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DANCE-MOVEMENT THERAPY IN A BLACK
REHABILITATION WARD: AN EXPLORATORY STUDY

by

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This study was conceived as the author struggled to find a meaningful and effective way of working psychotherapeutically with people who are culturally very different from her. Yalom's (1983; 1985) approach to group psychotherapy, especially in-patient group psychotherapy, seemed to work relatively well, albeit with a number of modifications, for those black people in the rehabilitation ward who were high-functioning and could speak either English or Afrikaans well. Yet for those black people who could not speak either of these two languages reasonably well, and who functioned on a fairly low level, that approach proved ineffective and highly frustrating for both therapist and patients.

An alternative way had to be found which would facilitate the establishment of a therapeutic relationship and render therapeutic interventions effective. In her search for a solution the author stumbled upon dance-movement therapy. Intuitively it made sense to use this mode of therapy in the work with black people. Accordingly, a pilot study was conducted. The results were promising and a proper study was planned and implemented.

Eight group dance-movement sessions were conducted over a period of approximately four weeks. The group consisted of six members, three men and three women, all of whom were inpatients in a rehabilitation ward of a psychiatric hospital. Non-verbal communication served as the medium for building therapeutic relationships and for introducing change. Verbal communication was also made use of, though to a much smaller extent. Some props, including items of clothing and primitive musical instruments, were employed to, amongst others, get the group members to become actively involved. Music, particularly by local and overseas black artists, played an important role in therapy.
Certain factors which were singled out by Yalom (1983; 1985) as operating in verbally-oriented group psychotherapy, were also observed to form part of the process of the dance-movement therapy. Group cohesion developed, to a large extent by non-verbal means. Both the group leader and group members introduced and reinforced norms. Therapeutic factors such as interpersonal learning and the provision of a pleasant, supportive experience played an important role.

The changes which took place during the session were conceptualized by the author in mainly ecosystemic terms such as Bateson's orders of learning, unconscious processes, as well as redundancy and randomness.

The most important conclusion to be drawn from this study is that dance-movement has the potential to be a viable mode of psychotherapy where therapist and client are culturally different, specifically where the therapist is a white South African and her clients black South Africans whose level of functioning is relatively low. Dance-movement is effective in enabling the therapist to gain an empathic understanding of her culturally-different clients and in communicating that understanding to them. By widening the movement repertoire of the group members, dance-movement can serve to foster health in the sense of a vital balance of different forms of behaviour and experience.
OPSOMMING

Hierdie studie het ontwikkel uit die outeur se poging om 'n effektiwe psigoterapeutiese werksmetode te ontwikkel vir persone wat kultureel baie van haar verskil. Sy het bevind dat die terapeutiese tegnieke waaraan sy in haar nagraadse opleiding blootgestel was, tot 'n meerdere of mindere mate ongeskik was vir die werk met swart pasiënte, veral dié wat op 'n relatief lae vlak funksioneer en nóg Engels nóg Afrikaans magtig is.

Alternatiewe tegnieke wat 'n terapeutiese verhouding daar kon stel en die effektiwiteit van terapeutiese ingrepe sou bevorder moes gevind word. In die soeke na 'n tegniek het die moontlikheid van dans- en bewegingsterapie hom voorgedoen. Intuïtief het dit sinvol geblyk om hierdie terapeutiese model te gebruik. Gevolglik is 'n loodsstudie beplan en geïmplementeer. Die resultate was bemoedigend en die studie is voortgesit.

As deel van die studie is agt dans en beweging-groepsessies oor 'n periode van ongeveer vier weke gehou. Die groep het bestaan uit ses lede, drie mans en drie vroue. Die groepslede was almal pasiente in 'n rehabilitasie saal van 'n psigiatriese hospitaal. Nie-verbale kommunikasie het gedien as die medium vir die bou van 'n terapeutiese relasie en om verandering teweeg te bring. Tot 'n kleinere mate is gebruik gemaak van verbale kommunikasie. Ten einde die groepslede in staat te stel om aktief betrokke te wees en hulself uit te leef, is 'n aantal items insluitende primitiewe musiekinstrumente en kledingstukke gebruik. Musiek, veral dié van plaaslike en buitelandse swart kunstenaars, het 'n belangrike rol gespeel in die terapeutiese proses.

Daar is bevind dat sekere faktore wat volgens Yalom (1983; 1985) van belang is in verbaal-georiënteerde groepsterapie ook deel uitmaak van die proses van dans- en bewegingsterapie. Soos in verbaal-georiënteerde groepsterapie het groepskohesie ontwikkel, veral deur middel van die nie-verbale medium. Beide die
groepsleier en lede het nuwe norme daargestel en ou norme bevestig. Terapeutiese faktore, onder andere interpersoonlike leer en die bied van 'n aangename, ondersteunende ervaring het 'n belangrike rol gespeel.

Die ouer het die veranderinge wat gedurende die groepsessies plaasgevind het in ekosistemiese terme, byvoorbeeld Bateson se ordes van leer, onbewustelike prosesse sowel as reëlmatiegheid en onvoorspelbaarheid, gekonseptualiseer.

Die belangrikste gevolgtrekking wat op grond van hierdie studie gemaak kan word is dat dans- en bewegingsterapie potensieel 'n effektiewe psigoterapeutiese model is waar terapeut en klient kultureel verskil, spesifiek waar die terapeut 'n wit Suid-Afrikaner en die klient 'n swart Suid-Afrikaner is. Dans en beweging kan die terapeut in staat stel om 'n empatiese begrip vir haar klient te verkry en om hierdie begrip aan die klient oor te dra. Deur die bewegingsrepertoire van die groepslede te verbreed, kan dans- en bewegingsterapie helend wees in die sin dat dit die noodsaaklike balans van verskillende norme van gedrag en ervaring kan bevorder.
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Alperson (1972) argues that pragmatic technological society has produced human beings who lack wholeness because they have lost touch with their less rational and less conscious levels of awareness. According to Selvini-Palazzoli et al. (1978) our conception of reality is based on the linguistic model which for us is the same thing as reality. However, language is not the same as reality. While language is descriptive and linear, reality is living and circular. The extent to which Westerners are influenced - largely unconsciously - by the linguistic model is indeed overwhelming. The very nature of language forces us to dichotomize and, thus, forces us into a position of being "unwhole". Laban (1968) describes how the incredible extent of intellectual knowledge needed to cope with modern life creates an unbalanced state in human beings. The work-place has become ever more dehumanized and sterile as tasks have become increasingly specialized and focused (Warren, 1984). That is, the experience in the work-place has become one-sided. How could the state of affairs as described above, be remedied? Keeney (1983), Selvini-Palazzoli et al. (1978) and Capra (1983), amongst others, have produced works which are major breakthroughs in this area.

Others, like Warren (1984), have argued that by practising the arts, human beings can redress the imbalances in their lives. In this dissertation the focus will be on one specific art form, namely dance. According to Nussbaum (1987) movement can serve as a bridge to the intuitive and creative aspects of ourselves. Laban (1968) believes that the practice of new dance techniques can serve to balance out the extreme emphasis on intellectual knowledge. Rhythmic action is a very powerful tool which can be used with all populations because it provides a link between the conscious and unconscious (Bernstein, 1981). This dissertation is an
exploration into the unfolding of the therapeutic process where dance-movement was the most important, though not the only, tool used by a white therapist involved in therapy with a group of black patients.

The psychologist who has been trained in the largely verbal psychotherapeutic techniques taught in post-graduate courses in South African universities is often at a loss when faced with clients who have had a relatively limited exposure to Western culture. These clients frequently have only a limited grasp of the language(s) spoken by the therapist while the therapist usually has no knowledge at all of the client's home language. Matters are made even worse when the client is more severely disturbed, especially when he is psychotic.

Jones (1980) argues very strongly for the matching of therapist and client in terms of culture. More specifically, he maintains that black psychologists are far better equipped to deal with black clients than are their white colleagues. Black therapists, being familiar with black life, are said to be in a much better position to assess the presenting problems of their black clients within the context of the latter's environment. It is argued that the black client will more readily provide information about himself to a black therapist and misunderstandings emanating from language and style will be minimized. Although this argument is recognized as valid, it must be considered against the background of the practical situation in South Africa. Firstly, there is an immense shortage of trained black psychologists and it may be expected that it will take many years to fill the gap. In the interim, many people in need of psychological intervention would remain unattended to, if there were an insistence on the matching of psychologist and client in terms of culture. Secondly, black psychologists in South Africa are trained mainly in
the Western theories and techniques of psychotherapy and are, in this sense, as poorly equipped to deal with black clients as their white colleagues.

Brookbanks (1988) raises the point that traditional healers are available and that much more extensive use should be made of their services. This, too, is a very valid argument but, once again, there are practicalities to be considered. People in authority need to be convinced that traditional healers have a vital role to play in the healing of black clients. Furthermore there are many black people in mental hospitals who have been treated unsuccessfully by a traditional healer or who have been referred to the hospital by such a healer because he has not deemed himself competent to deal with the problem. Finally, there are a number of black people who prefer not to receive treatment from a traditional healer.

These are the facts with which the white psychologist working with black people is faced. In the light of these facts, it was decided that an investigation be conducted into the use of group dance-movement therapy as a means for establishing rapport with, gaining an understanding of, and making interventions into the lives of black patients. It was felt that dance could serve as a potential common meeting-ground between the white psychologist and her black client. According to Espanak (1981) movement language is universal, it is for this reason that dance, as an art as well as a therapeutic medium, has such enormous powers of communication.

Schmais (1974) maintains that dance-movement can be used by the therapist to gain an empathic understanding of her client and to share that understanding with the client. In this way dance-movement would be particularly useful where the therapist and client do not share the same language. Chaiklin (1975) refers to Marian Chace, one of the founders
of dance therapy, who found that by moving like the client but without directly imitating him, she could establish rapport.

It was felt that black clients would feel at home with dance-movement as a therapeutic tool because, according to Bernstein (1981), movement as a form of expression is widely used by black people from early childhood. Dance is an integral part of community life in Africa and it is frequently used in ritualizing crises and in celebrations (Nussbaum, 1987). It would appear that in present-day black South African communities, dance still fulfils an important function in healing and in rites of passage (Bührmann, 1984).

Several of the therapeutic factors which Yalom (1983; 1985) found to be operative in group psychotherapy would seem to play a role in group dance-movement therapy. Two of the most important goals of in-patient group psychotherapy, as distinguished by Yalom (1983), namely a lessening of iatrogenic anxiety and the provision of a supportive, pleasant and constructive experience for group members, can be attained by means of shared rhythmic action.

Group cohesion which has been found by Yalom (1985) to be a precondition for effective group psychotherapy, can be built most effectively by means of movement shared by all participants (Boas 1971). Rhythmic action can provide frequently isolated and withdrawn patients with a bridge for communicating with others, since it is something that is shared by all people. Catharsis, i.e. the open expression of affect, is an important aspect of communication. In the dance, emotions can be shared directly on a pre-verbal and physical level as the dancers move together to a common rhythm. Social learning is, according to Yalom (1985), a therapeutic factor which plays a role in all therapy groups. Imitative behaviour is an essential element of social learning. Although specific imitative behaviour may be
short-lived, it can serve to release the individual from rigid behavioural patterns and enable her to experiment with new ways of behaving. The dance-movement therapy group gives the members an opportunity to experiment with new modes of behaving within a relatively safe environment. In this environment the group members obtain direct and visible feedback about themselves.

Having provided the rationale for this study, the lay-out will now be discussed. Chapter Two is concerned with mental health services in the black communities of South Africa. Issues such as the context of mental health services, including the social, economic and political aspects, are discussed. The main focus is on the cultural element. Accordingly, the nature of African culture is considered. Problems of transcultural psychology and the viability of transcultural psychology are considered.

Having suggested in the previous chapter that dance-movement therapy may be a suitable working method for use trans-culturally, Chapter Three provides an overview of dance-movement therapy as it has been described and explained by important authors in the field. A historical perspective is given, as is an overview of the development of dance-movement therapy to professional status. The premises of dance-movement therapy are set out, as are its goals. Evaluation, as well as the process and techniques of this type of therapy, are considered.

Chapter Four entails the description and qualitative analysis of the group dance-movement sessions which were conducted as part of this study.

Chapter Five is aimed at gaining an understanding of dance-movement therapy from a systems, as well as from the group therapy, perspective. An attempt is made to explain change
brought about by dance-movement in ecosystemic terms.
Chapter Six contains a summary of the study, and conclusions
which can be drawn from it.
CHAPTER 2
MENTAL HEALTH SERVICES AND THE BLACK COMMUNITIES
OF SOUTH AFRICA

Traditionally, the black wards in mental hospitals are regarded as the back wards. These wards tend to be overcrowded and understaffed. Mental health professionals who work in these wards are often at a loss as to how they can deal effectively with the patients. Diagnosis or - for those who work outside the medical model - an analysis of the problems, is fraught with difficulties. Therapeutic techniques available to the mental health worker who deals with black patients are very often blatantly unsuitable and ineffective.

2.1 THE CONTEXT OF MENTAL HEALTH SERVICES

In analyzing the reasons for this situation, it is important to take a very broad perspective. Kruger (1980) makes the point that psychotherapy is always embedded in a cultural, economic and political context. Social, political and economic factors have a pervasive influence on people's functioning and mental health, as well as on the practice of psychology (Shmukler, 1986). What these authors have written about psychology no doubt applies to mental health services in general. What aggravates the situation further is that, according to Allwood (1986), there has been a general deterioration in the mental health of black people. He ascribes this to a number of factors, including the scepticism with regard to traditional healing practices, poor nutrition and concomitant abuse of substances leading to psychoses and instability, an unmanageable birth rate and the disruption associated with recent unrest. Manganyi (1973) believes that black communities are at special risk because they are plagued with poverty and have been subjected to the greatest organized disruption of family
life which, in turn, has led to a decrease in the number of supportive social relationships. Official mental health services are poorly equipped to deal with such issues (Allwood, 1986).

While the importance of the political, social and economic context in which mental health services are embedded is acknowledged, a detailed consideration of these elements falls outside the scope of this study. Here the focus will be on the cultural aspects. Cheetham (1975) comments that psychiatrists, and this would seem to apply to other mental health professionals, have given little consideration to the conceptualizations of illness and the beliefs about causation and therapeutic techniques held by the black people of South Africa. Yet an understanding of the black person's beliefs, customs, culture and philosophy of life is essential for mental health professionals working with black people (Allwood, 1986; Cheetham, 1975). Bührmann (1984) refers to Madura (1978) who maintains that an unwillingness to take cognisance of a person's culture, is tantamount to treating him like a fragment rather than as a whole person.

2.2 AFRICAN CULTURE

According to Gqomfa (1987, p. 29), "Culture is a way of life, an organized set of customs, beliefs, ideas and habits shared by a group of people. Culture also includes traditional systems for the transmission of methods of regulating behaviour and attitudes".

It would seem that culture is not fixed or stagnant but that it evolves. This is especially true of African culture which has undergone changes as a result of contact with Western culture and associated urbanization and industrialization. There are differences of opinion regarding the extent to which traditional African customs are still applicable in the lives of black people, particularly those living in the
urban areas. According to Kiev (1972), the "ancestral authority" vested in the fathers and the elders has decreased considerably, and so have the protective powers of this authority. He argues further that group protection, which he likens to the psychological "prop" of the African, is removed by migration to the cities. Consequently, the urban African is left isolated and vulnerable. Schoeman (1986) maintains that many of the black person's customs and traditions have been eroded by the impact of the Western world view. He warns that an emphasis on thought and behaviour patterns which are no longer applicable, has little value in psychology or psychiatry. Nevertheless, he considers it meaningful to pay attention to traditional African culture, because acculturation is not a uniform process.

Sow (1978), on the other hand, argues that appearances of modernity can be deceptive. He maintains that, despite these appearances, daily social relations at all levels of African society are strongly influenced by traditional cultural values. Despite rapid changes in life-style and cultural adjustments, some highly educated people, when faced with crises, revert to traditional beliefs regarding illness and misfortune (Bührmann, 1983). Western ideas, when adhered to by black people, tend to manifest themselves within the framework of African ontology (Manganyi, 1973). Even urbanized black people return to African ontology from time to time. As long as stress remains below a certain level, African ontology as an organizing force remains latent but as soon as stress rises above this hypothetical level it (African ontology) is again reverted to. Gqomfa (1987) also maintains that the black person's world is dominated by powerful traditions. Customs, rites, rituals and ancestral spirits all go together to make up a complex culture, especially with regard to illness and misfortune.
2.1.2 Holism

According to Holdstock (1981), the African approach to life is holistic. Kruger (1974) explains this approach well when he states that the world of the diviner is an undivided one in which ancestor, dream, plant and body all belong together. For the people of Africa all things - living and non-living - form a unity. The black person experiences a cosmic relatedness which enables him to be a part of the created world and to share in a meaningful way in the process of the world being created (Bührmann, 1984). In terms of the African world view, no sharp distinction is made between the material and the mental, the natural and the supernatural (Lambo, 1971). It is a world in which all things, be they visible or invisible, are dynamically interconnected. In this frame of reference, man mirrors and contains the universe.

Bührmann (1984) refers to a Zulu medical practitioner, according to whom the human being is an entity and not a creature divided up into various parts like the physical body, the soul and the spirit. The traditional Xhosa does not have any concepts in terms of which he can draw a distinction between himself and the body he has (Kruger, 1974). While Western medicine divides illnesses into different classes such as somatic, psychological and psychosomatic, the black people say that "when part of me is ill, the whole of me is ill" (Bührmann, 1983, p. 218).

A unified approach is also evident in the relationship between word and action and between verbal and non-verbal behaviour. Holdstock (1981) points out that dance, rhythm and music become firmly embedded early in the life of the African child, thus setting in motion the integration of word and action.
2.2.2 Interconnectedness with the other

Africa's holistic approach to life also becomes evident at the level of the relationship between the individual and his fellow human beings. Manganyi (1973) makes the point that in terms of the black approach, the community enjoys priority above the individual. The life of the African person has always been organized and regulated by his tribal group to the extent that his sense of identity is derived from the group (Kiev, 1972). Black people are deeply involved with one another and participation by the community as a whole is at a very high level (Holdstock, 1981). Sow (1978) writes that, in Africa, the person is not regarded as, nor does he experience himself as, a closed system. The personality is an evolving system of social relationships and a system of interaction with the symbolic realm. According to Kruger (1977, p. 12), African selfhood has been formulated as follows: "I am because we are and we are because I am".

The black person's interconnectedness with the other includes his relationships with the ancestral domain. Contemporary society, from the African point of view, represents a relatively small group of people within a massive group consisting mainly of the dead, ancestors and other deceased (Sow, 1978). The relationship with the ancestors and through the ancestors, with God, is omnipresent in the lives of black people (Holdstock, 1981).

2.2.3 The conceptualization of illness and misfortune

The African experiences being ill as a state of disharmony between himself and his basic interactions with his total existential situation (Manganyi, 1973). Bührmann (1983) sees the reasons for illness and misfortune as falling into two broad categories. These are, firstly, the description
of the harmonious relationship which ought to exist between the living human beings, their ancestors and nature, and secondly, the evil activities of sorcerers and witches.

2.2.3.1 The role of the ancestors

In order to understand the African's conceptualization of health and ill-health, it is necessary to become familiar with concepts surrounding ancestors and ancestor worship (Bührmann, 1983). According to Mdleleni (1987), ancestral spirits are the invisible members of society who are responsible for those still alive. Bührmann (1984) distinguishes two categories of ancestors. The first is the "living dead", who are clan members, and the second consists of non-clan members. Here only the "living dead", who are also referred to as "shades" in the anthropological literature, will be discussed. They play a vitally important role in the everyday activities of all the members of the family and clan. They are omniscient and omnipresent. Generally speaking, the "living dead" are well-disposed mentors and protectors. Yet the relationship is not one-sided. The living are responsible to the ancestors in the sense that, during important crises in the life cycle, they must perform specific rituals to keep the ancestors informed (Hammond-Tooke, 1975). Certain rituals and ceremonies are performed by the black people in order to communicate with the ancestors and to learn their wishes (Bührmann, 1984). In order to assure themselves the guidance and protection of the ancestors, the living have to adhere to the customs of the culture (Gqomfa, 1987). If they fail to do so, the ancestors may withhold their guidance and protection, thereby exposing the individual and the family or clan to the evil machinations of witches and sorcerers who can cause illness.

