him here today and asking each child if each they wanted him in the group. Each group member said they did, however, the child continued to be resistant, but eventually came out and briefly participated. To end the group, the student DMT reviewed the "4 B's" gave each boy a hand out for the group to remember and practice them. Before leaving, two deep breaths were taken as a group. The boys transitioned back to class with no problems; 2 stopped to get a drink of water.</p>
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>Movement/Behavioral Assessment</p> <p>Today continued the pattern of Child 2 entering the therapy space and independently chose to not be a part of the circle, without being prompted to join in. He appeared to be initially resistant in participating in the group today; this may have been impacted by the unseasonably hot weather and hot school classrooms today. During the verbal check in Child 2 had a flat affect, but verbalized he was "mad and happy". Child 2 was able to control his impulses and follow directions in the warm up when asked to start and stop quick movements. While the group was disrupted by two group members needing and asking for a time out, Child 2 remained engaged in the warm up activity. Child 2 demonstrated his desire to be connected physically with the group when he was reaching as far as he could, while remaining in control of his body, to connect with the boy next to him. Due to the diameter of the circle, the boys were not able to connect initially, but Child 2 made adjustments within the circle to achieve his goal of connecting physically with everyone. The "4 B's" were a concept the group had heard in their classroom, although this was the first time they were explicitly taught and moved. Child 2 made full use of his kinesphere and expanded his arms as wide and as high as he could when leaning the "brakes" and "breathe". It was explained there was a lot of high energy and excitement and they were to grasp all of it and capture it in between their hands. The movement of "breathe" extended the arms over one's head to slowly release all the energy just captured in the hands. Child 2 fully extended his hands over his head, as well as lengthening his spine and sat up straight. When discussing how self talk is an effective way of controlling one's actions, Child 2 appeared to be skeptical initially. He was willing to test his skepticism and engaging in holding his arm out while the student DMT pressed down saying "I'm weak" or "I'm Strong". When Child 2 repeated "I'm weak", he was not able to maintain his arm extended out to the side while the student DMT pressed down, however, he demonstrated his physical and mental strength and showed no movement in his arm when he repeated "I'm strong". When he realized the impact of his self talk, his affect brightened and he maintained a bright affect, with occasional laughter. Child 2 verbalized it was difficult for him to stop short during the "Put on the Brakes" activity, but he was able to do it each time he tried. He said if he "put one foot out and straightened it" he was able to stop himself. He also verbalized he liked being "the mover" and "the mirror" in the final activity, but at times he said it was hard for him to follow the leader. If "the mover" modulated his movements, and used more sustainment and controlled movements, Child 2 said it made it easier to follow. When the student DMT was the mover and Child 2 and his partner were "the mirrors", he focused attention on her movements and made fleeting moments of eye contact with her. Overall, Child 2 is encouraging of and patient with the other group members, especially those who may be struggling to maintain their behavior in the group. He told the child who ran in and out of the closets he wanted him to come out and be a part of the group again.</p>
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>Child 2 should continue to attend the special group Dance/Movement Therapy sessions to work on experiencing and verbalizing internal sensations he may have during group activities, especially those which require controlling of impulses.</p>
<p>Clinician Signature:</p>
<p>Date:</p>

Clinician Name:



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 1

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #				
Week 4											

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>The boys were in their language arts class when the student DMT arrived. When Child 1 entered the therapy space, he sat between the professional and student DMT. The group began by the student DMT acknowledging it was the final group, and as per the group's request for the past three sessions, she may allow them to use the parachute pending their following directions throughout the group. A "feelings ball" was passed to each person for a verbal check in; each person said their name, how they were feeling today, and one thing they liked the most about the groups. There was rising tension between Child 1 and a group member across from him in the circle, the professional DMT and Child 1 traded places in the circle. The warm up, led by the student DMT, began with the feet outstretched into the center of the circle. The warm up traveled up through the body, and allowed for each child to show the group 1 "trick" they were good at (i.e. headstands or summersaults). The warm up moved to standing in a circle and reaching for the people on either side of them. If the person did not want to connect, others had to respect their wishes. As one group member reached for Child 1, he did initially did not want to touch, the other group member respected his wishes. Child 1 abruptly grabbed the group member's hand. Pressing against each other's palms was initiated by another group member, which was joined in by the rest of the group. Child 1 and the boy standing next to him began to press against one another with more intensity; what appeared to begin as playing, turned into aggression. Another group member began laugh; the student DMT addressed the laughter while the professional DMT separated the two boys pushing against one another. The group "restarted" by sitting on the floor, and the boys being asked to explain what happened. Once calm, the group stood up and held hands, moving in and out of the circle together in synchrony. Child 1 did not want to participate, and began to run around the outside and weaving in and out of the circle. He was willing to take turns with others weaving in and out of the circle; everyone who wanted a turn was able to take one. As the other children weaved in and out, Child 1 attempted to trip each child, despite multiple redirections by the student and professional DMTs. The student DMT asked the boys to sit down and review the 4 B's introduced in last week's session. When introducing the 5th B, Child 1 continued to struggle to sit still and asked to take a time out; he was allowed to sit outside for 25 seconds. The next activity was "Giving Our Weight to the Stretch Cloth". Ground rules were set for using this prop and the student Dance/Movement Therapist facilitated various activities re-familiarize the children with the prop. As the intensity of the group was high, the group began using the stretch cloth sitting on the floor. The group was "showing their muscles" as they pulled on the stretch cloth and leaned back in synchrony. Multiple images began to emerge while sitting and giving our weight to the stretch cloth. Each boy laid down in the cloth and covered themselves up. Child 1 began to invade the space of another group member, who then became frustrated with Child 1, but was able to keep himself in control. While sitting in and being supportive of one another in the stretch cloth, the activity "Guessing Games" was introduced. Each child had the opportunity to make a facial expression to display an emotion, and the group was to guess what it was. The boys earned the opportunity to use the parachute. Multiple structured therapeutic activities were done with the parachute and a small ball to focus on group movement synchrony, cooperation, turn taking, following directions, and impulse control. When the parachute was being put away, Child 1 and another group member began to wrestle over the ball. Another group member ran to hide in the closet while the two professional and student DMT attempted to separate the two boys. When all three boys were separated, the 4 B's practiced to calm down. Child 1 continued to be disruptive and was asked to leave the room. The group ended with two deep breaths and verbalization about things the boys had learned in the groups, and some things that were more difficult and should continue to be worked on. The boys returned to class with no problems.</p>
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>Movement/Behavioral Assessment</p> <p>Child 1 struggled to remain in control of himself throughout the session. He initially entered the space and did not sit in the circle, and required multiple redirections to do so. Child 1 continually asked to use the parachute, and became agitated when he was told the group had to earn the privilege of using the special prop based on their behavior in the session. Child 1 frequently vies for the individual attention of the therapists; if he does not get it from them, he seeks it from other group members. Child 1 typically targets one group member, whom he knows will become agitated with him and give Child 1 the attention he desires. The non-verbal confrontation between Child 1 and the boy across the circle is one example of this. He instigated the negative interaction, and when the other boy(s) give into his provoking, Child 1 frequently plays the victim role and seeks the nurturing attention from the therapists. When the group was demonstrating their "tricks", Child 1 joined in, and shared something he felt he was good at. Child 1's difficulty with connecting with others when it is not his idea was displayed by abruptly invading the space of the child next to him who had respected his wishes not to make a physical connection, and pressing so hard against his hand to get an aggressive reaction from the other boy. When the professional DMT asked the boys what happened, Child 1 did not take responsibility, and claimed he was doing what he was told. Child 1 chose to exclude himself from the group activity of moving in and out the circle in synchrony, and was distracting to the others. His weaving in and out of the circle was incorporated into the activity, but Child 1 appeared not to like the other boys mimicking his movements, as he continually attempted to trip them while moving around the circle. As the group was "showing their muscles" by pulling on the stretch cloth, Child 1 shared there were only 4 strong people in the group; when the student DMT corrected him and said she saw 5 strong people, Child 1 responded by saying he was weak and didn't have any muscles. The stretch cloth provides a sense of safety and containment, which the group needed due to the events early in the session today. Child 1 needed that containment to slow his movements down; he demonstrated brief periods of stillness and group cohesion while laying under the stretch cloth until he invaded the personal space of another child. During the "Guessing Games" activity, Child 1 was able to control his impulsive behaviors and pay attention to others while they took a turn creating a face; Child 1 was appeared to be very away of other's expressions, but struggled to express his emotions. He participated and created facial expressions, however, the expression and verbalization of what the expression was supposed to be did not always match. While using the parachute, Child 1 was able to control his impulsiveness, follow directions, cooperate with others, and move together in synchrony. Moving in synchrony also helps to promote group cohesion. The end of the group proved to be the hardest time for Child 1 to keep himself under control; this may be his way to express his upset about having to stop the parachute activity, as well as today being the final group and his not wanting to it to be over.</p>
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>Child 1 should attend future individual, rather than group dance/movement therapy sessions. Future goals should focus on controlling his impulses and intruding in other people's personal space. Child 1 should also work on allowing himself to not always be the center of attention, and continue to build empathy and awareness of others. Child 1 should also be encouraged to use the tools he has learned in the DMT groups, and apply them to coping with everyday life.</p>
<p>Clinician Signature: _____ Date: _____</p>
<p>Clinician Name: _____</p>



