ADTA 2016 Member Survey and Practice Analysis

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Preface

The American Dance Therapy Association (ADTA) Practice Analysis was named by the Board of Directors as a Vision 2016 strategic project. We hope that this first full practice analysis conducted by the ADTA is useful to professional dance/movement therapists who are making decisions about their own careers, advocating for new positions and for those in the society who can benefit from dance/movement therapy services, educating new dance/movement therapists, or conducting research. The ADTA intends to repeat the practice analysis on a periodic basis, and the project team for this Vision 2016 project has submitted recommendations to the ADTA board to inform the next practice analysis by the ADTA.

This survey is divided into three sections: A. Member Survey, B. Practice Analysis, and C. Supervision. Survey results are shown primarily in terms of frequencies and descriptive statistics. In some graphic representations, raw numbers are given along with percentages (i.e. #,%). Relationships between selected variables are also shown in the report.

Methodology

- The survey was designed using examples from several other practice analysis surveys of related disciplines. A first draft of the survey was distributed to the ADTA Board of Directors and the Dance/Movement Therapy Certification Board (DMTCB) in the Fall of 2015 for review and input. Revisions were made and a final version of the survey was ready for launch in the spring of 2016.
- The survey was sent to 1019 people and recorded responses from 266, a 26% response rate. A total of 266 (265 web surveys and 1 manual entry) responses were collected from July 25, 2016 to August 22, 2016. A final survey question: "Would you like to be added to the lottery?" was a mandatory question and was included in order to screen out duplicate or incomplete responses. The lottery was for a free one year membership to the ADTA.
- The survey was sent to all professional members of the ADTA and to all those with active credentials with the DMTCB (the R-DMT or the BC-DMT). The rationale for this choice was that the survey was intended to describe current practice.
- The ADTA membership was informed of the practice analysis survey in several ways: (1) a brief announcement in the 2015 Business Meeting; (2) a newsletter piece in the spring of 2016; (3) three e-blasts to those who would receive the survey link. The survey was delivered using the SurveyMonkey program. The survey was kept open for four weeks in the summer of 2016.
- A dedicated e-mail helpline for technical assistance to respondents was created and provided in the survey. Several people took advantage of this assistance during the data collection phase.

The Board of Directors of the ADTA wishes to thank the following members of the project team for this Vision 2016 project: Sherry Goodill, Karolina Bryl, Adele Gonzaga, Leslie Armenoix, Gloria Farrow, Yvette Hinson and Renee Wolf. We appreciate your commitment to dance/movement therapy and thank you for this important contribution and resource for our membership.

Jody Wager, MS, BC-DMT
President
American Dance Therapy Association

A. Member Survey

Demographic information

ADTA survey respondents' ages clustered around the 30-39 years cluster, and the 60-69 years cluster. Respondents were predominantly female and white. Figures 1 through 3 provide a summary of ADTA survey respondents' age, gender, and ethnicity.

Figure 1. Age of respondents

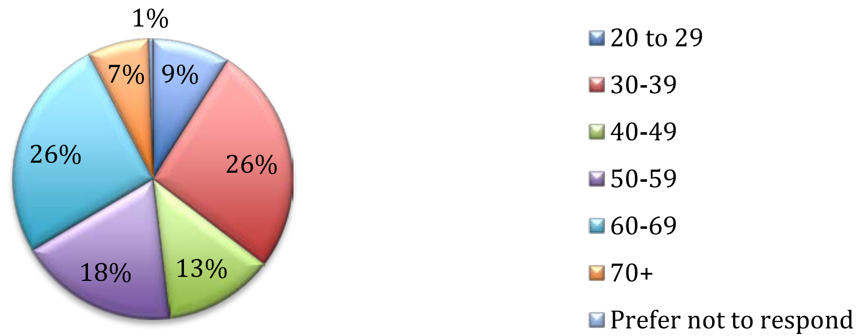


Figure 2. Gender

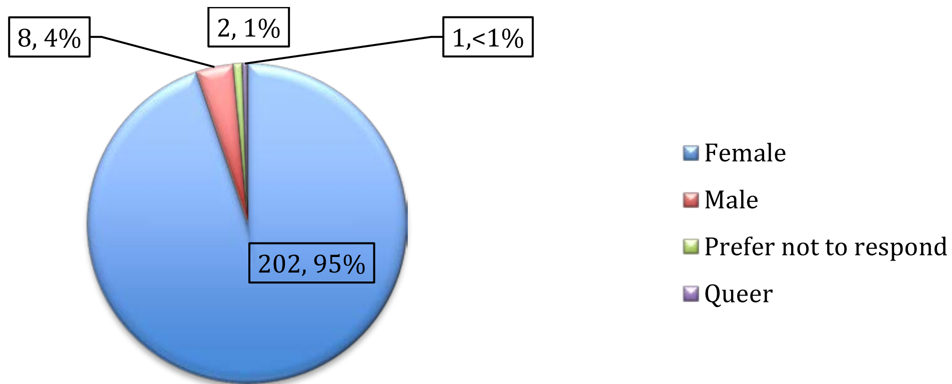


Table 1. Respondents' reported ethnicity

	N	Percent
White / Caucasian (non-Hispanic)	178	83.6
Asian / Asian American	8	3.8
Multiracial/Biracial/Blended	8	3.8
Prefer not to answer	7	3.3
African American/Black (non-Hispanic)	6	2.8
Hispanic or Latino	4	1.9
Pacific Islander	1	0.5
Jewish	1	0.5
Total	213	100

Dance/Movement Therapy education

Respondents were asked to share about their education and training. A majority of respondents hold a Master's degree in DMT education (88%), and received their degree from a US College or University (87%). Figures 3 and 4 provide more information on the highest level of DMT education and training.

Figure 3. Highest level of DMT education

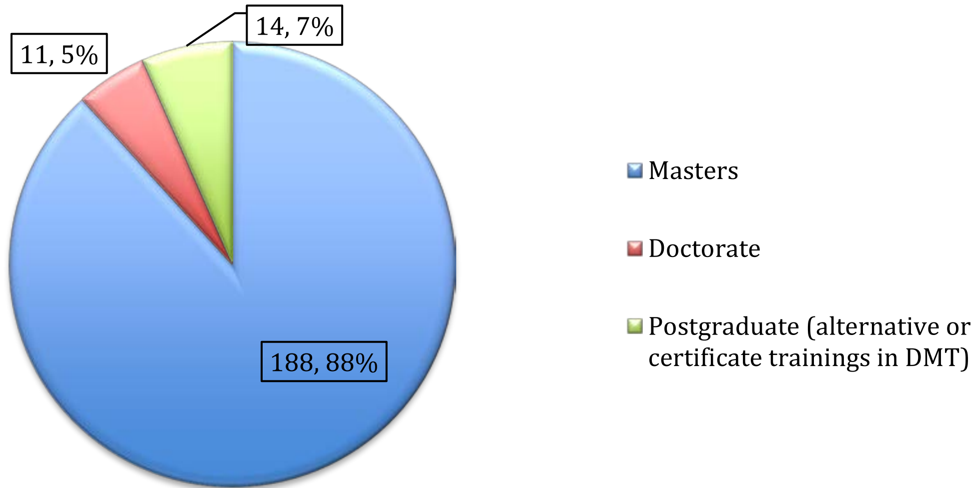
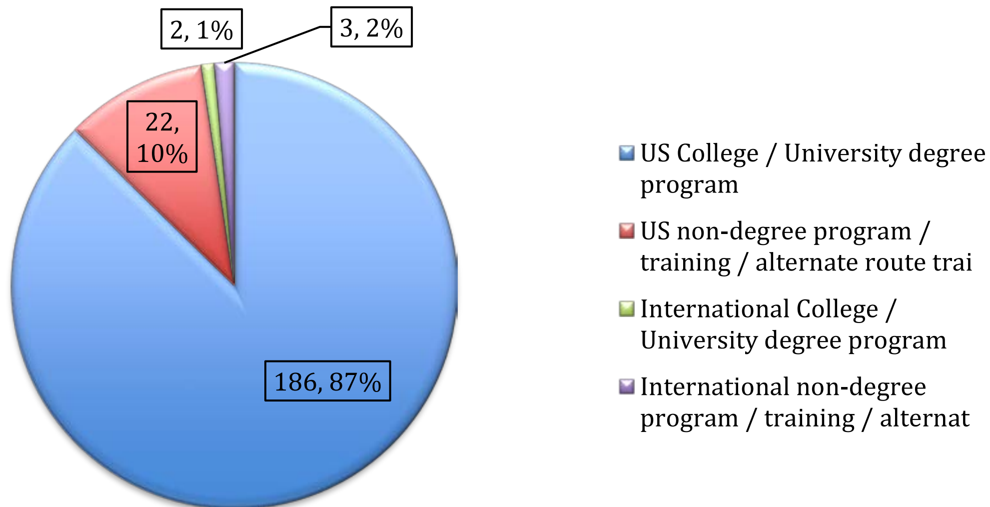


Figure 4. DMT training institution



The top three training institutions where respondents received their training were *Antioch University*, *Columbia College of Chicago*, and *Drexel University (formerly Hahnemann).*

Table 2. DMT training institution

Institution	N	Percent
Antioch University	37	17.4
CCC/Columbia College of Chicago	32	15
Drexel University (former Hahnemann University)	28	13.1
Hunter College	17	8
Lesley University	16	7.5
Pratt Institute	11	5.2
NYU	11	5.2
Naropa University	10	4.7
UCLA	7	3.3
Goucher College	6	2.8
California State University	3	1.4
JFK	2	0.9
Goddard	2	0.9
Other (please specify)	6	3.0
No Response	25	11.7
Totals	213	100

Other Responses included: pioneer DMT program, SLC, Lone Mountain College, Immaculate Heart, CUNY, Antioch West

Among the alternate DMT training programs, 8 indicated that they had been a part of pioneering training program. A complete list of alternate DMT training programs reported are found in Table 3.