According to Bührmann (1984), the ancestors may also cause illness. However such illnesses are not evil and their
purpose is to draw people's attention to the error of their ways. The measures by which these illnesses can be cured are aimed at re-establishing communication with the ancestors.

2.2.3.2 Witchcraft and sorcery

Cheetham (1975) maintains that the community life of the Xhosa and Zulu is permeated by witchcraft and sorcery. Witchcraft is practised by human beings who are motivated by envy and malice, to harm their fellow human beings (Hammond-Tooke, 1975). The power of evil is situated within the person him-or herself (Bührmann, 1983). According to Hammond-Tooke (1975), witchcraft entails the manipulation of psychic powers. In most instances mythical monsters called "familiars" are utilized as the medium for witchcraft. Bührmann (1984) writes that being bewitched leads to extreme suffering. The afflicted person is at the mercy of omnipotent and omnipresent evil spirits who are aware of everything the individual does or says. Those who are bewitched experience themselves as having been deprived of life.

Sorcery, unlike witchcraft, entails the use of medicine or magical substances (Hammond-Tooke, 1975). Thus, whereas in witchcraft the evil is vested in a person, in sorcery it is vested in a substance or thing. Not just witchcraft but sorcery, too, is based on jealousy, malice and envy and anger, as well as all feelings and attitudes perceived as evil (Mdleleni, 1987).

Cheetham (1975) argues that in the absence of witchcraft and sorcery the social structure of black South African communities, which has existed in its present state for 300 years, would collapse - with disastrous consequences. Witchcraft provides a conceptual and behavioural framework which allows for the expression of a broad spectrum of feelings (Kiev, 1972). Hammond-Tooke (1975) provides an
explanation of what is meant by the abovementioned authors. Tension, enmity and jealousy are bound to arise in the family or settlement. Competition for scarce resources is inevitable where people live together in groups. Most societies have set measures for dealing with such tensions and conflicts. Hanna (1977) describes the Ubakala dance plays of Nigeria which provide individuals with the opportunity to vent feelings considered unacceptable under normal circumstances. However, there are situations in which measures such as judicial arbitration, rituals of rebellion and joking relationships are inadequate (Hammond-Tooke, 1975). At times conflicts develop as a result of deep-seated contradictions that are part and parcel of the social structure. In such instances, conflicts cannot be resolved by the usual means. It is in these cases that witchcraft beliefs function to maintain group values. In this respect, the concept of persecution is of importance. Sow (1978) regards the idea of persecution as a socialized intracommunity defence. It serves to defend both the individual and the community, in that it provides them with a degree of coherence. Specifically, coherence is maintained by means of the externalization of conflict and specific group identification of the persecutor. Thus, conflict which threatens to disrupt or destroy the community order is displaced onto a single person, the witch.

2.2.3.3 Interest in the question “why?”

What emerges from the above is that black people in Africa will always search for the meaning of their experiences and of the situations in which they find themselves (Bührrmann, 1984). Hammond-Tooke (1975) writes that in the pre-scientific world view there is a burning interest in the question “why”. In the traditional world view, cause and meaning are of much greater importance than the symptom as such (Sow, 1978). According to Gqomfa (1987), the Xhosa
people - and from the literature this would seem to apply to most black people in Africa - live in a world where everything has meaning and nothing occurs just by chance.

Thus, attempts are made to interpret chance so as to give it structure and meaning (Sow, 1978). The conclusion to be drawn from this section is that the black person, in the anthropological context of Africa, always conceptualizes illness, madness and death in terms of conflict in the relational networks which form the structure of the individual's daily life.

2.2.4 The role of the traditional healer

Holdstock (1979) cites a study by the Soweto Society for Marriage and Family Life, conducted in 1977, in which it became clear that the majority of people living in Soweto still have faith in the power of traditional healers and traditional remedies. It is estimated that approximately 90% of the population of black Africa still make use of the services of traditional practitioners (Sow, 1978). Holdstock (1979) refers to a study by Robbertze (1976) in which it was found that indigenous healers are therapeutically more effective than psychiatrists, psychologists or medical doctors in the treatment of certain conditions.

2.2.4.1 Interpreters of reality

In Xhosa society the traditional healer is the most important exponent of the nature of cosmic reality to the members of the group (Kruger, 1977). Thus the traditional healer or, more specifically, the diviner, carries the responsibility for explaining those aspects of the world which other people find difficult to understand. The traditional healer provides a structural diagnosis which
functions to determine the meaning of the illness (Sow, 1978). In this way existential anxiety, as well as fear and doubt, are dispelled (Kiev, 1972). Sow (1978) makes the point that the diviner functions as the keeper of the codes which enable him to interpret the various messages sent to mankind. It is in their capacity as mediators between the living and the dead that the diviners are able to decipher these communications (Gqomfa, 1987).

2.2.4.2 Conflict resolution

Kiev (1972) observes that traditional healing methods contain many elements of conflict resolution. The traditional healer, with the help of the affected person's family and community, needs to determine in which sector of his relational network the afflicted person is experiencing conflict (Sow, 1978). The broken bond between the afflicted person and the designated sector of his relational network needs to be re-established. He must be reintegrated into, and reinstituted in, the niche from which he has been shut out. Communication must be re-established. To achieve these aims the traditional healer creates opportunities for catharsis and for the sharing of feelings, attitudes and ideas (Kiev, 1972). Sow (1978) describes how the traditional healer, realizing that the individual cannot function without the support of his kin, may bring the people concerned to talk about their problems and/or to make peace in public. The traditional healer makes sure that aggressiveness caused by frustrated needs and desires, is aired publicly and dramatically. It is by means of these measures that the traditional healer provides all those involved with a corrective emotional experience (Kiev, 1972).
2.2.4.3 Maintaining social stability

In helping to resolve conflicts, the healer plays a vitally important part in maintaining social stability (Holdstock, 1979). Kiev (1972) shows how traditional healers make possible such stability, even in times of upheaval and change, in the sense that they develop new ideologies and belief systems.

2.2.4.4 Involvement of the community

Bührmann (1983; 1984), Holdstock (1979) and Kruger (1977), among others, describe how the family and/or the community of the afflicted person is/are drawn into the healing process. The traditional healer, by enlisting the support of the community, enhances the patient's belief in the efficacy of the treatment (Kiev, 1972). By using the beliefs and ideas of the group for therapeutic leverage, the healer heightens the chances that the afflicted person will be successfully reintegrated into his community. However, as Sow (1978) points out, it is not just the patient who benefits by the therapeutic order. The benefits permeate into the cultural order and the relational structure of the entire group.

2.2.5 Right-hemispheric functions and dreams

Holdstock (1979; 1981) and Kiev (1972) note that Africa places a high premium on the intuitive, the imaginative, the symbolic and on dreams. The world of black people is mainly intuitive and non-rational in nature (Bührmann, 1984). The focus is on symbols and images. Dominated by the non-verbal right- hemisphere consciousness (Holdstock, 1979) the black people of Africa act out, in their singing, dancing, rituals and ceremonies, what Western people think and talk about (Bührmann, 1984). Black people give external and concrete
form to fantasy and dream images, thereby rendering them more meaningful and less threatening. Sow (1978) refers to Thomas and Luneau (1975) according to whom ritual is firmly integrated into all human activities. These authors believe that ritual serves, inter alia, to unite the group, to resolve conflicts and to effectively handle social tensions. Sow (1978) argues that most African rituals in their basic structure include a return to original chaos, with the aim of rebirth and recreation, as well as the transcendence of current uncertainties.

2.2.5.1 The dance

From a review of the literature it would appear that dancing plays an essential part in many rituals. Bühmann (1984) provides important insights into the nature and role of dancing in the rural Xhosa communities. She describes the "xhentsa" which is a slow, rhythmic movement involving the pounding of the ground by the feet while the dancers proceed in an anti-clockwise direction. The dancers move slowly and individually. The dancing is accompanied by singing and clapping of hands. Such dancing, singing and clapping creates an atmosphere of tension and instils a sense of anticipation prior to the start of the "diagnostic" and treatment session conducted by the healers. It would seem that, by means of their activity, the dancers contribute to a central pool of energy and wake up the "umbeleni", which is essential in treating an afflicted person. The word "umbeleni" generally refers to a feeling of anxiety or anxious anticipation (Bühmann, 1984). The traditional healers attach a broader meaning to the word and briefly call it "life-forces". The xhentsa is part of the ritual called the "intlombe". In the intlombe all those involved experience a keen sense of participation, physical as well as psychic. In this sense it is a process of whole-making.
2.2.5.2 Dreams

Gqomfa (1987) writes that dreams play a vitally important role in the lives of black people. Whereas the Westerner generally considers dreams to be remote from reality, the black person, according to Sow (1978), never draws a sharp dividing line between dreaming and reality. Both Gqomfa (1987) and Kiev (1972) point out that, for many groups of black people, dreams provide a link to the ancestors. The ancestors communicate their needs and desires as well as their approval or disapproval of individual behaviour in dreams. They also provide directions and guidance in dreams (Burhman, 1983). The instructions given in dreams are taken seriously and are followed.

Bührmann (1984) describes how dreams may be used in rituals, in a way which resembles a group psychotherapy session. Such a course may be followed where dreams revolve around feelings and relationships in a group of people. Those involved in the ritual assist the dreamer to "say it out as it was ... not to withhold ... or to be ashamed" (p. 55).

In concluding this section on African culture, Mdleleni's (1987) call on mental health workers to regard black patients' beliefs and customs as an asset, rather than as a hindrance to modern medicine, seems to be particularly apt. She argues for the potential therapeutic value of non-medical beliefs and practices and for the incorporation of their beneficial aspects into comprehensive health care programmes.

2.3 PROBLEMS OF TRANSCULTURAL PSYCHOLOGY

Having provided a short overview of African culture, particularly as it pertains to concepts of health and ill-health and harmony and disharmony or disturbance, it is
important now to gain an understanding of the Western approach to mental health services and its applicability to African people.

Holdstock (1981) makes the important point that psychology has its roots in North America and in Europe. The South African medical system, which is operative in mental hospitals, developed from and continues to be influenced by Scots, British and American medicine (Cheetham, 1975). Holdstock (1981) cites various authors including Aime Cesaire, Laurens van der Post, Senghor and Frantz Fanon who have expressed severe criticism of the wholesale and unquestioned application of such Western models to the African situation. Biesheuvel (1987) also makes it clear that concepts and constructs such as intelligence, achievement, drive, self-expression and autonomy, while meaningful in Western culture, are not applicable to African people. The analysis of the behaviour of blacks in Africa in terms of constructs which are alien to their own culture, usually turns out to be to the detriment of these people.

2.3.1 Some philosophical underpinnings

Much of psychology and the mental health services in general are dominated by an emphasis on logico-deductive reasoning (Capra, 1982), whereas the black African person relies largely on intuition, especially as far as healing is concerned (Kiev, 1972). In contrast to Africa's holistic approach, the Western world view is characterized by an adherence to rationalism and to outer physical reality (Holdstock, 1981). The Western world is characterized by increasing fragmentation and by the compartmentalization of life into separate elements. Sow (1978) argues that as a result of such dissection, sense and meaning are lost. Kruger (1977) believes that, if mental health professionals are to understand black African people, they have to gain an understanding of their world of meaning. However, empirical
scientific procedures tend to strip everything of meaning in an effort to fit phenomena into a framework of cause-effect and of measurement. The Westerner is inclined to treat the findings of science as the only reality. Holdstock (1981) believes that the abovementioned factors have led to a dehumanized psychology.

2.3.2 Diagnostic measures and treatment models

Cheetham (1975) points out that rural black people are subjected to diagnostic measures and treatment methods which are very strange to them. Even those black people who have lived in the city for a generation or more, find it difficult to adapt to these measures. Shmukler (1986) also argues that commonly used European and American psychodiagnosics are not applicable to vast sections of what she calls the culturally disadvantaged and non-Western middle class groups. Many of the problems of transcultural psychology are the result of the basic assumption that the Western diagnostic systems are applicable to all situations (Mdleleni, 1987). On the basis of this assumption, Western mental health professionals attempt to translate culturally-specific conditions to the conceptualizations that are part of their own systems.

2.3.2.1 History-taking and psychiatric examination

History-taking, as performed in Western mental hospitals, is completely strange to many black people (Cheetham, 1975). These people often fail to see the relevance of much of the information that is asked of them (Bührmann, 1977). Patients are frequently unable to provide adequate answers to questions, not only because their grasp of the English or Afrikaans language is limited, but also because certain words are taboo. For instance, a Xhosa woman may not use her husband's name or any word which sounds like it, with the
result that her answers may appear devious or evasive. Certain areas such as customs and ceremonies and, especially, their neglect, which may cause much concern and guilt are seldom enquired about by mental health workers trained in the Western tradition. In the writer's experience, patients' complaints about having been bewitched are, at best, ignored during history-taking.

Bührmann (1977) writes that, in the psychiatric examination, the appearance and behaviour of black people may well be misleading because they have their own ideas about what constitutes appropriate behaviour and good conduct. Their behaviour may also appear strange or even paranoid owing to the fact that the unfamiliar situation facing them, which may well produce suspicion (Cheetham, 1975).

The pitfalls of assessing intellectual functioning cross-culturally have been discussed by numerous authors including Anastasi (1976), Franklin (1980) and Miller (1980). As regards speech and thinking, Bührmann (1977) has found that Xhosa-speaking patients think and talk in a less logical, consequential and goal-directed manner than Western people do. Such a cultural difference may easily be labelled as loosening of associations. As far as perception is concerned, Lee's (1969) observation that hallucinations are legitimate expectations within the belief systems of the Zulu society, is apt. Certain perceptions which, from a Western point of view, would be considered abnormal, are normal in the context of black culture because they are generally shared (Hammond-Tooke, 1975). Bührmann (1977) writes that in assessing black people's insight and judgement, we have to take into consideration that their world view is in many ways different from that of the Westerner.

It should be clear from the above that to assess black people in terms of Western conceptualizations is not only inaccurate, but speaks of blatant disrespect for the
realities of people from other cultures. Furthermore, as Bühmann (1977) has pointed out, such a practice tends to confuse the patient as to his own perceptions and relating. This can have a highly traumatic effect on the person.

2.3.3 Treatment models

2.3.3.1 The sickness model

In this writer's experience, the sickness model is closely adhered to in mental institutions in South Africa. Kiev (1972) espouses such a model when he maintains that behavioural patterns and symptoms which have been learned in a culture are superimposed on an underlying disorder. Kruger (1980), in an article on cross-cultural contact between the white therapist and black client, states his belief that the commonly-used metaphor of "mental illness" fails to provide a suitable or adequate avenue for gaining an understanding of problems in living. Holdstock (1981) also criticizes the tendency of mental health professionals to work in terms of the sickness model and to emphasize pathology, while the potential of the vast majority of people whose functioning is adequate is virtually ignored.

2.3.3.2 Personal autonomy

Kruger (1980) shows that much of Western psychology expounds the desirability of personal autonomy. Kruger (1977) argues further that the overriding conceptualization to which the Westerner adheres in terms of his individual existence, is that of a bounded self set off against the world as a separate entity. This adherence to the ideal of personal autonomy has developed out of a long process of individualization and secularization and is in accordance with the economic system and religious beliefs of the majority of white Protestant South Africans. The problem is
that Western mental health professionals who work transculturally are inclined to adhere to this image of self. From the writings of Kiev (1972), Manganyi (1973) and Sow (1978) (see paragraph 2.2.2), it becomes clear that such a conceptualization is unsuitable for black African people, whose sense of identity tends to be derived from the group. It is in view of these considerations that Shmukler (1986) calls for an expansion of the Western models of psychotherapy beyond the intrapsychic and the individual.

2.3.3.3 One-to-one method

Holdstock (1981) notes that mental health professionals are apt to attach disproportionate value to the one-to-one method of therapy and to underemphasize group and community approaches. This approach is inefficient in countries like South Africa, where there are vast numbers of people who require treatment, and where there is a severe shortage of mental health professionals who can serve them. The one-to-one method of treatment, besides being inefficient and economically wasteful, is alien to black African people. In the traditional world, treatment never involves just a relationship between two people (Sow, 1978). The one-to-one method of treatment, together with other characteristics of Western mental health services such as the isolation of people in hospitals, increases the disturbed person's alienation from society (Holdstock, 1979).

The great majority of Western techniques are culturally too alien to provide a suitable psychological approach to the healing of the black people of South Africa (Holdstock, 1979). In view of this situation, Shmukler (1986) has called for the development of skills and techniques other than verbal intellectual ones. She envisages the use of non-verbal techniques such as art, movement, music, street
theatre and relaxation. Furthermore, she points to the need for methods that will be suitable in dealing with the effects of violence, intimidation and traumatization.

2.3.4 Communication

Kruger (1980) points out that a black client and a white therapist involved in a therapeutic relationship are unlikely to have been reared and socialized in the same language. Where there is a reliance on verbal techniques, such differences may make it impossible to form a therapeutic relationship. Kruger (1980) describes just such a situation, where the therapist operating in terms of a client-centred model, attempts to elucidate the feeling aspects of a client's existence. Even if client and therapist have some knowledge of each other's languages, the therapist is unlikely to be capable of high levels of empathy. Manganyi (1973) goes so far as to claim that the problem of communication is, for therapeutic purposes, an insurmountable one. The problem is further exacerbated by the political situation and a long history of racial separation which makes it virtually impossible for client and therapist simply to experience themselves as fellow human beings. Instead, they will inevitably perceive themselves and one another in terms of black client and white therapist.

2.4 TRANSCULTURAL PSYCHOLOGY: A WRITE-OFF?

Holdstock (1979) argues very strongly that counselling and psychotherapy are most effective when the healer and the person to be healed are culturally similar. Does that mean that we should forget about transcultural psychology? Transcultural psychology still appears to have relevance for the following reasons,
2.4.1 **Shortage of black mental health professionals**

In the first place there is a severe shortage of psychologists, and of black psychologists in particular (Holdstock, 1979). This applies to many of the other mental health professions. According to Allwood (1986), it is estimated that amongst the white population, there is one psychiatrist for every 25,000 people; in the black population there is one for every 500,000 people. He notes further that in South Africa the attempts made to train large enough numbers of black mental health professionals have been totally inadequate.

2.4.2 **Unsuitable training**

In the second place, as Shmukler (1986) has pointed out, black mental health professionals find that their training does not prepare them adequately for the reality of the situation of which they are part. Allwood (1986) notes that the training of black professionals fails to make them immediately available and helpful to black clients even where the professional and client share the same language. He cites the example of black social workers in Soweto who have found the reflective interview technique of Carkhuff, in which some of them were trained, to be of little use in their dealings with black clients. Holdstock (1979) refers to Collomb (1975), according to whom black professionals who have been trained in a Western model tend to be regarded as strangers within their own communities. Present training is elitist and very costly, and is basically geared to equip people for private practice within a very small and privileged section of the community (Shmukler, 1986). Thus, the argument that black professionals are inevitably more effective in treating black clients is not necessarily valid.
2.4.3 Traditional healers: not a total solution

This author agrees with Holdstock (1981) that traditional healers provide an invaluable service to the community, and that the psychological world should open itself up to what these people have to offer. However, to argue that all black patients should be treated by traditional healers rather than by white or even black Western trained mental health workers, is not valid. Firstly, there are many black patients in mental hospitals who have been treated by a traditional healer, but unsuccessfully so. They have subsequently been referred to the mental hospital by the healer, or have come there on the basis of a decision made by the family. Secondly, there are a considerable number of black people who prefer to be treated by Western-trained mental health professionals rather than by traditional healers.

The idea expressed by authors like Holdstock (1979) and Kruger (1974; 1977), that mental health professionals consult with traditional healers, is very valid. A limitation is that the people in authority at mental hospitals need to be convinced of the desirability of such an approach.

In view of the above it seems likely that, at least for a few years to come, psychologists will be faced with clients who are different, in need of help and who cannot be referred to a more suitable therapist or other practitioner. Faced with this practical situation the therapist has basically three options:

1. She can refrain from helping the person in the knowledge that being culturally different he has less chance of being effective.
2. She can attempt to work with the client in terms of the models he has been trained in, which invariably will be Western type models.
3. She can try to develop techniques and methods which may be effective in bridging the cultural gap, and of use to her culturally-different client.

In this study the third option is chosen.

2.4.4 Urbanization and acculturation

Cheetham (1975) observes that the rural person’s entire self-concept, his process of identification and the formation of a personal identity are questioned when he is confronted with Western technology. Patterns of behaviour and expectations which stress community and family ties and obligations are hardly applicable in the market-place, urban area or factory, where the emphasis is on individual self-interest and self-reliance (Kiev, 1972). O'Brien (1987) notes that with Western civilization and associated urbanization a splitting of the sense of wholeness occurs.

