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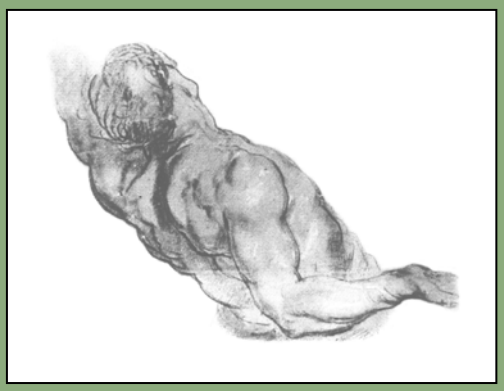

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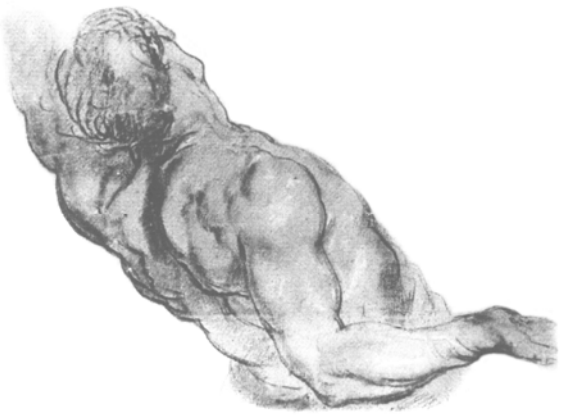

USABP Mission Statement
The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999)

Dance/Movement Therapy in a Psychiatric Rehabilitative Day Treatment Setting

Patrizia Pallaro, LCMFT, ADTR
Angela Fischlein-Rupp, ADTR, BTD

Abstract

The theoretical basis and practical applications of dance/movement therapy within a psychiatric rehabilitative day treatment are explored. The unfolding of psychotherapeutic process through the embodiment of one's own subjective experience is consistent with the philosophy of a psychiatric rehabilitative day treatment modality, which allows room for integration of different experiential levels.

Concepts of body level integration, facilitation, maintenance, or improvement in interpersonal functioning, provision of a safe, contained forum to address emotional issues by using group movement, imagery, symbol, and metaphor are pivotal to the psychotherapeutic interventions created in dance/movement therapy groups. A case presentation illustrates how dance/movement therapy carries forward a process of physical, emotional and psychological integration.

Keywords

Dance/movement therapy in a psychiatric rehab – Dance movement – Intervention – Psychotherapeutic

The Creative Arts therapies in Psychiatry

Creative arts therapy programs, including art, dance and movement, music and drama therapy, were an integral part of the overall programming in several day treatme-*+nt centers in this country until the advent of managed care. In these progressive settings, a philosophical belief that creative development of the individual is necessary to ensure the highest possible psychological and functional levels was respected. As Fink (1988) states,

> Using the media in which they have been trained, art, music, dance, poetry, and drama therapists all play a significant role in the overall armamentarium of psychiatric institutions and agencies in the care of the mentally ill. Their specific roles in assessment are valuable. As contributors to the assessment of the patient, they play a prominent part in helping to shape the diagnostic work. Their knowledge of symbols and their use of the clues derived from unguarded patient interaction are often essential in the diagnosis and treatment planning effort. . . . every patient deserves a full biopsychosocial assessment. It is important for patients to be viewed from every dimension (pp. 175-176).

Badaines and Ginzberg (1979) also stress the role of creative arts therapies as pivotal to an holistic approach to the person, much needed in the psychiatric arena.

Zwerling (1989) indicates that:

> . . . the nonverbal media employed by the creative arts therapists more directly tap emotional rather than cognitive processes in patients . . . . [and that] the creative arts therapies evoke responses, precisely at the level at which psychotherapists seek to engage the patients, more directly and more immediately than do any of the more traditional verbal therapies (p. 23).

