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The Development of a Dance/Movement Therapy Method for Social Engagement with Adolescents in a Partial Hospital Program

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Abstract

Mental health can significantly impede navigating the social domain during adolescence. Research has indicated social development of adolescents may be impacted by psychopathology and emotional development, further hindering one's formation of self. There is also limited research showing the effectiveness of Dance/Movement Therapy (DMT) with the adolescent population. This writer designed and adapted one DMT session for adolescents to understand this topic better. This capstone will present an adaptable method utilizing a DMT intervention with participants between the ages of 13-17 in a Partial Hospital Program (PHP). This project aimed to examine how DMT can support self-identity and the acquisition of interpersonal social skills with adolescents in a PHP through movement experiences and emotional content. The participants were asked to engage in an intervention, including movement exercises, body awareness, improvisation, and emotional expression. The method aimed to bring attention to DMT's contribution to social engagement and its value and benefits. The facilitator's reflections on the group's process identified several themes that suggested the intervention had a positive effect and may benefit adolescents in a PHP setting.

Keywords: adolescence, depression, anxiety, dance/movement therapy, emotions, social engagement, identity, partial hospitalization

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"I see dance being used as communication between body and soul, to express what is too deep to find for words."

— Ruth St. Denis

Dance/Movement Therapy (DMT) is defined as "the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual" (ADTA, 2020). It is an embodied practice made of creative and improvisational movement that serves as a vehicle for self-expression and a bridge between emotion and motion for integration and healing (Payne, 2006). The current Capstone suggests the effectiveness of dance/movement therapy interventions to improve social engagement with adolescents in a partial hospitalization program (PHP). According to Pelcovitz et al., (2023), "The reasons for admissions to PHPs are typically high-risk issues, such as suicidal ideation, suicide attempts, non-suicidal self-injury, or severe behavioral programs" (p. 106). Moreover, research has found that the relationship between anxiety and depression in youth is multi-faceted and "global deficits in affect regulation, distress tolerance and/or behavioral activation put youths at risk" for both (Trosper et al., 2009 as cited in Pelcovitz et al., 2023, p. 107).

Many research studies have revealed a strong relationship between proper social functioning and social, academic, and psychological adjustment in childhood, adolescence, and adulthood (Rosa et al., 2022, as cited in Serrano-Pintado et al., 2022). Social skills deficits have been linked to an "increased risk of behavioral problems in interpersonal relationships, difficulties in psychological well-being, academic performance, and a greater likelihood of disruptive

behaviors" (Carmona & Lòpez, 2015; Armada Crespo et al., 2020; Shinde et al., 2020 as cited in Serrano-Pintado et al., 2022, p. 2). Thus, the featured dance/movement therapy intervention will focus on two themes: identity and the development of the use of self and interpersonal social skills to support the adolescent relational dimension and transition to adulthood using a non-verbal, body-oriented approach. Self-awareness, body language, emotional regulation, and empathy are the social skills that will be featured in this capstone as highlighted through DMT concepts. This writer aims to implement DMT to foster an adaptive skill set to help adolescents navigate their social domain and strengthen intrapersonal functioning.

Social engagement "refers to the extent to which adolescents are motivated to interact with others and value their interpersonal relationships" (Wang and Hofkens, 2019, as cited in Scanlon et al., 2020, pp. 1007-1008). The efficacy of creative art therapies, including music, visual art, dance, drama, and expressive writing, is evidenced by growing research demonstrating psychosocial improvements and relational health (Chiang et al., 2019). According to Bolton Oetzel & Scherer (2003), adolescents engage better in psychotherapy with therapists who adopt a positive and direct approach, are empathetic, acknowledge the client's competence, and are confident in the therapeutic process. Through DMT and the expressive arts, adolescents can have a creative outlet individually and collectively to bring awareness to their challenges and those of their peers (Beardall, 2017). Therefore, it is possible that DMT adjacent to talk therapy can strengthen the therapeutic experience, promote social engagement, decrease mood-related symptoms, and reinforce the therapeutic process.

Keeping in mind that adolescence is a time of physical and cognitive growth and social-emotional development, this facilitator created a method incorporating dance/movement therapy for adolescents between the ages of 13-17 in a Partial Hospital Program. This method serves to

understand how DMT can enhance the social engagement of adolescents, in particular those who struggle with depression, anxiety, or other mood-related symptoms. When working with the adolescent population at the Partial Hospital Program, traditional talk therapy is the primary approach offered that draws upon aspects of cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), and acceptance and commitment therapy (ACT). This facilitator's goal was to apply a body-oriented approach and assess the client's social engagement. In thinking about the importance of the body, Halprin (1999) emphasized, "Movement is an agent of change in the physical body which also has the ability to change moods, to channel emotional responses and to shape our ways of thinking about ourselves, others and the world in which we live" (p. 137). This emphasis will highlight the implementation of dance/movement therapy, determine the effectiveness of the approach, and possibly promote the social engagement systems of adolescents in treatment.

