

# **Moving on from childhood trauma: the remedial potential of body-centered psychotherapy for children**

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A dissertation submitted to Auckland University of Technology in partial  
fulfilment of the requirements for the degree of Master of Psychotherapy

2021

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### **Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which, to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Anna Maria Engelbrecht

28 April 2021

## **Acknowledgements**

I would like to thank all the people who have supported me in undertaking this research project. This dissertation would not have been possible without all of your support.

To my supervisor Mariana Torkington, thank you for your encouragement, insight and guidance through this process. Thank you for all your investment which was given so freely.

To the teachers who invested so greatly in my learning at AUT and on this research, thank you for all your time and wisdom that you passed on.

To my friends who supported me with loving patience and encouragement. Thank you for your curiosity about my research, our conversations, and your unwavering belief in me.

To my husband, thank you for your kindness and care throughout this lengthy process. You have been a wonderful blessing to have by my side and to cheer me on.



## **Abstract**

Within Western approaches to trauma, the physical body has been relatively neglected in comparison to clinical interventions targeting the mind and the brain. Childhood trauma is an event which significantly imprints on the mind, brain, and body, placing the child at increased risk of mental and physical health problems in later life. This dissertation employs thematic analysis to study the use of movement-based therapeutic approaches for treating trauma in children. The primary research question is, “how can movement ameliorate the effects of childhood trauma?” The research revealed four main themes and eight sub-themes which highlighted the ways in which movement as a therapeutic modality can help children communicate, and express their trauma in symbolic and non-verbal ways, and to fundamentally change their relationship to their bodies and their sense of self. The research highlights how childhood trauma imprints on the mind, brain and body of the developing child, and optimal treatment approaches for children and young people are needed that incorporate the non-verbal and somatic legacy of trauma.

## Chapter One: Introduction

In my child psychotherapy work at a children's hospital, I have had the opportunity of working with several children who had experienced medical trauma, and I became increasingly curious about the impact of such trauma on their developing bodies and how that pain may be stored in the body. My training had equipped me to focus predominantly on the mind, emotions and the dynamic unconscious of the child, but I felt attention to the vast workings of the body was missing. I had a desire to expand my way of working with these children to address their embodied experience, and draw upon the body as a resource for bringing about psychic and emotional healing. Therefore, this dissertation reflects my personal interest and desire to expand my clinical knowledge and skills into 'bottom-up' ways of working with traumatized children, in adjunct to traditional psychodynamic approaches.

### 1.1 The Mind-Body Split & Trauma Treatment

Childhood trauma significantly imprints on the mind, brain, and body, and is associated with a wide range of negative mental and physical health sequelae (Felitti et al., 1998). This places the child at increased risk of mental and physical health problems in later life. Childhood trauma is associated with impairments in emotional, cognitive, neurological, and adaptive functioning, and is underpinned by autonomic nervous system and affect dysregulation. Within Western approaches to trauma, the physical body has been relatively neglected in comparison to clinical interventions targeting the mind and the brain. This is in part due to the longstanding split between mind and body which existed in ancient Greece and was made famous by René Descartes, a French philosopher during the 17<sup>th</sup> century, now known as *cartesian dualism*. This metaphysical stance held that the mind is nonphysical, and radically different in substance from the body and hence separate. This view paved the way for the positivist, analytical method of scientific inquiry. This was used to study the body using the biomedical model which developed from these views, by examining constituent parts (reductionism) and viewing humans as biological organisms (materialism) (Mehta, 2011). This view overlooked the significance of the interconnected nature of the mind and body, and treated the body as an object. Since then, contemporary views of health and human nature have emerged challenging the biomedical model and its view of the body as a machine. Although new conceptions of human nature and health have developed and infiltrated public consciousness, mind-body dualism continues as the philosophical framework of medical and healthcare practice.

