AN EXPLORATION FROM A STRUCTURAL POINT OF VIEW OF THE USE

OF THE GREEK TRADITIONAL FORM OF DANCE IN A DANCE MOVEMENT

THERAPY GROUP OF GREEK SCHIZOPHRENIC PATIENTS

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by

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ABSTRACT

The aim of this study is to explore schizophrenic patients' use of the Greek form of traditional dance in a dance movement therapy session with a group of Greek Schizophrenics. A critical review of the group therapy structure and leadership style was employed for this purpose. In addition, some clinical examples are presented of six long-term institutionalized Greek schizophrenic patients in order to support and clarify the finding of the literature review.

The findings of the literature review sustained the notion that a well-structured session and a clear and directive leadership style is necessary for working with schizophrenics. Furthermore, it is shown that the use of the Greek traditional dance "Syrtos" is structurally an effective therapeutic tool when working with Greek schizophrenic patients.

I

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the patients who participated in this study.

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INTRODUCTION

This study started when I participated in a clinical placement in Greece, in the summer 1993. I worked as a dance movement therapist in a rehabilitation unit of long-term institutionalized psychiatric patients. This unit is part of a big program of deinstitutionalization that the Greek government has employed since October 1990 in order to encourage long-term institutionalized patients of psychiatric hospitals to return to the community.

The Greek government, with the financial support of the European Community, decided to start this program in this hospital because the living conditions for patients were below standard. According to the Greek newspaper "Eleytherotypia" (1989,Sept. 11) this psychiatric hospital has been described by the British newspaper "Observer" as a "concentration camp". Another Greek newspaper "Mesimvrini" (1991,March 7) described this particular hospital as a "dammed" place which was a cause for shame for Greece.

In this hospital there lived about 1300 patients varying from young children to very old people. Most of them were always naked and the staff used to chain up them to their bed

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for many hours every day. They lived in dirty conditions and suffered many privations waiting only for death to come (Eleytherotypia, 1989, Sept. 11). In the hospital there was only one psychiatrist and 800 staff members who were not qualified to do their jobs. They are just residents of the hospital's geographic region who used to be shepherds, fishermen and farmers before the hospital employed them. Because this geographic region was very poor this hospital became the financial solution for the most of the residents.

The patients who participated in my study came from this psychiatric hospital. They are all chronic schizophrenic patients who had had at least one immediate or long psychotic episode in the past. In addition, they are long-term institutionalized patients; by long-term I mean that they have been institutionalized continuously for over 25 years and some of them have been in institutions for 40 years. All patients are between 45 and 61 years of age and they come from the same geographical region of the country.

This study is going to discuss the importance of the structure in a dance movement therapy group session with Greek schizophrenic patients and explore the use of structure in order to create a positive therapeutic environment. In addition, I would like to discuss from a structural point of view, the significance of the Greek traditional form of dance as used with Greek schizophrenic patients and how the Greek traditional form of dance can facilitate the therapeutic process for them.

Thus, a critical review of the structure and the leadership

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style of the therapist will be employed to explore the above points. In addition, an examination of a dance movement therapy session of two different groups of Greek schizophrenics is utilized. This study describes some clinical tasks in order to theorise the findings of my practice with these particular groups.

It is very important for the dance movement therapist who works with inpatient chronic schizophrenic patients to consider the element of dance movement therapy group structure in order to create a positive therapeutic environment for them. In other words, to facilitate a safe and reliable structure (Stanton-Jones,1992). Structure is defined by Johnson, Sandler and Eicher (1983) as "a discernible pattern of behaviour maintained by group members".

The therapist's job is to create an appropriate structure for the patients. In group therapy, the therapist is the person who is clearly responsible for setting the frequency of sessions, the time and the place of the meeting, the rules of the behaviour and the interaction among the members, defining the primary task of the therapy and employing techniques (Johnson,Sandel,Eicher 1983). The therapist is the one who controls the level of differentiation in the session by setting and structuring the roles, the tasks and the spatial structure (Sandel and Johnson,1983).

Schizophrenic patients, as well as the majority of the patients who live in an inpatient unit, are confused, frightened and disorganized, so the last thing they need is to be put into an enigmatic, anxiety-provoking situation.

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Structure which provides clear, familiar and concrete spatial formations, tasks, rules and roles in the group can give a sense of stability and help schizophrenic patients to reduce their anxiety. In addition, they are helped to develop and maintain a sense of self by external organizers, such as the therapist and/or a well-structured environment (Yalom,1983; Sandel, Jonhson,1983). Research has been carried out on structural aspects of leadership styles with very significant results. This research conducted by Johnson, Sandel and Eicher (1983) showed that the leadership style which evokes an intimate and well-boundarized social environment is preferred by the groups of schizophrenics.

Other research on the structure and the process of the nascent group has shown that the therapist is the one who has to maintain an internal representation of the group identity by adapting a clear and directive leadership style because in groups of severely disordered patients there is no sense of group identity (Sandel, Johnson, 1983).

Furthermore, Liebowitz (1992) suggests that dance movement therapy can contribute to the treatment of schizophrenic patients in psychiatric hospitals because working with the body can address a main problem of schizophrenia, which is the lack of cohesiveness in the bodily ego. In addition, dance movement therapy contributes greatly to the improvement of schizophrenics interpersonal function because they can develop their social skills, learn through imitation and participate in group cohesiveness through the interactive movement experience that it provides.

On the other hand, when discussing Greek traditional form

of dance, I am referring particularly to the Greek national dance "Syrtos" which the patients of both groups introduced during the sessions. This dance, as well as most of the Greek traditional dances, is a well-structured dance. Its spatial formations, rules and roles are very clear and concrete.

The dancers move in a circular spatial formation with hands joined. There are certain steps which all dancers follow. These steps are usually in a sideway, forward or backward direction and include hopping movements. The first dancer of the chain is the leader of the dance and the rest of the dancers follow him/her, who from time to time performs rhythmic movements which are improvisations and they are called "scherza" (Crosfield, 1948).

There are national as well as local dances in Greece. The national dances such as "Syrtos" are danced all over the country. On the other hand, the local dances differ from one geographical region to the other. There are differences in the rhythm, the number of steps, the way that the dancers join hands etc. But Greek traditional dances do have particular and similar structures. In addition, "Syrtos" is one of the most well known dances in Greece so, it was very familiar to the schizophrenic patients of my study.

Thus, when working with Greek schizophrenics this dance can be an appropriate and effective therapeutic tool because it offers the structure that is effective for them as well as the participation in the group cohesiveness and interaction.

Furthermore, I believe that this study will be useful for other dance movement therapists who are going to work with

Greek clients because they are very likely to confront in the dance movement therapy process some elements of Greek traditional form of dance. This is why the Greek traditional dances are an inseparable part of the Greek culture. It is very critical for dance movement therapists to take into account the cultural background of the patients. If the therapist recognizes and understands the meaning of different cultural patterns and behaviours then he can better serve patients by adapting the theory and practice of dance movement therapy to this context (Hanna, 1990).

In conclusion, I would like to say that this study, from the perspective of the structure and the therapist's leadership style, will attempt to explore the way in which Greek traditional form of dance can facilitate the therapeutic process for Greek schizophrenic patients.

CHAPTER 1

SCHIZOPHRENIA

1.1 INTRODUCTION

In this chapter I would like to discuss the essential features of schizophrenia as well as to give an overview of the different variables of the nature and the causes of this disorder. Thus, the reader will gain a better understanding of the dysfunctions of the patients that I describe in my study. In addition, according to that dysfunctions this chapter will form the basis of the discussion on the effectiveness of the structure and the use of the Greek traditional form of dance in the therapeutic process when working with schizophrenics. In other words, this chapter gives the background of the disorder which is necessary to be known by the dance movement therapist in order to contribute to the cure of schizophrenia.

Kreapelin was the first person to introduce the concept of "dementia preacox" almost one hundred years ago. The criterion which he chose to use in order to infer dementia preacox was similarities in onset, course and outcome of the illness, i.e. if a group of people have similar changes of behaviour (onset), there is similarity in development over time (course) and the group goes to a similar final point

(outcome) (Boyle,1992). According to Boyle (1992), Bleuler, an other pioneer, developed Kreapelin's ideas and changed the name of the dementia preacox to "schizophrenia", which has been used to date.

But what do we mean by the term schizophrenia today? The most recent definition of schizophrenia is contained in the Revised Third Edition of the American Psychiatric Association's Diagnostic and Statistic Manual of Mental Disorders. According to the DSM-III-R, schizophrenia is a functional psychosis, meaning that there is not an organic factor initiated and maintained the disturbance. Schizophrenia is characterized by the presence of characteristic psychotic symptoms (such as, auditory hallucinations, bizarre delusions, flat or grossly inappropriate affect, incoherent associations, odd beliefs) during the active phase of the illness. In addition, during the course of the disturbance the patient's functioning is markedly below the highest level previously achieved. Difficulty is experienced in interpersonal relationships and marked impairment in areas such as work and self-care, poverty of content of speech, social isolation or withdrawal. The person's behaviour is markedly peculiar (e.g., collecting garbage, talking to oneself in public, hoarding food) and is influenced by odd beliefs which are inconsistent with his cultural norms.

Schizophrenic symptoms can be divided in two categories: the "positive" or "florid" symptoms, and the "negative" symptoms. Positive symptoms are characterized by hallucinations and delusions, and negative symptoms by

"flatness of affect, slowness, poverty of speech, underactivity, inability to use nonverbal means of communication"(Wing,1987). According to Wing (1987), the negative symptoms are present for longer periods of time especially in long-term patients and, as a result, patients face social withdrawal.

According to Slade (1992), a further distinction is suggested with regards to negative symptoms. They can be divided into two groups: (a) negative symptoms - type 1 : such as poverty of speech, poverty of affect etc.; (b) negative symptoms - type 2 : such as speech disorganization, incongruity of affect etc.

In addition, he suggests that this psychiatric classification can be also understood from a psychological point of view. That is to say that a specific psychological dysfunction is possibly underlying each of the above three groups of schizophrenic symptoms. What underpins psychological dysfunction of the positive symptoms is the patient's difficulty to control and/or to understand private experiences which are internally originated. On the other hand, the underlying psychological dysfunction of the negative type 1 - symptoms, is the patient's difficulty to initiate responses, and of the negative type 2 - symptoms, is the difficulty to control and direct behaviour continuously (Slade,1992). In addition, the prognosis is better when positive symptoms occur without negative symptoms in periods when the person is not in the phase of an acute attack. Furthermore, when positive and negative symptoms occur together then the negative symptoms play a more important

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role in the prognosis of the social effect(Wing,1987). In the next chapters I will discuss how dance movement therapy can address all these underlying psychological dysfunctions and in particular how this occurs in my project.

Despite these attempts at a specific definition, there is still argument in modern medicine about the concept of schizophrenia. The research into the aetiology of schizophrenia started 100 years ago but so far little progress has been made. Claridge (1992) states that even after recent discoveries in biochemistry, psychiatric genetics and neuropathology the exact nature and causes of schizophrenia are still unknown and perhaps will remain so longer. There are many hypothesized causes of schizophrenia. These include issues of genetics, abnormal brain structure or biochemistry, diet, season of birth, structure of the family, social stress, life events.

Bentall (1992) states that one possible answer about why the aetiology of schizophrenia is still unknown is that because of the complexity of schizophrenia it takes time to fully understand its nature. Research is constantly going on.

One possible explanation that Boyle (1992) suggests is that something went wrong from the beginning in relation to the diagnosis of schizophrenia. He argues that there are problems with the criterion of similarities of onset, course and outcome which Kreapelin used to introduced the concept of dementia praecox. Firstly, Boyle mentions that the terms "onset", "course" and "outcome" were use by Kreapelin to describe simple events but in fact these are very complex.

Therefore, what exactly is meant by these terms can be arbitrary and can differ among the researchers. Secondly, he states that Kreapelin didn't give guidance for important and specific similarities. As a result, when this method is used for heterogenous populations the result can be unstable. Different researchers (or the same researcher at different times) could use different criteria to decide if a similarity is important or not. Thirdly, the term "outcome" means that one could only make conclusions when all the members of the investigated population reach the point of no further possible changes (e.g. all have died). This poses a serious problem for diagnosis and research (Boyle,1992).

Furthermore, Boyle suggests that what Kreapelin and Bleuler have described may relate to totally different people than the contemporary schizophrenics. He supports his opinion by stating that Kreapelin's and Bleuler's descriptions about dementia praecox / schizophrenia are identical to the descriptions of encephalities lethargica and very different from the descriptions of schizophrenia today. Thus, he concludes that researchers have to reconsider the concept of schizophrenia as an independent variable.

1.2 BIOLOGICAL VARIABLES

Since Kreapelin's and Bleuler's time the majority of research focuses on the biological role. For example, Kreapelin spoke about cerebral lesions, where as Bleuler suggested a psychobiological cause of schizophrenia

(Jackson,1992).

Some research into schizophrenia has focused on the structural abnormalities of the brain. According to Jackson (1992), structural abnormalities of the brain could account for schizophrenic symptoms, given that some of the features of function are located in the brain. Thus, there may be a connection between localized lesions in the brain and schizophrenia.

Recent research involving autopsies of the brain show that there is cerebral atrophy in schizophrenics (Weinberger, Jeste, Wyatt, 1987). That is to say, that the number of cortical cells and nerve fibres is smaller in schizophrenics than in normal people (Jackson,1992).

On the other hand, according to Jackson (1992), there are also researchers who claim that there was no cortical atrophy in their sample of schizophrenics.

He also notes that the cerebral atrophy correlates to neuroleptic drugs, diet, institutionalization etc. Despite that, Weinberger et al.(1987) could not prove a correlation between cerebral atrophy and drug treatment or institutionalization.

Some other researchers into structural anomalies of the brain focus on the subcortical abnormalities. According to Jackson (1992), Lidsky et.al suggested that there is a link between basal ganglia abnormalities and some schizophrenic features such as catatonic, affective and attentional features. Another possible reason for schizophrenic symptopathology is pathology in the limbic system (e.g. hippocampus etc.)(Jackson,1992).

Focus has also been placed on the dysfunction of the lobes and, especially, on frontal lobe dysfunction. According to Reading (1991), there is a connection between frontal lobe dysfunction and schizophrenia as well as Parkinsonism.

Other research showed that some schizophrenics had larger left frontal areas, or had lower frontal action (Jackson,1992). According to him, research has also been done on the pariental as well as on the temporal lobes.

Another area which is under research is biochemistry. Many neurochemicals such as dopamine, noradrenaline, seretonin, acetilocholine etc. have been considered as possible causes of schizophrenia but none has been proven yet (Jackson, 1992).

Finally, research has been done to show the role played by the genetic factors in the aetiology of schizophrenia without any definite result to date (Marshall,1992).

Thus, it is true that in order to explain the concept and the aetiology of schizophrenia, greater emphasis has been placed on biological factors but without any definite result yet. In my opinion this happened because it is mainly medical science that funds the greatest amount of research into schizophrenia. Thus, medical science tries to explain schizophrenia by using a scientific methodology and searches for biological explanations of the illness. This produces a medicinal explanation of schizophrenia by reducing an accent of a mental illness to the same logic as that of other physical or physiological illnesses.

1.3 COGNITIVE/NEUROPSYCHOLOGICAL VARIABLES

Neuropsychological research makes great efforts to understand why schizophrenics very often demonstrate cognitive deficits. According to Heaton and Drexler (1987), chronic schizophrenics show similar cognitive impairment to brain damaged patients. Thus, there may be a link between neuropsychological deficits, brain structure and function abnormalities.