Literature Review

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

Partial Hospital Programming

Partial hospitalization programs (PHP) are a less intensive yet robust clinical treatment experience for those struggling with acute symptoms. Khawaja & Westermeyer (2010) define PHP as providing crisis-oriented and recovery-based treatment, including medication management, skills classes, and group psychotherapy. PHP is the midpoint between outpatient therapy and inpatient hospitalization and can offer an individual a smooth transition back to the

outside community. A 2014 study evaluating the efficacy of a PHP for adolescents among 35 participants with mood disorder symptoms found decreased symptom severity and increased relational health over six weeks (Lenz et al., 2014). PHP is primarily group-based, which fosters social connection and a sense of community. The Lenz et al. (2014) study showed significantly greater perceptions of relational health with peers and an increased sense of relational authenticity, empowerment, and engagement with meaningful peers and mentors after the program. These results suggest that while in a program, relationships are formed and developed over time as peers socialize, interact, and engage appropriately.

Similarly, a study in 2016 measured treatment outcomes for adolescents at a PHP receiving dialectic behavioral therapy (DBT) for depression and anxiety symptoms and found that the 66 participants reported a more significant gain in their emotion regulation and interpersonal effectiveness over seven weeks (Lenz et al., 2016). Brown (1999) states that adolescents in the residential setting will perceive their peers as more accepting and relatable than their usual peer group and develop strong connections with each other during admission through acknowledgement of ‘they have problems like me’ and ‘they understand me.’ Further, residential settings can give those adolescents who are socially isolated at home and preoccupied with family and personal responsibilities a sense of acceptance and belonging (Brown, 1999). Considering how this relational health aspect is valuable to one’s psychosocial functioning after discharge is essential.

Adolescence

Adolescence is a developmental stage marked by significant biopsychosocial changes as one evolves from childhood. It is important to acknowledge that the following developmental tasks and stages are culturally bound, and these mentioned theorists are speaking within

dominant US norms. According to Christie & Viner (2005), developmental tasks of adolescence include puberty, new cognitive skills (e.g., abstract thinking), clarity in the sense of personal and sexual identity, and emotional, personal, and financial autonomy. Jaworska and MacQueen (2015) describe this developmental stage as associated with increased risk-taking behaviors and emotional reactivity in light of social and environmental changes. Further, behavioral changes result from developmental changes influenced by external and internal factors that bring about and reinforce behaviors (Jaworska & MacQueen, 2015). Individuals are exercising their independence and exploring a more profound sense of self while simultaneously responding to changes in their external environments. Consequently, there is crossover between the physical, psychological, and social changes during this period that lay the pathway toward adulthood.

Identity Formation

Marcia (1980) defines *identity* in adolescence as a process where individuals make sense of their childhood identifications through physical development, cognitive skills, and social expectations as a working foundation toward adulthood. The development of the self is another integral part of adolescence because individuals will come to know themselves, adapt, respond, and interact with others in the social world. One's sense of self may be informed by many variables and become flexible over time. According to Auerbach & Blatt (1996), "The construction of a self-representation requires reflexive self-awareness – the ability as a subject to reflect on oneself as an object" (p. 298) and harmonize subjective and objective perspectives on the self. Self-identity is significant, for it can be rooted in self-esteem and emotional self-regulation and help shape one's sense of belonging. In support of this, Tsang et al. (2021) discuss how achieving a positive identity can lead to more healthy and sustainable developmental outcomes for the adolescent. As adolescents begin to interact with their social environments,

their self-identity may be challenged. Crowds, for example, are made of a large body of peers defined by reputations and stereotypes that contribute to identity development in early adolescence and can affect self-esteem (Steinberg & Morris, 2001).

Erikson's (1968) theory of the adolescent identity crisis suggests adolescence as a time of self-exploration (Steinberg & Morris, 2001). As adolescents identify themselves, they waver between various perceptions of self, such as the idealized self and subjective self, and how others perceive them, which can also be associated with emotional and behavioral problems (Tsang et al., 2012). From early youth to middle adolescence, individuals form a "more consonant" view of themselves (Harter & Monsour, 1992, as cited in Steinberg & Morris, 2001, p. 91). Other literature has found that young individuals view themselves differently when with peers than parents and teachers (Harter et al., 1998, as cited in Steinberg & Morris, 2001) and come to define others in relation to themselves (Christie & Viner, 2005). Hence, adolescents assess themselves globally through academic, athletic, social, and personal means, emphasizing that so much identity development happens in relationships. Considering the implications of this constant evaluation of self and high susceptibility to social pressure in adolescent identity development is necessary, as well as how social development and identity formation are interdependent such as the role of social support.

Social Development

Learning how adolescents navigate their social domain begins with understanding how their social brain develops. The social brain is defined as the network of brain regions that help us understand others (Blakemore, 2008). Adolescence is characterized by a time of social change, which includes an increase in self-consciousness, complexity of peer relationships, and an improved understanding of others (Blakemore, 2008). Teenagers are experiencing an influx of

hormones due to puberty and changes in their social settings, which may further influence their social development. The literature demonstrates how rapid changes in social behavior during this stage result from functional changes in the adolescent brain, evidenced by a decrease in prefrontal activity on social-cognition tasks such as face recognition and mental-state attribution and structural development including synaptic reorganization (Blakemore, 2008).

