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Dance-Movement Therapy for Geriatric Populations

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DANCE-MOVEMENT THERAPY FOR

GERIATRIC POPULATIONS

Sharon Kirsch, A.B.

A Digest Presented to the Faculty of the Graduate School
of the Lindenwood Colleges in Partial Fulfillment of
the Requirements for the Degree of
Master of Art

1982

Thesis
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1982

DIGEST

The aging process is characterized by the onset of physical limitations and emotional stress. It is vital to find outlets for social interaction, physical activity, and relaxation.

Dance-movement therapy is a form of psychotherapy in which the therapist utilizes movement interaction as the primary means for accomplishing goals. Dance-movement therapy is the use of rhythmic movement as a means of self-expression and communication, which aids in the healthier integration of mind and body.

This study investigates the effects of dance-movement therapy for the elderly. Dance-movement sessions were presented to three groups of senior adults: an active mobile group at an open activity center, a moderately ambulatory group at a day care program, and a nonambulatory group of elderly patients at a physical rehabilitation hospital. Following numerous sessions the leadér/researcher investigated the physical, social, and emotional benefits

derived by the various groups by means of interviews. Attitudes of staff members toward dance-movement sessions for their clients was also explored.

Results of this exploratory study demonstrated that dance-movement sessions provided physical, emotional, and social benefits for senior adults in various settings. Social interaction proved to be the greatest benefit of the sessions. Staff members indicated holistic benefits of the sessions for their clients.

DANCE-MOVEMENT THERAPY FOR

GERIATRIC POPULATIONS

Sharon Kirsch, A.B.

A Culminating Project Presented to the Faculty of the Graduate School
of the Lindenwood Colleges in Partial Fulfillment of
the Requirements for the Degree of
Master of Art

1982

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1982

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DEDICATION

In memory of my dear mother Edith Komm Sheinbein, who instilled in me her "Dance of Life," and encouraged me to share it with others.

ACKNOWLEDGMENTS

To my Committee members, Peggy Szwabo and Joan Katz, I would like to extend my thanks for your time, effort, and special interest in this project. To my Faculty Advisor, Dr. Wendell Rivers, I am grateful for your time, advice, and constant support.

To Dr. Arlene Taich, Director of Lindenwood Colleges for Individualized Education, I am indebted for your special assistance.

To Maggi Speer, my typist, my appreciation, for without your efficiency, friendship, and extra effort this manuscript would not have been completed.

To my husband Morton and children Steve and Aimee I am especially grateful for your time, understanding, and unwaivering support. I would like to acknowledge my friends as well, expecially Nancy Kranzberg, Jan Baron, and Millena Horton, for your constant encouragement in my endeavors.

To my father Jake Sheinbein and mother-in-law Ethel Kirsch, for all your help during these busy years, thank you.

Special credit goes to the agencies that allowed me to present movement-therapy sessions to their clients; without this opportunity this study would not have been possible.

Finally, to all of the senior adults with whom I have worked, my love and thanks. You have brought me more pleasure than I had thought possible; without you my ideas would still be a dream.

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CHAPTER I

INTRODUCTION

How marvelous to observe what pure ecstasy dance brings to young children where the movement has become an exploration of the total being--spontaneity and creativity working together toward a knowing, doing, and waking experience (Dimonstein, 1971).

An article from the Dance Research Journal (Helm & Gill, 1975) in the 1970s stated that dance as defined in America, when applied to the young, means one thing, to the middle aged another, and to the aged something entirely different. To many the whole spectrum of movement is diminished for the aged. Within our system we have subtle culturally determined reinforcers that encourage negative self-images and attitudes as people grow old. Our society prescribes, along with what we eat, wear, and think, even how and when we shall grow old. Individuals are forced to assume characteristic physical and mental attitudes of the aged,

once they have acquired a certain number of years. Aged populations have been a product of its upbringing--of the youth culture. Forced into obsolescence, the bodies of the aged become "folded inward" reflecting and enforcing their withdrawal from society. Their perception of themselves as fragile appears in their every movement.

This author believes this view of the elderly and by the elderly does not have to continue to exist. Since movement is an essential factor for all forms of life, it is an element of being in the world that is continuously present from birth to death. Movement reaffirms vitality. Although the movements of the elderly certainly cannot take on the sam physical exuberance as the movements of a child, can they remain being a vehicle for the expression and transmission of joy in the quest for survival and the meaning of life? Rather than focusing on the diminished movements of the elderly, why can't one focus on movement as a statement of being alive?

More and more society is focusing on aging as a natural biological process. Paramount to an understanding of the aging process is the ability to view aging as the culmination of an evolving continuum.

Growth and maturation occur throughout the entire course of a lifetime. The manner in which individuals conduct themselves during the stages of life preceding old age may have a significant effect on the relative state of their health in later life. Health behaviors related to diet, amount of exercise, and smoking may influence the prognosis for healthy aging. The ability to respond and adapt to environmental change can also be an important determination of functioning in later life (Fersh, 1980).

How an individual approaches old age is contingent on a wide range of factors: physical health, personality, level of intellectual and psychological functioning, the availability of support systems, the adequacy of economic resources, and the possibility of fulfilling social roles. These systems, which can be divided into physical, emotional, and social components, engage in dynamic interaction contributing to the whole functioning of the individual (Fersh, 1980).

Rather than focusing on the losses of the aged, rather than focusing only on the most basic needs of the elderly, old age may be a unique opportunity to undertake creative pursuits which provide the means for self-expression and self-satisfaction. Learning and growth as intrinsic

lifelong processes may be fostered for maximizing motivation. Several theorists support the possibility of old age as a positive culmination experience. Erikson (1963) discussed the final phase of "ego integrity vs. despair" describing ego integrity as:

> . . . the ego's accrued assurance of its proclivity for order and meaning . . . (which) implies an emotional integration which permits participation by fellowship as well as acceptance of the responsibility for leadership. (pp. 268-269)

Jung (Von Franz, 1975) described the path to maturity as an individuation process in which the individual experiences:

> . . . an inner certainty, peace and sense of meaning and fulfillment in the presence of which he can accept himself . . . instead of being a fragmented person who has to cling to collective supports, he now becomes a self-reliant whole human being who no longer needs to live like a parasite of his collective environment, but who enriches it and strengthens it by his presence. (p. 74)

Implicit in the notion of aging as part of a developmental cycle is the concept of change. A Zen view of life expresses this philosophy: "If we do not change, we are lifeless. We grow and age because we are alive" (Kapleau, 1971, p. 8).

Change means movement, a progression from one phase of existence to the next. As dance therapist Isabel Fersh (1980) mentions, when working with the aged, Newton's law of physics comes to mind. A body at rest remains at rest, unless activated by an outside force, and once in motion, a body remains in motion. Motion and dynamic changes in movement are motivated by energy, probably the most basic life force and certainly a fundamental component of dance-movement therapy--a psychotherapeutic use of movement as a process that furthers the physical and emotional integration of an individual (American Dance Therapy Association, 1975).

This author does not intend to ignore the characteristics almost inevitably associated with living into later years. These include declining energy loss of earlier adult roles, cosmetic changes, onset of physical illness and/or disability, reluctance to adjust to change, sensitivity to new activities, failure to recognize that aging is the entrance into a new period of life, the tendency to accept stereotyped concepts of old age, loneliness, living in the past, and others (Institute for Research in Social Science, 1954).

It is because of these characteristics of the aged that programs must be offered to provide comfort, support, and opportunities for healthy personality growth.

Any type of program or activity that is offered to senior adults, in this study those 60 years and older, should enable them to find the means of satisfying the needs formerly satisfied in other ways in previous years. Some of these needs are the need to be considered as a real part of the community, the need to occupy expanded free time in more satisfying ways, the need to render some socially useful service, the need to enjoy normal companionships, the need for recognition as an individual, the need for self-expression, the need for achievement, the need for health protection and care, and the need for suitable mental stimulation.

Can dance-movement sessions meet some of these needsfor the elderly as a part of activity programs? As a student of dance-movement therapy, The author has spent the past year and a half incorporating dance-movement sessions into activity programs for active-mobile senior adults at an open activity senior center; for moderately active senior adults at a day care center, and for nonambulatory senior adults at a rehabilitation hospital.

In an article on the creative therapies in MD Magazine (June 1981) the following contradiction was stated:

> The burgeoning of creative art therapies (art, music, dance) has caused some anxieties in the psychiatric community. The Task Panel on the Arts of the President's Commission on Mental Health did warn in 1978 that these art therapies should not be regarded as a new panacea. But Dr. Bertram Brown, former director of the National Institute of Mental Health, predicts the therapeutic use of the arts will probably be "possibly the most important social movement of the 1990's." (p. 69)

The author set out to explore if dance-movement therapy actually had any potential in helping to meet some of the needs of the elderly. With so many needs to be met, could movement therapy, which holistically involves the mind and the body, provide physical, emotional, and/or social benefits for the senior adult?

Can movement be put back into the lives of he aging and become a source of pleasure rather than pain? For the senior adult, can movement be an exploration of the total being, as it is for the child?

This study is an exploratory study of the problem.

CHAPTER II

LITERATURE REVIEW

Theories, Concepts, Goals of Dance-Movement Therapy

Before reviewing research on dance-movement therapy with the elderly, it is imperative that one has an understanding of dance-movement therapy, its theories, concepts, and goals.

Although dance-movement therapy as it is known today is a relatively new field (it has only begun to be recognized in the last 10 years) the roots of dance-movement therapy may be found in ancient times in the tribal rituals of almost every pretechnological society. Primitive people have searched for physical ways of communicating with the supernatural and to heal spiritual ills. Rhythmic and symbolic movement has provided expression for individuals' fears and joys throughout the centuries (Caplow-Linder, Harpaz, & Samberg, 1979).

The impetus for the interest in using dance therapeutically has come chiefly from dancers themselves. They came to appreciate the social integrative force of dance and to understand its psychodynamic values in terms of individual adjustment. Dance as therapy was first introduced in work with the mentally ill. The pioneers in the field such as Marion Chace, Blanche Evan, Franziska Boas, and Trudi Schoop developed tools for defining and directing individual progress toward well-being (a sense of comfort, adjustment, and fulfillment), and dance-movement therapy has become an independent form of nonverbal therapy (Rosen, 1957; Caplow-Linder et al., 1979).

Dance-movement therapy is defined as the psychotherapeutic use of movement as a process that furthers the physical and emotional (psychic) integration of an individual (American Dance Therapy Association, 1975). Dance therapy is the use of rhythmic movement as a means of self-expression and communication to aid in the healthier integration of mind and body. Dance-movement therapy provides outlets for expression and socialization.

In order to understand dance-movement therapy techniques, it is essential to understand what is meant by the mind-body relationship. Schoop (1974) has analyzed this

relationship, and the following five points are based on her description:

1. Man manifests himself in his body; the body is the visual representation of the total being.

2. Mind and body are in constant reciprocal interaction, so that whatever the inner self-experiences comes to full realization in the body, and whatever the body experiences influences the inner self.