Research by Harrow, Marengo, Pogue-Geile and Pawelski (1987), showed that long-term institutionalized as well as revolving-door chronic schizophrenics, are characterized by intellectual deficits. They conclude that environmental factors, e.g. continuous institutionalization, are not responsible factors for the cognitive deficits of schizophrenia.

Heaton and Drexler (1987) summarize some neuropsychological research findings. They suggest that some cognitive deficits are linked with the onset of schizophrenia. In some patients the cognitive deficits are reversible but in other patients there is stable or progressive impairment. The cognitive function of schizophrenics is not seriously affected by ageing. Also ECT and acute drug effect do not explain the cognitive deficits of schizophrenics, although more investigation is needed on the neuropsychological effects of long-term neuroleptic therapy.

Thus, it is crucial the dance movement therapist to take in consideration that schizophrenics demonstrate cognitive deficits so the structure of the session has to be appropriate

and not over-demanding for them. In chapters two and three I discuss these points more specifically.

1.4 PSYCHOANALYTICAL VARIABLES

Despite the psychiatric attitude which assumes that patients have a lack of insight to their illness, psychoanalysis speaks of a failure in reality-testing (Rycroft,1972). Freud argued that in normal conditions the "reality principle" governs mainly the ego. In psychosis because the reality-testing is impaired, the psychotic ego needs a substitute for its lost reality such as a delusion. Freud believed that this substitute was the individuals attempt at cure (O'Shaughnessy,1992).

Winnicott (1971) mentioned that there are some individuals to whom the external reality remains to some extent a subjective phenomenon. He referred to them as schizoid. He suggested, for example, that hallucinations are dream phenomena which, unlike real dreams, come into the waking life. Thus, schizoid people are not satisfied within themselves; they don't want to spend their lives out of reality so they may go into therapy in order to be helped to reach a unified status.

M. Klein saw psychosis from an anxiety point of view. She believed that a normal infant at a certain developmental point can work through and modify anxieties of a psychotic nature. On the other hand, an abnormal infant cannot do that. Thus, the primitive anxieties remain unmodified and dominate

the psyche of the psychotic child. Consequently, the ego makes an excessive use of the defences of splitting and projective identification (O'Shaughnessy,1992).

Freud believed that psychotics are not suitable for psychoanalytic treatment because they cannot form a "transference" with the analyst (Rycroft,1972). On the other hand, Kafka (1987) mentions that Frieda Fromm-Reichmann was the first who suggested that schizophrenics can form transference, too.

Kafka (1987) suggests a therapeutic model for schizophrenics which is based on the "bridge-building" between the psychotic and nonpsychotic phases of the patient. In other words, the content comes out when the patient is in an acute psychotic phase and is dealt with by the patient when he is in a nonpsychotic phase.

Blatt (1991) based her work on an integration of cognitive developmental psychology and developmental psychoanalysis. She mentions that one of the earliest and fundamental developmental phases is that where the infant gains the ability to experience independent persons or events as separate and different from himself.

According to her, schizophrenics perceive other people and reality as more unstable and fluid. Schizophrenics have difficulty with interpersonal relationships because they experience them as unstable, painful and dangerous. As a result schizophrenics replace these by withdrawing into more autistic fantasies.

She suggests that most of the symptoms such as disturbances in perception, cognition, attention, interpersonal

relationships are results of disturbances in boundary articulation. Schizophrenics exaggerate differentiation by keeping other people at a distance, heighten their attention and become over suspicious in order to maintain firmly their sense of separation and individuation. In that way they defend against the threat to experience fusion, instability and dissolution of their boundaries. In the chapter 3 I will discuss how dance movement therapy can address the above problem and in particular how I address it in my project.

1.5 PSYCHOSOCIAL VARIABLES

Wing and Brown (1970) mention that there is evidence that symptoms of schizophrenia are effected by the social environment. There are some examples of exacerbation in intensity of delusions of hallucinations during the initial days of admission in hospitals. In long-stay patients who had not any "florid" symptoms for many years these re-emerged when the patients transferred to other units.

They believe that negative symptoms are also affected by the social environment. Long-term institutionalization has an effect on patient behaviour and attitudes. This is to say that features such as apathy, poor social skills, decreased ability for independent functioning, deterioration of personal habits and postural abnormalities may be related to the chronicity of the institutional care.

For Wing and Brown two different processes take place. When the social environment is under-stimulating, like old

fashioned mental hospitals (and indeed life in the community at times), where the patients mainly do nothing, negative symptoms such as social withdrawal, passivity, lack of motivation etc. are increased. My particular patients come from a hospital like that and symptoms such as withdrawal, passivity and lack of motivation were very strong among them. In addition, a hospital which is highly restrictive is also an under-stimulating environment because the patients' activities are more habitual than interesting for them.

On the other hand, "florid" symptoms can be increased within an over-stimulating social environment. Such social environment can be the community but also some hospitals which tend to be over-enthusiastic.

Wing and Brown explain the above two processes based on the hypothesis that negative symptoms are protection of patients' cognitive impairment. Thus, the patient withdraws as far as the environment permits him to do so. On the other hand, if the environment demands from him more than he is able to do, then his thought disorder is manifested in "florid" symptoms.

According to Lamp (1987) "the key to helping these patients adapt is to provide support appropriate to their needs, to reduce pressures they can not handle, and to provide treatment and rehabilitation that will maximize their potential without pushing them beyond their capabilities" (Cohen, 1987, p.205).

Strauss, Rakfeldt, Harding and Lieberman (1989) suggest ten different psychosocial situations in which negative symptoms arise. Thus, a schizophrenic patient can appear to

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have negative symptoms because:

1.He cannot afford the psychological pain and the social cost of a relapse into positive symptoms (e.g. a motorcycle racer who started developing schizophrenia, gave up his favourite activity because if he was close to winning, delusions of persecution and threatening auditory hallucinations would become unbearably intense).

2.He feels hopeless and has low self-esteem.

3.He wants to avoid impulsive or bizarre behaviour.

4.He has difficulty to be considered by the community as not a patient.

5.He feels guilty about previous dysfunction.

6.He is afraid of being involved in very complex and stressful social situations.

7.He is in a situation where he is completely helpless because of his disorder or because of the environmental factors such as economic capacity, low social class, few skills etc.

8.He is institutionalized.

9.He losses the social benefits when he has found a job but then he cannot afford the living costs because he has to pay, in addition, for his own medication and treatment.

10.He confronts the stigma of the mental illness.

However, research by Johnson, Cunningham-Owens, Gold, Crow and MacMillan (1981) showed that when they compared the negative symptoms of the in-patients with the negative symptoms of the out-patients and made the correction of age and duration of illness no difference was found. So they conclude that institutionalization does not effect the negative symptoms.

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Barham and Hayward (1992) mention Warner's arguments that, historically, the most successful rehabilitation for schizophrenics was in periods of great need for labour, ie war. In these periods, schizophrenics could easily have a job. In Western societies schizophrenics are usually unemployed and consequently they feel a sense of uselessness both in relation to themselves and to others. Although the results of projects showed that schizophrenics are fully socially responsible people. This was supported by research with Greek, elderly, long-term institutionalized, schizophrenics which showed that their main handicaps were their disability in social and living skills rather than the effects of their illness (Lyketsos, Richardson, Aritzi, Lyketsos, 1989).

Family is another very important factor as well. Research has suggested that the use of the family and relatives for rehabilitation results in a reduction of relapse rates and that this is very beneficial for the schizophrenics, their relatives and the mental health services (Tarren,1992).

But it is not easy for the relatives and for the patients to live together. Many relatives take a lot of time to realize that social withdrawal is not laziness or unfriendliness. Most families, when for a first time a family member shows schizophrenic symptoms, pass through an initial turbulent stage. Then, gradually patients and relatives learn to deal with the problems and to live with the schizophrenia. However, many families cannot do this and the family ties are broken so many patients become institutionalized or vagrant (Wing,1987).

Furthermore, the above argument can explain why the patients of my project have so many years of continuous institutionalization.

1.6 AN INTEGRATION OF MORE THAN ONE VARIABLES

The three-phase model of schizophrenia by Ciompi (1987) warrants mention. It is based on an integration of many variables instead of focusing on one particular variable, in the belief that it is worthwhile to look for answers in the integration of knowledge.

This model is based on the combination of psychodynamics, systems theory and Piagetian theories, and integrates genetic, biological and psychosocial-environmental factors.

In the first phase genetic and other biological factors as well as psycho- and socio-dynamic factors are responsible for a pre-disease vulnerability with deficient coping patterns.

In the second phase the vulnerable information processing system is over-stimulated by stressful situations which demand major cognitive-affective adjustments such as, for example, adolescence or young adulthood. Thus, biological and psychosocial factors lead to difficulties with communication and behaviour which finally end in acute florid psychotic symptoms.

In the third phase a variety of psychosocial influences combined with the pre-existing deficient coping patterns and the consequences of the acute illness lead to different evolutions, such as remission, relapses, residual states. On

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this basis he saw as a "social artifact" residual states which are characterized by negative symptoms (Ciompi,1987).

In conclusion I would like to say that in this chapter I tried to cover the concept of schizophrenia (aetiology, symptoms) from every perspective in order to give a better understanding of this disorder. Today, even after this amount of research in biology, neuropsychology, psychoanalysis and psychosociology the cause of schizophrenia is still unknown and still under investigation. I believe that the answer to the cause of schizophrenia is not only in one of these areas but in all of them. Thus, more research such as that I have mentioned above by Ciombi (1987) or Blatt (1991), should be conducted because, in my opinion, the way forward is to be faced always in the integration of knowledge.

In addition, when working with schizophrenic patients the dance movement therapist has to keep in mind and to integrate the knowledge of all the different variables. In particular for my project, in the next chapters I will discuss the structure that is more appropriate and effective for those patients and how Greek traditional dance facilitate it, having as criterion the meeting of the dysfunctions that I described in this chapter.

CHAPTER 2

GROUP THERAPY STRUCTURE

2.1 INTRODUCTION

In this chapter I would like to discuss the meaning of
structure in relation to therapy groups defining specific
components of group therapy structure which support and
contain schizophrenic inpatients, and in doing this show how
therapy can be more effective to them. I focus more on Yalom
because I believe that his work is more relevant to my
study.

Johnson and Sandel defined group therapy structure as "the
overt, understood patterns or rules of organization which
guide the group's interaction"(Bruno,1981), and Levine
(1979) mentions that group therapy structure is the "when,
where and how" of the therapy group.

According to Levine (1979), the structure of the therapy
group is a very important element of the group therapy because
the group development and the successful completion of the
group aims can be facilitated or inhibited by structure.

2.2 ASPECTS OF GROUP THERAPY STRUCTURE

Among the aspects of the structure which the therapist must consider are the time and the place of the meetings, the number of meetings, the duration and the frequency of the meetings, whether the group will be closed or open, the format of the group (e.g. spontaneous or prearranged), and how much direction and control the therapist will retain in the group.

Yalom (1983) suggests that group therapists can provide structure for the group by showing clear spatial and temporal boundaries, by giving clear and fully expressed orientation for the patient and preparing new group members. Also by providing an unchanging and explicit group procedure, and by using leadership style which is clearly expressed, decisive and flexible as well.

When discussing clear spatial boundaries, Yalom refers to, for example, rooms which are of appropriate size and are clearly delineated, preferably with a closed door. Yalom also suggests that the group have to sit in a circle so every member of the group can see everybody else. The reason is that clear delineated spatial boundaries cause a sense of inner stability and encourage the members to interact with each other rather than just to address the therapist. In addition a punctual beginning and a punctual end to the session are important because they create a sense of unchanging structure for the patients.

Levine (1979) adds that feelings of intimacy can be disturbed by a room that is too large. Or a room that is too

small can frighten patients because it disturbs their sense of personal space.

Another important element of the structure is the format and the procedure of the session. According to Levine (1979) very often when therapists speak about group structure they refer to the format of the sessions. The format can vary from verbal to nonverbal interaction and from spontaneous to prearranged and preplanned experiences. Yalom (1983) argues that the therapist's technique of creating an explicit and consistent sequence to the group sessions is a very powerful structure-providing technique. For Yalom the important issue is not the content of the structure but the process of providing structure itself. In other words, the structure is clearer and more direct. This enables the patients who are involved in a given task, (whatever the task may be), to be contained within a structure which eliminates ambiguity and avoids an anxiety-provoking situation.

The leadership style of the therapist is an important aspect in providing structure for the group as well. According to Levine (1979) the therapist initially has to find out the amount, and the type of control that the group will need. Some forms of groups need more control by the therapist and other less. He suggests that generally the younger groups and the groups with low social and emotional capacity need more directed leadership by the therapist.

Yalom (1983) suggests that a therapist who is clear, firm and decisive - but also shares with the patients the reasons for his actions - reassures patients who are confused, frightened, etc,. Especially in inpatient groups, when a

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major, disruptive event occurs it is an error for the therapist to be passive or nondirective because such patients are too frightened and stressed and unable to deal with such events. They are reassured and tend to feel safer if the therapist is firm and decisive.

Leszcz, M., Yalom, I., and Norden, M., (1985) did research into patients' perceptions of the value of inpatient group psychotherapy. In this study an unstructured, mandatory and functionally heterogeneous inpatient psychotherapy group was compared with a structured, voluntary and functionally homogeneous inpatient psychotherapy group.

Almost every patient in both groups agreed that it was necessary for the group leaders to be active in structuring, integrating and focusing. They described as "wasteful" the meetings where the therapist was waiting for the group to activate itself. They criticized the therapists' passivity and silence as being harmful, especially when they failed to set limits to monopolistic, disturbing patients or when they allowed patients to do provocative things and/or make unrelated comments which fragmented the group. The researchers suggested that "it seems far more efficacious to provide this structure and anchoring, than to treat it as group resistance that the group must work through on what could well become a daily basis." (Leszcz, M., Yalom, I., Norden,M., 1985, p.430).

2.3 EMERGENT LEADERSHIP ROLES IN THE STRUCTURAL DEVELOPMENT OF GROUP PROCESS

An other important element of the group structure is the different roles that group members appear to have within the group. In this section I will describe some of them and their function in the group process.

According to Brusa,J., Stone,M., Beck,A., Dugo,J., and Peters,L., (1994) during the development of a therapy group four different types of leadership roles, as well as a nonleader member role, emerge as a result of the group member's interaction. These leadership roles are part of an on going group process and are different from the formal role in a therapy group i.e. therapist and client. The four leaders that emerge during the group's life are: The task leader, the emotional leader, the scapegoat leader and the defiant leader. A brief description of the roles in terms of their characteristic functioning in therapy groups (from Beck,A. et al, 1983, and Brusa,J. et al, 1994) is given below.

The therapist is usually the task leader in a therapy group and, as such, is a guide to the task of the group, provides support and facilitates members' self-exploration and interpersonal interaction. This leader influences goal clarification, style of communication, depth of emotional issues addressed, level of participation and also deals with the boundaries of the group related to the surrounding organization and the world.

The emotional leader is usually the most motivated and willing member of the group to participate in the task of the

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group. This leader is interested in and focuses on the emotional issues, is concerned about others and involved in the group, and is well-liked by others. This member motivates the personal change in the group and can be the group's spokesperson if necessary.