According to Jaworska & MacQueen (2015), these behaviors are in the context of novelty seeking, peer interactions, consummatory, and hedonic. Christie & Viner (2005) explain that while abstract thinking progresses in this stage, the adolescent creates an awareness of outcomes for others but forms a belief in "personal invulnerability – being 'bulletproof'" (p. 303). Nevertheless, Jaworska & MacQueen (2015) discuss how controlling impulses and delaying the gratification of goal-directed and optimized outcomes and behaviors is a central and defining cognitive feature. Data has proven behavior to be biased in motivationally charged contexts, and that sensitivity to rewards takes shape during this stage (Jaworska & MacQueen, 2015). The arts can be useful in addressing the suspension of gratification by consideration of others and self in relation to others. As the literature supports, adolescence is a time of significant cognitive improvement; however, as teens begin to engage more in their social environments, it is essential to consider how psychosocial factors and emotional development contribute to mental health.

Emotions & Mental Health

It is important to acknowledge that the following literature explains emotional development in adolescence within dominant US norms. In early childhood, the child possesses the six primary emotions within the first year before more complex emotions emerge later (Rosenblum & Lewis, 2003). It is within the second birth year that conscious self-awareness emerges, made up of evaluative (e.g., shame, pride, and guilt) and non-evaluative

(embarrassment, envy, and empathy) parts that informs behavior and skill development (Lewis, 1992, as cited in Rosenblum & Lewis, 2003, p. 271). Further, children develop emotional competence, including regulation/coping, expressive behavior, and relationship-building skills (Rosenblum & Lewis, 2003). It is during adolescence that individuals articulate emotional expression can be opposite of what is internally felt (Harris & Gross, 1988, as cited in Rosenblum & Lewis, 2003). Yet as individuals reach the end of middle childhood, there is a wide array of influences that can impact adolescent emotional life.

In adolescents, cognitive capacities enhance. For example, abstract thinking, reflecting on the past, and anticipating the future can elicit emotions, and emotional responses amplify in examining the self, understanding others, and being in relationships based on personality traits (Rosenblum & Lewis, 2003). Research has also found emotional changes such as mood variability and effects on body image to be associated with hormonal fluctuations but can also coincide with life stressors (Rosenblum & Lewis, 2003). Stressors such as a new school transition, social pressure to be sexually active, or date can further strain the emotional experience for the adolescent (Rosenblum & Lewis, 2003). The coping skills developed in childhood may not benefit these newfound stressors requiring the adolescent to build ones that complement adaptation to new social environments.

According to Merikangas et al. (2022), research has shown mental health disorders to begin in childhood and adolescence, and there is a high risk in adolescence for the onset of major depression, eating disorders, substance use disorders, and anxiety disorders (McLaughlin et al., 2015). Moreover, the risk for psychopathology results from varying emotional antecedents such as exposure to stressful life events, adversity, increased stress associated with daily responsibilities, changes in social dynamics and interpersonal relationships, conflicts with

family, and academic performance (McLaughlin et al., 2015). Other risks include heightened emotional and physiological reactivity and increased emotional lability (McLaughlin et al., 2015). Developing adaptive emotional regulation strategies can help manage distress tolerance and promote resilience (McLaughlin et al., 2015). Other literature demonstrates the role of positive and negative emotional regulation abilities in relation to depressive and anxiety symptoms, highlighting the implications of maladaptive emotional regulation capacities (Young et al., 2019). Of note, the development of one's self-regulation may be inhibited by cultural factors and access to resources (Young et al., 2019).

Mental health disorders can vastly disrupt one's ability to socially engage and build connection with others. For example, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; DSM-5; American Psychiatric Association, 2013) characterizes social anxiety disorder (SAD) as an intense fear of social situations and judgment from others over the way one acts or behaves inhibiting the ability to function due to persistent avoidance and distress. The DSM-5 has found that the onset age of this disorder is between 8 and 15 for 75% of individuals (American Psychiatric Association, 2013). This significant fear can lead to social impairment for an adolescent, further causing functional consequences that disrupt academic, athletic, or employment performance. Other literature supports this as evidenced by negative peer relations at school, rejection sensitivity, fewer friendships, less close relationships, and decreased social support and acceptance from classmates (Ginsburg, La Greca & Lopez, 1998, as cited in Kashdan & Herbert, 2001).

Another common mental health problem in adolescents is depression and "depressive disorders have been found to be the common cause of risk behaviors leading to a referral of youth to higher levels of care" (Gould et al., 2003; Hallfors et al., 2004; Shaffer et al., 1996 as

cited in Pelcovitz et al., 2023, p. 107). Thapar et al., (2012) characterize depression as a cluster of symptoms that lead to social and educational impairments, an increased rate of substance use, and obesity. Further, depression in adolescents' places those at high risk for suicide, urging it is "the second-to-third leading cause of death in this age group, with more than half of adolescent suicide victims reported to have a depressive disorder at time of death" (Thapar et al., 2012, p. 1). Those who have depression during adolescence are at an increased susceptibility of mental health disorders, suicidal behavior, unemployment, and physical health problems in adulthood (Thapar et al., 2023). This information is both helpful and urgent in preventing and treating adolescents with this diagnosis.

Dating, sexual health, and having a partner may also be impacted by mental health illness and how individuals can develop healthy and supportive relationships. Gowen (2011) discusses having a mental health condition can delay the progress of intimate relationships, stating that research had found individuals found it easier to pursue and maintain romantic relationships when their symptoms were well-managed and that when this was not the case, a relationship was reported as an additional stressor. Moreover, mental health conditions, such as borderline personality disorder (BPD), "are associated with impulsivity, poor decision-making, and unstable, intense interpersonal relationships," which can affect sexual behaviors and partner choice (Gowen, 2011, p. 16).

