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Effects of movement training on body awareness, self-concept, and antisocial behavior in forensic psychiatric patients

McConnell, Judith Ann, Ph.D.
The Ohio State University, 1988

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EFFECTS OF MOVEMENT TRAINING ON BODY AWARENESS, 
SELF-CONCEPT, AND ANTISOCIAL BEHAVIOR 
IN FORENSIC PSYCHIATRIC PATIENTS 

DISSERTATION 

Presented in Partial Fulfillment of the Requirements for 
the Degree Doctor of Philosophy in the Graduate 
School of The Ohio State University 

By 

Judith Ann McConnell 

* * * * * 

The Ohio State University 
1988 

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FIELDS OF STUDY

Major Field: Movement Arts

Minor Field: Psychology

Minor Field: Education/Staff Development
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CHAPTER I
BACKGROUND OF THE STUDY

Introduction

Physical movement is a fundamental medium for self-expression and a primary and basic means of communication. Some individuals are able to express in movement emotional conflict and anxiety, which they cannot express as well in any other medium. The dance affords opportunities for the expression of such emotions in a socially acceptable and sublimated form and can therefore be viewed as a means of releasing tension.

Because dance uses physical movement of the human body as a means of communication--because of its psychodynamic quality, its social character and its cultural meaning in our society--dance can be utilized in the rehabilitation of the mentally disturbed. The growth and development of dance/movement therapy as a professional field affirms its use of rhythmic movement form and techniques as fruitful means of regaining health and stability.

The American Dance Therapy Association has worked to establish and maintain high standards of professional education and competence in the field. They give a definition of dance therapy as "the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual" (Govine, 1973).
Purpose of the Study

It was the purpose of this study to explore the value of movement and rhythmic physical activity as a therapeutic adjunct in the treatment of forensic psychiatric patients. Because there has been little recording of clinical experiences in the field of movement, an additional purpose of the study was to make available a record of observations of individual patient's activities and reactions in an experimental movement program, and to review the actual methods and materials used in these movement sessions. It is hoped that these records may become a significant part of the clinical data needed to establish movement as a valuable adjunct in the therapy of forensic psychiatric patients.

Terminology

There exists terminology that is unique to this Movement Study. For purposes of this study, the following terms were used and defined as follows.

Movement Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<td>EFFORT/SHAPE</td>
<td>method of describing changes in movement quality in terms of the kinds of exertion and the kinds of body adaptation in space</td>
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<td>EFFORT</td>
<td>how the body concentrates its energy in relationship to flow of tension, and the movement factors of time, weight, and space</td>
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<tr>
<td>WEIGHT FACTOR</td>
<td>changes in the quality of weight in relationship to gravitational pull</td>
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TIME FACTOR  changes in the quality of time in movement, either sustained or quick resurgence of energy
SPACE FACTOR  changes in the quality of spatial focus or attention, becoming either direct or indirect
CENTERING  being aware of a line from the top of your head to the floor between your feet; the feeling of being balanced and integrated within ourselves (Hendricks, Gay, 1975)
FLOW  the tension flow factor being the changes between bound or free flowing energy, a movement quality
SHAPE  the varying shapes that the body takes on as it forms itself in space  

(Cecily Dell, 1977)

Forensic Terminology

FORENSIC PSYCHIATRY  the application of psychiatric knowledge to questions of law affecting life or property; dealing with a law court

Psychology Terminology

SELF ESTEEM  belief in oneself
BODY AWARENESS  having knowledge of one's body through alertness in observing or in interpreting what one sees, hears, and feels
ANTISOCIAL BEHAVIOR  against the basic principles of society; harmful to the welfare of the people generally
SELF CONCEPT an individual’s conception of himself and his own
identity, abilities, worth

(Webster’s New World Dictionary, 1982)

Need for the Study

It has been stated that there exists a recognized need for experimental techniques directed toward increasing the accessibility of the psychotic patient in treatment. On the basis of what is known about patients with certain types of psychoses, any activity which provides opportunities for the reestablishment of normal interpersonal relationships and assists in the breaking down of barriers to resocialization might be viewed as an important treatment aid.

Because psychotic patients usually have difficulty in the ordinary forms of verbal communication, there is a need for nonverbal means for initiating contact and stimulating social responses.

While considerable psychiatric recognition has been given to the value of creative expression for psychotic patients, there exist few records of clinical experiences of movement as a suitable and appropriate medium and, indeed, few theoretical evaluations. Since the value of any technique can be assessed only through the observation of many individual patients’ reactions and behavioral changes, the need for additional clinical data can be readily seen (Rosen, 1974).

Within recent years, much has been written about dance therapy and movement training with autistic children, mentally ill
individuals, and the mentally retarded. In the field of forensic psychiatry, an arena where awareness of movement and its significance might be deemed beneficial, little has been done. The positive results with other groups of individuals who have common characteristics such as poor body image, low self-concept and antisocial behavior, encourages one to think that a movement training study with forensic patients seems to be in order. The forensic literature reinforces the conviction that the mentally ill have such problems as poor self-concept, confused body image, and extreme antisocial behaviors.

Organization of the Remainder of the Dissertation

Chapter II contains a review of significant literature in the field of human movement, specifically, movement as it relates to self-concept, body image, and antisocial behavior.

Chapter III describes the method of the study with detailed emphasis on description of the study, detailed lessons of the discussion group, and detailed lessons of the movement group.

Chapter IV is composed of an analysis of the data.

Chapter V includes an interpretation of the data, relevance of the data, implications of the study, and the need for further research.

Summary

This chapter focused on the purpose of the study, definitions of terminology specific to the study, and a description of the need for the study. The problems of the mentally ill such as poor
self-concept, confused body image, and extreme antisocial behaviors were emphasized here and throughout the study.
CHAPTER II
RELATED LITERATURE

The study of human movement is complex and difficult. Movement involves a continuous flow of varying elements, gestures, energies, postures, and body parts. All of these contribute to the character and personality of the total person. This chapter will review the existing literature related to movement and therapy.

Movement has been described in a variety of ways. Sweigard (1972) defines it as the combination of neuro-musculo-skeletal phenomena. Her emphasis is on the neurological processes, and she has developed several techniques that are designed to improve posture by changing skeletal alignment through neurological imagery, or "ideokinetic facilitation." These techniques are based on the understanding that the nervous system is responsible for coordinating all movement.

North (1973) refers to two kinds of movement being vital to all people; personal and functional movement. The first type consists of our "personal" movement patterns, many of them so persistent that they are recognized as characteristics of our personality. Other patterns of personal movement are more temporary, and reveal only the mood of the moment, arising from a particular situation. This kind of movement serves no practical or functional purpose, but reflects an inner state of mind and feeling.
The second type is described as functional movement that is directed to a practical purpose which is external to the individual. For example, the same motions might be used in order to throw a football or to jump a hurdle which are functional movement patterns. However, the tensions of muscle which vary from person to person and the individual dispersion of energy are elements which determine personal movement patterns. Both kinds of movement are important.

Marion North has worked to develop personality assessments through movement and Nadine Jette works with specific movement activities centered around the effort-shape movement factors. Other assessments based on Laban's principles have been devised by Martha Davis, a psychologist, for use with the hospitalized patient. She has also written detailed descriptions of movement analysis and notation (North, Marion, 1972). Irmgard Bartenieff, founder of the Laban Institute of Movement Studies in collaboration with Dori Lewis has also written on this topic (Bartenieff, I., Lewis, D., 1980).

Creative movement, a form of dance, is employed by dance educators or physical educators to teach basic body mechanics of human movement and then deal with the aesthetic experiences gained from participation in movement activities. The pioneer of this type of dance/movement experience was Rudolf Laban. Laban identified and studied the motion factors, weight, space, time, and flow. No person can be involved in a single motion factor exclusively since efforts are to evolve in space as well as in time. Strong, direct and sudden movement struggle against weight, space, and time, while light,
flexible, and sustained movements indulge these motion factors. It is the way in which weight, space, time and flow are used which gives each effort its distinctive power, shape, duration, and rhythm. (Laban, 1947).

Laban devised a system of analyzing and describing movement behaviors (Laban, 1971). Dance/movement therapists who studied this system found that it helped them to observe and record the movement process of a dance therapy session.

Rudolf Laban probably has done more than any other individual to systemize the analysis and notation of movement. His basic notation system called kinetography in Europe and Labanotation in the United States, is widely used to describe direction, body part, weight transference, and duration of movement. Since its introduction in 1928, it has become a standard method of dance notation.

Of even greater interest to dance/movement therapists is Laban's insights into the qualitative realm of movement; that is, how movement is performed and how effort can be analyzed in terms of its components: space, weight, time, and flow. The system has been modified by a number of others, particularly Marion North and Irmgard Bartenieff, who were instrumental in introducing the system into this country (Feder, 1981).

As a discipline, dance therapy emerged in the 1940's. During the Second World War, thousands of young men were rejected from military service for various emotional disorders and when the war was over, large numbers of veterans had to be rehabilitated. Psychiatric theory was evolving and new therapeutic techniques were developed to
facilitate the treatment of large numbers of people. Group therapy, activity therapy and a variety of new approaches to treatment came into being, drastically changing the climate of the mental health profession.

Dance therapy as a non-verbal modality of therapy had its start in 1942 when Marian Chace began to work with psychotic patients at St. Elizabeth Hospital in Washington, D.C. (Chace, 1975). Integrating the art of dance and the traditional form of therapy, she developed the client-oriented dance, in contrast to the technique-performance oriented approach to dance. Marian Chace focused on "personal needs through movement" and emphasized the integration of body and mind.

There were other pioneers such as Trudie Schoop who paralleled much of Chace's work on the West Coast and worked primarily with the psychotic patient in mental hospitals. She was a professional dancer and pantomimist before becoming a dance therapist in the mid 1940's (American Dance Therapy Association, 1973).

Irmgand Bartenieff was a colleague of Rudolf Laban and, consequently, his work was instrumental in her development. She was also trained in the fields of biology, art, and dance. Bartenieff met Laban in 1925 not far from her birthplace in Berlin and studied with him and his other colleagues, Dussia Bereska, Ruth Loeser, Albrecht Knust and later, with second-generation colleagues, Warren Lamb, Marion North, Lisa Ullmann, and Laban's daughter, Azra von Laban.
In America, with the late Irma Ott-Betz, she introduced Labanotation at the Hanya Holm Studio. She became a physical therapist and then gradually rebuilt her personal connections to dance and art. In 1943, she was invited to become a member of the Dance Notation Bureau in New York, and in 1965, with Martha Davis and Forrestine Paulay, started the Effort/Shape department at the Bureau to extend the training in observing affinities between shaping and the dynamic aspects of movement process. In 1978, with the assistance of the Effort/Shape faculty, she founded the Laban Institute of Movement Studies in New York to further develop the work and its applications. She has worked over fifty years in the field and this strengthened her convictions that Laban’s multifaceted approach to the study of human behavior through body movement has a unique contribution to make to the understanding of our world (Bartenieff, 1980).

She has also supported Effort/Shape as a primary tool in movement therapy and has applied this to various approaches in psychotherapy and neurophysiology (Bartenieff and Davis, 1970). She has provided the rationale for the use of Effort/Shape as a therapeutic tool (Travis, 1977).

Another contribution to the concept of body/mind awareness is Bioenergetics development by Alexander Lowen. It is based on the work of Wilhelm Reich. He was Lowen’s teacher from 1940 to 1952 and his analyst from 1942 to 1945.