The scapegoat leader is usually a group member but can at times be the therapist as well. This leader is often attacked openly or receives nonverbal negative feelings from group members especially in the early phases of the group life. In later phases the group members usually change their perception of him or her to become more positive. This leader facilitates the clarification of many of the group's issues and significantly enables members of the group to maintain their states as group members and also to preserve their individuality.

The defiant leader is usually a group member who openly expresses ambivalence regarding participation in the group. He/she does this in relation to the closeness that develops amongst the group members. He/she also feels that the therapist does not promote autonomy in the group members. He models the struggle between dependence and independence for the group as a whole.

Brusa,J.,Stone,M., Beck,A., Dugo,J., and Peters,L.,(1994) argue that these leaders have important and consistent maintenance functions, and by taking turns (usually in pairs), carry the dialectical process by which group concerns are explored and worked out across the nine phases of the development of group structure. However, groups do not usually reach all nine phases. An important reason for this is

that when membership changes the group returns again to the initial phase and different individuals will fill the four leadership roles.

According to Beck,A., (1983) a brief description of the nine phases is as follows:

Phase 1: An initial agreement is created to become a working group based on the members' initial assessment and an initial statement of the goals. During this phase the task leader plays an important role.

Phase 2: A group identity, goals and initial norms for operation are constructed. Leaders are selected in a competitive work style. That is to say, that it is not the therapist who gives the different roles to the group members. Each group member tries to show the role that he/she wants to play and/or the roles that the rest group members will take. This competitive style must be resolved in order for the group to move to the next phase. The scapegoat leader and the emotional leader play an important role.

Phase 3: Group members start to work together to define personal goals and to disclose themselves. The emotional leader becomes the member who motivates the group, the defiant leader is more active and the scapegoat leader has started to be reintegrated into the group.

Phase 4: Group members explore closeness in the group and in relationships outside the group. They form a positive peer bond.

Phase 5: The implications of intimacy, as dependence and independence are explored.

Phase 6: During this phase the task leader is integrated into

the group.

Phase 7: During this phase the formal and informal roles have changed into flexible and spontaneous responses.

Phase 8: The group evaluates and reviews what has been achieved and focus on how to transfer what has been learnt to life outsid the group.

Phase 9: The group deals with the issues of loss, separation and termination.

This description of the nine phases will help me later to identify in which phase the groups of my project are and what roles the group members have within the group.

2.4 APPLICATION OF GROUP THERAPY STRUCTURE TO GROUPS OF SCHIZOPHRENICS

Research by Dies,R., (1983) on the structured versus nonstructured therapy groups, showed that patients with impaired capacity in social interaction prefer structured therapy groups. Nonstructured approaches to group treatment, even with interpersonally skilled therapists, will be of less value. In addition, structured therapy groups are of greater value to patients whose personality style is more dependent and externally oriented. Structure also depends on the developmental stage of the group. There is greater need for structure in the initial phases of the group development than later on. In addition, Yalom,I., (1983) suggests that as the severity of the patients' psychopathology increases the degree of explication and

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direction that is needed increases as well.

Greene,L., and Cole,M., (1991) take an analytic
perspective and argue that as the degree of structuring of a
group increases regressive functioning of the participants
decreases. When discussing regressive functioning they refer
to the shift in object relations from whole to part objects,
the need for gratification as the primary base for
relationship, regression to primary defenses of projection
and introjection, deskilled cognitive capacities.

They suggest that an ambiguous clinical situation is
countertheraputic for psychotic patients, taking into
account that the primary goal for these patients is the
facilitation of development of the fundamental self / other
boundaries. So a well-structured therapy group promotes the
basic psychological structualization that is lacking at this
level of psychopathology. The results of their research
showed that psychotics had a more positive view of the self
than borderline patients in the task groups. This supports
the argument that psychotic patients need a social content
that can contain and organize their amorphous and confusing
experience.

Kanas,N., (1991) set up a research project for short-term
group therapy with schizophrenic patients. In his groups he
failed to find any developmental stages similar to the 9
phases of Beck,A., et al (1983) that I mention above. He found
that there is a tendency to increase cohesiveness and
decrease problem avoidance and interpersonal conflict over
the treatment period. On the other hand, Beck et al believe
that schizophrenics remain longer in Phase 1 working on how to

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represent themselves to others.

Another important element of group structure is its homogeneity (or heterogeneity). Kibel suggests that "psychotherapy groups are productive when they are homogeneous with respect to ego functions but heterogeneous with respect to conflicts, symptoms, behaviour, and coping style" (Kibel,H., 1991, p.8).

Kanas,N.,(1991) suggests that homogeneous groups in terms of diagnosis are more beneficial for schizophrenic patients than heterogeneous because they can provide reality-based support and structure. On the other hand in heterogeneous groups in which neurotic patients are included as well, therapists frequently use uncovering techniques which can raise the anxiety and cause regression and increase psychotic symptoms to schizophrenic patients. In order for the therapist to keep the anxiety low he must make supportive and task-oriented interventions that also assure patients that there is someone in charge who will take control if the situation becomes threatening or tense (Kanas,N.,1991). Yalom,I.,(1983) and Kanas,N., (1991) suggest that because schizophrenic patients have disorganized thinking and are sedated from medication therapists must be active, directive, clear, concrete and offer support to the patients. The therapist must also provide schizophrenics a supportive, pleasant and constructive experience if only because to simply participate in a therapy group is demanding enough for them. If schizophrenics are placed in an over-demanding group then they will experience failure easily and they feel more anxious and unworthy after the session than they did before.

Yalom argues that the therapy group must provide experiences of success to schizophrenic patients. Therefore, the group tasks must be designed according to the patients capacities, keeping in mind that schizophrenics concentrate more successfully on several shorter tasks than on a single longer one.

For Yalom,I., (1983) the reduction of anxiety is a very important element in group therapy of schizophrenic patients. Therapists must provide a group structure and climate which keep anxiety low. Because schizophrenic patients experience great anxiety in extended interpersonal interactions, the therapist must provide undemanding social interactions which are given in short time tasks and with periods of solo activity between. Then some techniques that are often useful to reduce anxiety are selected physical exercises, muscular relaxation and games (Yalom,I.,1983).

Yalom also believes that self-exploratory therapy increases schizophrenic patients' anxiety and therefore it is not appropriate to provide brief psychotherapy to them. In groups of severely schizophrenic patients the therapist must respond to any arising material with a clarifying rather than an uncovering interpretation (Betcher,W., Rice,C., Weir,D., 1982). Furthermore, Arriaga,K., Espinoza,E., and Guthrie,M., (1978) argue that unstructured, dynamically-oriented groups often cannot be tolerated by schizophrenic patients especially when they arrive in the hospital early in their treatment because their anxiety is already high. Thus, if they are put in such groups dissatisfaction develops on the patients and on the staff that nothing is effective for these

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patients.

According to Betcher,W., Rice,C., and Weir,D., (1982) a very important aspect of group structure for schizophrenics is the consideration of the physical space. They suggest that because schizophrenics are not able to maintain a clear sense of interpersonal boundaries,close physical proximity with other patients in the group can be frightening and overwhelming. So the therapist must think how far one chair is placed to the others, who sits next to whom, about physical contact etc. Some helpful techniques to reduce patients' anxiety include allowing them to go out of the room for some time and then come back, or to permit them to sit on a particular chair which they have chosen. For some very frightened patients a physical buffer between them and the rest of the group is very helpful (Betcher et al, 1982).

2.5 THE IMPORTANCE OF STRUCTURE TO THE THERAPIST

Leading a therapy group with regressed inpatients is very emotionally demanding for the therapist and can effect his/her involvement or make him/her feel confused, uncertain, threatened (Betcher,W., Rice,C., Wier,D., 1982 and Stone,W., 1991). Yalom (1983) argues that leading a therapy group, especially with psychotic patients is a high-anxiety provoking situation for the therapist. There is slow progress, the work is often bewildering and unrewarding for the therapist.

Thus, structure is very important for the therapist to enable a feeling of competence if some principles or rules

are followed (Stone,W., 1991). Yalom (1983) suggests that the therapist can defend against anxiety by following a structured therapeutic model. The importance at this is that there is a model (rather than which model).

He argues that when the therapist follows a model he experiences an inner clarity and mastery which is automatically transmitted to the patients. Thus they experience a sense of clarity and mastery as well.

In conclusion I would like to say that structure is a very important element of group therapy that the therapist has to take in consideration in order to work effectively. In this chapter I discussed the most important elements of group therapy structure (such as spatial boundaries, format / procedure, therapist's leadership style and group members' roles in the group). Because of the psychopathology of schizophrenic patients the therapist has to provide clear spatial boundaries with not very close physical proximity, he must be task-oriented, active, directive, clear, concrete and supportive. In addition, clear roles and rules play an important role to the therapist who works with such patients as well, because they help him/her to overcome his/her anxiety.

The application of the above elements of group therapy structure to the dance movement therapy group of schizophrenic patients I will discuss in the next chapter. Thus, I will show what dance movement therapy group structure is effective for schizophrenics and how Greek traditional

form of dance can create and facilitate that structure.

CHAPTER 3

THE IMPORTANCE OF STRUCTURE IN DANCE MOVEMENT THERAPY GROUP AND ITS SIGNIFICANCE FOR WORKING WITH SCHIZOPHRENICS.

3.1 INTRODUCTION

In this chapter I would like to discuss firstly, the definition of dance movement therapy mentioning the five theoretical principles which are fundamental and unique for dance movement therapy. In addition, I will describe eight guided group experiences which are of great therapeutic value in dance movement therapy groups. I would like to discuss these because they form the theoretical base of my approach in the context of the two groups of Greek schizophrenics which I run in Greece and which I describe fully in chapter 6.

Secondly, I would like to discuss how these particular elements of structure that I describe in the previous chapter are applied on the dance movement therapy group, and which structure is appropriate in dance movement therapy groups of schizophrenics.

Dance movement therapy, in order to be effective with schizophrenic patients, has to use that kind of structure

which address the patients' dysfunctions that I discuss in
chapter 1.

3.2 DEFINITION OF DANCE MOVEMENT THERAPY

According to the American Dance Therapy Association, dance
movement therapy has been defined as "the psychotherapeutic
use of movement as a process which furthers the physical and
psychic integration of the individual"(Bernstein,1979;3). It
uses the expressive aspects of movement and dance as a
therapeutic tool for personal integration and growth.
Through movement, unconscious mental process become
tangible. The dance movement therapist can create a safe
environment for such expression (Payne,1992; Stanton-
Jones,1992).

Dance movement therapy utilizes knowledge,theories and
methods of many different areas such as individual and group
psychotherapy, group dynamics, developmental psychology,
neuropsychology, nonverbal communication, movement analysis
etc.

However, dance movement therapy is a unique type of
therapy. Part of its uniqueness is in the five theoretical
assumptions which are fundamental to it and which
characterise dance movement therapy. The first one is that
there is constant interaction between body and mind and when
considerable changes take place in the movement level of the
individual these can influence the cognitive and/or
emotional level of the individual and vice versa. In

addition, the patients' connection between movement experience and verbal insight can be promoted by the dance movement therapist usually by using free association and interpretations of the movements.

The second assumption is that aspects of the personality are reflected in the movement. These aspects include psychopathology, psychological developmental processes, social patterns of relating.

The third assumption is that the therapeutic relationship between the patient and the dance movement therapist is of great importance to the effectiveness of the therapy. The dance movement therapist mainly uses nonverbal responses and interactions with the patient such as mirroring, synchronizing etc.

The fourth theoretical principle is that movement can be evidence of the unconscious processes. Movement symbols and metaphors that the patients use during the movement process help them to gain access to their unconscious.

The fifth principle is that the creative process of a movement through improvisation is of great therapeutic value. The patient through new ways of moving feels new experiences (Stanton-Jones,1992).

Particularly in doing dance movement therapy with groups, I believe that the eight group experiences which Schmais (1985) has described as "healing processes" have great therapeutic value thus, this is worth taking into consideration by the dance movement therapists. Furthermore, I believe that these "healing processes" can be composed as a guide for all movement therapists who work with groups and especially for

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new ones because it helps them to evaluate their work. In my project, in order to examine the use of the Greek traditional form of dance in groups of schizophrenics I will discuss whether it promotes the appropriate structure for them as well as if it promotes some of these healing processes.

These eight "healing processes" according to Schmais (1985) are: synchrony, expression, rhythm, vitalization, integration, cohesion, education and symbolism.

Synchrony can be viewed as the summary of early developmental processes such as when mother and child move in synchrony they can feel a shared experience (Stanton-Jones, 1992). Schmais notes that the first step towards communication is when people move in the same rhythm, and when people move in the same rhythm with the same spatial configuration they become identified with one another. Thus, a social group identification is encouraged by dance movement therapy because it offers structured activities where people are moving together in time and space. Very often movement synchrony is supported by touch, visual contact and/or sounds and words. Thus Schmais notes that synchronous activity aids resocialization and promotes contact and group cohesion. In my opinion this element is very important especially when working with schizophrenic patients because they usually face social withdrawal (see chapt.1).

There are three types of synchrony: rhythmic, spatial and effort synchrony. People who are moving in time with one another are in rhythmic synchrony. Spatial synchrony describes people who are moving in time with one another and also making the same spatial figure with the same body parts.

Effort synchrony describes people who are moving in time with one another using the same efforts, for instance one person presses with his hand and the other with his foot to the same rhythm. Initially, rhythmic synchrony develops at the evolution of the group, then spatial synchrony appears and finally comes effort synchrony when the group members are for long time together.

The second healing process is expression. Schmais mentions that patients through their participation in different rhythms, patterns and themes of the collective dance gain a movement vocabulary that allows their emotional expression. Emotional expression is the first step towards identifying them, the next step is to discover the context in which they happen and finally the willingness to change the overall emotional state which can be stimulated through the pleasure of movement (Schmais,1985).

Rhythm is another healing factor. Schmais notes that suggestive rhythms of early developmental processes can be symbolic gratification of infantile demands. thus, when the group rocks in a common rhythm they might share a regressive fantasy that holds them together. Furthermore, rhythm can give information about the developmental stage of the group, or the individual, because according to Kestenberg (1975) there are different bodily rhythms at different developmental stages.

A further healing process is vitalization. Schmais notes that motion and activity is characteristic of infancy and the first entertaining interaction between infants and adults. Many patients because of their defences or their anxiety lack

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vitality and appear powerless. Some patients because they hold back impulses and emotions for a long time they do not feel their tension or sense their immobility. Because dance movement therapy uses motion as a medium for therapy it can relieve anxiety and loosen the rigidity of the body. Especially within a group situation, the repetition of a rhythmic phrase can reduce physical inhibitions and bring into awareness covert feelings (Schmais,1985).

Another healing factor is integration. "Integration in therapy implies achieving a sense of unity within the individual and a sense of community between internal and external reality"(Schmais,1985;26). Schmais also notes that integration necessitates experience to be felt and symbolically represented, and movement must be used by the dance movement therapist as an experience that is considered or reflected on. Movement metaphors and symbols can externalize the internal state of the individual. The dance movement therapist uses also words to label, classify, discuss and reflect upon this internal state. In this way, the dance movement therapist helps the patients to integrate feelings ,thoughts and actions in the current experience of the group (Stanton-Jones,1992).