Goodwoman (1993) states that,

The arts and creative expression help to build interpersonal and communication skills, increase

> avenues for [raising] self esteem and providing opportunities for problem solving and decision making. . . . Most importantly, the arts program offers opportunities for empowering the patient by enhancing and building strengths [i.e. creative thought, insight, self motivation, decision making, interactional skills] which are essential to recovery and re-entry into the community (p. 43).

Furthermore "the arts offer the opportunity to use symbolism to express difficult issues in the life of one person and the life of society" (Stanton-Jones, 1992, p. 95). It is unfortunate that current managed care practices have stripped away many opportunities to address the whole person for those in need of mental health services. The use of creative arts therapies has often been eliminated because they were deemed superfluous, expensive and/or un-reimbursable. It has often been decided, without any input from accurate longitudinal studies, that it is more "cost-effective" to prescribe medications and "case manage" patients using psychopharmacology, behavior modification techniques (Donald, 2001; Kessler, 1998; Robinson, 2002; Schreter, 1995) and evidence-based therapy (Mace, Moorey, & Roberts, 2001) than to devise a comprehensive treatment plan addressing the different and varied needs of an individual in need of psychiatric services.

Dance/movement therapy in psychiatry

As defined by the American Dance Therapy Association (1974), dance/movement therapy is "the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual." Since its first appearances in the U.S. mental health system (during the 1940s), dance/movement therapy has continually refined its theoretical foundations through contributions by many fine clinicians; their work solidly connected the pioneers' intuitive assumptions with the larger body of psychological theory and practice. All movement therapists share a belief that "body movement is the most primary means of communication" (Bernstein, 1982, p. 5), and employ a variety of bodily techniques, aimed at fostering self awareness and connecting inner psychic processes with feelings and experiences in the outer world. Individual styles reflect each practitioner's preference for one or more of the major psychological frames of reference, providing a variety of different approaches, such as Adlerian, Jungian, Gestalt, systemic, psychoanalytic, experiential, transpersonal, and so forth (Bernstein, 1979, 1984; Levy, 1988).

Dance/movement therapy's early pioneers, such as Marian Chace and Trudi Schoop, worked in psychiatric institutions: St. Elizabeth Hospital (Washington, D.C.), Chestnut Lodge (Washington, D.C.), and Camarillo Hospital (California), thus laying the foundations for the current body of theory and knowledge (Bernstein, 1979, 1984; Levy, 1988). More recent literature explores the role of dance/movement therapy in psychiatry and specifically in day treatment settings (Govine, 1971; Payne, 1992; Stanton-Jones, 1992).

Because dance/movement therapy uses both verbal and nonverbal modalities, it is deemed "especially effective in engaging patients whose capacity to participate in strictly verbal group therapy is limited" (Sandel and Johnson, 1983, p. 134). For psychiatrically disordered individuals, dance/movement therapy may offer ways to develop healthier defenses against anxiety and emotional pain by exploring their own movement coping strategies, by relating to others on a nonverbal level within the group's movement, by uncovering feelings through symbols and imagery in a safe environment. Creativity, movement expression, group interactions, connecting nonverbal material to personal meaning through the use of words, and containment and metabolization of group processes by the therapist are all important factors in the unfoldment of a dance/movement therapy session (Bernstein, 1979, 1984; Chaiklin, 1975; Dosamantes-Alperson, 1979, 1981; Govine, 1971; Pallaro, 1993, 1996; Payne, 1992; Romero, Hurwitz, and Carranza, 1983; Sandel, 1982; Sandel and Johnson,

1983; Schmais, 1981; Silberstein, 1987; Stanton-Jones, 1992; Stark, 1989).

