

Applying Elements of Contra Dance to Reduce
Symptoms in Children with High-Functioning Autism

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Abstract

This paper will focus primarily on a child diagnosed with Autism Spectrum Disorder, specifically High-Functioning Autism, who attended a summer camp in 2015. A definition of autism and how it affects a diagnosed child will be explained. Analysis of the benefits of group dance/movement therapy (DMT) with children diagnosed within the autism spectrum will also be presented. Additionally, past documented studies regarding this population and the use of dance/movement therapy as a catalyst for reducing symptoms of autism will be described. Focusing on three specific goals (commitment, community, interpersonal/intrapersonal relationships) this paper will describe how the Contra Dance form can be implemented into DMT sessions with this population. Finally, this paper will conclude with a case study, demonstrating why incorporating Contra Dance form into group DMT sessions within autism populations can reduce symptoms of those diagnosed.

Keywords: Asperger's Syndrome, autism, contra dance, dance/movement therapy, group work, neurodiversity

Introduction

The first time I met Alex, it was a humid afternoon in late June. The sun beamed down on children running and playing. Many games were occurring at the same time: tag, soccer, and a game of baseball. About half of the camp, many children from different age and camp groups, were congested in the center field of the campgrounds. One child, Alex, about three feet tall with a head of brown curls, stood in the middle of the soccer field. I observed that his focus on the soccer game continuously moved in and out. He ran, looked for the ball, stopped and looked at other games, went back to looking for the ball, stopped and stared at the clouds in the sky. This in and out behavior occurred religiously throughout the game to which he kept returning.

Alex repeatedly hit the palm of his right hand to his forehead while he was playing, which made him noticeable. None of the other children passed the soccer ball or engaged with Alex. It was obvious that he was trying his best to emulate the others, but his energy began to wane and he kept coming to the sidelines where the counselors kept the water. I was in charge of Alex's group, the B Comanche, and gave him water several times.

After finishing his fourth cup of water, Alex ran quickly back to the field and into the middle of the game where he tried to get the soccer ball. Eleven excited boys surrounded him and Alex began to cry. Alex's crying quickly turned into screaming, accompanied by forced leg and arm gestures lashing out at the other boys around him. The boys closest to him began to move further away. Fortunately, I had alerted my boss by walkie-talkie when Alex first started crying. As the outburst escalated, David, my supervisor, was at my side. David and I intervened immediately using the crisis prevention intervention (CPI) techniques we had been taught: I took Alex's feet and David took Alex's arms. Alex was not pleased when he was restrained, but due to the intense training and practice David and I received we were able to eliminate any dangerous activity.

After we restrained Alex, hands crossed over his chest and feet crossed at his ankles, we brought him to a small room about four feet wide and four feet long. David left and the door closed. Alex started to slap his right palm against the top of his forehead again. His forehead began to turn red in the shape of a handprint between his eyes. We were alone, in a white room with the door closed. I kept my distance because Alex's movements were so large the room seemed smaller than it already was. Alex's movements grew even more expansive, and the slapping of his palm grew louder in sound and quicker in motion. I wanted to stop him but I did not know how. The room began to close in and I started to feel trapped.

I opened the door for fresh air and in that split second Alex charged out of the room. I had no choice but to follow. Worried he would again become the "center of attention" for the other children to make fun of, I made sure to keep him in sight. Alex was a fast runner so keeping track of him was hard. He ran past the ongoing soccer game to the lower portion of the camp, where two other Comanche boys had wandered away from the game and were engaged in self-stimulating behavior (commonly known as self-stimming) alongside the playground. Each child's behavior was different. One child was doing self-soothing movements and gestures using a rocking motion. His rocking occurred in the trunk of his core, expanding out into his entire torso. The other child would pick a leaf off a nearby tree and flick the leaf back and forth until it fell. Once the leaf had fallen he would pick another leaf from the tree and repeat the action over again.

I watched Alex approach the vicinity of the two boys but neither of them seemed to have noticed. He kept slapping his forehead with his right palm but stopped running. Just a few feet away from where Alex and the other boys stood was the playground, filled with toys, a jungle gym, and a huge set of four euro-bungee bounce trampolines. However, instead of interacting

with these objects each boy was preoccupied with his own individual movement. I became keenly aware that these children had not only separated themselves from the larger group but also were displaying key behaviors of children with autism. They were separate but also together.

Alex's primary diagnosis is High Functioning Autism (autism spectrum disorder) along with two secondary diagnoses being Attention Deficit Hyperactivity Disorder (ADHD) and Obsessive Compulsive Disorder (OCD). Comorbidity, which is the concurrent existence of two diseases or disorders, is common in those with autism, and often includes these two secondary diagnoses (Bartak, 2011). This makes Alex's situation "typical" as the many other children in my camp group had similar circumstances regarding their diagnoses.

Alex's parents reported that he is extremely intelligent with a mathematical and scientific knowledge of a sixth grader and a special interest in outer space and the galaxy. Understandably, his parents' main concern was Alex's ability to experience a sense of himself, form relationships, and experience himself in a community. Alex, and many of the other boys who were in my group, had the ability to talk and play with others; however, they often became overstimulated and confused. This in turn restricted them from carrying on a conversation or participating in a game. I often observed them engaging in self-stimulation, which is viewed as "not typical" by others trying to engage with these children. These repetitive movements can be interpreted as an obstacle in their ability to form desired social connections (Volkmar, Lord, Bailey, Schultz, & Klin, 2004).

Alex's concerned parents were not alone, as I received many phone calls and e-mails from ten other parents/caregivers about their five to ten year-old children who were in my camp group. They all expressed the same concern regarding their child's missing integration into social

relationships, their inability to be part of a community, and difficulty maintaining a sense of self in social settings. Their eagerness to see their sons play, engage, and communicate with others their own age was palpable. In fact, all ten parents articulated a desire to schedule individual play dates for their children.

The History of Autism

“The concept of neurodiversity provides a paradigm shift in how we think about mental functioning. Instead of regarding large portions of the American public as suffering from deficit, disease, or dysfunction in their mental processing, neurodiversity suggests that we instead speak about differences in cognitive functioning” (Armstrong, 2011, p.3). The concept of neurodiversity allows for parents, caregivers, and therapists to approach children diagnosed with autism spectrum from the angle of their successes rather than their weaknesses. This approach allows for achievable goals and expectations in the areas of social interactions and emotional circumstances. This is a welcomed perspective from a past in which autism was thought to be an issue in the child rather than a child who thinks, learns, and communicates differently from other children.