In recent decades, the connection between the brain and body has become more widely accepted, and has significantly influenced trauma treatment, focusing on an integration of ‘top down’ cognitive restructuring interventions, as well as ‘bottom up’ psychophysiological interventions, however the latter has been under-utilized historically. Body psychotherapy (BP) as a discipline remains comparatively unfamiliar, and the body has historically been under-privileged as a useful medium of psychotherapy intervention. Freud originally emphasized body drives which he believed motivated much human behaviour, however since the inception of psychotherapy, the body has taken a backseat in favour of the mind. In Western cultures, medication and verbal therapies predominate as the main treatments for psychological healing, whereas in other cultures such as Eastern and African cultures, movement, mindfulness, rhythm and action are relied on and are commonplace approaches (van der Kolk, 2014). Practices include tai chi, martial arts, meditation, and rhythmic drumming. It is only within the past couple of decades that Western approaches have begun integrating body-based approaches for healing. The neuroscience revolution has significantly helped to provide scientific evidence for the brain-body connection, such as how early life stress can impact brain development, and increase risk for psychopathology later in life by being linked to higher levels of inflammation and immune activity (Danese & Lewis, 2017).

Looking at trauma treatments specifically, few trauma treatments have targeted somatic and psychological symptoms (Nemeroff, 2004). The majority of current treatments centre around narrative, memory-processing, or cognitive processing/re-framing, which deemphasize the role of the body (Bradley et al., 2005). Van der Kolk (2003) advocates that trauma leaves a deep imprint on a person’s psychobiology, and therefore requires some form of somatically oriented therapy to establish a sense of safety and mastery over their bodies.

## **1.2 Dissertation Overview**

This dissertation will thematically analyse the shared meanings and patterns across different forms of body-centered psychotherapy approaches used with children and adolescents in the treatment of trauma. This dissertation expands the knowledge base on the mind-body connection, and discusses ways of healing the effects of trauma for children between the ages of 5- 18 years, by working specifically with the dynamics of movement.

**Chapter 2:** This chapter provides a comprehensive review of the literature including the history of the study of trauma, childhood trauma and adverse childhood experiences, the impact of trauma on the developing nervous system and psyche of a child, the development of body

psychotherapy and dance/movement psychotherapy approaches for treating trauma, and movement approaches used with adults and children.

**Chapter 3:** In this chapter I describe the ontological position and methodological framework for the research.

**Chapter 4:** Chapter four gives a detailed description of the process of conducting the research using a thematic analysis method.

**Chapter 5:** This outlines the results of the research study, consisting of four global themes.

**Chapter 6:** In the final chapter I discuss the implications of the research, the strengths and limitations of the study, and future research, and provide my conclusion.

## Chapter Two: Literature Review

This chapter provides an overview of the relevant literature pertaining to my research question, *‘how can movement ameliorate the effects of childhood trauma?’* I begin with a look at the history of the study of trauma, including childhood trauma and current research findings about the various impacts on development of childhood trauma. The second section of the chapter provides a literature review of body psychotherapy and its use with traumatized adults. The final section looks at body and movement approaches for traumatized children.

### 2.1 A History of the Study of Trauma

The study of psychological trauma has a history of episodic amnesia, at times disappearing from professional interest and public awareness, only to resurface later. Our present understanding of trauma and its various psychophysiological and relational consequences, come from the synthesis of these previous studies over the past century. The study of psychological trauma started with interest in hysteria in the late 19<sup>th</sup> century by Jean-Martin Charcot, Pierre Janet, Sigmund Freud and Josef Breuer. Hysteria was understood as a disorder where psychological stress was converted into physical symptoms. Charcot, a French neurologist at the Salpêtrière hospital in Paris, established that the symptoms of hysteria were psychological in nature, linked to childhood trauma, and could be treated successfully with hypnosis (Herman, 1997). Whereas Charcot focused on exact observation and documentation of the symptoms, his followers strove to uncover the causes of hysteria. Janet, a French psychologist, paid particular attention to the inner lives of patients, spending hours with them listening to their stories. During the 1880s, Charcot, Freud and Janet, studying hysteria patients in detail, concluded that psychological trauma was the cause of hysteria (Herman, 1997). The unbearable emotions of the event caused an altered state of consciousness, which Janet termed ‘dissociation’ and Freud used the term ‘double consciousness’ (Ringel & Brandell, 2012). Both agreed that the somatic symptoms of hysteria were bodily expressions of the trauma, which had been banished from memory. Breuer & Freud wrote that these patients “suffer mainly from reminiscences” (1895, p. 7). Janet published the first scientific account of traumatic stress in 1889, which recognized that trauma survivors tend to continue an attempt at action, which began with the original traumatic event. This highlighted an innate bodily impulse for movement and action following the trauma.

