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Dance Therapy and Self-Concept Change in Psychiatric Patients

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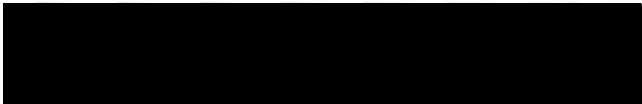
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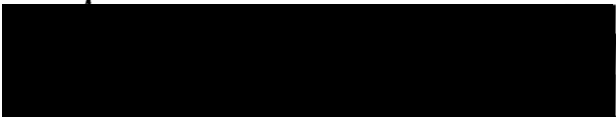
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AN ABSTRACT OF THE THESIS OF Cheryl Jeanne Hall for the
Master of Science in Psychology presented December 3, 1982.

Title: Dance Therapy and Self-Concept in Psychiatric
Patients.

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:


Hugo Maynard, Chairman


Gerry Guthrie


Martha Landowne

This study investigated the effects of various forms of therapy (individual, occupational, and dance) on self-concept. Subjects were 29 psychiatric patients at Providence Medical Center who volunteered to participate in this study. The Tennessee Self-Concept Scale (TSCS) was used to measure self-concept both at time of admission and prior to discharge. The data were analyzed in a step-wise multiple regression to determine which of the various forms of therapy are the best predictors of self-concept at second TSCS application. The results of the step-wise multiple

regression did not support the hypothesis that exposure to dance therapy would be a significant predictor of self-concept prior to discharge.

DANCE THERAPY AND SELF-CONCEPT CHANGE
IN PSYCHIATRIC PATIENTS

by

CHERYL JEANNE HALL

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requirements for the degree of

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CHAPTER I

INTRODUCTION

HISTORY OF DANCE THERAPY

Dance is "a transient mode of expression, performed in a given form and style by the human body moving in space. Dance occurs through purposefully selected and controlled rhythmic movements . . ." (Kealiinohomohu, 1976, p. 12). Kraus (1969) lists several of the functions dance has played throughout history such as: a vehicle for worship, a means of unification among tribes, a courtship ritual, a means of communication, and as a healing experience.

It [dance] summons and dispels the forces of nature, heals the sick, links the dead to the chain of their descendents; it assures sustenance, luck in the chase, victory in battle; it blesses the fields and the tribe. (Sachs, 1937, p. 4)

Dance, therefore, becomes a vehicle for social identification; a means of defining self in relation to other tribal members and the universe.

As a form of therapy, dance has its roots in "ancient times in dances of celebrations and crises, in dances that define individual and group identity, and in dances of death and exorcism" (Schmais, 1977, p. 7). It is the healing function of dance that is apparent in the role of shaman, or medicine man, where a release of tension produces changes

in physical and mental health. The various functions of dance such as its ability to enhance social identification, to provide expressive communication, and to release tension, combine in dance therapy.

X The use of dance as a therapeutic form, in America, dates back to the work of Marian Chace at St. Elizabeth's Hospital in Washington, D.C. in the 1940s. She introduced dance therapy to the back-ward patients before the wide-spread use of psychotropic medications. Her belief was that dance therapy gives an individual "a means of relating himself to the environment or to people" (Chaiklin, 1975, p. 137).

Mary Whitehouse combined her skills as a creative dance teacher with elements of Jungian analysis in the 1950s. She explored the expressive movements of her students within the symbolic meaning of Jungian psychology.

Others who were leaders in the development of dance therapy are Trudi Shoop, Liljan Espenak, and followers of Rudolf Laban (Bernstein, 1979). The technical approach used by these various dance therapists is influenced by their theoretical framework.

The basic concept on which Chace's work was built is that "dance is communication." She states that:

. . . since muscular activity expressing emotion is the substratum of dance and since dance is a means of structuring and organizing such activity, it might be supposed that the dance could be a potent means of communication for the reintegration of the seriously mentally ill patients. (Chaiklin, 1975, p. 71)

This "reintegration" occurs when the person is able to experience the movement of his body and "have it become meaningful to him" (Chaiklin, 1975, p. 229). Some of the goals which guided Chace in her work were to help individuals: establish their own identity, create a realistic body image, sense their vitality, expand their symbolic repertoire, activate and integrate body parts, and to increase acceptance of self. These goals include important aspects of the client's self-concept.

