to experience synchrony, reciprocity and the repair of mismatches (Tronick, ibid). This intervention encouraged Z. to develop positive coping strategies as he began to experience more rewarding social interactions with peers and adults. These interactions seem to enable the formation of new emerging organizational experiences. As Stern suggests (1985), because such matrices catalyze ongoing affective appraisal of events, these new experiences played an important role in Z's sense of self as he related to others in his environment.

References


**Dynamic Play Therapy: An Integrated Expressive Arts Approach to the Family**

*Treatment of Infants and Toddlers*

*Steve Harvey, Ph.D., ADTR, RDT, RPT/S Colorado Springs, Colorado*

The father of a very securely attached little boy recently told me about the jumping game that he and his son developed and extended during the boy’s first two years. During the boy’s third and fourth months, the father would begin bouncing his son as the boy bent his knees — to the baby’s great delight. Throughout the next several months, the boy began regularly to “ask” for this game by crawling over to his father and placing himself in the “jumping” body position. Later he would place his father’s hands on his own waist, and during his second year, the boy would gesture and babble to indicate his desire to start the game. When, as a toddler, the boy would run away from his father during chase games, he would raise his arms when he was ready to be “caught” and lifted. The father, of course, played along, and both father and son thoroughly enjoyed what became a rejoining or reuniting “dance” when the father returned from work. Through repetition and development over the years, the jumping/lifting game was full of meaning, even though no words were used. It was a way for father and son to generate, express, and remember their positive feelings for each other.

Dynamic Play Therapy is an intervention style which encourages parents and children to engage in mutual expressive activities. This approach involves an integration of movement, dramatic games, art activi-
Dynamic Play Therapy techniques are helpful not only in work with birth parents and their children, but also with infants and toddlers who have been abused and are now in foster care or adoptive families.

Dynamic Play Therapy builds on Bowlby's (1982) conceptualization of attachment as the psychological and emotional relationship that develops between a parent and child and is characterized by parents' ability to provide a sense of security for their young children. Parents foster secure attachment in part by meeting their children's nonverbal expressions of distress in a sensitive, attuned, and contingent manner—often through nonverbal, emotionally and physically matched interactions. The successful practice of Dynamic Play Therapy also incorporates concepts of interactive mismatch and repair (Tronick, 1987), affective attunement (Stern, 1985), mirroring (Kohut, 1971), and prefacing (Tard, 1992).

The Dynamic Play approach emphasizes the playful interaction between parents and children. It assumes that healthy, secure parents and children will generate dances, drawings, turn-taking dramatic games, and videotapes easily and with pleasure. Expression builds from the interaction, and small interactive problems are solved easily through creative and imaginative negotiation. For example, a young child who playfully runs off, distancing herself from her parent, might spontaneously become a bird in search of a nest who, returning to her parent's lap or "nest," expresses joy with her entire body. As early as the second year of life, children attentively watch videos of themselves and their parents playing with pillows, gymnastic balls, and scarves; then they repeat and elaborate on their past enactments with pleasure.

As a therapeutic approach, Dynamic Play Therapy uses movement, art, and interactive games to identify expressive mismatches between parents and children who have difficulties with intimacy, attachment, and emotional expression. As suggested by attachment theory, the goal of Dynamic Play Therapy is to help parents generate security; to help children produce organized behavior which shows both exploration and return, related to their own internal needs; and to help both parents and children experience trust, leading to pleasure in their relationship.

Dynamic Play Therapy uses various expressive forms to help parents and children generate positive behavior during the actual experience of play, so that they discover their own natural creativity in a context that encourages the enjoyment of mutual, spontaneous, uninhibited expression within their relationship. Parents and children create new experiences together. From these new experiences, which generate significant, positive feelings between parents and children, families begin to understand what positive change, leading toward increased attachment, might feel like for them.

Some of the theoretical models and intervention techniques involved in the expressive arts therapies are similar to those of other parent-infant therapies that involve coaching, generating playful experience, video review, enactment, and encouraging reciprocity. However, Dynamic Play Therapy differs from other approaches in two significant dimensions:

- a much enlarged use of physical engagement for both parents and children;
- an emphasis on spontaneous creativity in moment-to-moment playful expression.

While most, if not all, parent-infant intervention utilizes the concept of a parent being able to follow or mirror the young child's nonverbal gestures and expressions, the expressive arts approach emphasizes the use of a parent or child's whole body expression, whether in following or in turn-taking activities.

**Techniques of observation and intervention**

In order to encourage large-scale physical interaction, Dynamic Play Therapy is usually carried out in a large room furnished with attractive large props. This context encourages a much wider range of interactive movement possibilities, including the use of all limbs, large locomotive movements (such as running, crawling, climbing, and movement through space), as well as movement on all levels—from crawling on the floor to jumping and swinging in the air. With these resources, a movement interaction between, for example, a very withdrawn toddler and his parent might cover the range from matching finger games, to the parent and child rolling together across a large expanse of floor, to crawling together underneath large parachutes.

Large foam pillows in various shapes are especially helpful in organizing mutual movement. Rectangles, squares and cylinders are used to build houses (which are sometimes knocked down), walls (to be crawled over or under), and "lands." Heart-shaped pillows five feet across can be used to represent Mom's or Dad's Land or Heartland. The pillows' softness helps to channel even children's most energetic movements into activity which is potentially more interactive. The large hearts and other pillows can also be used to rock and soothe children towards the end of sessions.

Parents and children use large gymnastic balls, stretch ropes, and stretch blankets to pull towards and away from each other. Large brightly-colored scarves and life-sized stuffed animals also stimulate creativity and dramatic play with children, especially with children over two.

The large scope of Dynamic Play Therapy also facilitates dramatic enactment (any interaction which involves turn-taking or the use of role, even in nonverbal activity). For example, a young toddler dealing with issues of object constancy might run across the space and hide from her parent under several large pillows,
while the parent takes on the role of finder. Enlargement of the scope of such games helps in the identification of difficulties in role examples in interaction, as well as in finding new role possibilities. An example of mismatching roles occurred in dramatic play between an adoptive mother and her two-and-a-half-year-old boy. The boy had experienced significant physical abuse prior to entering his adoptive placement. In a play episode, this boy would repetitively crawl on top of a large dog and fall off, playing that he was hurt. The adoptive mother kept encouraging him to continue his initial story, without acknowledging his fall. Clearly the boy was taking a role of "being hurt," while the mother's activity of watching and urging him to continue his story didn't match. The mother was then coached to catch and help the boy "rider," first "nursing" him back to health and then "teaching" him how to ride safely.

It is extremely helpful to have a video camera and monitor available to capture interaction and immediately feed this back to both parents and children. I have found children as young as 18 months to be extremely interested in such visual feedback of their interactive play.

The expressive arts therapies emphasize creativity in interaction. In people of any age, creativity involves a curious engagement with the environment, intrinsic enjoyment in expression, and pleasure in attempts at mastery. Such curiosity can occur in interactions as well. The creativity of young children is easily recognizable: toddlers begin to dance or sing and engage in scribbling or mark making; two- and three-year-olds engage in imaginative role play. But even young infants can be creative in their playful use of variation in interactive games with their parents. Emphasizing creativity, the Dynamic Play therapist attempts to go beyond simple face-to-face activity or mirroring of body parts.

In Dynamic Play Therapy, parent-child activities include both therapist-directed games, to help promote coordinated interaction, and free play. All activities are designed to produce interaction in which parents and children match each other in complementary ways. Therapist-directed activities include games, such as face-to-face play; swinging the child, sometimes to produce an excited state between children and parents; sometimes for soothing and calming down; playing peek-a-boo with the large scarves; and playing hide-and-seek using the large pillows. In free play, parents are coached to help set the structure of the activity, and then to follow the child's lead throughout the room —

swinging, hiding, falling, and rolling over pillows are common activities. Drawing activities (scribbling on newsprint, drawing outlines of body parts or full bodies) and dramatic play (especially with stuffed animals) also produce interaction.

**Natural creativity and "breaks"**

Natural creativity in interaction can serve as an ongoing resource to help build or rebuild relationships between parents and children. It is useful to think of certain aspects of a parent-child relationship as an improvisational dance or drama, in which one partner's nonverbal expressions stimulates the other partner's expressions, by eliciting a creative response. In healthy relationships, the natural creativity within a parent and child keeps their "dances" moving from gesture to gesture, facial expression to facial expression, etc. One partner's expression stimulates and moves the other, in a pleasurable, problem-solving flow that generates good feeling. This natural creativity can be thought of as the magical "it" of a relationship, in which parents and children fill out and continue their emotional expressive experience with each other from moment to moment.

From this perspective, children and parents with problems in their attachment might be thought of as experiencing breaks in this ongoing creativity. The gaps created by their mismatched expressions become so great that mutual creativity stops. Expressive arts intervention, then, helps parents and children become aware of and use their natural curiosity within creative responses to each other as they occur in the moment, during mismatches. This style of intervention attempts to help parents and children engage or re-engage with each other in activities which generate creative mutual responsiveness. The goal, in other words, is to help restart an ongoing improvisation that has stalled.
The following case vignette illustrates the use of enlarged physical engagement and emphasis on natural interactive creativity.

**Renee and Sam**

Renee was a 22-year-old woman who had been diagnosed with schizophrenia at the age of 16. Throughout her young-adult years she had complained of hearing voices that told her to kill herself or her boyfriend. By the time Renee was 22, she was able, with proper medications and support, to work part-time and was living with a constant male companion. During this period she gave birth to Sam. Sam was seven months old when Renee began creative arts therapy. She was also in ongoing follow-up treatment with a psychiatrist at a local mental health center.

Renee was seen initially in individual dance/movement-oriented sessions. She would begin her sessions by describing some of the events of her life and then, together with the therapist, would design physically-oriented activities to address the conflicts in a metaphoric way. During these sessions, Renee reported that throughout her early and mid-adolescence, she had been repeatedly assaulted sexually by an uncle. This information was important, as body boundaries, feelings of trust, and feelings of overwhelming fear in relationships with others became major issues addressed in individual sessions through movement improvisation involving physical play metaphors.

After approximately two months of individual treatment, Renee asked if she and Sam could be seen together, as she was having some difficulty caring for him. Sam had begun to crawl and was becoming quite difficult for her to manage. When Sam was eight and one-half months old, he and his mother began several months of weekly sessions. Renee continued weekly individual movement-oriented sessions as well.

When Renee had first begun dance/movement therapy, she was a slightly overweight, lethargic young woman who showed very little animation in her facial or gestural expression. During initial sessions, she rarely moved her hands or arms away from her body. Because she showed very little rotational movement in her shoulders, hips, or spine, her movement had a very one-dimensional quality.

When Renee was first seen with Sam, she held him awkwardly. Because of her rigidity, Renee could not mold or adjust her shoulders, arms, or spine to offer Sam a comfortable place for his body to be in her arms or lap as she picked him up. Mother and son showed little face-to-face activity. Sam presented as a quite energetic and reckless little boy who used locomotive behavior (crawling, and later walking) to move rapidly away from his mother, rarely returning to her. Because of his quickness, he was constantly bumping into furniture and walls and falling down stairs with much greater frequency than other infants. Renee talked about her difficulties caring for Sam. She said that the more energetic he became, the more lethargic she felt and less motivated to protect and contain him. Clearly, this mother and son showed several significant mismatches in their nonverbal interactive style and emotional communication with each other. Moreover, this situation was producing a potentially dangerous situation in the home as Sam negotiated his environment with little adult protection and/or interaction.

**Intervention**

In her individual sessions, Renee and the therapist began with activities in which she could instruct him verbally where to move in space, then show him with gestures involving her hands and then arms, and then use full body movement. Next Renee and the therapist began to move in the room together. Renee used both verbal and nonverbal communication to control the therapist's distance from her. As sessions continued, Renee became quite animated and began using her arms and torso actively and spontaneously. The therapist responded in a complementary fashion. As sessions progressed, Renee began to enjoy these activities, especially moving simultaneously with the therapist. Mutual dances began to continue for 20 or 30 minutes, as Renee became quite creative in using her body to influence the interaction between herself and the therapist. The goal of spontaneous dance-making was to increase Renee's movement initiation, while the therapist matched his response to hers.

Interactions were extended with props. Renee and the therapist placed large pillows between them, moving the pillows across large spaces at different speeds and body levels while leaning into the pillows with their weight. The pillows represented various issues in Renee's life, finally coming to represent cooperation between Renee and the therapist in raising Sam.

In these activities, Renee needed to actively engage her weight, spine, and all of her major joints, responding creatively, spontaneously, and in an ongoing way to the therapist. This was important because Renee was now feeling her body rather than exhibiting the protective, defensive, non-moving response that may have been a result of earlier boundary violations and molestation. The pillows may have been a metaphor for a buffer between Renee's self and the outside world, which helped her to move more easily, and with full body weight, through space. The therapist, for his part, followed Renee's physical initiations sensitively and contingently. For example, when she would initiate a light use of weight by leaning on the pillow, he would merely match it; when she began to initiate more joint movement, he would respond to that in the moment.

When Renee first brought Sam to sessions, he would crawl away from her quickly, and Renee would simply sit watching him, apparently exhausted. Renee described this exhaustion as coming from her many efforts to hold or "contain" Sam. Sam, for his part, be-
gan crawling away from Renee as soon as he could wiggle his body down to the floor. Once away from his mother, Sam moved away quickly, without looking for Renee at all. The therapist and Renee then decided together to pile pillows in a circle approximately six feet in diameter, so that Renee could keep Sam in a range where she might actively try to engage him. As Sam would approach the pillows, Renee could follow behind him. Renee and Sam spent several sessions falling into the pillows. The interaction was now clearly a game of chase and catch (as Sam may well have wanted all along). Both mother and son began to laugh together, sharing positive emotional exchange for the first time.

Gradually, the game enlarged. Sam began to climb over the pillows, but Renee was able to catch and hold him while rolling down one side or another of the pile. Like the initial chase and catch game, the rolling produced much enjoyment, mutual laughter, and many variations over time. Interestingly, in the rolling, Renee was able to adjust her torso, arms, and weight to hold Sam — much different from the awkward holding observed earlier.

Individual and parent-infant treatment continued for approximately 10 months. At that time Renee and Sam began to engage in long periods of interrupted pleasurable play together, including spontaneous improvised games of chase and following each other throughout the room. In such activity, when Renee would stop, fall, or change direction, Sam would follow or initiate his own movement ideas to which Renee would then respond. Such give and take generated laughter and other expressions of joy between mother and child. Sam became far more interested in his mother and Renee found her time with her son more relaxing and energized. In her individual therapy, Renee developed more ease in her improvised movement play as well, as she no longer introduced themes related to her past molestation and victimizations. Rather, in both individual and parent/child therapy, Renee introduced play which was responsive to the present moment, freely developing movement play related to the props in the room, her present “in the moment” body feelings, or her son’s interests. Significantly, this style of play began to offer both Renee and Sam opportunities to express emotions in response to each other in a spontaneous way, and such spontaneity provided the energy to keep them engaged with each other in a natural, easy manner.

Jen and Johnny

Much of the author’s longtime practice has involved helping foster and foster-adoptive families create attachment relationships with young children with histories of neglect, abuse, and multiple separations and placements. Many of these children are referred because of problems with emotional constriction, nightmares, inability to accept soothing from foster caretakers, and excess aggression and/or withdrawal.

Jen brought her adopted son, Johnny, for parent-child treatment when the child was 10 months old. According to social service records, Johnny’s birth mother had attempted to abort him by taking an overdose of cocaine. Johnny was born two months prematurely, showing signs of cocaine addiction. He was taken from his birth mother at the hospital and placed in two foster placements before finally arriving at his adoptive home.

At 10 months, Johnny was extremely clingy and continually distressed. Jen reported that she was exhausted; she could go nowhere by herself without Johnny holding onto her leg. He could not tolerate any separation and would let only Jen hold him. However, even being held did not soothe Johnny or calm him down.

During their initial session, Jen sat primarily in one position, without bending or shifting her shoulders, face, or back to match Johnny’s movement in any way. She seemed to be physically very uncomfortable and very tense even being on the floor with her infant. Johnny was actively crawling around her. At one point, the therapist asked Jen to move approximately 10 feet away from Johnny, who then became extremely disoriented and unable to locate his mother. At this point, he began to crawl in the opposite direction, get lost, and became extremely distressed. Although Jen was able finally to calm him down by holding and rocking, this effort took quite some time, and Johnny and Jen were not able to generate any further interactive play.

Clearly, the breaks in interaction included Johnny’s inability to tolerate any separation without becoming extremely disorganized and anxious. Such anxiety interrupted active search behavior. Jen, meanwhile, was not using energetic interactive play to help Johnny remember or orient to her position in the room.

The therapist used a large balloon, which Johnny could activate with very little effort, as a prop to capture his attention. As Johnny reached for and touched the colorful balloon, it would move immediately, capturing Johnny’s interest in a physical way. Gradually, as the balloon play between the therapist and Johnny became more coordinated, Jen was encouraged to extend and enlarge the scope of the play by reaching out, changing levels, and leaving her basic sitting position. At first, Jen found this exhausting rather than relaxed and easy. But as she began to extend herself more with the balloon play, Jen was able to accept Johnny’s efforts with more enjoyment. A parachute was used to rock Johnny so that he could maintain eye contact with Jen. At first, Johnny had difficulty relaxing in this activity, but when peek-a-boo was added to the rocking, he was able to laugh and seek out his mother’s face while being soothed at the same time. As Jen’s and Johnny’s repertoire of activities grew and became more self-sus-
taining, Jen reported that Johnny was able to separate more easily from her and was becoming far less anxious and clingy. His sleeping also improved.

**Susan and Alice**

Susan brought her adopted two-year-old daughter, Alice, for treatment because the little girl could not be soothed, was showing aggression toward other children in the house, and had difficulty separating from her mother. At the same time, however, Alice openly rejected Susan’s physical advances and efforts to hold her, arching her back when she was held. In initial sessions, Alice showed extreme tantrum behavior when Susan attempted to leave the room. Alice did not speak but was extremely controlling throughout the interactive play, grasping and screaming at Susan. While Susan was generally patient, she clearly was frustrated.

The therapist and Susan began together to rock Alice on the large, soft heart-shaped pillow. The therapist chose this activity to help Alice experience physical softness close to her body while being rocked gently. Alice initially resisted this, and showed some tantrum behavior. Then the therapist and Susan began to roll Alice gently back and forth between the two of them, until Alice was able to roll from the therapist’s arms across a lifted pillow into her adoptive mother’s arms. Although Alice could tolerate this activity for only brief amounts of time in early sessions, she soon came to enjoy it and asked for it eagerly with gestures and babbling during her sessions. Alice and Susan also began scribbling together, with Susan matching Alice’s style and energy level in drawing. A final activity involved Alice moving freely throughout the room with Susan following as closely as she could. Alice then began to fall on the pillows, enjoying it when Susan would fall next to her. As had happened with Renee and Sam, this activity became a game of “chase and be caught.”

Over a six-month period, Alice became much more open to Susan’s holding overtures and began to seek out holding at home. She was also able to be comforted, and her tantrum behavior decreased significantly as her language increased. Alice’s increasing curiosity and active, fun-filled exploration and enlargement of activities in therapy sessions were accompanied by growing enjoyment of relationships at home. More specifically, Alice began to show active and spontaneous use of shaping behavior, adjusting her body to match Susan’s holding gestures in a soft way, matching the rhythms of gestural movement to Susan’s expression, eye contact, and relaxed, responsive participation in game-playing with her adoptive mother. Two years after the beginning of treatment, this adoption is proceeding positively and without incident, despite its having been viewed as at high risk for disruption because of Alice’s earlier behaviors and inability to form relationships.

**Bill, Gail, and Ben**

Bill and Gail, the foster-adoptive parents of Ben, brought this 26-month-old boy for treatment because he was being excessively aggressive toward other children in the home. Aggressive outbursts included biting and pinching. Ben had difficulties being soothed and in sleeping. During the intervention period, Ben was supposed to be seeing his birth father weekly. However, the father was extremely inconsistent, and after a missed visit, Ben’s aggression and moodiness would increase significantly for several days.

Ben was seen with Gail and Bill on alternating weeks to accommodate their work and child care responsibilities. Interestingly, the initial breakthrough in play came in a session when Bill was instructed merely to follow Ben through the large playroom. Ben moved quickly from wall to wall, but as soon as he realized his adoptive father was following him, he initiated several games, such as crawling through the pillows. Coaching helped Bill turn this game into hide-and-seek and a version of peek-a-boo, much to Ben’s enjoyment. These games developed over several sessions. For example, the therapist would make a house for Ben and a house for his father out of pillows. Both father and son would go in and out of each house easily and also knock them over in their play.

These play episodes were videotaped, and Ben and Bill were instructed to watch the tapes throughout the week. Ben became extremely interested in the tapes and would ask repeatedly for “his movie,” which he would watch attentively for episodes of several minutes over many hours. Ben’s increasing curiosity and engagement in play sessions suggested that the tapes may have helped him to focus. The tapes were particularly useful when Ben’s birth father had missed a scheduled visit. When the foster-adoptive parents played the videos for Ben, he was able to watch with interest and then begin to engage in positive play with them, rather than exhibit his previously typical tantrum behavior.

Several years after treatment, Ben has been adopted by Gail and Bill, and his aggressive behaviors toward other children have become almost non-existent. Ben still enjoys watching his movies occasionally.

**Summary**

Healthy parent-child interactions can be thought of as improvisational dances and dramas. These interactions produce a motivated flow of active expression, which rises and falls to match internally felt emotional impulses. Dance/movement, art, drama, music, and video techniques can help parents engage creatively and positively with their young children. Creative arts therapists observe how interactive play emerges between parents and children and notice breaks and deviations within it. Therapeutic intervention then works to re-engage family members in game-like activities which generate curious, playful, creative interaction.
While many parent-infant intervention styles make use of activities and video, the creative/expressive arts therapies offer two unique contributions to the field of parent-infant psychotherapy. First, when parents and children make use of their whole bodies to move through space, using multiple levels of locomotion and an enlarged movement repertoire, their physical, artistic, or dramatic interactions seem to generate an "expressive momentum" which creates new, positive experiences. Second, building on naturally occurring motivation, curiosity, and mutual enjoyment helps parents and children who are experiencing difficulties in their relationship create engaged, playful exchanges in the therapeutic setting. As these are repeated and elaborated upon at home, the style of playful give-and-take of these parents and children comes to resemble the spontaneous, joyful interaction of healthy parents and children.

References and bibliography

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What is Dance/Movement therapy?

Dance is the most fundamental of the arts, involving a direct expression of one's self through one's body. It is an especially intimate and powerful medium for therapy. Based on the assumption that body and mind are interrelated, dance/movement therapy is defined by the American Dance Therapy Association as 'the psychotherapeutic use of movement as a process which furthers the emotional, cognitive and physical integration of the individual.' Thus, dance/movement therapy effects changes in feelings, cognition, physical functioning and behavior.

The dance/movement therapist focuses on the movement behavior as it emerges in the therapeutic relationship. Expressive, communicative and adaptive behaviors are all considered for both group and individual treatment. Body movement simultaneously provides the means of assessment and the mode of intervention.

What do Dance/Movement Therapists do?

They work in hospitals, clinics, rehabilitation facilities, nursing homes, senior centers, and special schools with a wide variety of clients; they conduct individual and group sessions and collaborate with members of the professional staff; they use movement observation skills as part of a research team; they train other professionals to understand movement as communication and expression; and they consult with community leaders in recreation, education, and mental health.

What kinds of work experience would be helpful for a future Dance Movement Therapist?

Dance teaching of all kinds with all age groups, performing, choreographing, and working in human service professions such as recreation, teaching and social work.

What undergraduate preparation should one have?

Extensive dance experience and a liberal arts background with coursework in psychology. For specific prerequisites contact each graduate program.

What degree do Dance/Movement Therapists receive?

Professional training is on the graduate level. Graduates receive a master's degree in dance/movement therapy. Graduates from an "approved" dance/movement therapy program are eligible for a D.T.R. (Dance Therapist Registered).

What does approval of graduate programs mean?

An approved program has met the basic educational standards of the American Dance Therapy Association.

What does D.T.R. (Dance/Therapist Registered) mean?

It signifies to the public and professional communities that an individual is prepared to practice dance/movement therapy in a clinical, educational, or rehabilitative setting.

Can one receive a D.T.R. with a Master's degree from a related field plus Dance/Movement Therapy coursework?

Yes, there is an alternate route which requires a master's degree, specific dance/movement therapy courses and supervised internships. For further information write to A.D.T.A., 2000 Century Plaza, Suite 108, Columbia, Maryland 21044, for materials on the alternate route D.T.R. requirements.

What does A.D.T.R. (Academy of Dance/Therapist Registered) mean?

This is the advanced level of registry, signifying that an individual has the education and experience to teach dance/movement therapy and to supervise interns.

Approved ADTA graduate programs in Dance/Movement Therapy

ADTA approves programs that meet the requirements stated in the ADTA standards for Graduate Dance/Movement Therapy Programs. Graduates from approved Dance/Movement Programs meet all professional requirements for Registry (DTR Level).

For further information about financial assistance, prerequisites, housing, etc., please write to each college or university.

Antioch New England Graduate School. 105 Roxbury Street, Keene, NH 03431. Telephone: (603) 357-3122, Ext. 222. Masters Program in Dance/Movement Therapy, Department of Applied Psychology. Susan Loman, M.A., A.D.T.R., Director.


University of California, Los Angeles. 405 Hilgard Avenue, Los Angeles, CA 90024. Telephone: (310) 825-3951. Gradu-
Other graduate programs and graduate coursework in Dance/Movement Therapy

Recognizing that many regions of the country do not have an integrated comprehensive sequentially ordered program in dance/movement therapy, the ADTA recognizes an alternate route to registry. The alternate route is designed for individuals with extensive dance/movement background wishing to pursue a master's level degree in dance/movement therapy education and training in combination with study in a related field (i.e., social work, psychology, counseling, special education). For specific information about attaining the alternate route DTR, write to ADTA Credentials Committee.

Courses in the following colleges and universities may meet requirements toward registry:


California State University, Hayward. Department of Kinesiology and Physical Education. Hayward, CA. 94542. 3062. Special Graduate Major in Dance/Movement Therapy. Telephone: (651) 881-3108. Cynthia F. Barroli, Ph.D., A.D.T.R.


Maryland College. P.O. Box 201, Maryland, OR. 97036. Telephone: (503) 638-8111, Ext. 351 or 403. Dance Therapy Certification Program. Dance Therapy Department. Christine Turner, M.S., A.T.R.


Southampton College. Long Island University, Southampton Campus, Southampton, NY. 11968. Telephone: (516) 283-4000 or (516) 653-6750. Dance/Movement Therapy Intensive, Two Week Institute, Fine Arts Department. Linn Deilh, M.F.C., A.D.T.R.


Undergraduate Dance/Movement Therapy coursework

These courses help students evaluate their interest in dance/movement therapy and may serve as prerequisites for graduate study.

Barat College. 700 Westleigh Road, Lake Forest, IL. 60045. Telephone: (706) 461-9926. Dance Department with major emphasis in Dance Therapy. Gena DeMoss, A.D.T.R.


Goucher College. Driane Valley Road, Baltimore, MD. 21204. Telephone: (410) 337-6387. Dance Department. Crystalline Trump Bond, M.S.A.

Hope College. Dover Center, Holland, MI. 49423. Telephone: (616) 994-7701. Dance Department. Maxine DeBruyn, Chair of Dance


Metropolitan State University. 121 Seventh Place E., Suite 121, Metro Square, St. Paul, MN. 55101-2197. Psychology Department. Telephone: (612) 332-0278. MaryLee Hardenbergh, A.D.T.R., C.M.A.

The American Dance Therapy Association

Since its founding in 1966, ADTA has worked to establish and maintain high standards of professional education and competence in the field.

ADTA stimulates communication among dance/movement therapists and members of allied professions through publication of the ADTA Newsletter, the American Journal of Dance Therapy, monographs, bibliographies, and conference proceedings.

ADTA holds an annual conference and supports formation of regional groups, conferences, seminars, workshops and meetings throughout the year.

For further information, contact the American Dance Therapy Association, 2000 Century Plaza, Suite 108, Columbia, Maryland 21044.
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