3. Whether thoughts and feelings are rational or irrational, positive or negative, split or unified, acknowledged or inhibited, state of mind becomes embodied in the physical being. It is manifested in the body's alignment, in the way the body is centered, in its rhythmical patterns, in its tempo, sounds, use of tension and energy, in itsrelationship to space, in its potentiality for change. All of these factors determine the body's expression. They affect the way it moves and moves about.

4. Through the body, man experiences his reality. His senses inform his mind of his very being. They tell him how he is, who he is, and where he is. Sight, sound, smell, taste, and touch incite his mental processes.

5. Mind and body are fused by their reciprocal interaction. The collaboration ensures human unity.

In reference to the aging individual the feelings of loss, isolation, fear, acceptance of stereotypes manifest themselves in the physical structure of the individual: folding inward, slow moving, withdrawal, depression, dependence. Physical disabilities and illnesses of the aging person become transformed into anxiety and depression, which complete the mind-body cycle and are manifested into a whole train of somatic ills (Garnet, 1974).

Movement therapists work from various theoretical frames of reference depending on their background of psychological study and the population with which they work. Some are based on Jung, Adler, Gestalt, transpersonal-transformational, and psychoanalytic theory.

In approaching the geriatric population the author has incorporated a holistic frame of reference in dance-movement therapy. The theoretical base is one of holism. The individual is viewed in relation to self as an integrated unity; mind and body reflect and affect each other. Muscle tonus affects the psychic attitude and vice versa. The individual in relation to the environment is viewed as the mind, body, organic functioning and behavior are interwoven with the environment.

The development of the individual is believed to develop in an organized sequential manner. Developmentally related, intermeshed somatic experiences, unconscious material, and conscious behavior are stored in the individual. Present experiences may be influenced by and trigger past stored experience bringing past behavior to present.

The individual has an innate capacity for continuous growth. The individual's natural rhythm and timing is used when engaging in growth.

A formal construct of dance-movement therapy is body image. This is the mental representation of one's body at any given moment both at a conscious and unconscious level. The body image is dependent on the visual and tactile

exploration of the surface of one's body as well as on sensations derived from inner organs, skeletomuscular systems, and the skin. This representation provides an awareness of the differentiation of and optimum comfort space between self and the environment (Bernstein, 1979).

In dance-movement therapy there are two concrete somatic propositions. The first is the body; the health-dysfunction continuum is reflected in the body. A healthy body is an integrated, unified body, a balanced aligned body; it has normal breath flow and natural energy flow. A dysfunctional body shows body-mind splits, is imbalanced, has dysfunctional breath flow and muscular body blocks. Another somatic proposition is body movement; Health shows itself in adaptive range of movement qualities and in graceful coordinated integrated movements. Range of motion is using body part in space to its fullest capacity. Dysfunction manifests itself in habitual nonadaptive limited range of movement qualities and in distorted, uncoordinated, unintegrated movements (Bernstein, 1979).

Movement therapists view health as the capacity to be aware of and accurately perceive present experiences (Bernstein, 1979). This entails the capacity to experience the full range of human feelings as they emerge. Lack of

involvement is reflected in sustained, habitual, often developmentally related distortions of self, body image, expression, others, and of his/her being in the world.

Health and dysfunction are reflected in the degree to which an individual meets his/her needs. Health is also reflected in the capacity one has for engaging in meaningful social interaction (Bernstein, 1975).

Dance-movement therapy entails the use of dance-movement. The particular use of dance-movement can include:

Contraction-relaxation patterns

Postural-gestural patterns.[1]

Range of movement qualities

Rhythmic dance

Spontaneous movement-creative dance

Thematic movement improvisations

Unconscious symbolic body movement

Group dance

---

[1] This refers to whether a movement is isolated in one part of the body or whether movement spreads throughout the entire body (Schmais & White, 1969).

Dance-movement therapy is used for the purpose of integration toward wholeness. This purpose may result in:

Intrapsychic changes or reorganization

Conflict resolution

Realization of individual's potential

Capacity to meet one's needs

Maintenance of present awareness

Natural flow of energy

Improved body alignment/functioning

Increased capacity for vitality and relaxation

Meaningful social interaction

In summary, dance-movement therapy is a process entailing the use of dance-movement for awareness, expression, exploration, identification, and integration toward the experience of wholeness.

One other area of dance-movement therapy that is necessary to define is Rudolph Laban's effort-shape language, or movement analysis. Effort describes how one's inner impulses or energies are manifested in movement, whether conscious or unconscious. Shape is the system that describes how and where movement goes through space. Shape is usually described in terms of growing or unfolding in contrast to

shrinking or folding. Shape is used often, as shall be seen, in geriatric movement sessions as the dance therapist incorporates growing and reaching movements into the sessions (White, 1974).

It is also important to note that dance-movement therapy is not physical therapy or exercise sessions. Many programs of physical exercise for the aging emphasize physical fitness and concentrate on cardiorespiratory efficiency. Dance-movement therapy sessions, which hope to achieve physical benefits, include activity that is more relevant to the development of improved body alignment and relaxation. It also provides opportunities for emotional release and social interaction. Physical participation is usually the sole purpose of physical therapy and exercise sessions, whereas dance therapy sessions also provide the opportunity for emotional reactions and insights. Sensitive and reflective comments or questions from the leader and statements, gestures, or queries from the participants are ways in which the session is incorporated into one's personal awareness (Caplow-Linder, et al., 1975).

Physiotherapy is often a required and nonvoluntary part of a patient's care, which is unmistakably beneficial, but may be uncomfortable or painful. Dance-movement sessions

are informal and often involve personal choice and individual expression in free, rhythmic participation. The emphasis is on pleasure and enjoyment. It has been noted by Ruth Bright (1972), a music therapist, that restorative exercises (which are often resisted when presented as rehabilitation per se) are performed enthusiastically when presented as a game or action song.

Dance-movement therapy does not work to develop certain skills, but to encourage broader concepts, insights, and feelings. Physical therapists and movement therapists both use the action of the arm forward and upward. The physical therapist emphasizes the increased range of motion of the arm and shoulder and the movement therapist uses the movement to develop self-pride and a feeling of reaching and growing emotionally as well as physically.

In a sense and especially with geriatric populations, movement therapy must be regarded as a feeding of ever-waxing and waning needs, not as a prescription hastening a cure of a disease (Garnet, 1974).

Literature Review of Dance-Movement Therapy for Senior Adults

Because this study is concerned with the physical, emotional, and social benefits of dance-movement therapy with the elderly, the literature review shall be divided into those three categories. Some literature supported the holistic approach so completely that a section on holism will be included.

Physical Benefits

According to Helm and Gill (1974), in our present state of knowledge it is often difficult to separate whether observed physical changes in aging are the result of a disease, degenerative processes that develop more fully with time, or true aging--a gradual diminishing of the physiological adaptation of the organism.

Probably of most importance to fitness in later years is the proper functioning of the heart, lungs, and blood vessels. A strong and responsive heart is needed to pump blood to nourish body cells, good lungs are needed for the exchange of gases of cell metabolism and oxygen, and elastic

blood vessels free of obstruction are important to the distribution of blood throughout the body (U.S. DHEW, 1973).

In the normal aging process, most hearts undergo some atrophy whereby the muscle fibers become smaller, and fibrous tissue in the heart muscle increases, as does the amount of fat surrounding the heart (Helm & Gill, 1974).

Research supports the contention that exercise increases cardiac and vascular fitness. This improvement does not depend upon having exercised vigorously in youth. Benestad (1965; cited in Helm & Gill, 1974) determined that those who had been least active in early life benefited most from exercise. DeVries (1970) determined that exercise has a beneficial effect on patients with peripheral vascular and coronary disease.

Another result of the aging process is the narrowing and degeneration of the elastic tissue in blood vessels. Also there can be an increase in the amount of lipids found in the blood. Ricitelli (1972) found that exercise augments circulation resulting in vessel dilation and increasing circulation. According to White (1970) exercise promotes blood flow in the lower limbs of patients with peripheral vascular disease. Frequent motion of the limbs in conjunction with an anticoagulant was found to aid in the

prevention of venous and arterial thrombosis. According to White, muscle action of the leg is believed to facilitate blood return to the heart against gravity. Active leg muscle contraction yields more of the power required to sustain the movement of the blood which reduces the work of the heart by a corresponding amount.

Specific changes in the lungs occur with age; this lowers the efficiency of the respiratory system predisposing disease (Kronberg, 1971; cited in Helm & Gill, 1974). Breathing capacity is decreased, creating less oxygen available for energy production. Stooped posture of the upper thoracic spine contributes to decreased chest capacity. Studies by DeVries (1970) support the fact that exercise, especially proper breathing exercise, can strengthen the respiratory muscles, provide better ventilation, improve the motion of the diaphragm, and increase expiration. Exercise was not found to alter the underlying pathology of disease such as asthma and emphysema, but it may aid in the individual's ability to function better within the confines of these diseases.

According to Volson (1967), movement is essential for the maintenance of the musculoskeletal systems. These systems require basic tonicity and intermittent work loads.

Normal activity promotes endurance, strength, and coordination of the muscles.

Normally with aging the content of the bone material changes from organic to inorganic. This means that bones are less fibrous with a tendency toward brittleness. The supply of calcium to the bone is depleted, causing a porousness. When this occurs, bones lack a structural formation and become deformed and compressed. With the likelihood of bone fracture increased, the fear of injury is also greatly increased, often causing an inhibition of activity (Helm & Gill, 1974). According to Lila A. Wallis, M. D., in the article "Postmenopausal Osteoporosis" (Neaman, 1981), as estrogen production of the female ceases, bone loss speeds up, leading postmenopausal women on a path to osteoporosis, hip and bone fracture, and back pain. Dr. Wallis is in agreement with most experts that osteoporosis patients can benefit from regular exercise and the progression of the disease can be slowed down. She believes that the three preferred methods of prevention of osteoporosis are "exercise, exercise, and exercise" (p. 6).

Muscles, which make up 40% of the body, undergo drastic change in the elderly. Lack of movement and disuse lead to atrophy, which in turn leads to decrease in both size

and strength. Joints become less flexible, reflex action time diminishes, and muscle fiber becomes smaller. According to Ricitelli (1972) the only way to maintain efficiency and flexibility in muscles is through exercise.

A study on movement and aging was conducted by Dr. Hans Kreitler and his wife (1970; cited in Frankel & Richard, 1980), in which they compared the joy with which children and young people engage in motion for the sake of motion with the reluctance to be physically active that sedentary adults tend to feel more and more as they age. The Kreitlers found that adults who led inactive lives experienced muscle deterioration as they grew older. They also found that those who were habitually inactive gradually lose confidence in their physical abilities and come to view themselves as weak or clumsy. This distorted perception of themselves and their bodies very often becomes a reality. They do become clumsy and awkward and develop a real fear of any physical activity at all. As stated earlier (Benestad, 1965), these individuals would benefit most from exercise.