In the early 1900s, children with autism symptoms were often thought to have childhood schizophrenia (Feinstein, 2010). The misdiagnosis of schizophrenia was mainly due to the similarity in the symptom of loss of contact with the environment, which is commonly observed in children with autism. This confusion persisted over sixty years (Feinstein, 2010).

One distinction between those diagnosed with schizophrenia and those who have autism is that schizophrenics often live in a world filled with hallucinations and delusions, a world of disordered thought and perception, and of “wish fulfillment and ideas of persecution” (Feinstein,

2010, p. 76). Children with the diagnosis of schizophrenia show progressive loss of contact with those surrounding them (Feinstein, 2010, p. 76). Symptoms of disengagement from the environment in children with the diagnosis of autism do not worsen over time, and psychotic behaviors are not visible in what is now diagnosed as autism (Feinstein, 2010).

The word autism is derived from the Greek word “auto” meaning “self” (Feinstein, 2010). Eugen Bleuler, a Swiss psychiatrist, coined the word “autism” in 1919 (Feinstein, 2010). Even though Bleuler acknowledged the need for a separate term or definition, Bleuler believed autism was just another form of schizophrenia. There were two men who differentiated autism as its own diagnosis rather than placing it under the umbrella of schizophrenia, Dr. Leo Kanner and Dr. Hans Asperger.

Dr. Kanner, an Austrian psychiatrist and physician, explained that these two conditions were separate (Feinstein, 2010). Kanner launched his career at John Hopkins University of Medicine in 1930, six years after living in the United States (Feinstein, 2010). Kanner both studied and worked at John Hopkins, which allowed him to be the first to develop a child psychiatry service in a pediatric hospital (Feinstein, 2010). Through his studies with children who he believed had autism, Kanner was able to notice the children's social and emotional problems. His observations helped him differentiate autism from schizophrenia (Feinstein, 2010). Dr. Hans Asperger was an Austrian pediatrician, medical theorist, and medical professor (Feinstein, 2010). During Asperger's childhood, he was considered to be a lonely, “remote” child (Feinstein, 2010, p. 51). His daughter, Maria Asperger Felder states that her father “didn't need much social contact. He was content with his own company. He loved nature. He even climbed the Matterhorn” (Feinstein, 2010, p. 51). Later on, Asperger was appointed director of play-pedagogic, lecturer, and director of the children's clinic at Vienna University. Asperger's work

with children, his own lonely/isolated childhood experiences, his interactions with other colleagues and their use of multidisciplinary therapies, all helped form his theories on autism and furthered the understanding and identification of different branches of autism (Feinstein, 2010).

In the beginning, it was difficult to conceptualize these children under one label due to the drastic differentiation between each child who was believed to have a form of this disorder (Feinstein, 2010). However, in 1943 Kanner defined “early infantile autism,” which encouraged Asperger to conduct a study in 1944 of four boys (Feinstein, 2010). The conclusion of this study found that the boys had similar atypical traits, which resulted in Asperger’s definition of a form of autism, which he called Asperger syndrome (Feinstein, 2010). In 1946, Sister Viktorine Zak (Asperger’s nursing colleague) utilized speech, drama, play, and music therapeutic approaches to teach the children social skills (Feinstein, 2010). Using multidisciplinary therapies was found effective for those unsure of how to treat the diagnosed because of the unique presentation of each individual.

Initially, bad parenting was thought to be one of the causes of this disorder (Feinstein, 2010). Blame was placed on the caregivers, which motivated them to agree to provide whatever treatment enabled their children to be “cured” (Feinstein, 2010). Even though the use of multidisciplinary therapeutic processes was available, doctors and specialists also began to use medication as a “cure” for the symptoms of autism (Drezner, 2011). It was not until 1970 that people started to completely differentiate autism from schizophrenia and recognize autism as a separate neurological disorder. This was predominately due to a greater understanding of how the disorder can affect an individual, as well as the elimination of blaming the caretaker’s ability (Autism, 2013; Feinstein, 2010). Pharmaceutical interventions were drastically reduced based on the changing understanding of the needs of the child (Drezner, 2011). In the absence of

pharmaceutical intervention, the focus turned toward certain forms of therapy that became the forefront in considering treatment – a return to Zak’s original approach. This change in approach enabled doctors, parents, and those involved in the individual’s life to seek ways to enhance the person rather than “fixing” or “curing” him/her. This shift in perspective, from “fixing” the child to providing outlets for the needs of the child, is paramount today (Drezner, 2011).

The Development of Autism Spectrum Disorder and Initial Therapies

The implementation of a combination of different forms of therapy is used today as a way to address the differences between each child diagnosed with autism. Even though medication is still prescribed, it is not used as often as it was in the past (Pringle, Colpe, Blumberg, Avila, & Kogan, 2012). It is stated that the most commonly used services are social skills training and language or speech therapy (Pringle, Colpe, Blumberg, Avila, & Kogan, 2012). These forms of therapy are utilized to reduce the symptoms as much as possible, not completely eliminate them (Pringle, Colpe, Blumberg, Avila, & Kogan, 2012). Focusing on inherent differences rather than the disability has transformed people’s perspective on what autism is and how those diagnosed relate and communicate with the outside world.

Facial expression, eye contact, body language, and gesture play a huge role in human communication. During conversations, people tend to utilize physical gestures and movements to support their ideas. People have a natural human tendency to provide emotional clues to others without verbalizing what they are thinking (Ritter, 1996). Embodied communications are powerful interactions that go beyond a mere exchange of words and they support cognitive learning, social and emotional connection. This ability is lacking in children on the autism spectrum, who generally do not form eye contact, recognize others’ facial expressions, and have

the inability to notice their own and others' gestures within communication (Block, Block, & Halliday, 2006). The inability to notice all aspects of communication can negatively influence the way others interact with children diagnosed on the autism spectrum, as well as how these children interact with the world around them.