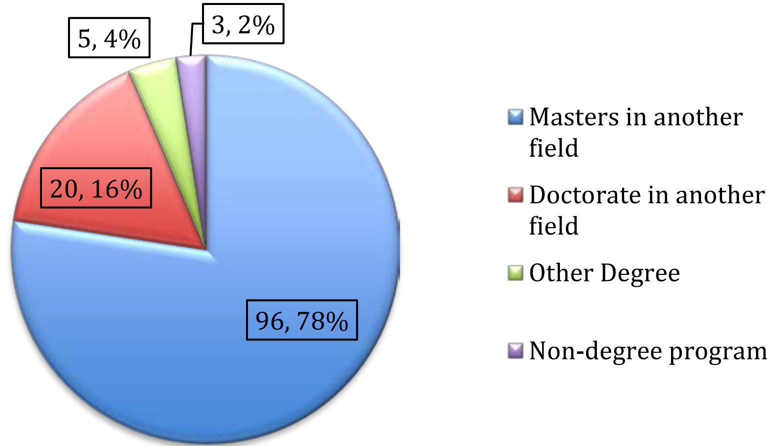
Table 3. Alternate DMT training programs: US & International Programs

Training program	N
Pioneer training programs/apprenticeships[1]	8
Kinections	4
92nd St Y	2
Vermont College of the Union Institute	1
Various California DMT supervisors	1
Texas Beyond Words	1
Marylhurst College	1
Total	18

[1] Two respondents indicated that they were part of pioneer DMT programs; six respondents listed the following dance therapy trainers: Marian Chace, Rhoda Winter Ellis; Blanche Evan, Mary Whitehouse; Lillian Espynak, Alma Hawkins, Elizabeth Polk, Trudy Schoop, Valerie Hunt, Irmgard Bartenieff

Excluding their degree in Dance/Movement Therapy, 78% (n=96) of respondents held a second master's degree, and 16% (n=20) held a doctorate in another field. See Figure 5 for the distribution of highest level of education completed.

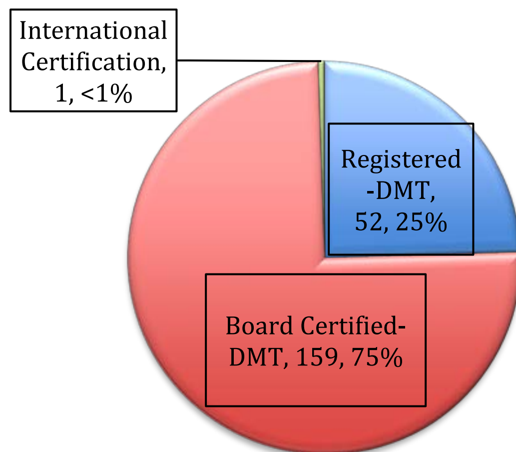
Figure 5. Highest level of education completed



Note: A complete list of degrees by level of education is available to ADTA members upon request to the ADTA national office.

Information regarding DMT certification can be found in Figure 6, with BC-DMT being most common certification held (75%).

Figure 6. DMT Certification (n=212)



Note: Student member refers to former professional members who are currently students.

In addition to their DMT certification, respondents hold 66 different certifications and licensures, with "National Certified Counselor" (n=43) being the most commonly held credential, closely followed by "Licensed Professional Counselor" (n=40). Table 1 lists credentials held by at least 2 respondents. A complete list of credentials is available to ADTA

members upon request to the ADTA national office. Thirty-five respondents did not list any credentials or licensure in addition to R-DMT or BC-DMT.

Table 4. Other credentials and/or type of licensure

Credential/Certification/Licensure	Respondents
National Certified Counselor, NCC	43
Licensed Professional Counselor, LPC	40
Licensed Creative Art Therapist, LCAT	26
Licensed Mental Health Counselor, LMHC	23
Licensed Clinical Professional Counselor, LCPC	20
Graduate Laban Certificate in Movement Analysis, GLCMA	16
Registered Yoga Teacher, RYT	15
Certified Movement Analyst, CMA	13
Licensed Professional Clinical Counselor, LPCC	8
Licensed Marriage and Family Therapist, LMFT	8
Psychologist - degree in psychology; MS, PhD, PsyD	8
Licensed Clinical Social Worker, LCSW	7
Licensed Clinical Mental Health Counselor, LCMHC	5
Licensed Independent Clinical Social Worker, LICSW	5
Licensed Massage Therapist, LMT or other state license title	5
Somatic Experiencing Practioner	5
Credentialed Alcoholism and Substance Abuse Counselor, CASAC	4
Certified Laban/Bartenieff Movement Analyst, CLMA	4
Registered Expressive Arts Therapist, REAT	3
Registered Addiction Specialist, RAS	3
Certified Group Psychotherapist, CGP	3
Kestenberg Movement Profile Certification	3
Clinical Supervisor	3
Body Mind Centering	3
Licensed Independent Social Worker, LISW	2
Licensed Psychoanalyst, LP or NCPsyA	2
Advance Practice Registered Nurse: APN, ARNPP, ARPN, and/or MHN	2
Registered Nurse, RN	2
Psychotherapist	2
Somatic Movement Practitioner	2
Professional Clinical Counseling Intern	2
Teaching License	2
Aquatic Therapy Rehab Institute Certificate	2
Certified Alcohol and Drug Abuse Counselor	2
Certified Substance Abuse Counselor	2
Licensed Professional Counselor - Provisional/Candidate	2

Note: More than 1 credential could be selected, thus responses will exceed the total number of survey respondents.

Dance/Movement Therapy Career Information

Respondents were asked to share information regarding their career as Dance/Movement Therapists. When asked to share the number of years they have been in full-time DMT practice, responses were highest for those with 21 years or more of experience (n=55) and 3-5 years of experience (n=35). Responses were a little more spread out for those who engaged in part-time DMT work: responses were highest for those with 21 years or more of experience (n=26). Figure 7 and 8 provide the breakdown of full-time and part-time DMT work.

Figure 7. Years in Full-time DMT work

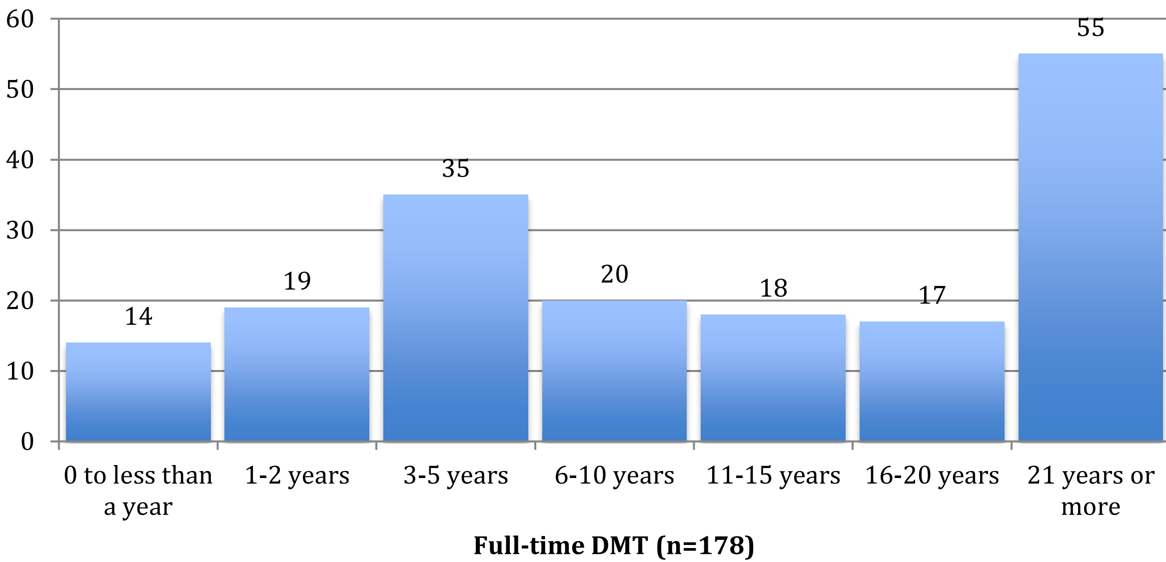
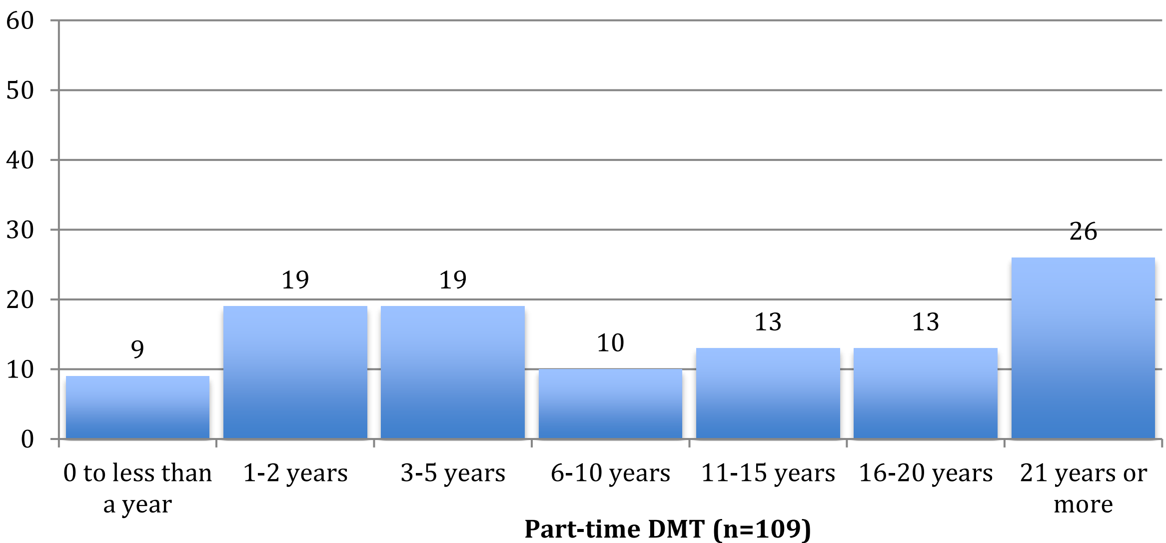


Figure 8. Years in Part-time DMT work



Respondents were also asked to share their current employment status for their Dance/Movement therapy work. The majority indicated that they were currently employed and working full-time (48%). A full list of employment status is found in table 5.