Reich in 1940 was a professor at the New School for Social Research in New York, where he was giving a course on Character
Analysis which involved the functional identity of a person's character with his bodily attitude or muscular armoring. Armoring refers to the total pattern of chronic muscular tensions in the body. It is regarded as an "armor" because it serves to protect an individual against painful and threatening emotional experiences. It shields him from dangerous impulses within his own personality as well as from attacks by others.

Reich included a discussion of the problem of hysteria into his course on Character Analysis. He emphasized that repression and the subsequent conversion of the repressed ideas and feelings into the symptom constituted the dynamic factor in an illness. Although the concept of repression and conversion were at that time well-established tenets of psychoanalytic theory, the process by which a repressed idea was converted into a physical symptom was not at all understood. Reich believed that the suppression of sexual feeling together with the characterological attitude that accompanied it constituted the true neurosis; the symptom itself was only its overt expression.

For a number of years prior to his meeting Reich, Lowen had been pursuing an investigation into the mind-body relationship. This interest grew out of his personal experience with physical activity in sports and calisthenics. Lowen underwent therapy with Reich which lasted about one year. He expressed in the book, Bioenergetics, that his therapy with Reich was effective. It did not fully resolve all of his problems, but helped make him more aware of them. More important, it opened a way to self-realization and advancement toward
that goal. It deepened and strengthened his commitment to the body as the basis of the personality, and gave him a positive identification with his sexuality.

In the fall of 1945, he began working as a Reichian Therapist and continued through 1953. Although he had not yet gone to medical school, Reich encouraged this move on the basis of his educational background and his training with him, including his personal therapy.

Reich's greatest contribution was his delineation of the central role the body must play in any theory of personality. His work provided the foundation on which the edifice of bioenergetics has been built, and was the support for Alexander Lowen to be known as the founder of the bioenergetics movement.

Bioenergetics is a therapeutic technique to help a person get back together with his body and to help him enjoy to the fullest degree possible the life of the body. This emphasis on the body includes sexuality, which is one of its basic functions. But it also includes the even more basic functions of breathing, moving, feeling, and self-expression. A person who doesn't breathe deeply reduces the life of his body. If he doesn't move freely, he restricts the life of his body. If he doesn't feel fully, he narrows the life of his body. And if his self-expression is constricted, he limits the life of his body.

The goal of bioenergetics is to help people regain their primary nature, which is the condition of being free, the state of being graceful. Freedom, grace and beauty are the natural attributes of every animal organism. Freedom is the absence of inner restraint to
the flow of feeling, grace is the expression of this flow in movement, while beauty is a manifestation of the inner harmony such a flow engenders. They denote a healthy body and also, therefore, a healthy mind.

Bioenergetics is an adventure in self-discovery. It differs from similar explorations into the nature of the self by attempting to understand the human personality in terms of the human body. Most previous explorations focused their investigations on the mind. Much valuable information was gained through these inquiries, but the domain of the personality was left untouched. His position was that the energetic processes of the body determine what goes on in the mind as well as determining what goes on in the body (Lowen, 1975).

The Feldenkrais Technique which also focused on the dynamics of self image, is based on another theory through which thousands have found renewed health and increased sensory awareness as well as improved self-image.

The Feldenkrais Technique focuses on the dynamics of self-image and teaches that our self-image consists of four components that are involved in every action, movement, sensation, feeling, and thought. The contribution of each of the components to any particular action varied, just as the persons carrying out the action vary, but each component will be present to some extent in any action.

Two states of existence are commonly distinguished: waking and sleeping. A third state is defined as awareness. In this state the individual knows exactly what he is doing while awake, just as sometimes it is known when awake what was dreamed when asleep.
The innovative exercises provide a practical program for achieving the perennial ideal of a healthy mind in a healthy body. They may appear to resemble, yoga exercises but there is no mystic esoteric to this system component. The pupil is not obliged to master or adhere to any particular mind/body theory.

"Feldenkrais demonstrates that nothing is permanent about our behavior patterns except our belief that they are so. He offers people a way of integrating physical and mental development. The easy exercises expand the boundaries of human possibility. Exercises for the posture, eyes, imagination will simultaneously build better body habits and bring into focus new dimensions in awareness, self-image, and human potential" (Feldenkrais, 1977).

Moshe Feldenkrais emphasized developing man's full awareness and potential to move with ease and efficiency (Feldenkrais, 1970). There are others such as Alexander (1969) who also studied movement from this perspective.

Going to Alexander became quite fashionable in the intellectual circles of England and America during the 1920s and the 1930s. With so much competition it is a bit surprising that the Alexander Technique is still available and has not been replaced or absorbed by other and newer systems. The Alexander Technique doesn't teach something new to "do." It teaches how to bring more practical intelligence into what is already done; how to eliminate stereotyped responses; how to deal with habit and change. It leaves the client free to choose his own goal but it gives him a better use of himself while he works toward it (Jones, 1976).
F. Matthias Alexander developed his method after losing his voice as a result of his work as an orator. Rest and medical aid would not cure this and he became incapacitated. He began investigating his behavior while reciting and decided that something he was doing to himself while reciting must be causing the trouble. He learned that he was speaking in a stressful pattern and that he could consciously inhibit this stressful pattern. Once he had learned this, he found that he could initiate new activity toward any end or goal he might choose.

Alexander began writing pamphlets and books about the Technique, but it was always difficult to characterize and describe in words. His effort to communicate the means of inhibiting habitual and damaging use of the body in order to achieve this kinesthetic lightness in action led, as is always with new domains of concern and investigation, to special terminology. The result was instructions containing such terms as concentrate on the "means whereby" rather than "end gaining," 'think of the head as 'forward and up' but do not actively thrust it forward or up,' and such theoretical constructions as 'position of mechanical advantage,' 'primary control' and 'faulty sensory appreciation.' Although such words, by themselves, failed to communicate, the Alexander teachers could quickly use their hands to induce, in nearly anyone who would expose himself to a 'lesson,' a relationship among head, neck, shoulders, and back that induced a dramatic impression of kinesthetic lightness in action. So long as one retained this new postural relationship ('primary control'), one could readily carry out common actions without the accustomed sense
of effort and strain. This impression of kinesthetic lightness from a single demonstration persists, at least for a short time, and memory of it lingers for life. Moreover, once an individual had learned to achieve the new postural relationship ('primary control') of the Alexander Technique on his own initiative, stress-produced problems disappear. Although few physician's have ever become attracted to the Technique for therapeutic purposes, Dr. Wilfred Barlow and a few others have reported finding it useful in such varied conditions as 'peptic ulcer, spastic colon, ulcerated colitis, eczema and rheumatoid arthritis' as well as 'tension headaches, asthma, low back pain, and fibrositis.'

Although F.M. Alexander wrote, in captivating fashion, about the Technique, his words, as such, seldom elicited faith in its efficacy and validity. It demonstrated the dramatic experience of kinesthetic lightness coupled with relief from distressful symptoms of misuse in those who learned through lessons to achieve 'primary control' voluntarily. It convinced such figures as Sir Stafford Cripps, John Dewey, Aldous Huxley, James Harvey Robinson, and Bernard Shaw of its validity. John Dewey was one of Alexander's earliest American pupils. In 1918, he wrote an introduction to a new American edition of Alexander's book entitled *Man's Supreme Inheritance*. Dewey considered the Alexander Technique a demonstration of the unity of body and mind.

**Movement Training and Special Populations**

B.F. Booth (1982) in "Movement Therapy Programme with Emotionally Disturbed Children" investigated movement-play activities with
emotionally disturbed children and the effects on social behavior control and self worth. He exposed a select group of partially institutionalized prepubescent boys to progressively increased social content in games. It was hypothesized that more positive social behaviors would be induced by gradual increments of success in a controlled movement-play environment. The program helped the children focus upon specific forms of social control and to experience stronger feelings of self-worth.

Wise (1981) in "Dance Movement Therapy as Treatment in Obesity" investigated dance/movement therapy as treatment in obesity and its effects of exhilaration. It has been shown there is direct correlation between food intake and exercise for people whose response to stress involves overeating. Dance movement therapy provides tension release and exploration of the relaxation response. Techniques to elicit this response include: guided relaxation, breathing exercises, and meditation. Dance movement therapy appeared to be an important modality in the treatment of obesity.

Romero (1983) in "Dance Therapy on a Therapeutic community" examined the results of dance therapy as to positive rapport between psychiatric patients and others in their lives. He concluded that body image which was directly related to the concept of persona was positively affected. The patients began to perceive that they had an image to present to themselves and to the world. As their joints became more flexible and their movements more spontaneous, their body image and self esteem improved greatly.
Christolup (1962) in "The Effects of Dance Therapy on the Concept of Body Image" set up a study with hospitalized chronic schizophrenic population between the ages of 20 and 50, with no other known involvement such as organicity or physical impairment. She followed the philosophy that the medium used in dance therapy is the body itself and part of the therapeutic process lies in increasing the individual's awareness of his body and his ability to use it as a means of expression.

All subjects were asked to produce two drawings according to a standardized procedure. Two raters scored the drawings on the Goodenough Scale and the Swensen Sexual Differentiation Scale. From these patients, then, one group of 12 women and one group of 15 men were placed in dance therapy for a period of 13 weeks (21 sessions). The remaining two groups served as controls. The dance sessions were conducted in the usual manner. During each session, standardized observations were made.

It was noted that, though results significant at the .05 level of confidence were not obtained on the Goodenough scores between the first and second sets of drawings, both experimental groups approached significant levels, whereas the control groups did not.

One may therefore conclude that significant positive changes did occur among the female subjects and that these changes are probably a result of the introduced variable, that is, the dance. One may further conclude, on the basis of the results of the analysis of variance, that those subjects, both male and female, who were most active in the sessions, showed significant improvement.
The most notable observation which can be made from the data is that all the results indicated that improvement was taking place and would have been more marked had the duration of the dance therapy been longer. The implications of this for further study are that the duration of the experimental period should be longer and that behavioral criteria should be utilized in studying the longer-term effects resulting from dance therapy.

Aristreik (1981) in "The Emerging Self," attempted to determine with a psychiatric patient if using breathing as a tool in dance therapy, for insight and separation, was useful. The patient had entered dance therapy because she felt blocked and isolated from her feelings. She said that she felt as if she were dead most of the time. The study found that, through breathing exercises and movement therapy, she was helped to slowly become aware of what was causing her asthma. She gradually learned to gain control of the situation.

Siegel (1981) in "Alexander Technique: An Innovative Approach to Reducing Physical Tension and Stress," investigated a system for teaching people how best to use their bodies in ordinary action to avoid or reduce unnecessary physical stress that is inevitably linked to pain and disability. She relates how the treatment effects change through increasing patient awareness of poor body posture habits, to inhibit them, and to replace them with proper patterns of muscular movement.

The Alexander Technique awakens and reeducates the kinesthetic sense so that the patient no longer feels at ease in unhealthy postures and movements. Patients who are chronically under stress
will benefit both physically and emotionally from training in the Alexander Technique. The voluntary releasing of unnecessary muscle tension is a critical part of what is learned in the Alexander Technique.

Moshe Feldenkrais (1977) in _Awareness Through Movement_, described _The Case of Nora_, which is an account of his program of body awareness with a stroke victim who was unable to read or write or even put on her own shoes. With his help, she was able to resume normal functioning after only a few months, much to the amazement of doctors and friends.

