their art. They then explore the personal meaning of dance for themselves. When one is involved in the creative aspects of any art form, it is not possible to dismiss the personal and one's individual perspective. It is the root of the creation of the product. Dancing is not merely an exercise to be accomplished, but rather a statement of one's feelings and energy and desire to externalize something from within. When one creates a dance, it is based on a concept, realistic or abstract, that needs to be communicated to others. This understanding led to the use of dance/movement therapy not only in groups but in sessions for the individual in his or her search toward self-integration.

The Pioneers

After many years of performing, choreographing, and teaching, several dancers began to observe more closely those who came to study with them. Some of these, mainly women, had gone through psychoanalysis, which was the main psychiatric form of treatment at that time. All were familiar with the psychiatric theorists emerging during and after Freud, and interpretations of how the psyche and emotions were intertwined. Due to the influences around them and their own inclinations, some learned more about psychoanalytic thinking, and others went on to study the work of H.S. Sullivan, Jung, and Adler, among others. This psychological background provided them with an understanding of human development and behavior that they then began to use to observe the movement behaviors of others. Each of the women who first pioneered the use of dance in therapy understood the power of the movement for themselves and its significance in their own lives. They had the curiosity to wonder how it affected others and what could be learned through the personal dances individuals might explore for themselves.

Marian Chace, who performed with the company of Ruth St. Denis and Ted Shawn (Denishawn) in the 1930s, choreographed and later taught in her own studio in Washington D.C. She questioned why pupils who had no intention of being professional came to take dance classes. She observed how each moved, then gradually shifted her teaching to focus on the needs of the individual. She organized classes for her students that led to an integration of the body and its movement, thus enabling personal self-harmony. As her work became known by mental health professionals, in 1942she was invited to work at St. Elizabeths Hospital, a large federal institution where many soldiers were returning from World War II. Group therapy was beginning at this time in response to the needs of so many. Dance/movement therapy fit closely into this new form of therapeutic intervention. Chace developed her concepts of treatment, working with schizophrenic and psychotic patients before the advent of psychotropic

medications (Sandel et al., 1993). She trained many others and later served as the first president of the American Dance Therapy Association from 1966 until 1968. As one of those who interned with Marian Chace at St. Elizabeths Hospital (1964–1965), I was fortunate in being to observe her work with very regressed patients and began my own practice under her tutelage.

Marian Chace worked very deliberately and carefully. As her student, I followed her onto large ward areas, most often locked, carrying the large record player. This was before the advent of tapes and CDs. The moment the door was unlocked, attention was paid to those in view, greeting each or merely nodding. As we went into the common room used by all, Chace would notice the moods, tensions, formations of groups, or lack of them, and begin to make decisions as to how to begin a session. As patients gathered, she would greet each one and explain who she was and why she was there. She usually chose the waltz to begin as it is rather neutral and, as she noted, not likely attached to many memories. Some would join immediately in the circle she was gradually forming, others waited and she was able to allow them to take the time they needed to stand up to be part of the session. Others never joined the circle but were nevertheless recognized where they sat, so that they too took part in their own way. The session would unfold with varying degrees of energy, intensity, intimacy, laughter, and sharing. A range of emotions might be expressed through the movement and perhaps verbally. Each individual left with a different and clearer sense of self and with having related to others when they might have previously been isolated. It all occurred through sensitive awareness of the symbolic movement expressions that were offered and to which there was validation and response. (Sandel et al., 1993).

Mary Whitehouse was another major figure. She evolved her own way of working during the 1950s and attributed her approach to both her background in studying dance with Mary Wigman, and her own Jungian analysis. She worked with those who were higher-functioning and had more ego strengths than did Chace, who worked primarily in institutional settings. She used the Jungian concept of active imagination as the foundation of her work. By making use of spontaneous body movement that arose from inner kinesthetic sensations, individuals recognized the symbolic nature of their communications, which then opened the door to self-awareness and possible change. She called her work Movement in Depth. This later was called Authentic Movement by her followers.