Table 5. Employment status

Status	N	Percent
Employed, working full-time	103	48.4
Employed, working part-time	75	35.2
Not employed, looking for work	9	4.2
Retired	5	2.3
Offer DMT services on an unpaid bases	3	1.4
Not employed, not looking for work	2	0.9
No Response	3	1.8
Other	13	6.1
Total	213	100

Other work includes: administration, not DMT; healthcare coordinator; independent contractor; not practicing DMT; Private practice; private practice and adjunct faculty; self-employed in self-created combined modality

Annual Salary as a Dance/Movement Therapist

Respondents were asked to indicate the salary range for their current work as DMT, and all DMT positions and roles. Annual salary ranges were then analyzed by years of experience as full-time and part-time Dance/Movement Therapists, work region, work locale, and advanced degrees. To prevent sample sizes from getting too small, variables were combined and results were adjusted accordingly.

As can be seen in Figure 10, salaries were clustered around the $50,000 - $79,999 range, and $30,000 to $49,999 range. When distributed across full and part-time work status, full time respondents' salaries clustered around the $50,000 - $79,999, and $30,000 to $49,999 range. For part-time respondents, numbers were evenly distributed, although the number of respondents per salary range decreased as salary range increased (Figure 11).

Figure 9. Annual Salary for DMT work

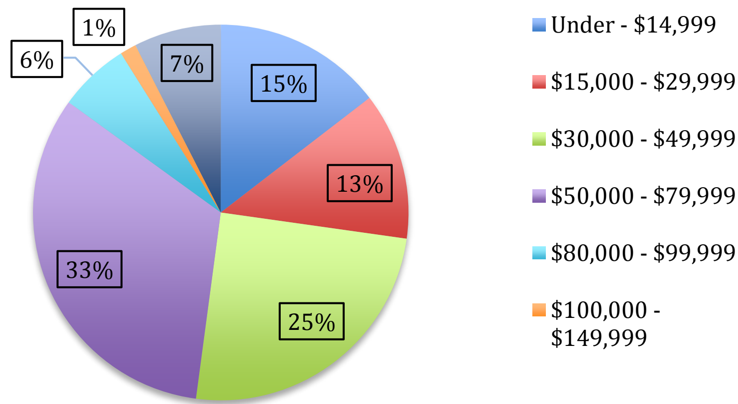
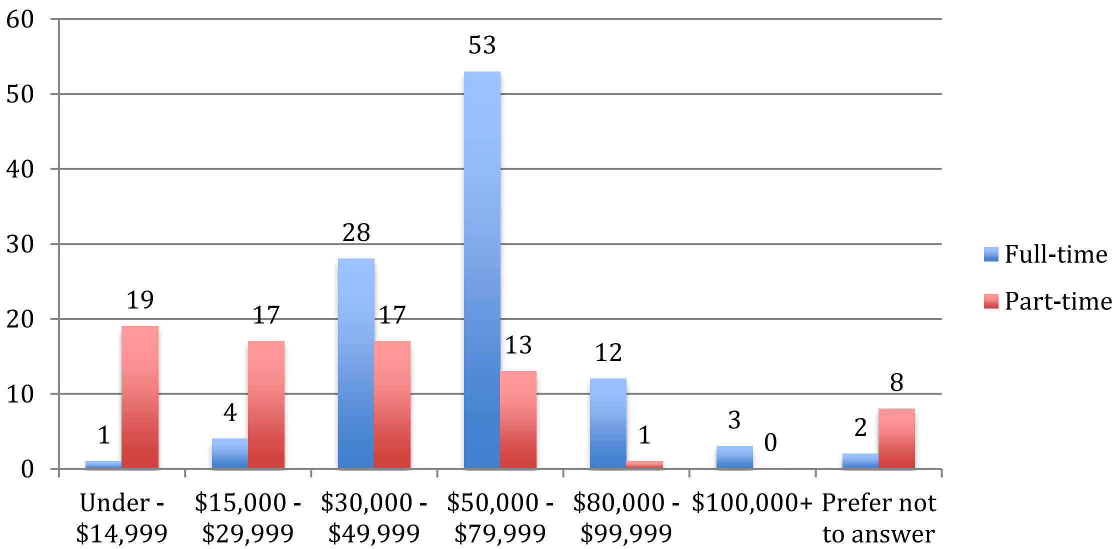


Figure 10. Total annual salary by current DMT full-time and part-time status



Note: Full-time DMT work respondents: 103, Part-time DMT work respondents: 75

Respondents with more years of experience reported higher annual salaries and respondents with over 16 years in full-time DMT practice earned more than all other groups. Salaries varied more among those in part-time DMT practice. The figures that follow provide a breakdown of annual salary by full-time and part-time DMT practice.

Figure 11. Annual salary by years in full-time DMT practice

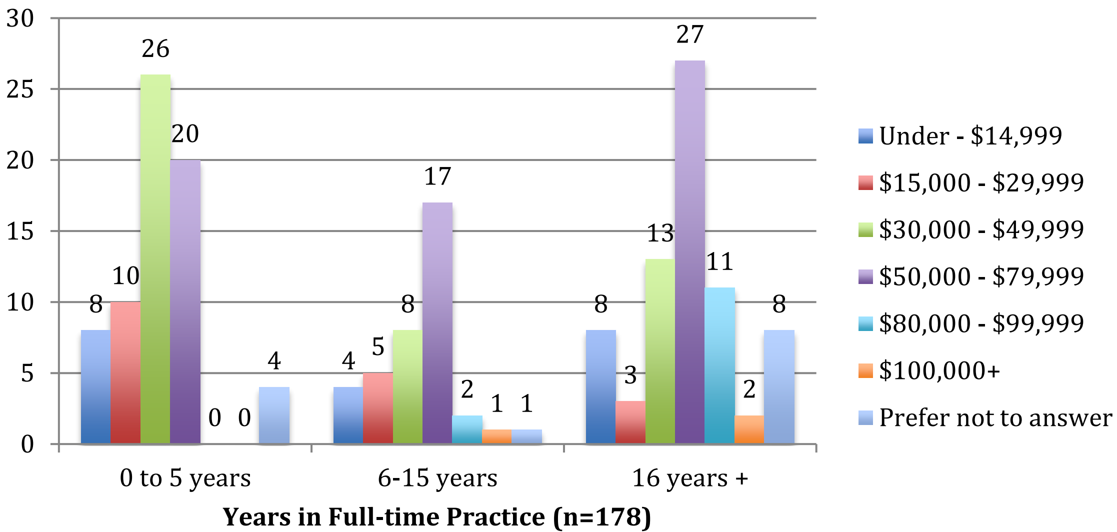
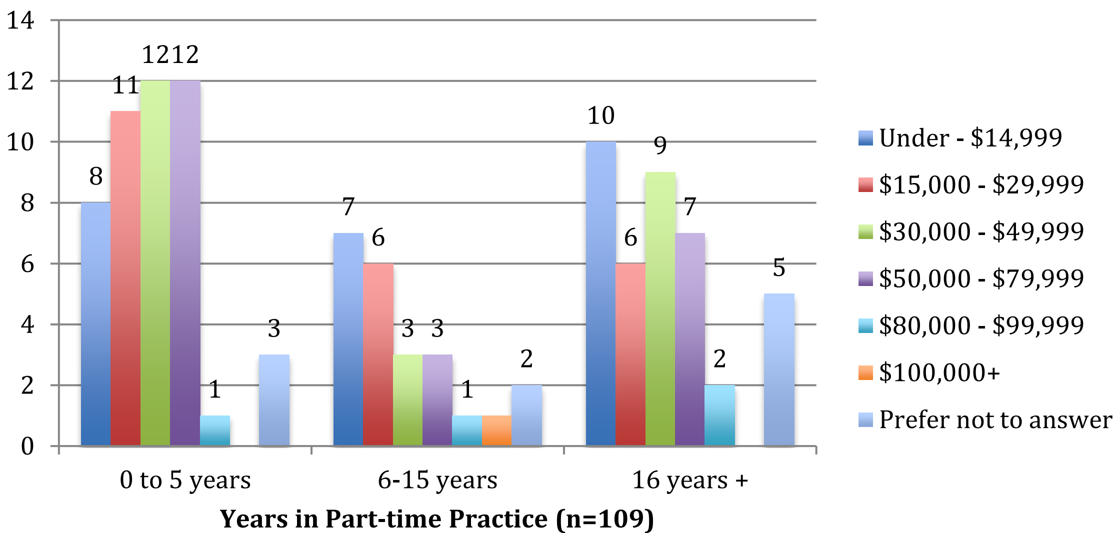


Figure 12. Annual Salary for Part time DMT work



When looking at salaries by geographic region and locale, salaries appear higher for respondents in the Northeast, and West; and for respondents who work in a major metropolitan area. Figure 13 and 14 provide information on salary by region and locale, respectively.