Sandel (1983) in "Structure and Process of the Nascent Group: Dance Therapy with Chronic Patients," expressed concern that only a few adventurous therapists have shared the experience of being with severely disturbed patients. Working with chronic patients is difficult and can easily discourage therapists. She concluded that judging the effectiveness of these groups by usual standards of group therapy experience is inappropriate and leads inevitably to a devaluation of group members, of the therapy, and of the therapist.

Sandel (1982) in "The Process of Individuation in Dance-Movement Therapy with Schizophrenic Patients" investigated that in dance therapy with schizophrenic patients there are often subtle but powerful forces at work on both patient and therapist to maintain the fantasized omnipotence of the therapist as mother. She found that the structure of the dance therapy session can facilitate or impede the individuation process as the patient attempts to move toward autonomous functioning.
Siegel (1982) in "The Mirror of Ourselves," a Psychoanalytic Study in Dance-Movement Therapy, constructed a theoretical framework for dance movement therapy from psychoanalytic ego-psychology. A body-mind unity was examined from a concrete and metapsychologic perspective. Most important, though, dance movement therapy was viewed as a primary, rather than as an adjunctive treatment mode.

Chace (1964) in "Dance Alone Is Not Enough" examined the effect of dance movement therapy with patients who were hospitalized and in institutions. She was the most inspirational in this area as she described her work with dance therapy as a therapeutic modality and brought recognition and value to this therapy when she joined the staff of St. Elizabeth's Hospital in Washington, D.C., in 1942 as a dance therapist.

Schoop (1973), American Dance Therapy Association, was also a model as she worked with the extreme psychotic patient and has described in detail the puzzling delusions of these extremely ill individuals and shared the progress that has been made with this population through dance therapy. She demonstrated that dance therapy, in making use of the basic form of communication, offers the individual a means of relating to the environment, or to other people, when he/she is cut off in the majority of areas of communication by patterns of his/her illness.

Goodnow (1968) in "The Use of Dance in Therapy With Retarded Children" studied the effects of square dance, modern dance, and social dance classes on the development of verbal and nonverbal social skills and also physical development. She learned that
improving coordination skills, increasing the attention span, developing an awareness of the body in movement, learning appropriate social behaviors, and achieving self-expression through movement were areas which could be emphasized in dance groups. Dance groups also help the retarded patient to acquire skills which will help him to achieve his potential functioning ability, whether he returns to the community or remains in an institution.

Rogers (1977) in "Contributions of Dance Therapy in a Treatment Program for Retarded Adolescents and Adults" discussed the use of nonverbal communications by the mentally retarded.

A clinical approach involving dance therapy was described as having increased subjects' nonverbal communication over a one year period. The method of observation and description used in the study was the effort shape system developed by Rudolf Laban in 1950. A table comparing cognitive rating and movement complexity reestablished the finding that higher cognitive rating showed greater movement complexity. The social relationship assessment correlated less clearly with complex movement. Intervention without interpretation was emphasized and examples of intervention in non threatening ways were given. It is concluded that dance therapy can intervene with both cognitive and emotional functioning, operate on both a verbal and nonverbal level, and deal with both concrete and abstract concepts.

Duehl (1979) in "The Effect of Creative Dance Movement on large Muscle Control and Balance in Congenitally Blind Children" reinforced the benefits of movement training. An attempt was made to enhance
large muscle control and balance in congenitally blind children aged between eight and ten years, by exposing them to a program of creative dance movement. Subjects were tested before and after training, using an evaluative test based on measures designed by Cratty. A sighted control group was also tested without training, for the purpose of seeing their performance on the test. Post-training test results for the blind group revealed improvement on a significant percentage of the evaluative tasks. The scores of this group also came closer to the scores of the sighted control group. Observations of persons involved with the subjects in other areas of their education and daily life, concurred with the test results, in that they overwhelmingly noted overall improvement in movement abilities.

Best (1974) in "Movement Therapy in the Treatment of Autistic Children," addressed movement therapy in the treatment of autistic children. Results indicate that a physical activity program may be of great value to the treatment of autism in that such children are capable of learning motor skills to a discernible level. Specifically, a movement education program helped achieve self-motivated gross motor activity in autistic children.

Jones (1975) in "Movement Therapy in the Treatment of autistic Children: Its Intellectual Changes," described the changes in four autistic children aged 2 years 10 months to 9 years in estimates of intellectual development during their period of motor education. It was concluded that physical activity and movement therapy appeared to coincide with an increase in each child’s developmental skills judged
by the Pels Behavior Rating Scale, Merrill Palmer Scale of mental tests, Purdue Motor Development survey, and other measures.

Apter (1978) in "Movement therapy with Psychotic Adolescents" discussed the effectiveness of a movement therapy program with adolescents. The movement therapy program was on an adolescent unit with thirty 13-18 year old psychotic patients. The results of the program confirm the effectiveness of movement therapy for psychotic adolescents.

Sandel (1978) in "Movement Therapy with Geriatric Patients in a Convalescent Home" discussed the use of movement therapy to promote socialization and expression of feelings in elderly patients through movement exercises that stimulate interaction. A registered dance therapist established a movement therapy group for long term geriatric patients in a convalescent home. Results showed that during the first six months, patients showed increases in verbalization and spontaneous expression of feelings, and improved in interaction and assertiveness.

Kojic (1974) in "Some Characteristics of the Treatment of Alcoholics in the Center for Treatment and Prevention of Alcoholism in Skofljica," described the therapeutic regimen of the Center for treatment and Prevention of alcoholism, Skofljica, Yugoslavia. Its main characteristic was the absence of individual psychotherapy and the transfer of the therapeutic role from the therapist to the patients. The patients were organized into dance therapy, physical education, and the discussions of world problems. The effectiveness
of this treatment was not mentioned except to say that this therapy was being used.

Bartholomew (1976) in "The Need for Recreational Activity in Forced Confinement" described conditions in penal institutions that lead to psychological maladjustment. For a high percentage of the inmate population, recreational activity could take the place of time spent simply in confinement. The absence of general recreational activities could make a psychological condition worse by a person's stay in prison.

The literature review did not reveal any movement training studies within forensic facilities but did reveal forensic psychiatry, forensic psychology, and legal psychology studies. The insanity defense in a court of law is presently a priority area for authors in this field. Perhaps in time, more articles involving forensic activity programming will be available.
CHAPTER III
PROCEDURES

Introduction

This study was formulated after realizing that in the field of forensic psychiatry, little has been done with movement awareness. This reaffirmed the need for a movement training study with forensic patients.

The forensic literature reinforced the conviction that the mentally ill have such problems as poor self-concept, confused body image, and antisocial behaviors. This study was envisioned as an investigation of these problems by establishing a movement training group and comparing this group with a Life Skills discussion group (Roesch, 1977).

Specifically, though, this was a study of body awareness, self-concept, and antisocial behavior in forensic psychiatric patients. The purpose was to assess a movement education program employed with incarcerated adult forensic patients and compare the results with a forensic discussion group. The sessions for both groups were held in the Timothy B. Moritz Forensic Unit at the Central Ohio Psychiatric Hospital.

The forensic patients are placed in a maximum security setting due to deviant behavior and psychiatric illness. Examples of crimes that have placed patients in a forensic unit are battery, assault,
prostitution, and murder. Psychiatric illnesses such as paranoia or schizophrenia are examples of the mental illnesses.

The patients involved with the groups were selected by the treatment teams and then placed into the groups according to patient needs. The facility has six treatment teams each consisting of professional direct care staff responsible for the treatment of these patients. The professionals on each team were the psychiatrist, psychologist, nurse, social worker, activity therapist, and teacher. Criteria for patient selection was determined by the group leaders and presented to the treatment teams.

**Participant Selection Process**

Due to the nature of this facility, random selection of patients for the two groups was impossible and this is viewed as a limitation to the study. The needs of the patients must be considered in the selection process or the services to the patients would be neglected. The groups would become staff-serving instead of patient-serving.

The control group consisted of the discussion group called Life Skills Group. It initially involved twenty-one forensic patients and co-leaders for the group, who were also the leaders of the experimental project. There were three patients discharged from the facility halfway through the group. They were assessed, though. All of the patients were considered normal to high functioning in aptitude ability. The procedure established for this group included discussion with emphasis on positive thinking and strategic
resolution of individual problems relating to their personal lives and experiences. Two ninety minute sessions per week were conducted for ten weeks.

Support materials used in the conducting of group sessions included *Feeling Good, The New Mood Therapy* by David D. Burns, M.D., the individual treatment plans of each patient, and individual goal sheets established for each patient (See Appendix).

The criteria established for patient selection in both groups was:

a) patient judged as motivated to participate;
b) patient demonstrated ability to follow simple/complex directions;
c) patient showed ability to socialize with others verbally;
d) patient was referred by the treatment team;
e) patient was judged to be in need of help to set realistic goals and was capable of problem solving;
f) patient was able to understand his/her individual treatment plan.

The experimental group was called the Creative Movement Group. Initially it involved eleven patients and co-leaders. Two patients were discharged from the facility halfway through the group. They were assessed, though, and their data was included in the overall results. Six patients out of the eleven were considered low functioning in aptitude ability.

The materials used in the conduct of this group's sessions included: a video camera, video recorder, musical records, musical
instruments, gymnastic floor mats, pillows, and a stereo record player. Specific instruments used were bells, triangle, drums, wooden clacker, tambourine, and maraca. A variety of music was chosen ranging from classical to rock depending on the scheduled activities and their purpose.

Evaluative Techniques

Tennessee Self Concept Scale

The Tennessee Self Concept Scale was chosen because it is simple for the subject, widely applicable, well-standardized, and multidimensional in its description of the self-concept (Fitts, 1964).

The individual's concept of himself has been demonstrated to be highly influential in much of his behavior and also to be directly related to his general personality and state of mental health. Those people who see themselves as undesirable, worthless, or "bad" tend to act accordingly. Those who have a highly unrealistic concept of self tend to approach life and other people in unrealistic ways. Those who have very deviant self concepts tend to behave in deviant ways. Thus, a knowledge of how an individual perceives himself is useful in attempting to help that individual, or in making evaluations of him/her. The Scale, therefore, can be used for a variety of purposes -- counseling, clinical assessment and diagnosis, research in behavioral science, personnel selection; etc.

The Scale consists of 100 self descriptive statements which the subject uses to portray his own picture of himself. The Scale is
self-administering for either individuals or groups and can be used with subjects age twelve or higher. The reading level should be at least 6th grade.

Both groups were given the same test. There were 12 patients in the control group and 4 patients in the experimental group who were self administering; while 2 patients in the control group and 7 patients in the experimental group had to have staff read the questions to them. The answers were given verbally to staff.

For the purpose of this study, the overall level of self esteem was deemed to be the most important score on the Tennessee Self Concept Scale.

Draw-A-Person Test

The next area for study was body awareness, and the instrument chosen was an adaptation of the Goodenough Draw-A Person Test. This was also used in the form of a pre and post assessment. For the purpose of this study, awareness of stress areas is related to body awareness. Both groups were given the same test. The instructions were read to both groups at the same time. The patients were told to draw a picture of themselves. Afterward, they were instructed to place in their drawing, the organs related to breathing and relaxation, (heart, stomach, lungs). They were then instructed to place arrows at the particular points where they experience stress in their own bodies. Careful attention was given to the placing of the specified organs. It was hypothesized that identification of heart, stomach and lungs indicated the body’s stress areas. The first was
assumed to show awareness of stress areas within their own bodies. Specifically, the assessment showed the number of stress markers, and the placement of the stress markers.