This emphasis on self-concept remains consistent across the various theoretical approaches in the field of dance therapy. It is, therefore, an appropriate measure of therapeutic outcome of dance.

THE CONCEPT OF SELF

The concept of self has been of interest to many theorists and researchers. William James in Principles in Psychology (1890) set the stage for the subsequent ideas of self in psychology by distinguishing between material self, social self, spiritual self, and pure ego.

Raimy (1971) describes the self-concept as the more or less organized perceptual object which results from present and past self-observation; that is, what a person believes about himself.

In one of the first studies researching the concept of self, Secourd and Jourard (1953) hypothesized that a

person's body image is related to his/her feelings about self. They measured a person's degree of feelings of satisfaction or dissatisfaction with body parts and processes with a homonym test and Maslow's test of psychological security-insecurity. Their findings were that "feelings about the body are commensurate with feelings about the self" (p. 347). Low body cathexis was associated with anxiety related to concern about pain, disease, or bodily injury. It is also positively correlated with insecurity as measured by the Maslow test. Based on these findings, they assert that "an individual's attitude toward his body is of crucial importance to any comprehensive theory of personality" (p. 343).

Combs and Snygg (1959) in Individual Behavior: A Perceptual Approach to Behavior theorize that "the self is the most stable portion of the individual's phenomenal field and it is the point of reference for everything he does" (p. 122). They go on to say that thought and behavior are determined by the concept of self. That is, our perceptions of ourselves and the situations we are involved in influence our actions in any situation.

In an experimental design, Duncan (1966) studied the relationship between cognitive and interpersonal variables in what he calls organismic integration. He explains "organismic integration" as the total behavior of an individual which is composed of interpersonal, cognitive, and

physiological subsystems. His findings were based on information collected with questionnaires assessing social reputation with a college population. He found that a psychologically integrated person has a positive self-concept and perceives himself as responsible for what happens to him.

SELF-CONCEPT AS A MEASURE OF THERAPEUTIC CHANGE

Theorists and researchers agree upon the developmental nature of the concept of self. As Combs and Snygg (1959) state, man continually searches for a more adequate self. It is also this developmental aspect of self-concept which has importance for the present study.

Since a person's perceptions of his physical self contribute to his total perceptions of his phenomenal self, it may be possible that an increase in perceptual awareness of physical self may contribute to increased levels of self-esteem. The measurement of self-esteem before and after a course of therapy may then provide information about the effectiveness of therapy.

Wylie (1961) in The Self Concept states that "according to self concept theorists, if counseling or therapy is judged by external criteria to be 'successful,' it will bring about various changes in the self-concept, such as the following:

- a. Increased agreement between self-estimates and objective estimates of the self (the self-concept becomes more realistic);
 - b. Increased congruence between self and ideal self, if this congruence is very low at the outset of therapy; and
 - c. Slightly decreased in self-ideal where this was unrealistically high in the beginning of therapy."
- (p. 161)

Therefore, self-concept after a course of milieu therapy was selected as the outcome (dependent) variable in this study.

RESEARCH IN DANCE THERAPY

Since dance therapy is a relatively new field, the majority of the literature in the field of dance therapy is descriptive in nature, focusing on theories, techniques, applications, and goals of dance therapy.

One of the first to publish articles on dance therapy is Marian Chace, who was discussed earlier in this chapter. Her articles focus on dance as communication. Another author who describes the use of dance therapy with institutionalized psychotic patients is Rosen (1957). In Dance in Psychotherapy, she describes her use of creative (modern) dance which focuses on the communicative, socializing, and tension-relieving qualities of dance therapy.

Salkin (1973) discusses the use of body movement as an educational and therapeutic tool. The body ego technique, which she uses, is predominately a nonverbal educational method. The focus is on learning and experiencing physical movement patterns. She states that this technique facilitates "the development of self-identity, body image, ego structure and ego growth" (p. 34). She theorizes that the process by which body ego technique enhances self-identity is similar to the developmental sequence which a child goes through in the normal process of separation-individuation as described by Mahler (1952).