Figure 13. Salary by Region

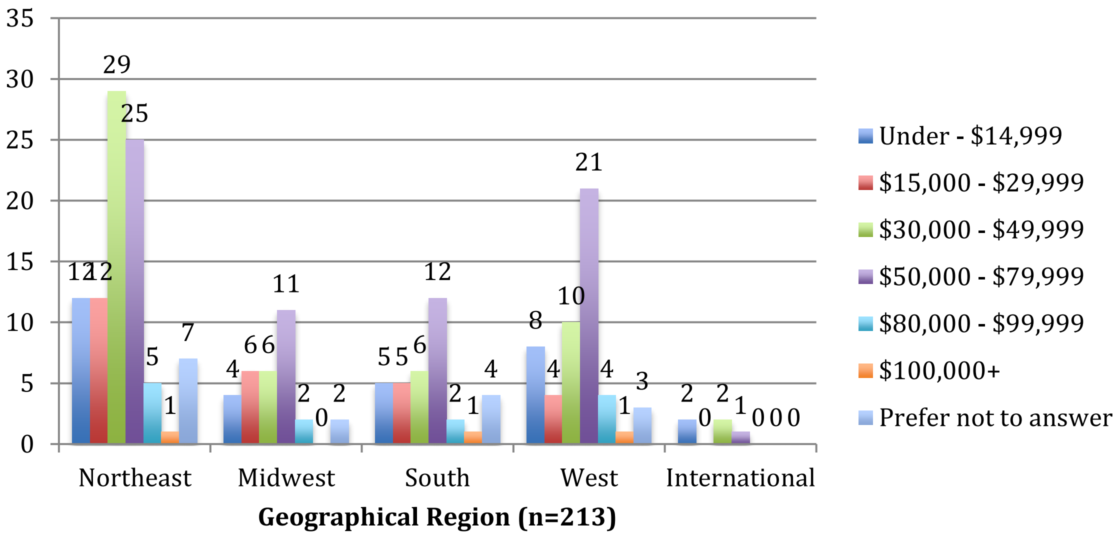
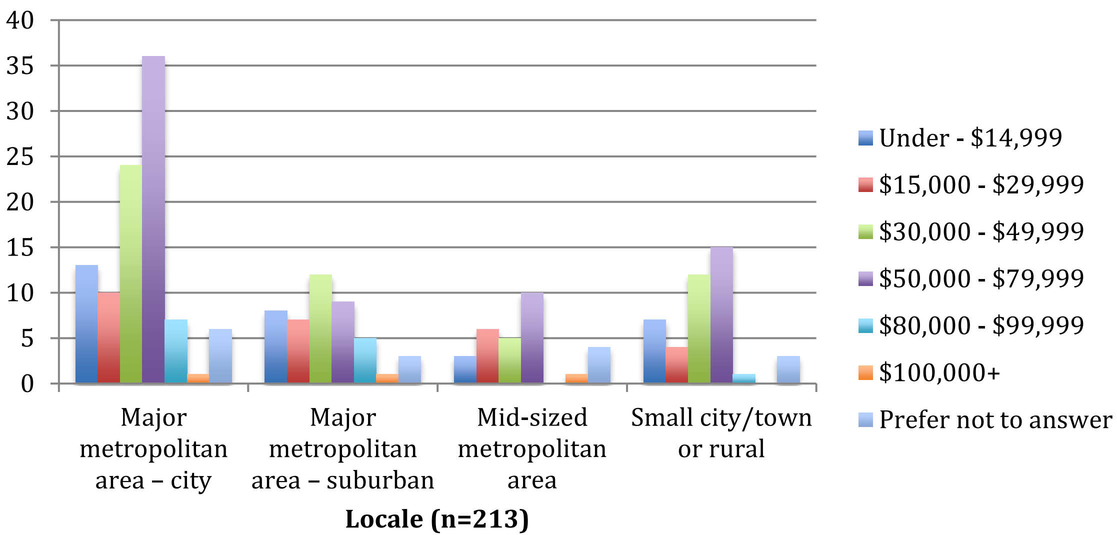
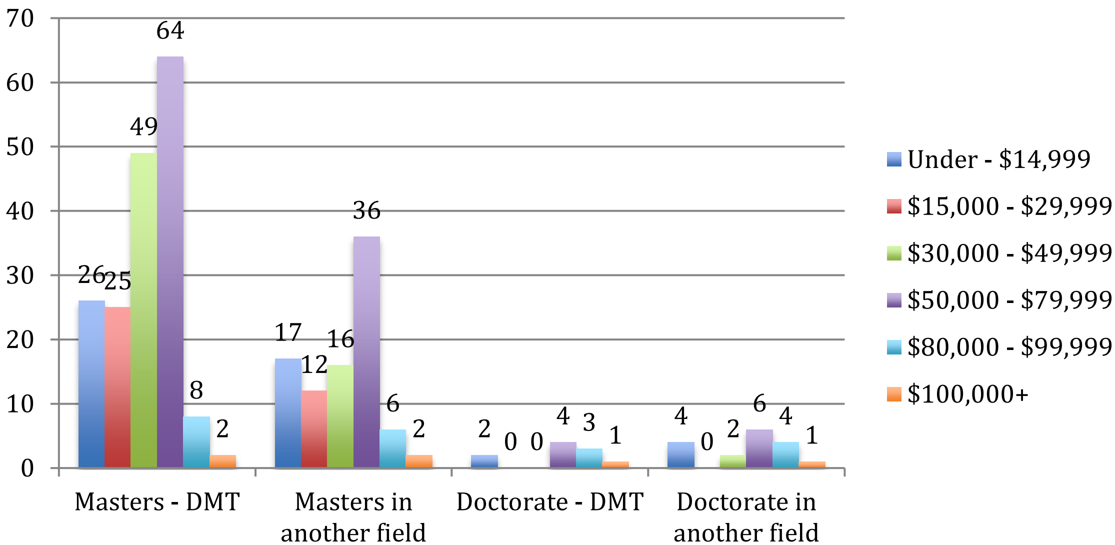


Figure 14. Salary by Locale



Annual salary was also cross-tabulated with advanced degrees, and results indicate that the highest earners were distributed across the four advanced degree categories. Figure 15 provides more information on the salary range by advanced degree.

Figure 15. Salary by advanced degree



Note: Responses for this graph come from two questions: Highest DMT degree, and highest degree in another field. Responses will exceed the total number of survey respondents.

DMT Career Information – primary and secondary positions

Respondents were asked to share information regarding their current primary employment in DMT, and if applicable, any substantial secondary employment. There were 55 respondents who indicated that they held a substantial secondary job; thus secondary career information is included below primary career information.

Among the job titles held by respondents, *Dance/Movement Therapist* topped the list for both primary (n=52) and secondary (n=19) job titles. Tables 6 and 7 contain the list of primary and secondary job titles.

Table 6. Primary Job Title (n=213)

Title	N
Dance/Movement Therapist	52
Psychotherapist	26
Activity/Recreation Therapist	16
Administrator	14
Professional Counselor	13
Teacher	13
Creative Arts Therapist	12
Professor (college or university)	12
Counselor	11
Expressive Arts Therapist	9
Psychologist	4

Title	N
Mental Health Therapist/Qualified Mental Health Therapist	4
Couple and Family Therapist	3
Rehab Therapist	3
Case Manager	2
Other	14

Other job titles included: Behavior Specialist; Behavior Health Professional; Child and Adolescent Therapist; Clinical Therapist; Clinician; Community Clinician; Meditation, yoga, and "body-based therapy; School Based Therapist, School Social Worker, Senior Allied Clinical Therapist, and Therapist

Table 7. Secondary Job Title (n=55)

Secondary Job Title	N
Dance/Movement Therapist	19
Teacher	12
Professor (college or university)	8
Expressive Arts Therapist	4
Psychotherapist	4
Professional Counselor	3
Trainer/Supervisor	2

Other categories included: Creative Arts Therapist

Respondents indicated that *direct service provider/therapist* was the most common primary (n=143) and secondary (n=25) job title. Tables 8 and 9 provides a list of primary and secondary job roles respectively.

Table 8. Primary job role

Job Role	N
Direct service provider/therapist	143
Educator	25
Administrator / manager	16
Consultant	9
Supervisor	6
Retired	3
Performer	2
Program planner / curriculum development	2
Community organizer	1
Evaluator / researcher	1
No Response	2
Other	3

Other roles included: Case manager, advocate; Manager of Organizational Change, Spiritual Director

Table 9. Secondary job role

Job Role	N
Direct service provider/therapist	25
Educator	23
Supervisor	9
Consultant	4
Administrator/manager	1
Evaluator/researcher	1
Program planner/curriculum development	1

Clinical setting (n=62) and *private practice* (n=61) were the most common primary work settings. Responses were similar for the secondary work setting. Tables 10 and 11 provide information regarding respondents' primary and secondary work settings.