Behavior Levels

Observing the behavior control of the patients was accomplished by reading the twenty-four hour ward charts on a randomly selected day and recording the behavior levels and any incidents involving restraints or seclusion at the start and at the end of the group. The patients function on a behavior level system (A to E), with "A" level being the level for the most appropriate behavior, and "E" level being the least appropriate. Level "S" is a special level for patients who have difficulty controlling inappropriate, antisocial behavior. They are maintained on level "S" until they can manage the level system, and be held responsible for the consequences that accompany each earned level. There is significantly more staff control while patients are on level "S." All of this observed behavior control was viewed as to the variable of increase or decrease in antisocial behavior on the part of patients in both groups.

Participant Orientation to the Research Study

Both groups were given the same orientation to the study and the assessments. One leader briefed them on the format of pre and post testing. A sample test and scoring profile were also shared with the group in order to help them better understand the purpose of the testing and how the results would be interpreted. A leader met with
each patient and explained their test results. When explaining the results, any variance between pre and post tests was explained. Significant differences were pointed out to the patients. Questions and comments from the patients were noted at that time.

Program Content

Program for Control Group - The Life Skills Group

The following is a description of the Life Skills Group agenda. The curriculum was divided into 3 modules: Module 1 focused on "Group Interaction" and consisted of sessions 1 through 6. Module 2 emphasized "Working with your Treatment Team" and was sessions 7 through 10. Module 3 proposed "Individual Work Plan" and was sessions 11 through 20. Each session lasted one hour and began with an introduction of the session topic, discussion, and wrap-up. At least three weeks was devoted to each module in the Life Skills curriculum which is outlined below. Samples of the assignments are included in the Appendix.

Module I

Session 1: Assessing (Pre-Testing)

1. Tennessee Self Concept Scale
2. Draw-A-Person Test

Session 2:

1. Discuss ground rules
2. Discuss expectations of the group
3. Get acquainted
Session 3:
1. Discussion of individual problems
   a. Examples from group members

Session 5:
1. Definitions of concepts
   a. "All-or-Nothing" Thinking:
   b. Overgeneralization

Session 7
1. Definition of Concepts (Mental Fitness)
2. Relaxation Training
3. Positive Self-Talk

Session 9
1. Treatment Team Review
2. Individual Treatment Plan

Session 11
1. Assertiveness Training
2. Treatment Team Review

Session 4:
1. Treatment team discussion
   a. question and answer session

Session 6:
1. Individual Work Plan
   a. Meeting with advisor
   b. Time and date
   c. Discuss individual treatment problems

Session 8
1. Definition of Concepts (3 parts)
2. Disqualifying the Positive

Session 10
1. Submit Individual Project
2. Definition of Concepts:
   a. Jumping to conclusions
   b. Magnification/Minimization

Session 12
1. Definition of Concepts
   a. Emotional Reasoning
   b. "Should" Statements
Program for Experimental Group - The Creative Movement Group

The experimental group was called the Creative Movement Group and was conducted by co-leaders. None of the participants had ever participated in this kind of experience before.

All sessions began with a fifteen minute "deep-breathing" exercise as preparation for the main lesson of the day. All of the lessons were formulated around Laban's effort factors; time, space,
force, and flow. The actions representing the factors were extended into activities of the curriculum. Music was used during the sessions in conjunction with movement efforts. A variety of movement experiences of exercises were offered. They included yoga exercises, trust/balance exercises, New Games, centering exercises, sculpturing exercises, role-playing, and instruments played rhythmically.

**Session 1**
- Breathing
- Inner Rhythm
- "Melting" Exercise
- Personal Space

**Session 2**
- Breathing
- Inner Movement
  - a) Yoga Breathing
- Trash Can Exercise
  - (Close and Open)

**Session 3**
- Breathing
- Emotional Expression
  - a) Inner Movement
  - b) Instruments
  - c) "Reflect the Music"

**Session 4**
- Breathing
- Directness/Indirectness
  - (Space)
- Assertiveness
  - a) Psychodrama

**Session 5**
- Breathing
- Psychodrama
- Doctor's Office Drama
- Movement Dynamics
  - a) Strength & Softness
  - b) Role Playing
    - (Effort factors, especially weight)

**Session 6**
- Breathing
- Movement Dynamics
  - a) Strength & Softness
  - b) Role Playing
    - (Effort factors, especially weight)

**Session 7**
- Breathing
- "Centering" Exercise
- Lie on Ground & Focus
- "That Moment of Uncertainty"
  - (Trust/Balance)
- Lean and Support

**Session 8**
- Breathing Exercise
- Partners Reflection
- New Game
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<td>Anger with Sounds (Voice and Movement)</td>
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Session 19
Review of Sessions

Session 20
Party
Refreshments

Individual Sessions: Control Group and Experimental Group

Control Group

Session 1
The session was introduced with a general discussion of the mini-course and a description of the curriculum component, course goals, and personal expectations of the participants. The Tennessee Self Concept Scale and Draw-A-Person Test were explained with the directions given in detail. Each participant completed both assessments. The psychology terms defined in the sessions were found in the book, Feeling Good, The New Mood Therapy, by David D. Burns, M.D.

Session 2
This session was an introduction to the ground rules of the group. The attendance policy was explained which required that all but two sessions must be attended in order to pass the course. The leaders of the group discussed the mini-course content. Each group participant would also have an advisor who would meet with them one other time throughout the week. The first topics to be discussed with the advisors were individual problems of each client, individual work plans and specific meeting times with the advisor. The initial
topics discussed with the entire group were "Concepts of Thinking" and working with their treatment teams. After discussing these topics, the large group was divided into smaller groups with their advisers.

**Session 3**

This session involved discussion of individual problems. Examples of problems were given by group members.

**Session 4**

This session involved discussion of their treatment teams. The purpose of this discussion was to help them work more productively with their teams which would ultimately help them with personal treatment problems. The participants were to understand priority problems and what criteria should be met for discharge.

**Session 5**

This session involved general discussion of cognitive distortion terminology. The two terms discussed were "All-Or-Nothing Thinking," and "Overgeneralization." Examples of behavior involving this terminology were shared and patient input was given. The terms were defined as follows: ALL-OR-NOTHING THINKING -- seeing things in black and white categories. If your performance falls short of perfect, you see yourself as a total failure and OVERGENERALIZATION -- seeing a single negative event as a never-ending pattern of defeat.
Session 6
This session involved individual work which included:
(a) meeting with adviser;
(b) time and date of weekly meeting with adviser;
(c) discussion of individual treatment problems.

Session 7
This session involved the whole group and was initiated with discussion of the definition, Mental Filter. The next section of the class involved relaxation training consisting of deep breathing and techniques for mental relaxation. The rest of the session involved positive self-talk with the whole group. Mental Filter was defined as picking out a single negative detail and dwelling on its exclusively so that your vision of all reality becomes darkened like the drop of ink that discolors the entire beaker of water.

Session 8
This session involved three parts and was similar to the previous session. There was a general discussion with the entire group on the concept, Disqualifying the Positive. The next part was additional relaxation training and then positive self-talk with the group. Disqualifying the Positive was defined as your rejection of positive experiences by insisting they "don't count" for some reason or other.
Session 9

This session involved a review session of the treatment team discussion. Any problems that individuals may have experienced that they chose to share with the group were discussed at that time. The patients were then divided into small groups and met with their advisers concerning any problems with individual treatment plans.

Session 10

This session was introduced with small group meetings and the advisors. Each patient was to begin working on goals for their individual treatment plan. Questions asked were: (1) What I want to work on my problems), (2) What I want to accomplish (my goals), and (3) How I will accomplish my goals, (How long I will take and how I will do it). They were then to sign a contract agreeing to work on these goals beginning on a certain date. The patient and staff member then signed and dated the agreement. After this, the small groups joined the large group and discussed the definitions of Jumping to Conclusions, Magnification, and Minimization. These terms were defined as follows: JUMPING TO CONCLUSIONS -- making a negative interpretation even though there are no definite facts that convincingly support your conclusions; MAGNIFICATION -- inappropriately exaggerating things out of proportion; MINIMIZATION -- inappropriately shrinking things until they appear tiny.
Session 11

This session involved assertiveness training with the patients in the whole group session. This was initiated through psychodrama of situations involving people being assertive vs. not being assertive. The patients shared life experiences as examples for the psychodramas. A discussion was held on the assertive vs. nonassertive aspects of the situations and how these relate to their lives.

Session 12

This was a whole group session and involved discussion of the concepts, Emotional Reasoning and Should Statements. A review was held of all previous concepts by playing charades and having individuals act out examples of behaviors portraying concepts that had been discussed. Relaxation techniques followed the mini-dramas. The following are definitions used for the terms discussed in this session. Emotional Reasoning -- your assuming that your negative emotions necessarily reflect the way things really are: "I feel it, therefore, it must be true." Should Statement -- trying to motivate yourself with shoulds and shouldn'ts as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment.
Session 13

This session also involved discussion of concepts with their definitions. The concepts were Labeling/Mislabeling and Personalization. A review discussion of all the vocabulary concepts covered in the group was held. The session was then expanded with the section on positive self-talk. The required text for the group was *Feeling Good, The New Mood Therapy* by David D. Burns, M.D., which emphasized an approach to mood modification and cognitive therapy. The introduction and Part I of the book, theory and research of treating mood disorders and understanding your moods, were the focus of discussion for this session. The following definitions were given in the group. Labeling -- Creating a completely negative self-image based on your errors. It is an extreme form of over generalization. When someone else's behavior rubs you the wrong way, you attach a negative label to him/her. Mislabeling -- involves describing an event with language that is highly colored and emotionally loaded. Personalization -- seeing yourself as the cause of some negative external event for which in fact you were not primarily responsible.

Session 14

This session involved meeting in small groups with the advisors and sharing individual projects on goal setting with the small groups. Each participant had met during the week with the advisor and had his/her individual projects approved before class. The small groups were then joined with the large group and open discussion on Part II of *Feeling Good* was held.
**Session 15**

The small groups met to review the individual goal projects and then joined the whole group to share the projects with the other groups. This concluded the session for the individual projects. A review of Part III of the text, "Realistic Depression" was then held.

**Session 16**

A discussion was held on Part IV of the text. This section pertained to "Prevention and Personal Growth," and focused on ways to become satisfied with yourself. A review of all the sessions in the course was then held.

**Session 17**

This session was for review of Part V of the text which focused on "Defeating Hopelessness and Suicide." Individual awareness on this topic was the focus of this session.

The last part of this session was the course evaluation which was completed in the group. The advisers met individually with the patients and discussed patient self-evaluation and their personal evaluations. These involved (1) attendance, (2) group participation, (3) individual projects and performance. The rating system was on a letter grade scale from A through E, with A being the highest.
Session 18

This group meeting reviewed Part VI of the text, "Coping with the Stresses and Strains of Daily Living" and focused on the daily practice of coping with our personal living situations. The last section of the group was a test over the concepts. If a patient had difficulty with reading the material, a leader read the material and wrote what the patient verbally responded to the concept. These tests were then scored and shared with the individuals.

Session 19

This group meeting concluded the discussion of the text with a review of Part VII, "The Chemistry of Mood." This covered the consumers' guide to antidepressant drug therapy and was an interesting discussion of drugs that were familiar to the clients. The rest of the session involved the post-test of the group which was the "Tennessee Self Concept Test" and the "Draw-A Person Test."

Session 20

This final session was a group party with pizza for everyone. All of the participants who met the attendance and grade requirements received a graduation certificate.

