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# Exploring use of the *Outcomes Framework for Dance Movement Therapy* to establish a group profile and objectives for psychomotor therapy interventions

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**ABSTRACT**

Fields of psychomotor therapy and dance movement therapy share a common challenge in the under-development of accessible assessment instruments that are easy for practitioners to use and relevant for diverse client groups. This study discusses the application of the *Outcomes Framework for Dance Movement Therapy* as an assessment tool in a community psychomotor therapy programme for adults with high support needs in Almada, Portugal. The *Framework* was trialled to create a group profile to support the development of therapeutic objectives for the entire group. 61 participants were observed by four raters across a series of sessions. Group profile results were obtained by averaging scores from sub-domains and 59 individual items for each participant, after an internal consistency test found acceptable to good reliability values. Findings indicate the *Framework* was suitable for use by psychomotor therapists to develop a group profile and set program objectives.

## Introduction

Psychomotor therapy (PMT) is a movement and body-oriented therapy with a plurality of practices and applications (European Forum of Psychomotricity, 2016; Rodriguez, 2007). It uses physical activities to optimise motor, cognitive, affective, and relational aspects of psychomotor functioning, informed by a biopsychosocial model and holistic view of the human being derived from the unity of body and mind (Probst, 2017). Body and movement experiences

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are the basis of PMT interventions in a supportive therapeutic alliance between the client and the therapist (Lesage, 2012).

The Portuguese Association of Psychomotricity identifies main goals of PMT as promotion of awareness of the body as the main vehicle for expression and communication, breathing control, sensory and perceptive awareness, balance, coordination, relaxation, and interpersonal relations, all perceived to contribute to adaptive functioning (Associação Portuguesa de Psicomotricidade [APP], 2012). Diverse techniques are used, including body awareness, play, and movement-oriented activities and relaxation.

Many characteristics of PMT are shared with dance movement therapy [DMT] (Kay et al., 2016), a modality that involves the 'relational and therapeutic use of dance and movement to further the physical, emotional, cognitive, social, and cultural functioning of a person, and the integration between these aspects of the person and into their daily life' (Dance Movement Therapy Association of Australasia, 2020). Both utilise an experiential orientation, involving unity of body and mind, and value the 'nonverbal' aspects in therapy (Heynen et al., 2017). There are also differences, with PMT more likely to involve directive movement activities towards functional outcomes, while DMT generally includes significant use of improvised movement to elicit creative and aesthetic expression.

PMT assessment tools are used for defining individual profiles, setting program goals and tailoring interventions (Probst, 2017). Dimensions in these tools vary, but may include movement control, movement expressivity, relaxation, self-confidence, activity involvement, focusing attention on the situation, social regulation ability, verbal communication, and relationships. Instruments include the *Louvain Observation Scales for Objectives in Psychomotor Therapy* (Coppenolle et al., 1989), or two developed especially for children, *PsyMot*, used for assessment, diagnosis-enabling treatment goals establishment (Emck & Bosscher, 2010) and the *Psychomotor Assessment Battery* (Fonseca, 1992).

The recognition of a pressing need for research that tests the effectiveness of PMT with different populations and settings is hindered by a dearth of reliable, validated instruments, particularly for use with adults. PM therapists' capacity to develop participants' profiles, identify program objectives and report achievements supported by data is also limited by a lack of assessment tools practical and suitable for use in diverse contexts (Michel et al., 2011). A dearth of instruments available in Portuguese is a further impediment to PMT assessment in Lusophone nations (Morais et al., 2016).

In DMT, there is also an under-development of assessment tools, with few agreed validated instruments in regular use (American Dance Therapy Association [ADTA], 2017; Dunphy et al., 2016). To address this deficiency, the *Outcomes Framework for Dance Movement Therapy* (Dunphy & Mullane, 2018) that underpins a technological tool, iPad app, *Movement Assessment and Reporting App [MARA]*, (Dunphy, 2020) was developed to assess

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outcomes of DMT. This instrument is specifically focussed on the needs of DMT practitioners within the demands and limitations of their diverse professional contexts. This includes low impetus from employers for assessment and reporting and commensurately little time beyond sessions to conduct these. It may also be suitable for PMT given the identified parallels in the modalities. The *Framework* comprises measures across five domains: Physical, Cultural, Emotional, Cognitive and Social, including a range that is posited to be broad enough to cover all outcomes that might be expected of DMT for diverse client groups and contexts (Dunphy et al., 2020).