The splits that become apparent are, amongst others, those of

* The individual from his community
* Work from livelihood
* The nuclear family as separate from the community
* Neighbours from each other
* Mind from body, body from spirit
* People from nature.

Most white people in Africa have been subjected to these separations. The black people of Africa are increasingly being exposed to these splits and alienations of urban technological society. It thus becomes apparent that, although there are large cultural differences between black and white people, there are also fundamental similarities. With the acculturation of the black person these similarities are likely to increase. It should, however, be
remembered that the move by black people towards Western civilization has its counterpart in the increasing movement of Westerners towards non-Western cultures and philosophies. Specifically, there have been significant shifts towards more holistic healing practices as reflected in, amongst others, the success of the National Conventions on Holistic Health and Healing held in Cape Town in 1987 and 1988. Developments in the physical sciences have heralded a departure from a mechanistic, Newtonian world view (Capra, 1982). The rise of environmentalist groups all over the world reflects a growing understanding of, and concern with, the interdependence between man and nature.

Thus, while it is recognized that cultural differences between black and white people are real and need to be respected, this author believes with Bührmann (1984) that we should guard against making a fetish out of cultural and ethnic differences. Bührmann (1984) refers to Kiev (1972) who maintains that an understanding of, and respect for, differences in cultures can be fostered by acknowledging the similarities underlying human groups. This author agrees with Karani (1986) that a bridging of the divide between the basic world views of black and white people is essential for the positive mental health of all. It is in view of these considerations that this study was undertaken, in an attempt to develop a therapeutic model which may be of help in bridging the gap between a therapist and clients who are culturally different.

Dance-movement therapy was chosen as a possible alternative therapeutic model for several reasons:

1. As has been mentioned in paragraph 2.3.4, a reliance on verbal techniques makes it impossible to form a therapeutic relationship between a therapist and a client who do not share the same language. Schmais (1974) maintains that dance-movement can be used by the therapist to gain an empathic
understanding of her client and to communicate that understanding to her client.

2. Holdstock (1979; 1980) argues that African civilization functions mainly in terms of right-hemispheric consciousness and that intuitive knowing is a basic mode of being in Africa. Dance-movement therapy can help to narrow the gap between white therapist and black client because, as Nussbaum (1987) has argued, movement can serve as a bridge to the intuitive and creative aspects of ourselves.

3. According to Bernstein (1981) movement as a form of expression is an integral part of black people's lives, right from the time they are children. Dance is a very important aspect of community life in Africa and it is frequently used in ritualizing crises and in celebrations (Nussbaum, 1987).

Having outlined the most important reasons for exploring dance-movement therapy as a therapeutic technique in working with black clients it is now necessary to provide an overview of this therapeutic mode as it has been discussed by the various authors in the field.
CHAPTER 3
DANCE-MOVEMENT THERAPY

3.1 A HISTORICAL PERSPECTIVE

"The historical role of rhythm and dance, in terms of its relatedness to emotional and psychic needs is an important frame of reference for dance therapy" (Espanak, 1981, p. 12).

3.1.1 Dance in tribal primitive communities

Meerloo (1968) points out that the dance of the traditional healer may be seen as one of the oldest forms of medicine and psychotherapy. Dance therapy was an accepted procedure amongst so-called primitives, and was practised successfully (Ellfeldt, 1979). The dance served as the medium for common exaltation, release of tensions and the transformation of human suffering. The ecstatic dances, according to Espanak (1981), provided an affirmation of life. The members of early civilizations utilized dance-movement to express many things such as religion, fear and awe of the unknown (Ryder-Toombs, 1968). Dance was of utmost importance in the lives of primitive people and of members of ancient civilizations (Sachs, 1937). It was certainly not an art form which detracted from the prerequisites of survival. On the contrary, it provided the nourishment needed to sustain spiritual life.

3.1.1.1 Group cohesion

Chaiklin (1975 B) indicates how the shared rhythmic action of tribal dances served to establish group cohesion. Thus, those taking part in the dance could be relieved of emotional isolation and could move beyond the usual individual limitations. Chaiklin (1975 A) notes that members of the
early civilizations used rhythmic action to solidify group feeling. Dance was a communal expression which, at the same time, fostered individual identification with the communal experience, reinforcing a sense of security and belonging (Espanak, 1981). Dance also strengthened cohesion in that it played a major role in the regulation of group and individual relationships, and in role definition (Bartenieff, 1972). Ellfeldt (1979) writes that the collective generation and expression of emotion served to mould individuals into a group that was much more powerful than any of its constituent parts.

3.1.1.2 Gaining power

Compared to modern man, early man, in order to survive, had to rely on his fellow human beings to a much larger extent. Lange (1975) explains how early man made extensive use of dance as a coordinating factor in his group activities. For instance, in the performance of certain tasks necessary for survival, early man used rhythm to tie the performance of individual human beings into one great, unified effort.

Rhythmic action in large groups has been used by human beings to gain a sense of power and control over, amongst others, the forces of nature (Ryder-Toombs, 1968; Ellfeldt, 1979). For early man, the world was a very uncertain and terrifying place in which the unprotected individual would surely perish. Moving in the unison of the dance was important for survival in a world wrought with the dangers of storms, savage beasts, fire and unknown terrors (Ellfeldt, 1979).

3.1.1.3 Elimination of fear

In the history of man, dance has played a predominant role in the elimination of fear, in that the dance allowed the individual to identify with forces and creatures who seemed much more powerful than man himself (Espanak, 1981). The
tribesman, by becoming the lion or some other powerful beast, through the process of role identification, was infused with the strength of that beast (Bernstein and Bernstein, 1974). Various people gave recognition to this type of transcendence of self (Espanak, 1981). This transcendence of the self entails not just identification with a higher power, but also serves the need to express powers which are inherent in the individual, but which need to be kept at bay for the greater good of the community.

3.1.1.4 Suspension of the conventional self

Hanna (1977) gives an exposition of the Nigerian Ubakala dance-plays. These provide the individual with the opportunity to vent that which would be socially inappropriate to express in everyday functioning and contact with people. In these dance-plays, alternative social arrangements can be enacted and contrary ways of behaving and thinking can be played out. Those who have little status and/or power in the community can ridicule and criticize those more powerful than they are, without losing face, and without having to bear the consequences. Bernstein and Bernstein (1973) refer to this process as role reversal.

According to Espanak (1981) and Ellfeldt (1979), the mask worn during ritual dancing enabled its wearer to hide, while at the same time, expressing whatever he needed to without having to fear retribution. Thus, the mask allowed for the suspension of the conventional self. The dance, in conjunction with other tools such as the mask, enables the dancer to participate in a form of release.

3.1.1.5 Catharsis

Bernstein (1981) writes that many of the ancient ritual ceremonies were cathartic in nature. In early man, the dance functioned as a representation or direct expression of major
emotional states (Espanak, 1981). Royce (1977) argues that dance is one of the most effective means of obtaining psychological relief. For both dancer and observer, feedback and catharsis are immediate in the dance.

3.1.1.6 Communication

Stark (1982) emphasizes the expressive and communicative nature of dance. In the dance, emotions can be shared directly on a pre-verbal and physical level, while the dancers move together to a common rhythm. In early civilizations, ritual dances functioned to establish empathic understanding between people. Such empathic understanding, in turn, enhanced harmonious relationships between group members.

Ellfeldt (1979) describes how the dance served to strengthen family and tribal ties. New members were integrated into the community by means of what he calls communication dances. These dances, relating to ancestral beliefs, custom and practice, were taught to children. The performance of these dances enabled the young to learn accepted modes of behaving and thinking.

3.1.1.7 Anticipatory psychic management

Integration of the individual into the group is enhanced by means of rituals which involve anticipatory psychic management. Hanna (1977) explains how the Ubakala dance-plays of Nigeria aid participants in handling psychic tensions by means of anticipatory psychic management. The individual is prepared for a frightening and strange experience, for example child-bearing, by rehearsing it until its potentially destructive emotional impact is reduced to a level which can be handled effectively by the
individual. Repetition can help the individual to master an anticipated future event as well as a situation or feeling connected with an event that occurred in the past.

3.1.1.8 Worship

According to Ellfeldt (1979), worship dances were performed in order to gain power and prestige by imitating the gods. Masks played a very important role in this respect. By means of the mask, among other things, the dancer could relinquish his own identity and take on another. The wearer of the mask assumed supernatural and sacred powers. The shaman would dance himself into a state of unconsciousness. In this state, his body could serve as the medium for establishing contact between the group and the gods. Sachs (1937) maintains that by means of ecstatic dances man could draw nearer to, and establish communication with, the realm of demons, spirits and the gods.

3.1.2 Dance in European civilization

From the onset of European civilization, people had already become estranged from dance as a spontaneous and commonly-known human manifestation (Lange, 1975). Dance had, instead, developed into a well-defined and cultivated activity.

Royce (1977) refers to Lawler (1964), who writes that in ancient Greece everyone was expected to show some prowess in dancing, although not to the point of professionalism. Dance was regarded as a necessity for everyone. Lange (1975) informs us that never again in the history of European civilization did dance regain this status. He further states that, although the classical revival of dance (1638-1715) firmly established dance as an art form in modern Europe, it was seldom practised beyond court circles and, later, on the theatre stages of Europe.
Considering movement in general, Laban (1968) notes how the range of movement carried out in everyday activities, specifically work, was drastically reduced with the advent of the industrial revolution. Movement came to be regarded as the servant of man, used to achieve an extraneous goal. However, in the early twentieth century this perception of movement was challenged as human beings came to recognize movement as being an independent power, capable of creating states of mind which often were stronger than man's will.

3.2 DEVELOPMENT OF DANCE-MOVEMENT THERAPY TO PROFESSIONAL STATUS

3.2.1 Modern dance

During the 1930's Isadora Duncan broke with the strict structure of classical ballet (Schmais, 1974). She re-introduced a form of dance expression in which there is no story behind the dances (Schmais, 1974). This artist's dances were, in her own terms, the expression of the life of her soul. According to Schmais (1974) Duncan regarded dance as the human being's most basic response to the universe. In her view, man's ability to live freely and fully could be renewed by reviving his capacity to dance. Fleshman and Fryrear (1981) point out that her understanding of dance in classical Greece formed the basis for some of her ideas and her way of dancing. She established the connection between modern dance and the therapeutic use of dance and music by the Greek culture. Other exponents of the new approach to dance included Ruth St Denis and Ted Shawn, who together established the Denishawn School (Murray, 1979). Much of this work of Ruth St Denis was based upon ideas which she obtained from her studies of the Orient, where dance had played a major role in religion and healing. The Denishawn Company, through its students and then their students, exerted a major influence on dance therapy (Fleshman and Fryrear, 1981). The early pioneers of modern dance, having
cast off the limitations of superimposed techniques, brought
to dance a bigger range of expressiveness and a focus on
personal experience.

3.2.2 PIONEERS OF DANCE-MOVEMENT THERAPY

The early developers of dance-movement therapy included
Marian Chace, Franziska Boas, Lilyan Espanak, Trudi Schoop
and Mary Whitehouse (Bartenieff, 1972). In 1942 Marian
Chace, many of whose dance pupils had claimed to have gained
physical and emotional benefits from her classes, was
invited to start work with patients at St Elizabeth's
Hospital in Washington D.C. In this way St Elizabeth's
became one of the first institutions in which dance therapy
was included as part of the ongoing treatment program
(Chaiklin, 1975 A). Chace's group-oriented, interactional
approach is still the basis for dance therapy with
hospitalized patients (Sandel, 1980).

Franziska Boas, in collaboration with Lauretta Bender, made
use of music and spontaneous dance activity in the treatment
of emotionally disturbed children (Marek, 1975). They
introduced into their sessions, activities such as walking,
crawling, jumping and rolling on the floor. This was done
in conjunction with role-playing. Fantasies and ideas that
developed from the role-playing were discussed, thus
providing a release for tension and feelings (Fleshman and

Trudi Schoop (1974) played a major part in the development
of modern dance in Europe during the period leading up to
the Second World War as well as during the war years. She
emigrated to the United States where she worked with
severely regressed psychotic patients in a state
institution. Schoop strongly believed in the interaction of
body and mind and argued that human beings could be
influenced from either side of their nature.
Lilyan Espanak worked with mentally retarded children as well as with neurotic and psychotic adults. Her approach placed much emphasis on reintegration of posture as a necessary condition for the reintegration of body and mind (Fleshman and Fryrear, 1981).

Mary Whitehouse used as her theoretical basis Jungian psychology. She maintained that authentic or spontaneous movement develops from body awareness, that is, awareness of an inner impulse to move. She saw dance-movement therapy in terms of symbolic representation of inner experiences through movement, but she also emphasized the importance of verbalizing (Bartenieff, 1972).

Another major influence on dance therapy was that of Rudolf Laban. He developed a system of describing and analyzing movement behaviour. His effort-shape system came to be used by dance-movement therapists as an aid in their observation and recording of their client’s movements during the dance therapy sessions (Fleshman and Fryrear, 1981).

3.2.3 The influence of psychology

Psychologists interested in human movement have, generally speaking, conceptualized it as expressive of self or of character or personality. One of these was Wilhelm Reich who believed that mental and physical rigidities form a unitary function (Feder and Feder, 1981). The implication thereof was that, by changing a person’s way of moving, the person could be changed in totality.

3.2.4 The Second World War

The Second World War and its aftermath also had a significant influence on the development of dance-movement therapy. Individual analytic therapy, the most widely practised and accepted form of therapy at the time, was
unsuitable for the treatment of large numbers of returning veterans. New approaches had to be developed to assist in the rehabilitation of these people. Schmais (1974) refers to Bromberg (1963) and Gaston (1968), according to whom group therapy, activity therapies, art therapies and instructional groups were among the techniques introduced in an effort to deal with the drastic changes occurring in the mental health field.

3.2.5 **Community responsibility and tranquilizers - 1950's**

During the 1950's more emphasis was placed on the responsibility of the community in caring for the mentally disturbed. Also during that period, tranquilizers were discovered. Consequently, many chronic patients were released from physical restraint and became more approachable. Large numbers of these patients did not communicate verbally. As a result, non-verbal techniques such as dance-movement therapy had to be developed to establish contact with and to reactivate these people (Schmais, 1974).

3.2.6 **Research in non-verbal communication and the human relations training movement - 1960's**

There were two major happenings during the 1960's which further increased the interest in dance therapy. Firstly, there was a resurgence of research in non-verbal communication. Bird Whistell was a pioneer in the field of kinesics, the science of body-behavioural communication popularly referred to as "body language". His research led him to contend that the bulk of human communication may be non-verbal. He argued that intonations, sounds, silences, postures and gestures constitute the actual substance of socially-organized interpersonal behaviour (Feder and Feder,
Another researcher whose investigations into kinesics have had an impact on the field of dance therapy, is Condon (1968). He found that human behaviour is ordered and rhythmical, at many levels, with respect to both speech and body motion and to personal and interactional behaviour. It is this startling rhythmical and participant nature of human communication which suggests that human interaction may be inherently dance-like in form (p. 22).

The other major development during the 1960’s was the human relations training movement (Schmais, 1974). Those involved in this field discovered that exercises requiring body movement resulted in increased awareness of themselves and others, and improved their ability to express themselves and to be more empathic in relationships with others.

3.2.7 Founding of the American Dance Therapy Association

In the autumn of 1964 a small number of dance therapists who had been taught by Marian Chace, met in Washington to discuss the possibility of an association of dance therapists (Feder and Feder, 1981). In 1966 the American Dance Therapy Association was founded by a group of seventy-three charter members. Dance therapy was defined as "the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual" (Feder and Feder, 1981, p. 159). The constituting of a formal association established a firm basis for the development of dance therapy as a recognized method of treatment.

3.3 THE PREMISES OF DANCE-MOVEMENT THERAPY

From a review of the literature, it would seem that the concept of dance-movement therapy is based on the following
premises: firstly the mind-body forms an inseparable totality (Scoop, 1973; Kelly, 1974); secondly, the body is the medium for our experience of the world; and thirdly, the expressive aspects of the human being, namely his movements, gestures and postures, are a function of the individual totality.

Thoughts and emotions are inextricably linked with physical movement. Body movements do not simply reflect thought processes but actually play a role in creating them. Feder and Feder (1981) cite research evidence which has given support to the idea that both body and mind can learn cognitively and affectively. "The body is itself a source of memory, response and learning" (Chaiklin, 1975 B, p. 703). According to Espanak (1981), the basis for dance-movement therapy is that physical phenomena can bring about the occurrence of an emotion.

A person who is mentally healthy uses a wide variety of combinations of movement qualities, which is indicative of flexibility and adaptability (Nussbaum, 1987). Movement qualities are factors like space, time, energy and flow, which entails continuity of movement. Pishney (1974) argues that, if a person can expand his range of movement, he will also be able to expand his range of coping, creating and behaving. A person who can widen his movement repertoire and develop a more flexible posture is likely to develop a broader range of potential behavioural responses (Chaiklin, 1975 B). The dance-movement therapist works on the assumption that the bigger the movement repertoire from which the individual can choose and the more adequately integrated these patterns are, the greater will be that individual's capacity to effectively deal with his environment and with his own emotions. An expanded movement repertoire enables a person to express impulses and feelings and to interpret the movements of other people more accurately (Fleshman and Fryrear, 1981).
Body movement is, in essence, an adaptation (Fleshman and Fryrear, 1981). If a person slouching with his upper trunk leaning can begin to walk upright, with the portion to the size of his body and a different "Blickfeld", that is, a g which opens up a wider range of merges (Siegel, 1984, p. 65). In a of the body and the schema of the body and the ingrained ways change (Schilder, 1964). If a person which previously has never perceived a change also perceive a change in her physical space in thrust and direction in space new dimensions in space. When a person tempos to different rhythms she sense of time.

Verbalization in Dance-Movement

I coined the term "inactive to the most fundamental way of therapies have, in general, not taken into account the felt level of experiencing must be verbal level (Alpers, 1972). Therapists regard movement therapists regard movement as their clients include a cognitive to Bernstein (1981) th that effective interventions individual on both these levels. Body and breathing patterns and breathing patterns are focused on client's verbal expression. By functions, the therapist functions, the therapist maintains or
even exacerbates the split between body and mind (Siegel, 1984). Cognitive processes need to be developed in relation to movement so as to maximize its potential (Chaiklin, 1975 B).

Alperson (1972) refers to Gendlin (1962; 1969) who differentiated between two levels of experiencing. The first level is referred to as the felt level of experiencing. It entails a body-sense of a situation or a problem. Sensory and kinesthetic awareness, including emotional states, are aspects of the felt level of experiencing. This level is pre-verbal and pre-conceptual. Flowing directly from this first level of experiencing is the symbolic level. At this second level the individual can conceptualize and verbalize her felt-experience. The conceptual/verbal level allows for the validation of experience in the presence of others. It also enables the clarification of ambivalent perceptions, feelings and actions. Personal growth and integration are dependent on the presence of, and interaction between, these two levels.

3.5 THE GOALS OF DANCE-MOVEMENT THERAPY

Stark (1982, pp. 314-316) provides the following framework within which the goals of dance-movement therapy can be placed:

* The body and its action
* Interpersonal relationships
* Self-awareness.

The goals as set out by the various authors in the field of dance-movement therapy can largely be accommodated within this framework. An additional category, namely "integration", has been added to Stark's framework. In reading the ensuing description of the goals it should be kept in mind that their separation is artificial.
3.5.1 The body and its action

3.5.1.1 Defining boundaries of the physical self

According to Espanak (1981), the first step towards body-mind unity entails the recognition by the patient of his own body. Patients, especially those diagnosed as schizophrenic, often lack clear body boundaries (Schoop, 1974). For such patients the most basic aim in using dance-movement therapy would be to bring them to a point where they can define the boundaries of the physical self.

3.5.1.2 Energizing, stimulating and catharsis

Another physical goal (Fleshman and Fryrear, 1981) entails energizing and stimulating the patients' bodies in free movement. Closely related to this goal is the concept of catharsis. Cathartic release of tension and feelings through body-movement is cited by several authors (Espanak, 1981; Hanna, 1977) as a goal of dance-movement therapy. According to Chaiklin (1975 B), human beings should be able to experience, on a bodily level, the tensions and emotions which form part of man's existence.