Dance therapy can also be seen as facilitating the integration of two modes of experiencing: the intuitive-preverbal with the rational-verbal (Alperson, 1974). Facilitating persons' awareness of their experiential body process, they learn to explore their internal and external environments. Serlin (1977) offers a Gestalt-phenomenological approach to movement therapy. She emphasizes "awareness, excitement, and involvement" (p. 145) as essential in the process of working toward greater self-acceptance and excitement in living.

The use of dance therapy has been studied with chronic schizophrenics and severely psychotic in-patients (Levy, 1974). Levy finds Piaget's developmental stages and Arieti's affective theory useful in working with severely

regressed patients. Shaskan (1972) describes the use of dance therapy as being appropriate for some populations where verbal therapy has proven ineffective.

All of the studies cited thus far are descriptive in nature. One of the earliest experimental studies was by Sonoko Ohwaki (1976). Ohwaki studied the effect of dance therapy on body image with a group of severely retarded adults. The human figure drawing test, the body-part test, and the movement imitation test were used to assess changes in body image following a one hour daily, five days a week, five-week course in dance therapy. Significant changes were found between pre- and post-test conditions. However, as the author mentions in the study, one drawback is that there is no control group used as a comparison.

Lofquist (1979) studied changes in self-concept as a result of an eight-week course of dance training (jazz format) in women over 35 years of age who volunteered for free dance classes. Her experiment included a control group of volunteers for dance classes whose classes were delayed until the experimental group had finished treatment. Her results showed significant changes in the experimental group on the Physical Self and Personal Self scales of the Tennessee Self-Concept Scale (TSCS). This scale is described more fully in the "Instrument" section, Chapter II. The Identity Score was also significantly different for the dance group.

One factor which may have influenced Lofquist's findings is the supportive and encouraging interpersonal style she used in teaching the dance classes. Dance therapists agree that one of the variables contributing to the effectiveness of dance therapy as a psychotherapeutic tool is an empathetic and supportive therapist.

Building upon Lofquist's findings, Anderson (1980) posed the question of whether or not technical dance training alone would be effective in producing changes in self-concept. Her subjects were women who enrolled in a modern dance class. These women were compared to a group of subjects who were enrolled in an introductory psychology course and who had no experience with dance training. Since her data did not show significant differences between the groups, she concluded that dance training by itself is not sufficient to produce psychotherapeutic change. Anderson goes on to say that the other variables which are present in dance therapy, such as an empathetic and supportive therapist, the group interaction, encouragement of self-expression, and movement play a part in the effectiveness of dance as therapy.

Dosamantes-Alperson and Merrill (1980) researched the effects of experiential movement psychotherapy on the degree of self-actualization, body-self acceptance, and individual expressive movement using Shostrom's Personal Orientation Inventory (POI), Secourd-Jourard's Body Cathexis Scale, and

the Dosamantes-Alperson Expressive Movement Scale, respectively, in a pre-test/post-test design with two experimental groups (both were experiential movement psychotherapy groups) and two control groups (a waiting list group and a ballet class) drawn from the same population.

Using analyses of covariance, they found significant differences between the experimental and control groups in degree of self-actualization on the following scales of the POI: Inner-Directedness, Existentiality, Feeling Reactivity, Spontaneity, Self-Acceptance, and Capacity for Intimate Contact. On the Secourd-Jourard Body Cathexis Scale they found significant change in positive attitudes toward body parts and processes.

Based on their empirical findings, they conclude that:

. . . experiential movement psychotherapy, an approach which integrates felt-movement, imagery and verbalization through a single unified process, can promote participants' physical and psychological personal growth. (p. 67)

THE PRESENT STUDY

At the present time, to this author's knowledge, there is no known study of the effects of dance therapy on self-concept using an in-patient population with a dance therapist who is recognized by the American Dance Therapy Association (ADTA). The ADTA defines dance therapy as the psychotherapeutic use of movement which furthers the emotional and physical integration of the individual.