Previous articles report the application of *MARA* and its underpinning *Framework* in a range of contexts including special needs education and adult disability day services. Different stakeholders in the therapeutic process, including DM therapists, students and education assistants, reported finding the tools useful in setting and assessing participants' progress against program objectives (Dunphy & Hens, 2018; Dunphy et al., 2016). Agency managers, staff, families, carers and clients found reports created from data generated by these tools to be useful and relevant (Dunphy & Hens, 2018). Good inter-rater reliability was reported for sub-domains of body connectivity (Physical) and social connection (Social) (Dunphy & Hens, 2018).

The current research explores another possibility offered by this instrument, of creation of a group profile to enable data-informed establishment of therapeutic objectives for a PMT program. In a group profile, data gathered about individual participants through assessment of specific items of relevance to the program are aggregated to create a profile of the group. This could be undertaken at any stage during the therapeutic process: intake, baseline, during, or at the end of a program. This data could be used for several functions, from offering a normative score of a specific client group on that item(s), to assess progress at a group level, or for the purpose here, of informing program planning. No articles reporting the application of group profiling were found in major journals relevant to the PMT and DMT fields, suggesting its potential as yet under-developed in the fields.

This study aimed to explore the following: What is the usefulness and applicability of the *Framework* for psychomotor therapists? Can the *Framework* be used to create a group profile in a community-based PMT program? Can such a group profile be used to define therapeutic objectives for such a program? Is the *Framework* reliable?

## Methods

### Participants

This study involved participants of a community program, *Dança e Gira[DG]* (*Dance and Twist*) for adults with high support needs who experience moderate

to severe activity limitations and restrictions to community participation. Their diverse diagnoses included intellectual disability (n = 50), physical disability such as cerebral palsy (n = 4) and spina bifida (n = 2); and psychiatric disorders, such as schizophrenia and bipolar disorder (n = 5). Participants are referred to DG by institutions who support them, mostly agencies offering independent living support and residential care for individuals with disabilities in Almada City, Portugal. 61 participants, aged between 16 and 69 years (M = 42.8 ± 11.31), male (n = 41) female (n = 21), from seven groups (7 to 15 participants each) of the program running in 2017/2018 contributed to this research.

## Program and activities

DG seeks to contributing to wellbeing, quality of life, promoting of psycho-motor, cognitive, social and emotional competences, and community inclusion through accessible movement opportunities. Other specific objectives of the program include elicitation of engagement, pleasure and guided expansion of participants' movement potential. The program, running since 2000, is managed by Almada City Council, led by a PM therapist and supported by Lisbon University. Weekly hour-long sessions are held in the Municipal Sports Centre or institutions' gymnasiums.

Sessions are typically structured as follows: Arrival, initial dialogue-sharing news, ideas and feelings (5–10 minutes); Warm up (therapist-directed work) inviting flexion, extension, and rotation of group of joints and body parts at low intensity (5–10 min); Main part-movement exploration (participant-centred work), invitation to explore movement possibilities individually and in groups, including body, effort, shape, and space movement qualities (20–-30 min); Closing-relaxation activity (therapist-directed work) breathing, slow movements (10 minutes); Final dialogue-reflection on session satisfaction and enjoyable moments (5–10 min).

## Assessment instrument

The assessment instrument used, the *Outcomes Framework for Dance Movement Therapy V. 46* (Dunphy & Mullane, 2018), utilises therapists' judgement to assess participants' demonstrated performance across five domains of 1.Physical (P), 2.Cultural (C), 3.Cognitive (CO), 4.Emotional (E), and 5.Social (S), divided into 17 sub-domains and 75 outcomes/items.

The *Framework* is not norm-referenced, but rather, utilises therapists' clinical judgement of individual's performance considered against the therapist's assessment of their potential at that time. Thus, its function is not to support therapists to enable clients to meet a norm, but to maximise their own potential given their age, ability level, health concerns and other factors influencing their current circumstances and future potential. Items are scored

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on a numerical scale, from 1 (not at all evident) to 9 (maximum conceivable). While the tool was available in a digital version *MARA* iPad, in this project three raters used an Excel version of the *Framework* formatted for recording data, because they did not have access to iPads.

While the therapist team had good English skills and were able to utilise the English version, they also chose to translate it into a preliminary Portuguese version to support their understanding of the items. They undertook the translation process themselves consulting with Framework's developer, author Dunphy, to check their understanding of items.