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OUTPATIENT PSYCHIATRIC CLINIC PROGRESS NOTE

CLIENT NAME: Child 2

DATE	HOURS	SESSION #	TIME	IND. THERAPY	GROUP THERAPY	TREAT PLAN	OBJECTIVE #
Week 4							

Use (D)ata (A)ssessment (P)lan format reflecting daily clinical activity, referencing individualized treatment plan

<p>Data (what happened, i.e. presenting behavior, information, interventions):</p> <p>Prior to the session, the student DMT learned Child 2 was on a "Freeze", meaning his negative behaviors were causing interferences in his following directions in class. The boys were in their language arts class when the student DMT arrived. When Child 2 entered the therapy space, he sat against the wall and needed prompting to join the group. The group began by the student DMT acknowledging it was the final group, and as per the group's request for the past three sessions, she may allow them to use the parachute pending their following directions throughout the group. A "feelings ball" was passed to each person for a verbal check in; each person said their name, how they were feeling today, and one thing they liked the most about the groups. Initially, Child 2 was sitting next to the professional DMT, however, due to rising tension between two other group members across from one another in the circle, the professional DMT and another group member traded places in the circle, causing Child 2 to move further away from the circle. The warm up, led by the student DMT, began with the feet outstretched into the center of the circle. The warm up traveled up through the body, and allowed for each child to show the group 1 "trick" they were good at (i.e. headstands or summersaults). The warm up moved to standing in a circle and reaching for the people on either side of them. If the person did not want to connect, others had to respect their wishes. Child 2 reached for another group member, who initially did not want to touch, Child 2 respected his wishes, and continued with the activity. The child who initially did not want to touch abruptly grabbed Child 2's hand. Pressing against each other's palms was initiated by another group member, which was joined in by the rest of the group. Child 2 and the boy standing next to him began to press against one another with more intensity; what appeared to begin as playing, turned into aggression. Another group member began laugh; the student DMT addressed the laughter while the professional DMT separated the two boys pushing against one another. The group "restarted" by sitting on the floor, and the boys being asked to explain what happened. Once calm, the group stood up and held hands, moving in and out of the circle together in synchrony. One child did not want to participate, and began to run around the outside and weaving in and out of the circle. This child was willing to take turns with others weaving in and out of the circle; everyone who wanted a turn was able to take one. The student DMT asked the boys to sit down and review the 4 B's introduced in last week's session. When introducing the 5th B, one child struggling to sit still and asked to take a time out. The next activity was "Giving Our Weight to the Stretch Cloth". Ground rules were set for using this prop and the student Dance/Movement Therapist facilitated various activities re-familiarize the children with the prop. As the intensity of the group was high, the group began using the stretch cloth sitting on the floor. The group was "showing their muscles" as they pulled on the stretch cloth and leaned back in synchrony. Multiple images began to emerge while sitting and giving our weight to the stretch cloth. Each boy laid down in the cloth and covered themselves up. While sitting in and being supportive of one another in the stretch cloth, the activity "Guessing Games" was introduced. Each child had the opportunity to make a facial expression to display an emotion, and the group was to guess what it was. The boys earned the opportunity to use the parachute. Multiple structured therapeutic activities were done with the parachute and a small ball to focus on group movement synchrony, cooperation, turn taking, following directions, and impulse control. When the parachute was being put away, two boys began to wrestle over the ball. Child 2 ran to hide in the closet while the two professional and student DMT attempted to separate the two boys. When all three boys were separated, the 4 B's practiced to calm down. One child continued to be disruptive and was asked to leave the room. The group ended with two deep breaths and verbalization about things the boys had learned in the groups, and some things that were more difficult and should continue to be worked on. The boys returned to class with no problems.</p>	