It seems evident that from a brief review of the current literature that exercise can lessen the intensity of the physical effects of aging.

Emotional Benefits

Working with the elderly differs from working with other groups in that therapists do not necessarily think of long-term goals but instead work for immediate responses and improvement of the ability to cope with present problems (Caplow-Linder et al., 1979). Recent literature and research gives much evidence of the emotional benefits of movement therapy for the aging.

According to Caplow-Linder, Harpaz, and Samberg (1979), enforced or voluntary inactivity results in accumulated tensions that are stored in the muscles and may cause restlessness, irritability, and even insomnia. The loss of independence, whether financial or social, may produce a loss of self-confidence that may result in self-pity, passivity, frustration, or resentment. The elderly often turn their unrealized aggressive tendencies inward, producing psychosomatic illnesses, which may lead to depression or outbursts of sudden anger. The elderly person may resort to regressions or delusions in an effort to withdraw from a too painful reality.

Many services provided for the elderly focus only on the most basic physical needs. Many therapeutic efforts are

directed toward curing specific conditions and not toward emotional needs of the individual. Many aged lose their identity and become a medical management problem. They often adopt the "sick role" in order to live up to society's expectations. This depersonalizing atmosphere offers no gratification and serves only to reinforce the isolation and the separation that is often the cause for institutionalization (Helm & Gill, 1974).

Some worthwhile studies on the emotional effects of recreation is taking place. A study was done in London Psychiatric Hospital, Ontario, Canada. A group-oriented activity program consisting of physical exercise, rhythmic sessions, art therapy, and group therapy was introduced on the psychogeriatric ward; three other geriatric wards acted as controls. The results showed that on the experimental ward both patient and staff benefited. Patients became less hostile with less behavioral deterioration, and as a result there was a higher discharge. The staff, who at first had been ambivalent, became interested and enthusiastic, and this carried over to a greater sense of cohesiveness on that ward (Reichenfeld, 1973).

According to Fersh (1980), dance-movement therapy plays a vital role in the creation of meaningful experiences.

She states that it offers an authentic experience of action in the present, thus reinforcing the ability of the elderly to take the initiative.

Arlynne Samuels (1968) states that individuals in dance-movement sessions are encouraged to explore new things that stress abilities rather than limitations as a means to explore and feel positive emotions. Older people, she states, derive a feeling of aliveness and vitality through spontaneous movement expressions. Isolation may be reduced while self-confidence and self-esteem are nurtured.

Eva Desca Garnet (1973) describes her work as a dance therapist with her "students" aged 66 to 81 years in a paper presented at the Seventh Annual Conference of the American Dance Therapy Association. The group represented a wide difference of backgrounds, particularly in exercise experience and physical health. Besides laughter and enthusiasm, the audience had the opportunity to observe the process of the growing sensory awareness of the participants. They saw and heard the transition as the demonstrators perceived the rigid painful movements of the spine, pelvis, and appendages relax and stretch into the enjoyment of carefree swinging actions. Kinesthetic awareness became first a therapeutic and then an esthetic response.

According to Susan Sandel (1979), group movement therapy sessions, in which mutual touching, the expression of memories, and the sharing of feelings, are encouraged, provide one place where the elderly may explore their sexuality. It was found that sound and movement activities create an atmosphere of excitement that can have a revitalizing effect on older people. She found that the therapist is often the first recipient of the client's erotic fantasies. A patient's sexually provocative behavior, especially when directed at the therapist, should be regarded as potentially meaningful since it may mask feelings such as neediness or rage. Issues including the longing for companionship, fear of physical deterioration, and sexual frustration commonly emerge in movement therapy sessions. These issues are acknowledged and explored in the supportive environment of the group, where a spirit of playfulness eases the discomfort of dealing with painful or embarrassing material.

Caplow-Linder et al. (1974) state that they incorporate relaxation and massage techniques into their geriatric dance-movement sessions for emotional release and well-being. They believe that when the body is held in the same position for long periods and when it reacts to stress

or anxiety by tensing, then the muscles contract, there is a decrease of blood supply, and pain may result. The pain is often transmitted from the direct source of strain to other body parts such as from the neck and shoulders, down the torso, to the legs. Built-up tension causes fatigue because of the needless amounts of energy expended. Emotional states such as anger and fear have a direct effect on the condition of the muscles, ligaments, and circulatory system. The relationship of mind and body is central as releasing physical tensions will also release emotional tensions.

These same movement therapists (Caplow-Linder et al., 1979) incorporate massage for emotional benefits of geriatric populations. The most obvious benefits of massage are the improvement of circulation, but they have found that it also has psychological and emotional advantages such as increased self-esteem, more accurate body image, and lowered anxiety levels. Self-massage promotes a soothing and calming effect within the individual and is also an excellent method of reality testing since the client recognizes himself and his place in space.

Garnet (1974) found that the good feeling the older adult experiences during movement therapy does not arise solely from the immediate sensations of pleasure from relief.

of restricted movement. She found that it is often linked to the muscle memory of past events through "reverberating circuits of association" (p. 61). A swing that feels free may awaken and hook into the kinesthetic memory of youthful feelings that, rekindled, reinforce a carefree experience.

The use of music in geriatric dance-movement sessions has been shown to provide various emotional benefits. Caplow-Linder et al. (1979) have found music to be extremely helpful in raising energy levels of regressed or depressed individuals. They found music to be a powerful mood modifier. The different qualities in music may be used for soothing and calming and others for stimulating. They also found music to evoke past experiences. The use of tunes from the 1920s and 1930s created reminiscences that developed into intellectual stimulation or life review of past experiences.

In an experiment at Yale Psychiatric Institute Sandel (1975) found that discussions after movement sessions directing questions about individual's reactions to certain movements and images brought out many unresolved feelings in the group.

In summary, current literatures demonstrates the emotional benefits of dance-movement therapy with the

elderly. Because the aging process is characterized by the onset of physical limitations and emotional stresses, it is vital to find outlets for self-expression and emotional release.

Social Benefits

A basic assumption in dance-movement therapy is that participation in a group movement experience constitutes a shared emotional experience that forms the basis for relationships with others. In the same experiment at Yale Psychiatric Institute as mentioned earlier Sandel (1975) found the idea of being allowed to touch each other and discussing how that felt was of predominance.

Fersh (1980) finds much socialization taking place in dance-movement sessions using the powerful therapeutic tools of physical closeness and touch. She found physical contact, in the forms of massaging each other, putting an arm around a friend, or embracing, reduced withdrawal during a time of time and provided a tangible social support system.

Fersh (1980) also found the developing relationship between the dance-movement therapist and the individual to serve as the most motivating force for the older adult in a

nursing home. The need for a trusting relationship was essential and the therapist almost came to assume the role of a surrogate child who comes to visit the person regularly.

Caplow-Linder et al. (1979) state that massage by the leader-therapist with an elderly individual often produces feelings of reassurance and acceptance. In addition, it fosters interpersonal relationships because it is an opportunity to give and receive pleasurable sensations.

Curtis and Miller (1967) write of a program developed by White Plains Department of Parks and Recreation and the Miller Center for Nursing Care. Its objective was to offer recreational services for the elderly who were not mobile and who were without transportation. The Miller Center offered its facilities and a program of rhythmic exercises, music, bingo, crafts. The nursing home patients benefited greatly from the interaction between the two groups and it was definitely felt that this program had helped to develop self-awareness and reestablish group relationships.

Holistic Benefits

A study by Berger and Berger (1973) at the Center for Adults Plus shows the holistic benefits of dance-movement

therapy. The center was equipped with a workshop for woodworking and leather working, art, and other task-oriented recreational activities, and an activity room for groups to engage in exercises. The goals of the group participation with the aging were resocialization and reduction of isolation through increasing interpersonal verbal and nonverbal communication; building self-esteem; an opportunity to allow for discharge of pent-up tension, anxiety, anger, and affection; creative self-expression and development of interest in new activities and people.

In the movement therapy provided group members mirrored staff as they reached upward with their arms outstretched and fingers reaching in the air. "What are we reaching for" was asked. A discussion followed. Then self-involving and self-loving movements followed. Group members were directed to tap and feel their own faces and caress themselves lightly.

To improve circulation and skeletomuscular mobility, gentle rotating movements of wrists, fingers, shoulders, and feet. Saying "No" with feet in motion as if stamping or kicking may lead to questions of "No, to what?" There was discussion of how it feels to touch one's body and to find how much it can respond when an effort is made to move

instead of sitting still in front of a television set. Rhythmic word games were introduced where one word such as like is introduced and others add words they believe are connected. This encourages the group to elaborate. As the sessions progressed, various types of subject matter or content were stirred up by spontaneous interaction and the stimulation of music, movement, and free association. Problems were discussed by group and staff in an educative, supportive way, which relieved the group members of anxiety, self-hate, or depression.

The researchers concluded that activity is the basis for joie de vivre throughout life. Passivity breeds paralysis, pessimism, and poor circulation, the effects of which are further compounded by isolation and depression. The practice of exercising the capacity to learn and to be active appears to delay the onset of any loss of ability to learn and to be active. In this study it was found that patients in an acute psychic and emotional decompensation because of a realistic stress, tended to recover from their agitated state. Patients with serious physical disorders whose self-image and body image were affected by deteriorating diseases such as Parkinsonism and hypertensive cardiovascular diseases were helped to relieve their anxiety

and accompanying depression. The group not helped were those seeking instant or magical solutions to problems.

Interpersonal activity and involvement with others diminished isolation, regressive behavior, and despair. Self-esteem and self-respect were revived through discussion, emotional involvement, and physical activity and touching. (Berger and Berger, 1973).

In summary, the current literature displays a great deal of evidence of the physical, emotional, and social benefits of dance-movement therapy for geriatric populations.

CHAPTER III

THEORETICAL ORIENTATION

This author suggests that dance-movement therapy provides physical, emotional, and social benefits for active, moderately ambulatory, and nonambulatory senior adults. This author also suggests that staff members of agencies serving the elderly will find movement therapy beneficial to their clients. This theoretical orientation is based on the relevant research literature on dance-movement therapy and this author's personal observations and exploratory work in the field of movement therapy with geriatric populations.

This author implemented dance-movement therapy to three different groups of aging adults in three different settings. It was a result of the structure of the sessions, how dance therapy goals were implemented, and what was observed that led to this author's theoretical orientation. Following is a discussion of the author's exploratory research.