Having lived these stresses and emotions fully, the body can then restore itself to a relaxed balance which forms the basis for the adequate handling of future experience. Espanak (1981, p. 7) regards the "stimulation and release of feeling through body movement and gesture" as an integral aspect of dance. This aspect helps to make dance an especially appropriate therapeutic tool. Dance is often restorative in that it enables a person to give expression to the impulsive, following the strain of adjusting to his environment and the weariness of doing what is expected of him (Hanna, 1977). In dancing, human beings can experience the joy of self-expression (Lange, 1975). Siegel (1984) maintains that in many cases it is necessary to dance
vigorously with the sole purpose of relieving tensions. Only after such dancing can direct building of body-image proceed.

3.5.1.3 Appropriate feeling expression, coordinated movement

Yet catharsis by itself is usually not sufficient. Scoop (1974) contends that mere discharges can amount to a totally mindless exercise, a type of self-indulgence. Here the argument mentioned in paragraph 2.4 applies, namely that movement and cognitive work must be treated as complementary. Thus, the patient is led to a point where feelings can be expressed in an appropriate and channelled manner (Sandel, 1980). Furthermore, the dance-movement therapist not only works to stimulate and energize the patients' bodies in free movement (Fleshman and Fryrear, 1981), she also directs her efforts at introducing some structure into random, uncontrolled movements (Chaiklin, 1975 A). Furthermore, body distortions are identified and corrected (Feder and Feder 1981).

3.5.1.4 Body image

According to Bernstein (1981), a healthy body image plays a large part in the development of a fully-functioning person. Espanak (1981) regards body image as being one of the major aspects of the total self-image. She defines body image as the individual's subjective perception of his own body and of his own reactions and those of other people to that manifestation. Patients in a mental hospital frequently have a shabby and stiff appearance and lack coordination - all of which contribute to low self-esteem (Romero, Hurwitz and Carranza, 1983).

The formation of the body image is based largely on movement, be it movement of an emotional or functional
nature (Bernstein, 1981). An example of functional movement would be getting up from the desk, walking to the bookshelf and selecting a book. Movement of an emotional nature would be stamping the feet, rolling on the floor and beating the fists into the ground in throwing a tantrum.

An important function of dance-movement therapy is that it can enable individuals to develop accurate body images (Feder and Feder, 1981). Furthermore, by fostering a patient's confidence in his own body action, dance enables that person to relate to others more adequately (Chaiklin, 1975 B). The chain of events through which this occurs may be described as follows: dance produces greater flexibility and increased spontaneity of movement; in this way body image and self esteem are improved; this, in turn, increases the likelihood of more complicated movements being initiated and performed. Having thus developed a wider movement repertoire the individual can relate to others in more effective ways.

3.5.2 Self-awareness

Through the dance, body-mind awareness can be heightened (Bartenieff, 1972). Self-awareness includes awareness of the body parts, of breathing, sensation, centring, areas of restricted movement, as well as non-verbal double messages (Chodorow Smallwood, 1974). Dance-movement therapy can serve, to increase kinesthetic awareness, that is, sensing through the muscles (Hawkins, 1973). Furthermore, body awareness is enhanced as the individual sees himself and his movements in relation to other people (Feder and Feder, 1981). The therapist herself and/or the other group members may reflect the patient's movement, thereby providing him with visual feedback about himself (Sandel, 1980; Schmais, 1974). By observing feelings being expressed in the bodies of other group members, the individual may be able to recognize and gain an increased awareness of his own feelings (Stark, 1981). Such increased awareness of feelings
is also brought about by heightened kinesthetic awareness. Having gained self-awareness, the patient can then begin to take responsibility for his behaviour and consciously choose to alter it (Sandel, 1980).

3.5.3 Interpersonal communication

There seem to be two aspects of interpersonal communication as related to dance-movement therapy. The first concerns the fact that dance-movement may be used instead of, or in conjunction with, verbal communication to establish contact and to build a therapeutic relationship with certain patients who cannot be engaged by means of verbal methods. The second aspect revolves around the finding by Kendon, referred to by Stark (1982), that the coordination of bodily movement with that of other individuals is conducive to the attainment of satisfactory social interactions.

Patients in a mental hospital are often extremely isolated from other people. They often experience themselves as being inadequate and this initiates a vicious circle whereby they restrict their communication with others. This, in turn, increases feelings of inadequacy. As a consequence of this vicious circle, many patients in mental hospitals rarely talk and when they speak, they do so only very briefly.

Many patients find it easier to initiate and sustain contact with the therapist and with each other through the language of movement rather than through verbal communication (Espanak, 1981). According to Bernstein (1981), movement is the most basic mode of communication. Dance-movement is an activity in which a person can be involved as a totality. Rhythm, an important component of most dance-movement therapy sessions, serves as a basic medium for interaction in therapy (Bernstein, 1981). Rhythm generates participatory behaviour in the sense of joining in and sharing an experience with other people (Espanak, 1981).
According to Kendon (referred to by Stark, 1982), individuals whose social interactions and communications are disturbed can relearn the necessary behaviour, that is, rhythmic coordination with others through dance-movement therapy. Espanak (1981) maintains that in group dance-movement therapy much emphasis is placed on accommodation. She regards accommodation as the individual's capacity to coordinate his movements with that of other human beings and to adapt his own rhythm to that of others. By working on and improving accommodation, social competence can be enhanced.

3.5.4 Integration

Dance-movement serves to integrate the total being (Bernstein, 1981). Such integration takes place at various levels. In the first place, dance-movement increases the conscious experience of interaction between body and mind (Espanak, 1981). Secondly, it serves to establish the unifying interactive relationship between fantasy and reality (Schoop 1973; 1974). Hanna's (1977) concept of paradox mediation can also be seen in terms of integration. She sees paradox mediation as being the resolution of conflicting opposites. It would seem, then, that this entails the integration of seemingly irreconcilable opposites into a larger unity. Such integration as described above is conducive to a feeling of well-being (Lefco, 1974) and to optimal functioning.

3.5.4.1 Integrating aspects of psycho-motor maturation

According to Bernstein and Bernstein (1973, p. 121), dance-movement therapy is in many ways akin to "a series of remedial ritual processes or rites of passage". They refer to Turner (1969), who explains how ritual processes help human beings to orient themselves in the complexities which
characterize organized societies. Bernstein (1981) believes that phase-related maladaptive experiences are stored in the body if a person's environment does not allow for adequate development. Thus, if an individual who does not function adequately is given the opportunity to organize and integrate those aspects of psychomotor maturation which, under normal circumstances, are experienced during the course of the growth process, that person will be enabled to live more successfully. Dance-movement therapy affords the individual an opportunity to face up to and work through her own crises in an environment which encourages such confrontation and supports the individual in the process (Bernstein and Bernstein, 1973). In this sense, then, therapy may be regarded as the remedial education of those individuals who, in the past, could not effectively deal with and integrate the various life crises. By means of movement-based experiences involving higher complexities of developmental tasks, the therapist, according to Bernstein (1981), enables the client to progress to the level of functioning appropriate to his age.

3.5.4.2 Rehearsal to master stressful past and future events

Hanna (1977) points out how, in less westernized societies, dance plays are used to master a situation or feeling relating to a past event. Through repetition, the situation or feeling can be dealt with effectively and assimilated. Anticipated future events can be mastered in a similar manner. The individual is thoroughly prepared for a threatening experience by rehearsing it until its potentially destructive impact is diminished to a point where it becomes manageable. Not only does integration occur at the level of the individual due to these dance plays, but the individual can also be integrated more successfully into his social context.
3.5.4.3 Socialization

Bartenieff (1972) and Marek (1975) refer to the potential of dance as a tool for integrating the individual into her community. By means of the interaction of dancing in a group, the ordering of human relations, and thus, socialization, can occur (Bartenieff, 1972). Marek (1975) maintains that, in view of findings that movement behaviour is culturally learned, teaching people social skills in terms of body movement may enable these people to successfully integrate into the social order.

3.6 EVALUATION IN DANCE-MOVEMENT THERAPY

Chaiklin (1977) maintains that the nature of the therapeutic goals, and how they will be attained, is based largely on the information gathered and the assessment made by the therapist. Authors in the field of dance-movement therapy appear to perceive evaluation as entailing two broad areas of investigation. The first involves the background against which therapy takes place, the broader system within which the therapist-client subsystem operates. The second entails the movement of the individual client.

There is very little, if any, mention in the literature regarding the assessment of the group process which evolves in group dance-movement therapy.

3.6.1 The background against which therapy takes place

Therapeutic goals are, to an extent, determined by the treatment setting. The time factor involved also deserves consideration. If the therapist is working in an in-patient setting the average duration of hospitalization will play a determining role in the setting of goals. Other factors to be kept in mind are the client's motivation and level of
functioning, as well as the therapist's strengths and shortcomings. The therapist needs to be knowledgeable about what the client perceives his problem to be and what he wants for himself (Chaiklin, 1977).

Furthermore, cognisance must be taken of the social systems within which the client functions and of which he forms a part. Bernstein (1981) argues that the therapist needs to remain aware of the fact that members of different cultures and subcultures move differently. The subtleties of communication in the patient's environment and cultural background must be kept in mind at all times (Feder and Feder, 1981). According to Bernstein (1981), questions to be considered by the therapist are as follows: firstly, is the individual returning to his subculture, and if so, will all the aspects of his life be lived out within that subculture or culture? Secondly, is the individual moving into a new subculture/culture which requires a different movement repertoire for successful functioning?

3.6.2 The movement of the individual

Scoop (1974) writes that her basis for evaluation is human expression as manifested by the body. Our gestures, working actions and the way we hold our bodies, reflect who we are (North, 1972). In reading the ensuing exposition it should be kept in mind that the separation of the various elements/aspects of movement is artificial. Since there is no clear separation between evaluation and treatment the following discussion will, at times, touch on issues of treatment.

3.6.2.1 Breathing

Bernstein (1981) argues that the flow of a person's breathing is the most basic factor to be considered in dance-movement therapy. Lyon (1981, p. 19) makes the
important point that "Breathing is being alive". In breathing, we become one with the universe (Detlefson, 1985). Our emotions are all reflected in the depth, tempo and ease of breathing (Bernstein, 1981). We cannot be healthy if our breathing is disordered (Scoop, 1974). Consequently the therapist, in assisting the client toward more adaptive functioning, places much emphasis on breathing. By focusing on breathing the process of awareness is set off and the individual is held in the here-and-now (Lyon, 1981).

3.6.2.2 Centring

Centring and breathing are very closely related in that the diaphragm, which moves spontaneously in breathing, is in a sense the central "organ" of the body. Scoop (1974) maintains that the individual's centre makes physical and emotional unity possible. Every movement we make either goes away from, or comes towards, the centre. Human beings always fluctuate between this "in" and "out" (Scoop, 1974). On the one hand we can temporarily shut ourselves in, and off from, the world when we need to gather strength and meditate. On the other hand, we can become completely outer-directed, as when we are completely absorbed in a task. This fluctuation may be disrupted in the sense that the individual may begin to emphasize one side of this in-out polarity to the exclusion of the other. When there is a centre disturbance, the individual's physical boundaries become blurred. In attempting to re-establish the functional centre the therapist introduces every conceivable exercise that will activate the muscles of the centre.

3.6.2.3 How the body moves

Centring may be seen as an aspect of how the body moves. North (1972) sees how the body moves in terms of general
style and quality of movement. With regard to style of movement, actions can tend towards being "spoke-like", that is, moving from the centre of the body to an outer object or position. On the other hand, the movements may tend to be "edge-like", which means that the movements do not return to the centre. Another aspect of style is the body shape of the individual - whether it is crouched or erect, open or closed (North, 1972).

Wethered (1973) points out that quality of movement is an integral aspect of how the body moves. It is these qualities of movement which determine how we communicate. These qualities include:

* Energy: strength, lightness
* Space: direct, flexible
* Time: sudden, sustained
* Flow: free, bound.

3.6.2.4 The nature of actions

The therapist observes which parts of the body move (North, 1972). She also looks out for gestures made, and for body carriage. Scoop (1974) draws attention to split-body conditions; for example, a person may show a proud, inflated chest and weak legs which seem to be giving way. Wethered (1973) notes that the individual may move both sides of the body at the same time or that he may move one side while the other remains still. Another element involved is the range of movement (North, 1972). The therapist looks out for restrictions in bending, stretching and twisting. Scoop (1974) places considerable emphasis on alignment. She sees the ideal body as being erect, with the various parts of the body fully integrated into the overall structure. Such body would, furthermore, have a pliant spine which could lend support to any position or movement. The weight would be distributed in such a manner that there would be no strain, contraction or pressure in any area of the body.
3.6.2.5 Where the body moves

Bernstein (1981, p. 19) notes that "Shape is defined as the form of the movement or how the body changes and moves through space as it adapts to its environment (both human and non-human objects)". Human beings always move at various levels and in different directions (Wethered, 1973).

Espanak (1981) distinguishes between three levels of movement. The movements at the middle level of space are regarded as the everyday movements, the movements that we use in the performance of our everyday tasks. This level is reality-based. It is what Bartenieff and Lewis (1980) refer to as the medium level. The high level, or what Espanak (1981) refers to as the upper level, is the one towards which human beings reach, stretch up their arms or lift their entire bodies. It represents our strivings and aspirations. The third, or deep, level symbolizes our search for security. It is expressed in crouching and bending and in movements carried out close to the earth.

Wethered (1973) provides an outline of the directions in which we move. These include:

- forward
- left
- right
- backward

By adding the abovementioned levels to these directions we get dimensions.

Patients tend to be afraid of using space and they feel invaded by space (Scoop, 1974). With the help of the therapist they are brought to a point where, rather than being invaded by space, they become the invaders of space.
Having discussed the goals of dance-movement therapy and the elements involved in evaluation, the actual process of evaluating and of working towards the goals, as well as the techniques utilized in the process, will now be considered.

3.7.1 The beginning or warm-up

As to the dance-movement therapy sessions themselves, the discussion here will focus on group sessions. There seems to be general consensus among authors in the field that the session begins with some type of warm-up. Some therapists, for instance Wethered (1973) and Scoop (1974), prefer to do fairly structured exercises together with the group members. These exercises may revolve around a theme which the therapist has in mind and which may have evolved from previous sessions. Other therapists work more like Chace did in that they put a record on the turntable and start to dance, leaving the choice whether to take part or not to the patients (Chaiklin, 1975 A).

3.7.1.1 Preparing the body for action

How the therapist uses the first part of the session depends largely on what aims she has in mind. Pishney (1974) believes that the warm-up provides the participants with the opportunity to isolate and loosen every joint. According to Wethered (1973), this period serves to prepare the body for action.

3.7.1.2 Gathering information

There seems to be considerable agreement among writers in the field that this first part of the session is used by the
therapist to gather information so as to be able to make an assessment. According to Chaiklin (1975 B), during this phase the therapist can carefully observe the patients for indications of what their needs are, and how the session is to progress. The information gathered is certainly not confined to the individual group members but includes what is happening in the group as a whole.

3.7.1.3 Building group cohesion

Yalom (1985) time and again stresses cohesion as an important therapeutic factor. He refers to cohesion as the equivalent, in group psychotherapy, of the therapist-patient relationship in individual therapy. It includes the relationship of each group member not only to the therapist but also to other group members and to the group in its entirety.

3.7.2 Structure

As has been indicated in the discussion of the warm-up, the different approaches to dance-movement therapy vary in terms of the degree to which the therapy session is structured. If the group members are in the main schizophrenic, the therapist will most likely increase the degree of structure. According to Sandel (1982) schizophrenic patients experience such structure as caring from the therapist. Chaiklin (1975 A) also argues that groups consisting of patients in a mental hospital have a need for limits to be placed on behaviour, and for organized instruction in the use of the body. However, the group leader should set the limits so wide that the group members experience them only as the need arises. Sandel (1982) makes the point that while preconceived exercises may, when indicated, form part of a therapy session, the group leader normally introduces these in response to the here-and-now interaction which is allowed to unfold spontaneously.
3.7.3 Kinesthetic empathy

It is of utmost importance that the therapist be extremely sensitive to the action initiated by group members. According to Schmais (1974) the therapist both reflects on, and responds to, the patient's movements. The therapist attempts to approximate the movements of the group members as nearly as possible. She attempts to incorporate into her body the same breathing pattern, level of muscular tension, posture and body movement as manifested by the patient (Stark, 1982). However, the therapist does not directly imitate the patient. Rather, she tries to take the role of the member and to infuse her movements with the same feeling-tone observed in the client. In this way the group leader satisfies two of the three requirements for accurate empathy as described by Egan (1975, p. 92), namely awareness and know-how, including the ability of the therapist to convey or communicate her understanding of the client's world to the client.

3.7.4 Widening the movement repertoire

Schmais (1974) describes how the therapist, on the basis of the patient's needs, decides how to enhance, develop, intensify or transform the patient's movements. Bernstein (1981) makes the important point that each person needs to be ready before she can explore, and possibly alter, aspects of her being. Consequently, the therapist's suggestions for movement explorations should not go beyond the patient's own process. The therapist takes what the patients are doing and develops this into a reality-oriented, functional expression (Chaiklin, 1975 A). The therapist, having picked up the patient's movements and verbal communications, explores themes and builds them out by making use of movement, other forms of non-verbal communication, as well as verbal communication (Wethered, 1973).
Social learning plays a central role in the widening of the movement repertoire. Yalom (1985) points out that imitative behaviour is an essential element of social learning. Although specific imitative behaviour may be short-lived, it can serve to release the individual from rigid behavioural oral patterns and enable her to experiment with new ways of behaving. The dance-movement therapy group gives the members an opportunity to experiment with new modes of behaving within a relatively safe environment. In this environment the group members obtain direct and visible feedback from the therapist and possibly from other members who mirror their expressive behaviours (Stark, 1982).

3.7.4.1 Exaggeration

One way of widening the movement repertoire is by means of what Stark (1982) terms exaggeration. There is usually one aspect of a client's movement which stands out very clearly. The therapist may draw the client's attention to this element of movement and request of the client that she make the movement more extreme. Scoop (1974) also makes use of this technique, particularly in working on alignment and tension/relaxation.

3.7.5 Transforming movement into communication

Stark (1982) describes how the therapist can take movements which are dysfunctional; for example, repetitive or distancing movements are used in his efforts to involve the client in movement interaction. For instance, if a person repeatedly hits out at others, the arm that is hitting out can, with the help of the therapist, be used in stroking other people. This approach of taking what is given by the patient and then altering it by, for instance, changing its meaning, is well-represented in the more verbal therapies (Haley, 1963; 1986; Watzlawick, Weakland and Fisch, 1974).
3.7.6 Building themes

According to Chaiklin (1975 B), the group leader connects the spontaneous movements of the group members. The therapist gets her ideas for conducting the group from the group members. The ideas may be generated by one of the group members who temporarily takes over the leadership, or by carefully observing the behaviour of the members. In this way the therapist may pick up a theme - for instance aggressor-victim - and develop the theme to the full. Wethered (1973) explains how such a theme can be woven through the entire session starting with body awareness, adding the principle of relationship, and exploring different movement qualities within the relationship. Remaining with the theme of victim-aggressor, the therapist could first establish body awareness by getting the members to perform kicking, slapping and punching movements with various body parts. Introducing relationship, she could let the group members work in pairs with the partners alternately performing victim and aggressor movements in relation to each other. Next, in letting the members explore quality of movement, she could request the partners to move at different levels or to explore the use of sudden or sustained movements.

3.7.7 Use of rhythm

According to Lange (1975), rhythm is an integral part of movement. Not only is rhythm familiar to each human being individually, but it is also readily recognized by a group and utilized as an organizing principle in its activities. Rhythmic action together with others may be employed to generate feelings of well-being, relaxation and fellowship (Espanak, 1981). In this way one of the most important goals of in-patient group psychotherapy, as distinguished by Yalom (1983), namely the provision of a supportive, pleasant and constructive experience for the members, can be attained. Stark (1981) notes that simple rhythmic action
such as folk dances can enhance group cohesion. Rhythmic action is an aid in sustaining involvement and it encourages an integrated use of the body. In her sessions, Scoop (1974) first acquaints each individual with her own rhythmical inclination. She does this by letting the group members clap their own rhythms and walk their individual beats. Furthermore, she gets group members to experiment with rhythmical acceptance and disagreement. In rhythmical acceptance all group members constantly repeat a definite rhythm together with the therapist. In rhythmical disagreement group members are requested to oppose the steady beat set by the therapist by introducing their own rhythms.