In his work, 'Beyond the Pleasure Principle', Freud (1920) discusses 'traumatic neuroses', which differed from hysteria by the 'subjective ailment' of the sufferer (Oorlog, 2016). The individual experiences a repetition of the past trauma, often in the form of dreams, which frighten the individual and occurs outside of their control. Freud distinguished between the conscious and the unconscious, and those suffering from 'traumatic neuroses' had little control over their re-experiencing symptoms. Freud states,

*the patient cannot remember the whole of what is repressed in him, and what he cannot remember may be precisely the essential part of it...He is obliged to repeat the repressed material as a contemporary experience instead of, as the physician would prefer to see, remembering it as something belonging to the past* (1920, p. 18).

Freud's work thereby brought up the question of agency, the power of the unconscious, and the role of the body in harbouring and containing the individual's past trauma.

The second interest in the subject came following World War I with the influx of war veterans with 'war neuroses', now known as Post Traumatic Stress Disorder (PTSD). WWI soldiers showed symptoms which resembled hysteria- uncontrollable crying, memory loss, screaming, paralysis, mutism, and emotional numbness (Herman, 1997). Initially the term 'shell shock' was used, which attributed the symptoms to the concussive effects of exploding shells. The soldiers were often found in frozen positions of self-defence following a shell bombardment (Scaer, 2014). Kardiner, an American psychiatrist, started treating traumatized war veterans in the United States and published the Traumatic Neuroses of War in 1941. He introduced the concept of physioneurosis and gave a clinical outline of the traumatic syndrome known today. Observing re-enactment, as Freud and Janet had also done before him, Kardiner noted that "*the subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion*" (1941, p. 82). During this time hypnosis continued as a primary treatment, but Kardiner and his colleague Herbert Spiegel advocated that integrating the traumatic memory into consciousness is crucial for long-term remediation of symptoms (Ringel & Brandell, 2012).

In WWII there was a revival of medical interest in the subject. It was during this time that much of the stigma around combat neuroses was lifted, as psychiatric casualties were reframed as inevitable outcomes, directly related to the intensity and duration of exposure to combat. After WWII, studies emerged on the impact of prolonged stress and trauma, such as experienced by

soldiers and concentration camp survivors. Krystal was a psychoanalyst among them who observed that “*traumatized patients come to experience emotional reactions merely as somatic states, without being able to interpret the meaning of what they are feeling*” (van der Kolk et al., 1996, p. 60). He stated that these individuals’ capacity to identify and symbolize their affective experience was extremely limited, and they tended to somatise these feelings, which could not be mentalized.

Following the Vietnam War (1975), veterans presented with severe symptoms, which were highly similar to the symptoms of adult survivors of childhood incest/sexual abuse and victims of domestic violence. In 1980 psychological trauma and the diagnosis of PTSD was included in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III). The DSM defined trauma as a person who “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (1980, p. 427). Since the 1980s, there has been increased and sustained attention on trauma and its various deleterious effects on the mind, brain and body, supported by robust scientific inquiry. The development of trauma treatment may also be usefully divided into three generations, the first starting in 1980s with a focus on reducing the individual’s symptoms of PTSD. The second generation used an empowerment focused perspective which inspired group trauma based therapy, and which encouraged interpersonal connection. The third and current generation of trauma healing is trauma informed care, which is a holistic person-centered approach attending to the various biological, psychological, social, and neurological aspects of the individual that have been impacted by the trauma (Goggin, 2018).