According to Troop-Gordon et al., (2021), "Over the course of development, peer stress impedes maturation of self-regulation systems, contributing to worsening mental health, which manifest in behaviors that exacerbate peer difficulties" (p. 9). It has been found that peer relationships and children's psychological well-being are inextricably connected, with a substantial number of children diagnosed with mental health challenges also reporting a range of

social problems (Troop-Gordon et al., 2021). Consequently, research has found that having relational needs met is considered vital for healthy development and peers are a primary source of that relational need fulfillment throughout the lifespan (Ryan & Deci, 2000; Sherman et al., 2000 as cited in Troop-Gordon et al., 2021).

Social Engagement

As teenagers begin to practice more autonomy away from their parents and spend more time with their peers, it can be challenging to navigate the social domain as one manages both internal and external influences; however, this relationship with parents can be a predicting contributor to peer interactions. Studies have found that authoritative parenting and healthy, supportive families promote increased social competence, positive friendships, and less negative peer influences (Steinberg & Morris, 2001). Influence from peers can enhance (e.g., prosocial behavior) or disrupt (e.g., substance use) adolescent development. It has been found that adolescents "choose friends with similar behaviors, attitudes, and identities" (Akers et al., 1998; Hogue & Steinberg, 1995, as cited in Steinberg & Morris, 2001, p. 93). Nevertheless, adolescents are also at risk of peer rejection and victimization. For example, rejected adolescents are often aggressive, irritable, withdrawn, anxious, socially awkward, have low self-esteem, and suffer from depression (Rubin et al., 1995, as cited in Steinberg & Morris, 2001). The effects of this may be harmful, so access to resources such as family support and therapy and development of social-emotional skills could be beneficial.

Social-emotional learning in adolescent development is imperative to understanding how to engage in socially and culturally appropriate ways. According to Serrano-Pintado et al., (2022), social skills are a set of interpersonal behaviors that enable one to interact and relate effectively with others, such as responsibility, active listening, empathy, and verbal and non-

verbal communication. Since social functioning is multi-faceted, having these skills are essential. Research has found that adolescents with strong social skills have self-awareness and social awareness and can monitor their own behavior (Konold et al., 2010, as cited in Bergeron et al., 2013). Consequently, poor social skills can manifest into feelings of loneliness and depression, external acting-out behaviors, increased isolation, inappropriate behavior, and hostility (Bergeron et al., 2013). These behaviors may be further exacerbated by bullying and social sensitivity.

According to Somerville (2013), social sensitivity is referred to as "a shifting motivation toward social relatedness is thought to intensify the attention, salience, and emotion relegated to processing information concerning social evaluations and social standing" (p. 121). Manifestations of social sensitivity can include increased emotionally reactivity to explicit cues of social inclusion or exclusion, more attunement to instances of real or perceived social evaluation, and greater preoccupation with what others are thinking and feeling (Somerville, 2013). For adolescents, there is an increased sense of vigilance to social evaluation, which can in turn bring on self-consciousness, pre-disposed anxiety and inform behavior changes. For example, research has shown adolescents engage in false self-behavior when among classmates and with a romantic partner either to mask their feelings of insecurity of their true self from mental health issues or to please others (Harter et al., 1996, as cited in Steinberg & Morris, 2001). Thus, fear of being socially rejected can be as harmful as much as social exclusion.

It has been found that social exclusion can cause high risk for mood and anxiety disorders (Lev-Wiesel et al., 2006, as cited in Somerville, 2013, p. 125). A recent study examined the frequency and severity of anxiety disorders among a sample of 158 adolescent PHP patients and found 75% of participants were diagnosed with an anxiety disorder (Pelcovitz et al., 2023). As stated before, social anxiety impedes the development of prosocial skills, acquisition of peer

relationships, and results in academic underachievement (Scanlon et al., 2020). A recent study examined the role of peer social support and social engagement in relation between adolescents' social anxiety and science achievement (Scanlon et al., 2020). Data found that socially anxious adolescents reported lower social engagement which led to decreased science performance and experienced less peer social support (Scanlon et al., 2020). Another study in 2021 looked at the influence of personal and extracurricular variables on socio-emotional skills in adolescence and found those that were a part of after-school activities scored higher on social awareness and artistic and musical extracurricular activities were associated with social-emotional skills (Portela-Pino et al., 2021).

Interpersonal Social Skills

A 2007 study examined the association between social skills and psychological well-being among a sample of 703 adults and found that social skills were positively correlated with all indicators of psychological well-being (i.e., life satisfaction, happiness) and positive interpersonal relationships (Segrin & Taylor, 2007). *Empathy* is a social skill that is defined as "the ability to share and understand others' thoughts and feelings" and is essential for promoting positive behaviors and facilitating social interactions with others (Eisenberg & Fabes, 1990; Hoffman, 2000 as cited in Allemand et al., 2014, p. 229). *Self-awareness* refers to knowing one's authentic self, the capacity for self-examination, ability to recognize oneself as separate from the environment and others (Kalaiyarasan & Solomon, 2016). For adolescents, self-awareness enables conscious knowledge of one's bodily and mental status changes, societal standards, and norms, how to live in social harmony, and focus attention as observant of self on the environment and inwards towards the self (Kalaiyarasan & Solomon, 2016).