Mobile-Active Group

Initial involvement with dance-movement therapy with this population was the author's instructing a dance class for active senior adults--ages 60 years and up--at the Jewish Community Center Association (JCCA) Senior Adult Department in St. Louis, Missouri. A grant had been secured in the fall of 1980 by the JCCA from the Missouri Arts and Education Council. The purpose of the grant was to incorporate movement into the lives of senior adults. The class was to meet one hour a week for six weeks with the possibility of renewal. It was free to anyone in the community 60 years of age and older and was held at the Covenant House Senior Adult Apartments in a large multipurpose room in conjunction with the JCCA Senior Adult Department. Because of earlier attempts with dance for senior adults at this setting, 15 to 20 individuals were expected to register and 5 to 10 people participating were expected to attend the entire 6 weeks. This is in agreement with the attitude of Helm and Gill (1974) that the whole spectrum of movement is diminished for the aging.

In planning sessions with the administrative staff in charge of this program, it was agreed that dance-movement therapy goals and techniques would be implemented in the sessions. The author agreed with the attitudes of Frankel and Richard (1980) that low-level exercises are an effective way for the older person to remain physically fit, but the author would be eliminating a straight exercise program, which becomes tedious. As supported by Frankel and Richard, the program would include no exercises or dance movements that would cause the heart rate to exceed 120 beats per minute. The leader stated that the "students" would not be asked to take their pulse. In a previous class the instructor had the participants check pulse rates after dances. This created an undo concern over bodily functions for some of the participants. Several stopped attending. This author agreed with the attitude of Fersh (1980) that an overconcern with one's bodily functions causes added anxiety. This leader structured the activity so that pulse rates would not exceed 120 beats per minute. More appropriate outlets for concern of the body would be found and thoughts could be turned outward rather than inward.

"Health must be one of the joys of life as no other joy is possible without it" (More; quoted in Garnet, 1974, p. 59). The title "Dance for Health and Happiness" was chosen for the sessions. Health was the major focus in promoting the program to the community. One lesson was the increasing knowledge of the relationship between physical activity and physical and mental health. It is known that physical activity can provide deep emotional satisfaction (Kreitler; cited in Frankel & Richard, 1980).

Contrary to what was predicted, 50 individuals--46 women and 4 men--registered for the session.

The treatment goals of various therapies (recreational, occupational, art, music) were summarized by Elizabeth Rosen (1957, p. 19) as follows:

1. Increase socialization.
2. Facilitate sublimation (redirect expression of primal drives into socially acceptable channels).
3. Alter self-attitudes (restore self-confidence and sense of security).
4. Develop new skills and interests (divert attention from personal systems).
5. Aid in adjustment to reality.
6. Assist staff understanding of patients' problems.

With these and the before-mentioned goals of dance-therapy in mind, the goals for the "Dance for Health and Happiness" sessions were as follows (though not in order of importance):

1. Improve flexibility
2. Improve cardiovascular endurance
3. Improve breathing techniques
4. Increase range of motion
5. Increase energy levels
6. Relieve tension
7. Improve self-confidence
8. Increase movement repertoire
9. Recapture youthful feelings
10. Improve self-image
11. Develop new skills
12. Create pleasure in moving rather than in pain
13. Allow for socialization

The following discusses the theory, methods, and techniques implemented in the movement sessions with 50 active and mobile senior adults aged 60 to 77 years implementing the above goals.

The sesions took place in a large mulltipurpose, well-lighted room. The entire session was set to music,

which is a mood alternator (Frandel & Richard, 1980). Music was used as a resource rather than simply being an accompaniment (Garnet, 1974). The sessions began with the participants seated in a large circle, as indicated by Samuels (1968).

The session was begun by introductions and welcoming everyone to the group. The leader/therapist welcomed each individual in the circle while the others socialized. This helped to develop a more personal relationship between the participants and the therapist. The seating arrangement also promoted conversation. Participants were congratulated for choosing to find time to take care of themselves and to have fun. The following goals were stressed: the class was to meet new people; to enjoy moving; to leave feeling more relaxed than before; this was not a class to "learn how to dance" but to learn or relearn how to enjoy moving and stretching, that there would be no right or wrong and everyone would "move" at their own level.

An effective dance-movement session should include a warm-up period, stimulus period, and cool-down period (Helm & Gill, 1974). This format was selected.

Warm-up Period

The warm-up period was done seated. Not knowing the participants' ability levels before beginning, a seated warm-up session would be a task everyone could master. Slow soft music was chosen.

Breathing exercises were done first. Bringing in more oxygen increases energy levels (Lowen, 1975) and also makes one aware of proper and improper breathing patterns. Bringing air into the abdomen constitutes deep, correct breathing. Placing one hand on the chest and the other on the abdomen increases awareness of how one is breathing.

More energy is used in keeping muscles tense than in using them, so much of the warm-up period was spent in releasing tension and rigidity in the neck, shoulders, arms, hands, legs, and feet. This was done in the following ways:

1. Neck exercises
    a. Head forward and back
    b. Ear to shoulder
    c. Head turned to look over shoulder
    d. Head rotated in circle.

The participants were instructed to become aware of tightness and to let the stretches feel good.

2. Arm, shoulder, and hand exercises

   a. Lift arms slowly and lower them slowly while taking deep breaths.

   b. Lift arms up as if being pulled by a string; the string is dropped, arm drops (must release tension to drop)

   c. Lift shoulders up as if being pulled by a string; the string is dropped, shoulder drops (must release tension to drop)

   d. Shake shoulders

   e. Shake hands

   f. Shake whole arm

Shaking releases tensions and increases circulation. Anotaher benefit was smiles and laughter, which are muscular actions and can relax the mind and body (Frankel & Richard, 1980).

3. The same movements are repeated using the feet and legs.

With some tensions alleviated, stretches and rotations using all parts of the body were next. The music remained soft and slow to produce easy, slow movements. The movements were as follows:

1. Fingers stretched open and closed
2. Hand rotations
3. Shoulder rotated forward and backward
4. Lower arm rotated in forward and backward circles
5. Entire arm rotated outward and inward
6. Opening and stretching arms sideways
7. Opening and stretching arms upward

These exercises were implemented to reduce tendencies toward inward and downward movements. Use of as much space as posible was always stressed.

There is much thought and purpose behind these exercises. First, progression from small movements to larger ones warms up various parts of the body slowly without expending a lot of energy (Samuels, 1968). Rotating joints in various positions increases range of movement (Samuels, 1968). As participants reach upward and outward physically

they also reach mentally. The emotional feeling of "I can stretch and reach out" is a goal of this movement. All body parts were moved in a variety of ways and directions to increase movement repertoire and to make the participants more aware of their personal "self."

Still seated, faster music was played for marching in place, jumping and stamping in place, and leg kicks. Staying seated alleviated fear of falling while being able to do more activity. Not only did the use of the legs in such ways increase strength in the thighs and abdomen, it also provided for much release of tension. Stamping and leg kicks relieve anger. Imagery of kicking a punching bag or stamping because something went wrong brought laughter along with quite forceful movements.

At this point body parts were sufficiently warmed up, tensions were eased, muscles were relaxed, and everyone was able to master the activities. Throughout the entire warm-up the participants were encouraged to focus on how good it felt to move and stretch and reach.

The next section of the warm-up was done standing, with assistance of the chair. This allows both physical and emotional support and allows the individual to succeed at larger movement. Leg and arm swings provide needed movement

in the hip and shoulder joint while providing a reaching sensation. Swinging movements provide release of tension on the downward movement. A swinging motion may awaken and hook into the kinesthetic memory of youthful feelings, which, rekindled, reinforces the carefree experience (Garnet, 1974).

The final exercise or movements done using the chair were knee bends and raising oneself up on one's toes. This warms up the knees and ankles and provides the first feeling of moving through space--as opposed to stagnation. While remaining on their toes, the participants were encouraged to sense themselves tall and straight (posture, body image). One hand was slowly stretched up as if held by a string and slowly the other arm followed. With the imaginary string support and the visual image of being tall and straight, most participants were able to balance for even a few moments. Besides providing body alignment this provides the psychological feeling of standing on one's own feet or being grounded (Lowen, 1975).

Socializing throughout the session was never discouraged, contrary to many other "dance" classes. The goal of socialization is as important to the session as physical or emotional involvement.

Stimulus Period

Dance-movement sessions will differ according to the physical and emotional make-up of the group. With an active-mobile group such as this one the stimulus period was done standing learning modified dance routines or movements adapted to the ability of the group. It is extremely important for the leader to be aware of the group's ability level. This leader's observations were if movements are too elementary the participants feel patronized; if the movements are too hard no self-confidence can be built, and the feeling of being too old to move is reinforced. Just as a verbal therapist must know how her client is feeling, a movement therapist must provide movements congruent to the individual's movement ability and repertoire. In this particular setting each dane was choreographed with the group's ability in mind. All movements served a physical, emotional, or social need. The first "dances" were moderately slow and stressed arm and trunk movements, swinging movements, and already familiar foot work such as marches. This provided easy learning, easy execution on steps, and success. Much excitement and applause followed, and the group was ready to take in the next task. The

leader's comments were "Doesn't it feel good to move?" "You have a lot of rhythm inside of you." "Reach out with your arms." "You're doing fine." Music was chosen from the 20s and 30s, for example, "Tea for Two" and the Charleston to revive memories, and "Raindrops Keep Falling on My Head" and "Staying Alive" were chosen for contemporary youthful feelings. Quicker music was interspersed with slower tunes to avoid fatigue. The last dance was always done in a circle holding hands. This was beneficial for group unity, socialization, warmth, and support. "Consider Yourself at Home" was the music that reflected the warm friendly atmosphere.

Cool-down Period

The final section of the session was the cool-down. It was important for heart rates and respiratory rates to return to a slower pace (Cooper, 1979). Once again seated in a circle, slow stretches were done. With warm, relaxed muscles, stretches are done more easily and help develop flexibility. Many of the same stretches done in the warm-up were repeated. Attention was focused on areas of tension in neck and shoulders. "Did those areas feel less tense after

use?" was asked. Much reaching up, out, and into the center of the circle was done. "Reach for something you want" was suggested. "Reach out and touch the person next to you" was proffered. The philosophy behind many movements were if you can reach out physically you can reach out emotionally.

In agreement with Caplow-Linder et al. (1980), self-massage was an important part of the cool-down session. At this point the leader stated that everyone was going to take time to be good to themselves. Each participant massaged the back of her neck and shoulders. At first many were hesitant. It's not often one takes time to care for oneself. Watching those who tried the massage gave the observers permission that it was acceptable to care about oneself. Rubbing and tapping motions on the arms, legs, and face provided not only sensory stimulation but defined body boundaries and gave a sense of physical self. Massaging from the extremities toward the center of the body also returns the blood to the heart.

The final movement was reaching out as far as one can and then folding inward as far as possible. Participants were instructed to sense how it felt to stretch upward and outward. The session ended with an upward and outward movement. Before leaving the participants were asked to sit

quietly for a few moments and try to become aware of how they felt physically and emotionally. Did they feel more tired or energetic? Did movement bring pleasurable feelings? Were they pleased with themselves? These and other questions would be explored throughout the session. The underlying philosophy was to help participants to become more aware of their feelings in connection with their body rather than concerned with illnesses connected with their body.