### Framework items assessed

Of the 75 items in the *Framework V. 46*, 59 were selected by the raters as relevant to *DG* groups. Items were included if: they were considered suitable to assess the established objectives of the program; reasonable given the skill level of the assessors; and not already assessed by another instrument the team was using. This third criterion resulted in the exclusion from consideration of a large proportion of the Social and Cognitive domains.

### Data collection

Observations were made in seven DG groups across a series of sessions, between four and nine per group, across 5 months. Program staff, one PM therapist, author Juma; and three PMT students (one Masters and two graduate level students on internship placement with *DG*) were involved in the rating process. The four had different levels of expertise in the modality and experience with these participants, from Juma who was a skilled therapist and familiar with the participant groups, to the students with less experience in both aspects.

They worked with authors Dunphy, the instruments' developer and Lebre, the students' counsellor to clarify scoring criteria. Prior to the rating process, the four practised the assessment process together twice within a session to develop their skills in using the instrument. Then as the task unfolded, because of the challenge of assessors using the instrument for the first time and rating across many items while also running a large group session, a decision was made to record entire sessions on video to enable raters more time for thoughtful reflection on the assessment process. The four raters watched the videos and scored their observations independently post-sessions.

### Procedure

### Statistical analysis

All data collected was exported from *MARA* and *Framework* scoring sheets into individual Excel files for each participant, and then merged into a single

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database in *SPSS 24* (IBM Corp, 2016). An average score for each item for each participant was calculated if the item had been rated more than once. Statistical analysis performed included descriptive statistics (number and percentage of items rated; mean (*M*), standard deviation (*SD*), maximum (*Max*) and minimum scores (*Min*) per items and sub-domains. Percentage of scores and mean scores per item and sub-domains were used to create the group profile. The scale reliability-internal consistency was calculated for each sub-domain using Cronbach Alpha.

### Ethics

Ethics permission for this study was obtained from the University of Melbourne, number 1,647,380.2. Group members were asked for consent to participate, with the agreed ethics protocol including a process for approaching the next of kin when the responsible professional considered that the person needed support to consent to research participation. Given that the majority of participants had intellectual disability, informed consent was obtained from participants or their legal representatives prior to the commencement of the program, as part of the standard enrolment process.

## Results

### Frequency of rating of sub-domains and items

The total number of ratings 3281, showed variability in the distribution across sub-domains and items. The sub-domains with highest number of ratings were: Body use (12.3%); Body organisation and connectivity (11.0%), Emotional expression and regulation (10.9%), Effort: access to movement qualities (10.4 %); Fun, pleasure and enjoyment (10%), while those with the lowest frequency of ratings were: Shape: access to body shaping (3.7%); Relationship and communication with others (3.4%); Connection with the here and now (2.9%); Knowledge, diversity, and heritage (1.6%); Fitness and coordination (0.2%).

In terms of the number of ratings per item, those more frequently assessed were Independent initiation of activity (4.1%); Access to movement quality of Weight (3.7%); Energy appropriately attuned to activity (3.5%); Crossing body midline (3.1%), while items rated less frequently were: Sense of belonging to shared past stimulated (0.4%); Capacity to reflect on experiences (0.3%); Stamina (0.2%) and Access to Shape flow (0.1%) (Table 1).

### Internal consistency across the sub-domains

Internal consistency across the *Framework* sub-domains, calculated using coefficient alphas (Table 1), ranging between 0.60 and 0.8 α, were mostly considered