Sonneborn (2012) defines *body language* as a form of non-verbal communication that conveys feelings, emotions, and attitudes and "plays a substantial role in any conversation" (p. 11). According to Phutela (2015), non-verbal communication regulates relationships, and "the quality of these relationships can be improved if you can skillfully read people and understand the emotions behind their words" (p. 45). Similarly, Young et al. (2015) define *emotional regulation* as the capacity to manage one's emotional responses, which includes strategies "to increase, maintain, or decrease the intensity, duration, and trajectory of positive and negative emotions" and enables flexibility in emotionally evocative situations (p. 1). Consequently, research has found that disruptions to emotional regulation can lead to an increased risk of anxiety and depression for youth (Young et al., 2015). It is essential to consider how DMT can support acquiring such skills.

DMT

According to the ADTA, DMT is a "holistic approach to healing, based on the empirically supported assertion that mind, body, and spirit are inseparable and interconnected; changes in the body reflect changes in the mind and vice versa" (ADTA, 2020). Moreover, in DMT, "Emotional content related to the mind-body experience is processed via the body and through movement that takes place within a safe environment" (Engelhard, 2014, p. 498). Former educator and pioneer of the field, Marian Chace, described the role of the dance/movement therapist as "an active one that requires a responsiveness to movement communication that the other has to offer" and through this reciprocal process enables a dialog (Chaiklin, 2017, pp. 144-145). DMT "has been developed as a healing practice through the use of movement and dance as a medium for enabling communication, assessing where it is blocked, and intervening on nonverbal and verbal levels (Koch & Fischman, 2011, pp. 60-61). DMT, as

an alternative form of psychotherapy, is made up of fundamental core concepts that are related to identity and the interpersonal skills of focus.

Kinesthetic Empathy

Kinesthetic empathy is described as "a 'recreation of the clients' bodily movements in the therapist's body, which enables the therapist to sense and respond to the client's emotional state" (Dosamantes 1992: 360, as cited in Federman, 2011). This can be exercised through mirroring, which involves imitating qualities of movement to enhance emotional understanding (Adler, 1970; Berrol, 2006; Mills & Daniluk, 2002, as cited in McGarry & Russo, 2011). Rhythm is another key element to DMT that reinforces social relationships. Marian Chace stated that a therapeutic movement relationship (TMR) is formed through attunement, witnessing, and mirroring the client's rhythmic movements (Young, 2017). Chace believed that the non-verbal rhythmicity within the TMR fostered acceptance and communication (Young, 2017).

Rhythmicity

Cruz (2018) describes rhythm as "a biologically intrinsic part of human physiology," stating that "rhythms we hear prime our bodies to move and provide timing for our movements" (p. 145). Through DMT, rhythms are created within the body, and music is used to help expand a client's movement repertoire and treatment goals (Cruz, 2018). There is a process known as entrainment, which refers to the connection between the auditory system and motor structures that elicits movement responses (Thaut & Abiru, 2010, as cited in Cruz, 2018). Cruz (2018) suggests that our neurological "wiring" for rhythm and movement entrainment is a natural tool for neurological resilience (p. 145). When pathologies disrupt motor functioning, it can help be restored by using rhythm and movement in DMT. In addition, greater awareness of internal and

external rhythms can promote interpersonal and intrapersonal understanding. According to Chaiklin (2017), “Movement acts as the bridge between the inner experiences and the outer world” (p. 145), and it was through Chace’s work that individuals who had challenges reaching out to others were able to receive validation and often through moving together in a rhythmic way.

Body Identity

DMT approaches identity development from a somatic lens. Pass Erickson (2021) defines *body identity* as “a present moment phenomenon of feeling and moving that results from both one’s physical form and lived experiences; experiences act as input, and the body generates output in the form of narratives and movements” (p. 205). The mind-body connection is brought on by internal and external sensory information and linked to behavior as a motor response (Caldwell, 2014; Cohen, 1993, as cited in Pass Erickson, 2021). Interoceptive awareness is the internal sense of self and experience of the body and a basic form of self-awareness and self-knowledge (Damasio, 1999; Manos & Critchley, 2016, as cited in Pass Erickson, 2021). Consequently, Pass Erickson (2021) proposes an Embodied Identity Development Model that supports how identity is formed and expressed through overlapping cycles of sensing and moving.

Embodiment

"Embodiment refers to bodily phenomena in which the body as a living organism, body movement, and person-environment interaction play central roles in the explanation of perception, cognition, affect, attitudes, behavior, and their interrelations" (Koch, 2006, as cited in Koch & Fischman, 2011, p. 60). "The embodied perspective – by unifying body and mind,

perception and action, creativity and recognition, cognition, and emotion – reminds us that our existence is related to our own way of experiencing" and highlights that we are our own agents of change (Koch & Fischman, 2011, p. 66). Further, the psychotherapeutic facets of DMT facilitate development by allowing the unfolding of each individual's way of relating, qualities of the self, creating new ways of being with another, and much more (Koch & Fischman, 2011).