In dance therapy, several variables, such as group interaction, an empathetic therapist, and encouragement of self-expression, interact. To review previous experimental studies described so far:

- (1) Lofquist (1979) explored the interaction of these variables in dance classes using a jazz format. The results indicated significant changes in self-concept which may have been, in part, related to the encouraging interpersonal style of the researcher.
- (2) Anderson (1980) studied women in a modern dance class where the instructor would not have been expected to be especially encouraging to the participants. The results of the study indicated that training in dance technique, by itself, will not necessarily contribute to positive change in self-concept.
- (3) Dosamantes-Alperson and Merrill (1980) studied the effects of movement psychotherapy on feelings of satisfaction and found positive changes in both degree of self-actualization and on physical body-self acceptance.

The purpose of the present study was to build upon the previous experimental work in dance therapy in order to explore the variables which contribute to therapeutic change. The TSCS was used to measure change in self-concept

for an in-patient population of psychiatric patients. Several predictor variables were correlated with self-concept at the time of second testing during hospital stay. Among these were individual therapy, group therapy, occupational therapy, gender, and previous hospitalization. Of specific concern to this study is the power of the dance therapy variable to predict self-concept, as measured by the TSCS, at the time of second testing.

CHAPTER II

METHOD

SUBJECTS

Subjects were 29 psychiatric patients at Providence Medical Center in Portland, Oregon, who remained in the hospital for at least five days and who volunteered to participate in this study. Providence Medical Center (PMC) is a 458-bed, private, Catholic, nonprofit hospital, administered by the Sisters of Providence. The hospital has two psychiatric units with a total of 35 beds.

The in-patient psychiatric program provides milieu therapy which offers opportunities for individual, group, occupational, dance, and chemotherapy. The treatment staff includes psychiatric nurses, mental health therapists, dance therapist, occupational therapists, psychiatric social workers, admitting psychiatrists, and clinical psychologists. The average length of stay for a psychiatric patient during July and August 1981 varied from 10-12 days at a cost of \$260 per day.

The TSCS was initially administered to 67 patients. Between 5 and 12 days after first testing (mean = 7.55 days) 29 participants took the second TSCS. Of the 35 patients who did not take the second TSCS, one left the hospital

against medical advice (AMA), two refused to take the second TSCS, and the remaining 25 were discharged before the minimum number of days between tests designated for this study.

Of the 29 remaining subjects, 21 were women and 8 were men. Ages ranged from 15 to 60 years for women with a mean of 34.35. For men, ages ranged from 13 to 55 with a mean of 41.75.

Table I shows the diagnostic categories for the 29 subjects according to sex.

TABLE I
DIAGNOSTIC CATEGORIES FOR FEMALE AND MALE SUBJECTS

Diagnostic Category	Females	Males	Totals
Substance abuse disorder	4	3	7
Affective disorders	12	4	16
Adjustment disorders	1	1	2
Eating disorders	1	0	1
Schizophrenic disorders	1	0	1
Anxiety disorders	1	0	1
Disorders of impulse control	<u>1</u>	<u>0</u>	<u>1</u>
	21	8	29

PROCEDURE

This study was initially presented and approved by the Institutional Review Board of Providence Medical Center (PMC). In addition, it was approved by the Human Subjects

Research Committee of Portland State University. Following the approval of these review boards, this researcher gave a brief description of the study to the staff of the psychiatric units at PMC during staff meetings. In addition, the admitting psychiatrists were personally given a brief description of the study and asked if they were interested in having their patients participate in the study. All the psychiatrists contacted were willing to have their patients participate in the study with one condition. That was, that if a person was severely agitated and in need of a "low-stimulus" environment, he/she would be excluded from the study.