## **2.2 Childhood Trauma (CT)**

It is common for children and adolescents to experience trauma, with two thirds of community samples having been exposed to at least one traumatic event by age 16 in the United States (American Psychiatric Association, 2020). A traumatic event is typically defined as an incident that is perceived as terrifying, shocking, sudden, or that poses a potential threat to one’s life or personal integrity or safety. It is usually a sudden external event that creates feelings of shock, fright, terror, fear and helplessness, and overwhelms the individual’s ability to cope. Trauma has also been defined as a “psychophysiological event that has happened to an individual whose involuntary autonomic nervous system becomes overwhelmed” (Elbrecht & Antcliff, 2014, p. 20). Trauma is an experience of toxic stress, where there is “strong, frequent, or prolonged

activation of the body's stress management system" (National Scientific Council on the Developing Child, 2014, p. 2). Ranging from mild to severe trauma, a range of events may be traumatic such as abuse, neglect, loss of a loved one, natural disasters, witnessing violence, accidents, and traumatic losses. Traumatic experiences are also common in youth, with an estimated incidence of 20% (Finkelhor et al., 2009). The DSM-5 includes the following symptoms of PTSD for the paediatric population: "involuntary and distressing intrusive memories of the event; nightmares; trauma-specific re-enactment in play; avoidance of thoughts, feelings, and places that might arouse memories; inability to remember the trauma; hypervigilance; exaggerated startle response; sleep disturbances; and dissociative reactions" (APA, 2013, n.d.). Distinct diagnostic criteria are used for children under the age of six. Children differ in their reactions to trauma, but often more severe psychological trauma elicits greater reactions and maladjustment (Monahan, 1993). Short term distress following a trauma is normal and expected, and young people commonly exhibit difficulty sleeping, emergence of new fears, separation anxiety, somatic complaints, difficulty concentrating and changes in mood (APA, 2020). Most children exhibit resilience in the aftermath of a single incident traumatic event, and return to their baseline functioning with an unaltered developmental trajectory, however, a subset of children develop PTSD.

For children, whose coping mechanisms are still developing, they are extremely reliant on their caregivers to regulate their physiological arousal and affect, however in cases of child maltreatment by family members, the caregiver becomes the source of fright and terror. This leaves the child more vulnerable and alone and unable to turn to the caregiver for regulation and comfort. These overwhelming physiological experiences have a negative impact on the development of the mind, brain, and body, and residues of the trauma may remain within the individual's psyche and body for many years. Numerous studies have shown the association between CT and autonomic and affect dysregulation later in life (Ford et al., 2005; Siegel, 1999).

### ***2.2.1 Adverse Childhood Experiences***

Over the last two decades, substantial research has amassed showing that early life stress (ELS) generates a vulnerability towards physical and mental illness in later life (Syed & Nemeroff, 2017). The Adverse Childhood Experiences (ACE) study compared adult health status with ACEs, and showed that children's emotional experiences had long-term effects on emotional, mental and physical health as adults (Felitti, 2002). The number of ACE's is associated with the severity and complexity of psychopathology, mental comorbidities, and poor mental and



physical quality of life (Edwards et al., 2003; Pirkola et al., 2005). For example, a person with an ACE score of 4 (a total of 4 ACEs), were 460% more likely to be depressed as an adult compared to those who had zero ACEs (Felitti, 2002). Many of the diagnoses of psychopathology managed and treated by the medical and psychiatric disciplines are ‘downstream’ tertiary consequences of ACEs. These early stressful events are often not processed or worked through, and many years later manifest in the mind as mental illness, or in the body as physical illness. Traumatic childhood experiences increase the child’s risk of developing mental or physical illness in later life (Goodwin & Stein, 2004). Severe childhood stress is considered a robust risk factor for the development of psychopathology, especially anxiety and depression (Penza, Heim, & Nemeroff, 2003), as well as PTSD (Cougle et al., 2010), and psychosis (Varese et al., 2012). Several studies have also illuminated the close association between ELS and adverse physical health outcomes, such as cardiovascular, gastrointestinal, neuromusculoskeletal, pulmonary, inflammatory, metabolic diseases, and chronic pain conditions (Scott et al., 2011; Dong et al., 2004; Wegman & Stetler, 2009). ELS has a high universal prevalence, with an estimated 30-40% of adults experiencing some form of ELS, making ACE’s a major public health concern (Agorastos, et al., 2019). The risk of impaired physical and psychological wellbeing following ELS is believed to be cumulative. Many negative risk factors often co-exist, such as poverty, parental absence, parental illness, or substance abuse, creating an environment of multiple chronic stressors.