3.7.8 Role-playing

Wethered (1973) argues that by providing group members with the opportunity to have different experiences and to live different emotions in playing imaginary people, they may be helped to break out of their shells. Bernstein and Bernstein (1973) state that role identification through imagery and symbolism is a very important technique in dance-movement therapy. Just as the tribesman, by becoming the lion or some other powerful animal, was infused with that animal's strength, so patients, too, can gain confidence and power. Members can experiment with new ways of behaving by being galloping horses, pattering raindrops or raging seas.

Role reversal is commonly used in behaviour therapy but it is also incorporated in dance-movement therapy. By assuming the role of the other person in relation to whom the client may be experiencing his problem, the client can experience the type of feelings which may plausibly be experienced by that other person (Rimm and Masters, 1973). In this way the individual can go beyond the perceptual bias toward the other. Insight can thus be gained and negative affect removed (Bernstein and Bernstein, 1973). Sandel (1930)
makes the point that drama techniques can be used very effectively to practise assertive behaviour and unfamiliar roles.

3.7.9 Use of props

Scoop (1974) describes very vividly how isolated patients in hospitals can become. Such people may find the experience of relating directly to others extremely frightening or painful. Inanimate objects may be used to bring such people in contact with each other (Stark, 1982). Furthermore, props can allow group members to express often frightening feelings, such as aggression. Wethered (1973) suggests that a punchball be used to express aggression because, being attached, the aggression can be focussed. A. Fiske (personal communication, 13 April 1988) believes that, by using props, even very withdrawn persons can be induced to participate and to become aware of their bodies. For instance, she had long-term, chronic patients in a mental hospital attempt to keep balloons up in the air. By concentrating on the object they could involve themselves in natural movement.

3.7.10 Closure

According to Chaiklin (1975 B), the intensity is lowered at the end of a session. Furthermore, during this period each individual can clarify his boundaries, become aware of the integrity of his own body and sense or contemplate the warmth and support of an experience shared with others. Chace (1953) in Chaiklin (1975 A) ended her sessions by letting group members listen to contemplative music for approximately fifteen minutes while sitting or lying in reasonably close groups, but without touching each other, and without speaking.
3.8 CONCLUSION

In this chapter, the changing role of dance throughout history was discussed. It played a vitally important part in the life of primitive man and in early civilizations. The status of dance declined in European civilization and it became a formal art practised in court circles and on stages. During the 1930's, Isadora Duncan introduced modern dance and many dancers followed her initiative. In modern dance, the range of expressiveness is broadened and strong emphasis is placed on personal experience. Various factors which eventually culminated in the founding of the American Dance Therapy Association in 1966 were considered.

Dance-movement therapy is based on the premises that mind-body forms an inseparable unity, that humans experience the world through their bodies, and that postures are an expression of the individual totality. Not just the mind, but the body, too, can learn cognitively and affectively. If a person can expand his movement repertoire this will enable him to broaden his range of behaving, coping and creating.

The goals of dance-movement therapy can be conceptualized in terms of four elements, namely the body and its action, interpersonal relationships, self-awareness and integration. As in any method of therapy, goals in dance-movement therapy are based on the information gathered and the assessment made by the psychologist.

The next chapter reports on how the principles, techniques, processes and goals discussed in this chapter were implemented in practice.
CHAPTER 4
DESCRIPTION AND ANALYSIS OF THE PILOT STUDY
AND THE FINAL STUDY

4.1 INTRODUCTION

In January 1988 the author found herself working in a black rehabilitation ward at Sterkfontein Hospital. This work formed part of her internship.

Having been trained in mainly Western models of psychology, she experienced herself as being unable to form therapeutic relationships with the patients.

As described in Chapter Two the author then decided to research the possibility of using non-verbal methods that would be compatible with black South African culture.

A short pilot study was undertaken to assess the viability of using dance-movement therapy with black patients. The pilot study also served to acquaint the author with the process of dance-movement therapy and to develop her skills in this regard.

Subsequently the final study was undertaken.

This chapter sets out to briefly report on the pilot study and to describe, in a fairly detailed way, the final study.

4.2 THE PILOT STUDY

4.2.1 The groups

Two groups consisting of between six to eight members each, had a session once a week over a period of approximately three weeks. Group membership was fairly unstable due to a high patient turnover on the black rehabilitation ward where
the study was undertaken. In total, 18 patients participated in six group sessions. The sessions were more or less forty-five minutes long. The group members were asked which music they enjoy and who their favourite artists are. The therapist, as far as possible, obtained music to suit everyone's choice. Much of the music chosen was by black artists and represented a wide variety in terms of rhythm, mood, tempo, vocals and instruments. In selecting the first piece of music the therapist judged the group's predominant mood on a particular day. If the majority of group members appeared to feel lethargic or quiet she would reflect the group feeling verbally and find a piece of calm, quiet music. In choosing music, she considered requests from the group members.

Once the music was playing the therapist started to dance. She made contact with each member in the sense that she moved closer to that person and executed movements similar to the member's. Kinesthetic empathy was communicated in this way (Chaiklin, 1975 A; Stark, 1982). If members remained seated she would dance up to them, stand still for a while and ask the member whether she felt like joining in. She sometimes reached out to the person but did not touch her. In the context of initial individual dancing, the group member - not the therapist - initiates touching (Chaiklin, 1975 A). If the individual indicated that she wanted to remain seated, the therapist acknowledged the wish and added that the member could join in whenever she felt ready. This initial part of the dance-movement may be seen in terms of the therapist entering as far as possible into the patient's internal frame of reference and being respectful of the patient's desire for stability, for remaining the same (de Shazer, 1982).

However, if change is to occur the therapist needs to feed information of a difference into the group. Therefore, when a number of people had been dancing for a while and she had established contact with each member, the therapist would ask one member to lead the dance. Everyone then followed the
appointed leader in a circle formation and attempted to move exactly like the leader. If the therapist noticed a member to be moving very differently from the leader, she would draw that member's attention and dance next to him, in the same way as the appointed leader had. At times the therapist modified the movements of the leader slightly. The overall aim of the abovementioned part of the session was to feed information of a difference into the system that is the group.

4.2.2 Findings

Patients spontaneously expressed to the therapist that they enjoyed taking part in the dance-movement sessions. Several of these patients also spontaneously expressed their dislike for the largely verbal groups which were run by the therapist prior to starting the dance-movement sessions. It would seem then, that for some patients at least, dance-movement therapy is a pleasant experience.

It was observed that group members would start to dance in pairs and spontaneously converse with one another during and after the dancing. Communication with the group leader was observed to increase. After the first session one patient who had never before initiated a conversation with the therapist started talking to her and even made a request. This would seem to indicate that dance-movement can indeed provide a bridge for communicating.

As for providing group members with diverse forms of experiencing and behaving, during the second session one person clearly utilized the variations which the therapist had brought in on his movements during the previous session. More importantly, he went beyond what the therapist had given him and devised his own improvisations. From having moved with his arms held close to his body he could, during the second session, move his arms up, down and sideways and could even swing the upper part of his body from the waist.
4.2.3 Conclusion

On the basis of the pilot study it was concluded that performing dance-movement therapy on a black rehabilitation was a viable venture. Consequently a more structured study was planned and executed as reported in the next section.

4.3 METHODOLOGY

4.3.1 Introduction

A number of changes were made, relative to the proceedings in the group sessions constituting the pilot study. The therapist relied less on dance and more on non-verbal communication in general as a medium for therapy. Furthermore, she took a more directive approach in terms of which the sessions were given increased structure. Empathy was communicated, not so much by the therapist moving like each patient, but by incorporating movements of individuals into group exercises. In this way a group empathic response was generated. Empathic understanding was also communicated verbally by the therapist when that seemed appropriate.

By picking up certain themes from the group interaction and by exploring and building on these (Wethered, 1973), the therapist also expressed her empathic understanding of the group as a whole and of the individual members. For instance, in one session the therapist sensed a general feeling of sadness and mourning. She decided to work on this theme by introducing sad, mournful music and asking members to move or dance to this while thinking of something sad. On another occasion one member made a very strong "no" movement. The therapist commented on this movement and how she experienced it. She then asked the group members to say "no" with their bodies. The theme was developed further into standing one's ground, attacking, giving way and saying "yes" with the body.
4.3.2 Music used

The therapist used music for which the members had expressed a preference. Much of the music had been produced by local South African artists, especially black artists. Amongst these were Ladysmith Black Mmambazo whose music is especially suited for slow movement. Juluka provided material for fast, aggressive movements. The music of Billy Ocean seemed to be particularly suitable for a type of "social" dancing in which no specific theme was being explored. Hugh Masekela songs were familiar to at least some of the group members and they responded with enjoyment to them. The theme music for "The Mission" proved to be very effective for use in exploring themes of attack and retreat. Productions by Stimela were very popular among group members and were used mainly for when the members danced in a circle, imitating the movements of the leader. Different leaders were chosen every few minutes. Music by Grover Washington Junior was used for the same purpose.

4.3.3 Props used

Apart from recorded music being played for the group members, they also had opportunities to make their own music. The musical instruments provided were very basic and well-known in black culture. These included a drum which had been made by a craftsman of the Kavango people who live in northern Namibia. Several hollowed-out fruits, particularly calabash, which had been attached to a short stick and decorated with some animal skin, were also provided. These instruments sound somewhat like a baby's rattle when shaken. A type of primitive guitar was also amongst the instruments used. It consists of a hollowed-out calabash cut in half length-wise. Thin metal rods of varying length and thickness are attached so that their loose ends are over the hollow "tummy" of the calabash. The metal rods can be plucked to
produce sounds. All these instruments require very little, if any, skill to play them and were found to evoke interest in most group members.

The members also had at their disposal various items of clothing which could be used in dramas and traditional dances. These included a doctor's coat and colourful, square pieces of cloth which could be used by the women to tie around their shoulders or waists.

4.3.4 Method of interpretation

The original intention had been to have an observer – a fellow intern psychologist – present behind the one-way mirror. This arrangement turned out to be impractical mainly because the fellow intern had too many other commitments in the hospital. Furthermore, her knowledge of dance-movement being very limited, she felt that the contributions she could make did not justify the amount of time spent behind the one-way mirror.

All group sessions were videotaped and viewed by the author, both after each session and after the group experience had been concluded. An attempt was then made to describe, in writing, what had happened during each session. The next section (4.4) is a record of these descriptions.

Necessarily, interpretations based on the observations by only one person who was also the group leader can lay no claim to objectivity. As Keeney (1983) states, all observations and interpretations are always self-referential and include the observer. No doubt the author's own world-map contributed significantly to the ways in which she observed the group members and interpreted their behaviours, including her own behaviour.

As dance-movement therapy is by definition largely a non-verbal technique it is not possible to include, as in
the case of verbal therapies, a transcription of the sessions for first-hand interpretation by the reader. The author can, at this stage, see no solution to this difficulty.

4.4 A DESCRIPTION AND QUALITATIVE ANALYSIS OF THE GROUP SESSIONS

Eight dance-movement group sessions were conducted over a period of a month. The group consisted of six members, all of whom were present on all but one occasion, when a group member returned late from week-end leave. One of the female members left after the second session and was immediately replaced by another woman who had been on the ward for at least a week. All the group members, three females and three males, were drawn from the black rehabilitation ward at Sterkfontein Hospital. In terms of the black wards as a whole, all six members were relatively high-functioning, but in terms of the rehabilitation ward, five members were low-functioning, at least when they started participating in the group-sessions. The large majority of members could not express themselves well either in English or in Afrikaans. As such, they would not have benefited from the largely verbal, regular psychotherapy groups run by the two psychologists on the ward, neither of whom speak a black language. The group sessions were conducted a few metres away from the ward in the very sparsely furnished video-room. The sessions were on average forty-five minutes long.

What follows is a short description of what was done in each group session and an analysis, based on Yalom's (1985) work, of what happened in the sessions. The sessions will be reported on in chronological sequence.
4.4.1  2 June 1988

The therapist briefed the group members on the nature and purpose of the group sessions, the period over which they would be conducted, and the number of sessions to be held. She also explained that all the sessions would be video-recorded.

As a warming-up technique and also to obtain an idea of where the members were at, the therapist asked each person to say his/her name and to make a movement while doing so. All the group members then repeated the name and the movement three times. One man said a name other than his own, whereupon the therapist requested that each member choose a different name and make a movement, different to the previous one, with it. All these names and accompanying movements were repeated by the entire group three times.

Having noted a considerable degree of tension among group members, the therapist decided to explore the theme of tension and its opposite - relaxation. The members were asked to work in pairs, with one partner tensing her entire body as she imagined lifting up a very heavy weight. The other partner supported the first. Roles were then reversed.

Next, members were asked to think of a situation which made them very tense and to pace around the room as tense as they could possibly be, while thinking of the situation. The therapist enquired what they were thinking of. One woman demonstrated and verbally explained how she would like to release the tension. The group members were asked what they did to release tension. All the members performed these movements a number of times.

Everyone was then asked to lie down for group relaxation. This consisted of becoming aware of individual muscle groups, and of tensing, then relaxing certain muscles. The session ended with the execution of a few centring movements. In performing centring movements, the members may
sit on their knees or buttocks or they may stand. The hands are held, touching slightly, at the level of the solar plexus with the arms held at the sides of the body. The arms are then moved in a circular motion away from the sides of the body and stretched overhead. The hands are then cupped slightly while the arms, bent at the elbows, are drawn down the sides of the body until the hands are returned to solar plexus level with the palms facing downwards. The energy which has been symbolically drawn from the universe is thereby centred. The next step is to symbolically give that energy back to the universe by turning the hands so that the palms face upwards and stretching the arms and hands out in front of the body. The session was concluded by the group members shouting "ho" out loud a few times. The ideas for the closing of the session were gleaned from experiences of creativity workshops conducted by Nina Romm who has studied art and movement techniques in the U.S.A., England and locally.

The first session was characterized by considerable shyness and uncertainty. Specifically, members showed uncertainty as to whether they wanted to be part of the group or not. There were some expressions of unwillingness to let themselves be known by the group. There was very little depth and congruence in the movements. Furthermore, movements tended to be restricted and closed. Some members' bodies expressed fear. A conflict between wanting to give to the group and keeping to oneself was evidenced. The group was characterized by passivity and members acted on the group leader's instructions. There was a strong reliance on the group leader who had to make the connections. Members kept a large distance from the leader. Members showed little spontaneity and hardly initiated activities.

4.4.2 6 June 1988

The therapist used the warm-up technique of letting members make a sound and a movement with it. The sound and movement
were then repeated three times by all the group members. One member made a cackling sound and combined this with a "flapping" of her arms. Responding to this the leader suggested that each member make a sound and a movement characteristic of an animal.

Following this, the group leader played some music for which the members had previously expressed a liking. The members danced individually or in pairs, as they chose, with the group leader attempting to make contact with each of them. They were then asked to dance in a circle, moving around with one person leading the group and the others attempting to move as much as possible like the leader did.

The therapist subsequently requested that the members demonstrate how they would perform a daily activity like making their beds. This was done with a view to gaining an understanding of their style of movement and rhythm (Scoop, 1974).

Following this, everyone sat down in a circle formation. Members were asked what they would like to do during the group sessions. One member suggested that they dramatize something, but nothing else was brought up.

The group session was closed by doing some centring movements and by the members symbolically ridding themselves of surplus energy.

Initially, while the group members were waiting for the therapist to enter, they showed much passivity and very little movement. What little movement there was, was performed very sluggishly. Each individual appeared to be absorbed in his/her own world. The moment the members left their chairs and, on request of the therapist, seated themselves on the floor in a circle formation, their bodies became more energized. Thus, in moving from what is
representative of Western civilization to what is fitting in African culture, a change in body attitude could be perceived.

The first person who made a movement and accompanying sound, yawned: thereby providing a reflex which serves to create distance. She gave the other members an opportunity to repeat her movement with ease. Even at this very basic level some members did not respond and remained disengaged from the group. Another member produced a cough thereby defining the group members as being sick and seeking sympathy from the group leader.

The coughing and another member's spluttering and sniffing seem to have been means to test the limits with the therapist. The covert question which was being asked with these movements was whether the therapist would find the movements and sounds unacceptable and reject those who produced them. The initial movements and sounds produced by the group members reflected their here-and-now situation quite clearly. They were expressive of waking up to something new and of clearing themselves of old things to create space for new experiences to be absorbed.

During the beginning stages of the session the therapist expressed her willingness to make contact, but that she found this difficult to achieve. By becoming transparent the group leader moved the group towards the beginnings of cohesiveness. One woman who produced her movement and sound immediately following the therapist showed acceptance of the therapist's transparency. The beginning of group cohesion was in a sense signalled by the next member who crowed and "flapped" her arms. The crowing was followed by a movement of the torso towards the middle of the group, thereby creating less distance. The leader did not realize that cohesion was being built and did not follow through on the process. Instead she introduced another activity - dancing. Nevertheless, the group members managed to maintain the cohesion.
In this second session and specifically towards the middle and end of it, the group members became more spontaneous as compared to the first session. Some of them began to take the liberty of improving on another's performance. In dancing, they experimented with different types of movement, thus beginning to broaden their repertoire.

In retrospect it became clear to the group leader that it is unnecessary, indeed counter-productive, to put much effort into keeping the group going. It would have been much more productive, particularly in this session, if she had allowed the group process to develop by itself.

4.4.3 9 June 1988

Since a new member entered the group in this session, the therapist once more used the warming-up technique whereby each person said his/her name while making a movement at the same time. The name and movement were repeated three times by all the members. One man introduced warming-up movements and, in accordance with Wethered's (1973) claim that limbering up is of much value in the first part of a dance-movement group session, the therapist asked the other members to devise similar warming-up movements.

Scoop (1974) contends that some time in dance-movement sessions should be devoted to an exploration of rhythm. Each person was asked to take their pulse and to make a noise which marked the rhythm of the pulse. After this, the members were asked to clap to the rhythm of their pulses. In both exercises all members soon adopted the same rhythm. The group leader then altered the rhythm in an attempt to explore rhythmical opposition. Following this, group members walked to the rhythm of their pulses. Each person then got a chance to beat on the drum, with the others attempting to walk or run to the beat. After this, the members were asked
to make up an orchestra with the instruments mentioned under 4.3.3. Some members then performed daily, routine activities like eating and brushing teeth while the others beat the rhythm on their instruments.

Having noted a tendency among members to vary between "yes" and "no" movements the therapist allowed them to explore these two sides of the polarity in greater depth. To end the session the therapist got everyone to stand in a circle and to move from side to side while holding onto each other's shoulders.

During this session the new-found group cohesion was threatened as a result of an old member leaving and a new one joining the group, without the members having been prepared for this. Members seemed to express in their movements their conflicts about, on the one hand, wanting to be part of and, on the other hand, rejecting the group. The therapist explored the conflict on a non-verbal level. In retrospect it seems that the members would have derived much benefit from linking this conflict to the cognitive level by discussing their feelings. On the other hand such an exercise might have been threatening to the new woman.

Despite the fact that a new member had joined, cohesion was quickly re-established. Firstly, one of the older members in the group kissed the new one's hand thus expressing his willingness to welcome her into the group. Secondly, one woman spontaneously expressed caring towards another individual by removing a bit of cotton wool from his face and kissing him gently. These incidents served to bolster cohesion. Both these members who expressed welcoming, caring feelings helped to establish the group norm of mutual care and support. Thirdly, cohesion was furthered by the joint rhythmic behaviour of the members in making a sound to accompany their pulse, in walking to the beat of the drum and in forming an orchestra.
Another norm which began to be established, though still on a covert level, was that everyone participates. When one person, right at the start of the session, did not say his name, at least two others became visibly tense and uncomfortable but relaxed as soon as the member indicated that he needed help.

What also emerged in this group session was a more overt acceptance of the leader. Whereas in the previous session there had been testing of the limits and one member had specifically told the therapist that he could dance alone when she attempted to move closer to him, the very same member expressed appreciation of the leader by thanking her for the drum.

4.4.4 10 June 1988

The same warming-up technique used in the second session, namely making a movement and an accompanying sound, was utilized here. The therapist expanded on the warming-up movement produced by one member to begin to warm up the entire body. Following this lead provided by the group leader, the members spontaneously produced similar exercises.

Picking up on a theme which had partly been explored during the second session, the therapist asked everyone to provide movements and accompanying sounds of wild animals. After each sound and movement had been repeated three times by the whole group, the "animals" were asked to move around the room and to communicate with each other.