Trudi Schoop, who lived in California, as did Mary Whitehouse, had been a well known performer of dance and mime throughout Europe prior to World War II. When she settled in California, she began to work with hospitalized patients and developed her own way of thinking about this work. Making use of creative explorations and natural playfulness, she

worked with fantasies and body awareness to lead to expressive movement and changing postures.

Others who added to the body of knowledge of dance/movement therapy included Blanche Evan, Liljan Espenak, Alma Hawkins, and Irmgard Bartenieff. Some, such as Norma Canner and Elizabeth Polk, primarily worked with children. Since the beginning, many have learned and carried on with their work, continuing to contribute new ideas and ways of working in many new and different settings. The work is not only in psychiatric hospitals, agencies, and private practice but in any setting where there is a need for healing. These might include working in multiple settings such as educational (autism, special needs, delayed development), prisons, outpatient settings, and with the elderly, including Alzheimer's patients. Practitioners work with those with physical disabilities such as blindness, deafness, chronic pain, anorexia, closed head injuries, Parkinson's disease, and where there is acute illness such as in oncology. Therapists work with abusers of drugs and alcohol, where there is domestic violence, and with those who have survived trauma and abuse in many situations. Dance/movement therapists use their skills and knowledge to work with people toward self-validation, resolution of past trauma, and to learn how to better relate and have positive interactions with others.

Brief Case Study

Within my dance/movement therapy private practice, I worked with a fairly well functioning middle-aged man who came because of his difficulties in relationships. It was clear to both of us that he struggled to allow himself to move freely in space and could not dance out whatever feelings he struggled with at the moment without censoring them. His movement exhibited tension and interruptions, and lacked flow or rhythmic continuity. He appeared stuck to one place on the floor. With continued therapeutic work over time that dealt with his family and his own low self-esteem, with starts and hesitations, there came a day when, after a brief verbal exchange, he moved out into space and moved through one of the most beautiful dances I had ever seen. The beauty came from the total of integration of his body, his movement, and his intention to express something within himself. It had not been planned beforehand but rather emerged complete and whole at that time. He understood what had happened for himself, as did I as the therapist, and there was little need for discussion. He had accepted himself and his feelings and was willing to have them be seen. It was a complete and satisfying moment that indicated that treatment was near its end.

When the therapy is in group settings, the projections and anxieties of relating to others emerge and need to be managed. An individual may

receive group support for the individual struggles, pain, and emotions that might unfold. The realization that others similarly struggle enables people to feel less isolated on their journey toward health. For example, anger is one emotion often difficult to express or to receive from others. Structuring movement that encourages but contains strong aggressive actions, and modeling various ways of acceptance and response, lessens the fears that emerge with the emotion. Similarly, expressions of loss and sadness can be shared as a universal experience. Further discussion of the practice of dance/movement therapy in several settings will be found in chapters that follow.

Professional Structures

Active in the founding of the American Dance Therapy Association (ADTA) in 1966, I served as the first vice-president when Marian Chace was president, and I then became the next president. Some of this chapter is based on what I was part of and observed. Initially, there were a few people working in very isolated situations, trying to understand what was important about the dance in therapy. Gradually they, including myself, sought out those first pioneers to learn and then to share with each other their ideas and questions. Several students of Marian Chace became convinced that it was important to form an organization for communication and continued learning. After a 2-year period of organizing, searching for those interested in the field, and deciding on the mission of the organization, the ADTA was incorporated as a non-profit association in 1966. There were 75 charter members … some of whom still remain active. There was now a way communicating with each other through newsletters, a directory of members, an annual conference, and eventually a professional journal. Over time, standards were set for what knowledge was needed to be a dance/movement therapist, and what ethics were to be followed. As the profession grew, treatment opportunities and knowledge continued to increase. As graduate programs were introduced in academic settings, the ADTA began to officially recognize and approve programs meeting specific standards. Similarly, individuals apply for registry (or certification process), which sets standards and thereby recognizes one's achievements in reaching those standards in order to be a professional. There was and continues to be outreach to the public and other professionals to educate them about dance/movement therapy.

Aside from understanding and having dance be part of one's life, there is much learning involved in becoming a dance/movement therapist. Theories and practice of dance/movement therapy, human development and behavior, issues over the span of life, movement observation, and group processes are a few of the courses that are covered in graduate