**Table 1.** Descriptive statistics – Sub domain/Items (N = 3281).

| Domain/Subdomain/Item | Number of ratings N(%) | Cronbach alpha α | M | SD | min | max |
|---|---|---|---|---|---|---|
| 1. Physical | - | - | - | - | - | - |
| 1.1. Body: Body Use | 402(12.3) | .665 | 5.3 | 1.8 | 1 | 8 |
| 1.1.1. Ability to access breath to support movement | 43(1.3) | | 6.0 | 1.9 | 2 | 8 |
| 1.1.2. Ability to utilise breath | 96(2.9) | | 4.8 | 1.6 | 2 | 8 |
| 1.1.3. Use of body parts – upper | 93(2.8) | | 5.7 | 1.4 | 1 | 8 |
| 1.1.4. Use of body parts – lower | 91(2.8) | | 5.0 | 1.8 | 1 | 8 |
| 1.1.5. Use of body hemispheres | 79(2.4) | | 5.1 | 1.9 | 1 | 8 |
| 1.2. Body organisation and connectivity | 361(11.0) | .752 | 4.9 | 1.8 | 1 | 9 |
| 1.2.1. Crossing body mid-line | 102(3.1) | | 5.8 | 1.6 | 3 | 8 |
| 1.2.2. Contra-lateral movement | 61(1.9) | | 5.0 | 1.8 | 2 | 8 |
| 1.2.3. Control of movement: initiation, sustainment, conclusion | 54(1.6) | | 5.6 | 1.3 | 3 | 8 |
| 1.2.4. Sequencing of body parts | 40(1.2) | | 4.1 | 1.8 | 2 | 7 |
| 1.2.5. Integration of body parts through movement | 33(1.0) | | 5.6 | 1.1 | 3 | 8 |
| 1.2.6. Balance | 71(2.2) | | 3.5 | 1.8 | 1 | 9 |
| 1.3. Effort: Access to Movement Qualities | 342(10.4) | .764 | 5.3 | 1.4 | 2 | 8 |
| 1.3.1. Time: sudden, sustained | 58(1.8) | | 5.1 | 1.3 | 3 | 7 |
| 1.3.2. Space: direct – indirect | 91(2.8) | | 6.0 | 1.4 | 3 | 8 |
| 1.3.3. Weight: active (light – strong); Passive (limp – heavy) | 122(3.7) | | 4.9 | 1.3 | 2 | 8 |
| 1.3.4. Flow: bound, free | 71(2.2) | | 5.0 | 1.4 | 3 | 8 |
| 1.4. Shape: Access to Body Shaping | 122(3.7) | .791 | 5.5 | 1.4 | | |
| 1.4.1. Directional shaping | 69(2.1) | | 5.1 | 1.5 | 2 | 8 |
| 1.4.2. Space carving | 31(0.9) | | 5.4 | 1.5 | 2 | 8 |
| 1.4.3. Shape flow | 2(0.1) | | 5.7 | 0.7 | 5 | 7 |
| 1.4.4. Shape qualities(open-close) | 20(0.6) | | 6.7 | 1.0 | 5 | 8 |
| 1.5. Space: Use of body in space | 252(7.9) | .699 | 6.1 | 1.7 | 1 | 9 |
| 1.5.1. Access to kinaesphere: near, mid, far reach | 35(1.1) | | 5.8 | 1.5 | 2 | 8 |
| 1.5.2. Movement across planes | 63(1.9) | | 6.3 | 1.6 | 3 | 8 |
| 1.5.3. Spatial intention | 40(1.2) | | 6.5 | 2.3 | 1 | 9 |
| 1.5.4. Access to levels in space | 57(1.7) | | 5.9 | 1.5 | 8 | 8 |
| 1.5.5. Body boundaries in space | 57(1.7) | | 6.2 | 1.8 | 2 | 9 |
| 1.6. Fitness/coordination/1.6.1 Stamina | 8(0.2) | - | 3.8 | 1.2 | 2 | 5 |
| 1.7. Relaxation | 259(7.9) | .795 | 5.2 | 2.1 | 1 | 9 |
| 1.7.1. Relaxed stillness | 95(2.9) | | 5.6 | 1.9 | 1 | 8 |
| 1.7.2. Deep, slow, regulated breathing | 72(2.2) | | 4.5 | 2.1 | 1 | 9 |
| 1.7.3. Release of physical tension | 35(1.1) | | 5.4 | 2.0 | 2 | 9 |
| 1.7.4. Release of psychological tension | 57(1.7) | | 5.4 | 2.0 | 2 | 9 |
| 1.8. Breathing | 145(4.4) | .625 | 5.0 | 2.3 | 1 | 9 |
| 1.8.1. Ability to access breath | 49(1.5) | | 6.2 | 1.9 | 1 | 9 |
| 1.8.2. Ability to utilise breath | 96(2.9) | | 3.9 | 2.1 | 1 | 8 |
| 2. Cultural | - | - | - | - | - | - |
| 2.1. Fun, Pleasure, Enjoyment | 327(10.0) | .945 | 5.7 | 1.6 | 2 | 8 |
| 2.1.1 Level of engagement | 65(2.0) | | 6.2 | 1.3 | 2 | 8 |
| 2.1.2. Level of enthusiasm | 63(1.9) | | 5.5 | 1.6 | 2 | 8 |
| 2.1.3. Smiling | 67(2.0) | | 5.4 | 1.6 | 2 | 8 |
| 2.1.4. Body ease | 49(1.5) | | 6.1 | 1.4 | 2 | 8 |
| 2.1.5. Verbal, vocal and non-vocal communication indicating enjoyment | 23(0.7) | | 5.5 | 1.8 | 2 | 8 |
| 2.1.6. Playfulness | 60(1.7) | | 5.7 | 1.9 | 2 | 9 |
| 2.2. Creativity and aesthetic sense | 158(4.8) | .763 | 4.5 | 1.2 | 1 | 8 |
| 2.2.1. Connection between body sensations, feelings, thoughts and imagination | 37(1.1) | | 5.0 | 1.7 | 1 | 8 |
| 2.2.2. Creativity inspired or expressed | 60(1.8) | | 4.4 | 1.8 | 1 | 8 |
| 2.2.3. Experience of aesthetic enrichment | 30(0.9) | | 4.1 | 2.6 | 1 | 7 |
| 2.2.4. Making an aesthetic decision | 31(0.9) | | 4.4 | 1.9 | 1 | 7 |