Table 10. Primary work setting

Work Setting	N
Clinical setting	62
Private practice	61
Non-for-profit organizations	29
College or university (higher education)	20
For profit organizations	12
Public social services	6
Nursing Home/Older Adult Facility	5
Public School System	5
Managed care	3
Social Services	2
No Response	7
Correctional Facility	1

Table 11. Secondary work setting

Work Setting	N
Private practice	17
Clinical setting	8
Managed Care	1
Public social services	2
Recreation setting	3
Not-for-profit organizations	5
University	16
Other	3

Others include: Alternate Route Institute Training; Private Organization; Private School – Early Childhood through grade 8

Respondents were also asked to share their area of specialization. *Rehabilitation services (*n=131) was the most common area of primary specialization, while *education –*

students (n=29) was the most common area of secondary specialization. Tables 12 and 13 provide information regarding the primary and secondary areas of specialization.

Table 12. Primary area of specialization

Specialization	N
Rehabilitation services	131
Behavioral health	96
Education - students	54
Family and children services / couple services	48
Addiction services	46
Mental health services	46
Elderly services	38
Gay / Lesbian / Bisexual / Transgender services	30
Community services	28
Intellectual disability services	26
School social services	22
Area of specialization - career counseling	13
Medical, hospital or health services	10
Hospice services	9
Recoded Other (please specify)	8
Correction services	5
Business and industry	4
Child protective services	4
Immigrant and refugee services	4
Adult protective services	3
Variety	2
Military	2

Other responses included: All special needs; Children; Eating Disorder Treatment; Preventive care, wellness, adult/professional education

Table 13. Secondary area of specialization

Area of Specialization	N
Education - students	29
Mental health services	24
Behavioral health	13
Family and children services / couple services	11
Elderly services	8
Medical, hospital or health services	7
School based services	5
Addiction services	4
Community services	4
Intellectual disability services	4
Gay / Lesbian / Bisexual / Transgender services	3

Other responses included: Child Protection Services; Hospice Service; and Clergy

Respondents asked to share information regarding their employment status. Fifty one percent indicated that they worked *full time*[1] in their primary job (Figure 16), while the majority of those who held a secondary job worked *half time*[2] (Figure 17).

Figure 16. Employment status primary job (n=213)

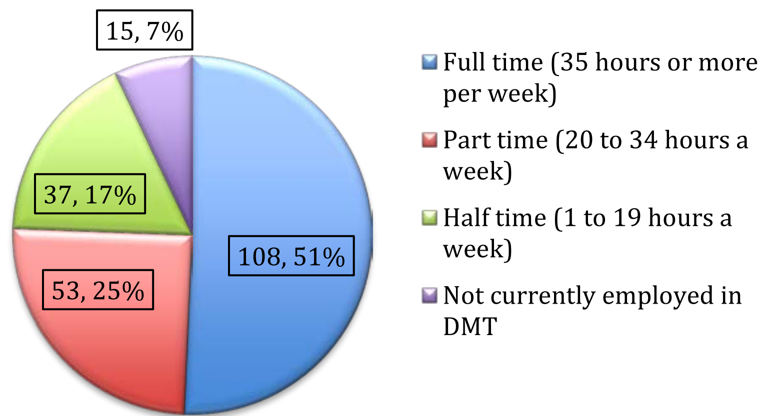
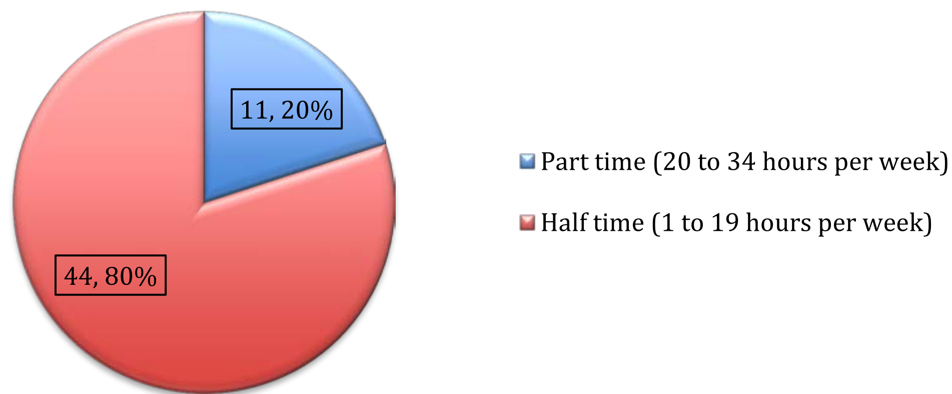


Figure 17. Employment status secondary job (n=55)



[1] Full time is defined as working 35 hours or more per week
[2] Half time is defined as working between 1-19 hours per week

New York had the highest number of respondents, followed by *California*. It must be noted that there are five international respondents. See Table 14 for a complete list of respondents in each state.

Table 14. Primary work region

State/Territory	N
New York	32
California	28
Massachusetts	19
Illinois	18
Pennsylvania	16
New Jersey	10
Virginia	9
Colorado	7
Maryland	6
Minnesota	6
New Hampshire	6
Oregon	6
Florida	5
Washington	5
Maine	4
North Carolina	4
Georgia	3
Arizona	2
Connecticut	2
Delaware	2
District of Columbia (DC)	2
Iowa	2
Missouri	2
Texas	2
Vermont	2
International	*5*
Canada	2
India	1
Italy, Turkey and China	1
Japan	1

US work regions with 1 respondent: Hawaii, Kentucky, Louisiana, New Mexico, Ohio, South Dakota, Utah, and Wisconsin

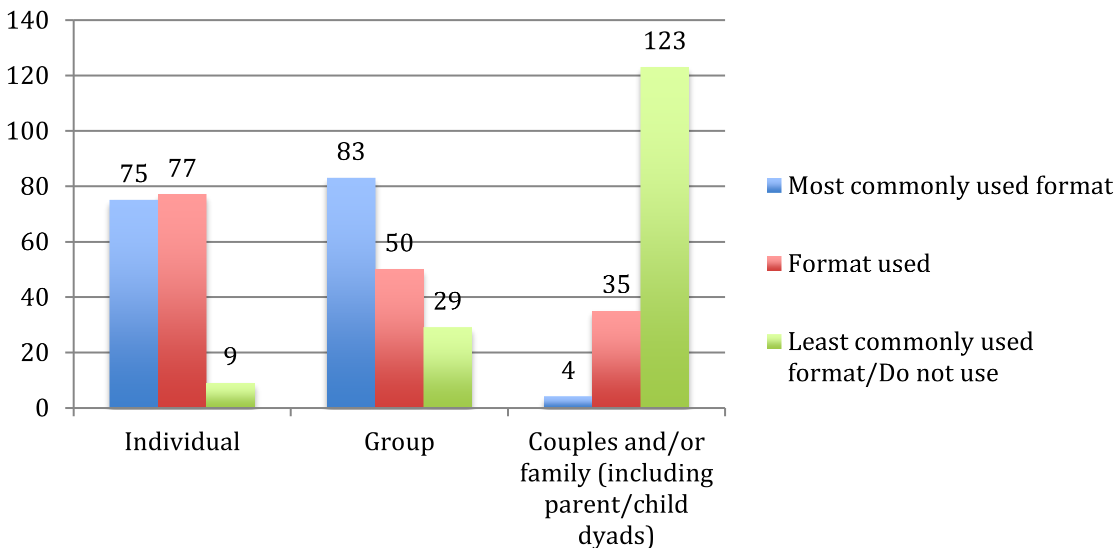
B. Practice Analysis

The next section provides an analysis of respondents' clinical practice. Seventy-six percent (n=162) of survey respondents indicated that they were currently providing clinical DMT services, and the most commonly used format when conducting DMT sessions was *group therapy*, closely followed by *individual therapy*. This corresponds to the responses for the question on the number of individuals seen each week: answers clustered around 1-15 individuals per week; 26-30 per week, and 50 or more individuals per week. In terms of sessions conducted per week, the majority conducted 1 to 5, and 6 to 10 sessions per week. Table 15 provides information regarding DMT clinical services provided, and Figure 18 provide information regarding DMT formats used.

Table 15. DMT clinical services provided

Response	N	Percent
Yes, I provide clinical DMT services	162	76.1
No but I do provide clinical supervision	15	7.0
No but I do attend and provide clinical supervision	4	1.9
No but I do attend clinical supervision	6	2.8
None of the above (exits survey)	26	12.2
Total	213	100

Figure 18. DMT format used



Note: Respondents were then asked to indicate the formats used when conducting DMT sessions, rating the most commonly used format as "1", and the least used format, or format they do not use as "3".

Table 16. Individuals seen in current practice

Individuals seen each week	N	Percent
1 to 5	24	14.8
6 to 10	24	14.8
11 to 15	20	12.3
16 to 20	16	9.9
21 to 25	14	8.6
26 to 30	22	13.6
31 to 35	8	4.9
36 to 40	5	3.1
41 to 45	3	1.9
46 to 50	5	3.1
over 50	21	13.0
Total	162	100

Note: Individuals seen more than once a week are counted as one; for group settings, each individual in the group is counted as one; for families, each individual in the family is counted as one.

Table 17. DMT sessions conducted in a typical week

Session per week	N	Percent
1 to 5	65	40.1
6 to 10	52	32.1
11 to 15	14	8.6
16 to 20	18	11.1
21 to 25	6	3.7
26 to 30	4	2.5
more than 30	3	1.9
Total	162	100

Clinical Practice: Assessment

The next section addresses specific activities and methods used in clinical practice.

Among those who indicated that they provided clinical DMT services, 27% (n=43) indicated that they assigned clients to services, while 53% (n=85) shared that they conduct a movement assessment of an individual's movement repertoire. Respondents were asked to indicate what they took into consideration when assessing nonverbal behavior and movement. As seen in the table that fellows, the items respondents regarded the most when assessing nonverbal behavior and movement were *body awareness* (n=137), *communication and social skills* (n=121), and *emotional functioning* (n=121).