Stanton-Jones (1992, p. 10) summarizes five theoretical principles underlying the foundations of dance/movement therapy in psychiatry as follows,

- the mind and the body are in constant complex reciprocal interaction;
- movement reflects aspects of the personality, including psychological developmental processes, psychopathology, expressions of subjectivity and interpersonal patterns of relating;
- the therapeutic relationship established between the patient and the dance/movement therapist is central to the effectiveness of dance/movement therapy;
- movement evidences unconscious processes, in a manner similar to dreams and other psychological phenomena;
- the creative process embodied in the use of free association in movement is inherently therapeutic.

She also indicates (p. 92) the fundamental goals that dance/movement therapy promotes in a day treatment setting as:

- body level integration;
- facilitation or maintenance or improvement in interpersonal functioning;
- provision of a safe, contained forum to address emotional issues by using group movement, imagery, symbol, and metaphor.

Effective use of dance/movement therapy in a day treatment program

A prominent psychiatric rehabilitative day treatment center for adults in San Francisco offered services to approximately eighty patients, provided by a multidisciplinary staff of clinical psychologists, psychiatrists, counselors, family therapists, social workers, nurses, psychiatric technicians, substance abuse counselors, vocational, activity, art, dance, music, and drama therapists. It also featured a training program for interns from varied mental health disciplines. This program was pivotal to the global delivery system of community mental health services provided by the City and County of San Francisco, until its restructuring-within new managed care parameters- in 1995.

Patients were referred to this day treatment program by various sources within the county such as hospitals, acute diversion units, crisis clinics, transitional residential treatment facilities, supportive housing systems, board and care homes, outpatient clinics, as well as private practitioners and agencies. The sexual orientations, ethnic and racial origins of its clientele were diverse, reflecting the cultural diversity of San Francisco's population as a whole. Patients suffered from a wide range of psychiatric disorders, such as schizophrenia, affective disorders, and personality disorders. Quite a few also presented with polysubstance abuse problems.

The agency stressed a "therapeutic community" model, with staff working with clients in a "living-learning" context, providing a secure, supportive environment and numerous arenas for participation, team building, responsibility taking, self-examination and change. Badaines and Ginzberg (1979) describe a therapeutic community as "a structured environment conducive to learning new, more adaptable behaviours, achieving greater self-understanding and awareness and increasing self-responsibility" (p. 74).

The day treatment program offered individual and group psychodynamic psychotherapy, behavioral-cognitive therapy, family therapy when possible, psychopharmacological treatment, mental

illness education, crisis intervention, art, dance/movement, music, drama and activities therapies, substance abuse recovery, academic, pre-vocational and vocational training, independent living, communication and social skills development. This unique program aimed at the integration of several aspects of each individual's life and prepared the client for re-entry into the community at large. Patients were responsible for the development and implementation of their own treatment goals, aided by their primary therapists and their treatment teams. They participated daily in several groups (from the categories listed above) which were selected based on: (1) the goals that they themselves wanted to achieve and (2) the stage of their treatment (initial phase, active-treatment phase, and termination phase). Patients were followed by a primary therapist who acted as advocate for them and maintained contacts with other care providers (within and outside the county system) and the patients' families. The primary therapist was part of a larger treatment team which, in weekly meetings, discussed and reviewed patients' progress, appropriate treatment modalities and plans, as well as the emergence of individual and team transference and countertransference issues.

This program offered three weekly dance/movement therapy groups for patients whose individual treatment plans included movement explorations of their particular treatment issues. The size of these groups varied according to the overall census and the patients' treatment needs, never exceeding a maximum of twelve participants. Patients could enter these groups at any time but they needed to commit themselves to work within this therapeutic form for an extended period: drop-ins were not encouraged. Two weeks' notice was required for termination purposes. A registered dance/movement therapist led the group, often aided by a dance/movement therapist in training, and reported patients' progress or difficulty to the client's primary counselor. The room was a spacious one, in the basement of the facility.

Structure, goals and interventions in dance/movement therapy with psychiatric patients

The basic structure of a dance/movement therapy session in a day treatment setting, as facilitated by these two authors, involves an interactional approach to dance/movement therapy, including utilization of rhythmic body movement, development of group images, and attention to both socialization and cooperative play. Different stages of group process and cohesiveness are noted as each session unfolds, and differing interventions are warranted (Pallaro, 1993; 1996).