In the early 2000s, dance/movement therapist Rena Kornblum created an anti-violence curriculum focusing on movement and pro-social skills for elementary school students (Kornblum & McCutchan, 2002). The curriculum was to be offered weekly over twelve to fifteen weeks by classroom teachers and made to be applicable to all ages. One of Kornblum's work is *Disarming the Playground*, which highlights that violence prevention requires an integration of the mind and body (Kornblum & McCutchan, 2002). Body skills include assertion, energy modulation, anger management, body awareness, relaxation, and empathy (Kornblum & McCutch 2002). One of her techniques, called the 4 Bs of self-settling include brakes, breathing, brain, and body (Kornblum, 2002). Kornblum also describes being in synchrony while moving with others and having spatial boundaries be respected as other body-level skills that foster peaceful interactions (Kornblum & McCutchan, 2002). Thus, this curriculum uses the body and mind in equal partnership to develop the essential skills for creating safe environments.

Similarly, somatic movement educator/therapist Susan Bauer is notably known for her work *The Embodied Teen*, a somatic curriculum for teaching body-mind awareness, kinesthetic intelligence, and social and emotional skills to support adolescent development (Bauer, 2018). Bauer posits that a somatic approach to kinesthetic learning enables the mind to receive feedback from the body, which activates a back-and-forth dialogue (Bauer, 2018). In a recent review, DMT's Beardall and Furcron noted that Bauer's curriculum is adaptable to DMT in that she

highlighted four transferable approaches: body awareness, structured movement interventions, movement explorations, and touch (Beardall & Furcron, 2019). The article supports that somatic education and DMT guide adolescents in their body and movement awareness and promote the expression of thoughts and feelings via experiential and movement-based activities (Beardall & Furcron, 2019). It was further mentioned that social engagement can grow from the relational connections and social-emotional skills learned while working in groups (Beardall & Furcron, 2019).

Nancy Beardall's work focused on DMT and development utilizing dance/movement and the expressive arts in public schools serving students K-12. According to Beardall (2017), the term embodied knowing is "an inner knowing or body sense that you know more than you can tell" (pp. 459-460). Through her work, she developed the Spiral Integrated Learning Process, a multidimensional learning approach to embodied knowing and embodied response in adolescents (Beardall, 2017). This process aims to offer "experiences for the students to move, sense, create, witness, and dialogue as they become more mindful and empathic, assisting them to embody and transfer their knowledge into action" (Beardall, 2017, p. 464). Further, the process fosters more group cohesion as students support their well-being and peers (Beardall, 2017). One of the works featured in 2005, entitled *Creating a Peaceable School: Confronting Intolerance and Bullying*, was a program for sixth graders to promote respect for differences (Beardall, 2017). The goals of the course were to "promote respect for cultural differences, present guidelines around anti-bullying behavior, and to illustrate the role of the witness and active bystander" through interactive experiences utilizing dance and the expressive arts, designed to help students navigate relationships and build community (Beardall, 2017, p. 469).

DMT and other expressive art therapy modalities have made their way into hospitals and residential settings to support the individual's treatment and healing journey. A 2007 study examined the effects of a dance intervention on the decrease of depression and the increase of vitality and positive affect in 31 patients in a psychiatric hospital carrying a depression diagnosis and found those that participated in the dance group, which included an upbeat, stimulating circle dance, showed significantly less depression (Koch et al., 2007). Another clinical case example included a DMT group with adolescents in a residential setting who were observed as having an increase in engagement and interaction (Brown, 1999). Similarly, research from a 2014 study of 402 adolescents in a psychiatric therapeutic program who participated in a DMT group showed a significant increase in mood states (Anderson et al., 2014). DMT can thus be a beneficial and enriching experience for oneself and a group both in the academic and psychiatric environment.

Methods

The following intervention explored the effects of dance/movement therapy on social engagement with the adolescent population in a partial hospital program through the method below. Of note, group dynamics within a PHP setting change daily as individuals are newly admitted and discharged daily. Individuals may admit to the program as a self-referral, referral from their outpatient treatment team, or as a step down from an inpatient admission. Those joining partial from an inpatient admission may recognize other peers who also completed an inpatient admission during the same time as them. Some of these peers could have been former roommates; therefore, individuals may already have formed a connection and are encouraged to be mindful of this before transitioning to the group space during the intake process. For some peers, it is their first time presenting to this level of care; for others, it may be their second or third. Lastly, program participants are often assigned to a room based on age and developmental

level. Peers who are too enmeshed will be separated so that they can prioritize their own treatment.

Participants

Participants in this capstone presented with a history of depression, anxiety, attention-deficit/hyperactivity disorder (ADHD), disordered eating, autism spectrum disorder (ASD), school refusal, post-traumatic stress disorder (PTSD), aggressive or threatening behavior, substance use, and suicidal ideation. The session included eight participants between the ages of 13-17. Six of the eight participants self-identified as female, and two as male. Six participants' racial identity was White, and two participants' racial identity was African American. All participants spoke English as their primary language. Two participants out of the eight had been newly admitted to the program the day the intervention was offered. All participants were either self-referred or referred by an outpatient provider.

Intervention

The dance/movement therapy intervention was offered in the larger group room of the two on the adolescent partial hospital program unit. The session lasted 45 minutes and consisted of a warmup, theme development, and closure. Participants were brought together during the warmup by engaging in a self-identification exercise using an assorted array of greeting cards. The creativity and imagination allowed participants the freedom to have fun and settle in comfortably. Throughout the theme development, participants learned how to self-soothe using the body, engaged in mirroring and rhythmicity, and explored a wide array of emotions and emotional expression through body awareness and body language. The closure included wrapping up by attuning with others to create a movement sequence. The session referred to

Rena Kornblum's 4 Bs of self-settling, Marian Chace's mirroring and rhythmic action, and Nancy Beardall's embodied knowing.