Table 18. Nonverbal behavior and movement assessment

Item	N
Body awareness	137
Communication and social skills	121
Emotional functioning	121
Coping with stress and stressors	118
Affect regulation	114
Strengths and limitations	109
Self-concept/self-esteem	104
Body image	99
Behavioral functioning	91
Trauma assessment	87
Attachment	85
Cognitive functioning	80
Ability to adapt to changing life situation	79
Individual characteristics	78
Developmental functioning	75
Motor functioning	66
Personality traits	63
Diagnosis or mental disorders	61
Executive functioning	54
Other	11

Note: Respondents were asked to check all that apply, thus, responses will exceed the total number of survey respondents

Respondents indicated that they typically used *informal assessments* (n=131), while among the published movement assessments, *Laban Movement Analysis LMA* (n=85) was frequently used. The tables that follow provide a summary of the typical movement assessments, and published movement assessments used.

Table 19. Typical movement assessment used

Movement assessment	N
Informal assessment	131
Self-designed DMT assessment	38
Both formal and informal assessment	28
Formal assessment	6
Other published movement assessments	5

Note: Respondents were asked to check all that apply, thus, responses will exceed the total number of survey respondents

Table 20. Published movement assessment used

Published movement assessment	N
Laban Movement Analysis (LMA)	85
Kestenberg Movement Profile (KMP)	51
Behavior Rating Instrument for Autistic and Other Atypical Children (BRIAAC)	4
Movement Psychodiagnostic Inventory (MPI)	4
Nonverbal Assessment of Family Systems (NVAFS)	4
Other (please specify)	4
Movement Pattern Analysis (MPA)	2

Note: Respondents were asked to check all that apply, thus, responses will exceed the total number of survey respondents

Coping (n=71), and *mood* (n=51) were among the top items respondents assessed when using psychological and educational instruments. It must be noted that nine respondents did not understand this question, or found it unclear. In addition, one respondent shared that, while they used informal assessments, they would like to receive formal training in these assessments. The table that follows provides the complete list of items respondents assessed for using psychological and educational instruments.

Table 21. Psychological and educational instruments for assessment

Items assessed	N
Coping	71
Mood	57
Attachment	49
Abilities	47
Individual characteristics	47
Relationship	45
Diagnosis or mental disorders	44
Developmental functioning	42
Attitudes	36
Interests	36
Learning	29
Family functioning	28
Personality type	28
Disabilities	25
Achievements	13
Aptitudes	10
Other	2

Others included: Risk to self/others; Trauma.
Note: Respondents were asked to check all that apply, thus, responses will exceed the total number of survey respondents

Respondents were also asked to share what they cover during clinical interviews. *Assessing the client's motivation for therapy or readiness for change* (n=113) and *assessing the risk of danger to self and others* (n=109) were among those frequently covered. The table that follows includes a list of other clinical interviewing items covered.

Table 22. Clinical interviewing

Items	N
Asses the client's motivation for therapy or readiness for change	113
Assess the risk of danger to self and others	109
Diagnosis of persons with mental, emotional, and behavioral disorders and appropriate application of diagnostic information provided by other health care providers	93
Assess the nature and severity of clients' crisis situations	85
Needed level of care	71
Needs for supportive services beside DMT or CAT	70
Use the MSE, the mini MSE or another clinical interview protocol	33

Note: Respondents were asked to check all that apply, thus, responses will exceed the total number of survey respondents

When asked if they typically obtained client history, respondents indicated that these were primarily obtained *from the client* (n=125). Table 22 provides a full list of responses.

Table 23. Obtaining client history

Client history source	N
From client	125
From other records	95
From client's family members (spouse, parent) or/and legal guardians	62
I do not typically obtain client's history	8
Multidisciplinary team	5

Note: Respondents were asked to check all that apply, thus, responses will exceed the total number of survey respondents

Among the items respondents typically gathered from clients, *family* (n=132) and *cultural background* (n=128) were among the most frequently gathered information. The table that follows provides a summary of information typically gathered.

Table 24. Typically gathered client information

Information gathered	N
Family	132
Cultural background	128
Biopsychosocial history	119
Environmental aspects for example: use/abuse of alcohol, drugs, medication	117
Medical	113

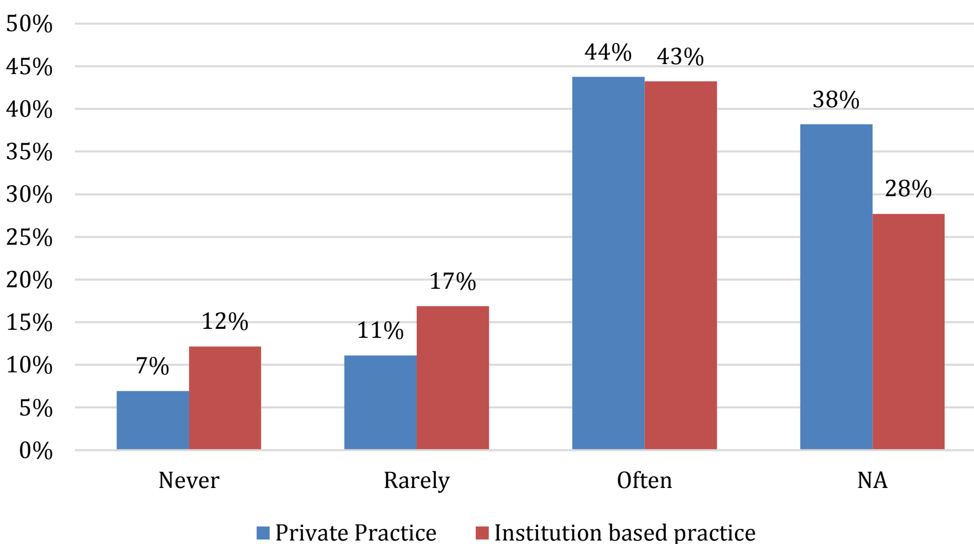
Information gathered	N
Current willingness to engage in DMT or other CAT	110
Addictions (e.g. to assess the impact of addictions on the client's system)	108
Asses level of readiness for making changes	103
Employment/career/education	101
Preferences for therapy	97
Spiritual beliefs	94
Affectual orientation	79
Religious practices	79
Past experience with DMT or other CAT	75

Note: Respondents were asked to check all that apply, thus, responses will exceed the total number of survey respondents

Theoretical formulation

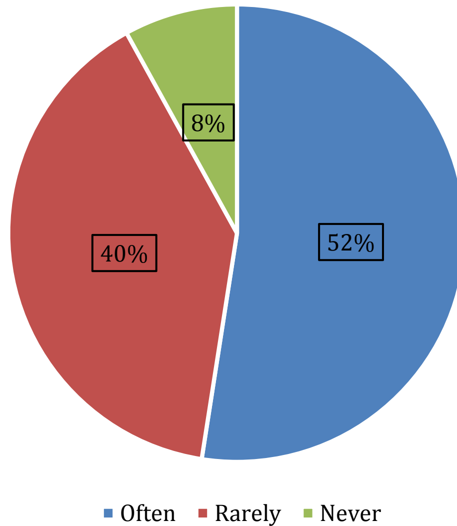
When asked if they developed a case conceptualization (theoretical formulation) based, 70% of respondents said yes. A follow up question asked them how often they developed a case theoretical conceptualization based on assessment. As seen in the figure that follows, respondents indicated that they did this *often* in both private practice (44%), and institution based practice (43%).

Figure 19. Use of case theoretical conceptualization



Respondents were also asked if they drew on research and program evaluation findings to inform treatment planning: 52% indicated that they did this often (Figure 21).

Figure 20. Use of research and program evaluation findings to inform treatment planning



Respondents were asked to share if they read clinical literature related to a case to inform practice. They indicated that they did so to *stay informed*, and when *working with a specific population*. The table that follows lists all available responses.

Table 25. Reading clinical literature related to inform clinical practice

Response	N
Yes, in general to stay informed	135
Yes, on working with a specific population	127
Yes, to get ideas for clinical interventions	114
Yes, about culture and diversity	90
Yes, on theory	85
Yes, to do evidence based practice when possible	73
Yes, for learning about the impact of differences between therapist and client (regarding race, gender, age or other characteristics) on the therapy process	63
No, I hardly ever read clinical literature	11
Yes, for fun/inspiration	2
Yes, for other reasons (please specify)	2

Other responses included: for teaching DMT Alternate Route Course; to provide psychoeducation

Referrals

When asked if they took in referrals, 77% (n=125) of respondents said yes. Respondents were also asked if they referred clients for other services, with 76.5% (n=124) responding yes. Among those who responded yes, 101 respondents indicated they informed the client of such judgment, and 98 respondents indicated that they communicated this as requested or deemed appropriate to such referral sources.

Tasks and competencies

Respondents were asked to rate treatment planning items, direct service delivery items, and indirect service delivery items by *level of importance* (1=not important, to 5=extremely important), and *level of use* (1=never, to 5=daily). The mean differences between the averaged *level of importance* scores, and averaged *level of use* scores were found to be only 0.53 for the treatment planning items, 0.27 for the direct service delivery items, and 0.58 for the indirect service delivery items, thus only the *level of use* items are reported.

Among the treatment planning items, *monitoring interventions with clients using results of standardized instruments* was the most frequently used item, while *monitoring interventions with clients using results of movement observation assessment tools* was used much less. All treatment planning items can be found in the table that follows.