As the sessions continued for the six weeks, more movements were added to increase their movement repertoire. As their movement repertoire increased it was hoped that the activity repertoire would also increase.

At the end of the six-week session more individuals were registered than had been the first day. The average number attending each session was 45. The grant was renewed for another six-week session.

When the grant was completed, a twice-weekly, two-month session was offered for a small fee. A minimum of 35 participants was necessary. At this time 40 individuals registered, 32 returning participants and 8 new participants. Every 8 weeks a new session was offered, and presently there are four sessions weekly.

During the first session, 4 or 5 standing dances wereexecuted. With increased stamina, presently 8 to 10 dances are incorporated in the hour. Self-confidence has risen as the group has been asked to perform for other groups of senior adults. At the first performance only 10 persons were willing to participate. The second performance attracted 19 performers; the third, 22. Watching the growth and excitement of the "Dance for Health and Happiness" participants led the author to explore the use of dance-movement sessions with less active aging adults.

Nonambulatory Group

The next exploratory venture was more difficult. An institution was approached that had never incorporated dance-movement therapy. The setting was Anthony House, a division of St. Anthony's Hospital in St. Louis, Missouri. Anthony House is a physical rehabilitation center where patients stay for rehabilitation after strokes, accidents, or operations. The center offered occupational, physical, and recreational therapy. The recreational therapy staff agreed to begin the movement therapy sessions once a week for 12 weeks. Although the author was unable to secure permission

to interview the patients and receive necessary data, it is necessary to discuss the author's theoretical orientation with this group and how it supported the hypothesis. The staff was allowed to complete a questionnaire.

All of the participants were confined to wheelchairs. Their participation in the sessions was usually voluntary and were selected due to their lack of involvement in physical therapy at the time. The group was not consistent because of scheduled admissions and discharges. There were several who attended multiple sessions.

In observing the participants in this setting much withdrawal was noticed. A pulling inward and sinking of the body were prominent. Because of physical disabilities there was obviously a lack of physical activity and few body movements were possible. Movement sessions must be flexible enough to meet the needs of individuals on whatever level they are functioning.

Goals for this nonambulatory population were as follows:

1. Provide a source of enjoyment.

2. Provide social stimulation.

3. Provide a sense of movement in each individual, no matter how small.

4. Provide an outlet for tensions.

5. Provide sensory stimulation.

The participants were wheeled into a circle and each one greeted. They were introduced to the participants on either side of them. An explanation of the program was given. There was to be movement to music and each individual could do as much or as little as he/she chose. Parts of the body that could move would be used. Everyone has movement inside of him/herself, and enjoyment of that movment was stressed along with the enjoyment of being together.

Trying to provide pleasure to people who are in physical pain is a challenge. The place to start was to concentrate on their breathing for everyone who is alive automatically has that movement.

In this type of group verbal explanations of why a specific movement is unnecessary. Since there were many hearing problems and much hesitancy, the method of mirroring was chosen. Visual cues are much easier and larger to follow than verbal cues. It was always stressed that each individual could do as much or as little as he chose.

After deep breathing to increase energy levels and to provide movement that everyone could master, the sessions included the same format of warm-up period, stimulus period, and cool-down, as described earlier, geared to the needs and abilities of this nonambulatory, hospitalized group.

The warm-up period consisted of sensory stimulation and easy stretches. It has been demonstrated in experimental studies that complete sensory deprivation for a period of 30 hours causes hallucinations in healthy young athletes (Garnet, 1974). This helps us to understand the plight of older individuals who are experiencing sensory losses. The sensory impairment of deafness, loss of taste buds, increasing blindness, and the decrease of tactile sensations and of affectionate relationships, and the loss of kinesthetic sensations for lack of physical activity--all add up to sensory deprivation. Lost senses cannot be restored, but sensory stimulation can be supplemented. The sensory stimulation provided:

1. Tapping face--cheeks, forehead, chin.

2. Rubbing face.

3. Rubbing hands and fingers.

4. Tapping and rubbing arms and legs.

5. Rubbing shoulders and neck.

6. Rubbing back--if individual cannot do this staff may provide massage.

These simple activities provide sensory stimulation, define body boundaries, increase circulation, and provide warmth to areas to make the participant "feel good."

Because this type of group has multiple physical problems that are attended to through physical therapy, the importance of using unaffected body parts for pleasure was stressed. A combination of stretches, reaches, rotations, twists, and extensions were used to gentle music. The movements are designed to meet physical needs that stimulate improved somatic feelings and to meet psychological needs with a whole spectrum of feelings. At the tissue level, improved physiological balance and relief from tension are noted.

With this group it is during the stimulus period that the psychological needs are met. As wide a range of movements as possible needs to be offered. Again, mirroring techniques were selected. The participant sees the therapist and hears the verbal accompaniment of instruction,

encouragement, and reinforcement. Concentration rather than memory is focused on.

After following the movements of the leader, each individual is asked to show his favorite movement and be the leader. This provides initiative for the participant and allows him to show something about himself. There often were participants who would not do this activity first but would consent after seeing others be the leader. This activity transfers leadership, thought, and creativity from the therapist to the participant.

One of the most important aspect of the stimulus period for a nonambulatory hospitalized group is interpersonal tactile experiences (Garnet, 1974). This goal was incorporated in several ways. First, the participants were seated close enough together so that they could reach to the side and touch another participant. First fingers were touched, then palms, then hands held. With held hands the group swayed from side to side to music. Everyone was incorporated into the group and the activity. It was interesting to note that no one ever refused this interaction. Those members who had participated only in a small way previously, accepted the support and interest

of others. This was one of the most beneficial aspects of the session.

To keep the group feeling alive and to offer supports for movement, an elastic circle is offered for all participants to hold. With everyone's help the circle can move up, down, in, and out. A rowing action became the most popular activity. Although these participants were not very verbal, smiles and laughs spoke for themselves.

In this particular group the musical acoustics were poor and many participants suffered from hearing impairments. Rhythms were passed on visually and kinesthetically more than auditorally.

To avoid fatigue each portion of these sessions is much shorter than with a mobile group. The entire session usually lasted only 30 minutes.

A cool-down period is necessary for physical purposes, while it is important to keep the emotional and social spirits high. To achieve this goal, the leader encourage participants to hold hands during relaxation and breathing exercises. Self-massage of neck, shoulders, face, arms, hands, legs, and back were interwoven with shaking a partner's hand. Then the leader went around the circle and held each person's hand and told them she was glad that she

was able to spend time with them and that she enjoyed "dancing" with them.

Reflective questions dealing with participants' feelings about movements was tried. This led to poor group discussion. Individual conversations were more successful. Some of the comments were:

"It's nice to have something to do that's fun."

"I used to love to dance when I was younger." (This could develop into a life review discussion.)

"It feels good to move. I get so tired of sitting all day."

"You should have seen me when I was younger. I could really dance."

"I love the music."

"Thank you for coming to see us."

Since it was not possible to collect data from this group this exploration was qualitative in nature. It is assumed that the sessions benefited the participants by the smiles and laughter, by the increased social interaction, by a renewed interest in the present moment, by the reduction of

discomfort, by the obvious pleasure that some of the participants showed, and by the conversation of those individuals who participated several weeks in a row.

Moderately Ambulatory Group

The third population to be exposed to movement therapy and exploratory research was a group of elderly men and women, aged 68 to 93 years, at the JCCA Co-ordinated Day Care. This is a government-subsidized program serving the needs of the elderly. One group of individuals come two days a week and one group comes the alternating three days. The dance-movement sessions were offered to the two-day group.

This was a moderately mobile group. Some individuals needed canes or walkers, but could move independently. Most walking movement was slow and required much effort.

Goals for this group were to:

1. Provide physical stimulation and exercises.

2. Provide an outlet for tensions.

3. Provide social interaction between group members and members and staff.

4. Provide a source of enjoyment.

The author had preliminary discussions as a visitor to the group. This group was functioning cognitively well and appeared social.

Morning exercises were the routine and most did not question the activity. There were several who said they would watch because they weren't feeling well.

The session was similar to the nonambulatory group session described earlier, with the exception that more movement and verbalization took place.

With this group the leader explained that each person has his own limitations that need to be accepted and that each person could move and exercise within his own limits. The leader explained to them how tensions get "trapped" in the body and that the muscles and joints need to be moved to release tension and keep their strength. It was also stressed that movement is fun and can feel good if done within each person's range of movement. Movements would be employed that felt good to them.

This group was seated in a circle. Music that could be heard was used. The warm-up portion was similar to that described earlier. Deep breathing, extensions, rotations, flexions, stretches, bends, pushes, pulls, twists, shakes,

and massage were done. Slow soft music was used at first, but moderate waltz music seemed to awaken and energize this group. Sways, swinging movements, and shaking movements seemed the favorites. Reaching up and out, reaching for something, punching movements, stamping movements while saying "No" brought smiles, laughter, and verbalization of some of these needs. It was interesting to note that those few who wanted to watch joined at this time.

Mirroring techniques were used and follow-the-leader techniques were used. Half of the participants agreed to be a leader.

In the stimulus portion music from the past such as the "Charleston" and "Tea for Two" along with Disco music was incorporated. Simple four-count movements were introduced using arms and legs to give the feel of "dancing." Much laughter and verbalization took place.

Group activities such as holding hands and using scarves and elastic ropes proved enjoyable. The elastic rope brought everyone into the group reaching, stretching, pulling. The group decided that they were going on a boat trip together and began singing together "Row Row Row Your Boat."

The cool-down period was similar to that described earlier, letting heart and lung rates slow while keeping spirits high.

Much discussion followed as to how much fun they had and how good they felt. One individual who had not wanted to participate commented that exercises are fun when they are not too strenuous or difficult. The leader must always be aware of the movement and emotional level of the group. The goals are feelings of success and relaxation, not physical accomplishments.

The exploratory work done with these three groups led me to believe that dance-movement therapy can provide physical, emotional, and social benefits to active, moderately ambulatory and nonambulatory groups of senior adults.

CHAPTER IV

RESEARCH METHODS

This study was an exploratory survey of the physical, emotional, and social benefits of dance-movement sessions based on personal interviews given to participants of the "Dance for Health and Happiness" sessions at Covenant House Senior Center (active-mobile group) (see Appendix A) and to the participants of dance-movement sessions at Co-ordinated Day Care Services (moderately ambulatory group) (see Appendix B). As mentioned earlier, the participants at Anthony House (nonambulatory) were not allowed to be interviewed, although staff members were. The interviews were developed by this researcher based on those given by other movement therapists (Caplow-Linder et al., 1979). Physical, emotional, and social goals of dance-movement therapy were explicit in the interviews.