### **2.3 The Impact of Childhood Trauma on the Central Nervous System (CNS)**

Early trauma interferes with the normal functioning of the CNS, and alters the developmental trajectory of neural networks, as it affects the development of key structures and circuits in the brain. This can cause significant changes to brain structure and function. The brain structures and circuits that are activated more grow stronger and become permanent, which Perry (2001) describes as the brain developing in a ‘use dependent’ manner. This is problematic for children who experience early life trauma, which exposes their developing brains to prolonged stress. Specific areas involved in the stress response system is the limbic system (including the amygdala, thalamus and hippocampus) and the pre-frontal cortex (pFC). Abnormalities in the fronto-limbic system have been associated with experiencing trauma (Karl et al., 2006), and may be permanently altered. A decrease in prefrontal cortex activity causes difficulties with thinking clearly and inhibition (Weniger et al., 2008). Decreased size of the amygdala (the brain’s alarm system), is often found (Bremner, 2006). The prolonged activation of the

amygdala causes it to become sensitized to threat, as the brain adapts to its environment. These changes have a detrimental impact on the way emotions are processed and managed, how information is processed, and the capacity to relate to others. Children who have experienced early life stress have been found to have smaller intracranial volume, smaller corpus callosum, and reduced hemispheric integration (Pechtel & Pizzagalli, 2011). Furthermore, children with PTSD have smaller frontal lobes and corpus callosum (a large bundle of nerve fibres which connects the two cerebral hemispheres), affecting inter-hemispheric communication (Karl et al., 2006). Trauma changes the brain, however the extent and impact of this depends on the age of the child and the severity and duration of the trauma.

Lanius and colleagues studied people's brains when they were not thinking and their brains were idling (the 'default state network'), comparing 'normal' adults with no trauma, to people with a history of chronic child abuse (Bluhm et al., 2009). They found that all the midline structures of the brain involved in their sense of self (the posterior cingulate, anterior cingulate, insula, and the medial prefrontal cortex) were offline, where in the normal group they were activated. This showed that as a coping mechanism, chronically traumatized individuals cut off the visceral feelings and emotions, deactivating those brain regions involved in self-awareness and self-sensing. Furthermore, abnormal activation of the insula is commonly seen in brain scans of traumatized individuals (van der Kolk, 2014). The insula receives input from internal organs and interprets and organizes the information to generate a sense of embodiment. Trauma changes the brain, it interferes with areas that register sensory input, and the interpretation of information and experiences. Trauma disrupts the perceptual boundary of a person's safe sense of self from the rest of the world (Scaer, 2014), and the result is a compromised sense of self.

### ***2.3.1 Stress Reactivity***

In early life, the stress response system is underdeveloped, and is highly responsive and sensitive to environmental stimuli. CT and other early life stressors generate acute psychological stress, which triggers the neural stress response system. In the short-term, the physiological changes performed by the stress response system sustains the viability of the individual by achieving allostasis, enabling adaptation and survival. In the case of frequent or prolonged stress, the hormonal stress mediators increase the individual's vulnerability towards mental and physical disease (McEwen, 2000). Under chronic stress, the internal adaptive changes become deleterious to growth and wellbeing. Some of these effects include inhibited neurogenesis, neurotoxicity, and disrupted neural plasticity. Thus, the early environment

provides the input around which the Hypothalamic-Pituitary-Adrenal (HPA) axis is programmed, to aid the individual's optimal adaption to its environment. Traumatized individuals' stress response system has been sensitized and stress hormones take longer to return to normal (van der Kolk, 2014). Following trauma, especially early life trauma when the brain is highly malleable, the amygdala (the brain's 'smoke detector' for danger) becomes faulty, misperceiving danger. Individuals have difficulty perceiving when they are safe and when they need to protect themselves and often respond to neutral stimuli as if they were back in the original event, with the same hyperarousal and activation of the brain stem (Perry et al., 1995). Innocuous images and stimuli can trigger powerful trauma reactions as they are interpreted as threatening. These children are always geared for attack and survival. Bremner (2006) states that individuals with PTSD exhibit higher levels of cortisol and norepinephrine in response to a stressor.