Autism Spectrum Disorder (ASD) can only be seen through abnormal actions, but cannot be seen through physical features (Block, Block, & Halliday, 2006). Cognitive development is less typical for children on the autism spectrum as their cognition varies among children diagnosed. This causes difficulties with verbal and non-verbal communication, social interaction, internal and external body-awareness, interpersonal and intrapersonal relationships and everyday play (Scharoun, Reinders, Bryden, & Fletcher, 2014, p. 210). Children with autism also have difficulties connecting with the world they live in (Block, Block, & Halliday, 2006; Drezner, 2011). This is due to the inability to share a common focus of attention with another human being (Volkmar, Lord, Bailey, Schultz, & Klin, 2004, p. 143).

Disruptive behaviors, such as repetitive jumping, flailing limbs, rocking forward and backward are common for children diagnosed with autism. These abnormal behaviors often are attempts to self-soothe but may not be socially acceptable to others, which further prevents positive social interactions (Block, Block, & Halliday, 2006). Moreover, the children typically have strong emotional attachments to certain objects and are highly disturbed by changes to their daily routines. These issues also provoke behaviors that hinder social interactions (Block, Block & Halliday, 2006; Drezner, 2011).

Autistic Disorders, Childhood Autism, and Infantile Autism are the three different titles pertaining to the same disorder: Autism (Volkmar & Wiesner, 2009). The diagnostic criteria of

the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for autism spectrum disorder are presented in Table 1.

Autism is a spectrum disorder, which is a large umbrella under which individuals can be placed depending on their symptoms. Children present a range of symptoms and needs depending on their age, development, and presenting features (Baudino, 2010, p. 115). This can make it difficult for parents to determine whether or not their child has autism. Autism manifests within the first three years of a child's life, which is when a parent may suspect that their child could be classified under the autism spectrum (Block, Block, & Halliday, 2006). The way a parent/caregiver may notice signs of autism is through the absence of eye contact, being unresponsive to certain or all sounds, being abnormally attached to one parent, and physical distancing between themselves and other children their age (Block, Block, & Halliday, 2006).

Since autism often presents differently for each individual, symptoms can vary (Barid, Cass, & Slonims, 2003). There is not one specific biological exam to test autism (Barid, Cass, & Slonims, 2003). The Autistic Continuum (Wing, 1988) is an assessment tool a doctor uses to evaluate a child who is thought to have autism (Barid, Cass, & Slonims, 2003). Within this continuum, a doctor can more easily determine what developmental issues the child is experiencing. This continuum consists of specific categories: social interaction, social communication (verbal or non-verbal), social imagination, repetitive patterns of self-chosen activities, language (formal system), responses to sensory stimuli movements and special skills (Barid, Cass, & Slonims, 2003). These categories are each rated on a four-level scale, ranging from no visibility to complete visibility. This scale allows the doctor to evaluate and classify the child's behavior in each of the given categories.

When a parent or teacher suspect autistic-like behaviors, they can further their

Table 1

DSM-5 Diagnostic Criteria for Autism Spectrum Disorder

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive,):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted repetitive patterns of behavior.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Table 1 (continued)

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level. (American Psychiatric Association, 2013, pp. 50-51)

investigation by using the Autism Spectrum Rating Scale (ASRS). The ASRS is a way for both teachers and parents to access where the child is placed on the autism spectrum. The child can range from being low functioning (being the most severe), to high functioning (being the least severe). There are both verbal and non-verbal scales, a scale depending on the age of a child (2-5 years old and 6-18 years old), and there are short forms of the scale and longer, more in-depth, forms of the scale (Goldstein & Naglieri, 2012).

High-Functioning Autism, also known as HFA, is less visible to others than a child with Low-Functioning Autism (Levy, 2005). Sensory issues and social communications are the main concerns of a child who is considered to have HFA (Notbohm, n.d.). Sensory disconnection can occur due to lacking a sense of danger as well as repetitive self-stimulation such as rocking or repeated hand motions (Notbohm, n.d.). Children diagnosed with HFA often have marked difficulties in social contexts, such as making friends and relating to others (Volkmar & Pauls, 2003). These children are in fact intelligent and may even exceed peers in developmental intellectual capabilities (Notbohm, n.d.).

Over the past 10 years, the diagnosis of autism has increased throughout the world (Barid, Cass, & Slonims, 2003). This increase may be attributed to the fact that autism is considered to be on a spectrum scale rather than a distinct disorder (Barid, Cass, & Slonims, 2003). There are a variety of ways in which autism may affect a person. As of 10 years ago, one in 1,000 children was considered to be on the autism spectrum. Five years later, one in 500 children had some form of autism. The most recent estimate reports that one in 68 children living in America is diagnosed with ASD (Autism, 2014). Due to the rapid increase in autism diagnoses within the past 10 years, scientists believe that the rate of diagnoses will only multiply in the future. With greater access to tools to detect this disorder at an early age, it is vital that basic

needs of the child are met with comprehensive therapeutic practices that address the range and variability of behaviors (Barid, Cass, & Slonims, 2003). Seeking creative forms of therapeutic processes and individualized plans for particular therapeutic approaches, which address the present challenges of social connection is crucial in treating a child with ASD.

Dance/Movement Therapy

One form of therapy that has been found to be effective in treating children with ASD is dance/movement therapy (DMT). Experiencing a sense of self, forming relationships, experiencing oneself in a community, and creating social commitment are concepts all directly embedded in DMT (Flinn, 1995, p. 249). Children who are on the autism spectrum are typically challenged in areas of socialization, interaction, and self-commitment, which can result in isolation, confusion, and a sense of uneasiness (Scharoun, Reinders, Bryden, & Fletcher, 2014, p. 210). These effects can create agitation and irritability, which can manifest itself visibly to the outside world. In particular, built up agitation and irritability within a child can hinder the way he/she communicates with others.

Through the use of movement, many people experience improved mood and outlook (Ritter, 1996, p. 250). Movement has the ability to release inner tensions and built up negative emotions, providing a person with relaxation. Additionally, it has also been found that dance/movement therapy can have a significant impact on traditional group psychotherapy sessions. When a group DMT session precedes psychotherapy, the psychotherapy session has the potential to be much more effective, providing more group cohesion and participation, as well as self-confidence in achieving received tasks (Ritter, 1996, p. 250).