Following approval of the study and providing the information to PMC staff, the procedure for data collection continued for a period of six weeks. The author, who collected the data, was a different person than the person who conducted the dance therapy sessions. Data collection (summarized in Table II) began by contacting the ward secretary to obtain the names of any newly admitted patients. Then, the therapist assigned to the newly admitted person was contacted to find out if he/she appeared capable of participating in the study. Patients judged incapable of participating were either brain damaged, severely agitated, or requested to have a "low-stimulus" environment by their admitting psychiatrist. After a patient was judged appropriate for the study by the primary therapist, he/she was

contacted by this examiner, presented with an informed consent sheet (see Appendix A), and given an opportunity to ask questions regarding the study. If the person was willing to participate in the study after understanding what she/he would be asked to do, he/she was given a copy of the TSCS for completion. The location of the testing varied according to where the person felt most comfortable. If a person was having difficulty reading the test manual or recording responses, he/she was assisted by this researcher. These variations in application of the TSCS were considered less important than insuring that each subject took the scale under the most comfortable and stress-free conditions possible in order to insure the test scores were accurately reflective of current self-assessment.

The demographic data compiled for this study included: individual therapy sessions, group therapy sessions, occupational therapy sessions, dance therapy sessions, diagnosis, medications, age, sex, prior hospitalizations, and days between tests. This data compiled for each subject is presented in Table III.

INSTRUMENT

The Tennessee Self-Concept Scale (TSCS) was used to measure the dependent variable (self-concept). It was developed by William H. Fitts, for research in mental health,

TABLE II
PROCEDURAL ORDER FOR DATA COLLECTION

No.	Procedural Order
1.	Names of newly admitted patients obtained from ward secretary
2.	Inquiry made to primary therapist assigned to patient, regarding person's appropriateness for study
3.	Patient interview to provide information regarding study--informed consent obtained
4.	First testing with TSCS administered
5.	Second testing with TSCS done between 5 and 12 days after first testing
6.	Data collected from patient chart: <ol style="list-style-type: none"> a. Number of movement sessions attended b. Hours of individual therapy c. Number of group therapy sessions d. Number of occupational therapy sessions e. Diagnosis

and so this seemed appropriate for this research (Fitts, 1965).

The test was standardized on 626 people ranging from ages 12 to 68. There were approximately equal numbers of both sexes, black and white subjects, and all socio-economic, intellectual, and educational (above 6th grade) levels were represented.

The TSCS is a paper and pencil questionnaire which is self-administered. There are 100 self-descriptive items

TABLE III

DATA FOR EACH S

Subject Number	Male/ Female	Age	Pre- hospi- taliza- tion	Number Days be- tween Tests	Number Move- ment Ses- sions	Number Hours Indi- vidual Therapy	Number Group Ses- sions	Occupa- tional Therapy	Diagnosis
1	F	45	Yes	8	4	5.50	4	0	Affective disorder
2	M	55	Yes	8	5	5.50	4	5	Affective disorder
3	F	16	Yes	7	4	7.00	4	3	Impulse control disorder
4	F	22	Yes	7	2	3.00	0	0	Affective disorder
5	M	33	Yes	7	0	4.50	4	0	Substance abuse disorder
6	F	45	Yes	8	2	8.00	8	1	Substance abuse disorder
7	M	44	Yes	8	1	4.00	0	2	Affective disorder and sub- stance abuse disorder
8	M	46	Yes	8	0	6.00	8	4	Affective disorder
9	F	21	No	8	1	12.00	1	3	Affective disorder
10	F	25	Yes	6	4	9.00	7	1	Affective disorder
11	F	43	Yes	7	5	8.75	3	2	Affective disorder
12	F	38	No	12	5	13.70	3	1	Affective disorder
13	F	36	Yes	12	0	13.50	7	2	Affective disorder
14	F	15	No	10	1	11.00	4	2	Adjustment disorder
15	F	22	Yes	7	2	12.50	5	3	Affective disorder
16	F	60	NO	7	2	7.90	1	1	Affective disorder