The results of the interviews were categorized according to the following variables of the active group: age

of participants, marital status of participants, type of housing (subsidized, nonsubsidized), perceived health of participants, and activity history of participants.

The results of the interviews with the moderately ambulatory group were broken down according to the following variables: perceived health of participants, activity history of participants, and amount of friendships away from center.

The study was also based on questionnaires given to staff members at Co-ordinated Day Care Services, Anthony House, and Covenant House pertaining to any physical, emotional, and social positive changes noticed in the participants (see Appendix C)

Subjects

The subjects for the active-mobile senior adult study were 40 members of the "Dance for Health and Happiness Sessions," held at Covenant House. This included 39 females and 1 male, ranging in age from 60 to 77 years. Having only 1 male, his interview results were eliminated from the study. After gathering the data on ages of subjects, the questionnaires were divided into three age groups--60 to 65,

66 to 69, and 70 to 77. Those three participants who were unwilling to state their ages were eliminated from the study.

Ten participants fell into the first group; twelve participants fell into the second group; and fourteen participants fell into the third group. The researcher chose to have an equal number of interview sheets from each group. The number 6 and 12 were randomly chosen by the researcher to be the interviews eliminated until 10 forms remained. Thus 10 interviews from each age group were used in evaluating the study.

The subjects of the moderately mobile group of senior adults were ten members of the Tuesday-Thursday group of participants at Co-ordinated Day Care Services, a government-subsidized day care program for the elderly. There were fifteen members of this group. The ten members interviewed were those who attended all of the dance-movement sessions offered.

The subjects of staff evaluations were the instructor of the Health Dance session (also the interviewer), two staff members of Co-ordinated Day Care Services who worked daily with members, and the recreational and assistant recreational therapist at Anthony House.

Procedures

The subjects in both the active group and the moderately ambulatory group were told that the instructor (interviewer) was doing a study on dance-movement sessions. She explained that she needed their help in gathering data and would appreciate their time for a short interview. Subjects were told that this was voluntary, that no personal information would go beyond the interviewer, and that no names would be presented in the study. It was also explained that age would be an important factor in the tabulated results.

The interviews were given before an after multiple "Health Dance" sessions. The first section of the interview gathered data pertaining to the subject that would be used later in catagorizing certain groups according to the variables. These included age, sex, type of housing, marital status, children, friendships, length of time in the class, and activity history. Age, marital status, housing, and perceived health were later chosen as variables to be studied with the active group.

In the next section questions were asked pertaining to the subjects' perceived physical improvement in various areas and in range of motion. Questions were answered "Yes" or "No." Next, questions were asked that pertained to perceived emotional benefits from the sessions. Answers again were "Yes" or "No" (see Appendix A).

Additional positive or negative comments were asked for if so desired. These were not tabulated in the results since these comments were often repeated in earlier responses. See Chapter V, "Conclusions," for a discussion of comments made by the participants.

The Day Care interviews were given after the final dance-movement pilot session. Each subject was asked to answer the questions, although they were told that they did not have to answer if they did not wish to. Initial data on the subjects were gathered such as age, marital status, housing, friendships, perceived health, and exercise history. The next section asked about physical, emotional, and social benefits of the sessions. This interview was geared to the group's level of comprehension (See Appendix B).

Following each interview the subjects were thanked for their cooperation.

The recreational therapists at Anthony House were contacted by telephone for permission to answer a questionnaire. The questionnaires were mailed to them and returned to the interviewer by mail. It was explained to them that the results were for a study being done on dance-movement therapy for the elderly. Although the participants at the hospital could not be interviewed the staff's opinions would be of importance (see Appendix C). The staff subjects of Co-ordinated Day Care were asked for their involvement before the project began. They were told that they would be asked to fill out a qustionnaire at the end of the pilot sessions. The two staff members were handed the questionnaire at the completion of the sessions by the instructor (researcher).

The staff member of the "Dance for Health and Happiness" class was the instructor researcher. It must be noted that all staff member subjects involved used observation of others in completing the questionnaires.

CHAPTER V

CONCLUSIONS

Active-Mobile Group

The interview with the active mobile subjects of the "Dance for Health and Happiness" sessions consisted of a series of questions pertaining to physical, emotional, and social benefits that may have been gained from the dance-movement sessions. This researcher did not attempt to assemble large numbers of responses or to identify specific data for each respondent. The tabulations were not for statistical purposes. This interviewer tried to determine a consensus of the overall reaction regarding the value of the activity to various groups. As predicted, physical, emotional, and social benefits were noted, although to different degrees according to age. The results were tabulated in the following ways.

First, all responses were tabulated in the three different age groups--60 to 65, 66 to 69, and 70 to 77. The responses were tabulated according to the number of positive responses to questions of physical benefits, then emotional benefits, and finally, social benefits. The positive responses ("Yes") in each category were tabulated by the percentage of participants responding positively to that question.

Group 1

It is interesting to observe that physical benefits were not strong in the 60-to-65-year-old group (Group 1) but increased in the 66-to-69-year-old group (Group 2) and increased even more in the 70-to-77-year-old group (Group 3) (see Table 1). Physical improvement was attested to in an average of 43% of the participants in Group 1; 51%, in Group 2; and 68%, in Group 3. From these results it can be assumed that more physical benefits from dance-movement therapy will be found with advancing age. It must be realized that advancing age will bring more physical problems; therefore there is more to correct.

Table 1

Physical Benefits of Dance-Movement Therapy
--By Age Group

Physical Benefit	Percentage Answering Yes		
	Group 1 (60-65) (n=10)	Group 2 (66-69) (n=10)	Group 3 (70-77) (n=10)
Improvement of:			
Sleeping habits	50	50	60
Flexibility	70	70	80
Coordination	50	60	80
Breathing	50	60	90
Headaches	30	30	50
Posture	40	50	90
Relaxation	60	70	90
Stress reduction	70	60	80
Use of shoulders	60	60	80
Use of arms	40	50	50
Use of hands	40	60	50
Use of wrists	40	60	40
Use of fingers	40	30	70
Muscle strength	50	40	50
Weight loss	-	20	-
Speed of movements	40	30	70
Improvement in Range of Movement:[1]			
Shoulders	50	50	80
Wrists	40	40	80
Head and neck	40	50	80
Legs	30	70	70
Knees	40	70	80
Hips	30	60	80
Average percentage	43	51	68

[1]Movement between full extension and full flexion.

It is noteworthy that the sessions did not benefit weight loss in any age group, whereas flexibility, stress reduction, and relaxation scored high on improvement in all age groups. Weight loss is not a goal of dance-movement therapy, whereas flexibility, stress reduction, and relaxation are goals of dance-movement therapy.

The emotional benefits derived from the dance-movement sessions with an active group of senior adults proved higher than the physical benefits in all three age groups. In Group 1, 54% of the responses were positive; in Group 2, 64% of the responses were positive; and in Group 3, 88% of the responses were positive. The amount of perceived emotional benefits also increased with advancing age (see Table 2).

The social benefits of the dance-movement sessions with an active group of senior adults proved to be the highest of all benefits in Groups 1 and 2. In Group 1, 74% of the responses were positive; in the Group 2, 71% of the responses were positive; and in Group 3, 80% of the responses were positive., With questions pertaining to social benefits Group 3 responded the most positively, Group 1, the next; and Group 2, the lowest (see Table 3).

Table 2

Emotional Benefits of Dance-Movement Therapy
--By Age Group

Emotional Benefit	Percentage Answering Yes		
	Group 1 (60-65) (n=10)	Group 2 (66-69) (n=10)	Group 3 (70-77) (n=10)
Alleviation of anxiety	50	60	70
Positive changes of self-image	60	40	90
Concentration	50	50	90
Alertness	40	70	90
Willingness to try new activities	70	100	100
Mean percentage of positive responses	54	64	88

Table 3

Social Benefits of Dance-Movement Therapy
--By Age Group

Social Benefit	Percentage Answering Yes		
	Group 1 (60-65) (n=10)	Group 2 (66-69) (n=10)	Group 3 (70-77) (n=10)
Made new friends	80	90	50
Strengthened old friendships	50	60	70
More comfortable being in group	70	60	80
More comfortable exercising in group	60	50	100
Enjoy touching activities	70	50	80
Enjoy working with partner	90	90	80
Enjoy interaction with leader	100	100	100
Mean percentage of positive responses	74	71	80

Overall Group 3 perceived the most physical, emotional, and social gains of the three groups.

The survey was then analyzed as to the individual variables--marital status, type of housing, and perceived state of health. This was done for each of the three age groups.

In Group 1 seven were married and three widowed. Each positive response was counted as one point. Points were added and a mean emotional benefit score and a mean social benefit score was recorded for the two groups (see Table 4). The emotional benefits were the same for married and widowed participants. The social benefits showed very little difference between the two groups (mean: 5.4, married; 5.6, widowed). Marital status was not statistically significant to this group.

Then Group 1 was examined according to type of housing. Two participants lived in subsidized housing and eight lived in nonsubsidized housing. The mean for emotional benefits for those living in subsidized housing was 3.0; the mean for those living in nonsubsidized, independent housing was 3.2. No significant difference was noted. The emotional and social benefits are shown in Table 5. The mean for social benefits for those living in subsidized housing was

Table 4

Emotional and Social Benefits of Dance-Movement Therapy for Group 1--By Marital Status

Marital Status	Number of Respondents	Positive Emotional Responses	Mean	Positive Social Responses	Mean
Married	7	21	3.0	38	5.4
Widowed	3	9	3.0	17	5.6

Table 5

Emotional and Social Benefits of Dance-Movement Therapy for Group 1--By Type of Housing

Type of Housing	Number of Respondents	Positive Emotional Responses	Mean	Positive Social Responses	Mean
Subsidized	2	6	3.0	10	5.0
Nonsubsidized	7	26	3.2	45	5.6

5.0; for those living in nonsubsidized housing, 5.6. Housing was not significant.

Next, Group 1 was divided into those who perceived their health to be good and those who perceived it to be fair. Physical benefits were noted for the two groups. The results shown are in Table 6. Those who perceived their health as being fair received more physical benefits from the sessions than those who perceived their health as good. As noted earlier, the participants who perceive their health as being only fair may have more physical problems that can be helped than those who are already in good health.

Group 2

Group 2 was categorized according to marital status, housing, and perceived health. In this group six participants were married and four widowed. Both emotional and social benefits were higher for those widowed than for those married (see Table 7).

Five participants lived in subsidized housing, 5 in nonsubsidized housing. The emotional and social gains were greater for those living in subsidized housing (see Table 8).