Communication by means of movement is a vital factor involved in DMT (Payne, 2006). Dance/movement therapists work with individuals or groups, using body movement to assess, as well as provide treatment intervention (Levy, 2005). Through movement, DMT can help children with a wide range of psychological disorders and disabilities, including children diagnosed with ASD, achieve greater self-expression, develop their capacity for interpersonal/intrapersonal relationships, and form a community (Koch; Levy, 2005; McGarry & Russo, 2011). Group DMT is a powerful method of interaction and treatment for children on the autism spectrum.

Interventions have been done with the ASD population utilizing dance/movement therapy as a catalyst to reduce patient's symptoms. *Loving Lampposts* is a documentary about children diagnosed with autism. This film brings greater awareness of the diagnosis of autism, while also providing perspective on what autism is (Drezner, 2011). The documentary is a useful film, which additionally provides awareness for the field of dance/movement therapy.

A major accomplishment of *Loving Lampposts* is that it informs the audience about the realities of autism, thus dissolving the exaggerated stigmas of this disorder. In the beginning of the film, a young boy is shown and described by his father as loving lampposts. His interests were different from peers his own age, as he did not enjoy playing with other children. Instead he enjoyed visiting different lampposts in the parks with his parents. Just like Alex, the boy in the documentary's inability to form social relationships with children his own age is clearly apparent. Just like many of the concerned parents from the camp that I worked at, the parents in the film questioned whether pharmacotherapy was necessary or if social interactions could develop with the use of alternative forms of therapeutic treatment (Drezner, 2011).

Koch, McGarry and Russo all have formed documented study-based research regarding the benefits of using mirroring through dance/movement therapy (in particular the Chacian circle)

with children on the autism spectrum (Koch; McGarry & Russo, 2011). Each of these studies used mirroring to increase empathy in individuals diagnosed with ASD (McGarry & Russo, 2011). Recognizing that empathy is crucial in social connection, but does not form the whole of it, there are even more techniques and theories that can contribute to the DMT field and benefit those diagnosed with autism.

The autism population is unique and growing each year. Since it is a spectrum disorder, and represents a wide range of behaviors and needs, those treating autism need to have the ability and access to utilize the vast amount of tools that could benefit those diagnosed with ASD. More research is necessary to identify and assess the different treatment modalities available to the wide range of children with the same diagnosis. Since the focus of empathy has been explored and tested by using dance/movement therapy, it is vital for us to focus on the many other goals that the autism population lack: the ability to experience a sense of oneself, form relationships, and experience oneself in a community (Koch; McGarry & Russo, 2011).

Introduction and History of Contra Dance

Contra Dance, which is a specific form of English Country dance, began in America during the late seventh century (Horton, 2001, p. 204). This dance form derived from the Europeans and eventually made its way across the world. When the Contra Dance style emerged, the European contradances and quadrilles developed into different cultural hybrids, specifically in the Caribbean Islands (Tomé, 2012, p. 403). Contra Dancing was different than the typical intrapersonal dance. It was a social dance that incorporated intrapersonal concepts as well as interpersonal relationships.

Contra Dance, which is a specific partnered *folk* dance, created a unique codified technique of its own (Flinn, 1995, p. 62). This style inevitably formed connections and commitment among multiple people (Flinn, 1995, p. 62). It allows individuals to feel as though they are involved in a community, which also incorporates spiritual aspects. Contra Dance is the connection of two people to the music, and to the specific *caller* or the *leading couple* (Horton, 2001, p. 205). The *caller*, or the *leading couple*, acts as the director of the entire room full of contra dancers (Tomé, 2012, p. 406). The steps are verbally stated by the caller, enabling the others in the room to be aware of the next step.

Contra Dance “acts to transform individual members into a ‘community’ or a ‘collective’” (Hast, 1994, p. 1). This dance style developed during a period of strict social stratification, therefore it was very unusual to see clusters of people from different social and economic groups engaging socially with one another. However, Contra Dance was able to draw a significant variety of people such as the Spanish, the French, and the English settlers into one dance space, leading to interaction among all (Tomé, 2012, p. 405). America’s “melting pot,” served to form a multicultural style of dance that no one had created before.

Contra Dance allows for greater interpersonal connectivity than what is generally observed in everyday interactions between individuals. In many ways, Contra Dance forms connections between people and ties them together, similarly to religion (Flinn, 1995, p. 62). In addition, it solidifies individual values. For example, Contra Dance emphasizes interpersonal and intrapersonal connection, which encourages the development of social awareness, in that it provides people with the opportunity to notice that they are not the only person in existence; others surround them as well. Selfishness is left behind, allowing people to learn everyone is invaluable in this dance (Flinn, 1995, p. 62). Equality is heavily emphasized and embedded into

people's minds and bodies through Contra Dance.

In Contra Dance, connections between dancers are intimate, which can make the dance feel more complex than the dance truly is (Flinn, 1995, p. 64). In addition, Contra Dance requires a large number of people, which makes the space limited and congested. The dancers can feel overwhelmed by the congestion and experience the dance as difficult. However, in reality Contra Dance is easy and enjoyable due to the simplicity of the steps. The simplicity of the movements and the fact that there are not many steps involved makes this dance accessible to anyone interested in learning it (Flinn, 1995, p. 64).

As these dances were held in public settings, community centers, church halls, and schools, the dancers wanted to decorate the space to express their ownership (Horton, 2001, pp. 203-204). Eventually, the dancers made quilts to hang on the walls enabling them to feel comfortable in the space. These quilts became a symbolic portion of Contra Dance. The handmade quilts served a "connective" purpose creating something individually as well as within a community (Horton, 2001, p. 208). When the dancers created these quilts, it provided a more personal effect on both the Contra Dance itself and the dancers involved in the dance (Horton, 2001, p. 209).

Another element of Contra Dance is its in-depth spiritual side, which enables dancers to become spiritually connected during the dance. The dance begins with people moving down the line. As the groups of people become larger, the entire Contra Dance community must move in synchrony with one another (Flinn, 1995, p. 64). Within Contra Dance, there is free and bound flowing movements, which allows the dancer to feel in sync with the music through the constant beat (Flinn, 1995, p. 64). The flow of the movements creates a sense of strong "mutual energy." Flow also allows each dancer to become completely rooted in the movement and sense "total

involvement” (Flinn, 1995, p. 64).