TABLE III--Continued

Subject Number	Male/ Female	Age	Pre- vious Hospita- lization	Number Days be- tween Tests	Number Move- ment Ses- sions	Number Hours Indi- vidual Therapy	Number Group Ses- sions	Occupa- tional Therapy	Diagnosis
17	F	19	No	7	5	4.00	7	3	Eating disorder
18	F	36	Yes	7	3	5.60	2	1	Affective disorder
19	F	51	Yes	7	2	6.00	0	1	Substance abuse disorder
20	F	19	No	7	3	3.60	3	4	Schizophrenic disorder and affective disorder
21	M	34	Yes	7	0	8.00	2	0	Substance abuse disorder and affective disorder
22	F	36	No	7	0	6.00	1	2	Affective disorder
23	F	44	Yes	7	1	7.00	4	2	Affective disorder
24	M	55	Yes	7	0	4.80	0	0	Affective disorder
25	M	13	No	8	0	6.80	5	1	Adjustment disorder
26	F	31	Yes	7	3	9.50	3	3	Affective disorder
27	M	54	No	7	2	8.00	3	3	Affective disorder
28	F	46	Yes	5	0	4.00	1	0	Anxiety disorder
29	F	52	Yes	7	4	2.50	3	3	Affective disorder

which subjects rate according to applicability to self. The rating scale presents the subject with five possible responses on a continuum from "completely false" (1) to "completely true" (5). It measures both global and specific self-esteem. The Total Positive or Total P Score is a measure of overall self esteem.

The subscales of the Total P Score are: Identity, Self-Satisfaction, Behavior, Physical Self, Moral-Ethical Self, Personal Self, Family Self, and Social Self. The score on the Physical Self subscore was selected as the dependent variable since it specifically measures a person's view of his/her self-concept in terms of his/her body and health, one of the traditional focuses of dance therapy.

CHAPTER III

RESULTS

The data were analyzed with a step-wise multiple regression on selected measures (SPSS Version 8.1b) (see Table V).

The results of the regression indicate that self-concept, at time of first testing, is the best predictor of self-concept at the time of the second test ($R = 0.63$, $p < .01$)(see Table IV). The other variables which approached significance are gender and individual therapy ($R = 0.32$, $p < .05$ and $R = 0.36$, $p < .05$ respectively).

In particular, dance therapy did not reach significance as a predictor of second test self-esteem. Therefore, the data do not support the hypothesis that dance therapy would be a significant predictor of self-concept at the time of second TSCS.

TABLE IV
SUMMARY TABLE OF MULTIPLE REGRESSION

Predictor Variables ^a	Multiple R	R Square	RSQ Change	Simple R	B	Beta
Test 1 Positive Physical Self	0.62866	0.39521	0.39521	0.62866 ^b	0.6921587	0.66049
Diagnosis	0.66988	0.44874	0.05353	0.04410	1.1986116	0.24292
Prior Hospitalization	0.69820	0.48748	0.03874	0.09242	-3.2430425	-0.16651
Days between Tests	0.71266	0.50789	0.02040	-0.27864	-0.8965277	-0.20128
Age	0.73465	0.53972	0.03183	-0.13245	-0.1604858	-0.23411
Gender	0.76019	0.57788	0.03816	-0.31691 ^c	-6.1719966	-0.29728
Movement Sessions	0.77666	0.60320	0.02531	-0.06485	0.9410729	0.18018
Occupational Therapy Sessions	0.77770	0.60481	0.00162	-0.09591	-0.4424691	-0.06385
Group	0.77930	0.60731	0.00250	0.04598	0.2613546	0.06653
Individual Therapy Sessions	0.77995	0.60833	0.00101	-0.35776 ^c	-0.1441408	-0.05306
					41.2920449	

^aPredictor variables are presented in descending order.

^b $p < .01$.

^c $p < .05$.