Experimental Group

Session 1

The session was introduced with the deep breathing exercise for about 20-25 minutes. The participants and co-leaders would sit on the mats in a crossed leg position and control a straight position
from the waist to the top of the head. This emphasis would straighten the spine and pull the body into an excellent breathing position. A member of the group, participants as well as co-leaders, would take turns leading the rest of the group with inhaling and then exhaling to the count of twelve. This exercise proceeded to the second portion of the deep breathing. Everyone in the group would lie on their backs flat on the mats. Their legs were then pulled up so their knees would face the ceiling and turn in toward each other. Their arms were then crisscrossed over the chest with the elbows pointing to the ceiling. The small of the back was held as flat to the floor as possible. The position was relaxing and was held like this for about ten minutes. The leaders would encourage the participants to think positive thoughts. Classical music was played in the background during the deep breathing session. An example of music would be Debussy by the London Symphony. After the relaxing part of the class was over, the "Inner Rhythm exercises were held. This focused on developing inner awareness of the individual and stressed that each participant try to discover their own personal rhythm style. Each participant was asked to think about his/her personal rhythm style. Each participant was asked to think about his/her own displayed effort throughout most of the day. Does this effort reflect personal inner feelings and show true and sincere feelings. Each participant was then asked to dramatize a feeling and then share the effort portrayed in the actions. The whole group discussed how often we feel a certain way but either through
difficulty with the feeling or the environment is such that true feelings and reactions to a situation cannot be expressed.

The effort factors were introduced to the group by the exercise called the "Melting Exercise." Every participant in the group was to pretend they were an object that was made of a substance that could melt. This encouraged all participants to begin thinking about the effort factors of time and flow. Some specific examples of the objects dramatized were ice cream, butter, and soft steel. All dramatizations consisted of the elements, slow, sustained and heavy. After the short drama, there was discussion of the elements that were displayed and what each member in the group thought of the exercise.

The exercise consisted of the "Personal Space" exercise. This consisted of short discussion concerning each individual's use of space and personal feelings toward respect for his/her own and other's space.

**Session 2**

This session was introduced with the two sets of deep breathing exercises as described in Session 1. The only difference in this section of Session 2 and that of Session 1 is that a different leader would be chosen to lead the breathing exercises. As each session progressed, the group became stronger with the relaxation section of the exercise. The group was introduced to "Inner Movement -- Yoga Breathing." The participants sat in a comfortable space and breathed in deeply for four counts; then exhaled for four counts. They breathed in deeply for four counts; then let their breath carry their
arms up toward their heads. They exhaled for four counts, and let
the arms come to rest on the knees. The exercise involved standing
straight and in a centered position with both feet together and arms
at the side of the body. Slowly they raised the arms over the head
and rose on tip toes at the same time while inhaling. They stretched
and bent over slowly to the knees exhaling at the same time. They
pulled their heads to the knees and held as long as possible giving a
good stretch to the back of the legs.

The "Trash Can" exercise was the final part of the group in this
session. This emphasized the opening and closing movements that are
similar to the gathering and scattering movements of basic movement.
The directions were to pretend being an object crumpled in a trash
can and then come out of the can and be a new and complete object.
Various objects such as paper wads, tin cans, pop cans, and small
paper boxes were dramatized by the group participants. Another good
thing about this was that the participants would usually start on the
floor and eventually rise to a standing position. This helped them
to work on a bi-level as well as just sitting and standing. There is
also the "in-between" level that would then be experienced. This was
a chance to discuss and demonstrate the horizontal, vertical, and
sagittal planes. The participants are known to have great difficulty
with feelings of insecurity. This opening and feeling sensation was
part of the nurturing concept.
Session 3

This session was introduced with the deep breathing sessions. More work was then done with inner movement and emotional expression. Daily living activities and the feelings and expressions personally involved with these were discussed. This activity also involved some mini-dramas of their daily activities with discussion on the effort factors involved. The emotions tied with specific movements and their feelings when involved with particular movements were also discussed. Examples of the drama were scenarios of behavior problems which the participants face on the unit, problems that participants face with staff and finally, problems connected with criminal charges. All of these brought specific movements such as "punch," "slash," "wring," or "dab" when working through the emotion of these various problems.

The last part of the session also concentrated on emotional expressions but this was accomplished by using musical instruments. Every participant and co-leader had an instrument and coordinated the sound with the records. The instruments were bongos, bells, triangles, sticks, and wooden clackers. The music was stopped and discussion was held on "Reflecting the Music" with movements and not instruments. Each participant moved to the music as the rhythm was felt. Examples of music were again Debussy, London Symphony, and Jazz Band, Juke Box by Reggie Andrews and Bobby Harris.
Session 4

This session was introduced with the deep breathing exercise. After this was the exercise, "Directness, Indirectness." The discussion was held so that the participants were encouraged to experience the feelings of directness and indirectness. The exercise was then conducted where one person led the other person across the room by voice only as the follower had to have eyes closed. This encouraged the element of trust as well as experiencing directness and indirectness. The exercise was encouraged so that one time the leaders would be direct with vocal instructions and have the follower travel straight across the room and the other time the follower would be led indirectly and with loud and soft voice demands that purposely would confuse the follower. The first part of the lesson was working with psychodrama and assertiveness. This was conducted through dramatizations of any past work experiences the participants may have had. The focus was on the assertive movements involved in the job and then discussion with the group after the mini-dramas were completed. Examples of jobs that were dramatized were a waitress, factory worker, gardener, and baby sitter.

Session 5

The session was introduced with the deep breathing. This particular session was longer than the other sessions because the group was prepared for the psychodrama of the doctor's office which was videotaped. The discussion focused on the movements associated with assertiveness, nonassertiveness, and aggressiveness. The
effort factors emphasized were particularly force and space. The specific movements involved were dab, punch, and flick with consistent mention of open and closed. The roles in the drama were the doctor, nurse, and patient. The scenario involved the patient's wanting to see the doctor and the nurse responded with "No, this is not possible right now." The patient then had to work to see the doctor and this involved being assertive, non-assertive, aggressive, or non-aggressive. The group viewed the taped session. It was clear as to the variables of movement prioritized in the lesson. The patients discussed the video and shared feelings about personal movements.

Session 6

This session was introduced with the breathing as were previous sessions. This exercise emphasized movement dynamics, especially strength and softness. The dynamics of strength and softness and then the movements expressing these were discussed. Examples such as slow, sustained, indirect, direct, strong, quick and hard were mentioned. Specific movements mentioned were punch, dab, flick, and wring. Role playing was then introduced and this extended the examples of strength and softness given previously. The focus of the mini-dramas was strength or softness displayed in the interactions of communications. Examples were given and one, in particular, was a participant talking with a friend and agreeing on an issue. This displayed softness. The opposite was shown with an example of a patient disagreeing with staff on an issue.
Session 7

This session followed the previous introductory exercise of deep breathing. The first exercise was a "Centering" exercise which helped the participants to specifically work on centering and its use with behavior control. The participants were to pretend that a straight line ran all the way through the body from the top of the head to the feet. They were then to stand with feet together and align themselves with a straight line formed by the creases in the gymnastic mats. They then were to try and feel the straight line going through their bodies. This would help them naturally straighten their bodies and give them the awareness of a straight body. After they completed this standing up, they were then to lie down and center their bodies on a straight line on the mats. Once again, they were to feel the straight line going through their bodies. They were then to roll off of the line from one side to the next and then roll back on and lie focused and straight. This sensation of "falling off" and then rolling back on the straight line helps develop the awareness of being centered. A discussion followed this exercise about the importance of centering and its use with deep breathing and behavior control. The participants were then asked if they felt they could use it on the units when they were getting upset and were feeling confined. A participant gave the example of deep breathing and centering when he felt like stealing from someone on the unit.

The last exercise was the beginning of a series of exercises involving development of trust with the group and individuals. This
particular exercise was called "That Moment of Uncertainty" (Trust/Balance). Participants joined with a partner and shared roles as to the person having to trust (truster) and the person who was trusted (leader). The person trusting (truster) would turn his/her back to the leader and gradually relax enough to the point that his/her whole body would "drop" backwards in the arms of the leader and create a "trusting balance" in the process. The group worked in partners.

**Session 8**

This session was introduced with the deep breathing. The first exercise was called "Partners Reflection" and involved each participant joining with a partner and facing the partner while music is played. Each took turns leading the movements to the music while the other partner followed. After this activity was finished, each participant took turns leading the whole group in movements to the music. In this section, the music changed periodically so that various tempos were reflected in the music. Examples of music were *Love Will Follow* by George Howard and *Precious Moments* by Jermaine Jackson. The last exercise was called "Lean and Support" and was a follow-up to the previous lesson "Trust/Balance" in Session 7. This exercise involved facing back to back with each other and arms linked with each other behind the back. Each partner then leaned on the other with one partner then lifting the other up on his/her back and holding for a few seconds in this position.
Session 9

The session was introduced with the deep breathing. The first exercise was called "Body Awareness-Standing Position." All the patients stood in a wide circle and spaced themselves accordingly. They were told to close their eyes and listen carefully to the directions given by the leader. The leader then vocally directed them to focus on the various body parts until all general parts from head to toe were covered. For example, "Think about your head. Is it relaxed and in touch with the rest of your body? What about your neck? Is it stiff and in pain or relaxed and in touch with your head and body? Take five deep breaths and allow deep breathing to fill your body. Let this be positive and fulfilling to your mind and body." The dialogue continued until the group was ready to stop. The next exercise was called the "Shrinking Circle" and once again started with everyone in a large circle. Everyone joined hands and stood for a few minutes in this position. They then came to the middle of the circle, still holding hands, but now making a much smaller circle. When they moved to the middle, all bowed their heads and shoulders to the floor and then raised their heads and shoulders up to the ceiling. All participants then continued to hold hands but bent at the knees to the floor. When everybody was in this position, they all leaned back with the strength of their joined arms and hands supporting the circle.
Session 10

This session was introduced with the deep breathing exercises. The next exercise was called "Folk Circle Reflections" and involved the participants forming a large circle and each participant taking a turn leading the group in basic dance movements. The rest of the group would follow the leader of the movements. The next exercise was called "Moving Backwards" and involved developing an awareness of the space around them. It started in the large circle again with all participants joining hands and forming a unified group for support. Everyone was then directed to close their eyes and squeeze the hands of the person beside them for extra focus and support. They were then to walk slowly backwards assessing and feeling the space around them until the leader said "stop." They were then to turn around and walk slowly back to the mats with their eyes closed experiencing the sensation of returning to the group by an awareness of the space around you and the others with you.

Session 11

The session was introduced with the deep breathing exercises. The next exercise was the Yoga breathing which had been introduced earlier in the group sessions. This particular session, then, consisted of three fourths class time directed toward breathing, meditating, and centering work. The last exercise was called "Legato and Staccato" and focused on awareness of shapes. The effort factors, flow, (free, sustained), and time, (slow, quick) were primarily emphasized. The exercise was completed in partners with
partner "A" moving in legato smoothly and flowingly. Partner "B" moved sharply, percussively, in staccato. This partner related strongly, assertively. The partners continued to move alternately.

Session 12

The session was introduced with the deep breathing exercises. The first exercise was called "Give and Receive" and involved the participants moving freely in the group as the music played. An example of the music used was *You Had Better Listen* by Jimmy Owen and Kenny Barron Quintets. As the participants moved, they had to pass an object such as a book or beanbag from each other which helped transmit the feelings of giving and receiving. Everybody was to take turns being the giver and the receiver. There was discussion afterwards concerning what it was like to be a "giver" and what it was like to be a "receiver." The last exercise was called "Sightless Sculpture" and involved working with the sensation of feeling into space and using the imagination of figuring out imagery in nearby space.