In a Contra Dance every dancer is connected to the group. This is specifically a group and partner dance. Each person is placed with another person, forming a pair. The pair is then incorporated within multiple pairs to create a group (Flinn, 1995, p. 64). Contra Dance’s focus is the entire group. Even though each person is paired with another, the focal point is not on each pair of partners, it’s on the entire group as a whole (Flinn, 1995, p. 64). Contra Dance is a powerful experience for everyone: the dancers, as well as the people observing and not dancing. Contra Dance allow two people to connect not just mentally but physically (Flinn, 1995, p.65). Physical touch, eye contact, and the synchronicity of movements create a connection among the people dancing (Flinn, 1995, p.65). Unlike many other dance forms and styles, the use of touch is allowed, encouraged, and required within this dance form.

Relying on others within this dance is a key piece of the dance. Contra Dance places an emphasis on partnering, which can be difficult for many people. It is important to take into consideration and recognize individual boundaries during this particular dance. Since the sense of touch is intensely important, it is vital for each member to be aware that touch of hands, feet on the floor, and other body parts are crucial in this style of dance (Hast, 1994, p. 109). The distance of the touch can range depending on the person. Partners can extend their proximity or create a very close interaction depending on their comfort with touch (Hast, 1994, p. 109).

Each and every individual involved in Contra Dance states that they are immersed in a community. In fact, they (the dancers) “create the community” (Dart & Rothman, 1997, p. 204). They use the term, “dance community,” or, “contra community,” to describe who they are (Hast, 1994). This word, “community,” is a valid and vital term to use for Contra Dance groups because it means more than just a group of people meeting together and dancing. Tradition, power, and

solidarity are emphasized within Contra Dance and its dancers (Horton, 2001, p. 204). “The community is composed of active participants who share experiences and vocabulary, some of whom facilitate the dance-callers and musicians, most of whom can’t or don’t try to earn a living at it and the majority who dance” (Hast, 1994, p. 106).

The people who dance the Contra Dance style consider the form a leisurely activity for a variety of reasons (Hast, 1994, p. 107). One reason is that Contra Dance provides both psychological and physiological pleasure. It also provides educational and aesthetic satisfaction (Hast, 1994, p. 107). A sense of freedom, transcendence, challenge, involvement, knowledge gain, stress-relief, exercise, and enjoyment are aspects embedded in Contra Dance that keep all members coming back for more (Hast, 1994, p. 107).

Contra Dance has been spreading worldwide and encourages outsiders to become knowledgeable as well. Since it is a very open dance form, Contra Dance allows anyone, from beginners to advanced dancers, to become involved in both the practices and performances. The fast pace movement made by one’s body creates direct and quick motions. Due to the fact that the movements are easy and repetitive, many people can do and enjoy Contra Dance. Additionally, the dance can be adjusted for those who are mentally or physically disabled, allowing them to participate and contribute to the experience.

The tradition of Contra Dancing has been well established with specific aspects defining the dance as “good fun” (Harris, Pittman, Waller, & Dark, 2000, p. 181). Contra Dance’s main goals are to promote positive results: a sense of community, of being, of identity, and just simply having fun (Hast, 1994, p. 1). For these reasons, it is understandable that Contra Dancing is still currently active in the 21st century with even more vitality than ever. It is also understandable

why the use of this style of dance within a dance/movement therapy group session can be beneficial to those lacking skills in intrapersonal/interpersonal and community relationships.

Contra Dance and Dance/Movement Therapy

Contra Dance can create positive outcomes when implemented into group DMT sessions. The involvement of multiple individuals enforces the “community” element, which (as stated previously) is prominent in the Contra Dance form. The action of moving together allows for interaction among children with ASD, which further assists in helping them become aware of self and other. Providing clear, structured, repetitive movements also engages and entices the children. In addition, the structure and repetition expand the participants’ ability to sustain their attention for a longer period of time.

Since Contra Dance is rooted in specific movements and steps, incorporating individualized interpretations of the steps within DMT sessions and naming these steps is beneficial when working with an ASD population. This can bring awareness to each child’s way of moving and allow others in the group to “try-on” each other’s movements. Individualization is an important aspect of therapy because it enforces attention to self and other. *Self* can be defined as the creation of the movements, and *other* as the interpretation of the movement in each child’s body. Finding a connection with other human bodies is also intertwined in this style of dance, which increases interpersonal relationships by connecting with others mentally, physically, cognitively, socially, and emotionally (Tomé, 2012).

Several initial sessions should be devoted to teaching the steps of Contra Dance. Introducing steps gradually will reduce anxiety and further differentiate DMT from a dance

class. Once steps are introduced and established as a ritual of the sessions, the therapist can then introduce the role of the *caller*.

The *caller* of Contra Dance provides the opportunity for children to take turns controlling the movements of the group based on their own actions. They have the opportunity to become creative by moving in ways they enjoy and empowered to expand their movement repertoire. The *caller*, when introducing partnering into the practice, can enforce social interactions. However, particularly for children on the autism spectrum, touch may or may not be appropriate, thus the partnering aspect may not be beneficial. Therapists should keep this in mind when determining whether or not this role can be introduced. Additionally, it is important to consider the overall comfort of the group as well as the specific participants' needs.

Implementing Contra Dance into DMT Sessions

Creating a group DMT intervention while incorporating Contra Dance for children on the autism spectrum is a task that will take time. Beginning each session with a clear ritualistic opening is vital. Children on the autism spectrum often have difficulties with change (Block, Block & Halliday, 2006). Maintaining consistency and minimizing change in the first few sessions will eliminate any drastic outbursts or *meltdowns*. Beginning with the Chacian circle invites everyone to notice one another as well as establish a community from the start. The use of a stretch band can be used at this time to create a clear boundary for these children, enabling them to become connected with the group through the presence and physical touch of the stretch band. This boundary, which the prop creates for the children, enables the participants to remain focused on the movement. During the first few sessions, finding a connection with self should be encouraged. It is important for individuals to seek connections with the self before finding

connections with others around them.

Within a DMT session, Contra Dance is introduced by the sound of music. The music should be chosen particularly for the group as well as an introduction to this dance form. The music played can introduce Contra Dance without addressing the therapist's intention, group intention, and possible goals. Moving in and out of the circle occurs as the session progresses and use of the stretch band eventually diminishes due to the children's focus on the movement by simply dropping the band on the ground toward the middle and end of the 45-60 minute time frame.