Depending on the energy level of the group, patients may start out sitting or standing in a circle. A dance/movement therapy group typically begins with a warm-up, to help the participants get in touch with their bodies. Each participant's mood and affective state-as well as the atmosphere of the whole group-may be sensed through this initial contact. When music is used, the therapist tries to match its rhythmic components to the energy level of the group. If the group stabilizes through rhythmic action and allows cohesiveness to emerge, more expressive themes and specific feelings are explored. There is always an improvised movement closure and an opportunity for verbal exchange at the end of the session.

In working with psychiatrically ill patients, the first fundamental goal is to encourage body level reintegration by increasing body-self awareness (Pallaro, 1993, 1996). Using the so called "Chace approach" (Bernstein, l 979; Sandel, Chaiklin and Lohn, 1993), the dance/movement therapist utilizes movement reflections to establish a therapeutic relationship, offering each client an opportunity to integrate his/her split off parts, and reintroduce a sense of physical reality. Establishing such a nonverbal bond allows basic trust to develop, upon which further movement explorations may be built.

Movement warm-ups and non-directive improvised movements typically promote vitalization, integration, activation, and motivation in the client (Schmais, 1985). Working with the psychiatric population, Chaiklin (1975) defines her basic goals as:

- aiding body integration and awareness;
- fostering a realistic sense of body image;

- increasing movement vocabulary and affect;
- strengthening impulse control.

Frequently, dance/movement therapy groups in a day treatment center consist of patients who are still in the process of stabilizing after an initial recompensation while hospitalized. The dance/movement therapist gauges and moderates both pace and content for the group's work so that even the lowest-functioning member may participate. Thus, one immediate goal may be to help patients to overcome their fears about being in a group as opposed to focusing on self-exploratory or interpersonal themes (Yalom, 1970).

The development of a realistic body image is a concept frequently mentioned in the context of body level reintegration. Body image formation is linked to the process of early psychological development which, in turn, correlates with a series of movement tasks progressively unfolding during each developmental phase (Bernstein, 1979; Mahler, Pine and Bergman, 1975; Stern, 1985). While body image formation is in part "dependent upon the visual and tactile exploration of the surface of one's body as well as the sensations derived from inner organs, skeleto-muscuIar systems and the skin" (Siegel, 1979, p. 93), it is also influenced by both verbal and non-verbal as well as bodily responses from others throughout one's own life (Banchero, 1988; Bernstein, 1979; Chaiklin, 1975; Espenak, 1981; Geller, 1974; Pallaro, 1993, 1996).

According to Siegel (1979, 1984) and Naess (1982), outer aspects of body image include the awareness of body boundaries (as to where one begins and ends), and the sensibility of body space (as an inner felt knowledge which allows one to be spatially comfortable in relation to other persons and things). Body image, awareness of body boundaries, sensibility of body space, all partake in the formation of the body-self. To achieve a realistic sense of body-self, movement interventions need to address both the inner aspects of body image formation and its outer aspects, leading to the interpersonal dimension within a group context.

Involving both conscious and unconscious components, body image as a felt-sense of self is defined by "positive investment in, awareness of, and control of the body" (Rice, Hardenbergh and Hornyak, 1989, p. 253). Thus,

> In the psychotherapeutic process, in order to strengthen, modify, or integrate the representations and the experiences of one's own inner self, it is absolutely necessary to start from the body and its experiences (Pallaro, 1993, p. 289).

Specific movement interventions aimed at fostering awareness of one's own sense of self, via explorations of the body-self, include sequential warm-ups, patting one's own body, defining its outer limits, centering, grounding, molding, reflecting, and mirroring.