The participants worked in partners with one partner standing or kneeling in a statue-like image nearby the other partner. The other partner pretended that he/she was blind and carefully touched the other partner with eyes closed trying to figure out the posed imagery of the partner. The second partner then posed in the position that he/she imagined. He/she then looked at the posed image to see if the imagined pose was accurate. The group discussed this process and the partners shared what it felt like to be involved with the blind approach to a project.
Session 13

The session was introduced with the deep breathing exercise. The next exercise was called "Family Reflections" and involved group sculpturing with the figures in the group. A family theme was chosen by the group leader such as "The Family," "Family in Leisure," or "Family at Work." Everyone was appointed to a specific family role such as father, sister, or brother. One at a time, each member added on to the sculpture by joining the members already posed. Each individual decided on the pose to portray his/her designated role. After the sculpture was completed, each member took a turn observing the creation for a few minutes. A discussion on the roles of the family followed. The last exercise was called "Frisbee Fakeout" and this fit into the category of a New Game. The components of the game were as follows: boundaries were laid out on a field so that there were three areas -- two end zones with a slightly larger zone between them. Two teams were formed. One team stood in the central zone while the other team divided its players; half in each end zone. The end zone team had possession of the Frisbee and tried to pass it from one end zone to the other without missing it or dropping it and without its being intercepted or knocked down by the other team. Everyone had to stay within the boundaries. If the end zone team failed to complete three attempted passes, or if the central zone team sent half of its players into each end zone, the end zone players moved to the middle section of the field to try to regain possession of the frisbee. (The quicker this rotation was accomplished, the more exciting the game.)
Session 14

This session was introduced with the deep breathing exercises. An exercise named Charades was played. This involved emotions which were dramatized by the patients with peers guessing what emotion was being dramatized. After this, Frisbee-Fake-Out was played again.

Session 15

This session was introduced with the deep breathing exercises. We repeated the exercise, "Moving Backwards" because the area of space seemed to be a difficult but needed one for this group. For this exercise, though, we increased the distance that the participants moved away from the mat and the distance they then had to return. The last exercise was the game "Twister," which was played on the gym floor. The game consisted of a piece of plastic about five feet long and two feet wide on which were painted various colored circles. Two participants moved on their hands and knees at the same time from one end of the game board to the next. Each hand or foot must be in the middle of a circle which caused the five participants to become twisted with each other.

Session 16

The session was introduced with the deep breathing exercises. The first exercise was called "Reflections in a Circle" and involved all the participants in the group. A leader was chosen to begin a free movement sequence to music. The music initially used was lively and had an emphasized beat. The other group members followed the leader or "reflected" the movement. The present leader then called
the name of another group member who chose a movement that was reflected by the other group members. This exercise was then directed toward slower and lighter movements. The second exercise was called "Guided Imagery" and involved mini-dramas with individuals and small groups. An imagery theme was chosen by the group staff leaders and then shared with the group. Usually two or three themes were adequate for the group and the time allowed. Examples of themes were "family," and "occupations." The individuals sculptured these themes with human movements. The sculpture was then held for several minutes as the other group members observed this. Discussion was then held following the sculpturing.

Session 17

The session was introduced with the deep breathing exercises. The first activity was a review of the centering process which involved additional breathing with focus on centering and floor activities designed for centering practice. These were previously explained in Session 7. The next activity was called "Expressed Anger" and involved first a discussion of situations that were reminiscent of angry feelings and how the participants would react to these. They were not forced to dramatize their reactions but were encouraged to do so. After this segment of the "Expressed Anger," "Anger with Sounds" was introduced which included voice and movement. Music was played in the background which had a strong beat to it and the group then freely moved to the music with movements that were indications of anger, i.e., punch, wring, and flick with
the entire body. If they chose to do so, they could verbally express
themselves at the same time with sounds of anger that were familiar.
An example of music would be Jazz Band Jukebox by Reggie Andrews and
Bobby Harris.

**Session 18**

The session was introduced with the deep breathing exercises.
The activities emphasizing "Centering" were reviewed in this
session. Centering becomes an important help to behavior control and
was reinforced with the patients as a means to handle themselves in
the forensic facility and when they are discharged to a lesser
restrictive environment. The next activity was called "Repressed
Anger" and involved mini psychodramas which focused on behaviors that
arise due to repressed anger. Movements that were emphasized were
walking, standing, and sitting. The session then expanded into a
repeat of the previous sessions with the activity on "Anger with
Sounds." This activity was explained in Session 17.

**Session 19**

The session was introduced with the deep breathing exercises.
This session was designed for a review discussion of all the
sessions. The post testing with the Draw-A-Person Test and Tennessee
Self Concept Scale was then administered.
Session 20

The last session was a party with a certificate ceremony following. This helped reinforce positive self concept attempts made throughout the entire group.

Summary

This chapter outlined the study's procedures, participant selection process, evaluative techniques, participant orientation and selection and finally, described the individual sessions in detail.
CHAPTER IV
RESULTS AND ANALYSIS OF DATA

This chapter analyzes the testing results of the two groups, control and experimental. Nonparametric measures were used in statistically analyzing the research data. The Signed Rank Test was used to analyze the difference between pre and post testing on the total positive score and total variability score of the Tennessee Self Concept Scale, Draw-A-Person Test, restraint/seclusion orders, and on the behavior levels of each patient. The raw data of these measures is also recorded in this chapter.

Signed - Rank Test

The Signed Rank Test was applied in order to compare the results of the pre/post tests within the groups. The Signed Rank Test gets its name from the fact that it uses plus and minus signs rather than quantitative measures as its data. It is particularly useful for research in which quantitative measurement is impossible or infeasible, but in which it is possible to rank with respect to each other the two members of each pair.

The Signed Rank Test gives more weight to a pair which shows a large difference between the two conditions than to a pair which shows a small difference.
This test is most useful for the behavioral scientists with behavioral data, it is not uncommon that the researcher can (a) tell which member of a pair is "greater than" which, i.e., tell the sign of the difference between any pair, and (b) rank the differences in order of absolute size. That is, he/she can make the judgment of "greater than" between any pair's two performances, and also can make that judgment between any two difference scores arising from any two pairs (Siegel, 1956).

The results of the statistical analysis of the Signed Rank Test were used to measure the difference between the pre and post results of the control as well as experimental. For each group, the null hypothesis is that the difference between pre and post test scores is zero. That is in examining the variables, significant change was looked for in the pre and post tests of the control group as well as in the pre and post tests of the experimental group. The level of significance used to test the null hypothesis was the .05 significance level.

**Tennessee Self Concept Scale**

For purposes of this study, the pre/post measures of the total positive score and total variability score are only needed.

The Tennessee Self Concept Scale is simple for the subject, widely applicable, well standardized, and multidimensional in its description of the self concept. It has become a popular and important means of studying and understanding human behavior and has provided a common thread for tying together many research and
clinical findings. The Counseling Form was used in scoring the tests.

Total P Score. This is the most important single score on the counseling form. It reflects the overall level of self esteem. Persons with high scores tend to like themselves, feel that they are persons of value and worth, and have confidence in themselves and act accordingly. People with low scores are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves.

The Variability Scores (V). The V scores provide a simple measure of the amount of variability, or inconsistency, within each area of self-perception. High scores mean that the subject is quite variable in this respect while low scores indicate low variability which may even approach rigidity if extremely low (below the first percentile).

Total V. This represents the total amount of variability for the entire record and is the sum of variability scores. High scores mean that the person's self concept is variable from one area of self-perception to another as to reflect little unity or integration. High scoring persons tend to compartmentalize certain areas of self and view these areas quite apart from the remainder of self. Well integrated people generally score below the mean on these scores but above the first percentile. The percentiles of the total positive scores and variability scores are also given in the chart (Fitts, 1965).
Signed Rank Test-Tennessee Self Concept Test

For the control group, no significant difference between pre and post Total Positive Scores was found at the .05 significance level. But the experimental group had a significance probability or p-value of .04 which would be enough to reject the null hypothesis. There was an estimated difference of 4.5 point increase in the Total Positive Score. The estimated difference between the pre and post test Total Variability Scores for the experimental group would be an increase of 5 points at the .042 significance level. It can be concluded that the experimental group did increase in self concept whereas there was insufficient evidence for reason to believe that the control group did. Also, the experimental group had more variability from one area of self-perception to another.

Results of Tennessee Self Concept Scale

The raw data from the Tennessee Self Concept Scale shows that in the control group; 5 out of 14 patients (35%) increased their scores on the post test of the Total Positive Score. They showed that 4 out of 14 patients (28%) increased their point on the post test of the Total Variability Score. All of the other scores were lower on the post test. The largest number of points dropped on the Total Positive Score post test was 28 points and the largest number of points gained was 23 points. The greatest number of points dropped on the Total Variability Score post test was 25 and the most gained was 11.

The results of the experimental group showed that 7 out of 11 patients (63%) increased their scores on the Total Positive Score post test and 6 patients (54%) increased on the Total Variability
Table 1

**Tennessee Self Concept Scale Results (Control Group)**

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*Discharged early*  

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Refused Post Testing
Score post test. There was 1 patient whose results on the pre and post test were the same. The greatest increase on the Total Positive Score post test was 20 points and the greatest decrease was also 20 points. The greatest increase of the Total Variability Score post test was 58 points and the greatest decrease was 27 points. In summary, these results show that more patients increased their Total Positive Scores with the Tennessee Self Concept Scale and more increased their scores on the Total Variability Score in the experimental group than in the control group. It also seemed there was more change occurring with the Total Variability Scores in the experimental group than in the control group. The treatment for the experimental group seemed to have more of an effect in accomplishing change in behavior than in the control group.

**Conclusions**

The results of the Tennessee Self Concept Scale showed that the experimental group had an estimated difference of 4.5 point increase in the Total Positive Score. It is likely that the experimental group did increase in self-concept at a higher rate than did the control group. The experimental group had more variability from one area of self-perception to another with an estimated difference of 5 points increase in the Total Variability Score. Therefore, it is concluded that changes in self perception did begin to occur.

**Draw-A-Person Assessment**

The next area for study was body awareness, and the instrument chosen was an adaptation of the Goodenough Draw-A-Person Test. This was also used in the form of a pre and post assessment.
1. Signed Rank Test-Draw-A-Person Test

The pre and post test differences, though, in the variables from the Draw-A-Person Test was not significant at the .05 level for either group.

2. Results of Draw-A-Person Test

In the control group, 4 patients (28%) increased the number of stress markers, 1 patient (7%) decreased the number of stress markers, while 7 patients (50) maintained the same number from the pre test to the post test. There was 1 patient who was discharged early and did not complete the post drawing. It can be concluded that in this group more patients remained the same as to the number of stress markers identified.

In the Creative Movement Group, there were 4 patients (36% who increased the number of stress markers on the post test, while 3 patients (27%) maintained the number and 3 patients (27%) decreased the number of stress markers. Only 1 patient (9%) refused to complete the post test drawing. It is difficult to conclude from these results that significant change occurred. The raw data showed that the number of stress markers did not increase or decrease significantly enough to indicate change.

The patients in both groups did not have difficulty placing the markers at realistic stress areas on the body and seemed to seriously consider the task. If they felt they could not complete the task, they refused to do it. All stress markers were placed between the top of the head and the lower back area. Once again, the overall results showed greater change in the Creative Movement Group. They
made more additions to the number of perceived stress areas in their bodies. Stress markers appeared in the same areas but the number of stress markers increased. This indicates there was no greater sensitivity to other body areas but there was an increased intensity of awareness in the same parts of the body.