Subsequently the therapist requested that the members dance to the theme of victim-aggressor. The therapist played music suited for the purpose. The group was closed by means of centring movements.
Although nothing much seemed to happen on a content level during this group session, a great deal took place on a process level. When the group leader walked into the room, one of the members gave her some sweets and asked her to hand these out to the group members. This behaviour served to reconfirm the cohesiveness of the group and the norm of caring for each other which had been introduced in the previous group session. Furthermore, this behaviour was expressive of acceptance of the leader and it served to introduce into the group the norm of sharing.

The relatively new member was the first to offer a sound and a movement. This, together with the nature of the sound she made (a loud hip! hip! hurray!) indicated that she considered herself to be a full member of the group and she expressed exuberance at this. Furthermore, by performing this movement and making this sound, she started the group at a more complicated and personal level than the level at which the previous group was started, namely that of primitive reflexes.

In this session there was considerably more vertical movement than in previous sessions. This was indicative of a greater willingness to be vulnerable. Members seemed freer than in previous sessions to enter one another’s personal space. They also used more of their bodies in movement. In a sense the rigid schematas of their bodies seemed to be loosening up and they were expanding their movement repertoires and, thereby, their ways of being-in-the-world. The need for warmth and contact was more readily and directly expressed.

Spontaneous imitation of behaviour during the initial stage of limbering up served to reconfirm group cohesion. Realising the extent of group cohesion, the group leader decided that the time was ripe to further non-verbal communication between the group members and to stabilize the microcosm. Consequently she introduced the exercise which required of the members to be wild animals and to
communicate with each other as such. In working in this medium which, traditionally, is well-known to black people, the therapist took the lead. She let them imitate her movement, thereby attempting to build contact with group members. By asking them to guess what she was representing, the leader tried to assess whether the members were attuned to this way of communicating. By showing interest in what the leader was doing, by guessing what she was trying to represent and by their subsequent movements, the members indicated that they were indeed attuned to and accepting of the movement communication. They also showed an ability to respond in similar fashion. The therapist encouraged the members to explore within the limits she had set them.

Members seemed to have some initial difficulty in making contact in this medium. They seemed sluggish to communicate non-verbally, at least initially.

During this session the therapist introduced the norm that members were expected to accept and respect each other's choices. She made it clear that members were welcome to suggest to one another how they could move, but that the acceptance or rejection of the suggestions was the prerogative of the individual the suggestions were made to.

The group norm of participation was reinforced quite considerably. A fair amount of pressure was brought to bear on the one man who had consistently remained relatively passive during this and previous sessions.

The therapist attempted to move the group from a fairly basic and concrete level of non-verbal communication to a rather complicated level, that is, from communicating as wild animals to dancing victim-aggressor. In so doing, she created considerable confusion and anxiety and increased passivity. However, from the moment she introduced music and demonstrated what was expected, the members were enabled to perform the task in a way which was very expressive of their interactional styles.
The group leader got the members to do various warming-up exercises. Some members quite spontaneously suggested movements. The therapist then asked them to adopt bad postures and to walk around the room while sustaining those postures. Subsequently everyone walked around in a circle imitating the bad postures and walks of whoever served as the leader. The therapist then tried to establish a link between this level of experiencing and the cognitive level, by asking members to think about the effects that different walks had had on their interactions with others.

The members were then asked to stand in parallel lines with three people in each and to try to communicate with each other while taking on various stances which hampered communication. They subsequently related their experiences of what this was like.

It would appear that there was a fairly limited development of process in this session. This seems to have been the result of a very high level of activity on the part of the leader. Her active structuring of the group left little room for the unfolding of group process.

In accordance with their position as patients in a hospital, the members mainly chose walks that were characteristic of ill or crippled people. Attempts to connect the movement level to a cognitive level were largely unsuccessful. When the leader asked members to give associations to their walks, they remained largely on a concrete level. This frustrated the leader considerably, especially in view of the fact that her readings had led her to believe such a connection to be of major importance.

Social learning played a fairly prominent role during this session. Members made suggestions as to how others could conduct themselves and these suggested behaviours were experimented with. The leader made use of role-playing to
demonstrate potentially irritating behaviour in certain members. Thus, by making use of mirroring, members were provided with direct feedback on their behaviour. Unfortunately the process was not developed into the teaching of alternative ways of behaving. The leader made use of the group to strongly reinforce positive behaviour and the absence of annoying behaviour.

Considerable freedom and spontaneity was observed in the actions of group members. When asked to conduct conversations with each other while adopting various postures which tend to restrict and hamper communication, for the first time, they spoke at length in their own language. This seemed to indicate that members perceived the group as existing for them and not for the sake of the leader.

Noticeable during this session was that, despite considerable group cohesion having been established during this and previous sessions, no one leader evolved. In fact no one or even two people ever emerged as the leader. Until the last group session, the leadership role was shared amongst five of the six members. There seemed to be little concern with matters of hierarchies and of who would be top dog and who underdog.

4.4.6 17 June 1988

To start the group off, the therapist asked members to make a movement which would involve contact with other members and an accompanying sound.

Next, members stood in two parallel lines with one partner pushing the other, who first resisted and then gave way. It was decided to explore this theme because the leader had noticed, in the session of 10 June 1988, that some people
remained in the role of victim, i.e., of being pushed away and over, while others remained in the role of aggressor, i.e., they never gave way.

Noticing that several individuals did not work from the centre (Scoop, 1974) the therapist asked members to perform some tasks which would make them aware of their centres. They first pushed against the wall as hard as they possibly could and then imagined hanging a picture high up on the wall. The exercise of pushing against partners was then continued.

Working in parallel lines again, the members experimented with different ways of approaching and greeting their partners. More specifically, they performed a direct advance and firm greeting in contrast to an ambling, sluggish advance and a soft, uninvolved greeting.

Subsequent to this, members were asked to imagine moving vigorously towards their partners as if to attack them. The partners who were being advanced upon were asked to alternatively give way to the attack or to brace themselves and stand firm in the face of the attacker.

The group members then directed and performed their own drama. The play depicted how a family took a sick member to a doctor. The doctor, instead of helping the family member, claimed that she was not really ill and sent the family home. She gave no logical reason for doing this. Only after she had turned the family down a number of times did the doctor assist the sick person.

In this session it was noted that members were more active and in contact with each other, also before the group leader walked into the room. Movement was looser than in previous sessions and physical contact was made more readily.

Members expressed considerable caring towards each other. They seemed to feel more secure in the group in that they
could express feelings which might have been threatening. Members also appeared to feel more secure in interaction with the leader, and to be more trusting of her than in previous sessions.

By allowing all members to experience giving way and standing their ground in relation to one another, their movement repertoire was opened up and for one or two individuals it was possibly even expanded, despite the short duration of the exercises. For instance, one man who had constantly been a victim in a previous session, now learned to stand his ground: both in relation to the other group members and in interaction with the therapist. While the member began to stand his ground on a physical level, incidents during the following sessions seemed to indicate that he could do so on a more abstract level as well.

With the introduction of the drama there was a move away from very basic emotions and actions towards more complex and free-flowing ones. The drama gave members the opportunity to be creative and to initiate action to a much larger extent than they had done in previous sessions. They also had the chance to experiment with what had been learnt in previous sessions. In the drama, members were able to be critical of each other. Furthermore, there were strong efforts at acculturation through the medium of the drama. There was a clearer role division in this context, but it was tentative in the sense that the person who took the leadership role was challenged.

In the drama, the members played out their real feelings about being in a mental institution. They depicted their own powerlessness in relation to the staff members. The leader, after the drama, reflected the group's feeling of anger and asked members to provide movements expressive of anger. It seems, however, that the therapist's reflection was not completely correct. The result was that members corrected her, in the sense that they expressed frustration and a lack of understanding in their movements, rather than anger. In
individual verbal therapy, such a correction may well not have taken place. In the group dance-movement session there was more opportunity for correcting the mistake made by the therapist.

4.4.7  21 June 1988

The therapist once again used the warming-up technique whereby all the members, including the group leader, made a movement and an accompanying sound. She then asked them to perform a movement and make a noise which would involve contact with the neighbouring person.

The members had on previous occasions expressed a wish to perform traditional dances during the group sessions and there had been an agreement that the session under discussion would be used for the purpose. The group discussed this plan in view of the fact that one member had stated earlier on that she was feeling ill. Some members made suggestions as to what the woman's options were. The therapist then suggested that she sit down with the others seated around her. All the members were asked to give the woman some non-verbal expression of caring and concern, which they did. Each expression was taken up by all the group members.

Following this the therapist told the woman that she could remain inactive or join in the dancing, as she pleased. She then put on some suitable music for which group members had shown a preference. The group members, including the sick woman, then began to dance and to play on their instruments. After a while they all started moving around in a circle. At one stage they also formed into two parallel lines. After some dancing one of the members began to speak as though he was a traditional healer. All the members then played out what amounted to a traditional divining session. The "healer", in his own language, would give a type of speech which seemed to amount to an explanation of illness and a
prediction of future happenings. The other members would then all express agreement. After a while the dancing and singing would continue and this would be followed by another loud speech, punctuated by the agreement expressed by the members. While the "healer" spoke, one person carried on playing the drum.

The group leader ended the session by letting the members sit in a circle and do some movements which were representative of gathering all that is good from the universe, centring its goodness and then giving it out again. The members also symbolically rid themselves of excess energy.

Compared to previous sessions this one flowed quite easily and there was spontaneous initiation of movement. In the initial stages the group placed considerable pressure on the passive member to perform. They let him know that he was not giving of himself and that they were tired of babying him. One man suggested that the passive individual perform a movement which expressed going forward and being on the move. Another member initiated a movement which represented a definite affirmation of the group.

During these initial phases of the session the group also showed an ability to express positive, accepting movements and an inability to handle rejection. The group seemed not to be cohesive enough to deal with rejecting movements. When the leader, taking a cue from one woman, asked members to perform a movement indicative of rejection, they showed an inability to imitate the movement. Furthermore, another member almost immediately introduced an accepting movement and sound.

By asking everyone to comfort the individual who felt ill, the members were provided with a pleasant, trusting experience. They were also enabled to experience safety. The group norm of caring was further reinforced as was the norm that physical contact between members is acceptable, indeed
desirable. During this session the group leader was less active and she withdrew a little from the group. This she did, firstly, in anticipation that the next meeting would be the last and, secondly, because the members had expressed a willingness to do something on their own initiative. In the traditional dance, roles became more clearly defined and everyone remained in his/her role. The movement produced by the group involved going round and round and was very monotonous, as in a meditation. The group had become involved in a self-healing process and the group process could evolve unhindered. It was observed that much growth had taken place in terms of interaction and that a well-functioning system had been moulded by means of movement.

What also became particularly clear in this session though it had also emerged from previous meetings, is that by working in the medium of movement, members' attention can be held much more readily for the duration of the group dance-movement session than in verbal group therapy.

4.4.8 28 June 1988

The group leader asked everyone to sit in a circle on the floor and reminded the members - she had prepared them in the previous meeting - that this would be the last session. She informed them that she was to leave the ward shortly and work at another location. The group members spontaneously expressed various emotions ranging from regret to thankfulness.

The therapist then requested that each member provide some movement and sound that would be suited to a situation of saying good-bye or farewell. The whole group then repeated the movement and sound for as many times as seemed appropriate. One of the members provided a movement which was expressive of loneliness. The group leader then
demonstrated a posture of loneliness and isolation. She asked everyone to adopt that posture and to become aware of the feelings it evoked.

Following this, the people were asked to relate instances in their life where they had had to say good-bye. One woman told how she had had to leave her village and her relatives to undertake studies elsewhere. Her packing, and receiving phone calls from relatives who wished her well, was then role-played. One man remarked that, through the role-play, they were actually taking leave of the therapist. The therapist enquired whether members would like to bid her a more direct farewell by having a role-play involving herself. Two people then "phoned" the therapist. They expressed shock at her leaving and wished her well. Following this another woman related how she had felt when she had had to take leave of her young child to come to hospital. The situation was role-played with the woman comforting her "child". One of the members remarked that the grieving woman should not cry in front of the child because that would upset the child. This was a clear message to the therapist, who felt very sad by that time, not to lose control and to remain strong.

To close the group, members were asked to stand on their knees in a close circle while holding hands. The therapist included herself in the group and suggested that everyone be quiet and think about all the things they had received from the group and given to the group. After a while the group leader left the group, joining the hands of the two people who had held her hands. From outside the group she suggested to the members that, even though she would be gone, they would still have one another and the experiences they had lived in the group. The members spontaneously moved their hands up in the centre of the circle while still holding them. After some time the therapist suggested that they should leave the room one by one as soon as they were ready.
One man noted that he wanted everyone to cut some flowers for the therapist and give these to her. This they did as they moved out of the room one by one.

During this last session, members expressed many different emotions in response to the leader leaving and the group being dissolved. These emotions ranged from surprise to thankfulness and from happiness to sadness. Members were highly congruent in expressing these emotions. Various methods were used to deal with saying good-bye. Some role-plays were done, one of which, at the suggestion of the members, involved the leader of the group. The group members also made use of a supportive rhythm in their efforts to say farewell. At one stage, while holding hands in a circle, one man introduced a rhythmic motion of the arms, into and out of the middle of the circle. Furthermore, farewell rituals were introduced both by the members and the leader.

Group cohesion reached a very high point during this session and the feeling of unity was symbolically expressed. Members were able to show a high level of empathy with each other and with the leader.

During this session there was a further move - it had been introduced in the previous session - from a metaphor of illness to one of health and of being able to return home. One man provided a clear meta-communication that he was healed and ready to leave the hospital.

The group leader had much less need to initiate activity during this session, but that which she did initiate was fully accepted. The leader clearly started to withdraw from the group in her body language, even near the start of the session. Whereas the leader attempted several times to move into the there-and-then, the members brought the process firmly into the here-and-now. During this group meeting the leader became more transparent than in any of the previous meetings and the distance between leader and group members was greatly reduced.
4.4.9 An overview of the group sessions

Reviewing the development over the eight group sessions it became clear that the group had moved from being diffuse and amorphous to being a cohesive unit. Whereas at the start, the group meetings had involved activity which the members had little choice to accept or reject, the meetings later became an enjoyable activity, one from which members could draw support and caring. Furthermore, a whole range of feeling states were lived over the course of the meetings, ranging from disinterest and apathy through to aggression, caring, supportiveness and sadness. As the meetings progressed, members became more congruent and the sessions gained in depth. The participants also showed increasing creativeness and willingness to risk themselves and to be vulnerable. An increasing willingness to experiment with new modes of behaving was also evidenced.

Whereas in the first sessions the leader had been very active, the initiation of activity was left more and more to the group members who became increasingly spontaneous in their movements, and who began to use their entire bodies.

Initially the emphasis in the group had been on illness. Many of the movements were expressive of illness. By the time the last session had been reached, members had started to stress health and healing.

Ritual came to feature in the last three sessions. The members spontaneously introduced ritual into the group process. When the leader began to build in rituals, this was completely accepted. Ritual came to be used to express unity and belonging, caring, loneliness and saying good-bye.

4.5 CONCLUSION

In both the pilot study and the final study the therapist was in many ways groping, trying to enter an unfamiliar
world in which her training did not help her very much. However, she could not have coped with this strange world without the help of some familiar concepts or distinctions. The next chapter is devoted to an exploration of the concepts which were found to be useful by this particular therapist. It is hoped that by connecting the group experience to known concepts, certain observed themes, as they gradually manifested themselves, will be identified.
CHAPTER 5
THE DANCE-MOVEMENT THERAPY EXPERIENCE AS LINKED TO CONCEPTS FROM SYSTEMS THEORY AND YALOM'S GROUP THERAPY THEORY

5.1 INTRODUCTION

As this research represents an exploratory study, the writer set out with some concepts regarding dance-movement therapy, but also tried to maintain a receptive attitude towards any phenomena that she might observe. As her training was, to a large degree, systems-oriented, it is to be expected that she would perceive processes in terms of that theory.

In an attempt to reach a synthesis of various models, this chapter sets out to relate the dance-movement therapy experience to, mainly, two other distinct but related theoretical stances.

The first is general systems theory, with emphasis on the more recent literature pertaining to what is generally described as ecosystemic epistemology. The main exponents of this orientation who will be referred to in this chapter, are Bateson (1979), Keeney (1983; 1984) and Selvini-Palazzoli et al. (1978). The second is Yalom's (1983; 1985) classical work on group therapy which formed an important part of this writer's training.

The first section will deal with concepts from systems theory as it relates to the theory and practice of dance-movement therapy. The concepts of health and pathology will be discussed, firstly from a dance-movement perspective; secondly, from Yalom's (1985) group psychotherapy point of view; and thirdly, from the theoretical framework of the ecosystemic thinkers. Subsequently, examples from the dance-movement therapy groups will be given. For all the other concepts the following order will apply: first the ecosystemic concept will be considered and then it will be applied to the
dance-movement theory. Finally, examples from the

dance-movement therapy groups will be cited to illustrate

how theory and practice can come together. In the second

section of this chapter some of Yalom's (1983; 1985) work

will be reviewed and integrated with dance-movement theory.

5.2 DANCE-MOVEMENT THERAPY AND CONCEPTS FROM

SYSTEMS THEORY

5.2.1 Health and pathology

5.2.1.1 Health and pathology viewed from the

perspective of dance-movement theory

Chaiklin (1975 B) maintains that the dance-movement

therapist works on the assumption that, the broader the

movement repertoire from which a person can choose and the

better integrated these patterns are, the bigger will be

that person's capacity to handle his environment and

emotions effectively. If the individual can extend his

range of movement, he will also be able to extend his range

of coping, creating and behaving (Pishney, 1974). Nussbaum

(1987) makes the point that a person who is mentally healthy

uses a wide variety of combinations of movement qualities,

which is indicative of flexibility and adaptability.

5.2.1.2 Health and pathology viewed from Yalom's

perspective

A shortcoming of much of the literature on dance-movement

therapy is that it is based on intra-psychic concepts. The

interpersonal domain is largely ignored. Thus, health and

pathology tend to be viewed in intra-psychic terms. Even

when group therapy is conducted (Bernstein, 1981) it is

really individual, intra-psychically based therapy in the

context of a group.
Yalom's (1985) concepts of health and pathology are based upon his maxim that "we are at all times obliged to consider the human being in the matrix of his or her interpersonal relationships" (p. 19). He goes along with Sullivan who sees mental disorder and psychiatric symptomatology in terms of disturbed interpersonal relations. He insists on translating concepts like depression and anxiety in interpersonal terms. These interpersonal issues are then addressed in group psychotherapy. Group therapy fosters health in terms of providing the individual with the skills to establish and maintain intense, positive and reciprocal interpersonal relationships. Implicit in this approach is a conceptualization of pathology as limited interpersonal skills.

5.2.1.3 Health and pathology viewed from the perspective of ecosystemic thinkers

Keeney (1983, p. 126) sees health in human ecosystems as representing a "vital balance" of different forms of experience and behaviour. The healthy individual is "an integrated, whole unity of diverse differences" (p. 126). Pathology then entails a restriction or an absence of alternatives (Bateson, 1979). According to Bateson (1979) and Keeney (1983) pathology arises out of the efforts to maximize or minimize a specific variable or behaviour. Capra (1982) espouses a similar view when he argues that a healthy system is one which has a wide variety of options for interacting with the environment.

It would seem, then, that there are similarities between dance-movement theory and systems theory as pertaining to concepts of pathology and health. In terms of both theoretical perspectives, health is seen in terms of diversity and the availability of alternatives. Conversely, pathology is seen in terms of restrictiveness and a lack of alternatives. The difference between these theoretical perspectives lies in the fact that, from a dance-movement
perspective, the diversity/restrictiveness and availability/ absence of alternatives is seen in terms of the individual's movement repertoire. Systems theory, on the other hand, goes way beyond the movement repertoire of the individual. The "vital balance" of different forms of experience and behaviour may pertain to couple systems or family systems as well as to individuals. It may of course be argued that, on the basis of the principle of recursion, a diversification of the movement repertoire of the individual may lead to a diversification of experience and behaviour of the family system to which the individual belongs.

5.2.1.4 Examples from the case study

In terms of Capra's (1982) conceptualization, group members showed a marked lack of options for interacting with their environments. One man for instance, had extremely limited options for engaging. He withdrew most of the time and, at times, participated only when prompted to do so.