The second major objective in dance/movement therapy groups with a psychiatric population involves maintaining or increasing patients' level of interpersonal functioning (Geller, 1974; Stanton-Jones, 1992). Personal effectiveness and autonomy is fostered by encouraging each individual to initiate a movement, which is subsequently imitated by all other participants. This technique also explicitly allows for expression of nonverbal empathy among the group's members. By encouraging all patients to take turns at creating new movements and mirroring one another, socialization is learned:

> The object of a therapeutic process directed at fostering one's sense of self in relation to others will be awareness of feelings and states of mind associated with interactional movements. Movement experiences such as mirroring, leading, and following will provide the frame for the body-self to experience reflection, empathy, and engagement in relation to others (Pallaro, 1993, p. 289).

Group cohesiveness is enhanced through rhythmic movement experiences (Geller, 1974; Pallaro, 1993, 1996; Schmais, 1985; Stanton-Jones, 1992). The use of props such as balls, balloons, ropes, scarves, and so on, can further promote and deepen group members' interactions. When focusing on socialization, the dance/movement therapist utilizes verbalization primarily "as a stimulus for body action, differentiation of self, recognition and expression of feelings" (Stark and Lohn, 1989).

The third fundamental goal involves patients' release and externalization of their emotional processes within a safe "container" (Geller, 1974; Stanton-Jones, 1992). Simple dance steps or movements involving body action prepare the group members for increased emotional expression (Chaiklin and Schmais, 1979) and for kinesthetic imagery to unfold (Dosamantes Alperson, 1983). As soon as the group has developed sufficient cohesiveness, more expressive themes evolve. A clear group structure allows for controlled cathartic release of feelings such as joy, sorrow, rage, helplessness, and frustration. Movement statements, kinesthetic and kinetic exploration of symbolic images, embodiment of metaphoric themes and life stories are frequently accompanied by verbal acknowledgments and interpretations which clarify patients' experiences and may elicit insight. According to Chaiklin and Schmais (1979, p. 25), verbalization in dance/movement therapy, "serves to invite insight, identify affect, and further interactions."

Ultimately, verbalization allows the unconscious material, manifested either in the nonverbal behavior of the group or in each individual's body movements, to become conscious. Thus, verbalization can enhance the integrating effect of dance/movement therapy (Dosamantes-Alperson, 1984; Pallaro, 1993, 1996; Sandel, 1978; Siegel, 1984; Stark and Lohn, 1989).

To further illustrate the benefits of dance/movement therapy in a day treatment setting, a case study follows.

Case illustration

Jeremy was a tall, slender, and well-groomed thirty-four year old single Caucasian male who was referred from an inpatient acute psychiatric unit to the day treatment program. Stressors preceding Jeremy's current hospitalization were the death of a friend who had overdosed on heroin, his living situation, his loneliness and lack of intimate relationships, and a change of therapist. He increasingly became psychotically paranoid, feeling "physically attacked by negative energy and bad karma." He began to think that he could pick up other people's feelings and thoughts, and felt as if people were laughing about him. Out of despair at not having an intimate relationship with a woman, he became suicidal and was then hospitalized. He was diagnosed with schizoaffective disorder, major depression, alcohol and drug abuse. He was psychopharma-ceutically treated with a neuroleptic, an antidepressant, and a sedative.

Jeremy's psychiatric history goes back to his teenage years. He was born and grew up in the Carolinas with his younger sister. His father was a college professor, described by Jeremy as an alcoholic who was very threatening and verbally abusive toward him. Jeremy described his mother as distant and cold; he frequently stated that he felt abandoned by her, especially in situations when he needed her comfort and warmth. Jeremy did not recall ever having been hugged or held by his mother or father. He always spoke of his childhood in intellectualized and abstract terms, frequently describing it as "a traumatic time." As a teenager, he began to smoke marijuana and to ingest LSD, mescaline, and alcohol. Once he reached high school, he was already heavily into drugs, became a total loner, with no friends or activities he enjoyed, and started to display aggressive and violent behavior.