(*Continued*)

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**Table 1.** (Continued).

| Domain/Subdomain/Item | Number of ratings N(%) | Cronbach alpha α | M | SD | min | max |
|---|---|---|---|---|---|---|
| 2.3. Knowledge Diversity, Heritage | 52(1.6) | .885 | 5.8 | 1.8 | 1 | 8 |
| 2.3.1. New knowledge, insights, skills attained | 20(0.6) | | 5.0 | 2.3 | 1 | 8 |
| 2.3.2. Appreciation of diversity of cultural expression | 18(0.5) | | 6.8 | .4 | 6 | 7 |
| 2.3.3. Sense of belonging to shared past stimulated | 14(0.4) | | 5.9 | 1.6 | 4 | 9 |
| 3. Emotional | - | - | - | - | - | - |
| 3.1. Emotional expression and regulation | 357(10.9) | .780 | 6.3 | 1.6 | 2 | 9 |
| 3.1.1. Capacity to identify own feeling or emotional states | 57(1.7) | | 5.8 | 2.0 | 2 | 9 |
| 3.1.2. Appropriate mood, affect | 26(0.8) | | 6.6 | 1.1 | 3 | 8 |
| 3.1.3. Regulation of emotional expression | 31(0.9) | | 5.6 | 1.5 | 2 | 8 |
| 3.1.4 Energy attuned appropriately to the activity | 116(3.5) | | 5.9 | 1.6 | 2 | 9 |
| 3.1.5. Expression of appropriate feelings, emotions | 40(1.2) | | 6.0 | 1.4 | 2 | 8 |
| 3.1.6. Capacity to tolerate frustration | 35(1.1) | | 7.6 | .7 | 6 | 8 |
| 3.1.7. Reality orientation | 52(1.6) | | 7.2 | 1.4 | 2 | 9 |
| 4. Cognitive | - | - | - | - | - | - |
| 4.1. Initiative | 291(8.9) | .796 | 5.7 | 1.8 | 1 | 9 |
| 4.1.1. Indication of preferences and choice-making and making choices | 38(1.2) | | 6.5 | 1.6 | 2 | 8 |
| 4.1.2. Independent initiation of an action or activity | 133(4.1) | | 5.6 | 2.0 | 2 | 9 |
| 4.1.3. Leading, taking ownership of an activity | 52(1.6) | | 5.3 | 1.4 | 3 | 8 |
| 4.1.4. Confidence in expression of self | 57(1.8) | | 6.0 | 1.6 | 1 | 8 |
| 4.1.5. Capacity to reflect on experiences, make reflections via non-vocal, vocal and verbal communication | 11(0.3) | | 4.3 | 2.6 | 1 | 9 |
| 5. Social | - | - | - | - | - | - |
| 5.1. Relationship and communication with others | 111(3.4) | .910 | 6.2 | 2.1 | 1 | 9 |
| 5.1.13. Expressive vocal, verbal communication | 59(1.8) | | 5.8 | 2.0 | 1 | 9 |
| 5.1.14. Appropriate vocal, verbal communication | 52(1.6) | | 6.6 | 2.1 | 1 | 9 |
| 5.2. Connection with the here and now/5.2.1 Focus on the activity | 94(2.9) | - | 6.7 | 1.5 | 2 | 9 |

within acceptable values of 0.665 ≥ α ≤ 0.945, as recommended by George and Mallery (2003). Higher reliability values (α > 0.8) indicating good internal consistency were obtained in Fun, pleasure and enjoyment (α =.945), Relationship and communication with others (α = .910), and Knowledge, diversity, heritage (α = .885); whereas lower α values were obtained in Breath (α = .625) and Body use (α = .665). No calculation was made when only one item was rated in the any sub-domain. These results of acceptable values allowed us to proceed computing sub-domain mean scores.