Attempts were made in the dance-movement groups to expand the movement repertoire of members, for instance by letting them imitate one another's movements. During one session members were asked to dance in a circle and to try to move exactly like the leader, the leadership being rotated. At one stage, members were requested to dance the theme of victim/aggressor. The therapist noticed that some members consistently played the role of victim while others got stuck in the aggressor role. Consequently, it was decided to give all the members a structured opportunity to be both victim and aggressor. Thus the dance-movement therapy group can provide the members with an opportunity to experiment with new ways of behaving within a relatively safe environment.
5.2.2 Dichotomization

5.2.2.1 Dichotomization as viewed from the perspective of ecosystemic thinkers

Keeney (1983) notes that human beings have to draw distinctions to perceive and to cope with their world. However, it should be remembered that these distinctions are, to a large extent, arbitrary. Yet, people generally do not recognize the arbitrariness of the distinctions and, instead, treat them as if they were representations of an either/or duality, a clash of opposites. Underlying such distinctions is a logic of negation, that is, we speak and behave in terms of A/not A, good/bad, right/wrong. An over-emphasis on one side of a distinction, to the exclusion of the other, is potentially pathological. Keeney (1983) suggests that health in human ecosystems is based on the recognition and acceptance of both sides of a distinction, and that both sides should be embraced. This implies that a healthy person is not necessarily symptom-free.

One of the dichotomizations which holds within it the seeds of pathology, is that between body and mind. Capra (1982), one of the great systems-thinkers, shows that on the basis of the Cartesian, analytic method, mind and body have come to be seen as separate and fundamentally different. Western man generally does not see mind-body in terms of a totality. The Cartesian division between mind and matter has had many profound effects. Among these has been the tendency of medical doctors to ignore, or at most, pay scant attention to the psychological dimensions of illness. Psychotherapists, on the other hand, have largely failed to deal with their patients' bodies.
5.2.2.2 Dichotomization as viewed from the perspective of dance-movement theory

From a dance-movement perspective, Kelly (1984), like Keeney (1983), points out that in our efforts to concentrate and focus, we need to divide the world arbitrarily. The divisions we make are merely divisions to help us cope with the world.

Dance-movement therapy makes possible a transcendence of the mind-body dichotomy. One of the premises on which it is based is that mind-body forms an inseparable totality. According to Kelly (1974), mind, body and spirit are not merely interrelated, but are actually one and the same thing. Dance-movement increases the conscious experience of interaction between mind and body (Espanak, 1981). Yet the integrating function of dance-movement is not confined to the level of mind-body. It also serves to establish the unifying interactive relationship between fantasy and reality (Scoop 1973; 1974). Thus, dance-movement is very well suited for what Hanna (1977) calls paradox mediation, that is, the resolution of conflicting opposites. Paradox mediation would seem to entail the integration of apparently irreconcilable opposites into a bigger unity.

5.2.2.3 Examples from the case study

In the dance-movement therapy groups which formed part of this study, definite attempts were made to give members the opportunity to live both sides of a distinction. For instance, members were given a chance to experience tension and relaxation, taking and giving, of being aggressive and being victimized, as well as isolation and unity. The therapist, on several occasions, attempted to connect the felt level of experiencing to the cognitive level. Whether these exercises led to the formation of a greater unity is difficult to establish. This is so, precisely because, as Keeney (1983) has pointed out, we need to draw distinctions
in order to perceive the world around us and as soon as we draw distinctions we "lose" the greater unity. Consequently, it would be extremely difficult to formulate in writing, which is essentially a linear medium, the subjective experience of dichotomies being transcended.

5.2.3 Redundancy and randomness

5.2.3.1 Redundancy and randomness as viewed from the perspective of ecosystemic thinkers

Within any system, certain repetitive patterns can be observed (Hoffman, 1981). The concept "redundancy" has been coined to refer to these patterns. No living system can exist in the absence of redundancy, patterns and structure (Hoffman, 1981). However, systems are subject to change, in the face of which they have to reorganize if they are to remain intact. Bateson (1979) writes that for a new order to be created the workings of the random are essential. Furthermore, stochastic processes such as evolution, creativity, thinking and transformation can only occur in the presence of an unpredictable element.

However, the unpredictable element or newness can only be assimilated by a system if that system is ready to incorporate the new information. Both De Shazer (1982) and Keeney (1983) make it clear that the newness or information fed into the system by the therapist, must fit with the existing patterns of interaction within that system. According to De Shazer (1982, p. 6) the sender of the therapeutic message has to share a code with the receiver of the message, if the message is to be effectively transmitted from one component of the therapeutic system to the other. However, the message must contain "information that is about a difference that makes a difference". In the absence thereof, no change could occur.
Joubert (1987) writes that for a system to change three conditions are required. These are:

1. Alternatives, that is, newness or randomness must be present

2. The system must be ready to incorporate new information

3. The available alternatives must include at least one that can be selected on the basis of existing patterns in the system, i.e. the new information must make sense to the system.

Keeney (1983) notes that when the client asks of the therapist to change him, he is actually sending out a dual message in terms of which he asks for both change and stability. Thus, in terms of the cybernetic view, all requests for change express the need for both change and stability.

5.2.3.2 Redundancy and randomness viewed from the perspective of dance-movement theory

In dance-movement therapy the therapist respects the system's desire or need for stability, for remaining the same, by moving like the client. According to Schmais (1974) the therapist both reflects and responds to the patient's movements. The therapist tries to approximate, as nearly as possible, the group member's movements. Stark (1982) writes that the therapist attempts to incorporate into her body the same breathing pattern, level of muscular tension, posture and body movement as manifested by the client. Schmais (1974) describes how the therapist, on the basis of the client's needs, makes a decision as to how to enhance, develop, intensify or transform the client's movements. In ecosystemic terms, the therapist decides how to feed in information of a difference, but in a way that
fits with the existing patterns in the system. By moving like the client the therapist respects the system's need or desire for remaining the same. By altering the motions slightly, she feeds in information of a difference. Bernstein's (1981) point that each person needs to be ready before she can explore, and possibly alter, certain aspects of her being, is similar to what Joubert (1987) regards as one of the essential conditions that must be met if change is to occur, namely that the system must be ready to incorporate new information.

5.2.3.3 Examples from the case study

In this study, the therapist did attempt to approximate group members' movements as closely as possible, especially in the dancing itself and in the warming-up exercises in which members were asked to make a movement at the same time as saying their name or making a sound. In this way she respected the members' needs to remain the same (Keeney, 1983). Yet she also tried to meet the members' requests for change in the sense that she developed or altered their movements. By doing this she provided information of a difference. On one occasion, a member provided the group with a very strong and emphatic "no" movement. The therapist explored this movement in the sense that she introduced various ways of saying "no", and especially gentler ways of doing so. It should be noted here that the therapist did not by herself introduce information of a difference but relied to a large extent on the members to do so.

5.2.4 Semantic frames

5.2.4.1 Semantic frames viewed from the perspective of ecosystemic thinkers

One way in which information of a difference can be fed into a system is by providing the system with new semantic
frames. By describing a behaviour or interactional pattern differently to what it is normally described as by the individuals involved, the therapist can introduce significant changes in the behaviour or interactional pattern. Joubert (1987) refers to Foudraine (1971) who describes Sullivan's efforts to rehabilitate deteriorated patients in a chronic ward of a psychiatric hospital. His starting point consisted in changing the context of pathology to one of learning by changing some key words. The words "training centre", "instructor", and "student" took the place of the words "section", "nurse" and "patient". A period of adaptation was needed after which this redefinition or relabelling of the context brought about a significant change in both the staff and the patients.

5.2.4.2 Semantic frames viewed from the perspective of dance-movement theory

While dance-movement therapists see movement as being their most valuable tool, there seems to be general consensus among members of the profession that effective interventions into the lives of their clients include a cognitive and, therefore, a language component. Bernstein (1981) calls on dance-movement therapists to acknowledge the mind-body gestalt and to engage their clients on both these levels. Alperson (1972) expounds a therapeutic intervention which will enable a person to directly experience her body in motion, and which will facilitate the emergence of emotional states, images and ideas from this movement experience. Subsequently, these can and should be conceptualized through verbalization.

It is not clear from the abovementioned authors what role the therapist plays with regard to conceptualization. From the writer's personal experience of dance-movement therapy with Ann Fiske in Cape Town, it seems that the therapist and group members (if this is the mode of therapy) offer ideas
about an individual's dancing or movement. In this sense then, the therapist and other group members may be seen as feeding information of a difference into the system by providing new semantic frames with respect to the nature and meaning of the individual's dance or movement.

5.2.4.3 Examples from the case study

In talking to the group members who were involved in the present study of the therapy sessions, the group leader avoided the use of the word "therapy" but simply referred to "dance-movement groups" or "sessions." Similarly, the group members never referred to the group meetings as therapy but spoke of "exercises" or enquired as to when they were going to "dance" again. Throughout, the therapist de-emphasized the metaphor of illness. In this sense both the therapist and the group members defined the context in a way which was more conducive to healing than a definition in terms of "therapy", "treatment", "patients" and "illness".

In one of the sessions, one woman looked listless and pained. The therapist asked her whether she was not feeling well and whether she would rather not participate. The woman retorted that she was feeling ill and that she would rather sit down outside the group. This interaction with its emphasis on illness came very close to being anti-therapeutic. Fortunately, the therapist saw an opportunity in this incident and asked the member to sit down in the middle of the group and the others to convey to her some expression of caring. In this way she redefined ill-health as a need for caring. The group members were connoted, not as patients, but as people who were powerful and healthy enough to be of help to a fellow human being. The therapist defined "not feeling well", not as being a condition of an individual, but as being a matter of concern for the group.
5.2.5 Bateson's orders of learning

5.2.5.1 Bateson's orders of learning as viewed from the perspective of ecosystemic thinkers

Bateson's (1972) orders of learning are discussed in detail by Keeney (1983). Zero learning is the type of learning involved in those responses which are wholly determined by genetics or are automatic to the extent that correction seems to be an impossibility. This is the only order of learning which does not involve trial and error.

Learning I can occur within a situation where the perceived choices are limited to a set of specific behavioural alternatives. This means that Learning I refers to the learning of a particular simple action within a given context.

In Learning II, on the other hand, we find learning about a specific context of learning. In essence, it entails learning how to identify and organize one's action as part of a particular context. A way of denoting events or punctuating events rather than a specific behavioural response is learned. Whereas with Learning I the primary source of error is a particular response, with Learning II the major source of error is the punctuated context. Accordingly, in the case of Learning II, a different contextual punctuation must be learned. Keeney (1983) refers to Bateson (1972, p. 287), according to whom a "revision of the set from which the choice is made" is needed in this case.

Learning III entails a change of the premises at the basis of an entire system of punctuation habits. The person learns a whole new way of looking at the world as, in for instance, religious conversion. There is, thus, a change in the system of sets of frames from which a choice is made. This type of learning is very difficult and occurs only rarely.
5.2.5.2 Bateson’s orders of learning as viewed from the perspective of dance-movement theory

In the literature nothing has been written which bears even a remote resemblance to the orders of learning as discussed by Bateson.

5.2.5.3 Examples from the case study

It would seem that, in the dance-movement groups conducted as part of this study, Learning II took place. Initially, group members punctuated the group sessions in terms of a situation in which they were ill and the therapist had to cure them. However, they came to punctuate the situation as one in which they were capable of healing themselves. For instance, in the second last session they played out a divining session as conducted by black traditional healers (refer to paragraph 4.4.7). This was done spontaneously and with little participation on the part of the therapist.

Closely related to this transformation from a metaphor of illness to a metaphor of health, was a change from punctuating the relationship with the therapist as a complementary one, to punctuating it as a parallel one. The group members came to realize that they could take the initiative and responsibility rather than leaving it all to the therapist. In terms of Bateson’s orders of learning, the members revised the set of frames from which they could make choices.

The group members learned about the context of learning in the sense that they came to know that it is desirable to give both verbal and non-verbal expression to emotion, and to communicate directly and honestly. One man, in the last session, made use of the therapist’s method of working, in the sense that he spontaneously used both verbal and non-verbal communication to express himself. More specifically, right at the end of the last session, after
the therapist had asked the members to leave the room individually as they felt ready to do so, this man suggested that all the members cut flowers and give them to the therapist before leaving.

5.2.6 Unconscious processes

5.2.6.1 Unconscious processes as viewed from the perspective of ecosystemic thinkers

Keeney (1983) emphasizes that change often takes place in the sphere of the unconscious mental process. Samuel Butler, referred to by Keeney (1983), has drawn attention to the fact that one is least aware of that which one knows best. That means that the more basic a premise is, the less it will be available to consciousness. An example will help to clarify this. The inexperienced therapist is very much aware of the techniques he uses. What he does in therapy tends to be rational and logical, and as such, fully available to consciousness. With time and experience, the techniques and the premises on which interventions are based become, to an ever-increasing degree, unconscious. That is, the therapist is less and less aware of technique and seems to work intuitively to an ever-increasing extent.

The most distinctive characteristic of unconscious order of mind is "that they embody premises of relationship which can never specify any particular side of a distinction, tense (time) or negative" (Keeney 1983, p. 161). Conscious orders of mind, on the other hand, tend to distort the whole patterns of recursion and relationship, characteristic of unconscious orders of mind. This is so because, in order to become aware of something, in order to perceive something, human beings need to draw distinctions. There has to be figure and ground for perception to take place. That which is ground, is for that moment not focused on, that is, it is out of awareness. It is impossible at any time to be
conscious of a whole. Rather, according to Keeney (1985), man's experience is in terms of pairs, dualities or distinctions.

Distinctions may be perceived either as a duality of opposites that are mutually exclusive or "a recursive complementarity of self-referential sides" (Keeney, 1985, p. 48).

A perception of distinctions in terms of a duality of mutually-exclusive opposites, is potentially pathological because one is in danger of becoming stuck in one side of a distinction. Recursive complementarity, on the other hand, entails a higher-order view of a distinction, in terms of which the interaction between the different sides of a distinction is emphasized. There must be a distinction between the two sides in order for interaction to take place while, at the same time, the interaction connects the two sides as a whole system (Keeney, 1985).

Returning once again to unconscious orders of mind, it should be noted that these are recursively organized and are, as such, self-correcting. In this sense then, the unconscious is a reservoir of healing potential.

5.2.6.2 Unconscious processes as viewed from the perspective of dance-movement theory

In the literature on dance-movement therapy there are scattered references to the unconscious, but none of the sources researched offered a reasonably clear conceptualization of the unconscious or unconscious process. It may be hypothesized that the majority of the authors would hold an intra-psychic conceptualization of the unconscious, in view of the fact that the majority of these authors have adopted a psycho-analytic frame of reference (Bernstein, 1981; Espanak, 1981; Siegel, 1984). A notable exception is Kelly (1974) who perceives the unconscious, not
just in terms of man's internal states of which he is not aware, but also in terms of all external patterns of the cosmos which, although they are operating outside man's perceptual awareness, still influence the nature and meaning of his existence.

There are indications in the dance-movement literature that the unconscious is perceived to play an important role in healing. For instance, Bernstein (1981) writes that the capacity for rhythmic action to establish a link between the conscious and unconscious mind, renders it a powerful tool with all population groups, but she fails to explain this statement. Espanak (1981) seems to perceive the unconscious as the seat of repressed fears and emotions. That which is unconscious must be made conscious so that it can be integrated.

It may be hypothesized that dance-movement therapists trained in the Jungian tradition would view the unconscious in a more positive light. Jung (1983) most certainly saw the unconscious as a source of wisdom and as a guide.

5.2.6.3 Examples from the case study

In terms of the dance-movement groups conducted, it is not clear whether the healing potential of the unconscious mind was made available to the group. From the therapist's point of view a definite change, which is difficult to pinpoint or describe exactly, took place in the group. It may be said that, compared to the first few sessions, especially the last two sessions had much more depth and the members were considerably more congruent. Yet that does not fully describe the change that took place. The difficulty in determining whether these changes were connected with the unconscious being made more available, is that the unconscious is by definition not fully graspable by the conscious mind. Keeney's (1983) argument that a conscious, logical explanation of a recursive process can only deal
with a small part of a bigger recursive process, applies here. It is because of this that therapists can never have a complete understanding of the cybernetic processes that are occurring before their eyes.

5.2.6.4 The unconscious and dance in traditional healing

According to Ellfeldt (1979), the Shaman dances himself into a state of unconsciousness. In this state he can serve as the medium for building contact between the group and the gods. In systemic terms it would seem that the traditional healer, through the dance, comes into direct contact with the healing power of the unconscious mental process. In this unconscious state, this state of unawareness - in the everyday sense of the word, the traditional healer is the embodiment of a transcendent unity, transcendent meaning, here, above the division of opposites. It may be hypothesized that in this state, the traditional healer can directly experience that unity which is denied to human beings in normal consciousness. The healer thus acts as a medium for making available the healing potential of the unconscious to others. Bührmann (1983) describes the "xhentsa" which is a type of healing ritual among the Xhosa people. It would appear that as part of the xhentsa, patients dance themselves into a state of trance. It may be hypothesized that in this state the patient becomes more receptive to the healing potential of the unconscious.

5.2.7 An aesthetic basis for therapy

5.2.7.1 An aesthetic basis for therapy as viewed from the perspective of ecosystemic thinkers

In the previous section, the importance of living both sides of a distinction was underscored. This principle also
applies to therapy. According to Joubert (1987), an aesthetic basis for therapy is formed when conscious and unconscious processes of mind interact recursively and in a mutually self-correcting manner. This means that therapy is frequently based on intuition. (Here it may be noted that Nussbaum (1987), a dance-movement therapist, perceives movement as having the potential to make available to human beings their intuitive and creative parts.) Therapy manifests itself as an art in metaphors, paradoxes, anecdotes, dreams, dramatic announcements and other forms of analogue communication which arise from the therapist's and the patient's unconscious (Keeney, 1983).

Yet therapy, to be effective, needs to be pragmatic as well as aesthetic. Thus, Keeney (1983, p. 8) writes: "I prefer to view aesthetics as a contextual frame for practical action. A singular emphasis upon pragmatics potentially leads to an ecological decontextualization of therapy where one's bag of tricks, cures and problem-solving procedures is too easily disconnected from the more encompassing aesthetic patterns of ecology. Similarly, an aesthetics of therapy without appropriate regard for pragmatic technique may lead to free-associative nonsense".

5.2.7.2 An aesthetic basis for therapy as viewed from the perspective of dance-movement theory

Although they do not write of the different aspects or phases of their work in these terms, there seem to be clear pragmatic and aesthetic elements in the therapy conducted by dance-movement therapists.

Espanak (1981) divides therapy into two phases, namely restructuring and integration. The restructuring phase is very much pragmatic. Specialized exercises and rhythmic movements which have been designed to foster mind-body unity, constitute this first phase. The second part of the
therapeutic process entails integration of unconscious fears, repressed emotions and associations into consciousness. This process is initiated by means of individual dance or improvisations. This then would seem to be the aesthetic element of the therapy, in the sense that the therapist sits back and observes what is happening, without initially attempting to direct the process.

Scoop (1974) recognized the need for both pragmatics and aesthetics in her therapy with institutionalized patients. She was pragmatic in the sense that she chose themes for her sessions. These themes provided structure and enabled her to organize her ideas. On the other hand, she also allowed herself to be led by the processes that developed during the course of therapy. In fact, she illustrates the importance of not planning too carefully by describing her first-ever dance-movement session with institutionalized patients, which turned out to be a disaster because she had it planned in every detail and, therefore, could not be flexible.

5.2.7.3 Examples from the case study

It would seem that the dance-movement group therapy conducted as part of this study was both pragmatic and aesthetic. It was pragmatic in the sense that, at times, the therapist consciously decided on a task to be performed by group members. For instance, having observed that some members had difficulty standing their ground, she decided to introduce into the following session various ways of standing one's ground. Without this pragmatic aspect of the therapy and the structure it provided, there would hardly have been any group sessions at all. In the absence of structure, the members would most probably have experienced a great deal of anxiety and uncertainty, with resulting passivity.

The aesthetic side of the distinction was realized in that, at times, the therapist had no specific plans for a session
but relied on intuition to guide the group process. Furthermore, this aspect of therapy entailed the therapist holding back at times, and simply observing, with respect, the processes unfolding before her. There were two very important instances where this happened. In one, the group members had devised a drama involving a patient coming to a doctor with severe stomach aches and being turned down time and again instead of helped. The second instance involved traditional dancing, which the members had themselves suggested that they wanted to do, and a concomitant healing session.

In retrospect, it would seem that the therapist tended to become stuck in the pragmatic aspect of therapy. She was at times insensitive to the natural group process, interrupting it and preventing it from developing to full fruition by consciously and purposefully introducing new tasks or exercises.