Jeremy was first hospitalized at age sixteen, for two years, and finished high school in the hospital. For the next eight years, Jeremy went in and out of drug rehabilitation programs. At age twenty-five, he moved to San Francisco, where he first connected with Alcoholics Anonymous and Adult Children of Alcoholics self-help groups. Unable to hold a job, he lived in hotels and apartments throughout the city as a disability assistance recipient, and was periodically treated in half-way houses,

day treatment programs, and outpatient psychotherapy without perceived improvement. Although Jeremy's social and psychological functioning gradually declined, he maintained his sobriety for the eight years prior to admission.

Course of treatment

According to his understanding, Jeremy was hospitalized this time because he had developed a tolerance toward his antidepressant medication. He experienced an ongoing angst about his lack of intimate relationships with women. This, he thought, was his main problem. He wished for nothing more than a close relationship and went through "mental pains" thinking about meeting someone. His personality expressed itself in many paradoxical ways: he had an affinity for obscure and morbid aspects of life; he wanted to be special, to stand out. He desperately wanted to be close to others and loved but had no clue as to how to make that happen.

Jeremy was, at the same time, a very friendly, intelligent, and shy man. He hardly ever asked for attention. In any group of people, he would usually become invisible, fading into the background. Jeremy also had a wild and playful side, but he seldom expressed it for fear of being inappropriate. In the day treatment program, he had agreed to work on these goals:

- decrease paranoid and obsessive thoughts,
- reduce isolation,
- improve the ability to form and maintain relationships.

While maintaining his individual psychotherapy and psychopharmaceutical treatment, he was first assigned to a few verbal psychotherapy groups, but it was soon clear that he had difficulty participating. He was very preoccupied with paranoid thoughts; he would either be quiet and absorbed in his own reveries or would expound on his and others' problems, intellectualizing his emotional process, distancing himself from his feelings and from other people around him. The treatment team then decided to move him into the dance/movement therapy groups to facilitate achieving his goals through creative media.

Once in the dance/movement therapy group, Jeremy adapted to the role of the "reasonable" group member. Rarely if ever late, he never resisted nor refused to participate, always seemed to work hard and to give his best. During the first two months of dance/movement therapy, Jeremy did not actively initiate movements on his own, but predominantly followed what was introduced by other patients or the group leader. He simply did not consider the possibility that impulses coming from him could, should or actually would impact the movement adventure. Hardly looking around himself and too shy to take in the presence of other patients, he introduced exercise-like movements, preoccupied with "doing them the right way." He generally initiated movement at the periphery, hardly ever involving the core of his body, which was tense and rigid.

During this initial phase, Jeremy's treatment goals emphasized body-self awareness and body level reintegration, including exploration and expansion of his movement preferences and their opposites. The flow of his movements was bound, in part reflecting his tendency to repress and withhold his feelings from flowing freely. His tenuousness and difficulty in staying with his emotional process was reflected in the quickness of his movement effort. However, it was also this effort quality that carried Jeremy's "quick" mind, his creative and spontaneous side and, later on in treatment, his ability to become lively and excited in relation to ideas and people.

The movement dialogue between Jeremy and the dance/movement therapist first began with mirroring and amplification of his movement patterns, slowly moving from the periphery to the core of his body. Through encouraging a general body awareness, experiencing polarities within the continuum of all effort qualities, and learning to differentiate between inner and outer stimuli, Jeremy slowly gained and expanded his sense of body-self.

In the third month of dance/movement therapy, Jeremy became more trusting and subtle changes

began to take place. Taking turns in a Chacian circle, his face would brighten when he was to initiate a movement sequence. Excited and pleased as others followed his pathways and rhythms, he began to make contact with others and include interactional movements. As his rigidity decreased, he gradually let go of the exercise-like skits, began to expand his movement repertoire, challenging the group members with new and creative movement ideas, often wondering out loud, "Let's see if you all can do this!"