TABLE V

SUMMARY OF CORRELATIONS

	1st TSCS	2nd TSCS	Age	Days between Tests	Individual Therapy	Gender	Prior Hospitalization	Dance Therapy	Group Therapy	Occupational Therapy
1st TSCS	1.00000	0.62866 ^a	0.00436	-0.10398	-0.23275	-0.30400	0.36858 ^b	-0.21211	0.01845	-0.16559
2nd TSCS		1.00000	-0.13245	-0.27864	-0.35776 ^b	-0.31691 ^b	0.09242	-0.06485	0.04598	-0.09591
Age			1.00000	-0.18224	-0.30584	-0.20336	-0.22350	0.02166	-0.23520	-0.08523
Days between Tests				1.00000	0.72014	-0.10727	-0.01143	-0.00368	0.26241	0.08578
Individual Therapy					1.00000	0.15567	0.09519	-0.01005	0.26804	0.07264
Gender						1.00000	0.08051	0.38513 ^b	0.02472	-0.02142
Prior Hospitalization							1.00000	0.00291	-0.06622	0.19375
Dance Therapy								1.00000	0.16444	0.21360
Group Therapy									1.00000	0.20620
Occupational Therapy										1.00000

^a p < .01.^b p < .05.

CHAPTER IV

DISCUSSION

The results of the multiple regression indicate that the best predictor of self-esteem at the time of second TSCS application (as measured by the physical self sub-scale) is the score on the physical self sub-scale of the TSCS at the time of first testing (see Table IV). The remaining nine variables did not reach significance.

One possible explanation that the two variables, physical self at the time of the first TSCS and physical self at the time of second TSCS application, correlate so highly with each other is because they measure the same aspects of self and therefore, together, account for the greater part of the variance in the data. In addition, the ability of the correlational method to detect an effect was weakened by the fact that so many people received a value of zero in the dance therapy variable. (That is, they chose not to attend.) It may be possible that altering certain aspects of this design, such as using a longer length of stay in the hospital or using more subjects, would yield results supportive of the hypothesis.

The results of this study yield a significant correlation between gender and movement sessions. This correlation

implies that women are more likely to participate in movement sessions than men. However, since there are more women psychiatric patients than men in this study, there is need for cautious interpretation of this finding. One consideration is the well-known cultural standards which make it more socially acceptable for girls and women to dance than it is for boys and men. This is apparent in the high percentages of women participating in dance programs as compared to men. The results of this study indicate that this may also be the case for dance therapy in this hospital setting since there was a tendency for the hospitalized male patients to choose not to attend dance therapy sessions. In particular, five out of the eight patients who did not attend dance therapy (as indicated by a 0 value in Table III) were men.

The only other correlation which reached significance is that of individual therapy with the physical self subscale. This negative correlation indicates that the greater the amount of time spent participating in individual therapy, the less positive were the person's feelings about his/her physical self. This correlation appears to reflect the fact that the initial part of the therapy process involves the person's initial acceptance of the need for change. During this period of acceptance, there may be a decrease in self-esteem as the person begins reorganizing aspects of personality (Rogers & Dymond, 1954). This may

leave the person with feelings of vulnerability both physically and emotionally.

Since this study measured self-concept during the first 5 to 12 days of therapy, it appears that the more therapy a person engaged in, the lower his/her feelings of confidence in bodily self.

It was the purpose of this study to build upon the research in dance by Lofquist (1979) and Anderson (1980). There are several important differences among these three studies which merit further consideration.

Lofquist found a significant change in self-concept using the TSCS with a population of women over age 35 who signed up for free jazz dance instruction. The similarities of this study with Lofquist's include: an empathetic and encouraging leader, musical accompaniment, use of the TSCS, mean age of subjects. Some notable differences include: the failure of this study to obtain significant results, length of time the subjects participated in the study, and a dramatic difference in the population and setting characteristics.

Anderson did not find a significant change in self-concept among a college population participating in a modern dance class. The present study and Anderson's are similar in their use of the TSCS, in the use of musical accompaniment to the dance sessions, and the absence of significant findings. The differences between Anderson's finding and

those of the present study include: average age of subjects, length of subjects' participation, and a marked difference in the population and setting.

The most obvious differences between this study and those of Lofquist and Anderson are the population and the setting. The people participating in this study were experiencing distress in their lives acute enough to prompt them or their family to seek in-hospital treatment, whereas the participants in the Lofquist and Anderson studies were capable of functioning independently, even to the extent of taking college courses or volunteering for free dance classes. One factor to consider in interpreting the results of this study is the importance of the hospital setting. The psychiatric hospital experience is certainly unique as compared to other life situations. As people entered PMC their self-esteem was predictably at one extreme or the other on a high-low continuum as explained clearly in diagnosis found among this population such as manic episode or depressive illness. Also intrinsic to the hospital experience is the person's adjustment to the role of patient with its inherent loss of autonomy.