As intrapersonal relationships are established, minimal initiation of interpersonal relationship will be encouraged through mirroring with peers as well as with the dance/movement therapist. Small portions of Contra Dance will be introduced throughout these sessions. The therapist will choose Contra Dance movements that they feel the children can handle and benefit from. These movements should be taught indirectly to the children, one by one, through games that the therapist provides – for example: “huggie bear” and “passing the beanbag.” Once the children demonstrate their comfort with the use of peer interaction (touch) the therapist should strive to combine the many Contra Dance movements the participants have learned with multiple peers. Throughout, the therapist will need to identify distinct goals, consisting of: increasing the children's awareness of self and other, forming a community in the group, finding positive relationships, and creating commitment to themselves and others during the group DMT sessions. These goals will be reinforced by the intrapersonal and interpersonal relationships established in Contra Dance.

Case Study

During the summer of 2015, I tested the benefits of Contra Dance in group dance/movement therapy sessions with children on the autism spectrum. These sessions were implemented into a group enrolled in a program at a Long Island day camp in Huntington, New York. This group consisted of eleven children, five- to eight-years old, who were diagnosed as high functioning on the autism spectrum. The sessions ranged from 45 minutes to an hour, once a week for eight consecutive weeks. The primary goal for the group was to increase intrapersonal and interpersonal relationships among the participants. The secondary goals were to develop the ability to notice self and other, find connections, and form a community within both the group DMT sessions and the rest of the children's general camp interactions. I developed a checklist of goals to establish and keep track of both individual and group progress each week. The checklist also allowed me to detect whether or not Contra Dance was a dependable contribution to group DMT sessions (see Table 2).

The first session was an important one in which I had planned to follow William Schwartz's model, called the mutual-aid model (Steinberg, 2014). I made sure to keep in mind that this particular group of participants may or may not be the same or even similar to other groups seen throughout the day. It was vital to begin the group with a clear introduction and identify my role and the children's role in the group. A Chacian circle was formed from the start, and each child received an individual welcome. After this introduction, I turned on the music, which had a constant beat and rhythm. The song chosen had a beat similar to that of Contra Dance music, which is counted in fours (4/4 time) (Ravitz, 2002). The group's main focus for this initial session was being present, eliminating meltdowns, and noticing one another. The use

Table 2

Goals for the Children in the Comanche B Dance/Movement Therapy Group

- Demonstrates ability to sustain concentration throughout the entire session (30-40 minutes)
- Notices the importance of self and other within the group
- Demonstrates ability to self- regulate when tense or upset
- Accepts unexpected change or change within session(s)
- Uses appropriate attention seeking behaviors
- Actively resolves conflicts with peers
- Seeks connection with partner and/or group
- Compliant with rules and therapist expectations
- Demonstrates ability to form commitment to self and other
- Demonstrates ability to experience a sense of community with the group
- Notices difference and importance of intrapersonal relationship and interpersonal relationship through Contra Dance steps

Note: Each session, participants were evaluated on their progress achieving each goal using a rating scale (minimal, emerging, in evidence, practiced often, always evident, not applicable).

of the stretch band allowed the children to be present and notice those around them. By being present and noticing those around them the children were less likely to have meltdowns.

The second session had the group begin to learn what personal space is. Personal space was referred to as each child's "space bubble," enabling the children to move far enough away from their peers to experience their individual kinesphere. The children were asked to extend their arms as far as they could, enabling them to be certain they had enough room. Imagery emerged through the movement, and I encouraged the children to notice and consider the imagery as the "golden thread." The first image a child gave was that of an airplane. With the help of the group, I led the children through a short story about where they were going, what color their airplane was, how large their airplane was, and how fast or slow they were going.

As soon as the children displayed their competence that they physically and mentally understood what their own personal space meant within the larger context of the room, we proceeded to begin taking space away. A large parachute was used to limit the space in which the children could move. During this activity, they were asked to place their arms at their sides and to manipulate the parachute through the space remaining in their kinesphere. As the children began to move, I was able to observe the participants' creativity with levels and time. The children used a variety of levels and eventually everyone made their way to the ground. Observing such a productive experience with "space bubbles" and their competency in knowing their own kinesphere, I felt it was time to introduce peer interaction.

Peer interaction was introduced through the game "huggie bear." This game is a movement game, which allows for one child to be the *caller*. The *caller* has the responsibility to call out a number of his/her choosing. Once this number is chosen and stated by the *caller*, the children have to form groups of that number. Whoever is left without a group then joins the *caller*. When

there are multiple *callers* each child receives a turn calling out the number. During this session I observed that the game was difficult for the participants, as many of them were so internally focused it was extremely challenging for them to connect to others. However, with multiple repetitions, the children were able to find verbal and physical connections with those around them. Also, being the *caller* allowed each child to demonstrate a focused commitment to the group. Soft Contra Dance music was played during the game but was not specifically addressed.

After the “huggie bear” movement game came to a close, I re-grouped the children into a circle. A short discussion of what the difference between one’s own “space-bubble” and what connection is occurred during this time. The conclusion was that general space contributes to the difference between these two forms of connection: intrapersonal and interpersonal. Finally, the breathing techniques (deep three-dimensional breathing) were explored and became a ritual that ended each subsequent session.

I created a rough outline for myself to assist in guiding the group, however, the outline was not as flexible or conducive to modification as I initially had intended. The children had difficulty following my structure transitioning from the large Chacian circle to smaller pairs of two. I held a meeting with my helpers, which concluded that the use of any group-connecting prop (stretch band, octaband, or parachute) in the circle made the children too excited and led to an overload of stimulation. It was not until week four that I truly noticed the campers’ needs before imposing my own intentions and desired outcomes. During the following session, the use of a basketball to form the movement group and create the “community-like” effect (the therapist’s original intention) occurred immediately. When the children were asked to move into pairs they were able to do so without distraction. When I reflected back on the fourth session, while brainstorming for the next session, I asked myself these crucial questions: “With whom

was I doing movement?” “Who was I in service to?” “I have goals, but how can these children reach them through a process and session modified for how they are specifically on that particular day?” (Ellis, 2015). These questions allowed me to recognize that starting off the beginning of the sessions in a large group was not to the benefit of the children, but rather for the benefit of my own satisfaction by following the guideline, whether or not it was advantageous for the participants. This had to change, and it had to change immediately!