A sixth healing factor is group cohesion, a sense that a patient belongs to a group. Schmais mentions that dance movement therapy facilitates and promotes group cohesiveness through rhythmic and synchronous movements which put patients in time and in step with one another and bring them closer. Thus, when trust between group members has started to develop patients touch each other. Initially this touch is

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peripheral and lasts for a short time, but gradually it becomes less peripheral and more sustained. Thus "being a part of the dance by sharing and repeating simple steps and rhythms builds a sense of community, but it is not until people actively participate in each other symbolic statements that group cohesiveness takes roots"(Schmais,1985;31).

Another healing factor is education. Schmais notes that in dance movement therapy patients learn about themselves, relationships and life. They can gain that knowledge from their own experience, from watching and following others, and from the therapist's statements, questions or imagery with which he accompanies the dance. A study by Butler and Furham (Schmais,1985) showed that feedback is significant for therapeutic change because people learn to differentiate between attitudes that they have from the past and behaviour which relate to the here and now situation.

The last healing factor in symbolism. Schmais mentions that through symbolic expressions in dance movement therapy patients connect their internal and external worlds in a social context. Symbols can clarify old issues, express current concerns and foresee the future. It is important that symbolism allows for psychic distance from private preoccupations so it is safer and less threatening for the patients.

In the discussion chapter of this study I will discuss how successful my attempt was to follow all these as well as discuss the ways in which ways I could conduct the sessions more effectively for these particular patients.

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3.3 THE CONCEPT OF STRUCTURE AND ITS SIGNIFICANCE IN DANCE MOVEMENT THERAPY.

One of the most important questions that the dance movement therapist needs to answer before he/she starts a session is how he is going to organize it, what rules and how much directness are necessary in order to make the session effective and appropriate for the particular kind of client. Furthermore, the therapist can gain additional information by analysing certain components of the structure which then he can use therapeuticaly. In chapter 2, I discussed the definition and the most significant elements of the group therapy structure. Thus, in this section I would like to discuss how structural elements such as spatial boundaries, format/procedure, group members' roles and therapist's leadership style (see 2.2, 2.3) apply to dance movement therapy groups.

Structure of a dance movement therapy group (see also 2.1) is defined by Johnson and Sandel as "the overt, understood patterns or rules of organization which guide the group's interaction" (Bruno,1981). Bruno mentions that structure refers to how the group has organized itself to achieve overt tasks and not what these tasks are. In dance movement therapy the structure is constantly changing according to group needs and interactions. The therapist can be informed about the nature of the group functioning and his success in reading the group correctly by observing and analysing those changes (Bruno,1981).

A systematized vocabulary is developed by Johnson and Sandel in order to describe and measure the structure of group dance movement therapy sessions, known as SAMS (Structural Analysis of Movement Sessions). In my opinion, Johnson's and Sandel's work is the most complete work on the structure of the dance movement therapy group because it analyses the structure in much detail, it is very clear, systematic and easy to understand, and when used by the therapist covers the whole spectrum of the group structure. Furthermore, it provides a vocabulary of structural guidelines which helps the dance movement therapists to communicate easily. Thus, I use some components of SAMS in my results section in order to describe how the two sessions that I present were structured.

SAMS subdivided a group's activity into three structural dimensions: task structure, spatial structure and role structure (Bruno,1981; Stanton-Jones,1992), similar to the elements of structure such as format / procedure, spatial boundaries, and emergent group members' roles that I discuss in the sections 2.2 and 2.3.

TASK STRUCTURE: The task is the observable action and patterns that group does as a whole (e.g., the group is stamping feet and shouting, or the group throws the ball to each other). The task does not refer to the abstract therapeutic goals that the therapist wants to achieve by using the particular task (for instance to share feelings).

All group members may perform a task simultaneously, or some members may watch, or some members perform other tasks simultaneously. In addition, a task can have a clear and understood end, or can be repeated over and over.

Furthermore, the degree of interpersonal interaction of a task can vary. For example, a task can have no relationship to others in the group, or can be directed towards others, or can be a back and forth interaction with others.

SPATIAL STRUCTURE: A spatial structure is the group's formation, i.e., how group members relate to each other physically in the space. The four basic spatial structures are the circle (which can be double, centered, spiral or irregular), line, cluster, and scatter. All group members can form the formation, or group members in the formation can relate to people apart from it. In addition, these formations can involve touching each other or not.

ROLE STRUCTURE: The role structure refers to the formal roles that the group sets up on different group members in order to perform its activities and are different from the leadership roles that I discuss in the section 2.3 and which are part of an ongoing group process. Role structures are organized around:

(1) The leader. The leader can initiate actions which the group follows (group leader), or charge another group member to be temporary leader of a task (task leader), or can coach the group without taking part in the action (sidecoach).

(2) The object. Someone can be the focus of the group's activity, or can perform a necessary task for the group, e.g. to change a record, or can present a movement in front of the group.

(3) Subgroupings. Subgroupings can interact with each other, or not, and act independently. In these structures group members may alternate in the role of leader, object or within

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subgrouping.

These structures sometimes can be perceived by an observer and other times can not be observed because they are not clear. In other words, you cannot see if they exist because they are not formed clearly. In addition, it is possible for all group members to participate in the formation, thus the structure is stable, or for some members not to participate in the particular formation and then the structure becomes unstable.

I believe that the structure in a dance movement therapy group session is of great importance because, firstly, the therapist, by examining its specific components, can compare different groups or different parts of the same session. And, secondly, it enables the therapist to gain information about the content material or the relationship between content and structure.

For example, any disruptions in group structure (whatever component of it) make it more difficult for the patient to manage anxiety (Stanton-Jones,1992). In addition, Bruno (1981) mentions that structural disruptions might be an indication that patients feel overwhelmed by anxiety related to the task or role they have to accomplish. On the other hand, when the structure is rigid, and not flexible enough according to shifting group needs for development and support, members may be sticking to the leader and using the structure for protection against anxiety. This means that the achievement of some group goals in dance movement therapy such as active initiation and creative expression can be excluded (Bruno,1981).

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Specifically, therapists who expected the group members to show high ability to join in complex group tasks and interactions, as well as to take responsibility for structuring and controlling their own behaviour, resulted in low levels of involvement and structural stability. On the other hand, a leadership style which encouraged peer interaction, that demanded highly complex tasks but did not tolerate ambiguity in the group tasks and focused on the group's activities, making very clear to the group members rules and structures by explaining them verbally, resulted in high degree of involvement and helpful imagery. Groups showed high levels of stability and not any drop-outs or outright challenges (Johnson, Sandel, Eicher,1983).

Furthermore, the spatial formation of the circle is used by dance movement therapists mainly because it is a simple, basic and very important element of movement group experience. Sandel,S.,(1982) mentioned that the circle formation is very important for group members because it helps them to make contact and to communicate with each other. In addition, when group members form a spatial formation of a single circle with very small interpersonal distances between them it is an indication of the existance of group cohesiveness, closeness and trust (Dosamantes,1992). Furthermore, therapists can use a single circle with touch, such as holding hands, in order to solidify the group's boundaries (Johnson, Sandel, Eicher, 1983).

In addition, the circle formation helps the therapist to control the group, to see everyone and to monitor interactions. Sometimes, when the therapist shows over

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reliance on the circle formation this may indicate the therapist's anxiety about patients' efforts towards independent movement behaviour. That is to say that it is therapist's unconscious expression of anxiety when a patient leaves the circle and moves autonomously. This may be likened to the mother's anxiety when her child takes his first steps away from her according to Mahler's theory (Sandel,1982).

On the other hand, the scattered spatial formation i.e. the group members position themselves randomly within the space of the room, keeping large interpersonal distances between them, indicates low levels of trust within the group and feelings of insecurity (Dosamantes,1992).

Furthermore, Dosamantes suggests that the existence of equal size subgroups within the group, with smaller interpersonal distances in the same subgroup than between members of different subgroups reflects an increasing comfort and trust in the group. Group members in this case are open and bonded with others.

On the other hand, there can appear in the group two subgroups of unequal size where most of the participants belong to one group and only one or two participants belong to the other. Between the two subgroups there is a large interpersonal distance. Dosamantes suggests that this group splitting indicates a state of intensive conflict and confrontation. The two subgroups do not leave space for an empathic understanding between them.

Furthermore, the analysis of the movement therapy group structure can give valuable information to the therapist about the developmental stage of the group. For example,

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Dosamantes described four developmental phases of two-year long dance movement therapy groups with different characteristics of spatial patterns, interpersonal distances and subgroup formation each one. In the first phase which is called "pre-attachment" phase the group members scattered randomly within the space of the room, keeping large interpersonal distances between them. In the second phase, the "inclusion phase" subgroups of equal size appeared with smaller interpersonal distances in the same subgroup than between members of different subgroups. In the third phase, the "power phase" two subgroups of unequal size appeared with most participants belonging to one group. Within the same subgroup the interpersonal distances were small but between the two subgroups the interpersonal distance were large. Finally, in the forth phase, the "affection phase" a single circle appeared with very small interpersonal distances between the group members.

Furthermore, the therapist's leadership style can play a very important role in the effectiveness of the session and different leadership styles can have different effects on the patients. For example, Johnson,D., Sandel,S., and Eicher,V.,(1983) mention that therapists' leadership style which was characterized by minimal attention to the external boundary of the group and shows high tolerance to ambiguity and instability can result in high levels of drop-outs. In addition, the therapist's intention to pick up movement themes from the group members but not to structure them for the whole group can result in fragmented or dissipated group interaction. In chaotic moments if the therapist takes longer

to bring the focus to him using his voice or body rhythms, or to set an organizing structure this can result in lower levels of stability.

Leadership style which shows moderate tolerance for ambiguity and a control over group interaction and compose an organizing focus for the group by keeping a strong rhythm in therapist's body inviting others to join him/her, and encourage patients to be aware of him/her rather than peers, results in occurring images to him/her such as a teacher or mother. In other words, patients perceive the therapist as an authoritarian figure rather than a supportive one.

Furthermore, leadership style with active structuring and clarity of limits and boundaries can create a safe and trusting environment for the group (Johnson, Sandel, Eicher, 1983).

3.4 THE IMPORTANCE OF DANCE MOVEMENT THERAPY FOR SCHIZOPHRENIA

Disturbed movement patterns and restricted movement repertoire are one of the most important parts of the schizophrenic symptoms. For example, Martha Davis (1981; 1988) has developed a list of unique movement characteristics in schizophrenic patients based on restrictions in the use of body, spatial patterns and effort dynamics (Laban effort analysis system). A brief description of these movement characteristics is the following:

(1) Fragmentation: Sporadical movements in different body

parts with no clear sequence or connection, severely out of synchrony.

(2) Diffusion: Profound spatially defused movements with no clear directions or paths; movements without distinct beginning and ending; beginning of a new activity before the ending of the previous one.

(3) Exaggeration: More postural than gestural movements; abnormally large gestures; actions done in an exaggerated way.

(4)Fixed-invariant: Repetitive fidgeting and gesticulations; exact repetition or automation.

(5) Immobility: Body parts are still for long periods, actively held and restricted.

(6) Flaccidity: Flaccid body parts, complete limpness giving into gravity; actions performed very slowly.

(7) Low vitality: Very diminished effort qualities.

Furthermore, Liebowitz, G.,(1992) mentioned that schizophrenic patients have difficulty in relating to others on a movement level as well as they are afraid of physical touch with others and they disregard their body boundaries (see p.16).

In addition, the above symptomatology can result in a poor body image as well as in a very low self-esteem (Romero,E., Hurwitz,A. and Carranza,V.,1983).

Thus, because dance movement therapy uses the body and the body's movement as a medium for therapy it can address the above symptoms directly and effectively. In dance movement therapy the patients start to move more easily, their movements become more spontaneous and they start to perform

more complicated movements. Thus, their body image as well as their self-esteem improve greatly. Silberstein (1987) suggests that the improvement of the body image is of great therapeutic value for schizophrenics because they must first develop a coherent body image before they can develop an ego.

However, it is important when working with very regressed patients to modulate the movement to the patients' withdrawn and lethargic states rather than to overwhelm them with broad movements because it is more effective to establish contact in a non-threatening way (Silberstain, 1987).

Furthermore, dance movement therapy utilizes nonverbal patterns of communication and sympolic movements for self expression. In section 1.5, I mention that the patients' difficulty to control and/or to understand internally originated primitive experiences underpins the positive symptoms. Dance movement therapy addresses and works effectively on this psychological dysfunction because it promotes self expression and integration. That is to say that patients through their participation in different rhythms, patterns and themes of the collective dance gain a movement vocabulary that allows their emotional expression which is the first step towards identifying emotions. Furthermore, through movement metaphors and symbols the patients can externalize their internal state; the dance movement therapist uses also words to label, clarify, discuss and reflect upon this internal state thus the patients are helped to achieve a sense of unity and community between internal and external reality.

This is very important for schizophrenic patients because they can express their conflicts more easily in movement than verbally. For them language is more a defensive barrier than a mean of direct communication (Silberstein,1987). Thus they rely mainly on nonverbal patterns to communicate their emotions. In addition, Bernstein (1979) mentions that schizophrenics feel comfortable with the symbolic language of movement. They often cannot communicate through words, and verbal interpretations are not beneficial for them. The expression of needs, feelings and desires is easier for them under the camouflage of the movement symbol .

In addition, because the nonverbal communicative modes are less defended than the verbal, they can decrease the amount of the initial resistance of the patient to develop a relationship with the therapist which will be the beginning of the real therapeutic progress; in all therapies it is always very difficult with schizophrenics to develop a relationship with the therapist (Silberstein,1987).

In addition, with very regressed schizophrenics who are detached from the outside world and who experience great anxiety in any effort to make contact with the outside world, nonverbal approaches can be of great value (Silberstein, 1987).

Dance movement therapy contributes greatly to the improvement of schizophrenics interpersonal function. Through the interactive movement experience that dance movement therapy group provides they can develop their social skills, learn through imitation and participate in group cohesiveness. Furthermore, patients as they move and dance

together let other patients invade and share their own personal space and vice versa. This happens according to Romero, Hurwitz and Carranza (1983), with paranoid feelings diminishing.

3.5 THE SIGNIFICANCE OF DANCE MOVEMENT THERAPY GROUP STRUCTURE FOR WORKING WITH SCHIZOPHRENICS

The element of structure has great importance particularly when working with groups of schizophrenic patients because they are mainly isolated individuals with very impaired interpersonal contact and for them the notion of a group, most of the time, does not even exist. In addition, because schizophrenics are very confused they are helped to develop and maintain a sense of self by external organizers, such as the therapist and/or a well structure environment (Sandel, Johnson 1983). The type of structure of the dance movement therapy session that helps these patients to gain a conception that a group exists according to Sandel and Johnson (1983), is a strict maintenance of group boundaries, familiar spatial environment and ritualized tasks and roles. Group members progressively internalize tasks, spatial formations and roles which are repeatedly used in every session. Thus, they gain a basic vocabulary of interaction and the relatedness among them is improved.

In order for schizophrenics not to be put in an over-stimulating situation (see 1.5) the spatial formation used must be simple, the tasks must be simple and short in time

because schizophrenic patients concentrate more successfully on several shorter tasks than on a single longer one. For example, in my project in the group I I've used fourteen tasks and in the group II I've used nine tasks (see Chapt. 6). In addition, because of schizophrenics disorganized thinking and cognitive impairment (see 1.3), tasks must be designed according to their capacities and to provide experience of success to them.

In addition, because schizophrenics cannot maintain a clear sense of self-others boundaries (see 1.4), and close physical proximity can be frightening and overwhelming, the dance movement therapist must use spatial formations with not very small interpersonal distances.