<p>Assessment (effectiveness of treatment, client response to interventions):</p> <p>Movement/Behavioral Assessment</p> <p>Child 2 appeared to be very upset about being on a "Freeze" today; he entered the therapy space with a flat affect and he withdrew himself from sitting within the circle. When the student DMT prompted and encouraged him to join the circle, he made eye contact with her, and complied. During the check in, Child 2 verbalized he was "excited" and he enjoyed the mirroring with a partner the most within the special DMT groups. When the professional DMT and another child traded places, Child 2 moved away from the circle and the group member. Child 2's moving away from the group member may be indicative of his upset and frustration with him as the child has displayed his difficulty controlling his impulses and negative behaviors in all three past sessions. When the pressing of palms while standing in a circle increased in intensity Child 2 was less able to control himself and refrain from giving into the negative interaction initiated by the other child. When the professional DMT intervened and separated the two boys, Child 2 was able to step back and calm down. When it was asked the boys explained what happened, Child 2 put his head down and became extremely concave in his torso. After the "restart", Child 2 was able to pull himself together and appropriately participate in the group activities. He was the only participant who remembered the 4 B's, and demonstrated the motions and verbalizations that went along with each one. His ability to recall each movement and word may indicate him thinking about and possibly practicing the 4 B's throughout the last week. The 5th B asks each participant to think of a place or time they feel calm and in a good mood. Child 2 thought of a water park; as he explained this image, he affect brightened, and he became less rigid throughout his body. During the activity "Giving Our Weight to the Stretch Cloth", Child 2 was able to follow all directions with no problems, and able to modulate his movements to match those of the group. Moving in synchrony promotes group cohesion and cooperation. The stretch cloth provides a sense of safety and containment, which the group needed due to the events early in the session today. Child 2 was successful at making and guessing the emotions displayed during the "Guessing Games" activity. This activity aided each child in expressing and interpreting feelings, as well as increasing awareness of the self and others. While using the parachute, Child 2 was able to move with the group in synchrony, and maintain his focus while exchanging places with other group members underneath the raised parachute. At the end of the session when two group members began to wrestle over the ball, Child 2 appeared to become extremely anxious and feeling unsafe as he ran and hid in the closet. He responded to encouragement and reassurance from the student DMT to come out and finish the group. Child 2 was able to end the group on a positive note; he verbalized he had learned some things during the groups, and some things came easy to him, and he could benefit from continued focus on other areas.</p>	
<p>Plan (what aspects of therapy should be continued, changed, etc):</p> <p>Child 2 should continue to attend future group dance/movement therapy sessions to work on ignoring negative behavior. He should also be encouraged to increase his self awareness and verbalize his feelings, whether they are positive or negative. Child 2 should also attend groups to focus on not perseverating on one incident during the course of the day, and allowing it to have a negative effect on the remainder of the day. Child 2 should also be encouraged to use the tools he has learned in the DMT groups, and apply them to coping with everyday life.</p>	
<p>Clinician Signature:</p>	<p>Date:</p>

Clinician Name: