Movement Based Experiential Learning and Competency Development in Dance/Movement Therapy Graduate Education: Early Practitioner Perspectives

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Abstract

Experiential classes that use dance/movement as the primary means of learning are universal in dance/movement therapy (DMT) graduate education programs in the United States. Yet, there have been no studies to determine what competencies develop in movement based experiential classes in DMT education. This is a report of a qualitative study that used thematic analysis to identify competencies that DMT students develop from movement based experiential learning (MBEL). Competencies identified in this study were compared to the education standards set by the American Dance Therapy Association (ADTA). As expected, MBEL was most instrumental in developing competencies for clinical practice and professional development. MBEL was less effective in developing competencies for multiculturalism and theoretical knowledge. The study identified a set of new competencies related to emotional intelligence that is not in the ADTA’s standards and is unique to student experiences in MBEL. This study focused on the student perspective, which can help address some of the weaknesses of current education practices. The article ends with the benefits and limitations of a competence based education for DMT.

Keywords Dance/movement therapy education · Experiential learning · Movement based experiential learning · Competencies · Qualitative study · Thematic analysis

Introduction

The employment of dance/movement as a method of learning in dance/movement therapy (DMT) education is essential to ensure that DMT students develop the competencies to practice a form of therapy whose medium for therapeutic change is dance/movement. A foundational principle of DMT is that the mind and body
are interconnected (Acolin, 2016; Berrol, 1992) and that the therapeutic alliance borne from kinesthetic empathy (Berrol, 2006; Fischman, 2016; Young, 2017) is at the core of DMT. Dance/movement therapists create a safe, holding environment in which clients feel safe to lower their defenses, enter a state of receptivity and absorption (Goodman & Holroyd, 1993), express unconscious thoughts, feelings, and emotions through free association in movement (Lucchi, 2018; Musicant, 1994, 2001), and make meaning of the dance that unfolds. Defined as “the psychotherapeutic use of movement to promote emotional, social, cognitive and physical integration of the individual, for the purpose of improving health and well-being” (American Dance Therapy Association, 2014), the moving, dancing body is paramount in dance/movement therapy. For these reasons, dance/movement therapists need a living knowledge of how dance/movement is an agent for therapeutic transformations. This paper is a report on a qualitative study that used thematic analysis (Braun & Clarke, 2006) to identify competencies that develop when DMT students use dance/movement in experiential learning.

Experiential learning that uses dance/movement is universal in DMT graduate education in the United States, because the American Dance Therapy Association (ADTA) requires experiential classes as part of the standards for granting approval status to graduate education programs (ADTA, 2017). Sometimes referred to as personal development or self-awareness groups (Payne, 2001, 2004, 2010), embodied experiences (Schmais, 2004), DMT training groups or experiential groups (Panhofer et al., 2014), these variations in name suggest the multiple intentions and perspectives in which dance/movement in experiential learning is used in the classrooms. Due to a lack of consensus in the literature regarding terminology for this critical component of DMT education, the present study adopted the term Movement Based Experiential Learning (MBEL).

The main purposes of MBEL in DMT education is to develop DMT knowledge and skills (Schmais, 2004), increase self-awareness (Beardall et al., 2016; Behar-Horenstein & Ganet-Sigel, 1999; Panhofer et al., 2014; Schmais, 2004), and translate theory into clinical practice (Panhofer et al., 2014; Payne, 2004; Schmais, 2004). MBEL typically takes place in a studio-like setting as a closed group with a small number of students. According to Schmais (2004), open-ended directives help students use movement to explore various aspects of the psychotherapy process in DMT, such as creating a safe, holding environment, establishing a therapeutic rapport, maintaining physical and emotional boundaries, and non-verbally communicating empathy. The students develop a capacity to attend to and make sense of sensations in the body (Lucchi, 2018). They also can learn to attune to and respond to the non-verbal expression of thoughts, feelings, and needs of both self and others (Panhofer et al., 2014; Schmais, 2004). Additionally, students gain insights into the therapist-client relationship by being an as-if client or an as-if therapist (Payne, 2004; Schmais, 2004). The movement explorations and experiences in MBEL address both personal and professional development, but the primary objective is the development of knowledge, skills, attitudes, and values—the competencies that prepare DMT students for clinical practice.

Research studies on experiential learning in DMT education are scarce, and there have been no studies on specific competencies that develop when dance/movement
is the primary means of learning in DMT education. Payne (2001, 2004, 2010) conducted a descriptive phenomenological single cohort study with seven female students who participated in DMT-based personal development groups at a graduate level DMT education program in the United Kingdom. Payne (2004) found that when students took on the role of a client, it raised their awareness for what clients experience in DMT, and the students developed a capacity for empathy. Taking on the role of the practitioner made the students realize the differences in leadership requirements when in movement experiential classes versus when in DMT field placements. As such, the students learned to devise models of DMT that better suited their clients in field placements. In the 6-month follow-up interviews, Payne (2010) learned that self-reflection was key to the students’ transferring their experiences and awareness from the personal development groups to clinical practice. Another phenomenological study, a pilot study on the experiences of DMT students in a hybrid low residency program in the United States found that students valued opportunities for embodied learning when classes took place online (Blanc, 2018). Both of these studies offer valuable insights into how MBEL contributes to student learning in very different educational settings. Competencies, however, were not the focus of either study.

At this time, the use of MBEL in DMT graduate education is based in DMT tradition, not research. Marian Chace, considered the founder of DMT as a clinical practice in the United States, instituted MBEL as an instructional method with her students when DMT was still in its infancy (Sandel, Chaiklin, & Lohn, 1993; Schmais, 2004). When Claire Schmais and Elissa White, who were trained by Chace, subsequently developed the first DMT graduate program in the United States in 1971, they integrated MBEL into their curriculum because they recognized the value of this approach (Schmais, 2004). MBEL continues to be central to DMT education today, but without research to substantiate its use.

The main purpose of the present study was to identify the competencies that develop in experiential classes that use dance/movement as the primary means of learning in DMT graduate education programs within the United States. Rather than identifying competencies based on consensus of expert opinions from educators and leaders of the profession (Fouad et al., 2009; Gonsalvez & Crowe, 2014; Rodolfa et al., 2005; von Bonin & Müller, 2007), this study sought to give voice to the students.

ADTA’s Education Standards Revision Task Force included representatives from the various committees of the ADTA and the seven ADTA approved DMT graduate education programs. The Task Force also sought input from the ADTA membership (ADTA, 2014, Fall; 2016, Summer; 2016, Fall; 2017, Spring); however, student perspectives were not central in the process. Given that DMT students are the consumers of the education, their viewpoint is valuable in first, understanding the extent to which MBEL develops competencies, and second, in affirming or challenging current assumptions about competency development in DMT education.

The research question for this qualitative study was: What are the competencies that develop through MBEL in DMT graduate education? The three specific aims were: (1) to identify the knowledge, skills, attitudes, and values that are developed in MBEL; (2) to compare the competencies that are developed by the students in
MBEL to those delineated in ADTA’s standards; and (3) to identify facilitating and hindering factors in the development of competencies in courses that use MBEL in DMT graduate education programs. This paper will report on the first two of the specific aims. The third specific aim will be addressed in a separate paper.

It was expected that the competencies that develop in MBEL would be a subset of competencies listed in the ADTA’s standards, since DMT education incorporates didactic and experiential learning methods. Furthermore, it was possible that there would be competencies that are developed exclusively in MBEL which may not be named in the ADTA standards. Comparing competencies identified from the present study with those listed in the ADTA standards was expected to clarify which standards are being met, and if the ADTA standards reflect all the competencies that develop in MBEL. The current ADTA standards have a short list of 10 competencies (ADTA, 2013), but the new ADTA standards, which go into effect on January 1, 2023, have a thorough and detailed list of 145 competencies (ADTA, 2017). The findings from this study were compared to the new ADTA standards.

Knowledge gained from this study can be used to revise and strengthen the use of MBEL in DMT education and help establish evidence based standards and practices. Doing so will make it possible for DMT educators to: (a) be explicit about the purposes of MBEL; (b) design movement experiential exercises that will target specific competencies; (c) orient students on how to engage in movement-based experiential exercises to maximize learning while minimizing any risks of harm; and (d) set clear boundaries to differentiate experiential learning from therapy (Murphy, 2013). Outcomes from this study are expected to help establish evidence based standards and practices in DMT education.

Background

Experiential Learning

At the foundation of experiential learning in the classrooms are meaningful experiences which stimulate learners to take on an active role in creating knowledge that is holistic, interactional, and evolving. Active engagement in experiential learning inspires reflection, new ideas and perspectives, and self-other transactions (Maudsley & Strivens, 2000). Experiential learning engages the whole person, including the thoughts, feelings, emotions, sensations, and cognitions of individuals—in interaction with the internal and external environments (Beard & Wilson, 2006). Learners must make sense between the inner experience of the self and the outer world with the premise that knowledge is socially and culturally constructed from transformative experiences. New knowledge that is gained through experience tends to have long lasting impact, because it is internalized and embodied via multiple senses, neural pathways, and various forms of intelligence such as linguistic, logical, visual, musical, kinesthetic, interpersonal, intrapersonal, emotional, and spiritual intelligence (Beard & Wilson, 2006).

Experiential learning is used in training music therapists (Murphy, 2007), art therapists (Deaver, 2012), drama therapists (Butler, 2017a, 2017b), counselors
Competencies in Related Fields

Marriage and Family Therapy

Marriage and family therapy (MFT) underwent an educational paradigm shift over 2 years starting in 2003 when they moved from input oriented education to outcome based education (Chenail, 2009; Nelson et al., 2007). That is, the traditional method of focusing on the courses offered and hours of training completed (the input) did not ensure that students developed the desired competencies for MFT clinical practice. In contrast, an outcome based model requires that students demonstrate the competencies needed to provide safe and effective care (the output). This paradigm shift required that MFT faculty make learning outcomes transparent and use collaborative methods that allow students and faculty to jointly determine student progress in competency development (Chenail, 2009).

MFT now has 126 competencies under six primary domains, each with five sub-domains. The first four primary domains follow a client’s entry into treatment: (1) admission to treatment; (2) clinical assessment and diagnosis; (3) treatment planning and case management; and (4) therapeutic interventions. The last two are: (5) legal issues, ethics, and standards; and (6) research and program evaluation (Nelson et al., 2007). Organizing competencies in this manner has the advantage of elucidating the competencies that MFT practitioners need in guiding their clients through treatment.

Psychology

Professional psychologists also recognized that competency is not attained simply by completing requirements of a training program, hours in the field, or a national exam. Competency is multidimensional and requires taking action and using skills, knowledge, values, attitudes, reason, emotions, reflections, ethics, and morals for the benefit of the clients they serve (Fouad et al., 2009). Furthermore, competencies are not fixed, and practitioners need to gain higher levels of competence throughout their career (Rodolfa et al., 2005, 2013). A competency model that reflects these attributes is the three-dimensional Cube Model that was created by expert consensus (Fouad et al., 2009; Gonsalvez & Crowe, 2014; Rodolfa et al., 2005, 2013).

The three dimensions of the Cube Model are: foundational competencies, functional competencies, and stages of professional development. Foundational competencies include an understanding of ethics, diverse cultures, relationships, professionalism, interdisciplinary systems, self-assessment, and research methodologies that form the foundation upon which practitioners build their functional competencies. Functional competencies are those needed to perform the services of a
professional psychologist in areas such as assessment, consultation, intervention, supervision, management, and research. The third dimension, the stages of professional development spans from doctoral education through internship, fellowship, and continuing education. A strength of the Cube Model is its comprehensiveness and how it organizes the multiple components of competencies into a coherent model across the practitioner’s development.

**New Dance/Movement Therapy Competencies**

The ADTA’s new *Standards for Education and Clinical Training* (ADTA, 2017) go into effect on January 1, 2023. It consists of two sections: the first section is the input based standards that ADTA approved education programs must meet in order to maintain approval status. Approved programs must allocate financial, administrative, and human resources to run a program that will equip students with the necessary competencies for DMT clinical practice. The second section lists the competencies that students in the ADTA approved programs must develop. The competencies are divided into four content areas: (1) History, (2) Theory, (3) Practice, and (4) Professional Development. In total, there are 27 categories and 145 operationally defined competencies, which are intended to enable objective assessment of student outcomes.

It was expected that of the four content areas, MBEL will develop competencies most associated with the third content area, Practice, which has four categories: Treatment Planning and Evaluation, Therapeutic Movement Relationship, DMT Practice Skills, and Group DMT Skills. Another content area that was expected to be relevant to competency development in MBEL was the fourth content area, Professional Development. Professional Development includes six categories: Knowledge and Skills of Research, Professional Identity, Development of Best Practices, Self-Awareness, Supervision, and Advocacy for DMT.

**Methods**

**Philosophical Position**

The philosophical orientation for this study was constructivist (Guba & Lincoln, 1994; Lincoln & Guba, 2013). Ontologically, reality is not fixed but changes with context, circumstances, and social interactions. Multiple realities can exist based on individual interpretations and perspectives. Epistemologically, knowledge is an intersubjective co-construction that is subject to continuous revisions and includes those created outside of the privilege and power of the dominant culture. Methodologically, constructivism aligns with hermeneutic methods that support meaning making and promote the co-construction of reality and knowledge. Axiologically, individual histories, beliefs, values, and perceptions that researchers and participants bring to research are acknowledged and valued.
Reflexive Memoing

Reflexive memoing was used to create an audit trail of the decision making processes and the subjective influences in knowledge construction (Birks et al., 2008). Following Ahern’s (1999) guidelines for reflexivity, some areas for reflection were: the researcher’s personal interests in undertaking the study, the assumptions she has about research and its power hierarchies, value systems related to her identities and culture that influence her interactions with study participants, the positive and negative emotions that affect neutrality during data collection and analysis, influence of gatekeepers on the study, as well as biases when quoting study participants in the writing of the final report for publication.

As a cisgender, heterosexual woman of Japanese heritage, this researcher is a DMT practitioner and supervisor with over two decades of clinical experience. She is also a DMT educator and a dancer, who values knowledge gained through the moving body. Her own experiences in MBEL as a student in DMT graduate education were positive and transformative. As such, she believes that MBEL is a critical component of DMT graduate education that can enhance or diminish the DMT practitioner’s self-efficacy. She enjoyed a rich career as a DMT practitioner and is motivated to give back to DMT through research. She views research as contributing to the advancement of DMT as a profession. Reflexive memoing helped keep biases in check, ensured that each participant’s perspective was included in the analysis, and helped overcome moments of analytic paralysis (Birks et al., 2008; Bridges-Rhoads, 2015). Each memo was dated and entered on the computer as a Word document.

Study Participants

Purposeful sampling was used to recruit DMT practitioners who met the following inclusion criteria: (1) completed an ADTA approved DMT graduate program within 5 years of the study; (2) participated in experiential learning that used dance/movement as the primary means of learning; (3) holds the R-DMT credential with the ADTA; (4) receives compensation for conducting DMT sessions; and (5) has access to an internet connected computer with a video camera in a private space free of excessive noise and distractions. DMT practitioners could not participate if either exclusion criteria applied: (1) completed the alternate route to DMT training (since the ADTA standards are for approved programs); or (2) knew the researcher in her capacity as a supervisor or educator prior to the study.

A recruitment flier was posted on ADTA’s online bulletin board and was emailed to ADTA chapter presidents as well as to ADTA’s regional representatives, who notified ADTA members. The flier was also emailed to directors of the seven ADTA approved DMT education programs, who distributed the flier to their alumni. In order to recruit graduates from all seven ADTA approved programs, the recruitment flyer was reposted on the ADTA online bulletin board and the directors of the DMT programs that were not represented yet in the sample were contacted via phone and email. The directors helped identify alumni who met criteria.
A total of 15 dance/movement therapists participated in the study. Each DMT program was represented by at least two participants. The mean age of the participants was 31.1 years (range 25–56 years). Eleven participants identified as White, two as Asian, one as Black/African American, and one identified with three racial groups. Thirteen participants identified as female; one identified as gender fluid, and one identified as non-binary. Ten were employed full-time, and five were working part-time. At the time that the interviews took place, years of paid DMT work ranged from 6 to 49 months (mean = 28 months).

Consent

This study was approved by a university’s Institutional Review Board. Once DMT practitioners met eligibility for the study, they were verbally informed of their rights as research participants. Participants were free to withdraw from the study at any time and decline questions they did not wish to answer. Each participant signed an informed consent form prior to scheduling the interviews. They were reminded of their rights once again, before the start of their interviews.

Data Collection

Each participant completed a pre-interview questionnaire on Research Data Capture (REDCap), a secure web-based system for conducting surveys that met the requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA). The questionnaire asked for the participant’s age, race, gender, DMT program attended, DMT employment history, and dance background.

Semi-structured interviews were conducted using Zoom, a secure and HIPAA compliant video conferencing software, and the interviews were recorded. The interview questions were provided prior to the interview. The interview questions focused on participants’ positive and negative experiences in MBEL while they were students in a DMT graduate education program and the competencies that they developed. (See Appendix.) The interviews revolved around the core questions but were adjusted to each participant’s focus and emphasis. Each interview lasted approximately one hour.

A HIPAA compliant transcription service transcribed the interviews. Upon receipt of the transcriptions, this researcher did a line by line comparison of the transcript against the audio recording to check for accuracy. Any identifying data within the transcript was removed. Member checking was used as a strategy to add rigor to the study. The transcript was sent to each participant to review and approve. Four out of the 15 participants revised their transcript while the remaining 11 approved the transcripts without any modifications. Study participants were given a $25 gift card after approving their transcripts.
Data Analysis

Analysis of the 15 interview transcripts followed the six phases of thematic analysis (Braun & Clarke, 2006). The first phase, becoming familiar with the data included reflexive memoing after each interview, reading the interview transcripts in its entirety, checking each transcript for accuracy, revising transcripts as requested by study participants, and reading it once again in an active manner. Active reading of the data entailed paying close attention to the words, making notes on statements that stood out, highlighting sections that were relevant to the research question, and writing annotations on the margins to understand the participants as fully as possible.

The second phase, generating initial codes, was done manually on hard copies of the transcripts, using color highlighters and handwritten codes on the margins. Once initial coding was done manually, another round of coding was done on NVivo 12 Plus, a qualitative data analysis software, to clarify and organize the codes. As a strategy to add rigor to the study, triangulation was used during this phase. A peer reviewed three of the transcripts on NVivo to corroborate and amend codes (Nowell et al., 2017; Spall, 1998). After the triangulation, another round of coding ensued.

For the third phase, searching for themes, all 71 codes and 106 subcodes in NVivo were printed out and cut up into individual strips. Each code strip was pinned onto a large trifold poster board to determine relationships between codes. The iterative process of organizing codes, grouping codes, and identifying themes ended with a visual network of all the codes and themes on the poster board. The fourth phase, reviewing themes, required further sifting and reorganizing of the themes. Themes were selected based on relative importance rather than on consensus among the participants. For example, if a narrative offered new insights into how MBEL was experienced, or if there was emotional intensity with an aspect of a narrative, it was recognized as noteworthy, even if it was not the majority’s experience. The fifth phase of defining and naming themes was done through the construction of a thematic map and identification of key words from participant quotes. The following section is the sixth phase, reporting the results.

Results

Coding in NVivo resulted in 71 codes and 106 subcodes. After an iterative process of organizing categorizing, and reducing, this researcher identified 16 competency categories and four competency domains (Fig. 1). The competency domains were: 1) Clinical Practice, 2) Self of the Therapist, 3) Theoretical Knowledge, and 4) Professional Orientation. These labels derived from the synthesis of descriptions offered by study participants and language commonly used in DMT and in allied professions. Based on the Cube Model discussed earlier (Fouad et al., 2009; Gonsalvez & Crowe, 2014; Rodolfa et al., 2005), the four domains were categorized as either Foundational Competencies or Functional Competencies.
Domain I: Clinical Practice

Participants recognized that one of the main purposes of MBEL was to develop competencies for clinical practice:

I understood it as learning about the field, understanding what we would be doing...with clients and getting to practice those techniques. Also helping us as students ground and get more familiar with it and I think it also came up as being almost unethical to practice techniques with clients if you’re not familiar with it yourself. So this is a way to get familiar with things. (ID05)

Clinical Practice competencies, one of the two Functional Competencies, are knowledge, skills, attitudes, and values that dance/movement therapists need to function as a clinician and run DMT sessions. There are five categories in Clinical Practice: Therapeutic Relationship, Therapist Presence, Leadership, Interventions, and Creative Process. Each of these competencies contribute to the DMT practitioners’ effectiveness in using dance/movement to promote wellness and therapeutic transformations in DMT. See Fig. 2 for a thematic map for this domain and the specific competencies under each category.
Therapeutic Relationship

Many participants spoke about playing the role of the therapist or the client in simulated DMT sessions. As an as-if therapist, participants practiced meeting the clients at their functional ability, mirroring, attuning, and developing kinesthetic empathy. The purpose was to learn how to establish a therapeutic relationship based on trust. Being an as-if client helped participants be empathetic with patients who present as challenging or resistant:

Knowing what it is to be a participant in the dance therapy-like session is so important because... I was able to work through different moments of feeling resistant to movement or having days when...movement was everything and that really was a healing process for me...I think having gone through the movement experiential, I was able to know, to see how often times when I do offer movement as an option for my patients...I see that some of them are like, “I don’t know about this.” I understand what that feeling is about because I similarly had moments where it just wasn’t a moving day and I would much rather observe. (ID08)

By recognizing that patients have similar needs as themselves, participants learned to relinquish judgment and accept patients as they are.
Another clinical practice competency was being present with the clients—what it means to be present, and how to be present in the therapy process (Fischer & Chaiklin, 1993; Panhofer et al., 2014). In MBEL, participants discovered the importance of paying attention to inner sensations and thoughts while simultaneously attending to the influences of the external environment on the self. The difficulties of balancing inner and outer awareness manifested for one participant in the form of recurrent self-questioning: “How do I maintain my own integrity while still relating to others, like via movement (ID13)?” Another admitted to feeling challenged when there was a “mismatch,” or a conflict between what the participant needed emotionally, physically, or mentally and what the other person needed:

Sometimes working with some of my classmates, their movement was a lot different than mine, or their energy was different from mine. So sometimes when we mirrored, it was a lot—like if I was particularly exhausted that day and they want to jump up and down. It’s like, I don’t want to do that right now. (ID10)

These dialectical conflicts contributed to participants furthering their ability to remain present despite the heightened tensions and confusions. Participants learned to use the breath to slow down and to use self-reflections as ways of taking care of the self while remaining present. One participant claimed that MBEL helped develop the actual skill of self-regulation and being able to sit in those moments…a lot of the interventions in the moment was just for all of us to sit in it and feel it. So being comfortable with that with my peers is now like being okay containing with clients. And then witnessing the professor and then eventually practicing myself on how to guide somebody else, like de-escalation. (ID02)

Part of their learning was also to recognize that some sensations and emotions originate from others. Understanding intersubjectivity, somatic transference and countertransference was essential for the participants’ ability to remain present:

There was a time when I was crying in class and wasn’t sure why…I was having a hard time regulating. Then a peer shared that they were having a hard time and once they owned the emotions, my regulation kicked in. (ID02).

Another participant recalled how her experiences in MBEL gave insights into how feelings such as shame, which can inhibit a dance/movement therapist’s ability to remain present, can be recognized and managed:

I also understand because of the work we did with somatic countertransference that like if I’m…walking out of a session and feeling shame about
myself as a clinician, there’s probably a good chance that was induced in me and my client might be feeling shame. (ID04)

Leadership

Dance/movement therapists lead clients through a therapy process that is improvisational and sometimes unpredictable. Subsequently, a key clinical practice competency is developing relevant knowledge, skills, attitudes, and values around leadership. Participants often described movement experiential exercises in which they and their peers took turns leading simulated DMT sessions. For participants who were timid, they had to overcome their fear of leading a group. Others felt that the support of their peers in MBEL were opportunities to learn about themselves, take risks, experiment, and develop their own leadership style:

It was the group dynamics class. I learned a lot about myself as both a therapist and as a member of a group, because I learned like, kind of how I am. Then that therefore taught me sort of how I interact with other people, like outside of a group. So it served multiple purposes...being able to get up in front of a group of people and especially my peers and lead them...and trying new things...I think that type of environment gives you space to make mistakes, and gives you space to grow and do things that you wouldn’t maybe normally do in your setting as a student or whatever...So much happened in those classes. And we explored a lot of themes...successes and failures of doing that were for sure a big learning process. (ID09)

Participants also worked on developing competencies for building a therapeutic holding environment, a critical component in therapy and in their own learning. In MBEL, a key aspect of the holding environment was the formation of a supportive community of learners. They learned how “moving together and learning together, [helped] create a bond very quickly” (ID10), a process that was paralleled when developing a holding environment in DMT. Other aspects of leadership responsibilities that participants learned were working with resistance, making decisions about session structure (warm-up, theme development, and closure), and developing an “observing lens” to facilitate the unfolding DMT process.

Participants noted, however, that the practice of leadership skills in MBEL was mostly for group DMT. As a result, they felt that they did not learn enough on leading and structuring individual sessions. Nonetheless, some participants were able to adapt the knowledge about group leadership to other contexts, including family therapy sessions and to individual sessions:

For the most part, the principles that we learned group-wise, mirroring and then kind of offering alternatives, [I would bring] into the individuals. Even in terms of like when we talk about [being] in a circle, it’s actually that person across from me that you are looking at...so if you don’t want to be in somebody’s line of sight, you kind of get right next to them which is like counterintuitive. So even in terms of how I position myself one on one, I
very rarely stood right across from them. I either joined them side by side, or it was diagonal. And then for taking the temperature of the room of the group was also very easily translatable to an individual session, kind of getting the vibe or the temperature of that client and then, are they someone that needs a bit more structure to begin with? (ID11)

This participant also used her experiences of being vulnerable for the 2 years she was a student in MBEL to help her clients confront their fears of being vulnerable in individual sessions:

I always made sure in the individual, to be the one that looked sillier; the one that we could laugh at—me, until we got to the point where we didn’t need to laugh at anyone you know, either of us. And then it’s also—with adolescents particularly, I think it’s that confidence, like that confidence in dance therapy—like I’m doing this with you because I believe in it and we may do some silly things, but there is a benefit to it. And I believe that it is more beneficial for you right now than solely talk therapy. (ID11)

Interventions

The competencies for interventions include DMT skills, Movement Observation and Assessment, and Use of Language. Dance/movement therapists must have a large repertoire of techniques and approaches from which to choose, because they must select interventions that will have the desired effect in the unfolding therapy process.

In MBEL, study participants developed DMT skills related to Authentic Movement (Whitehouse, 1999), the Chacian method (Sandel et al., 1993), Body-Mind Centering (Bainbridge Cohen, 1993), and Disarming the Playground Violence Prevention Program (Kornblum, 2002). In addition, they explored the use of imagery, silence, touch, props, music, sculpting, sub-groupings, elements of Laban Movement Analysis (Dell, 1977), and spectrograms, a psychodrama technique (Blatner, 1988).

For movement observation and assessment skills, participants learned and embodied Laban Movement Analysis (Dell, 1977) and the Kestenberg Movement Profile (Kestenberg Amighi et al., 2018). Movement observation and assessment skills are included in this intervention category, because DMT practitioners rely on movement observation and assessment to select appropriate interventions. Furthermore, as one participant noted, working bottom up, from pure bodily movement experiences to cognitive insights is an intervention.

Language is a competency under interventions as well, because the use of verbalizations can facilitate or interfere with the clients’ dance. One participant appreciated having a language to speak about movements in a neutral, non-judgmental way:

I got an organization and a form to the language so I can describe movement excellently, because I found an organization that is used by others as well. That’s a competency I gained…So those kinds of like DMT skills in terms
of how to work with movement, how to name movement in a nonjudgmental way in a very just like—here is what I see, my hand is moving forward… like, not making meaning out of it, just really describing the movement. (ID12).

Creative Process

In MBEL, participants learned to be flexible, spontaneous, playful, and tolerant of the unknown. That is, they developed competencies to facilitate the creative process.

As students in MBEL, the study participants discovered that controlling the emergent process of movement interactions and experiences was impossible, and that they had to let go: “I think that was the hardest part for me, was learning how to not stick to exactly what I wanted the experiential to be” (ID07). They had to understand that the creative process is autotelic and that they have to learn to go with the unfolding process:

Learning how to hold the space and working with what presents in the room, that was huge for me, because I’m usually a big planner and I have to have it ABC; and the movement experientials really helped me in just being a little more spontaneous and working with what is. (ID01)

Domain II: Self of the Therapist

MBEL helped the participants gain self-knowledge, recognize their affective responses in movement based experiences, and clarify attitudes and values that are important to them as developing dance/movement therapists. Participants learned that therapists are individuals with experiences, beliefs, and biases that influence the process of therapy, and that removing the self of the therapist from the human interaction in therapy is neither possible nor desirable (Regas et al., 2017). As such, bringing the self of the therapist with awareness and intention is one of the Functional Competencies. See Fig. 3 for a thematic map of competencies under the domain Self of the Therapist.

Self-Knowledge

MBEL provided opportunities for participants to explore how life experiences, movement affinities, and their dancer/mover identities affect who they are and how they interact with others in movement. Some discovered their attachment patterns from childhood. Others acknowledged that as much as they knew how to use their bodies as dancers, they never connected with their bodies or got in touch with themselves in the manner that they did in MBEL:

For me, it really goes back to connection. Like, connection to self is just really the foundation for me of being a helping professional and being out
in the real world as a new clinician. Sometimes it’s really hard to stay connected to myself...And I know for a fact that if I did not - well, I don’t know for a fact, but I know in my body - my body tells me - is that if I didn’t have this foundational experience, these 3 years of bring it back to the body, bring it back to the body, bring it back to the body, experience, experience, experience, then I may not have as much of a - what’s the word, understanding, or knowing of the importance of being connected to my self as a clinician. (ID04)

Participants had to learn to use dance/movement in ways that differed from their dance training or somatic practices. Their understanding and definition of dance also had to change. As they integrated new self knowledge and began to formulate their new identity as dance/movement therapists, previously unknown biases or body prejudice (Moore & Yamamoto, 2012) surfaced:

I think I learned a lot about just like my preferences and kind of judgments that I would make unconsciously based on movements. You know, just like kind of, valuing movements that were like mine without any real basis behind them other than that. So I think that was really valuable. Before going into counseling—just to really help notice that I did have, you know, biases and I think,
I don’t know if I would have recognized them if I hadn’t had done the movement experiential training. (ID03)

Making new discoveries about the self and being in a state of suspension while adjusting their worldviews in MBEL were exhausting for many. Some found relief by connecting to their dance roots, and recuperated by returning to dance classes:

And I think for me it was consistent. [Taking ballet class] was calming because it’s stuff like, “Okay, I know this.” So even though I’m struggling in grad school and I don’t know, but when I walk into that ballet room I know it--like master it. So even though I’m not mastering and understanding it in grad school, I can find one thing that has made me feel really good every single day. (ID14)

As new clinicians, participants recognized the importance of dance to their own well-being and continued to engage in dance or other artistic expression as a means for self-care.

Affective Responses

Invariably, exploring the self and moving with others in MBEL meant that emotions were omnipresent and participants frequently felt vulnerable and uncomfortable. Participants reported many instances of feeling joy, connected, supported, and invigorated, but participants also reported feeling angry, anxious, confused, fearful, frustrated, overwhelmed, stressed, and worried at different times during MBEL. Circumstances that elicited negative affective states varied from feeling exposed, peer competition, judgments, lack of trust, feeling unsafe, self-doubt, tension, and need for privacy. Having an awareness of these affective responses and learning how to manage them were necessary, lest they shut down, which some participants admitted to doing.

Getting through the chaos of emotions while being a student engaged in MBEL was often difficult, because making sense of their experiences was elusive. With the benefit of hindsight, however, participants recognized the significance of these emotionally laden, tumultuous experiences to their eventual clinical work:

Often I felt on the spot, intimidated and exposed…And then also I felt confident, connected, comfortable and vulnerable. Again, that’s much like a group process when you’re working with people and they’re just learning that. But, kind of - need one to get the other kind of thing. I probably needed to feel exposed and vulnerable in order to feel confident and connected, and comfortable. (ID01)

Attitudes

The attitudes that participants identified most frequently were being open, non-judgmental, and curious. Openness was not limited to the mind, but referred to the body as well, so that they can be receptive to the unfolding process of DMT in dance/
movement. Curiosity was about willingness to explore and learn, and being non-judgmental allowed for openness and curiosity. One participant explained openness this way:

I think openness, but not like—I feel like openness not as like in the mind. I’m open to what you are going to say, but in the body—just that I feel that openness in the body. It feels like not only I’m open, but also like I am calm and I have brought my authentic self into the moment and there wasn’t any tension in my body and I wasn’t occupied about what I was thinking in my mind. And being open in that sense and allowing what happens to be reflected in my body. Yeah, so presence I guess, presence and calmness. (ID15)

Values

The participants placed high value on the body, their connections to their bodies, the depth and authenticity of the body in movement, and the bottom up approach in DMT. They also valued staying connected to their bodies through on-going movement practice. In addition, participants expressed strong values around multiculturalism—inclusivity, tolerance for differences, and equality: “Being in movement groups where people are moving differently and experiencing the same moment or the same prompt so differently, it really just increased my capacity to love difference as opposed to being afraid of it” (ID13).

Domain III: Theoretical Knowledge

Theoretical Knowledge is one of the Foundational Competencies and as students in MBEL, participants explored various theories related to DMT, Body-Mind Integration, Multiculturalism, and General Clinical from related fields of counseling, psychology, and somatic practices. While the participants’ narratives were richer around the Functional Competencies (the first two domains), participants found opportunities to embody theories helpful in their learning:

It kind of was like an embodiment of like mind and body learning. I feel like before, if I’d learned about—like learning about human development. You know, it was just like reading the book, writing reflections on that, discussing it…I remember being like really excited that you know, you can see so much in the movement as someone develops. And that had never really been emphasized for me before. (ID03)

DMT Theories

The DMT theories embodied in MBEL were those developed by the founders of DMT. Participants also explored metaphors, symbolism, meaning making, rituals,
and creativity. The centrality of movement experiences in MBEL meant, however, that some participants felt that they did not gain sufficient theoretical knowledge:

There were things that I felt that I wasn’t learning enough which is about the theories behind [the Chacian methods]. So when people asked me about the theories of dance/movement therapy, I wasn’t able to do that. Like I’m still having some troubles about just telling them what the theory is. I think I still have to develop it for myself. (ID15)

**Body-Mind Integration**

Participants recognized the importance of the body-mind connection to be effective clinicians, and that the body and the mind cannot be treated as separate. One participant found learning exclusively through MBEL was insufficient and that being grounded in theory through cognition was needed. The key was to bridge theory with experience, the mind with the body:

I knew that we would be moving. I knew that. And I knew that [DMT] was supposed to help people, but I didn’t really know how it happened -- like the process. I knew it was based in psychology, but I didn’t really connect the two. I think I was trying to separate the body and the mind instead of integrating it, so I figured it was like, more like exercise to de-stress type of a thing. It was the only way I could really compartmentalize how it worked, until I was rooted in theory. (ID10)

**Multiculturalism**

Many participants appreciated that their programs included opportunities to examine cultural diversity in DMT, and multiculturalism was in fact one of the values identified by the participants. Regardless, experiences in MBEL for developing competencies in multiculturalism were not always effective. Many participants reported that this aspect of their education was weak: “So even though it was addressed, I don’t feel as though—I mean, my mind was opened to understanding, but I can’t say that I got too much out of it, unfortunately” (ID07). For some, however, addressing culture in MBEL was significant, because it was their first time learning about power and privilege: “I don’t think I had ever heard of the term white privilege before that class and I had never had a way to talk about it before” (ID11). Another participant recalled how it was an opportunity to look at gender identity and how it was “one of the first points of my life that I came to become comfortable in identifying as a person of color—cause my father, he is white” (ID06). Yet others felt that they couldn’t delve into it:

Everybody was feeling that there wasn’t space for diversity in some way, shape, or form. For me personally, it was more like there wasn’t space for my type of personality … it never really felt okay…That was really about
what I was experiencing, about how much space can I take up…I think overall, it just wasn’t very conducive to different experiences. (ID13)

When there was a lack of diversity among the students, developing competencies for multiculturalism was also challenging:

We were trying so hard to stay aware of what it’s like to be with people who are different than you and all of the complexity that comes with holding space when you yourself have cultural identifiers that are associated with privilege and power. So yeah, it was definitely a journey for us to work through what that would be like in our movement experientials, especially because we were not a very diverse group. So we were always working in this like imagined space of diversity that wasn’t our reality. It is kind of bizarre. (ID08)

Other participants noticed that there was a tendency to focus on a limited number of cultures at the exclusion of others:

A lot of race and ethnicity, a lot of the discussions turn to the experience of African-Americans. And my client population is mostly Hispanic…We did very little LGBTQ stuff…Our cohort was 40% African-American, 60% Caucasian. So, most of the conversations were from our experiences. So it makes sense why, but it didn’t diversify my understanding beyond that so much. (ID11)

Another participant thought that the ADTA needs to look at the limitations of using a framework for movement observation, description, and assessment, such as Laban Movement Analysis (Dell, 1977), that is lacking a multicultural perspective:

It doesn’t really take into account people of the African diaspora. Like some of the things that may be looked at as sexualized in Eurocentric culture is not sexualized in African American or African cultures—like using your hips sometimes could be seen as something else when it—it’s not like that in other cultures. (ID10)

General Clinical

Some of the theories from psychology and counseling that participants learned in MBEL were group dynamics, transference and countertransference, diagnoses of mental disorders, trauma work, attachment theories, and neuroscience of the brain. Participants found that using MBEL helped further their understanding and retention of the theories. One participant noted that embodying different parts of the brain and its functions was particularly helpful. Some of the somatic practices that participants learned through MBEL were Bartenieff Fundamentals (Bartenieff & Lewis, 1980) and elements of yoga.
Domain IV: Professional Orientation

Competencies for this domain are related to the therapist’s ethical and professional conduct as a clinician working with diverse populations whether in private practice or in a collaborative, multidisciplinary treatment setting. Professional Orientation is a Foundational Competency.

Ethics

As students in MBEL, the duty to respect and protect their clients was already their guiding principle. Participants spoke about having an ethical responsibility to know through experience what it is like to be in DMT sessions, so that they can empathize with their clients. On the other hand, some participants felt conflicted when using MBEL to embody different clinical populations, because they were aware that their embodiment of others was based on assumptions and biases about a group of individuals whom they did not really know:

A part of movement experientials that I think are necessary but I consistently would have sort of ethical dilemmas with, it was when we were asked to do our best to embody a client. So first of all, I think it’s necessary because it offers you the opportunity to try on different movement preferences and try and gain an understanding about that person through their movement. And we were able to explore what it’s like to be a different population...[But] because there is no way to know how someone is feeling truly, their movement, you have to also ask them, not have assumptions about that. But when we were asked to embody these clients, we were acting on pure assumption. Sometimes it felt like, I could feel this weird ethical gut dilemma because I knew for a fact that we are not supposed to make assumptions about how people feel and yet I also knew that this was for the purpose of learning how to facilitate a group of people that might look this way or a group of people that might be moving in this way. (ID08)

Another participant found it “offensive” (ID10) when she observed her own classmates embody people with different diagnoses based on stereotypes and assumptions.

Professional Behaviors

Competencies for professional behavior can vary widely based on the clinical setting, but DMT practitioners must be able to conduct themselves in a manner that is congruent to the setting. As students in MBEL, it was expected that they get in touch with their feelings, and emotions often flooded over. One participant, however, spoke about the importance of learning to balance the emotional, sensitive self and the rational self as a DMT practitioner: “I’m tapping more and more, I guess, into both sides really—like going in deeper because I think that they are—they’re
married, and they need each other” (ID02). In other words, emotions that are aroused in DMT sessions must be recognized and managed, so that the DMT practitioner can use emotions and cognitions as equally critical components of the clinical decision making process.

Another aspect of professional behavior was the use of language to communicate clinical information to other professionals. Many participants were grateful to have Laban Movement Analysis (Dell, 1977) and the Kestenberg Movement Profile (Kestenberg Amighi et al., 2018) to speak about their clients in movement. However, they recognized that they would not be taken seriously if they failed to use language that is clinically relevant to other professionals: “If you’re going to go to the psychiatrist and sound like, ‘Well, they’re so free flow,’ [the psychiatrist would say,] ‘So who is this lady? What’s she doing here?’” (ID02).

**Collaborations**

Participants found opportunities to engage in experiential learning with other creative arts modalities (such as music and art therapy) informative, stimulating, and enriching. These experiences developed skills to engage in professional collaborations at their place of employment:

- My training helped me to become what I believe is - to become a competent professional but also helped me to work with teams and interdisciplinary teams. So I get really excited working with other people. I love collaborating and I have even collaborated in treatment processes. I have had therapists who will shadow a session with my client’s consent and it’s always really nice to gain their feedback and also to give my feedback if I am shadowing them and kind of co-lead a session with them (ID06).

**Comparison with ADTA Standards**

Competencies that were identified in this study were compared to the competencies listed in the ADTA standards (ADTA, 2017). Of the 27 competency categories in the ADTA standards, MBEL addressed all but six of those categories. The five categories not addressed in MBEL were under the content area for Theory: Knowledge of Anatomy and Kinesiology, Cognitive Development, Psycho-Social Development, Neurology of Movement, and Application of Neuroscience. The other category that was not identified in this study was Knowledge and Skills of Research, under the content area of Practice. All other competencies were either fully or partially identified. Partially identified means that one or more of the operationally defined competencies under a given category was not identified in the interviews. See Table 1 for a summary of ADTA competencies that were identified in this study.

Finally, this study identified competencies that are not listed in ADTA’s standards. These are competencies that were coded as Affective Responses, a Functional Competency under the domain Self of the Therapist. (See Fig. 1.) Study participants reported having affective responses during MBEL, and they recognized that as DMT practitioners, they must be able to navigate the myriad emotions that arise through
| Content area            | Competency No | Competency category                                                                 | Identified in interviews |
|------------------------|---------------|-------------------------------------------------------------------------------------|--------------------------|
| History                | 1.1–1.4       | Major founders & their contributions, and the impact of historical and societal trends on the emergence of the profession | Partially                |
|                        | 1.5–1.7       | Contemporary contributions from related fields                                       | Yes                      |
| Theory                 | 2.1           | **Dance**                                                                           | Yes                      |
|                        | 2.1.1         | Knowledge of anatomy & kinesiology                                                   | No                       |
|                        | 2.1.2–2.1.7   | Elements of dance and movement in health & healing                                    | Yes                      |
|                        | 2.1.8–2.1.10  | Creativity & aesthetics                                                              | Yes                      |
|                        | 2.2           | **Relationships (Intrapersonal & Interpersonal)**                                    |                          |
|                        | 2.2.1–2.2.5   | Therapeutic movement relationship                                                    | Yes                      |
|                        | 2.2.6–2.2.10  | DMT individual/group/system work                                                      | Partially                |
|                        | 2.2.11–2.2.13 | Psychology of groups and group process                                               | Yes                      |
|                        | 2.3           | **Human development through the life span**                                         |                          |
|                        | 2.3.1–2.3.3   | Core development across physical, cognitive, psychological, and social domains       | Partially                |
|                        | 2.3.4–2.3.7   | Physical development: Human development as related to movement                      | Yes                      |
|                        | 2.3.8–2.3.13  | Cognitive development: Developmental body movement and the interplay between learning and thought processes | No                       |
|                        | 2.3.14–2.3.15 | Psycho-social development: intersection of movement, psychological, and social development | No                       |
|                        | 2.4           | **Neuroscience**                                                                    |                          |
|                        | 2.4.1–2.4.4   | Body/mind integration                                                               | Partially                |
|                        | 2.4.5–2.4.7   | Neurology of movement                                                               | No                       |
|                        | 2.4.8–2.4.12  | Application of neuroscience                                                         | No                       |
|                        | 2.5           | **Assessment**                                                                       |                          |
|                        | 2.5.1–2.5.9   | Systems of movement observation, assessment, and analysis                             | Partially                |
|                        | 2.5.10–2.5.12 | Tools used for movement assessment and analysis                                       | Partially                |
| Content area          | Competency No | Competency category                                                                 | Identified in interviews |
|----------------------|---------------|-------------------------------------------------------------------------------------|--------------------------|
| Practice             | 3.1–3.11      | Treatment planning and evaluation                                                    | Partially               |
|                      | 3.12–3.21     | Clinical use of the therapeutic movement relationship                               | Yes                      |
|                      | 3.22–3.37     | DMT practice skills                                                                  | Yes                      |
|                      | 3.38–3.48     | Group DMT skills                                                                     | Yes                      |
| Professional Development | 4.1–4.3   | Knowledge and skills of research & evaluation in DMT & human behavior                | No                       |
|                      | 4.4–4.7       | Professional identity                                                                | Yes                      |
|                      | 4.8–4.18      | Development of best practices                                                        | Partially               |
|                      | 4.19–4.21     | Self-awareness                                                                       | Yes                      |
|                      | 4.22–4.26     | Supervision                                                                          | Partially               |
|                      | 4.27–4.28     | Advocacy for DMT                                                                     | Yes                      |
the body while moving with others. The ADTA standards do not include competencies around the DMT practitioners’ ability to decipher emotional experiences and content.

Discussion

Competencies that develop in MBEL were identified inductively. Thematic analysis of the interview transcripts showed that MBEL developed both Functional Competencies and Foundational Competencies. The participants’ narratives were particularly rich around their experiences of building therapeutic relationships, leading sessions, and learning about themselves, suggesting that MBEL was most instrumental in developing the Functional Competencies—Clinical Practice and Self of the Therapist. That is, as DMT students in MBEL, study participants developed Clinical Practice competencies to perform the duties of a dance/movement therapist in clinical settings, and Self of the Therapist competencies to know how the DMT practitioner’s self interfaces with the therapy process. Foundational Competencies were also identified from the interviews, but the narratives around competency development for Theoretical Knowledge and Professional Orientation were mixed; study participants reported that competency development in these domains was inadequate.

The findings from this study support the intentions behind MBEL in DMT education. According to the DMT literature reviewed earlier, the primary purpose of MBEL is to provide students with experiences that deepen understanding for the various aspects of DMT’s therapeutic processes. As such, it is not surprising that MBEL is not focused on developing competencies for Knowledge and Skills of Research. Likewise, the study found that MBEL did not address five categories of competencies under Theory: anatomy and kinesiology, cognitive development, psychosocial development, neurology of movement, and application of neuroscience. This study found that MBEL most developed competencies in two of the content areas that the ADTA’s new standards call Practice and Professional Development (ADTA, 2017). All of the competencies under these two content areas were identified either fully or partially in the participants’ narratives; the one exception was Knowledge and Skills of Research under Professional Development, as mentioned above.

Matching the competencies that were inductively identified in this study to the a priori operationally defined competencies in ADTA’s new standards was a challenge, because the language of each of the 145 operationally defined competencies was very specific. For this study, this researcher read through each of the competencies listed in the ADTA standards and checked to see if each competency was discussed by the participants in the way that each competency was operationally defined. In order to determine specifically which of the ADTA’s 145 operationally defined competencies develop in MBEL, a future study could be a survey that asks new DMT practitioners to go down the list of 145 competencies and check off those
that they developed in MBEL. This can be done online and yield a large number of respondents.

**New Discovery**

It was expected that there may be competencies that are unique to MBEL and not part of the ADTA standards. This study identified a group of competencies coded as Affective Responses under the Self of the Therapist domain. It is proposed that these are competencies most closely related to emotional intelligence and do not correspond directly to any of the competencies listed in the ADTA standards.

Emotional intelligence is the “ability to process and reason about emotional information” (MacCann et al., 2014, p. 359) and plays a central role in navigating social situations (Gribble et al., 2017; MacCann et al., 2014). According to one model of emotional intelligence, the ability-based model, emotional intelligence is comprised of four abilities: the ability to perceive emotions in self and others, the ability to use emotions to formulate thoughts, the ability to understand emotions, and the ability to regulate emotions (Kaplowitz et al., 2011; MacCann et al., 2014). Together, these abilities promote resiliency and personal growth. In a pilot study that examined the impact of the therapist’s emotional intelligence on psychotherapy, patients in Brief Relational Therapy and Cognitive Behavioral Therapy with therapists who had high emotional intelligence showed greater improvements in interpersonal problems and psychiatric symptoms. Patients were also less likely to drop out from treatment (Kaplowitz et al., 2011).

As students in MBEL, participants in this present study experienced a range of emotions that affected their ability to engage in MBEL. Emotions that had negative impact on their experiences in MBEL included anxiety, fear, frustration, and anger, which at times led them to feel confused, overwhelmed, stressed, or exhausted. Yet, it appears that in MBEL, they learned to attend to interoception while building body awareness, make sense of sensory information through self-reflection, self-regulate with breathing exercises, and set limits and boundaries to make choices that supported their own development.

Interoception refers to sensations and messages that arise within the body and is integral to one’s ability to experience and understand emotions, as well as navigate social situations (Hindi, 2012). Dance/movement therapists use interoception and emotions to inform the therapy process (Hindi, 2012; Panhofer et al., 2014). Negative emotions, such as embarrassment and shame, have been found to adversely affect the therapists’ self-worth and self-efficacy (Klinger et al., 2012). Positive emotions, on the other hand, have been associated with a reduction in client resistance (Westra et al., 2012), and improvements in the quality of the therapy relationship and process (Vandenberghe & Silvestre, 2014).

As DMT students in MBEL, the participants of this study developed the four abilities of emotional intelligence described above by embodying different components of emotional intelligence. That competencies around emotional intelligence were identified in a study that focused on the student perspectives is a reasonable finding, given the multitude of emotionally charged experiences in MBEL.
Implications

Study participants voiced the least satisfaction with competency development for Theoretical Knowledge. Participants suggested that perhaps the theories that are explored in MBEL need to be made more explicit or processed in depth after the movement based experiential exercises, not in a top-down lecture format, but in a bottom-up format with the use of additional art or dance making process. This would be a more time-consuming approach, but perhaps worth considering, if it would enable students to better digest and retain the relevance of key DMT theories. One participant recalled how additional art-making was done as assignments outside of class in an iterative manner, so that students can bring in their individual reflections and discoveries into class to co-construct knowledge. DMT educators can also be explicit about designing experiential exercises specifically to promote connections between theory and experience.

Attention must also go to the development of competencies for multiculturalism, because study participants were clear that there is room for improvement in this area. They recalled for example, that multiculturalism tended to focus on select races and that there was not sufficient time spent on the LGBTQI community. This lack of education and competence around multiculturalism appears to reflect a weakness in the larger community of DMT practitioners (Kawano et al., 2018), and is being addressed more actively by the ADTA more recently (Grayson et al., 2019). In addition, some study participants also felt that there wasn’t space for them and others felt that they were not heard.

It is evident that DMT programs are addressing competencies for multiculturalism—several participants recalled that their program had a section on world dance forms. They noted, however, that as much as they enjoyed learning dances from different cultures, those experiences did not necessarily develop competencies for multiculturalism. They thought that watching videos of different cultures and engaging in movement explorations afterwards might be more educational. Some suggested that having guest lecturers who have personal knowledge about bias, oppression, and marginalization because of their identities would be more informative. Golanka Carmichael (2012) offered suggestions for skills that dance/movement therapists can develop, but ultimately, multicultural competency is an “adapted life choice” (p. 108). It requires commitment, dedication, and continuous training, which often leads to a decision to focus one’s clinical work on a specific population. Becoming competent with multiculturalism demands that the dance/movement therapist “is willing to be self-aware, self-educated, and develop an uncompromising critical attitude towards their embedded assumptions” (Chang, 2016, p.330), not only in their clinical work, but in how they view the world.
Limitations

This study focused on the student perspectives to identify competencies that DMT students develop in MBEL. Study participants were 15 dance/movement therapists who had graduated from seven different ADTA approved DMT graduate education programs within the past 5 years. There was variability in race, gender, and sexual orientation to shed light on different experiences and perspectives, but a full representation of diverse identities was not possible. Certainly, a male perspective was absent.

A peer debriefer who is experienced with qualitative research methods was employed to review coding on three of the interview transcripts; however, the peer debriefing did not take place throughout the research process due to lack of financial resources. For member checking, each study participant reviewed and approved the interview transcript, but the final written report was not submitted for their review (Korstjens & Moser, 2018).

In Conclusion

This study identified the many competencies that students develop in MBEL and the areas in which MBEL is best utilized—for the development of competencies under two of ADTA’s content areas: Practice and Professional Development. A new discovery was that MBEL developed competencies related to emotional intelligence, which are not directly addressed in the standards. The findings from this study can be used to promote discussions between DMT educators and the larger DMT community. As a first step, Blanc (2019) conducted a phenomenological study in which she interviewed DMT educators about their pedagogical theories and practices, and Kawano and Chang (2019) articulated a pedagogical approach for DMT education based on critical race feminist theories. The shortcomings that the study participants identified must be addressed thoroughly, but there is also a need to consider the larger implications of moving forward with a competency based education model.

The benefits of competencies-based education are that it can: (a) make it possible for educators to identify specific weaknesses in students and emphasize competencies that need the most development; (b) improve supervision practices (Gonsalvez & Crowe, 2014); (c) add credibility to the profession, which may improve possibilities for inclusion in reimbursement and consumer access legislation (Miller et al., 2010); and (d) better indicate practice readiness better than course or program completion (Nelson et al., 2007).

The challenges with competency based education are that: a) a prescriptive approach to education may unintentionally limit individuality, creativity, innovation, and autonomy, because educators would feel pressured to teach towards the competencies (Miller et al., 2010; Nelson et al., 2007); b) competency based education and practice would require assessment tools (Nelson et al., 2007) but given the multidimensional and complex nature of competencies for each field, it is difficult to develop a tool that will measure all core competencies (Swank et al.,
2012); and c) some of the competencies such as attitudes and values which have greater impact than knowledge competencies in a practitioner’s effectiveness and competence are difficult to evaluate (Gonsalvez & Crowe, 2014). There is a risk that competencies that are not easily measured would become undervalued.

With the implementation of the new ADTA standards expected on January 1, 2023, discussion on the impact that a competence based education may have on the values that the DMT community espouses would be timely.

Appendix

Interview Questions

To begin, take a moment to reflect and to remember what it was like for you to be in movement based experiential classes as a student in your DMT program.

1. What are you remembering first and foremost?
2. What terminology was used to describe movement-based experiential learning activities in your program?
3. Which classes used movement-based experiential learning?
4. At what point(s) in the program sequence were movement-based experiential learning offered?
5. Can you describe how movement-based experiential learning was used in your training?
6. Were you aware of its purpose as a student? Please explain.
7. What was your understanding about Movement Based Experiential Learning (MBEL)?
8. What were some of your experiences in MBEL?
   a. What kinds of things do you recall exploring through MBEL?
   b. How did you feel moving/dancing in MBEL?
   c. What were some of the positive aspects of learning in this manner?
   d. What were the negative aspects of MBEL?
   e. What were some challenges you experienced in MBEL?
   f. What were your overall impressions of MBEL as a student?
   g. Have your impressions changed over time?
9. What did you learn/what competencies do you think you developed in MBEL?
   a. Knowledge
   b. Skills
   c. Attitudes
   d. Values
10. What did you learn about yourself in MBEL?
11. How did your identity as a dancer influence your experiences in MBEL?
12. How do your experiences in MBEL contribute to your current work as a professional DMT practitioner?
13. Is there anything you would change about MBEL?
14. Do you have any recommendations or suggestions for DMT educators on how MBEL is used in DMT education?
15. Is there anything else you would like to share with me about this topic that I haven’t asked?

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Declarations

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval Approved by Drexel University’s Institutional Review Board.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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