Research on the effectiveness of group structure by Johnson,D., Sandel,S., an Bruno,D., (1984) showed that schizophrenics preferred the less complex structures such as the spatial formation of the circle, unison movement, and one task leader. Complex rules made schizophrenics anxious and confused.

Marian Chace, who is the founder of dance movement therapy, worked mainly with institutionalized schizophrenic patients. Her approach is of great value and has strongly influence subsequent generations of dance movement therapists. In addition, my approach which I present in the results chapter matches with hers.

She started the session with some warm up movements which all the group members did together. Then, in the central section there was a share leadership format in which every group member took a turn to initiate a movement and the rest

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of the group mirrored or followed. This section often contained some shared group themes. She used the circle as the basic spatial formation. The session finished with a brief discussion of what the group had done in that session.

The spatial formation of a single circle is the most important formation that is used with groups of schizophrenic patients because it promotes the group cohesiveness, interpersonal contact and communication between group members (see also 3.3), skills that are impaired in schizophrenics.

Furthermore, Sandel (1982) mentions that simply forming a circle can be the goal of the therapy of some psychotic patients because for such patients the circle is the basis of the shared external reality which constitutes the social environment of the dance movement therapy session.

On the other hand, Sandel,S.,(1982) mentioned that the circle is not the only suitable spatial formation for dance movement therapy with schizophrenics. Schizophrenic patients may try to experience new behaviours, experiences such as moving with others in small subgroups sometimes of two, leading others around the room, or participating in a team activity (e.g. see section 6.2.2, tasks VI & IX). This can help them towards autonomy because there are schizophrenic patients who are able to progress to more differentiated roles and mature relationships in the course of their treatment (Sandel, 1982).

A very important role structure for schizophrenic patients is the shared leadership structure. The underlying psychological dysfunction of the negative symptoms of

schizophrenia (see also 1.5) is the patients' difficulty to
to initiate responses and to control and direct behaviour.
The dance movement therapist by using the the shared
leadership structure - where each group member takes the role
of the group leader in turns - gives the opportunity to the
patients to initiate movements which the rest of the group
follow and to control and direct the group as well as
themselves.

Shared leadership structure is the basic structure in
organizing interaction in dance movement therapy with
schizophrenics (Stanton-Jones,1992). Furthermore, letting
schizophrenics direct and control the group for a few
minutes can be healing because they feel much more a whole
person and their self-esteem increases (Romero,E.,
Hurwitz,A., and Carranza,V.,1983).

In section 3.3 I discussed some of the meanings of
structural disruptions in any of their aspects (task, spatial
and role structure). Particularly with groups of
schizophrenic patients a study contacted by Bruno,C.,(1981)
showed that there are times in the session that structural
disruptions may occurred. For example, in the task VI of the
group I of my project (see section 6.2.1) when the male
patient breaks the spatial formation by leaving the circle,
the rest of the group withdraw from participation in the task
that the group is doing at this particular moment and from the
role that each group member has this particular moment and
they scatter.

Another occasion is when a group member, who is the task
leader that moment, initiates a spatial configuration which

is too complex for at least one member and he/she does not follow the leader but continues in the previous structure then the group can became confused and stop every activity. For example, in the task XII of the group I (see 6.2.1) the male patient can't follow the figure of eight path that I initiated and he walks around on his own, thus the group gets confused and stops the activity.

In addition, disruption in the structure can occur when some group members express anger. The group members can leave the circle, and the group give up on the task.

Furthermore, the dance movement therapist who works with schizophrenics can keep the structure of group clear and definite by using props. Bruno (1981) suggests that the use of props and the use of music increase the definiteness of the structure and decrease the disruptions in groups of schizophrenics. In addition, schizophrenic patients showed that they are strongly dependent on music.

Regarding to leadership style of the therapist, according to Johnson,D., Sandel,S., and Eicher,V., (1983), schizophrenic patients prefer the task-oriented leadership style of therapist which focus on the group activities. They show great stability of participation in therapists who does not tolerate ambiguity in the group tasks and make very clear to the group members the rules and structures by explaining them verbally.

On the other hand, the leadership style of a therapist which is characterized by minimal attention to the external boundary and expect from the group members to show a high ability to join in complex group tasks and interactions as

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well as to take responsibility for structuring and controlling their own behaviour, cause anxiety and a chaotic atmosphere in the group of schizophrenics and very high drop-outs.

In conclusion I would like to mention that in this chapter I showed that dance movement therapy is a valuable mode of therapy for schizophrenic patients because it can address and work on many dysfunctions of schizophrenics. In addition, in this chapter I discussed how the dance movement therapist must structure the session in terms of spatial structure, task structure, role structure and leadership style of the therapist in order to work effectively with a group of schizophrenic patients.

In the next chapter I will discuss the structural elements of the Greek traditional dance "Syrtos" which were used in the two groups of Greek schizophrenics of my project (see Chapt. 6). Thus, then I will have the opportunity to discuss if this form of dance – from a structural point of view and according to what has been discussed in this chapter about the most effective structure for schizophrenics – is useful and appropriate to be used with them.

CHAPTER 4

STRUCTURAL DESCRIPTION OF A GREEK TRADITIONAL DANCE CALLED "SYRTOS"

4.1 INTRODUCTION

In this chapter, I would like to discuss some of the structural aspects of Greek traditional dances and particularly of a dance which is called "Syrtos or Kalamatianos", because this particular dance was introduced by Greek chronic schizophrenics in a dance movement therapy group which I run in Greece during the summer '93. In addition I would like to discuss some of the meanings that Greek traditional dances have within the Greek culture.

Indeed the traditional dance in Greece is a cultural phenomenon and is linked with the social and historical background of the country. But firstly, I would like to discuss briefly two questions. What do we mean when we say culture and what is its significance in dance movement therapy.

According to Hanna "culture is a dynamic ever-changing phenomenon encompassing the values, believes, attitudes, and learned behaviour shared by a group"(Hanna,J.,L., 1990;116). Hanna mentioned that people of the same ethnicity, race, age, sex, occupational group and so on, can be conceived as

belonging to the same culture.

Among different cultures the nonverbal behaviour and movement patterns which are characteristics of a particular culture may differ significantly. For example, a gesture which has a particular meaning in one culture may mean nothing or have another meaning in another culture. In addition, the unconscious distance-setting among members of a culture is different in various cultures (Dosamantes,I.,1992).

Therapy can be effective when if one is able to understand the cultural and ecological patterns which manage a clients life. For example, how the client might conceive differently concepts of mind, body, time, space, and other features of every day life and the arts. The dance movement therapist needs to integrate the relationships between body and self which originates from biology with the relationships between body and self which originates from within social and cultural forms. When a client's perspective is different from the therapist's theory and methods, then a barrier is created to the healing process as well as new anxiety being put on the client (Hanna,J.,L.,1990).

Thus, Hanna,J.,L.,(1990) believes that it is necessary for dance movement therapists to understand the meaning of behavioural patterns in different cultures and to be flexible in their work in order to work therapeutically with demographically changing populations. When the therapist is aware of other peoples' belief system and behaviour, this can better serve them. In addition, the theory and practice of dance movement therapy can be promoted by recognizing different cultural patterns. For example, by knowing the

significance of the Greek traditional dances for the Greeks the dance movement therapist, when working with Greek patients, can have a better understanding of his patients. Furthermore, the dance movement therapist can use the Greek traditional dances in order to facilitate the therapeutic process.

4.2 STRUCTURAL ASPECTS OF "SYRTOS"

Greek traditional dances are divided into the Greek national dances and the local dances. The Greek national dances are danced all over the country in the same way. There are two national dances: The "Syrtos" which also can be found as "Kalamatianos", and the "Tsamikos". Both of them are circular dances. Local dances are different from one geographical region to the other(Dimas,1986).

Most Greek dances are group dances and the role of the dancer in the group is regulated by purely local rules. Usually, the dancer functions as a member of the team and performs the fixed movement sequences of the particular dance. Occasionally, he/she can perform some improvisations (Loutzaki,1985).

Loutzaki (1985) and Dimas (1986) mentioned that Greek traditional dances are divided into four categories according to their spatial formation:

1) The circular dances. Dancers dance in a circle holding each others hands or shoulders, and form a chain. The circle can be

a closed circle or an open one. There are also some dances that take a spiral spatial formation.

2) The "face each other" dances. In these dances dancers dance facing each other. In some dances dancers form two lines one opposite the other.

3) The dances of pairs. In these dances male dancers dance with female dancers in pairs. Couples can join hands or not depending on the particular dance. The couple can be either part of a larger group or an integral formation on its own. Usually, in these dances the two dancers improvise on a given theme.

4) The single individual. In this dance the dancer dances by his/her own improvising on a given theme, using all his/her virtuosity.

The spatial formation of Syrtos is an open circle. Dancers hold hands and form a chain which moves in the circle in an anti-clockwise direction. Sometimes dancers may hold handkerchiefs and one holds the handkerchief of the next dancer (Crosfield,D.,1948).

There are twelve basic steps that all dancers dance in unison. These steps are in a forward, backward and sideways direction. Also, one leg can cross over the other. These steps include some hopping movements. There are not any arm movements or gestures except by the first dancer of the chain (Dimas,I.,1986; Crosfield,D.,1948).

The first dancer of the chain who can be a man or a woman is the leader of the dance. Only the first dancer can perform improvisations during the dance (Loutzaki,R.,1980, Raftis,A.,1985). He can perform intricate variations of the

steps, jumps, swirls, sinkings etc., while the rest of the

dancers continue the basic steps. These improvised movements

are called "scherza" or "figoures". From time to time the

leader can leave the chain to perform scherza and then join

the chain again. Thus, the leader gives to the dance something

of his/her personal style and character.

4.3 GREEK TRADITIONAL DANCES WITHIN THE GREEK CULTURE

According to Dosamantes,I.,(1992), Snyder mentions that

there are three factors on which the meaning of any dance form

within a culture depends. The first factor is the environment

which affect people who live in a geographically defined

region. The second factor is the subsistence patterns that

people must utilize in order to survive in that environment.

The third factor is the mythic complex of the culture.

The three of these factors influence the meaning of the

Greek dances as well. But what the Greeks exactly means when

they use the concept of dance ? Loutzaki (1985) mentions that

for Greeks dance is not a "choreographic creation" in the

strict sense of the term, meaning the performance of

particular steps in a particular order. Movement, lyrics and

melody are inseparably associated with dance, and "by these

three means Greeks give kinetic expression to the emotions

and mental reactions they experience on certain specific

occasions in their life" (Loutzaki,R.,1985,p.17). Thus, the

concept of dance includes the actual performance of dance,

the particular circumstances that the dance takes place and

the people who participate. Greeks regards dance as a group activity.

Usually, the Greeks dance at national celebrations, at weddings, at Easter, in the three weeks of pre-Lenten festivities, at the annual festival on the feast-day of the local church's patron saint, at public dances in the village square, at family celebrations, or even at work. The main purpose of dancing is for people to amuse themselves as well as to socialize and improve their relationships with others (Raftis,A.,1985).

In conclusion I would like to say that "Syrtos" is a well-structured and well-organized dance. The comparison of its structural aspects with the structure that a dance movement therapist must use when working with schizophrenic patients shows that there are many similarities.

That is to say that, "Syrtos" dance is danced on a circular spatial formation and, as a task, is very simple to be performed. Circular spatial formation and simple tasks are both very effective with schizophrenic patient (see 3.4). In addition, "Syrtos" has very simple rules and the dances have very clear roles which is beneficial when working with schizophrenics (see 3.4). That is to say that always there is a leader of the dance who is the first dancer of the chain and the rest dancers have to follow him. Only the leader of the dance can perform improvisations during the dance. All dancers can be leaders of the dance in turn which is similar with the shared leadership structure (see 3.4).

On the other hand, with regard to the physical contact that

the Greek dance "Syrtos" involves, this can be counter-therapeutic for schizophrenics because it can raise their anxiety (see 2.4). In that case, the therapist can ask the patients to hold handkerchiefs and the one to hold the handkerchief of the next, or he can ask the patients who cannot tolerate physical contact to follow the others or to lead the dance from a distance.

In addition, I would like to mention that Greek traditional dances are an inseparable part of the Greek culture and have a special meaning for the Greeks. They are not simply choreographic movements but they are linked with emotional expression and particular occasions. Thus, the initiation of the Syrtos dance by the Greek schizophrenic patients at the two dance movement therapy groups that I led, might has a significant meaning for them and needs to be explored.

In addition, in the next chapter I'll discuss the methods I used to collect the relevant data. This data will form the basis for the discussion in the last chapter as well.

CHAPTER 5

METHODOLOGY

5.1 DEGIGN

This study is going to discuss the importance of the structure in a dance movement therapy group session with Greek schizophrenic patients and explore the use of structure in order to create a positive therapeutic environment. In addition, I would like to discuss from a structural point of view, the significance of Greek traditional dances as used with Greek schizophrenic patients and how Greek traditional dances can became a useful therapeutic tool for the therapist. An examination of dance movement therapy session of two different groups of schizophrenic patients is utilized to explore the above points.

Thus, a critical review of the structure and leadership style will be employed to explore the initiation of schizophrenic patients' use of the Greek traditional form of dance in a therapy session. I decided to do this because I believe that is very important for a therapist and especially a new therapist to learn from his experience.

In the summer 1993, I was engaged in a position in Greece as a dance movement therapist for three months. I worked with long-term institutionalized patients and I was the only dance movement therapist employed by the institution. In addition, it was the first time that a dance movement therapist had worked at this institution and the patients had participated in dance movement therapy sessions.

When I conducted this study I was a first year student, thus my approach was a combination of all I had learned till then. That is to say, that I knew about the structure of a session but not about certain interventions or how to use, therapeutically, concepts such as transference or countertransference etc. I considered the most important thing was to accept as the starting point the level the patients had reached. What I tried to do in my approach was to be close to the five fundamental theoretical principles, (Stanton-Jones, 1992), (see appentix 1, table 5.1). In addition, it was in my intention that my orientation would be in accordance with the eight "healing processes" (Schmais, 1985), (see appentix 1, table 5.2).

This study explores a phenomenon (the initiation of the Greek traditional form of dance) which I recorded as a reoccurring phenomenon in a videocamera and in a journal book. The videocamera was present in all sessions. In addition, I maintained a journal of all sessions to fill in what occurred in each session. Thus, my strategy was the observation of the video tapes and reading the journal book. In addition, two independent movement observers reviewed the video tapes and answered a questionnaire devised by me.

5.2 SUBJECTS

All the participants in this study are long-term hospitalized patients who have spent at least the last twenty five years of their lives in a large psychiatric hospital. In 1990 the Greek Health Department decided to start a deinstitutionalization and rehabilitation programme. Thus, patients of this psychiatric hospital went to eleven different rehabilitation institutions at different regions of Greece. The role of those institutions is to prepare the patients to live in the community. The doctors evaluate when the patients are capable to live independently in the community, otherwise they remain in the security of the institution. This study took place in one of the eleven rehabilitation institutions.

In my study, all the patients volunteered to participate. Before I started any session I explained to all of them the procedure outlined in the study. Then I read and explained to them the consent agreement to participate in investigational research. This form is according to Laban centre standards. The patients who decided to participate were asked to sign this form. In addition, the institution gave me written permission to do this study. The original forms are located at Laban centre. In the appendices there is a sign form and a copy of the document that records the institution's permission for me to undertake the recearch.