For the next session, I decided to change some aspects of the structure in order to better serve the needs of the children. I walked into the large space with an extremely loosely written guideline, which allowed for the “here and now” in the present aspects of therapy to take over if necessary. This did not mean that I threw away all of my previous planning or objectives, because they did get me to where I was currently, but it was a step in the right direction.

This session began in two parallel lines; each child had a partner for the beginning short game of tossing a beanbag back and forth. Each time a child dropped the beanbag, the two groups had to move toward one another. The game was sustained until the entire right group was an arms distance away from the left group. In this first part of the session the children were able to form a “community-like” environment without the typical Chacian circle. Instead, it was key to make sure everyone was catching the beanbag, focusing on their partner as well as the other pairings. Establishing eye contact, sustaining attention, and demonstrating the ability to self-regulate when missing catching the beanbag were crucial goals to be observed during that time. Once tossing the beanbag had lasted a few rounds, the beanbags were removed and only the children's bodies were used.

Inevitably, the children learned two Contra Dance steps: Do-si-do and Seesaw. The Do-si-do involves two dancers standing and facing each other, slightly stepping the left foot forward,

passing each other on the right shoulder, sliding back-to-back, passing each other on the left shoulder, and ending facing each other (in their starting position). The passing of the beanbag back and forth until the beanbag is dropped, mimics the movement pattern of Do-si-do. The focus is for the participants to create and sustain eye contact throughout the tossing of the beanbag, while also noticing the switching of sides, initiated by moving past their partner on their right shoulder, sliding to the right, stepping back and sliding to the left, and ending facing their partner again. Because the seesaw is a left shoulder Do-si-do, many of the children learned this step simply by switching the side on which they passed their partner. It took time to differentiate these steps but the movement was ultimately achieved, along with solidifying a commitment to their partner, establishing eye contact, noticing their partner's body, their own body, and the other bodies surrounding them. These steps were repeated multiple times during the session, inviting the children to continue to explore their bodies in relation to their partners and the other couples. This session was unforgettable in that it allowed me to truly understand the meaning of authenticity and staying in service to my clients. The previous sessions were also invaluable in that they enabled the children and helpers to attune to one another.

The following week, the group built on the themes of the previous week. Forming two parallel lines again, the session began with the children sitting on the floor focusing solely on their breath. After the breathing techniques were finished and the group felt cohesive in that particular moment, two children began to mirror one another, not knowing the importance of mirroring. Observing the children's movements, I decided to take this aspect of mirroring and incorporate it into the warm up. The mirroring exercise occurred for fifteen minutes while the participants were all in a standing position. One child then stated: "Look, Ms. Ellis, we practiced what we learned last week" (D. L, Personal Conversation, 2015). The two children maintained

connection with each other and themselves by remaining in their own individual kinesphere and their couple's kinesphere, while completing the Do-si-do and Seesaw. Eye contact was present and the other children followed their lead and completed the same series of movements with their partners. At that point I determined they were ready to progress to the next level.

After the exploration of these two steps, one couple asked if they could join hands. Assessing the feeling of the room, the helpers, and most importantly the children, I asked if they were ready to incorporate touch into their movement. After a collective agreement, the Allemande was introduced. The Allemande requires one partner to grab the other partner's hand. Both partners grab the same hand (either both of their right hands or both of their left hands). Once hands are joined they are invited to firmly but comfortably bend the joining arm. Even though this step can turn one full turn, half-turn, or one and one-half turns, I decided to simplify it by creating a 180 degree turn (half turn). I encouraged slow turning in an effort to make sure that no one was endangering themselves or their partner. The children were also reminded to remain in their couple's kinesphere, inviting the turn to be "slow and steady." This portion of the session was more difficult and slow to establish due to the complexity of the connection required in this step. After repeating this step, the children were asked to move back into their two lines facing their partners. The children quickly moved into the lines and joined hands. The Balance, which is when each partner faces each other, was followed by the joining of the partners' two hands, and the movement of steps forward on his or her right foot and then back on his or her left foot. For the purpose of this group and maintaining focus, the accuracy of the "right" and "left" steps was not important. The importance for this step was for the children to find connection through eye contact and physical hand connection, as well as to be able to move closer and further away from their partner, while still remaining in their own personal "space bubble."

The middle portion of this DMT session was similar to the beginning because the children remained in pairs. However, during this time, the incorporation of Contra sound as well as Contra Dance steps was reintroduced. The sound was used as a catalyst for the children to move/dance and the silence an indication of when they should freeze. The helpers and I, who played the role of the *caller*, called out the steps. The introduction of the steps was more easily accomplished during this session, due to the fact that the transition from the first portion of the session to the middle portion of the session was fluid, rather than jerky and unorganized. After the four chosen steps were called by the *caller* and displayed by the children, the *caller* decided to call out "dance party." This call dispersed each pair into the group, creating many different types of movements. Some children decided to stay with the steps that they had learned, adding their own creativity and individuality to their steps. Others decided to create new steps and movements that the children had never seen prior to this session. All types of movements were invited at this time and appreciated. It was clear from observing the children that they began to borrow ideas from their friends and shared different movements that they particularly enjoyed and considered as "their favorite." This "dance party" eventually resolved and the entire group ended in a circle, where the ending portion of the session took place. The group's ritual breathing techniques and gentle hand squeezes were the closure for the fifth session.

The second to last session, was set to create quilts. The campers were to cutout pictures and words that represented who they were and their specific backgrounds, cultures, religions, and favorite objects and then paste them on a piece of paper. This activity was created with the flexibility to change if it did not seem suitable for the children. When discussing this plan to the helpers, a sense of apprehension arose around whether or not the activity would succeed or fail. Explaining that nothing is ever a failure, but is instead the most important learning tool a child

can experience, eased the helpers' emotions. I further stated that trusting the unknown and seeing what happens is a gift, which allows for change. However, going into the session I became apprehensive due to the nervousness of the helpers. Trying to eliminate these thoughts and focus solely on authenticity and the present moment was imperative and in the foreground of my mind.