## Average scores

Average scores for sub-domains (Table 1) were mostly situated above the mean (4.0), with the highest scores observed on Connection with here and now (*M* = 6.7) (S), Emotional expression and regulation (*M* = 6.3) (E); Relationship and communication with others (*M* = 6.2) (S); Use of Body in space (*M* = 6.1) (P); Knowledge, diversity and heritage (*M* = 5.8) (C), Initiative (*M* = 5.7) (CO) and Fun, pleasure and enjoyment (*M* = 5.7) (C). The lowest

mean scores observed were for Creativity and aesthetic sense ($M = 4.5$) (C) and Body organisation and connectivity ($M = 4.9$) (P).

Higher score values for items were in the Capacity to tolerate frustration ($M = 7.6$), Reality orientation ($M = 7,2$) (E), Appreciation of diversity of cultural expression ($M = 6.8$) (C), Focus on the activity, corresponding to the single item of the Connection here and now sub-domain (S) ($M = 6.7$), and Shape qualities ($M = 6.7$) (P), while the lowest values were observed in Stamina, the single item from the Fitness and coordination sub-domain included ($M = 3,8$) and Sequencing of body parts ($M = 4.1$) (P).

### Group profile

Figure 1 presents a group profile comprising the mean scores obtained from all DG participants on the 15 sub-domains assessed. This depicts the group's strengths in the higher-scoring Social (5.1, 5.2) and Emotional sub-domains (3.1) and areas of under-development in the lower-scoring sub-domains of Fitness and coordination (1.6.) (P) and Creativity and aesthetic sense (2.2.) (C).

We suggest that mean scores of participants' achievement on sub-domains and items can be utilised for program planning. If we assume that higher scores are indicative of higher performance of participants on these aspects, then we might choose to focus future planning on areas in which participants had lower scores, in this case Body use, Body organisation and connectivity, Effort, Shape, Fitness, and coordination, Relaxation, Breathing (P) and Creativity and aesthetic sense (C). We might offer activities that are
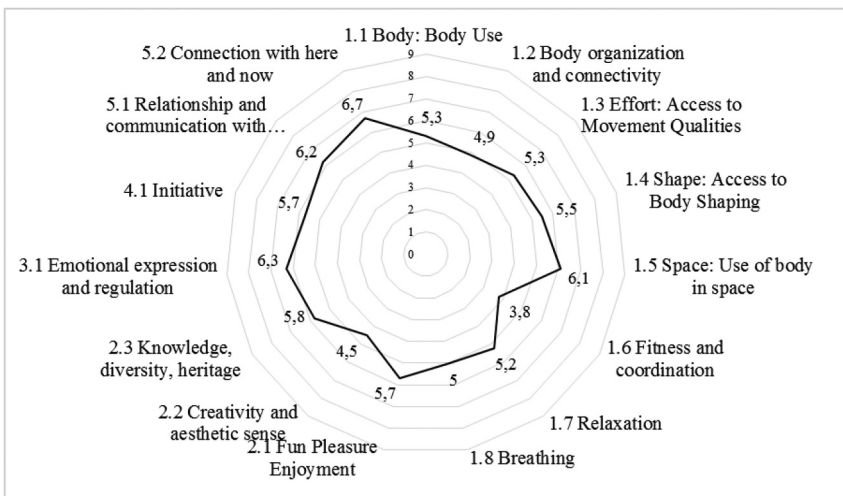


**Figure 1.** Group Profile – *Outcomes Framework for Dance Movement Therapy V. 46 (Dunphy & Mullane, 2018).*

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particularly targeted towards those outcomes, using more directive or guided discovery approaches. Sub-domains and items in which participants scored above the mean, in this case Use of Body in Space (P); Fun, pleasure and enjoyment, Knowledge, diversity, and heritage (C); Emotional expression and regulation (E); Initiative (CO); Relationship and communication with others, and Connection with the here and now (S), would still be addressed in the program given that they are priorities for the program funders, but may be given lower priority and a lesser focus. Given the basic skill mastery in these areas the profile shows, these activities might be addressed with less directive instruction modes, allowing participants greater scope for independent input, spontaneity and their own creative interpretation. It might also be prudent for therapists to intersperse activities in areas that are challenging for participants with activities in which they have good competence, to optimise motivation and engagement.