Also characteristic of this setting and not those of Lofquist's and Anderson's is the concept of milieu therapy. The majority of the people in this study participated in various forms of therapy such as: group, individual, occupational, and dance. Since dance therapy was only one

treatment modality among several which is expected to bring self-esteem to a "healthy" level for an individual, the actual change in self-esteem due to dance therapy may have been lost in the context of so many other treatment modalities.

In spite of the obvious interaction of the therapies, it was the expectation of this study that dance therapy would be a significant predictor of the physical self subscale on the TSCS prior to hospital discharge. This was based upon two factors. The first is the descriptive literature on dance therapy which agrees that it is the interaction between the empathetic and supportive dance therapist which enhances positive change in self-esteem. The second is the recreation elements of the Lofquist study which contributed to positive change in self-esteem.

However, it appears that the weaknesses of this study combined with difficulties inherent to the research setting may have impeded the detection of a positive effect of dance therapy on self-esteem. The weaknesses of this study are the small N and the short period of time subjects participated in the study (M = 7 days). During the course of this research the length of hospitalization was held to a minimum by rising hospital costs, high unemployment, and also to keep any negative effects of hospitalization to a minimum. Two unforeseen factors made it difficult to obtain subjects for this research. The first is the full therapy schedule

for each patient which made it difficult to find a time to meet with prospective participants. While this is a positive statement about the milieu therapy at PMC, it is a difficulty for the researcher. The second is the problem of obtaining subjects for testing prior to discharge. Patients were generally willing to take the TSCS upon admission to the hospital, but they were often not cooperative at the time of discharge. During the six weeks of data collection 67 subjects were tested and only 29 actually took the TSCS prior to discharge.

These types of difficulties are typical of research in naturalistic settings where subjects are not available to the researcher in carefully controlled environments. Based on the findings of this research, if a researcher were interested in pursuing the effects of dance therapy on self-esteem, the following are three suggestions for increasing the probability of detecting an effect. First, with a similar population it may be possible to increase sample size and make a more definitive statement about the relationship between dance therapy and self-esteem. Second, if the study were replicated, a measure which is more sensitive to short-term change, such as an attitudinal scale, might also increase likelihood of an effect. Finally, if one were to use a design similar to Lofquist's, using a dance therapist with a waiting control group, the chances of detecting an effect would be greatly increased.

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APPENDIX A

INFORMED CONSENT

I, _____, agree to serve as a subject in a research project investigating the effects of dance therapy. I understand that the study will involve taking a paper and pencil test on two separate occasions and filling out a questionnaire about myself, but I will not have to reveal myself in any identifiable way. I understand that I can obtain a thorough description of the study after my participation, and I am willing to wait until then to find out the specific experimental hypothesis.

I may not receive any direct benefit from participating in this study (other than obtaining direct experience with one of the ways psychological research is conducted), but my participation may help to increase knowledge which may benefit others in the future.

Ms. Hall has offered to answer any questions I may have about the study. I understand that I am free to withdraw from participation in this study at any time.

I have read and understand the foregoing information.

Date _____ Signature _____

If you experience problems that are the result of participation in this study, please contact Richard Streeter, Office of Graduate Studies and Research, 105 Neuberger Hall, Portland State University, 229-3423.

APPENDIX B

DATA COLLECTED AT TIME OF HOSPITAL ADMISSION

Age: _____

Sex: _____

Medication: Yes _____ No _____

APPENDIX C

DATA COLLECTED AT TIME OF DISCHARGE

Check which forms of therapy you have participated in:

<u>Type of Therapy</u>	<u>Number of Sessions</u>
_____ Individual	_____
_____ Group	_____
_____ Occupational	_____
_____ Dance	_____

How long was your stay at Providence Medical Center: _____

Were you prescribed medication: Yes _____ No _____

What type of medication: _____