Table 6

Physical Benefits of Dance-Movement Therapy for Group 1--By Perceived Health

Perceived Health	Number of Respondents	Positive Physical Responses	Mean
Good	8	92	8.5
Fair	2	17	11.3

Table 7

Emotional and Social Benefits of Dance-Movement Therapy for Group 2--By Marital Status

Marital Status	Number of Respondents	Positive Emotional Responses	Mean	Positive Social Responses	Mean
Married	6	12	2.0	23	3.8
Widowed	4	18	4.5	19	4.8

Table 8

Emotional and Social Benefits of Dance-Movement Therapy for Group 2--By Type of Housing

Type of Housing	Number of Respondents	Positive Emotional Responses	Mean	Positive Social Responses	Mean
Subsidized	5	25	5.0	23	4.6
Nonsubsidized	5	24	4.9	13	2.6

Finally, Group 2 was divided according to perceived health. As noted, those participants who perceived their health to be fair showed much greater physical benefit from the sessions than did those who perceived their health to be good (see Table 9).

In summary, in Group 2 those who were widowed, lived in subsidized housing, and perceived themselves to be in fair health gained the most from the health dance sessons.

Group 3

Group 3 was first divided into those married and those widowed. The emotional benefits were similar for both married and widowed groups, while emotional benefits were slightly higher for the widowed group. It is interesting to note that the widowed group enjoyed the activities that involved touch and partners (see Table 10).

Next, Group 3 was divided by type of housing. Those living in subsidized housing showed only a slight difference in emotional and social gains (see Table 11).

All of the subjects in Group 3 perceived themselves as having good health. Referring to Table 1, this group showed the most physical benefits of the three groups. This

Table 9

Physical Benefits of Dance-Movement Therapy
for Group 2--By Perceived Health

Perceived Health	Number of Respondents	Positive Physical Responses	Mean
Good	7	57	6.1
Fair	3	51	17.0

Table 10

Emotional and Social Benefits of Dance-Movement Therapy for Group 3--By Marital Status

Marital Status	Number of Respondents	Positive Emotional Responses	Mean	Positive Social Responses	Mean
Married	7	30	4.2	36	5.1
Widowed	3	13	4.3	18	6.0

Table 11

Emotional and Social Benefits of Dance-Movement Therapy for Group 3--By Type of Housing

Type of Housing	Number of Respondents	Positive Emotional Responses	Mean	Positive Social Responses	Mean
Subsidized	5	22	4.5	29	5.8
Nonsubsidized	5	21	4.2	25	5.0

negates the assumption that those with perceived health problems gained the most in physical benefits.

Summary

In summarizing the results, it can be said that an active-mobile group of senior adults benefit physically, emotionally, and socially from dance-movement sessions. Age has the greatest effect on perceived gains. The older participants (Group 3) showed the highest perceived benefits physically, emotionally, and socially. Emotional and social gains are slightly higher for those widowed and for those who live in subsidized housing. Physical gains were the greatest for those in Group 1 who perceive themselves to be in fair rather than in good health and those who were in Group 3.

Additional comments were not tabulated in the results because they often repeated earlier responses. Some responses are worth examining because they demonstrate feelings that are not as clear in a "Yes" or "No" answer:

> "I look forward to the sessions and hope that they continue."

> "The sessions are very good."

"I love the dancing and look forward to coming."

"I know that the sessions have helped tremendously because I can tell the difference when I miss. That tells a lot."

"Makes me feel great."

"I had a torn rotator cuff in my right shoulder and couldn't use my arm. I have almost full movement back, due to this class."

"Wonderful. Enjoyed the dancing very much. Met some lovely women. The teacher is marvelous."

I look forward to the class. Our teacher has a special quality of sincere friendliness and encourages us all the time."

In future research, it may be worthwhile to examine the leader's positive attitudes as a variable in the study of participants' perceived benefits and attitudes toward dance-movement therapy.

Moderately Active Group

The results of the interviews with the ten subjects from the Co-ordinated Day Care Center were evaluated somewhat differently. The cognitive understanding of what the questions were about was not always clear. In evaluating the results for those questions that were answered positively by at least six participants showed a trend of positive feelings. Many questions were answered positively by all of the participants. These were the areas that provided the greatest benefits.

All of the participants answered positively that they looked forward to dance-movement sessions. An interview administered by the leader of a session may foster responses of compliancy by the participants. A positive personal relationship had developed between the leader-researcher and indivdiuals in the group. Also, this leader-researcher approached all sessions with much enthusiasm, energy, and positive feelings about dance-movement therapy. She also approached the participatns with a caring and sensitive attitude. The leader may have been a variable in the

positive responses from this group and the previous, active group.

Physical Benefits

Due to the fact that the sessions lasted only one month it is difficult to perceive physical benefits in that length of time. As can be seen in Table 12, all of the participants stated that they felt better after the sessions and they all stated that the sessions made them feel more energetic. Six participants said that the sessions helped them to relax, and six claimed that the sessions had helped them to use their arms and hands with more flexibility. It is important to note that all of the participants felt more energetic since this question was the only question in the physical benefit section that implied a goal of dance-movement therapy. For this reason it is concluded that these sessions provided physical benefits, mainly feelings of energy and relaxation. Each participant found that the sessions helped with individual problems in different ways.

Emotional benefits proved to be more pronounced than physical benefits. All ten subjects answered positively the question, "Do movement sessions make you feel younger?"

Table 12

Physical Benefits from Dance-Movement Therapy

Question	Number of Positive Responses
Feel better after sessions	10
Feel more energetic	10
Feel more tired	-
Helped to relax	6
Improvement in use of hands	6
Improvement in use of arms	6
Improvement in breathing	4
Lessened appetite	1
Increased appetite	-
Improvement in bending	-
Improvement in walking	-
Improvement in climbing stairs	-

Also, all of the subjects answered positively that they were able to concentrate on directions and they all felt that the music brought past memories to mind (see Table 13).

In the analysis of the results shown in Table 13, the data may be inconclusive since the participants did not clearly understand all of the questions. Fersh (1980) spoke of dance-movement therapy's promoting a sense of aliveness and well-being. All ten subjects stated that they felt younger.

Social Benefits

The questions pertaining to social benefits were answered positively by all members. Through personal observation and the interview this group seemed to derive much socialization from the sessions. All answered positively that the sessions provided a friendly atmosphere, that they talked freely to each other during the sessions, and that they enjoyed movements that involved touching others or being touched. It is agreed that physical contact in the form of massage, putting an arm around a friend, or embracing may provide a tangible social support system (Fersh, 1980; Sandel, 1979).

Table 13

Physical Benefits from Dance-Movement Therapy

Question	Number of Positive Responses
Feel less tense	5
Feel more optimistic	2
Feel older	-
Feel less lonely	3
Feel younger	10
Feel more cheerful	5
Feel more tired	-
Feel more active	6
Feel more tense	-
Feel less anxious	-
Feel less confused	-
Concentration is better	10
Music brought back memories	10

It was difficult to implement variables with this group. All lived in nonsubsidized housing; all perceived their health to be "not so good"; all felt exercise was important; all had no friends at home but did have friends at the facility. All of the participants stated that they they had been active in the past but that their activity had been in professional or household work, not in exercise it is perceived today.

It is difficult for an interview with this type of group to capture the joyful feelings one sees in these individuals' faces during a dance-movement session and the group unity and fun that takes place.

Staff Questionnaire

Co-ordinated Day Care Program

As predicted, the two staff members of the Co-ordinated Day Care Program found the sessions to be beneficial. Both staff members felt that the participants looked forward to the sessions and that the sessions were important to the overall program. Measurements of change in participants were really subjective because there was no

follow-up of each individual. Positive changes in flexibility, posture, alertness, memory, concentration, self-image, attitude toward others, and tenseness were noted during the sessions. Positive attitudes in appetite, alertness, posture, and energy level, and attitude toward exercise and mobility were noticed after the sessions. It must be remembered that there were no guidelines in measuring positive changes except observation and choosing "Yes" or "No" answers to the questions.

Nonambulatory Group
--Anthony House

The two recreational therapists at Anthony House completed the staff questionnaire. Both felt that the patients looked forward to the dance-movement sessions and both felt that they were important to the program. Positive changes were noted in posture, alertness, attitude toward others, and tenseness during the sessions; and alertness, posture, energy levels, and attitude toward others after the sessions. Again, these were subjective observations. One staff members did add the following comment:

> We feel that an ongoing Dance/Movement program would be beneficial to the patients concerning all

aspects of their rehabilitation. The patients seemed to enjoy the "dancing" and interacting with each other.

Active Group--"Dance for Health and Happiness"

The staff member for this group was the leader-researcher. Tabulating the results of the interviews led to more objective results. Positive changes in all of the areas, except appetite, were noted. Also, this questionnaire was developed for less active movement session groups rather than for this active group.

CHAPTER VI

SUMMARY AND RECOMMENDATIONS

Dance-movement therapy is the use of rhythmic movements as a means of self-expression and communication that aids in the healthier integration of the mind and body. It provides outlets for expression and socialization (Caplow-Linder, et al., 1979).

This study was an exploratory survey of dance-movement therapy for various geriatric populations. The question was raised as to what potential dance-movement therapy has in helping to meet the needs of the elderly. With so many needs to be met, could dance-movement therapy, which holistically involves the mind and the body, provide physical, emotional, and/or social benefits? Would staff members introduced to dance-movement sessions, find them to be beneficial to their clients? This author's theoretical orientation was that dance-movement sessions would provide physical, emotional, and social benefits to senior adults.

Staff members would also find the sessions beneficial to their clients.

The researcher provided dance-movement sessions for three groups of senior adults: active mobile group (ages 60-77) at an open activity senior center; a moderately ambulatory group (ages 71-93) at a day care program; and nonambulatory patients at a physical rehabilitation hospital.

Sessions were made up of the following format: a warm-up period, a stimulus period, and a cool-down period. All were set to music. Different types of elderly populations called for variations in the approach, techniques, and expectations of the leader therapist. Although the sessions provided for different levels of physical, emotional, and social functioning, all implemented the following goals of dance-movement therapy:

1. Improve breathing techniques
2. Increase range of motion
3. Increase energy levels
4. Relieve tension
5. Improve self-confidence
6. Increase movement repertoire
7. Recapture youthful feelings
8. Improve self-image

9. Develop new skills

10. Allow for socialization

11. Provide sensory stimulation

12. Provide pleasure in moving rather than pain

Through observation and verbal feedback, the researcher felt strongly that many physical, emotional, and social benefits were being acquired by the participants. Formal interviews were then given to the active and moderately ambulatory groups. It was determined that dance-movement therapy did provide many holistic benefits (see Tables 1, 2, and 3). Using questionnaires, it was determined that staff members introduced to dance-movement sessions found them to be beneficial to their clients.

For tabulating the results, this active population was divided into three age groups--60 to 65, 66 to 69, and 70 to 77. Group 3 showed the largest percentage of benefits physically, emotionally, and socially. Although physical benefits were noticeable in all groups, emotional benefits rated higher than physical benefits in all age groups. Social benefits rated highest of all benefits in all age groups.