Table 26. Treatment planning

Treatment Planning - Level of Use	N	Mean	Standard Deviation
Monitor interventions with clients using results of standardized instruments	140	4.44	0.807
Provide information about clients' rights and responsibilities and confidentiality	138	3.80	1.237
Obtain clients' informed consent for services	137	3.58	1.360
Formulate measurable objectives to assist clients' change	139	3.40	1.202
Develop broad biopsychosocial treatment plan or service plan based on assessment findings	135	3.21	1.224
Engage clients and/or family members in planning and implementing service plans	140	3.21	1.302
Formulate time frame for intervention with clients	138	3.19	1.199
Inform patient about efficacy of treatment methods/interventions	139	3.13	1.172
Develop a movement specific treatment plan or service plan	136	3.12	1.129
Modify intervention methods to meet client needs	139	2.63	1.336
Select strategies for community action	138	2.40	1.212
Monitor interventions with clients using results of movement observation assessment tools	139	1.91	1.067

Respondents were also asked questions pertaining to direct service delivery. The results for this section are divided into s*pecialty activities*, non-specialty activities and are labeled accordingly.

Among the specialty activities, *helping clients express emotions through body* was most frequently used, followed by *enhancing spontaneity and creative abilities of clients*, while *facilitating choreography on issues important to clients* was used less frequently. The following table that lists means and standard deviation for the direct service delivery specialty activities.

Table 27. Direct service provided

Specialty Activities	N	Mean	Standard Deviation
Help clients express emotions through body	142	4.73	0.560
Enhance spontaneity and creative abilities of clients	141	4.67	0.629
Use client initiated imagery, symbol, and/or metaphor	142	4.51	0.788
Facilitate leading / following techniques	140	4.46	0.723
Use body awareness techniques	142	4.43	0.802
Use methods that focus on nonverbal communication	141	4.35	0.819
Assist client in developing verbal communication skills	143	4.34	0.880
Use relaxation methods	144	4.31	0.822
Identify awareness of self somatic-countertransference to perform work with client's	142	4.28	0.970
Use imagery, symbol, and/or metaphor	143	4.25	0.900
Assist clients to develop introception (awareness of internal sensory stimuli)	142	4.23	0.897
Give movement directives verbally	139	4.19	0.900
Conduct a warm at the beginning of sessions	141	4.16	1.119
Assist clients to develop spatial awareness	140	4.15	1.052
Facilitate breath techniques	143	4.15	0.927
Use elements of yoga	144	4.10	1.101
Facilitate dance performance on issues of importance to clients	139	4.04	1.049
Use elements of mindfulness practices	140	4.00	0.960
Use props during sessions	140	3.96	1.153
Use therapist Initiated imagery, symbol, and/or metaphor	142	3.88	0.978
Use music and/or accompaniment	138	3.86	1.131
Verbalize during improvisation	141	3.82	1.119
Conduct cool down and closure at end of sessions	140	3.73	1.162
Facilitate body sculpturing	140	3.71	1.166
Intentionally incorporate use of touch when clinically relevant	143	3.41	1.285
Moving to music	140	3.35	1.314
Use various dance styles	145	3.20	1.256

Specialty Activities	N	Mean	Standard Deviation
Facilitate dance or movement improvisation on issues of importance to clients	142	2.92	1.232
Facilitate mirroring	145	2.81	1.156
Facilitate shared rhythmic activity in movement	142	2.77	1.376
Facilitate structured dance sequence on issues of importance to clients	143	2.46	1.161
Facilitate Authentic Movement	140	2.37	1.177
Facilitate choreography on issues of importance to clients	144	1.80	0.920

Among the non-specialty direct service items, *establishing a therapist/client alliance* was used most frequently by respondents, followed by *providing a sense of psychological safety for clients in session*. Respondents indicated that they were less likely to *conduct e-practices with clients over the phone or online.* The table that follows lists the non-specialty direct service delivery items with means and standard deviations.

Table 28. Direct service delivery

Non-Specialty Activities	N	Mean	Standard Deviation
Establish a therapist/client alliance	144	4.83	0.443
Provide a sense of psychological safety for clients in sessions	142	4.79	0.593
Monitor changes in emotional needs of clients during sessions	142	4.75	0.525
Identify emotional needs of clients at the start of the sessions	143	4.68	0.612
Identify when the focus of a session needs to change	141	4.65	0.623
Help client to develop the skills to communicate more effectively	142	4.58	0.667
Help clients identify emotions and behaviors	139	4.56	0.638
Identify countertransference in therapist/client relationship	141	4.39	0.835
Identify transference in therapist/client relationship	141	4.38	0.815
Assist clients to understand the impact of their behavior	142	4.36	0.886
Provide psychotherapy/counseling to clients	142	4.32	1.108
Assist client in developing non-verbal communication skills	143	4.31	0.824
Facilitate interpersonal contact (verbal and nonverbal) between the group members	142	4.13	1.156
Provide psychoeducational services to clients	142	4.11	1.070
Assist clients in setting goals	142	4.01	0.967
Assist group members in developing trust/ongoing	139	4.01	1.183

Non-Specialty Activities	N	Mean	Standard Deviation
relationship with other group members			
Assist clients to understand how environment influences human behavior	142	3.99	1.072
Identify counter-transference issues between clients in group	142	3.93	1.253
Assist groups to work together to reach goals	140	3.89	1.239
Co-treating, working with co-therapist	142	3.67	1.115
Help clients regulate emotions	140	3.66	1.222
Offer "homework" for clients to engage in between sessions	141	3.47	1.181
Refer clients to other useful resources (e.g. readings, related services, community groups, etc.)	142	3.35	1.018
Provide neuroscientific explanations for behavior to clients	143	3.31	1.240
Facilitate conflict resolution within group	142	3.18	1.256
Identify transference issues between clients in group	141	3.06	1.258
Conduct e-practices (e.g. non-face-to-face assessments, interventions) with clients over the phone or online	147	1.86	1.108

Among the indirect service delivery items, respondents indicated that *keeping accurate and comprehensive documentation and correspondence using appropriate technology* was done most frequently.

Table 29. Indirect service delivery

Indirect Service Delivery	N	Mean	Standard Deviation
Keep accurate and comprehensive documentation and correspondence using appropriate technology	142	4.37	1.001
Participate as part of a member of an interdisciplinary team	143	3.87	1.252
Collaborate and communicate with other professionals in team meetings	144	3.66	1.264
Complete documentation for billing purposes	145	3.62	1.555
Prepare reports as required	143	3.58	1.291
Collaborate with other professionals regarding resources available to clients	143	3.54	1.067
Maintain information about resources and community services available to clients	140	3.09	1.144
Bill directly for insurance reimbursement for DMT services	146	1.87	1.371

C. Supervision

The following section provides information regarding ADTA member's current experience with supervision, as well as their role as BC-DMT Supervisors. Do note that the total number of respondents will vary for each question, thus, the total number of respondents for each question will be included in the table or chart.

Receiving supervision

Almost ninety percent of respondents received a form of supervision in the last two years, with a third of indicating that they received regular supervision. The majority of those who received supervision paid for this privately (59 %), and *individual supervision* was the most frequent form of supervision received (n=66).

Table 30 provides a summary of the frequency of clinical supervision, clinical consultation, or peer review of their work as dance/movement therapists in the last two years. Table 31 summarizes how the cost of supervision is covered, and Figure 21 shows the distribution of supervision attended.

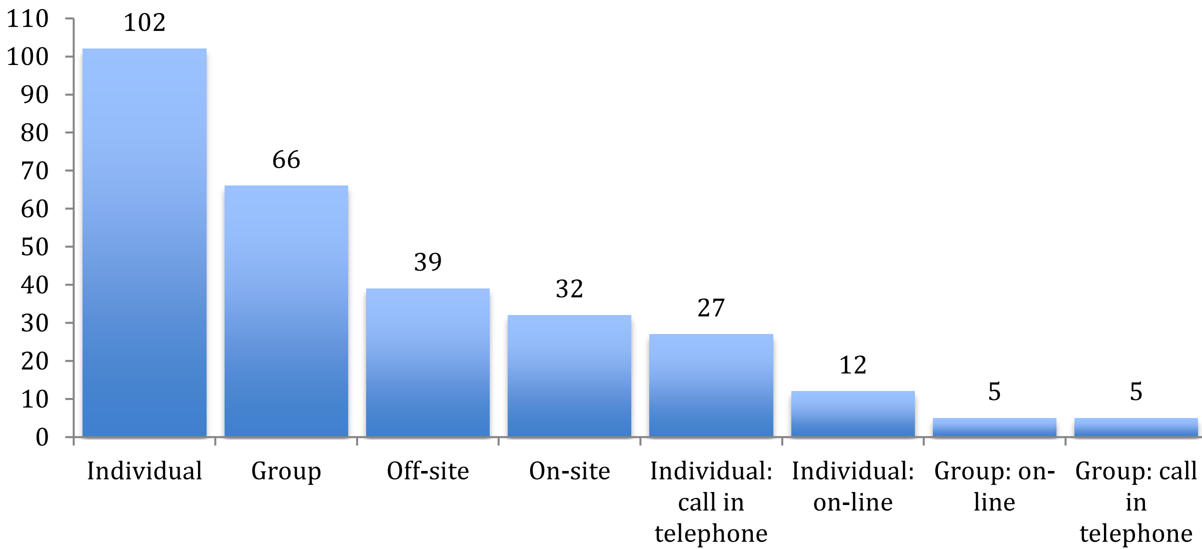
Table 30. DM/T supervision received in the last two years

Frequency of supervision	N	Percent
Yes, regularly	47	27.3
Occasionally	33	19.2
Approximately once a month	28	16.3
Every other week	21	12.2
Approximately once a week	14	8.1
Every other month	9	5.2
More than once a week	2	1.2
No, not in the past two years	18	10.5
Total	172	100

Table 31. How cost of supervision received is covered

Cost of supervision	N	Percent
Pay privately	90	58.8
Supervisor works at place of employment and that time is covered as part of my supervised job	37	24.2
No Cost - peer supervision	22	14.4
My employer provides financial support for private supervision	4	2.6
Total	153	100

Figure 21. Type of supervision attended



Note: For this question, respondents were permitted to check as many answers as appropriate, thus the total number of responses exceed the number of survey respondents.