5.3 DANCE-MOVEMENT THERAPY AND CONCEPTS FROM GROUP THERAPY THEORY

While the dance-movement therapist works with individuals within the group context, she also has to take cognisance of, and make use of, interactional processes between group members.

5.3.1 The social microcosm

5.3.1.1 Theory

The rationale of group psychotherapy, especially as practiced by Yalom (1985) is that, given limited structural restrictions, the group will develop into a social microcosm of the participant members. Given enough time each group member will interact with other group members as she does
with people in her/his social sphere. This means that members will come to display their characteristic and possibly problematic interpersonal behaviour in the groups.

5.3.1.2 Examples from the case study

In the dance-movement therapy sessions of this study, the group members were given the opportunity to form a social microcosm, mainly through the medium of non-verbal communication. Through movement they displayed their characteristic and, at times, problematic interpersonal behaviour in the group. One man's problematic interpersonal style found expression in his lack of movement and in the extreme reluctance with which he moved. Another man who had been diagnosed as schizophrenic, allowed other group members to transgress into his personal space and did not stand his ground in relation to them.

5.3.2 Interpersonal learning

5.3.2.1 Theory

It is within the social microcosm that interpersonal learning, regarded by Yalom (1985) as an essential therapeutic factor, can take place. The group allows for consensual validation and self-observation, and so enables group members to become aware of important aspects of their interpersonal behaviour. They can come to recognize their strengths and limitations, and their maladaptive behaviour which leads to unwanted responses from other people. This is made possible by the fact that accurate feedback is encouraged in the therapy group. Accurate feedback enables objective self-observation. The following interpersonal sequence is evident in therapy groups:

1. The member displays her behaviour, including maladaptive behaviour
2. By means of feedback and self-observation, she develops an accurate observation of her own behaviour and appreciates the effect of that behaviour on

* other people's feelings
* the opinions other people have of her
* the opinion she has of herself.

Having gained awareness of this sequence the person can then also realize that he is responsible for it. If he can come to accept responsibility for creating his own interpersonal world, he can start to alter it by changing his own behaviour.

Imitative behaviour is an essential element of interpersonal learning, according to Yalom (1985). Although specific imitative behaviour may be short-lived, it can serve to release the individual from rigid behaviour patterns and can enable her to experiment with new ways of behaving.

5.3.2.2 Examples from the case study

Interpersonal learning definitely played a major role in the dance-movement therapy groups conducted as part of this study. The leader used role-playing to illustrate to members their own behaviour, as well as the irritation it can present for others. Through the use of mirroring, members obtained direct and honest feedback on their own behaviour. Furthermore, in providing feedback, the group leader always made it clear that the person's behaviour and not the person him/herself was irritating or otherwise negative. Feedback was also given as to the effect which the absence of annoying behaviour and/or presence of positive behaviour had on other people, and positive reinforcement was elicited from the group. (Refer to
As far as imitative behaviour is concerned, the group members were sometimes asked to imitate one another's behaviour and at other times they did so spontaneously.

5.3.3 Group cohesion

5.3.3.1 Theory

Honest feedback, which is such a vital aspect of social learning, can only occur in a reasonably cohesive group. Yalom (1985) sees cohesion as the equivalent, in group psychotherapy, of the therapist-patient relationship in individual therapy. It includes the relationship of each member, not only to the therapist, but also to other group members and to the group in its entirety. While group cohesiveness is not a therapeutic factor per se, it is a necessary precondition for effective therapy. Group cohesiveness is an important determinant of positive therapeutic outcome.

5.3.3.2 Examples from the case study

Initially, the dance-movement group was diffuse and amorphous. There was basically no group-feeling. Accordingly, members risked very little. Their movements remained close to their bodies and there was very little spontaneity. Members displayed uncertainty about wanting to belong to the group. They seemed to be unwilling to let themselves be known to the group.

Various factors served to increase group cohesiveness over the course of the sessions. Movement shared by all members, including the leader, turned out to be a very effective way of building a feeling of "groupness". The group leader, early in the life of the group, became transparent in that
she expressed both her willingness to make contact and her feelings at finding this contact difficult to achieve. This incident fostered greater cohesion because at least one member showed clear acceptance of the therapist's transparency. Over the course of the sessions, individual members expressed acceptance of and caring for each other, thereby enhancing group cohesiveness. Eventually a high degree of cohesiveness was attained which allowed members to be critical of each other and to express aggressive feelings. However, cohesiveness remained at too low a level for members to be capable of expressing rejection. Greater cohesiveness was evident in the members' displaying more willingness to be vulnerable, and increased freedom to enter one another's space. The members expressed enthusiasm about the group.

5.3.4  A supportive, pleasant experience

5.3.4.1 Theory

A cohesive group does provide its members with a supportive, if not always pleasant, experience. (Being confronted with one's own negative behaviour can be quite unpleasant.) According to Yalom (1983), the provision of a supportive, pleasant and constructive experience for members is one of the most important goals of in-patient group psychotherapy. The therapist supports group members by expressing personal acceptance and liking of them. Furthermore, she acknowledges each member's contributions and takes him/her seriously. The in-patient group experience is rendered constructive by the leader's encouragement, in each group member, of behaviour which will allow that person to be accepted to a greater extent. The group leader ensures a pleasant experience by avoiding confrontation between members, and by the expression and examination of anger.
5.3.4.2 Examples from the case study

The group leader at all times acknowledged members' contributions and showed acceptance of each member. She did allow confrontation to take place on a non-verbal level, but the confrontation was structured as a role-play. Much the same applied to aggression and its expression. There was some spontaneous non-verbal expression of aggressive feelings, but this never progressed to the point where it could have had a destructive effect.

Joint rhythmic action was used to provide a pleasant experience, in view of the fact that it can generate feelings of well-being, relaxation and fellowship. Some structured opportunities were created for the expression of support and caring. During one session, a member who was not feeling well was asked to sit in the middle of a circle formed by the other members, who gave her some expression of concern and caring. In the last session, members were asked to stand on their knees in a circle formation, while holding hands, and to think of all the good things gained from and given to the group. This exercise was a symbolic expression of caring and support.

From the verbalizations of the group members as well as their non-verbal behaviour, it was clear that they experienced the group meetings as being enjoyable and pleasant, even though initially the meetings had been for them just another activity forced upon them.

5.3.5 The construction of norms

5.3.5.1 Theory

Yalom (1985) writes that each group develops a set of unwritten rules or norms. These determine how the group
members will behave. Norms are formed by the expectations of the group members and by the actions of the therapist. The therapist plays an all-important role in norm-setting. Group norms which enable the therapeutic factors to operate with maximum effectiveness, include self-disclosure, open expression of emotions and mutual acceptance, amongst others. Much of the norm-shaping as carried out by the therapist, is done by means of social reinforcement.

5.3.5.2 Examples from the case study

One norm which the group leader introduced right at the beginning of the first meeting, was that of participation by all members. She encouraged participation by, amongst others, enthusiastically accepting and praising all contributions made by group members. By the third session the members had begun to show, at least covertly, that participation had become a group norm. When one man, at the start of the third session, failed to perform the required task, at least two other members become visibly tense and uncomfortable, but relaxed when he made it clear that he needed help. By the fourth session, quite a considerable amount of pressure was brought to bear on the one member who had remained quite passive during the previous sessions.

The norm of caring and support for each other was also strongly reinforced by group members in the third session. One man kissed the new group member’s hand, thus welcoming her into the group. A woman spontaneously removed some cotton wool from another member’s face and kissed him gently. The therapist also at one stage initiated a structured showing of support. The incident is described in paragraph 4.4.7.

During the fourth session, a member introduced the group norm of sharing. He gave the leader some sweets which he had received from visitors and asked her to hand these out to the members.
Right from the start the group leader showed acceptance of, and respect for, all the members. This norm was strongly reinforced by her during the fourth session. When one member expressed some criticism of another's contribution, the leader made it clear that the contribution had been an acceptable one. She also praised the alternative suggested by the criticising member, and told the group that it was up to the criticised member to accept or reject the alternative.

5.3.6 The changing role of the leader

5.3.6.1 Theory

Yalom (1985) notes that, initially, the therapist is the group's primary unifying force. This means that, to start off with, the members relate with each other through the group leader. Members depend on the therapist for structure, and answers for approval and acceptance. Thus, the early group is dependent. One of the important early tasks of the group leader is that of culture-building, that is, the establishment of norms as described in the previous section. As time goes by and the group becomes more mature, spontaneous interaction between group members increases and the therapist's role of relaying communication decreases in importance. The important task of norm-building and reinforcement comes to be taken over by the group members.

5.3.6.2 Examples from the case study

Particularly during the first two sessions, the group was characterized by passivity. Members waited for the therapist's instructions and there was no spontaneous interaction between members. In a sense, the therapist was the glue that held the group members together. In addition,
group members maintained a large distance from the leader.

It was shown in the previous section that the group members played an increasingly important role in norm-building and maintenance as the group progressed. The group leader became progressively less active. During the second last session she withdrew a little from the group. While this was partly in anticipation of the next meeting being the last one, she also retired because members had indicated that they were eager to do something on their own initiative.

5.4 CONCLUSION

Dance-movement therapy seems to provide a technique by means of which culturally-different clients can be helped. It is possible to generate some concepts from Western psychological models that are compatible with the practice of dance-movement therapy with black clients. This possibility may tentatively provide white therapists with areas of conceptual certainty when embarking on the unfamiliar venture of working with black clients.
CHAPTER 6
SUMMARY AND CONCLUSION

6.1 INTRODUCTION

This study developed out of the writer's experience of a black rehabilitation ward which is part of the psychiatric hospital in which she spent a six-month period of her internship. She soon found out that the psychotherapeutic techniques which she had learnt during her university studies were totally inadequate in handling black patients. She was faced with the multitude of problems surrounding transcultural psychology in South Africa.

6.2 MENTAL HEALTH SERVICES AND AFRICAN CULTURE

African culture has undergone changes as a result of contact with Western culture and associated urbanization and industrialization. However, as Sow (1978) shows, daily social relations in all spheres of African society are strongly affected by traditional cultural values. Bührmann (1983) and Manganyi (1972) also point out that even urbanized black people revert to African ontology at times. The black people of South Africa adhere to certain beliefs, customs and a philosophy of life which are all very different to the beliefs, customs and philosophy of life which Westerners subscribe to.

Psychology - and this includes psychology as applied in work with black persons - is rooted in North American and European soil (Holdstock, 1931). The South African medical system, which is used as a frame of reference in mental institutions/hospitals, originated from, and is still strongly influenced by, British and American medicine (Cheetham, 1975).
Western diagnostic systems and treatment models are in many cases not applicable to black people. Cheetham (1975) and Bührmann (1983) show that history-taking is a very strange procedure for black people and that the questions which they are required to answer, often seem nonsensical to them.

As far as treatment models are concerned, the writer has found that the sickness model tends to be adhered to in mental institutions in South Africa. Holdstock (1981) notes that mental health professionals tend to attach disproportionate importance to the one-to-one method of psychotherapy while paying little attention to, and putting limited effort into, group and community approaches. Holdstock (1979) shows that the great majority of Western techniques are, culturally, too alien to serve as a suitable psychological approach to the healing of black people in South Africa.

Another problem of transcultural psychology is that of communication. A black client and a white therapist in the South African context are hardly likely to have been brought up and socialized in the same language, with the result that contact is difficult.

In the light of these factors and Holdstock's (1979) argument that psychotherapy is most effective when the healer and the person to be healed are culturally similar, the question arises as to whether there is any point in practising transcultural psychology. The author comes to the conclusion that transcultural psychology is a practical reality and is likely to be one in years to come. Faced with this reality the therapist has basically three options:

1. She can refrain from doing psychotherapy with the culturally different.

2. She can try to work with the client along the lines
of the largely Western models in which she has been trained.

3. She can attempt to develop techniques and methods which will be more likely to be effective for use with culturally-different clients.

This study developed out of the author opting for the last-mentioned possibility.

Dance-movement therapy was chosen as a possible alternative therapeutic model for several reasons:

1. It was realised that the therapist could not hope to gain or to convey to her culturally-different client an empathic understanding of his world if she relied on verbal techniques and according to Schmais (1974), dance-movement can be effectively used to achieve this goal.

2. Holdstock (1979; 1980) points out that African civilization functions for the most part in terms of right-hemispheric consciousness and that intuitive knowing is a basic mode of being in Africa. Movement can make accessible the intuitive parts of ourselves (Nussbaum, 1987). The white therapist can more readily make contact with her black clients if she uses dance-movement.

3. Bernstein (1981) and Nussbaum (1987) have pointed out that movement and dance form an integral part of black people's lives from the time they are children, and that it is a very important aspect of community life.

In view of these factors and Holdstock's (1981) argument that group approaches are more applicable to black people than one-to-one methods, it was decided to involve six black patients, all from a rehabilitation ward, in a number of group dance-movement sessions.
6.3 WHAT EMERGED FROM THE STUDY

As the group developed over time some important changes occurred. Firstly, the group developed from being diffuse and amorphous to being a cohesive unit. Group members became increasingly congruent in their expression of feelings and showed more creative responses. A greater willingness to experiment with new modes of behaving was also evidenced. Group members became increasingly spontaneous in their movements and used more and more of their bodies in movement. Initially the therapist had to provide much structure and played a very active role, but as the sessions progressed, the initiation of activity was to an increasing extent left to the group members. When the dance-movement sessions began, the emphasis in the group was on illness. By the time the second last meeting came up the group members had started to operate in terms of health and healing.

6.4 CONCEPTUALIZING THE DANCE-MOVEMENT THERAPY EXPERIENCE

Most of the literature on dance-movement therapy is written from a psycho-analytic perspective. The author's training was, to a large extent, systems-oriented. Yalom's (1985) classic work on group psychotherapy also played an important role in her training. Consequently she tended to perceive the processes which occurred in the dance-movement sessions in accordance with these two theoretical approaches.

6.4.1 Health and pathology

From an ecosystemic perspective, pathology involves a restriction or an absence of alternatives. It was found that the members of the dance-movement group tended towards
a restricted-movement repertoire. In the dance-movement group sessions, definite attempts were made to broaden these movement repertoires. It was hoped that, in accordance with the principle that change in part of a system can lead to change in other aspects of that system, a widened movement repertoire would bring about a greater role repertoire.

Dichotomization is an aspect of pathology. It entails living one-sidedly. For instance, attempting to live only the one side of the good/bad distinction. Some of the dichotomizations to which people adhere, for example, the split between body and mind and between fantasy and reality, can be overcome by means of dance-movement therapy.

6.4.2 Change

The changes which occurred in the group dance-movement sessions could be conceptualized in ecosystemic terms. Some parallels to the ecosystemic conceptualizations were also found in the dance-movement literature. Writers like De Shazer (1983) and Keeney (1983) have pointed out that, for a system to change, it needs to receive information of a difference that makes a difference. At the same time the information must show a fit with, that is, it must be similar to, what is already available to the system. In the dance-movement therapy groups the therapist, in accordance with what she had read in the dance-movement literature, approximated the group members' movements as nearly as possible. In ecosystemic terms, the information with which she provided the members fitted with what was already available to them. Also in accordance with what she had gleaned from the dance-movement literature, the therapist developed and altered the member's movements. Seen from an ecosystemic perspective she supplied members with information of a difference.

Palazzoli et al. (1978) show that the therapist can introduce significant changes in behaviour by punctuating
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behaviour, interactional patterns and contexts differently to the way in which they are normally punctuated. In this study both the therapist and the group members tended to avoid concepts like "therapy", "patients" and "illness", which only serve to reinforce pathology.

By learning to denote the group sessions and the relationship with the therapist differently, the group members showed that Learning II in Batenson's (1979) terms had taken place. Their conceptualization of the group sessions changed from one which entailed their being ill and the therapist having to cure them, to one which entailed their being able to heal themselves. Furthermore, the initial complementary relationship with the therapists was redefined as a parallel one.

Both the ecosystemic thinkers and the authors of the dance-movement literature perceive the unconscious to play an important part in healing. Keeney (1983) points out that change often takes place in the sphere of the unconscious. The unconscious is by definition not fully graspable by the conscious mind. For this reason, the writer could not determine whether certain important changes, which took place in the dance-movement sessions but which were difficult to pinpoint or describe exactly, were the result of unconscious process being made available to the group.

According to Keeney (1983), therapy needs to have both an aesthetic and a pragmatic element for it to be effective. There appear to be definite pragmatic and aesthetic aspects to the work done by dance-movement therapists, even though they do not write in these terms. The dance-movement group therapy of this study contained both the aesthetic and pragmatic elements. It was pragmatic in the sense that the therapist sometimes consciously decided on a task to be performed by the group members. The aesthetic element was realised in that the therapist at times relied on intuition and sometimes refrained from doing anything but simply observed with respect the processes evolving in front of
6.4.3 Yalom's group psychotherapy

It was found that many of the factors discussed by Yalom (1983; 1985) as operating in verbal group psychotherapy, also played a role in the dance-movement therapy groups. In the dance-movement therapy groups of this study the group members were provided with an opportunity to build a social microcosm, largely through the medium of non-verbal communication.

Social learning, seen by Yalom (1985) as an essential therapeutic factor, played a significant role in the dance-movement therapy groups. In particular, role-playing, imitative behaviour and feedback, important aspects of social learning, were in evidence.

To start off with, the dance-movement group was diffuse and amorphous. As group cohesion increased, spontaneity and a willingness to take risks become evident. Members could also express criticism of each other.

An important goal of in-patient group psychotherapy, as discussed by Yalom (1983), consists in the provision of a supportive, pleasant experience for the group members. The group members who were involved in the present study made it clear on several occasions that they enjoyed the group sessions.

One essential function fulfilled by the group leader is norm-building, according to Yalom (1985). While most of the group norms in this study had to be introduced by the group leader, they came to be confirmed and strengthened by group members.

Yalom (1985) points out that, initially, the group leader has to be very active and that interactions between members take place through him. That was definitely the case with
the dance-movement groups conducted as part of this study. With time the members did, however, become much more active and direct interaction increased.

6.5 IMPROVING THE TECHNIQUES OF DANCE-MOVEMENT THERAPY

There are several ways in which the techniques used in this study could be improved upon. These include the following:

1. Observers from behind a one-way mirror could, on the basis of their second order perspective, suggest useful interventions.

2. A discussion period during which members could share their experiences, even if in their own language, could be introduced after each session. This may involve playing the video of the session for the members with the therapist making comments about what she sees happening. This exercise could serve to link the motor experiences to the cognitive level (Alperson 1973) and could provide group members themselves with a second order perspective.

3. Use could be made of other art forms, e.g. drawing, in combination with dance-movement. These art forms could be integrated in the sense that the members could, for example, dance what they had drawn.

4. The group sessions could be extended in length so that issues could be worked through thoroughly. A critique of this study is that issues were not explored fully. The group leader tended to jump quickly from one activity to the next.
6.6 POSSIBILITIES FOR FURTHER INVESTIGATION

1. The possibility of making a type of interactional analysis in terms of movement and deciding on the basis of this what therapeutic interventions to use could be investigated.

2. A major shortcoming of group dance-movement therapy as practised as part of this study is that the larger system of which the individuals concerned formed part, were not involved in the therapy. Although it is possible, according to Dell (1982) referred to by Joubert (1987), that change in one part of a system can lead to discontinuous change in the system as a whole, the interventions directed at the individual may not be the most economic or effective. Future investigators, in attempting to remedy this situation, would have to establish, firstly, which larger systems play an important part in black people's lives. These may include extended kin, friends and neighbours and will probably differ for different individuals. Secondly, ways will have to be found to involve these larger systems in dance-movement therapy. The chances of getting fairly large numbers of people to far-away mental institutions seem remote. This may mean that the psychologist, like the traditional healer, will have to work at the home of the afflicted person. The idea of doing psychology in the community would have to be explored.

3. Closer cooperation between both white and black mental health workers and traditional healers working within black communities can be investigated in order to foster higher standards of mental health in general.
4. With regard to theory development it is suggested that the study of concepts of health and illness, as well as the models of healing as used by the traditional healers, can enrich equivalent Western concepts and models.

5. What emerged from this study certainly seems to indicate that dance-movement therapy may be a viable alternative to the verbal therapies where therapist and client are culturally different. Although the language of dance and movement differs across cultures, it is much more universal than the spoken language, thus enabling the therapist to gain an empathic understanding of her client and to convey this understanding.
LIST OF SOURCES


Odyssey, pp. 29-31.