Still, structured movements - as in the warm-up part of the session - were important to him. He never tired of the "nerfball" game during which group members call out each other's names: he needed this structure in order to feel safe, only then was he able to ask for contact. He became very pleased when his movement suggestions were heard, especially when he was asked to lead the group and all group members followed his movement ideas. As his confidence grew, his spontaneity and authenticity increased.

The more Jeremy gained access to his body, to his own rhythms and movement impulses, the more he seemed able to express his wish to interact with others. Jeremy's playful and spontaneous side began to emerge. Slowly, he started to take more risks. Jeremy usually moved with lightness, allowing room for his gentle and sensitive ways and manners. Although he regarded himself positively for this, he also felt incapable of taking a firm stand, setting boundaries, or expressing angry feelings. His spatial effort was direct, his movements did not expand beyond a narrow kinesphere.

However, Jeremy had become a very active member of the group; he had established his place, allowing himself to interact and to be seen. At one point, the group theme focused on the expression of anger through noises, screams and shouts, with matching angry movements. The goal for each group member was to become the most obnoxious with the loudest voice. Jeremy outdid everybody in strength and length of his scream and appeared elated, observing that he did not know he had this side to him. As it was generally difficult for Jeremy to be assertive, it was through play that he discovered he could in fact assert himself. Props - such as the "nerfball," that he could squeeze and twist, balloons that he could hit gently or very hard, and stretch-bands that he could pull and push - enabled him to tap into his strong movement effort and helped him to literally "get his feet onto the ground."

While slowly increasing his movement vocabulary, both his range of affect and his ability to process feelings increased. In the seventh month of dance/movement therapy, Jeremy's rigidity softened even more as he allowed himself to close his eyes, rhythmically swaying his body and snapping his finger to the beat of a slow song. After that, he began to request the same song at the beginning of every session, every time closing his eyes and entering "a state of mellow, soft, bouncy, and fuzzy feeling." In his experience, these moments felt as if he was removed yet present and unafraid to be abandoned.

This last movement sequence preceded Jeremy's kinesthetic experience of wishing to be held in someone's arms. When encouraged to give form to this image, he folded his arms around his own shoulders, closed his eyes, and gently swayed to the music, with a blissful smile on his face. The theme of holding and comforting oneself was carried on by other patients, until this specific group session ended with a group hug initiated by Jeremy. It seemed important for Jeremy to give expression to the theme of longing for closeness, which was central in his life, and to face his fear of abandonment. Jeremy took this chance and embodied his longing for closeness while others mirrored him and shared this experience with him. Jeremy had finally allowed himself to embrace his feelings, to give them a kinesthetic presence, and to feel supported by others around him.

In his treatment, this moment marked a shift from his pattern of distancing himself from his feelings and from other people by being absorbed in obsessive and paranoid thoughts. During his last dance/movement therapy sessions, he increasingly adopted the role of group leader. He had successfully internalized the structured movement experiences which allowed him to both explore and express his feelings among and with his peers. Interpersonal relationships became possible through Jeremy's increased ability to reach out. The group, as a safe container, helped Jeremy to stay with his emotional process while holding and allowing his experience to deepen. He had learned to release and

externalize his feelings in appropriate ways.

In fostering body awareness and body integration, Jeremy began a dialogue with his inner experiences. As he kinesthetically explored and strengthened his body-self, he gained access to his inner self, which in turn allowed him to make room for a greater range of movement and affect. Acceptance and validation of his inner experiences allowed him to feel safe enough to reach out to others and share his embodied metaphors. Feeling supported in sharing kinesthetic images and life stories with the group members permitted Jeremy to change his lifelong pattern of isolation.

Eventually, after more than a year of treatment, Jeremy transitioned from the half-way house into a supported independent living situation. His ability to relate had notably improved, enabling him to enter an intimate relationship with a woman and to start a twenty-hour per week volunteer position as a clerk.