Materials

The intervention included developmentally age-appropriate activities for adolescents to apply in various social environments. The components consisted of index cards, pens, and assorted greeting cards.

Procedure

The intervention consisted of five goals: expand the range and expression of movement and emotional repertoire; enhance the connection between self and others; increase socialization with others; increase body awareness and identify how emotions live within/affect the body; and promote self-expression and voice.

The intervention began with the three-part DMT session, which included the warmup, theme development, and closure. Participants were invited to define DMT in their own words before receiving psychoeducation on its definition and benefits. Group members began by being invited to gather in a circle and state their name, pronouns, and one current emotion. Then, participants were asked to choose from an arrangement of assorted greeting cards. The warmup was ten minutes in duration. Each greeting card had an image of an object, item, or landscape. The prompt was to have each person identify with the image on the card using 'I am' statements (e.g., "I am the tree because I am strong"). The purpose of this exercise was to foster self-reflection and promote ownership of their identity.

Once everyone shared, the facilitator began the 25-minute theme development by introducing the 4 B's (Kornblum, 2002) and had participants mirror along. Next, there were two

piles of index cards, one that listed various emotions and one that listed parts of the body on the floor at the center of the circle. Group members took turns drawing one card from each pile and performed the drawn emotion using the drawn part of the body (e.g., Move your foot as if it was sad). Group members were asked to mirror the movement continuously, so it became rhythmic. The facilitator prompted the participants to think about how the drawn emotion usually affects or lives within their body. This writer asked the group members questions that sounded like "Where do you usually feel sadness in your body?"**,** "How can you notice that someone else is sad without them saying anything?" and "How may you walk around the room if you were happy?"

In the second half of the directive, participants were asked by the facilitator to think about one emotion that they felt during the day and one small movement/gesture that they might do when feeling this emotion. Two group members who voluntarily chose to share practiced amplifying their movement with the group, and two group members practiced shortening their movement with the group. One group member started by sharing their movement and then going around in a circle; the following group member would make that movement more and more exaggerated, with the last person in the circle performing the movement as amplified as possible. This was then repeated only by making the movement small and subtle instead. The sequence was shortening, amplifying, shortening, amplifying. The facilitator then revisited the 4 B's (Kornblum, 2002), had group members follow along, and asked participants to state a feeling/emotion afterward to express any changes that had come up. This directive aimed to promote self-expression and find voice through movement utilizing body language to communicate non-verbally.

The facilitator asked participants to think of one movement/gesture to close. One member started by performing their movement, and the next participant mirrored them and added a

movement of their own. With each participant, a movement sequence was formed. Two movement sequences were made in total, switching from clockwise to counterclockwise. Upon completion, participants ended with stretching and stating a current feeling/emotion. The closing sought to encourage witnessing, synchrony, and independence as well as was success-orientated.

Data Collection

Unstructured data was collected and recorded to document the adolescents' emotions before and after the intervention was implemented. The facilitator's observations, adolescents' engagement and responses were also documented. After the session, the participants were invited to state an emotion and later welcomed to report on any highlights from their experience.

Results

The DMT intervention was completed in an effort to improve social engagement and group cohesion with adolescents. Observations and client comments were written and collected.

Observations

The facilitator's observations of each adolescent's behavior throughout the group were closely analyzed. Overall, the group had significant participation and included eight participants, except for two who left briefly to meet with their doctor. Their initial check-ins indicated feeling sad, anxious, or neutral, and participants shouted out words such as "music," "peaceful," and "healing" when describing their definition of DMT. The more engaged participants used movements with a greater range of motion, active body parts, and clear focus. Some of the less engaged presented with more sustained, subtle movements. Those that were less engaged demonstrated downward focus, retreating, and bound movements. Some of these participants commented, "Do I have to do this?" and "I do not know what that would look like."

During the warm-up, each participant was able to identify with the chosen card and the observed themes of the responses pertained to personal attributes, use of I statements and where participants place themselves in their treatment journey. Some participants were observed as eagerly raising their hand to share next and others remained quiet unless being called on. Upon inviting the group to standing the facilitator noticed some nerves amongst the members as evidenced by fidgeting and waning eye contact. During the directive, the facilitator decided to have the group identify a collective feeling to associate with the 4 B's. Two people expressed struggling with anxiety and the other participants were observed as nodding their head in agreement. Upon getting to the Brain part of the 4 B's, the facilitator challenged the participants to identify calming statements they've tried saying to themselves. Some participants stated, "I like to tell myself cheesy quotes" and "You can do hard things."

When it came time for participants to perform a movement in reference to the chosen emotions card and body part card, some peers were observed as feeling stuck and confused demonstrated by one participant who said, "I don't think my eyebrow changes if it is calm." One participant who happened to choose anger and hands as his cards stated, "This is easy, I do MMA fighting." He was invited by the facilitator to demonstrate his MMA stance and had the group mirror his jab punching using his fists. Group participants responded well to the questions that enabled thinking about how someone is feeling a certain way without them saying anything and locate where emotions live within their body. An open discussion emerged as members shared "You can tell if someone is anxious if they're pacing" and "Yeah or fidgeting with something." One member shared "When I'm angry I feel it in my shoulders" and another member said, "I feel a tightness in my chest." Group members were observed as making eye contact with one another, increased nodding and raising of hands to go next.