When the number of the participants become known the

institution decided to divide them into two groups, and asked me to start dance movement therapy with both groups. The team which made this decision consisted of one psychologist, the manager of the institution and two nurses. I am not aware of the exact criteria they used to divide the patients into those two groups because I did not participate in this process, although I asked to be included.

Two male and four female patients participated in my study, their ages being between forty-five and sixty-one years and the mean of their ages was 53.8 years. They are Greeks and come from the same geographic region. All patients had been diagnosed as suffering from schizophrenia when they were admitted for first time to a psychiatric hospital and they were under anti-psychotic medication. Group I consisted of one male and one female patient, and the group II consisted of the female patient A, the female patient B, the female patient C, and the male patient.

GROUP I:

Male patient: He is 61 years old. He has one older brother. His first admission to a psychiatric hospital was in 1953 for one year. He was admitted again in 1954 and in 1956. Both times, he stayed in the hospital for a few weeks. In 1960 he had his last admission. Since then he has lived in the hospital. His treatment was anti-psychotic medication and ECT.

Female patient: She is 55 years old and she is the youngest child of the family. She had two sisters and one brother. Her father and her oldest sister died in a psychiatric hospital.

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Her brother was killed during the second world war. In 1956, at the age of 18 she was admitted to the hospital where has lived till now. Since 1972 till 1976 she attempted to commit suicide several times. Her treatment was medication and ECT.

GROUP II:

Female patient A: She is 55 years old and she has five brothers. In 1954, at the age of 16 she was admitted to the hospital where she has lived till now. She was under medication.

Female patient B: She is 45 years old and she is mute and partly deaf. She had her first and last admission to the hospital in 1966, when she was 18 years old. Her treatment was medication.

Female patient C: She is 57 years old. She has six brothers and she is the third child of the family. When she was six years old she was adopted by her uncle. Her step father raped her and in 1951 she was admitted for the first time to the hospital at the age of 15. Her second and permanent admission was in 1953. Her treatment was medication and ECT. In addition she had a psychosurgery operation in the brain.

Male patient: He is 49 years old and he is the only child in the family. His father died when he was a child. In 1963 he was admitted to the hospital at the age of 19. He suffers from epilepsy as well. His treatment was medication.

The Greek traditional form of dance that the patients introduced in the sessions is the circular dance "Syrtos". I

discuss this dance in details in chapter 4.

5.3 DESCRIPTION OF THE STRUCTURE

The therapeutic team of this institution consists of one psychiatrist, one psychologist, one social worker and five nurses. There are regular meetings of the team once a week where a variety of issues are discussed. I have not participated in any of these meetings, although I asked to do so.

Each session took place in the same room, at the same time and on the same day of the week. The room was located on the ground floor of the institution building next to the lounge. The dimensions of the room were approximately eight metres by six metres. There were two windows and one mirror in the room. Also, there was a table and a lot of chairs.

The duration of each session was one hour. The available props for use were a stretching cloth, an elastic band, a parachute, a skipping rope, a balloon and two small soft balls. The choice of music that the patients had was Greek easy-listening music, Greek traditional music, disco or classical music.

I was the leader-therapist of the group and there was not a co-therapist.

Each session consisted of three main parts, the warm up, the process and the closure. The session begun with a very brief discussion. In this discussion each group member spoke about anything he/she wanted to bring up in the group and/or

they discussed their previous week. After that brief discussion there was a warm up led by me. In the warm up the patients were prepared physically and emotionally for the session.

The second part of the session, the process, was the longest part. In this part all the group members took the leadership in turns and initiated a movement which the other group members followed. In this part the patients explored non-verbal metaphors and symbols.

The session finished with the closure part which was a discussion about patients' experience in the movement part. For example, they could recollect the actual activities that had happened in the movement or they could speak about their feelings or thoughts that they might have had during the session. In addition, in this part the patients had the opportunity to verbalize the metaphors and symbols of the process. In that way, issues, metaphors, images etc. of the process part could be clarified and identified. Thus, the patients could realize their own feelings and behaviour.

5.4 DATA COLLECTION

Each group participated in ten sessions, with one session per week. The method of data collection used was the observation of one session of each group. The selection procedure of those two sessions being random and selected after I had completed all the sessions.

The procedures I used for gathering information were as
follows:

Videotaping. I videotaped all the sessions. The patients
were told in advance that the sessions would be videotaped.
The camera was in one corner of the room and left to run
itself. Because these videotapes are confidential they may
not be seen by anybody except myself and the two independent
observers.

Journal . I Wrote down in a journal the main content of each
session such as the structure, the tasks, the group
formation, the symbols and metaphors etc. I wrote these notes
directly after each session.

General liaison with the staff. I had a meeting with the
psychologist once a week. In addition, I had access to the
clinical files for background information, diagnosis,
medication etc.

Two independent qualified movement observers, Carola Gross
and Walli Meier, reviewed the video tapes separately and
answered a questionnaire which is devised by the author (see
appendices).

I will describe the two sessions by using some aspects of
the SAMS (Structural Analysis of Movement Sessions)
developed by Johnson and Sandel which is described in chapter
3. I use these categories because I believe that they are very

analytical, simple to use and they help me to gather information which is relevant to my work.

CHAPTER 6

RESULTS

6.1 INTRODUCTION

This chapter describes some clinical tasks. Two sessions, one from each group, are presented. In addition, it describes the responses to my questionnaire of the two independent movement observers. The information presented in this chapter will form the basis for discussion outlined in the next chapter.

6.2 PRESENTATION OF THE TWO SESSIONS

6.2.1 GROUP I

This session is the 6th session of the ten that group I followed. Group I consists of one male patient 61 years old and one female patient 55 years old.

When the patients arrive in the room for the session I am sitting on a chair in the middle of the room. I ask them to take a chair and to sit wherever they want in the room. The

female patient sits on my right about one meter from me and the male on my left about two meters from me. Thus, we form a semi-circle spatial formation with myself sitting in the middle.

I ask them to choose the music for the session and they both choose Greek traditional music.

WARM UP.

I ask them to follow the actions that I will initiate in this first part of the session. I initiate simple movements low in complexity such as moving shoulders up and down, rotating arms, bending the torso, extension of the legs etc. I give verbal directions and feedback for every movement that I introduce. The group follows me in every movement. During the warm up the group is sitting on the chairs.

PROCESS

TASK I

When the warm up is finished I ask the male patient to introduce a movement with or without a prop and the rest of the group follow him. He stands up, goes where the props are, brings a small ball and sits down. He suggests throwing the ball to each other. Thus, the whole group while sitting participate in this activity. Every time that someone fails to catch the ball and the ball goes away the female patient leaves her chair and brings the ball back. I follow the group without giving any extra directions or movements. I only

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verbalize what happens in the group in as far as who throws the ball to whom, who brings the ball back to the group etc.

TASK II

Suddenly, and when the ball is in the male patient's hands, the female patient stands up, goes where the props are and brings a balloon. Then the male patient leaves the ball and the female patient suggests continuing the previous task using now the balloon. The group easily agree to follow the female patient's suggestion. I have the same reaction as I had in task I.

TASK III

For a second time, when the balloon was in the male patient's hands, the female patient stands up and takes a skipping rope. She puts it on the floor creating a circlular formation. Then she walks over it having one step in the circle and one step out of the circle. The male patient stands up and copies her movement. I do the same too. The group repeats the same action several times in turns. When one group member steps in and out of the circle the other two members watch and wait their turn standing in a line formation. Then I alternate the task and I suggest jumping in and out of the circle. I do it first and the patients follow me.

After a few turns the male patient asks the female patient to bring another prop and to introduce another activity. I interrupt and ask him to choose the next activity.

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TASK IV

Then he goes and brings an elastic band of which both ends
are tied together. He asks the group to hold it and to pull
back in order to tighten it. The group holds the elastic in a
circle formation and pull back coping his movement. Thus, the
circle becomes bigger and bigger and I verbalize that. Then
the male patient leaves the elastic band and goes towards his
chair asking me how much time is left to the end of the
session. While I answer him the female patient brings the
parachute and gives it to us to hold. Thus, the male patient
doesn't sit down.

TASK V

The group holds the edge of the parachute and tightens it
and forms a circle around the parachute. Then the female
patient goes under the parachute and puts her head into a hole
which is in the centre of the parachute. I ask her what she
looks like and she answers that she looks like a priest. I ask
her what a priest does and she answers that he reads a book.
Then she leaves the centre of the parachute and goes to her
previous position. The male patient does exactly the same as
the female patient did before. He says that he looks like a
priest, too. After that and without saying anything he leaves
the group, sits down on his chair about three metres away from
the rest of the group and watches them. I continue to hold and
shake the parachute with her and I tell him that if he wants
he can sit down and watch from there without participating
actively in this activity. He simply agrees with me with a
head movement. The female patient leaves the parachute on the

floor, goes to where the props are and brings a stretching cloth.

TASK VI

She gives the stretching cloth to the male patient (he is still sitting) and to me to hold. She holds it as well, and she asks the group to pull the cloth in order to tighten it. Thus, all the group is around the cloth in a circlular formation and pulling it. After a while the male patient drops the stretching cloth. It seems that he is not interested to continuing participating in this activity any more and he looks around the room. I continue to pull the cloth with the female patient for a little more. Then she takes the cloth and puts it back with the other props.

At that moment there seems to be confusion in the group because nobody initiates anything. People scatter about the room so I ask the group if someone wants to introduce the next activity. The female patient says "Lets dance, now."

TASK VII (Greek traditional dance).

At once the male patient stands up, holds with his right hand the female patient's left hand and with his left hand my right hand. Thus, the group forms an open circle with the female patient as the first person of the chain, the male patient in the middle of the chain and myself as the last one. So the dance starts with the female patient leading. The chain moves anti-clockwise in a circular path and the people facing the centre of the circle. During the dance the female patient who is the leader introduces turns as "scherza" (movement

improvisations, see chapter 4). These turns are supposed to be followed by the group simultaneously. So, one step before she does the turn around herself, she says loudly to the group "..turn..". Then she leaves the male patient's hand, does a turn and holds his hand again. She performs a turn every twelve steps always with a warning one step before. I follow her initiative but not the male patient. After a few minutes she goes to the end of the chain, holds my hand and leaves the male patient to lead the dance.

He continues the dance as a leader and initiates exactly the same "scherza" as the female patient but without giving warning to the group when to turn. However, the group manages to follow him. After a while he goes to the end of the chain and holds her hand leaving me as first dancer.

I continue for a few minutes to dance in the same way as they danced before. Then I suggest to the group continue dancing but without holding hands now. They try to do that but after a few seconds the group scatters in the room, they stop dancing and go to their chairs. The female patient first sits down then the male. I follow them and I sit down as well.

TASK VIII

Everybody sits in the same position that they were in the beginning of the session. People look at each other without speaking or doing anything. I break this silence and stillness by asking the group if there is anyone who wants to introduce a movement. Then the female patient still sitting starts a movement sequence. She moves simultaneously both arms up over her head, then behind her back, then open on both

sides and finally she stretches them in front of her chest. She repeats this movement sequence several times and the rest of the group copies her movement. Afterwards she passes the leadership to the male patient and she asks him to introduce a movement.

He does exactly the same movement sequence as the female patient did before but he adds at the end one more movement. He crosses his arms and puts them on his chest. The rest of the group follows him. He repeats this sequence three times and then he passes the leadership to me by naming me.

I initiate rhythmic clapping according to the music. The patients follow the clapping having, especially the male patient, some difficulty to catch the rhythm. After a few minutes I pass the leadership to the female patient.

She does her first movement sequence adding bending the torso and touching the floor between her feet with her hands. The rest of the group does her movements with her. After a few repetitions of her movement sequence she passes the leadership to the male patient.

He repeats his previous movement sequence again. The group follows him and after four repetitions he passes the leadership to me.

I suggest to the group that as we sit we can hold our hands and move them up and down. Thus, we hold our hands and move them. Then I ask the female patient to introduce a movement.

She asks the others to make fists and with her fist claps on others fists while she sings a song. Then she says to the group to do what she does. I ask her if there is a particular meaning

to this movement. She answers that this is a game she used to play when she was a child. The male patient doesn't clap on others fists. Then she stops and tells the male patient to continue with another movement.

He stamps his heels on the floor and the others follow him. After a few seconds he stops and asks me to continue.

I take his movement and I change it a little. So I stamp the soles of the feet and they follow me. Then I pass the leadership to the female patient.

She does the movement sequence that she did when this task started and passes quickly the leadership to the male patient. He does his first movement sequence of this task, too. After two repetitions he passes the leadership to me.

I stretch my arms on both my sides and I move them slowly up and down. The male patient stops after a few seconds and watches. The female patient says that we look like flying pigeons. Then I pass the leadership to her.

She opens and closes her fists. The male patient stops and watches. Then she passes the leadership to him. He just repeats his previous movement sequence and passes it to me.

TASK IX

Then I change the task. I ask them to stand up with me. We hold each others hands forming a close circle and facing the centre of the circle. Then I suggest each of us pull the other two simultaneously. The group stays with this task only for a short time because firstly the female patient and shortly afterwards the male patient leave the circle and go back to

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their chairs. I follow them and sit down as well.

TASK X

I ask the group if someone has a movement to suggest but nobody answers or initiates anything. They just look at each other. The female patient makes a minimum movement with her foot so I start mirroring her and I suggest the group follows this movement. Thus, the male patient starts to move his foot in the same way with the rest of the group. After a short time the female patient stops moving her foot and when the male patient sees that, he stops too. Then I ask him to continue with another movement and he does his usual movement sequence stretching both arms up over his head, on both his sides, behind his back, in front of his chest and finishes by crossing them on his chest, only once and then he stops. I ask him if he wants to continue and he answers "No..".

TASK XI

Then I stand up and I take the skipping rope. I show them how to skip using the skipping rope. The male patient stands up, takes the skipping rope from my hands and tries to skip. The female patient stands up as well, comes closer to me and watches the male patient skipping. Then the male patient gives the rope to her and he walks around the room looking at the floor. Sometimes he looks at us. I stay with the female patient who is skipping. After a few walks around the room the male patient goes to his chair. He sits down and puts his hands on his face for a while. The female patient looks at him, stops skipping, goes to her chair and sits. I ask them if they want

to continue this activity but they answer "No..".

TASK XII

After that I suggest another activity. I ask them to form a line with myself first of the line, the male patient behind me and the female patient behind him. So I walk around the room in a figure of eight path and the others follow me. After a while the male patient leaves the line and walks around the room on his own without looking to the others. The female patient who is behind him at that moment gets confused not knowing whom to follow. Then she decides to follow me. I verbalize what happens in the group.

After that I change a little the task. I take two chairs and I put them one opposite the other. There is about three metres distance between the two chairs. Again the group forms a line and follows me. Now I walk in a figure of eight path among the chairs. The male patient joins the group behind the female patient. Afterwards I leave the female patient to lead the group and I go last. She walks around the two chairs in a circle and not in a figure of eight. After a while she leaves the male patient first and she goes last behind me. The male patient does exactly what the female patient did before. Then he again leaves the group and stands in front of a mirror looking at and touching his face. The female patient follows him.

TASK XIII

I stand with them in front of the mirror. The male patient is next to me on my left and the female patient next to him. We

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all face the mirror. Then I explain to them the next task. As
we look into the mirror I name a body part and they touch it.
The group stays with this task for a few minutes till the time
that the male patient leaves the group, goes to his chair and
sits.