Role of BC-DMT Supervisor

One hundred thirty-three, or 62.4% of all survey respondents indicated that they were board certified Dance Movement Therapy supervisors[3]. *Private supervision or case consultation for DMT therapists and graduates students* are the largest population served by respondents who indicated they were BC-DMT supervisors. *Individual supervision* is the most common format of supervision provided by these BC-DMT Supervisors. The amount of supervision provided by the BC-DMT varied, with 31% supervising once a week, and 30% supervising less than once a month. See Figures 23 through 25 type of supervision provided, the format of supervision provided, and the frequency of supervision.

[3] BC-DMT Supervisor is defined as (a) Board Certified Dance/Movement Therapist (BC-DMT) or (b) other licensed/credentialed related mental health professional possessing a minimum of five years of professional experience and is also a Registered Dance/Movement Therapist (R-DMT)

Figure 22. Population supervised

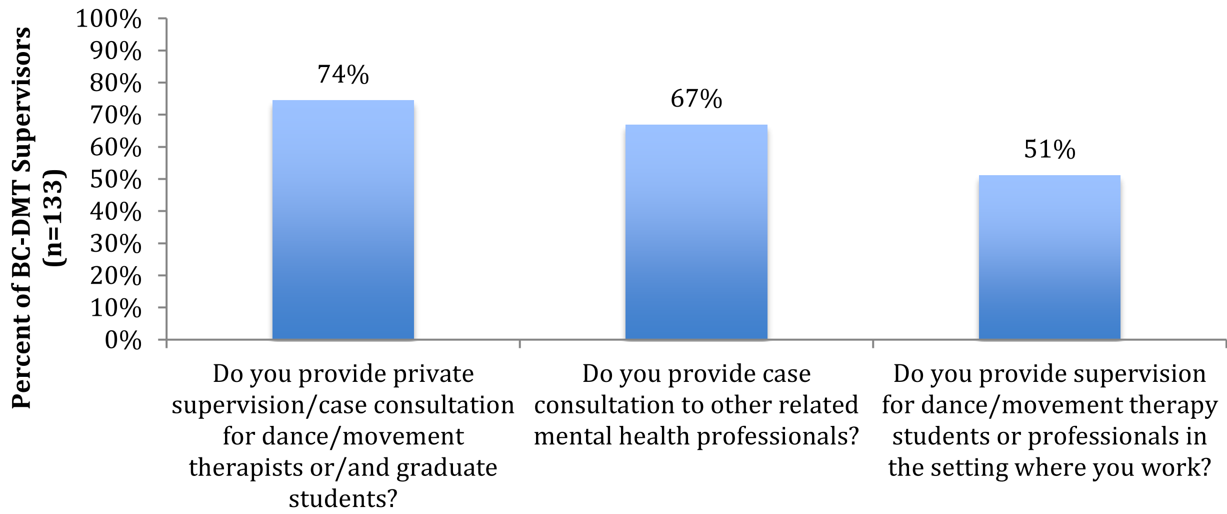
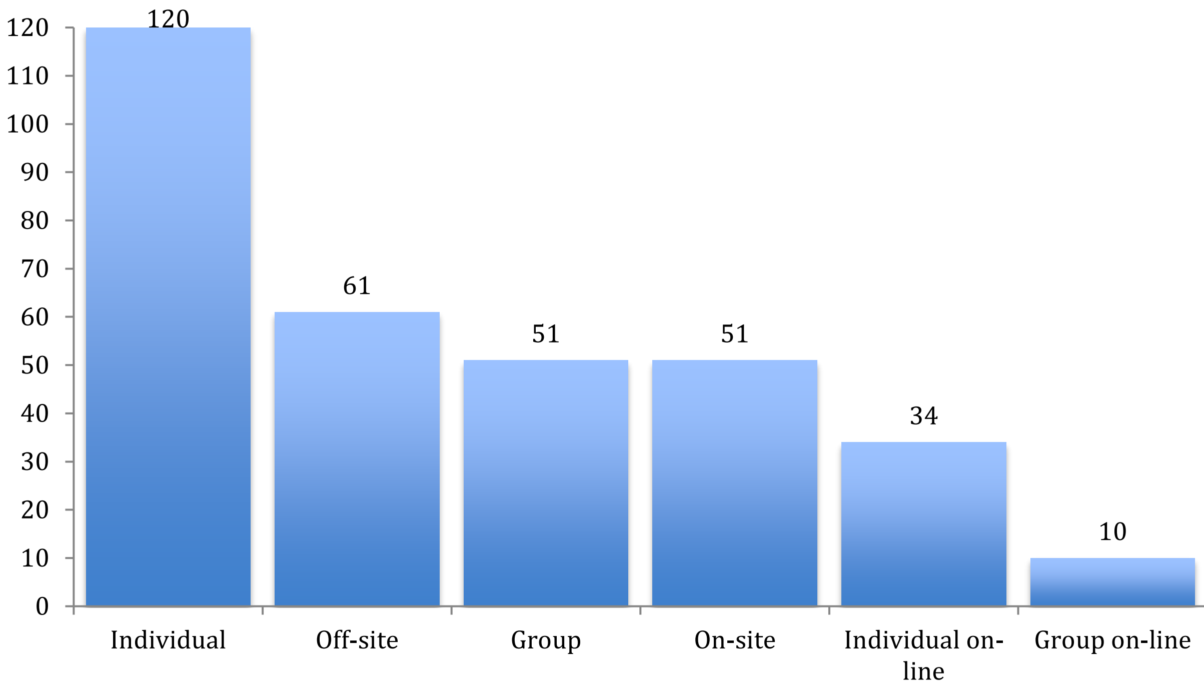
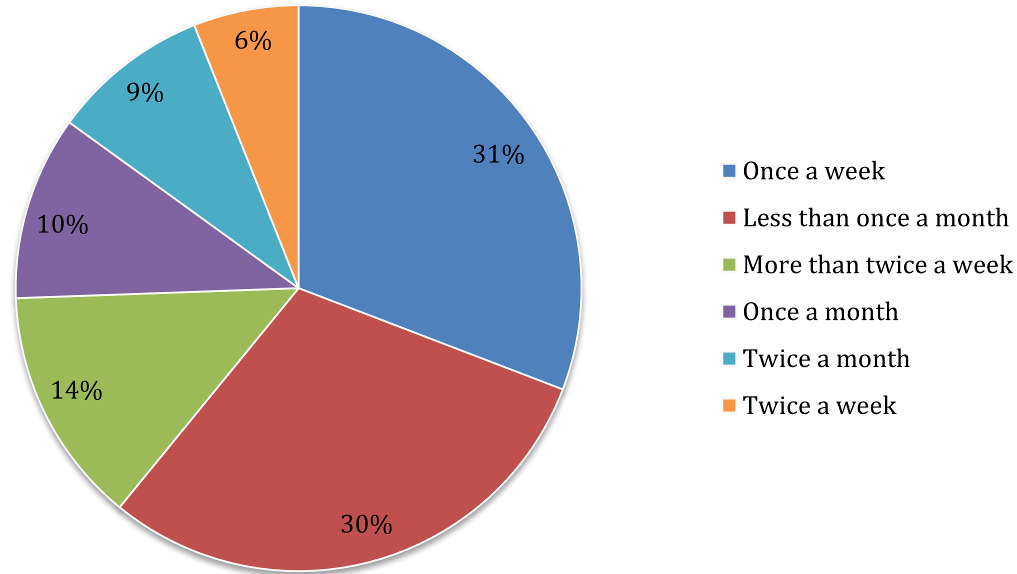


Figure 23. Form of supervision provided



Note: For this question, respondents were permitted to check as many answers as appropriate, thus the total number of responses exceed the number of survey respondents.

Figure 24. How often supervision is provided



Respondents were also asked to share their theoretical models and approaches to supervision through an open-ended question. Responses were collected and then categorized into theoretical models, or method of supervision. For respondents who gave more than one response, answers were capped at four. As seen in Table 30, *method of supervision* was the most cited approach, with *experiential method* being the most cited *method of supervision*. *Developmental method* was also cited by several. Table 31 provides a full list of theoretical models and approaches to supervision.

Table 32. Theoretical models and approaches to supervision

Type of Supervision	N
Method of Supervision	24
Experiential Method	*11*
Observational	*4*
Case Discussion	*5*
Session Analysis	*2*
Other	*2*
Developmental	23
Psychoanalytic/Psychodynamic	21
Person Centered/Rogerian	21
Other	23
Various	18
Chace	10
Mindfulness	11
Object Relation	7

Jungian	7
Authentic Movement	7
System/Biopsychosocial	6
DMT	6
LMA	5
Humanistic	5
CBT/Behavioral	5
Bernards Discrimination Model	4
Relational	3
Person of the Therapist	3
Mindfulness	3
Diversity, Multicultural Models	3
Blanche Evans	3
Psychotherapy	2

Others include: Learning, Existential; Learning, Interpersonal Process Recall; Gestalt; Feminist, Group; Feminist; DBT; Counselor Training and Supervision Triangle; Collaborative; Trauma-focus, Internal Family Systems; The ADTA Code of Ethics for Supervision; Sensory-integration