## Discussion

The present study was conducted to investigate the use of the *Outcomes Framework for Dance Movement Therapy* (Dunphy & Mullane, 2018) to establish a group profile in a PMT program using dance movement activities and the potential for this profile to enable data-based intervention planning. Results indicate the internal consistency, utility, and usability of the *Framework* for PMT intervention planning.

We offer some considerations of our results here. In addition to the relationship we presume between high scores and participants' level of demonstrated capacity, we also reflected on other factors that may have influenced the distribution, contributing to either higher scores or a higher number of observations on certain items. First, we consider that there may be a relationship between numbers of scores on items and participants' performance. A larger number of observations on any item may also indicate a stronger performance of participants on those items, with participants' behaviours scored more frequently perhaps because they were observed more readily. Conversely, for sub-domains and items on which participants were scored less frequently, it might be considered that they had activity limitations or restricted participation on those items, with a lower number of observations possibly indicative of less prevalent or obvious behaviours.

Second, issues to do with capacity of therapists in program planning and assessment might also be significant. We considered that a higher number and frequency of scores might be more likely if participants were offered an appropriate activity to elicit a particular behaviour, which would have required thoughtful planning and skills on the part of therapist. Conversely, if opportunities were not provided to participants to elicit the item being assessed, then they are likely to be less evident and be scored less frequently.

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Items might be scored more often by therapists who had a good under-standing of them and scored less often by those with less expertise in the area. In this study, three of the raters were students who had less experience with all aspects of the assessment tasks. It is possible that they scored less often on items that they had less understanding or familiarity with. A further consideration is that of therapists' own movement and aesthetic preferences. If these are not considered carefully in planning and assessment, and efforts made to reduce their impact, skewed or limited opportunities for participants might result.

Finally, a structural issue with the *Framework* itself will impact results, given that domains have different numbers of sub-domains and items, so that those domains having greater numbers of items by definition will receive higher numbers of scores. There is also a important consideration of the relationship between items in the *Framework* and existing individual and group intervention objectives, with those items most closely related to exist-ing program objectives likely to be scored more, given that they are likely to be the focus of sessions.

## Strength and the limitations of this study for clinical practice

This project had a number of limitations that impacted results. First, the assessment was undertaken by only one therapist with a good deal of practice experience, with the three other raters being relatively inexperienced students. None of the four had significant experience with formal assessment of a group using this instrument, which impacted their capacity to assess successfully and at the speed needed, given the number of items and participants.

The choice to rate so many items (59/75) in order to trial the *Framework* also meant that the task of assessment was substantial in these large groups of high support need participants. The use of video material therapists watched to score at a separate time was a solution in this case. This does address the challenge of enabling assessment of all participants against all items, but it does add significantly to workload, and is unlikely to be viable in practice settings in which therapists are not employed to undertake out of session preparation and follow up.

The decision not to assess items measured by other instruments in use at the time impacts the results, with items from the Social domain precluded, in a program in which social connection is a high priority. While this impacts the specificity of data about mean scores for items presented in the article, it does not impact our findings about the instrument's potential to enable the creation of a group profile.

As a result of the group profile process explored here, we offer a set of recommendations for group profiling processes. First, we suggest that the process of creating a group profile be undertaken in a carefully planned

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session that includes specific activities created to enable the observation of all participants on items selected. A manual of intervention options that have the potential to draw out specific outcomes would support this process. Clear, comprehensive definitions of items supported by video illustrations should be provided, particularly for elements those from the Physical domain that have very specific manifestations, and therapists well trained in understanding all items.

We might consider selection of a smaller range of items for scoring, perhaps those most closely tied to the program objectives; the agreement of a protocol for scoring the number and timing of observations on relevant items, which was not applied in this instance – which might include a decision to score each item only once, by the therapists deciding what they believed to be the average score for that item for that participant, or scoring several times, including each time the item was relevant or behaviour was observed, allowing for a full range of scores for each participant to be made and then averaged to contribute to the group profile; the designation of one or more staff in attendance to the task of assessment; and assessment undertaken immediately after the session while it is still fresh, precluding the need for time spent watching videos later.