In the control group, 3 patients (21%) increased the number of stress organs that were identified in their Draw-A-Person test, while 1 patient (7%) decreased the number of stress organs identified from 3 to 1. There were 8 patients (57%) who maintained the same number of identified stress organs in the pre and post tests. The reason for no change was probably due to the fact that 7 patients of the 8 correctly identified the three stress organs in the pre test and there was no reason to change on the post test. All of the stress organs identified were of the correct three; heart, stomach, or lungs. No patient was inappropriate with the identification selection. In this group, one patient was discharged early and did not participate in this test.

The summary results of the experimental group were that 2 patients (18%) increased the number of stress organs identified in the post test while 7 patients (63%) maintained the three correctly identified stress organs in the pre and post tests. They had no reason to change on the post test. There was 1 patient who had the 3 correct stress organs identified in the pre test but refused to complete the drawing in the post test. There also was 1 patient who did not identify any stress markers in the pre test and did not identify any in the post test. All stress organs identified were of
the correct three answers. In conclusion of this part of the Draw-A-Person Test, it seemed that both groups maintained or increased their levels of stress awareness and body awareness by participating in the planned activities of the sessions. There were no patients in the control group who refused the assignment or did not understand the concept of placing the stress organs in the pictures of their body image. The experimental group, though, had a higher percentage who had correctly identified the stress organs in the pre test and followed through the same in the post test.

Conclusions: Draw-A-Person Test

The post results of the stress markers or organs identified in the adapted Draw-A-Person Test showed little change among both groups. As a whole, the control group displayed more cooperation in identifying the organs involved with stress and stress control. The exact amount of body awareness that was achieved is not certain, but the movement exercises in the Movement Group were effective in relaxation and identification of feelings of stress in the body. The patients, while participating in the group, expressed this by acknowledging feelings of being relaxed and mentioning specific areas of stress in their bodies during the group and outside the group. It seemed appropriate to assume that some body awareness was beginning to form from observations concluded during the sessions. Something was "going on" with the movement group participants as to changes in body awareness and willingness to become aware of stress-related areas. The participants of the control group were not interested in body awareness exercises or discussion.
<table>
<thead>
<tr>
<th>Object</th>
<th>Stress Markers Identified pre</th>
<th>Stress Markers Identified post</th>
<th>Stress Organs Identified pre</th>
<th>Stress Organs Identified post</th>
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### Table 4
**Draw-A-Person Test Results (Experimental Group)**

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Ward Charting

The third area of evaluation was observing the behavior control of the patients by reading the twenty-four hour ward charts on a randomly selected day, and recording any incidents involving restraints or seclusion at the onset and at the end of the group. The patients function on a behavior level system (A to E), with "A" level being the level for the most appropriate behavior, and "E" level being the least appropriate. Ground privileges and freedom to move within the facility depend on the level earned. Level "S" is a special level for patients who have difficulty controlling inappropriate, antisocial behavior. They are maintained on level "S" until they can manage the level system, and be held responsible for the consequences that accompany each earned level. There is significantly more staff control while patients are on level "S." All of this observed behavior control was viewed as to the variable of increase or decrease in antisocial behavior on the part of patients in both groups.

Signed Rank Test-Ward Charting

In viewing the raw data, it is obvious there is no evidence of a difference between pre and post test scores. The Signed Rank Test indicated no change at the significant level of .05 between pre and post test results of ward charting in the control group or the movement group. There was actually no need to conduct a formal statistical test, since any such test would not reject the null hypothesis of no difference.
The ward charting results on the post test from the Creative Movement Group, though, did fluctuate more than did those of the control group.

Results of Ward Charting

All of the patients in the control group started the group on level A and ended the group at the same level. One patient did not have a post behavior level measured when the group ended, because he was discharged early. His behavior was at level A when discharged. In the experimental group, there were 3 patients who dropped their levels in the process of the group; 1 patient dropped from level A to E with 1 restraint; 1 patient dropped from level A to D with no restraints or seclusion orders written, and 1 patient changed from level D to S (Special Level). All of the other patients maintained the level A from pre to post testing except 1 patient who maintained at level D on the pre and post testing with 1 restraint and seclusion order written on the pre testing but not the post testing. Neither group showed much change as a whole in behavior from pre to post testing, but did maintain the behavior throughout the group. The Movement Group had some change with 1 patient starting on the special level. This seemed to be the start for this patient to begin working on his behavior. There was also 1 patient who started out with restraint/seclusion orders but did not have any at the end of the group. The behavior was obviously controlled at this point. He had started, though, to change his behavior and work toward increasing his level. The period of time that he was in restraints was shorter in duration than before. It seemed from viewing the results that
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Table 6
Ward Charting Results (Experimental Group)

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more change in behavior was brought about with the Movement Group than with the Life Skills Group. A promising note on the behavior level decreases was that all patients had started to control and change their behavior by the completion of the group. One of these patients who had extreme behavior problems was able to focus on the Movement Group which led to control of self-abuse outbursts and discharge from the facility.

Conclusions of Ward Charting

The patients in the Movement Group had more change with the behavior levels and restraint/seclusion orders than did the patients in the control group. All patients in the experimental group had started to control and change their behavior by the completion of the group, while the patients in the control group all maintained the same behavior control at the ideal behavior level of A.

Summary

This chapter analyzed the testing results of the control and experimental groups. It specifically described the details of the variables tested in this study; increase in self-concept, increase in body awareness, and decrease in antisocial behavior. The assessing measures described were the Tennessee Self Concept Scale, Draw-A-Person Test, and ward charting of behavior levels, restraint and seclusion orders.

The experimental group did increase in self concept whereas there was insufficient reason to believe that the control group did. Also,
the experimental group had more variability from one area of self-perception to another.

The overall results of the Draw-A-Person Test showed a greater change in the Creative Movement Group. They made more additions to the number of perceived stress areas in their bodies. The stress markers appeared in the same areas but the number of stress markers increased. This indicates there was no greater sensitivity to other body areas but there was an increased intensity of awareness in the same parts of the body.

The patients in the Movement Group had more change with the behavior level and restraint/seclusion orders than did the patients in the control group.
CHAPTER V
INTERPRETATION OF THE DATA

Relevance of the Data

Most of the successful Movement Arts studies worth further examination to which references were made in the Literature Review were studies in which Movement Arts were combined with other aspects of the arts such as Art Therapy or Music Therapy. The study of these combined art forms assisted in clarifying and evaluating the relative successes of the individual researchers and the studies which they conducted. For most of the studies, the sample sizes were small, yet yielded strongly positive results in support of the Movement Groups. This study, too, was conducted with a small sample size, yet results clearly support the Movement Group. The discussion groups, conversely, did not demonstrate significant change in any area, but remained relatively static. The Movement Group, on the other hand, demonstrated positive change in areas of behavior control, individual focus and overall body awareness. Movement Group members exhibited a greater degree of interest and motivation to be involved in group activities than did the members of the discussion group. This is of particular significance in light of the fact that the Movement Group consisted of patients who were identified initially as having more problems in behavior control and participation in group activities.
The positive outcomes resulting from this study clearly suggest that the Movement Group is worth replicating.

**Implications of the Study**

1. Creative Movement groups can be used as a factor in stress reduction.
2. This study can be used as a model allowing for ease in its replication for use with other populations.
3. The Creative Movement Group provides a realistic and workable alternative to violence in problem resolution.
4. The Creative Movement Group promotes an improved self-concept among group participants.
5. The Creative Movement Group can provide a framework for maintaining body-awareness among some populations.
6. The Creative Movement Group results in a decrease in episodes of antisocial behavior.
7. The Creative Movement Group expands movement repertoires of group participants.
8. The Creative Movement Group provides a channel for the appropriate expression of energy through movement.

The outcomes of this study imply that subsequent efforts with the forensic patient population in establishing Creative Movement Groups would continue to yield positive, productive results. Chief among these is the reduction of stress for both patients and staff members. The Movement Group establishes a common ground of shared experience among patients and staff which is both relaxing and fun.
To engage in the activities of the Movement Group was especially gratifying when contrasted with the obvious constraints and rigidity of the maximum security setting. It was always a welcome diversion to retreat from the routine demands of the facility and to then be "free" to focus on centering, deep-breathing and a range of movement activities. This shared opportunity was experienced with a sense of enjoyment an exhilaration by staff and patients alike. Staff members made a deliberate effort to establish a quiet, peaceful, non-threatening environment in which patients could experience the Movement Group. During each group, members engaged in structured breathing exercises which were accompanied by soft lights and relaxing background music. These deep-breathing exercises conducted in this atmosphere succeeded in bringing to the patients a feeling of physical relaxation and a peace of mind. The breathing exercises usually opened the sessions, and were followed by a period of greater activity in which patients participated in fun-filled noncompetitive activities. Sessions frequently were extended beyond allotted time because patients did not want to end the group. Several of the patients voiced having "a good time" in the Movement Group. These expressions of enjoyment by the patients to the staff were a source of gratification and motivation to staff members involved in conducting the Movement Group.

The structuring of the Movement Group, the flexibility in the size of the group, the selection of a broad range of movement activities at varying levels of skill and difficulty as well as the means of recording and reporting the resulting data from the Movement
Group are all factors of the experiment which lend readily to an ease of replication. Ease of replication is significant as a motivation for staff members working in a restrictive setting with a difficult, varied and often unpredictable population. Finding new activities in which patients can engage, especially activities which have a positive impact on the patients is often difficult. The ease with which the Movement Group can be undertaken is a significant factor for its use and study in the future.

Conversely, the population with which this study was conducted, the setting in which this study occurred are factors which are, in themselves, limiting and restrictive. The use of "sharp-ended" props or other musical instruments which could enhance the experience for all members of the group cannot be used in the forensic setting because of the potential for violence which is ever present. In addition, group sizes must be kept small because of the same violent potential. Other factors to consider when undertaking the experiment in this setting is the time conflict with other groups. Other staff members in the forensic environment do not always view the Movement Group with the same value and enthusiasm as does the group facilitator. Establishing the Movement Group as a priority with therapeutic value is not always easy to accomplish.

In the forensic facility, staff motivation can be seen to increase, or diminish in relation to the patients' response or lack thereof to staff efforts. Effectively and consistently addressing the criminally insane and mentally ill attitudes, thoughts, and behaviors of the forensic population requires an inordinate
expenditure of physical and emotional energy by staff members. The patient response to staff efforts is sometimes nonexistent. Yet, individual participants in the Movement Group reward staff with positive comments about the efforts which they, the staff had made for the group. The expressions of enjoyment voiced by group participants as well as the obvious pleasure which staff members witnessed firsthand lessened pressure and relieved some stress for staff members involved with the Movement Group. Evidence of this was reflected in actions of the forensic staff to plan additional Movement Groups and to begin an investigation and research into other kinds of movement programming. Staff members from the Activity Therapy Department were ultimately assigned to assist with the Movement Groups. Their groups were conducted with a greater degree of variety and vigor than was true with the first group. As a result, leadership for the Movement Group effort was strengthened and subsequent groups experienced a greater measure of variety and creativity for the Movement Group participation. Regular planning sessions for the Movement Group have continued to be a part of the activities curriculum for the past three years under the joint sponsorship of the Activity Therapy Department and the Education Department. Every program module developed since the Movement Group was first initiated for the purposes of this study has included a Movement Group component. The support for the Movement Group which continues to be expressed by both patients and staff is indicative of its acceptance and its success as a viable component of the forensic program.
The stress level and staff burnout rates are exceptionally high in the forensic environment. Program planners and facility administrators are constantly searching for new program ideas to help alleviate the impact of stress. The response of patients and staff to the Movement Group was strongly positive and the stress reduction experienced by both patients and staff was sufficient to warrant the implementation of further movement studies and the inclusion of a Movement Group component in the future program plans of the Columbus forensic facility. Similar initiatives have been examined by other maximum security facilities in corrections, and the establishment of a Movement Group component in that setting is imminent.