TASK XV

After that the female patient leaves the mirror and starts
to walk around the male patient. I follow her verbalizing what
is going on. She changes the walking into running around him.
Then she says that she is tired now and sits. I sit down as
well and I tell them that this was the last activity for that
day.

A discussion about what happened in the movement part of the
session follows.

Table 6.1 *Spatial formation of session*

TASK I	All group members form a half-circle. There are large interpersonal distances. The female patient is closer to me than the male patient.
TASK II	The same as task I .
TASK III	All group members form a line standing one behind the other. There are small interpersonal distances.
TASK IV	1.All group members form a circle. The interpersonal distances at the beginning are small but gradually become larger and larger. 2.The group members scatter in the room. The interpersonal distances are very large.
TASK V	1.All group members form a circle. When a group member goes into the middle the formation changes into line. There are small interpersonal distances. 2.The female patient and I form a line. She is close to me. The male patient is away from us.
TASK VI	1.All group members form a circle with small interpersonal distances. 2.The group members scatter in the room with very large interparsonal distances.
TASK VII	(Greek traditional dance) : 1.All group members form an open-circle, touching each other.

	2.All group members scatter in the room with very large interpersonal distances. 3.All group members are sitting forming a half-circle (see task I).
TASK VII	All group members are sitting forming a half-circle (see task I). For a while the group members touch each other.
TASK IX	1.All group members form a closed-circle, touching each other. 2.All group members are sitting forming a half-circle (see task I).
TASK X	The same as task I.
TASK XI	1.All group members are clustered around with small interpersonal distances. The female patient is closer to me than the male. 2.The female patient is close to me and the male patient walk around the room away from us. 3.The group is sitting forming a half-circle (see task I).
TASK XII	1.All group members form a line with very small interpersonal distances. 2.The group members scatter in the room with very large interpersonal distances. 3.The female patient and I form a line with very small interpersonal distances. The male patient is away from us.

	4.All group members form a line with very small interpersonal distances.
TASK XⅢ	1.All group members form a line with very small interpersonal distances.
	2.The female patient and I form a line with very small interpersonal distance. The male patient is sitting on his chair away from us.
TASK ⅩⅣ	1.The female patient and I form a line running around the male patient. The interpersonal distances are small.
	2.All group members are sitting forming a half-circle (see task Ⅰ).

Table 6.2   *Group members roles and subgrouping*

WARM UP	I am the leader of the group and the group members follow my initiations.
TASK Ⅰ	I order the male patient to be the leader of the group. The female patient is the person who always brings the ball back to the group. This is her decision and nobody ordered her to do it.
TASK Ⅱ	The female patient decides to become the leader. Also, she keeps her previous role.
TASK Ⅲ	1.The female patient remains the leader. In turns, each group member becomes the focus of the group by presenting the action in front

	of the rest group. 2.I take the leadership from the female patient. 3.The male patient tells the female patient to be the leader of the next task. I don't agree with him and I tell him to be the leader of the next task.
TASK Ⅳ	1.The male patient is the leader. 2.For a while nobody is the leader.
TASK Ⅴ	The female patient takes the leadership. She becomes the focus of the group firstly, and the male patient secondly. In the second half of the task there are two subgroups. One subgroup consists of the female patient and me, and the other subgroup consists of the male patient.
TASK Ⅵ	1.The female patient continues to be the leader. Only for a short time the previous two subgroups appear. 2.There is not a leader.
TASK Ⅶ	(Greek traditional dance) : 1.The female patient takes the leadership. 2.She passes the leadership to the male patient. 3.He passes the leadership to me. 4.The group stops following me and follows the female patient.
TASK Ⅷ	1.There is not a leader.

	2.The female patient takes the leadership. 3.All group members take the leadership in turns.
TASK IX	1.I am the leader of the group. 2.The group stops following me and follows the female patient.
TASK X	1.Nobody takes the leadership, so I become the leader and I tell the group to follow the female patient. 2.I pass the leadership to the male patient.
TASK XI	I become the leader. Each group member performs the activity in front of the rest of the group. There are two subgroups. The female patient and I comprise one and the male patient comprises the other. Afterwards the female patient joins the male patient thus the two subgroups change.
TASK XII	1.I continue to be the leader. For a short time there are two subgroups. One subgroup consists of the female patient and me, and the other of the male patient. 2.Each group member takes the leadership in turns.
TASK XIII	I become the leader. The previous two subgroups appear.
TASK XIV	The female patient become the leader. The same two subgroups continue to exist.

6.2.2   GROUP II

This session is the 7th session of the 10 that the group II participated in. Group II consisted of three females and one male patient. I will identify the three female patients as : female patient A, female patient B and female patient C. The male patient is 49 years old, the female patient A is 55 years old, the female patient B is 45 years old and the female patient C is 57 years old. An additional piece of information about the female patient B is that she is mute and partly deaf.

Furthermore, the female patient C didn't participate in this session. I weas informed by the institution in advance about that.

The starting procedure of the session is the same as in the previous session. Thus, the group is sitting in a semi-circular spatial formation. The female patient B is on my right about two metres away from me. The female patient A is on my left about half metre away from me and the male patient is on the female patient A's left, about three metres away from her. I ask them to choose the music for the session and they all agree on Greek traditional music.

WARM UP.

The warm up is very similar to the warm up of the previous session. In the first half of the warm up the female patient A does not participate in any movement. She only looks at the others. I verbally encourage her to follow the group, and

finally she decides to participate in the second half of the warm up.

PROCESS

TASK I

The warm up is finished and I ask the group if there is someone who would like to continue by introducing a movement or an activity using one of the props. The male patient responds to me, stands up, goes where the props are and brings to the group a balloon while the rest of the group waits for him. When he comes back he gives the balloon to the female patient A and sits on his chair. Then she throws the balloon to the female patient B and from that point the group starts to throw the balloon to each other. All the group members are involved in this activity. During the task, the female patient A gives verbal directions to the group such as who to throw the balloon to. The group seems to respond to her directions. Suddenly, the female patient B stands up and continues the activity standing. Now the group forms a close circle with three members sitting and one member standing. Every time that someone fails to catch the balloon and it goes away from the group, the female patient B goes and brings it back. Once, when the balloon falls on the floor near the female patient A and she tries to catch it the female patient B leaves the group, goes to the mirror and looks at herself. When the female patient A manages to catch the balloon the female patient B returns to her previous position and continues to participate in the task. After a while she goes

back to her chair and sits.

TASK II

Afterwards I tell the group that now it is female patient
A's turn to choose an other prop. She goes and takes a small
ball. Then she comes back and sits on her chair. She suggests
to the group repeating the previous task but using this time
this small ball. So the group starts to throw the ball to each
other. The female patient A continues to direct the rest of
the group to whom they should throw the ball. The female
patient B stays standing for a while, as she did in task I, and
then sits on her chair again. Every time that the ball goes
away from the group she brings it back.

The female patient B stands up again. Then the female
patient A suggests throwing the ball at the ceiling. I start
first, then the female patient A and then the male patient.
When the ball goes to the female patient B she doesn't throw it
to the ceiling but to me. She does the same when her turn comes
for second time. Then she sits on her chair and the group
continues with throwing the ball to each other. After a few
minutes she stands up again.

Afterwards the female patient A suggests again to the group
to throw the ball to the ceiling. This time everybody follows
her suggestion but after a few minutes the group changes again
the task and sometimes throw the ball to the ceiling and
sometimes to each other.

TASK III

The group stays in this activity for a few minutes and then

the female patient A suggests the group stop this task and continue with the parachute. I say that it is the female patient B's turn to choose the next task. So I ask her to decide what will be the next activity. While the female patient B walks to the place that all the props are, in order to take one, the female patient A tells her "Take the parachute". Finally, the female patient B brings two props, the parachute and the elastic band. She puts the elastic band on her chair, holds the parachute by its edge and gives it to the rest of the group to hold, as well. Thus, the group stands up forming a circle around the parachute, holding and tightening it. The female patient A walks under the parachute, while the others hold it, and puts her head in the hole in the parachute. Then she turns herself around once, puts her head out of the hole, holds again the parachute and sits on her chair.

Afterwards each group member copies her movement sequence. During this the female patient A gives instructions who and how to do it. When and the last one finishes I ask the male patient to introduce the next activity.

TASK IV

He takes the elastic band, of which both ends are tied together, from the female patient B's chair. He puts it around his back and asks the others to do the same. The rest of the group members respond, so the group forms a circle which is included in the circle that the elastic band forms. Then he says to everybody to walk backwards so the circle becomes bigger and bigger. Only the female patient A can not walk

because she is sitting. Afterwards the male patient says that he doesn't want to continue with this task any more. So I tell the female patient A that it is her turn to introduce the next activity.

TASK V

She goes to the props and brings the stretching cloth and the skipping rope. Meanwhile, the female patient B comes and asks me to dance with her. I answer that she can introduce a dance when it is her turn to initiate an activity and she agrees with me. The female patient A sits again on her chair, puts the skipping rope on the floor next to her and tells the group to hold the stretching cloth and to pull it. Thus, the group is around the stretching cloth and pulling it simultaneously. The female patient A is sitting and the rest are standing.

After a while the female patient A leaves the stretching cloth and just looks to the rest group members who continue this activity.

TASK VI

After a few minutes the female patient A takes the skipping rope from the floor. The female patient B approaches her, takes it from her hands and starts to skip while the rest of the group members watch her. After a while the female patient A stands up and goes to the female patient B. She stops her, takes the one end of the rope from patient B's hand and she gives it to the male patient. Then she asks them to hold the rope tight near the floor and she walks over it. She does this

a few times and then sits on her chair again, watching the others.

After that the male patient asks me to jump over the rope. I agree with him, so I jump over the rope that he and the female patient B continue to hold. Then I tell the female patient B to take my position. So, I hold the rope with the male patient and she jumps over it. After a while she changes roles with the male patient. When he finishes I suggest the group continue the same task but in pairs. In other words, two group members hold the rope and two group members jump over the rope simultaneously. The female patient A stands up and joins the group. Then the group decides that the one pair should consist of the male patient and myself and the other pair consist of the two female patients. Firstly, the male pair jumps.

Both pairs finish the task and the female patient B suggests the group continue with a Greek dance.

TASK VII (Greek traditional dance).

The group agree with her and I ask who is going to lead the dance. Immediately, the female patient B goes first and the group join hands. I am the second dancer in the chain, the female patient A is the third and the male patient is the last one. So, the group starts to dance. The way of dancing is the same with the group I except one difference. In this group the members do not initiate as they dance any extra movements called "scherza". While the female patient B is still the leader of the dance the female patient A leaves the chain and sits on her chair. She watches from there the rest of the group dancing.

After a few minutes the female patient B goes to the end of the chain and the male patient leads the dance. As he dances he invites the female patient A to lead the dance by touching her hand. Indeed, she stands up and becomes the first dancer. Afterwards, she tells the group not to dance any more and to sit down. The group agree with her and sits.

TASK VⅢ

I ask if anyone wants to introduce the next activity. Nobody responds so I ask the female patient B to choose a prop. She takes the small ball and suggests throwing it to each other. Thus, this task is a repetition of the task Ⅱ. Suddenly, the female patient B stands up and starts to dance but nobody follows her so she sits down again.

TASK Ⅸ

After a while and when the male patient throws the ball to the female patient B, she doesn't throw it to someone else but leaves it with the other props and takes the rope. Then I suggest and I explain the next activity which is the task Ⅻ of the group Ⅰ. The additional element with this group is that as the group members are one behind the other they hold the rope. All the group members participate in this task. I lead first the group and I walk among the two chairs in a figure of eight. All the rest of the group members who lead the group walk in a circular spatial figure around the chairs. Then I tell them that this is the end of the movement part of the session so the group sits and starts the discussion.

Table 6.3 *Spatial formations of session*

TASK I & II	All group members form a half-circle or a circle. The interpersonal distances are large except the female patient A who is very close to me.
TASK III	All group members form a circle with someone in the centre. The group members come closer to each other.
TASK IV	All group members form a circle. The interpersonal distances gradually become larger and larger.
TASK V	1.The group scatters in the room. The female patient B is very close to me. 2.All group member form a circle.
TASK VI	All group members are clustered around with small interpersonal distances.
TASK VII	(Greek traditional dance) All group members form a half-circle holding each other hands.
TASK VIII	The same as task I and II.
TASK IX	All group members form a line with very small interpersonal distances.

Table 6.4 *Group members roles and subgrouping*

WARM UP	I am the leader of the group.
TASK I	The male patient takes the leadership for a while and then he passes the leadership to the female patient A. The female patient B is the group member who brings back the balloon to the group.
TASK II	The female patient A is the leader.
TASK III	1. I tell the female patient B to be the leader. 2. After a very short time the female patient A takes the leadership.
TASK IV	I tell the male patient to be the leader.
TASK V	I tell the female patient A to be the leader.
TASK VI	1. The female patient B takes the leadership from the female patient A and become the focus of the group. 2. The female patient A takes again the leadership from the female patient B. There are two subgroups which interact with each other and one group member who doesn't participate. 3. I take the leadership. There are two subgroups which interact with each other. The two male group members comprise one subgroup and the two female group members comprise the other.

TASK VII	(Greek traditional dance) 1.The female patient B takes the leadership. 2.She passes the leadership to the male patient. There are two subgroups. The group who dance and the female patient A who sits. 3.He passes the leadership to the female patient A.
TASK VIII	1.Nobody takes the leadership. 2.I tell the female patient B to be leader.
TASK IX	1.The female patient B is the leader. 2.I take the leadership. 3.Each group member takes the leadership in turns.

6.3   RESPONSES TO MY QUESTIONNAIRE OF THE TWO INDEPENDENT MOVEMENT OBSERVERS.

In this section I would like to present the responses to my questionnaire of the two observers. They observed the two sessions that I have described above. The procedure that they followed has been presented in the previous chapter.

All the questions can be classified in three groups. The first group of questions refers to my leadership style, my dynamics and to the effect that these might have on the patients. In addition, it refers to the existence of any leaders (except myself) within the group. The second group of questions refers to the Greek traditional dance and the third

group of questions refers to the spatial formations, mainly before and after the Greek traditional dance.

6.3.1 RESPONSES TO THE 1st GROUP OF QUESTIONS.

According to the observers my leadership style is mainly supportive and encouraging. I am sensitive and caring and the patients develop trust and confidence in me. I have established a very good relationship with my patients.

I set some structure; I use more verbal than non-verbal interventions/reflections, directives, and encouragement. My non-verbal mirroring does not fully reflect the attitude of the patients. I could have non-verbally interpreted the movements of the patients, e.g. reflecting boredom, tiredness, shyness etc,.

I am matching the dynamics of the clients which is appropriate in meeting them. But I could have a bit more tension in my body, and more vitality. I give up too quickly with them.

The patients comply with my requests but they give up very quickly. They need more stimulation from me. I paid more attention to the female patient of the group I thus she felt encouraged to take several initiatives, whereas the male patient remained less involved throughout the session. I engaged with the male patient considerably less.

In the group I the leader is the female patient. In the group II the leader is the female patient B and there are moments that the female patient A takes the leadership.

6.3.2   RESPONSES TO THE 2nd GROUP OF QUESTIONS.

In both groups, before the Greek traditional dance, the patients were activating their weight (hopping, pulling elastic or rope). They were more connected by props. There was much more lively participation from the female patient in group I, and from the female patients in group II.

During the Greek dance the groups became more alive with full body involvement. There was more contact within the group, more complex movements, more authentic involvement and clearer spatial formation. All group members showed greater involvement.