Conclusion

Dance/movement therapy within day treatment centers and partial hospitalization settings is especially recommended for psychiatrically ill individuals who lack sophisticated verbal abilities and who need to learn socialization and interactional skills. They may benefit from the dance/movement therapy work because it allows them to explore their capabilities, fears, and longings in a supportive, playful and safe environment. Patients who display a distorted body image have opportunities to explore the internal images they have created about themselves and to modify them based on interactions with other group members. Patients who present diffuse body boundaries engage in movement experiences which strengthen the sense of their bodies' outer limits and ultimately their body-self. Those who rely upon enactment for communication learn to control their impulsivity and those who have difficulty expressing their emotions or hide them beneath their intellectualization defenses find a safe way to creatively access their feelings and understand the meaning of their unconscious behaviors.

Understanding their own behaviors ultimately assures both a better quality of life and the ability to critically rely on their own resources, thereby avoiding unnecessary services and further costly hospitalizations. Managed care in the mental health field today most often fails to provide patients with such opportunities. Until the advent of managed care systems, partial hospitalization and day treatment programs were highly structured, comprehensive as well as coordinated within the delivery of psychiatric services, and multidisciplinary in the treatment and care plans in which patients and their families could participate. They had been proven therapeutically valid as well as economically viable (American Association for Partial Hospitalization, 1990; Campling & Haigh, 1999; Cutler, 1992; Greenberg, 1983; Hamill, 1981;Mosher and Burti, 1989; Neffinger, 1981; Parker and Knoll, 1990; Schreer, 1988; Weiss and Dubin, 1982). Patients' rehabilitation was emphasized in their education about mental illness, in their learning of social and communication skills, in their engagement in purposeful activities, and in development of their vocational skills. Inpatient hospitalization was avoided as much as possible but made available when necessary.

Although U.S. health-care costs have escalated dramatically and health-care reform is absolutely necessary at this point in time, Eist (1995) asserts that "managed care poses such great threats to patients that it has no place in psychiatry" (p. 1). According to Alleman (2001), Bachrach (1995), Eist (1995), Kirschner & Lachicotte (2001), Kuttner (1995), Pipal (1995), Stoil (1995), and Stone (2001), managed care is profoundly and adversely affecting the course of medical and psychiatric services and the quality of care provided. The critique of managed care as "limiting the duration of treatment, interfering with necessary hospitalizations, and placing market concerns above clinical judgment" (Bachrach, 1995, p. 1229) has yet to positively influence the current strategic cut-downs of programs and dilution of provided services.

Jeremy's successful course of treatment with the preferential approach of dance/movement

therapy shows the crucial importance of creative arts therapies within a psychiatric rehabilitative day treatment program. Outcome studies and longitudinal studies are needed to effectively document such successes and thereby offer alternatives to the drastic cuts in viable multidisciplinary mental health treatment programs under managed care systems.

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Biography

Patrizia Pallaro, LCMFT, ADTR is an Italian psychologist, with a Master's degree in dance/movement therapy from UCLA, she has trained extensively with Janet Adler, the originator of the Authentic Movement discipline and edited two volumes on Authentic Movement. Member of the Academy of Dance/Movement Therapists Registered (ADTR) and the United States association of Body Psychotherapy (USABP), is in private practice in Silver Spring and Annapolis, MD. She teaches in the U.S. and Europe.

Angela Fischlein-Rupp, ADTR, BTD is an Austrian psychotherapist, holds a Master's degree in dance/movement therapy from Hayward State University, California. Member of the Academy of Dance/Movement Therapists Registered (ADTR) and the German Dance Therapy Association (BTD), is in private practice in Erlangen, Germany.

PATRIZIA PALLARO, LCMFT, ADTR
badreezyuh@aol.com e-mail

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Jacqueline A. Carleton, Ph.D., Editor (jacarletonphd@gmail.com)

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