This session looked similar to the prior two DMT sessions. Beginning in pairs, moving into Contra Dance movements and concepts, the children began to become aware of what was around them (both objects and other human beings). One child asked: "What are those art things in your bag?" (A .F, Personal Conversation, 2015). That is when the art project began. Luckily, I did not have to introduce the project. It appeared as if the children recognized that I had a different bag and sensed that something was about to change, which is a common observation made by those diagnosed with High-Functioning Autism (HFA) (Barid, Cass, & Slonims, 2003). Paper, scissors, glue, and cutouts of magazine pictures and words were used to create the quilt. Each child created a paper montage, which represented the patches of a quilt. The presence of the paper montages in the room allowed the children to take ownership of the movement space and invite their true selves to inhabit the space.

Unlike a typical Contra Dance class, this specific group's movement session did not end with a performance. This is because the focus was solely on the concepts of the steps and how they affect high functioning children on the autism spectrum, rather than perfecting and performing the Contra Dance. Focusing on the concepts of Contra Dance helped eliminate any confusion about whether or not this form of dance would be useful for therapy.

There were many aspects of the session that went well and other portions that could have been changed to enhance the process of achieving the identified goals. My "role" as the dance/movement therapist in this particular group was difficult to form and establish, due to the

fact that I was not only their Movement Specialist but also mainly their Group Leader. My Group Leader role did interrupt the movement sessions when a child needed my undivided individual attention. In those instances, I had to remove myself from the group and focus solely on that specific child. This interruption could have been avoided if I was not both their Movement Specialist and Group Leader. Embodying these two roles confused the children as well. Children on the autism spectrum, specifically High-Functioning Autism, have difficulties with change (Block, Block & Halliday, 2006; Drezner, 2010). Moving back and forth between roles did confuse many of the children, and thus, they were unable to obey my rules in the Movement Group. Had the rules and roles been consistent throughout, the children's confusion could have been avoided.

Another adjustment that might improve the outcome of the DMT group would be the location of the sessions, which occurred in a large outdoor space in the middle of the camp. Other activities were going on around the group, and the participants' focus on the task at hand was made more difficult than if the session was held in a more intimate enclosed space. As stated earlier, children on the spectrum have a difficult time sustaining attention for long period of time. Thus, having the session where the participants could be easily distracted was not ideal.

A last consideration is the frequency of the DMT sessions. Having only eight weeks of DMT sessions once a week made it difficult to implement all the elements that had been planned. Although the majority of the children were present for the full eight weeks, there were some sessions that children were absent. This did change the group dynamics and also had an effect on the absent children's outcomes.

Conclusion

There is no single cause of autism, which only makes it all the more crucial to notice and understand that there is no single therapeutic process to reduce symptoms for this disorder (Drezner, 2011). In view of the many studies focused on the effects of dance/movement therapy on populations with autism, it is important to be receptive to new possibilities and finding creative ways to enrich the practice of DMT groups and further benefit children and adults with ASD. Commitment to others, sense of community, social relationships and interaction, and the ability to notice one's own self-worth and body, are all aspects children on the autism spectrum lack on a daily basis (Notbohm). These four topics are, however, present in Contra Dance (McGarry & Russo, 2011). Through the presented study, it can be discerned that Contra Dance can offer a valuable contribution to the practice of dance/movement therapy.

“Every child, every adult, everybody wants what I call the three A's: affection, acceptance, and approval. If the child has that, regardless of his IQ or anything else, he will be all right” (Feinstein, 2010, p. 10). Toward the end of the summer, Alex experienced another meltdown. This situation was different than the previous one because he did not have to be restrained. Alex was on the main field of the campgrounds where the soccer games usually took place. However, in this scenario, the entire camp was participating in an “end of the summer” dance party. There was a DJ, party motivators, and many different groups, who varied in both age and level of functioning. It was congested, loud, and hot but Alex was independently dancing to the music along with children in his group as well as children not in his group. When dancing, like in the movement sessions, his self-stimulating behaviors reduced and he was able to concentrate on himself and those around him.

After a few minutes, Alex's eyes started to tear up and he began to cry. Alex immediately

stopped dancing. The self-soothing repetitive slapping of his right palm to his forehead occurred but not as consistently as it had in the past. When I walked over to him he ran away. Instead of running after him I let him go. I knew he was not a danger to himself or others; he just needed to breathe and be removed from the interaction and stimulation.

After a moment, I decided to take a look in the enclosed white room where the staff takes children when they need to be or are already restrained. There he was. Alex was sitting in the corner of the room with his face down in between his legs, sobbing. Alex's *stim* occurred less and less as he caught his breath and incorporated the breathing techniques we worked on over the past eight weeks. As Alex was one of the participants in my DMT group, I had observed that he was able to incorporate many of the techniques he learned throughout this summer during his camp day and life in general.

I moved my way over to Alex, sat next to him and mirrored his body attitude. He noticed me and I noticed him. This was the first time we were alone since the earlier more dangerous situation. I watched as he reached out in my direction, I in turn reached over to hold his hand. Alex said: "I am upset because camp is over. I am upset because I have friends here and I do not have friends at school. I am upset because I will miss you."

Alex was usually not expressive when speaking with others. He had the capability to talk but did not use his words as often as he used his hands and legs for kicking and hitting others and himself. The majority of the time, he was dangerous to others and had little to no positive connection with children his own age. Whether it was the movement group, or a combination of the group and the staff members' engagement with Alex, his ability to form connections and relationships had clearly grown. He was able to play with other children and genuinely form friendships.

The symptoms of the repetitive hitting of his right hand to his forehead and the emotional meltdowns did not completely disappear. However, it is evident and entirely encouraging that his symptoms were reduced over the course of working with him. Alex's improvement further encourages me that my focus on each individual child's needs instead of the diagnosis is the correct path to follow. Focusing on the child and basing therapy around his or her specific needs will ultimately allow for positive changes and results.

After the moment that Alex and I shared, I went home and began to reflect on what had happened over the past eight weeks and why this scenario occurred the way it did. Recognizing that I had the ability to help change these children and family members' lives in just eight weeks, enable them to feel "wanted" and a part of the world, made me want to share and empower others to search for new tools and creative practices to implement into DMT sessions. My hope is that this case study and analysis will inspire further research that will benefit children on the autism spectrum.

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