Then the three groups were subdivided according to marital status, type of housing, and perceived health. Both emotional and social benefits were greater for those subjects who were widowed and who lived in subsidized rather than nonsubsidized housing. Also, those subjects who perceived themselves as having fair health, as opposed to those being in good health, showed greater physical benefits in groups 1 and 2. Group 3, the oldest participants, had the greatest physical benefits of all.

Some interesting recommendations can be made from this study with an active-mobile group. Many exercise classes are offered to senior adults. Exercise classes stress physical fitness and cardiorespiratory efficiency (Caplow-Linder et al., 1979). The participants in dance-movement sessions gained physically in many areas (see Table 1) along with even greater emotional and social gains (see Tables 2 and 3). Many older adults develop the habit of inactivity, a habit that is difficult to overcome (Garnet, 1974). As Garnet strongly suggests, in order to motivate them to participate in any form of exercise, the sessions must be geared toward bringing pleasure and toward fulfilling needs. Dance-movement sessions that stress emotional and

social benefits along with physical benefits may be more appealing and worthwhile to the elderly.

There seems to be a growing interest in serving the needs of the healthy affluent segment of our population (Helm & Gill, 1975). This study showed greater emotional and social gains by those living in subsidized housing. There is a desperate need for providing such programs for those who live in subsidized housing. They may not be able to afford programs elsewhere.

It is significant that those participants in Group 3, the oldest group, gained the most in all areas. A program that stresses fun and relaxation may interest more people in the 70 to 80 age range. From this study, these individuals perceived the greatest gains. Perhaps the focus on physical fitness keeps the fearful elderly away. This author again recommends that movement programs stress emotional and social gains as well.

Working with partners proved to be a very popular activity (see Table 3). Many social dance or square dance sessions are offered to senior adults. Often married couples will take part in these, while widowed individuals feel

uncomfortable.[1] This study revealed that widowed participants gained more emotionally and socially from the health dance sessions than did married participants. Movement sessions that do not call for male-female partners may interest those widowed individuals who could benefit the most.

Willingness to try new activities was also a popular response. Movement therapy stresses that the therapist must work at the individual's physical and emotional level (Fersh, 1980). By keeping these sessions at the proper activity level to assure success, the participants showed a 90% positive response to a willingness to try new activities. It is this author's opinion that success at one activity provides the self-confidence to try another.

It was unanimous that the participants enjoyed the interaction with the leader. This finding agrees with Fersh (1980) that the relationship between the therapist (leader) and the older person may be the most motivating force for the older person, who needs a trusting relationship. This author stresses that this fact should be generalized not only to movement sessions but to all group activities for the

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[1] E. Kirsch, personal communication, April 20, 1982.

elderly. Often skills and tasks rather than personal interest are stressed. Individuals working with the elderly must demonstrate a genuine interest in each individual, highlighting their abilities while maintaining a compassionate understanding of their limitations.

It must be remembered that these interviews tabulated the participants' perceived benefits. No physician, physical therapist, or psychiatrist was monitoring changes in individuals. Perhaps a more thorough study would incorporate professional follow-up. This author believes that if an individual perceives benefits, he will feel more alive and continue to grow and experience new vistas. This may prove more important than a professional testing of results.

Moderately Ambulatory Group

Many positive benefits of the dance-movement sessions were expressed in the study with moderately ambulatory senior adults. Although these participants found themselves to be in fair to poor health, they all benefited from the dance-movement sessions in some way. All looked forward to the sessions; all felt better, younger, and more energetic after the sessions. It must be remembered that therapy with

the elderly consists of working for immediate responses and the improvement of the ability to cope with present problems rather than long-term goals. The movement sessions provided immediate pleasurable responses. They did this by emphasizing a sense of aliveness in each individual.

Music and touching proved most enjoyable to all participants. These are two elements that can easily be incorporated into any group activity with the elderly. Music can provide a stimulus for life review. Touching may help those elderly who are touched by no one in a caring way. Movement sessions may be a unique way of providing for self-expression and self-satisfaction.

In summary, dance-movement therapy is a nonverbal medium that avoids intellectualization and allows general participation. It is group oriented, yet it offers something of value to each participant. Each individual can benefit in a way that suits his needs, be it physically, emotionally, or socially.

Staff

The questionnaires for staff members were quite subjective. Therefore it is difficult to state how much each

participant benefited. But it can be stated that those agencies and staff members who were introduced to dance-movement sessions felt positively about the results. They all felt that movement sessions would be an important part of a program. Exposure of this relatively new modality to staff at agencies, hospitals, nursing homes, day care services, and activity centers is essential to the growth and productivity of this form of therapy with the elderly. One of the essential tasks a movement therapist must undertake is helping other professionals to learn how movement therapy can be integrated into various treatment sessions (Razy, 1969). One of the author's most rewarding experiences in this study was to note the developing sensitivities and acceptance of this new modality on the part of staff members. It is this author's hope that dance-movement therapy for the elderly will continue to grow. May humanity try to reach all aging individuals so that they may join and remain in the "dance of life."

APPENDIX A

"DANCE FOR HEALTH AND HAPPINESS"

PARTICIPANT INTERVIEW

COVENANT HOUSE SENIOR CENTER

Name or Initials (optional) ______________________________

Age ____________________________ Sex ____________________

Marital Status _________________ Children _______________

Type of housing: Subsidized or non-subsidized ____________

Do you live alone? ____________ With someone? _________

Do you have friends where you live? ______________________

Do you have friends in this class? _______________________

How long have you participated in health dance classes?

____

How would you describe your physical health now? __________

Do you feel exercise is:

Important ____________
Neutral ____________
Nonimportant ____________

Was exercise important to you in your:

20's __________
30's __________
40's __________
50's __________

How active in terms of exercise have you been in the past?

Very active __________
Moderately active __________
Not active __________

How active socially have you been in the past?

Very social __________
Moderately social __________
Not social __________

Do you look forward to Health Dance Sessions?

Yes __________
Moderately __________
No __________

Physical Benefits

Have you noticed any physical improvement in: (circle)

Sleeping habits	Yes	No
Flexibility	Yes	No
Coordination	Yes	No
Breathing	Yes	No
Headaches	Yes	No
Posture	Yes	No

Relaxation	Yes	No
Stress reduction	Yes	No
Use of shoulders	Yes	No
Use of arms	Yes	No
Muscle strength	Yes	No
Use of hands	Yes	No
Use of wrists	Yes	No
Weight loss	Yes	No
Increased speed of movements	Yes	No
Use of fingers	Yes	No

Have you noticed any increase in the range of motion (ability to move further in different directions) of your:

Shoulders	Yes	No
Wrists	Yes	No
Head and neck	Yes	No
Hip joint	Yes	No
Legs	Yes	No
Knees	Yes	No

Emotional Benefits

Have you experienced alleviation of anxiety?

Yes No

Have you noticed any changes in your self-image (how you picture yourself physically) since exercising?

Yes No

Are you more able to concentrate on directions?

Yes No

Has your alertness improved?

Yes No

Are you more willing to try new activities?

Yes No

Social Benefits

Have you made any new friends from the health dance sessions?

Yes No

Have you renewed or strengthened any old friendships?

Yes No

Are you more comfortable being in a group of people?

Yes No

Are you more comfortable dancing with a group of people than before?

Yes No

Do you enjoy the movement activities that involve holding hands or touching?

Yes No

Do you enjoy working with a partner?

Yes No

Do you enjoy the interaction with the staff member?

Yes Moderately No

Please add any feelings about the movement sessions or about how they have helped or not helped you in a specific area.

APPENDIX B

INTERVIEW FOR JCCA CO-ORDINATED

DAY CARE PROGRAM

JCCA CO-ORDINATED DAY CARE PROGRAM

Name ____

Age ____________________ Sex ____________________

Marital Status ____________ Children ____________

Type of housing: Subsidized or non-subsidized __________

Do you live alone? __________ With someone? ________

Do you have friends where you live? ________________

Do you have friends here? _________________________

Describe your health as of now ____________________

Do you feel exercise is important in your life now ______

Was exercise important to you in your:

20's __________
30's __________
40's __________
50's __________

Describe how active you were in the past: __________

Do you look forward to movement/exercise sessions? ______

Physical Benefits

Do you feel better after movement sessions? ____________

Do movement sessions make you tired or more energetic and wide awake? ______________________________

Do exercises help you with any special problems? Comment.

____

Do exercises help you:

Relax	Yes	No
Bend	Yes	No
Walk	Yes	No
Climb stairs	Yes	No
Use hands	Yes	No
Breathe more deeply	Yes	No
Use arms	Yes	No
Improve appetite	Yes	No
Lessen appetite	Yes	No
Relieve headaches	Yes	No

Emotional Benefits

Does the movement session make you feel:

Less tense	Yes	No
Less lonely	Yes	No
More cheerful	Yes	No
More tense	Yes	No
More optimistic	Yes	No
Younger	Yes	No

More tired	Yes	No
Less anxious	Yes	No
Older	Yes	No
More confident	Yes	No
More active	Yes	No
Less confused	Yes	No

Are you able to concentrate on the directions given?

Yes No

Does music or movement bring to mind any past memories?

Yes No

Social Benefits

Do you feel the movement sessions provide for a friendly atmosphere?

Yes No

Are you talking to others in the group while exercising?

Yes No

Do you enjoy movements that involve touching others or being touched?

Yes No

What part of the movement session do you enjoy the most?

Exercises ________

Touching ________

Having fun ________

Dancing ________

Music ________

Talking to others ________

Specific remarks and comments:

Notations:

APPENDIX C

DANCE/MOVEMENT THERAPY

STAFF QUESTIONNAIRE

Name of Staff Member (optional) ____________________

Name of Agency ____________________

General Condition of Group (underline one)

Active/Ambulatory

Moderately Ambulatory

Barely Ambulatory

Non-ambulatory

Do (did) clients look forward to Dance/Movement sessions?

Yes No

Have you (did you) notice any positive changes in participants behavior in any of the following areas during Dance/Movement sessions?

Flexibility	Yes	No
Posture	Yes	No
Alertness	Yes	No
Memory	Yes	No
Concentration	Yes	No
Self-image	Yes	No
Attitude toward others	Yes	No
Tenseness	Yes	No

Have you (did you) notice any positive changes in participants behavior in any of the following areas <u>after</u> Dance/Movement sessions:

Appetite	Yes	No
Alertness	Yes	No
Posture	Yes	No
Self-image	Yes	No
Energy level	Yes	No
Attitude toward others	Yes	No
Attitude toward exercise	Yes	No
Tenseness	Yes	No
Mobility	Yes	No

How important to your program do you feel exercise and Dance-Movement sessions are?

Very important____Important____Neutral____Not important

Please list any additional comments that you would like to make pertaining to Dance-Movement sessions. Please comment on any of the above questions if you so choose.

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