As suggested earlier, the potential for violent behavior to be exhibited by individuals in the patient population is a perpetual reality of the forensic scene. This irrefutable fact compels staff members to ceaselessly explore solutions for and alternatives to this violent conduct. Violence by the patients is pursued in most instances as an attempt by them at problem resolution. Any effort to introduce viable, nonviolent substitutes is ardently reinforced and encouraged throughout all departments of the facility. The Movement Group, though, often not a solution in and of itself, provides a viable, nonviolent, alternative for the expression of the patients' feelings of frustration and powerlessness. The opportunity afforded Movement Group participants to ventilate aggressive feelings within the structure and discipline of the group setting resulted in a notable reduction in the number of violent episodes in which Movement Group members were involved while on their respective residential
units. As a result, other disciplines began to use the Movement Group experience as a model to observe and follow. Among these, the Psychology Department developed and cosponsored with the Art Therapy Department an activity group the focus of which was relaxation and deep breathing. Group organizers repeatedly acknowledged the contribution of the Movement Group model.

Among Movement Group participants, one patient in particular had an extensive history of violent behavior. During his participation in Movement Group, his verbal self expression increased markedly and through the use of deep-breathing exercises he became more aware of and better able to identify and verbally express his internal feelings. As a result, he was able to exercise greater self control of his behavior. By the time the Movement Group ended, he was able to exhibit enough self-control that he was permitted to leave his unit without an escort on a limited basis. He was observed by staff to engage and interact "normally," appropriately and more frequently with other patients. As a result, by the end of the Movement Group, the treatment team recommended that he be placed on a regular behavior level and that his "restricted" status be lifted.

The status goals of the group, improved self-concept, increased body awareness and decreased antisocial behaviors were achieved to varying degrees by those who participated in the Movement Group. Since the three stated goals are closely interrelated it was essential to maintain a balanced focus on all three areas simultaneously.
One particular patient started the group feeling so strange about himself and his participation in the group, that he asked to be excused from the sessions early for fear he would have a seizure if he stayed and participated in the movement activities of the lesson. During one session, though, he had the chance to dramatize a personal scenario involving mainly open-closed movements. His performance was successfully completed in a mini-ballet fashion with expressive, flowing movements that appropriately matched the music. This performance surprised everyone in the group. The patient then shared that he had danced in the past and had really enjoyed it. From then on, he participated in the group and never missed a session. In fact, he had to be coaxed to return to the unit after the lesson because he didn't want to leave a "good time." All he talked about then was how great he had felt participating in the group. He requested to be placed in the Movement Group for a second time. His request was granted, but he did not finish the ten sessions because he was discharged from the facility to a lesser restrictive environment.

The body awareness factor did not show any increase on the Draw-A-Person Test, but patients did maintain the level of body awareness with which they started the group. Even though the formal assessment did not show definite increase there were individual patients who seemed to become more aware of themselves and their bodies as the movement sessions progressed.

An example of this was the patient who imagined and dreamed that he was in Africa and discussed this frequently. He would pretend
that he was beating on African drums and dance in circles until he became dizzy and sick. Through a mirroring exercise which was conducted in the Movement Group, he came to understand that these intense circular movements were resulting in his being dizzy and sick. He learned too that this wasn’t good for his heart. As a result he began moving with more flowing motion and listening to the background music. He actually was able to create a pleasant movement for a short time. He seemed to greatly appreciate that he was able to do this and laughed and smiled when he was complimented for his efforts. Another patient who initially started the group feeling closed and withdrawn, progressed into a leadership role and helper for the other patients. She was able to create through movement a complex scenario depicting "giving" and "love" in her own perspective. The scene had an extending and uplifting mode to it and showed that progress had been made with this patient in her ability to hope and plan for positive conclusions to some unfinished avenues in her life.

This last stated goal of the group was to decrease antisocial behaviors. Positive results were demonstrated in this area when behaviors of patients in the group began changing to more normal behaviors on and off the units. One patient was experiencing an affective bipolar disorder with frequent manic episodes during which he would become extremely loud and violent and scream irrational comments to everyone in the group. Sometimes he would say that he wanted to be excused. On other occasions though, he would gradually quiet himself by joining in the deep breathing exercises. Several
times, he became calm enough to lead the breathing exercises for the entire group. When he was feeling calm enough, his lead in the breathing exercises was precise and accurate.

Expanding the movement repertoires of those in the Movement Group was a goal carefully incorporated into the Movement Group curriculum plan. As the patients progressed in the group, they relaxed and seemed to have fun while in the group. Throughout the duration of the group, the movement patterns of most of the patients loosened and grew into more open posturing. This attitude led to general cooperation and participation by the patients in the group. It seemed also that those who relaxed developed a greater sense of accomplishment and better coping skills for participating in defense strategies and other interactions with staff and patients. An example was one patient who initially sat stiff through each class and would barely participate in the group activities at all except for the breathing exercises. He had been experiencing paranoia especially about hospital staff deliberately keeping him from being discharged from the facility. Gradually, he started extending himself by verbally expressing his ideas and needs. After participating in the Movement Group his skills were sufficient for him to meet facility discharge criteria. As a result of his more relaxed movement repertoire he was viewed as more healthy and appropriate for discharge from the facility.

As a result of his more relaxed manner and better coping skills, his paranoia appeared to decrease. He presented to the treatment team a list of personal objectives which he felt were necessary to obtain
his discharge from the facility. His discharge is currently being addressed.

Another definite positive of the group was the help given to patients in learning the appropriate expression of their energy through movement and dance. Several of the patients displayed violent behavior on the unit during the time between the Movement Sessions but not while attending the sessions. Leadership of the Movement Group focused on directing and channeling physical energy into personal expressions through movement activities rather than through violent behavior. One female patient in the group, was able to attend only 50% of the sessions due to extremely violent behaviors on the unit such as attacking other patients and staff or throwing objects with the intention of breaking them. Whenever she attended the Movement Group, though she controlled her violent outbursts enough to participate in the breathing experiences and in some cases the floor exercises as well. Her energies were directed at completing the exercises and not at striking out at others or throwing things.

Another patient who was chronically severely depressed would wander aimlessly from one activity to the next with little or no expression of interest or enthusiasm for what he was doing. This notwithstanding, he attended all Movement Group sessions and was able, with staff direction, to maintain his focus on the group activity for some portion of each Movement Group session. Of prime significance to this patient were the benefits to him resulting from shared observations of and communications with other patients in the
Movement Group. One patient who displayed relatively uncommon insight and balance observed that the patient in question lacked self-direction and seemed lonely and depressed. For the first patient what began with his very limited involvement in the Movement Group, developed into a meaningful and growth-producing channel of confident self expression. As a result of the Movement Group activities and a variety of expressions of concern and caring voiced by other Movement group patients, this patient received extraordinary help from the Movement Group. The depression has subsided; he is able to focus and remain on task. His discharge is scheduled for the near future.

As demonstrated by this study, movement as therapy works. It illustrates plainly the merit of nonverbal expression as a valuable tool of communication and treatment. Movement though, is but one of the expressive arts with value as a tool of treatment. Practitioners of all expressive arts share some fundamental assumptions about the value of nonverbal communication and expression. These shared assumptions are manifested in common concepts, goals, and functions of the arts. Yet the value of these expressive arts in treatment should be further explored and developed. This is an idea for further research and study.

The movement toward professional status of expressive arts in mental health is a major thrust in all of the expressive arts therapies. While referring to these occupations as professions, this designation has not been universally accepted by the dominant psychotherapists or by the public at large.
Probably the major immediate problem is the lack of clarity of the definitions in the arts therapies and the boundaries of the practices. What are the functions of the expressive arts therapies? What are the recognizable techniques that differentiate them from the clearly adjunctive therapies like occupational therapy or physical therapy, on the one hand, and the psychotherapies, on the other? At present, the practitioners in the arts therapies have not been able to identify what they do or the purposes of their practices in terms that are acceptable to many in the neighboring fields (such as occupational therapy and special education) or in the psychotherapies.

The preoccupation with defining the arts therapies emerges in the newsletters, the journals, and the conferences. "How Do We Define the Parameters of Our Profession?" ask dance/movement therapists. Art therapists are concerned with "Defining the Field" and with "Problems of Definition." Hodnett writes: "We will have to woo and soothe the psychiatrists, convince the thorny practicing artists that we are not in competition with them, threaten art educationists enough to make them seek to unite with us -- at least with a view to having us let most of their territory alone" (Hodnett, 1973).

The last area for development in the future is the expansion of the arts therapies into the community. This would be a long-range drive and result in the expressive arts therapies expanding their functions and a return of the creative and expressive arts to their ancient role in the development of healthy, functioning human beings (Siegel, 1982).
**Recommendations for Further Study**

Movement group reporting is difficult and needs improvement. In the future, emphasis should be on concise progress notes with movement observations carefully recorded. Behavior during sessions should be described with progress written in measurable terms relating to the treatment plan. Clear recommendations for further "treatment" should be stated. If an assessment of movement behavior is done, then behavior during the assessment session should be described. A description of the test administration is to be noted with the score documented.

More studies in the Movement field should be conducted within incarcerated facilities with patients and prisoners. Further insight into Movement sessions that will help this population to regain hope and plan constructive steps in their lives for the future will be accomplished by people working with the population. Successful future efforts will nurture additional efforts in the field to bring an extension of the art into many areas.

**Summary**

The last chapter elaborated on the relevance of the data, positive implications of the study, and projected need for further research. There were strong indications that studies in this field should be continued.
APPENDIX

Samples of Assignments from

The Life Skills Group

(Three Assignments)
(Life Skills Assignment #1)
INDIVIDUAL TREATMENT PLAN

DATE ________________

What are some things about yourself you would like to work on while here? This may include problems at work, with family or friends or a character trait you would like to change or improve.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What would you like to do in the future? You may set some of your goals from your problem list if you wish to. Decide what you want to accomplish while here and list under "short term." List under "long term" what you wish to accomplish after discharge.

Short term goals: ________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Long term goals: ________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Patient's Signature ________________________________________________________________
(Life Skills Assignment #2)
INDIVIDUAL TREATMENT PLAN

DATE: __________________

Have you accomplished any of your short term goals? Please Describe.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are there any goals you would like to change? If so, please write them.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are there any goals you would like to add at this time? Please list.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How do you plan on reaching the long term goals after discharge?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Patient's Signature ______________________________________________________
(Life Skills Assignment #3)

Patient: ____________________________ Discipline: ____________________________ Date: ____________________________

Case Manager: ____________________________ Representative for Discipline: ____________________________

PROBLEMS: (use description terms; do not use jargon such as "acting out," "seclusive," etc.)

GOAL: (the final level at which you intend for the pt. to be.)

OBJECTIVE: (measurable step towards the goal -- "The pt. will...."

INTERVENTION: (include frequency/duration, where, responsible staff objective attainment date -- include proposed interventions by other disciplines.)

Additional Information: (Discharge Criteria; Discharge Plan; Diagnoses; Record Access; etc.)
BIBLIOGRAPHY