Some of the observers' thoughts about the reason of the patients' initiation of Greek dance are the followings. They introduced Greek dance maybe to get the group together; maybe they wanted something familiar and meaningful after trying out so many props. In addition, maybe the Greek dance gives them a sense of normality or maybe brings memories such as these of engagement in festivals.

6.3.3   RESPONSES TO THE 3rd GROUP OF QUESTIONS.

In group I before the Greek dance the male client is sitting further away and the female patient with me form a dyad. The Greek dance ended with group members standing alone. After the Greek dance the group members are sitting in half-circle again.

In group II the group members are closer together before the

Greek dance, and after the Greek dance they are sitting in half-circle.

CHAPTER 7

DISCUSSION

7.1 A CRITICAL REVIEW OF MY EXPERIENCE BY LEADING TWO DANCE MOVEMENT THERAPY GROUPS OF GREEK SCHIZOPHRENIC PATIENTS

In both groups most of the tasks were introduced by the patients, there were several, short in time and very low in complexity (see chapt. 6). Usually, when a task was kept going for more than several minutes a patient suggested changing the task as happened in the task II of group I. In addition, when I introduced walking in a figure of eight (task XII, group I) the group could not follow me and they stopped. The male patient, especially, started to walk around the room on his own looking at the floor. He used to do this when he was anxious. Thus, the above examples support the argument that schizophrenic patients concentrate more successfully on several sorter tasks than on a single longer one and that tasks must be designed according to their capacities otherwise they become anxious and stop participating (see section 2.4).

Furthermore, in both groups most of the tasks involved the

use of props. Particularly, in group I only five tasks from the fourteen were without the use of props (task VII,VIII,IX,X and XIV) and in group II only the task VII (Greek dance) from nine tasks didn't involve any prop. In both groups the only task that was introduced by patients and didn't involve props was the Greek dance. As section 3.5 showed, the use of props can create structure in a dance movement therapy session and in my groups the patients showed that they preferred the activities with props because they were more clear and obvious (there is an external object to which the refer) and they had simple rules. The rules were simple because the patients set their own rules, thus they could follow them. On the other hand, I introduced some activities without props (see group I tasks VIII,IX,X,XIV) which resulted in the female patient's repetition of the same movement sequence, in male patient's copy of female patient's movements and finally both of them refused to continue this task. In my opinion, this happened because this task was over-demanding for them. The appropriate and more beneficial environment for schizophrenic patients is the one that maximizes their potential without pushing them beyond their capabilities, i.e. neither over-demanding nor under-stimulating (see 1.5). In this case, they had been asked to initiate a variety of movements, something that was very difficult for them because their movement repertoire was very restricted. What I should have done before is to expand their movement vocabulary by introducing a larger range of movements in the warm up as well as by developing the movements that the patients initiate. For example, in task X of the group I instead of asking the male patient to continue

with an other movement I could develop the female's foot movement in a whole body movement something that could be stimulating for them.

Overall, in both groups I believe that I didn't manage to keep the right balance between over-demanding and under-stimulating tasks. Thus, the most of the tasks were under-stimulating for them because I did not intervene appropriately in order to develop the activities that patients had initiated. Furthermore, my dynamics match with the patients' dynamics (see 6.3.1) which is appropriate in meeting them but I needed to have a bit more tension in my body and more vitality in order to stimulate the patients.

In addition, this extended use of props indicates that not only the patients but I also, preferred the tasks that involved props as well. My anxiety was high when I led these groups (see also 2.5) and I did not feel able enough to keep the session structured using my body. Thus, the use of props helped me to reduce my anxiety because they created a structure which I could follow, and so to the patients. For example, in group I, task XI after the discouraging tasks VIII, IX and X , I introduced the skipping rope (see 6.2.1).

Thus, the use of props can help the dance movement therapist (especially an inexperienced one) to keep the session well-structured but, on the other hand, he must find the right complexity for the tasks and rules he uses in order to make the activity neither over-demanding nor under-stimulating. For example, in most of the tasks I asked the patients to initiate the activities which is good because they had the opportunity to take initiatives but, on the other hand, what they

introduced was something which they had repeated many times in the past, thus it was an under-stimulating situation for them, as I described above.

As regards the spatial formations of the two groups (see tables 6.1 and 6.3) the predominant one was the circle which most of the times was introduced by the patients. Even before the session started, the patients took their chairs and sat in the room forming a half-circle. For example, in group II only tasks VI & IX didn't involve a circular spatial formation. All the other tasks, which involved the circle formation, were in a back and forth interaction with others and all group members participated. In other words, the circle facilitated the patients to make contact and to interact with each other as well as promoting group cohesiveness. On the other hand, tasks VI and IX didn't involved interaction between the patients and in task VI didn't all the group members did not participate.

Furthermore, this extended use of the circle formation by the patients, with small interpersonal distances sometimes, indicates the existence of group cohesiveness, closeness and trust between the group members. In addition, it shows that developmentally the groups have reached the last phase of their evolution (see Dosamantes' four phases model in section 3.3). This is a very important achievement with groups of schizophrenic patients because they have great difficulty in trusting and having a sense of group cohesiveness. However, this achievement did not happen in the few weeks of these groups' existence. These patients know each other and have lived together in the same institution for

two years but certainly these dance movement therapy groups support it.

Four times in group I and two times in group II (see tables 6.1, 6.3) the group scattered in the room to produce very large interpersonal distances and stopped participating in the activity. In all these cases, before the group members scattered, there were very small interpersonal distances (even touch) between them. There were two other times that after very small interpersonal distances only the male patient went away from the others and stopped participating.

Thus, this indicates that the patients could not tolerate being so close to the others for a long time and that is why afterwards they went away from each other. What I could have done is to make very short the time of the task which produced small interpersonal distances and afterwards to introduce a task with large interpersonal distances, thus the patients wouldn't have felt confused and they would have continued to participate without any interruption. Generally, most of the tasks were midway distanced tasks which kept the group together.

Another point is that in both groups the group members who sat very close to me at the beginning of the session, spent more time than the other group members close to me, and also they became the leaders of the groups after the warm up (see tables 6.2, 6.4 and section 6.3.1).

In particular, the female patient was the leader of the group I. She was the one who initiated most activities in the group and she took the leadership and initiated an activity

every time that the group was stuck.

On the other hand, the male patient showed that he accepted the female patient as leader (see chapt. 6.2.1, tasks II, III) and waits for her to do his work as well. In other words, he relies on her in order to reduce his anxiety by doing something that is demanding for him. On the other hand, I paid more attention to the female patient and I was engaged with the male patient considerably less. This happened unconsciously and shows my attempt to reduce my anxiety because the female patient was more active than the male patient. Both the above facts show that the male patient was excluded from achieving some group goals such as active initiation and expression. Thus, I should have given equal opportunities for initiation to both of them, to support more the male patient and to stop the female patient when she actively took the leadership from him such as in tasks II and III. My initial intention in both groups was to use the shared leadership structure (see 3.5) thus each group member would have equal opportunities for initiation. I kept that to some extent but not fully because sometimes I found it very difficult. The role of each group member was very clear in the group. What I should have done is to reflect back to the group verbally as well as non-verbally these roles so everyone would be consciously aware of these roles.

In both groups, there were not any drop-outs and the times that the group members felt confused or the groups stopped any activity were only a few. Thus, generally I could say that the structure set and my task-oriented leadership style were appropriate to keep the group together as well as to make them participate.

Another point that has great therapeutic value, and which my leadership didn't support, is the area of symbolic expression. For example, in tasks V and VIII of group I I should have used more non-verbal intervention rather than verbal in order to support and develop the movement symbols and metaphors that the patients initiated.

7.2 THE INITIATION OF THE GREEK TRADITIONAL DANCE "SYRTOS"

Chapter 4 showed that the structure of the Greek dance "Syrtos" has many similarities with the type of structure which is beneficial and appropriate to groups of schizophrenic patients. In other words, it is danced in a circular spatial formation, has simple steps that the dancers have to follow, and the roles of the dancer are very simple and clear. The first dancer is always the leader of the dance and every dancer became leader in turn, similar with the shared leadership structure.

Particularly, in my project the Greek dance "Syrtos" was introduced by the patients and during it, in both groups, all the patients showed greater and more authentic involvement, their vitality increased, and used more complex movements and clearer spatial formation (see chapt. 6.3.2).

In group I the female patient initiated the dance. Before the dance the male patient had refused to participate in the group activity and the group scattered about the room (see 6.2.1 task VI). When the female patient suggested the Greek

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dance the male patient joined in and was happy to participate. In addition, in group II during the dance the female patient A left the group and sat down but after a while the male patient took her hand and asked her to be the leader of the dance, so she stood up and continued to dance. This was the only time that a group member was asked to participate in a group activity by another patient. Thus, both times it is clear that the Greek dance promoted the group cohesion.

In addition, it was the only time that group II tolerated physical contact, which is very important for schizophrenics because as I discussed in section 3.5 physical contact can raise their anxiety. In group I there were another two times apart from the Greek dance where the group had physical contact but it was initiated by me and it lasted for a very short time. Thus, I can say that the Greek dance "Syrtos" can be used as a therapeutic tool with schizophrenic patients and as shown in my case this made schizophrenics less threatened by physical contact and allowed them to tolerate it for longer.

Furthermore, because the dancers of this dance move in synchrony using unison movement this increases its therapeutic value when used with schizophrenic patients. As chapter 3.2 showed unison movements and moving in synchrony promotes interaction and communication which is very important with schizophrenic patients.

In addition, chapter 4.3 showed that the Greek traditional dances are a form of expression as well as a form of amusement and socializing for Greeks. This point increases the therapeutic value of the use of this dance because apart from

its structure which promotes interaction and communication the dance itself is used by Greeks for that purpose.

What I cannot say is that the only reason that patients introduced the dance was because they needed more clear structure at that particular moment. Maybe they wanted something familiar and meaningful after trying out so many props, maybe the Greek dance gave them a sense of normality or maybe brought memories of engagement in social events. This assumptions need exploration, something that I could have done during the session.

7.3 LIMITATIONS OF MY STUDY AND IMPLICATIONS FOR FUTURE RESEARCH

This dissertation is mainly a theoretical review of group therapy structure, the structure of the Greek dance "Syrtos" and the use of both in dance movement therapy with schizophrenic patients. Although this study showed that from a structural point of view the use of this dance is beneficial for schizophrenic patients, empirical studies need to be conducted in order to verify the function of Greek traditional dances in dance movement therapy groups for schizophrenics.

This dissertation is referring only to Greek schizophrenic patients who are long-term hospitalized and explores only one Greek traditional dance. Further research could be done in order to explore the use of any Greek dance in dance movement therapy with any kind of Greek patients regardless of their

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diagnosis.

In addition, this study approached the initiation of the Greek dance "Syrtos" only from a structural point of view. Other aspects such as cultural, self-expressive and symbolic could be put under empirical examination in therapeutic situations.

This study does not provide an outline of guidelines for applying Greek dances in therapy.

7.4 CONCLUSION

In this dissertation a critical review of the structure and the leadership style is employed to explore the initiation of schizophrenic patients' use of the Greek traditional form of dance in a dance movement therapy session.

The findings of the literature review sustained the notion that a well-structured session and a clear and directive leadership style is necessary for working with schizophrenic patients. In addition, it showed that the use of the Greek traditional dance "Syrtos" structurally can be an effective therapeutic tool when working with schizophrenic patients.

On the other hand there was not enough evidence to show that the initiation of the Greek form of dance necessary indicates lack of structure.

APPENDIX 1

Table 5.1 *Five Fundamental Principles*

1. There is constant interaction between body and mind.

2. Aspects of personality are reflected in the movement.

3. The therapeutic relationship between the patient and the dance movement therapist is of great importance to the therapy's effectiveness.

4. Movement can be evidence of the unconscious processes.

5. Movement improvisation has great therapeutic value.

Table 5.2 *Eight Healing Processes*

synchrony	expression	integration
rhythm	vitalization	cohesion
education	symbolism	

QUESTIONNAIRE

1. What is my leadership style?

2. what are my dynamics?

3. what effect this has on the clients?

4. From the movement data what happened to the clients before the introduction of the Greek dance?

5. How they change (if they change) in movement when they dance the Greek dance?

6. What is the group formation before and after the Greek dance?

7. Why do you think they introduced the Greek dance?

8. Are there any leaders in the group (except the therapist)?

CONSENT AGREEMENT TO PARTICIPATE IN INVESTIGATIONAL

RESEARCH

1. Participant's name.....................................

2. Title of research: An exploration from a structural
   point of view of the use of the Greek traditional form
   of dance in a dance movement therapy group of Greek
   schizophrenic patients

3. You are been asked to participate in a research project
   that Mr Dimitrios Zachos, MA student of the "Laban
   Centre for movement and dance", is going to use as a
   MA dissertation in order to complete his studies on the
   MA Dance Movement Therapy course. Your are going to
   participate in one session per week for the period July
   - August - September 1993.

4. You have been told that the procedure is the following:
   You will participate in one session per week which its
   duration is 1½ hours, with other residents of this
   institution. Each session consists of the initial
   discussion, the warm up which is led by the
   therapist, the process in which each group member
   initiates a movement and the rest of the group members
   follow, and the final discussion. During the session
   there are props such as balloons, balls, cloths etc.
   which can be used by the participants. In addition,

there is music.

5. You have been told that there is not any particular
   risk by participating in this study.

6. You have been told that the possible benefits of being
   in this research project are physical and psychological

7. You have been told that the other treatments you can
   have if you do not join this research project are the
   ones that the institution offers till today.

8. You have been told that because of the possibility of
   unknown risks or results, you cannot be assured that
   there will be any useful outcome to you. This study is
   being conducted in the belief that it may be of benefit
   to you, others or for the advancement of science. Your
   participation in this study may have to be stopped for
   the following reasons: a) If required by change in your
   medical condition. b) If all or part of this study is
   discontinued by the sponsor or government agencies c)
   Other reasons such as harmful reactions experienced by
   others in the study, or if any other new information
   becomes known to the investigator.

9. You have been told that you can refuse to join the
   study or change your mind about continuing to
   participate at any time and doing so will have no
   effect on your right to receive health care.

10 You have been told that if you believe that have been
   injured by being part of this research project you
   should contact the psychiatrist of this institution
   Dr........ at tel:....... However, neither the
   investigator nor the Laban Centre will provide any

compensation for injury, illness or other loss
resulting from participation in this study. You have
also been told, in the event of physical injury
resulting from this investigation, medical care,
including hospitalisation, is available, but the Laban
Centre cannot assure you that this medical care will be
provided without charge.

11 As a subject in this study you have given your
permission for the Laban Centre to keep, preserve,
publish, use or dispose of the results of this study.
Your identity will be kept confidential.

I HAVE BEEN INFORMED OF THE REASONS FOR THIS STUDY. I HAVE
HAD THE STUDY EXPLAINED TO ME. I HAVE UNDERSTOOD ALL THE
QUESTIONS I HAVE ANSWERED. I HAVE CAREFULLY READ THIS
CONSENT FORM AND HAVE RECEIVED A COPY.

Date: 1/7/1993   ....
                              Participant

                        ....
                              Witness

                        ....
                              Investigator

PERMISSION OF THE INSTITUTION

TO:

Laban Centre for Movement and Dance

Dear Sir,

We give permission to Mr Dimitrios Zachos to use the data which he has collected (videotapes, notes) during his participation in our institution as a dance movement therapist. This data is going to be used for his dissertation.

The Manager

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