As the group moved into the activity on amplifying and reducing emotions, members were observed as being stumped on how to exaggerate and shorten their movement. One participant shared “When I’m really happy I smile, but I’m wearing this mask” and other members nodded. Another member stated she felt calm that day and her gesture was remaining idle in vertical position. Other participants were observed as not knowing how to shorten that movement as evidenced by shrugging their shoulders and asking, “What do you mean?” Lastly, when the facilitator reintroduced the 4 B’s, the group decided on another collective feeling as anger. One member demonstrated how they experience anger as stomping feet. Next, the participants began to stomp with intention and strong energy.

During the closing was when the group was observed as having the most cohesion. Members were observed as smiling, laughing and being silly while coming up with various movements. As each member went around in the circle, the other participants were helping each other remember the movement sequence by either verbally telling them or physically demonstrating it. Some participants were observed as being reluctant to do certain movements as evidenced by wide eyes and shaking their head. One participant stated, “This is cool.” Another participant asked, “Can we come up with another one?” All participants, even the ones who were at first less engaged maintained better eye contact and raised posture. During closing check-in, five participants indicated feeling better, lighter. Two participants shared feeling neutral and one participant indicated still feeling anxious.

Participant Feedback

At the end of the session, the participants were asked about their overall experience. Some participants were observed as holding their thumbs up; others stated, “I liked it” and “It was fun.” Some participants mentioned they were reluctant initially but less anxious towards the

end. The clients enjoyed the warm-up, the 4 B's, and the movement sequence. One participant stated, "I like to get up and move, so I enjoyed that part." Another participant shared, "I liked that it was guided, and you gave us examples." One participant shared, "The cards helped; the image gave me a source to use as a metaphor that resonates with what is going on in my life." Another participant agreed that describing the metaphor was an easy way to express their feelings. One participant shared that they preferred to see the pile of body part cards and choose the one that resonates most closely with their chosen emotion. Another participant agreed that they felt challenged by their chosen body part with their chosen emotion. Overall, most of the adolescents classified their emotions as different before engaging in the DMT intervention session.

Discussion

In agreement with the literature (Karkou et al., 2022), this writer's results show that while adolescents in a PHP may experience difficulties with depression, anxiety, or other mood-related symptoms, the use of creative arts and DMT can play an essential role in improving physiological states and enhancing psychological experiences. Dance and movement thus foster community and enables individuals to relate with each other while simultaneously allowing for self-expression of one's own needs within the group (Chaiklin & Wengrower, 2015). The engagement observed by the writer suggests that using a DMT intervention is more likely to increase group cohesion and socialization among adolescents. Only one of the eight adolescents who participated in the study indicated no change.

The engagement observed by the researcher showed that movement functions as a vehicle for communication and can strengthen peer interactions. Participants demonstrated better participation when they could express emotions through movements they relate to the most.

Despite moments of social discomfort, peers grew more vulnerable over the course of the intervention and remained together as part of one group. Lee (2014) permits, “Movements activate an interactive process between one’s outward expression and inner feelings/thoughts and serve as a gateway between one’s inner and outer world” (p. 400). This method thus exhibited the use of DMT in a PHP where clients had the opportunity to acknowledge and express their emotions through utilizing their creative capacities and engage in treatment in an alternative, arts-based way.

According to Engelhard (2014), "Movement in a safe and nurturing environment can, in therapy, be a transformative psycho-somatic experience allowing the adolescent to dream feelings, emotions, and thoughts, to express them and to know their significance" (p. 502). Other research studies with DMT interventions have yielded similar effectiveness in adolescents' social and emotional learning development. The outcome of utilizing DMT interventions with adolescents in a PHP further supports research with adolescents, such as Lentz et al. (2014), finding that participants in a PHP demonstrated positive relational change and social engagement over time. PHP programs may thus provide sustainable structure and support needed to promote stabilization and resilience for individuals whose symptom severity has decreased functioning and well-being.

The main barriers of the method include participants being required to wear a mask, the structure of PHP including the daily changes that altar the group dynamics, the mix of participants either having previously formed connections with peers from inpatient or presenting to the level of care for the first time and the interruption of the participants getting frequently pulled to meet with their treating doctor or therapist. Other noteworthy limitations include the sample size was relatively small, though most individuals participated. In addition, there was no

follow-up measurement to determine how long the positive effects of the DMT intervention would last due to the short-term nature of PHP.

The current method suggests that a group DMT intervention may effectively support social engagement in adolescents with mental health challenges. However, research on adolescent emotional and social engagement through expressive art modalities should continue to expand and develop. This intervention could be studied more thoroughly in individual therapy sessions and with participants of all ages. This type of group-form intervention may also help further support research involving how the Polyvagal theory supports individuals impacted by trauma. Lastly, additional findings may provide practical and effective study for healthcare providers, academic staff, and mental health practitioners with creative, art-based engagement methods valuable for adolescent development.

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THESIS APPROVAL FORM

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Student's Name: Kayleah Pensalfini

Type of Project: Thesis

Title:

The Development of a Dance/Movement Therapy Method for Social Engagement with Adolescents in a Partial Hospital Program

Date of Graduation: May 20th 2023

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

Thesis Advisor: Wendy Allen PhD, LPC, BC-DMT