Strategies therapists could employ to support participants towards achievement include selection of age-and skill-level appropriate tasks, scaffolding of the complexity of tasks, supportive verbal description, physical demonstration, the right amount of time dedicated to the activity, not too little or too much, repetition over session/s, again not too little or too much, and the interspersing of activities that are challenging for participants with activities in which they have good competence and motivating music or props. These strategies would address some of the possibilities we considered that items may not have been scored, or scored low, because participants were not offered opportunities to elicit such behaviours.

Significant technical skills were required in the group profile calculations, involving exporting of the ratings from Excel and *MARA* into *SPSS*. If the *Framework* is to be accessible to therapists for everyday practice, either making individual or group profiles, these tasks need to be facilitated more accessibly. Two tools have since been developed to address this issue, an Excel scoring sheet with embedded automatic formulas that calculate averages and other data as the therapist enters individual scores and *MARA* app's features that now includes automatic calculation and graphing of data as therapists score.

It is important to note that establishing a group profile and related objectives does not replace the need for individual profile and objective setting, but offers the possibility for programmes of establishing a clear understanding of the group, both strengths and areas for potential development. This information can also be useful for reporting purposes, enabling funders and agencies to understand participants' needs and potential benefits as an aggregate.

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In reflecting on the experience using the *Framework* for assessment in PMT, our raters considered first that it was valuable in helping them develop a shared understanding of what was being done in the program and why, thus bringing therapeutic decision-making from tacit to their explicit awareness. One aspect of particular note for PM therapists was the inclusion of outcomes from the Cultural domain that recognise the value of the creative expressive self. While these are not usually identified as a focus in PMT, the therapists recognised their use tacitly and their value in providing motivation for participants. This consideration of creative outcomes also led to reflection on the way PMT sessions can be planned and run, namely the possibility for elicitation of creative expression by using less directive instruction.

These findings substantiate data from previous research (Dunphy & Hens, 2018; Dunphy et al., 2016) that the *Framework* supports therapists' improved practice through more focussed planning and structured observation of participants' behaviour and useful discussion and collaboration between team members. In this case, it also offered further ideas for improvement of the therapist's practice, in a stronger focus on observation and prompting activities that are more participant-directed.

## Issues for future research

This exploratory study using the *Outcomes Framework* raises issues for further consideration. Our results indicate acceptable internal consistency values of the *Framework*, which complements findings from Dunphy and Hens (2018) on inter-rater reliability on two items. However, as our trial only used 59 of the full 75 options from the *Framework*, and the analysis included some items that had only a limited number of observations, we recommend that further validity and reliability analysis (internal consistency, test retest-reliability and interrater-reliability) be undertaken, and for all items of the *Framework*.

To address the identified issue for Lusophone peoples that instruments are required in Portuguese, a formal translation and translation validation process would need to be undertaken.

This process of group profiling was not used to offer any information about normative scoring for these participants on *Framework* items, given the heterogeneity of their diagnoses and presenting issues, but that is another possibility for future research. It may be useful for therapists to know the scoring range for other like participants on any item.

Other possibilities for future investigation of the use of the *Framework* include consideration of how regular assessment using it might contribute to improved practice, including potential impact on PMT participant outcomes, if therapists are catalysed by it to be more cognisant of program objectives and more focussed on those in session planning.

## Conclusion

This study explored the possibility that the *Outcomes Framework for Dance Movement Therapy* (Dunphy & Mullane, 2018) could be used to create a group profile in a community-based psychomotor therapy (PMT) program, and in so doing, whether such a profile could be used to define therapeutic objectives for a therapy program. We report results from a trial in which one PM therapist and three PMT graduate students assessed 61 participants of a PMT program in Almada City, Portugal across 59 items in the *Framework* in four to nine sessions over a period of months. Findings indicate that a profile can be created by averaging sub-domains and individual items scores for each participant, after internal consistency tests found acceptable to good reliability values. This profile could be used to set objectives for a program and support decisions about therapeutic interventions to meet participants' needs. It also offered the possibility of increasing therapists' awareness of their decision-making, by bringing tacit practices to explicit awareness, as was reported by PM therapists. Recommendations to improve the feasibility and quality of group profiling include a thorough training for users, a manual comprising a range of recommended interventions to elicit specific capacities, a structured protocol for assessment (number and timing of scores) and technological tools for management of data for practitioners working in low-resource environments.

# Notes on contributors

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