These neurophysiological changes caused by severe or chronic stress during childhood, negatively affect the developing brain's capacity to regulate affect and arousal. Traumatized children often struggle with emotional dysregulation and cognitive impairment. Trauma therefore predisposes children toward becoming anxious, avoidant or disorganized (Lohrasbe & Ogden, 2017).

### ***2.3.2 Language and Memory***

Neuroimaging studies have shown that when trauma victims think about the event, the left hemisphere becomes deactivated and the right hemisphere shows increased activation (van der Kolk, 2014). The Broca's area, a key language area, also goes offline, which helps explain why trauma victims feel as if they are re-living the event but cannot analyse it or put the experience into words as the trauma interferes with declarative memory (conscious recall of an event). The hippocampus, responsible for declarative verbal memory, is another structure in the brain that is negatively affected by trauma. Bremner (2006) has found that individuals with PTSD have deficits in verbal declarative memory, and several studies have found impairments in memory and cognition following a traumatic experience and a smaller hippocampus (Weniger et al., 2008; Karl et al., 2006). However, a smaller hippocampus has only been found in adults and not in children; it is believed this abnormality is not detected until adulthood (Karl et al., 2006). In 1990, the psychiatrist Lenore Terr discovered that individuals' trauma memories were less explicit or declarative, and more sensory, implicit and perceptual (Malchiodi, 2020). This finding has been echoed and supported by van der Kolk (1994) who proposed that trauma memories are often stored as non-verbal, sensory fragments. The trauma is no longer a

consciously accessible memory but lives on in the child's implicit memory, which are the emotional responses, habits, and sensorimotor sensations of the event. Normal day to day memories are subject to change and editing as memories are retrieved, however trauma memories tend to be preserved as the original memory. This memory is incoherent, fragmented, made up of images, sounds, and sensory data that is unintegrated. The trauma memory exists as a fragmented memory not integrated with the rest of the individual's identity. Often these memories are forgotten only to resurface at a later stage.

### **2.3.3 Trauma & the Body**

For young children who experience trauma, they experience fear, terror and helplessness, which overwhelm their immature nervous system and regulating capacities. The body stores a somatic memory of the event, such as the sights, smells, sounds, and embodied feelings. The young child responds to traumatic incidents with primitive defences driven by the fight-flight response of the reptilian brain. The child may turn inward, dissociate, shut down, or become hypervigilant and clingy towards the caregiver in an effort to maintain safety and survival. These behaviours are procedurally learnt, automatic, and unconscious patterns of behaviour which remain active after the event. The child retains these habitual responses and they are evoked in future situations that trigger or resemble the original trauma. The young child may tense its muscles when threatened or alarmed, and this becomes a lifelong tendency encoded in the body (Fisher, 2011). These behavioural tendencies and bodily responses are re-evoked in response to attachment stimuli in later relationships, such as shutting down (hypoarousal) or panic and fear (hyperarousal). Certain behaviours and emotional responses are evoked without the ability to recall the events in which these behaviours developed (Grigsby & Stevens, 2002). In this way the traumatic experience is being maintained by the habitual activation of behavioural and emotional responses that trigger the CNS. Terr (1990) states that "*traumatized children repeat in action. Whereas adults who are shocked or severely stressed tend to talk about it, dream, or to visualize, children take far more action*" (p. 265).

The trauma is not just experienced in the mind and emotions, but on a sensory level. This may explain why children who have experienced early or chronic trauma are often disconnected from their bodies, and have poor interoceptive awareness (Ogden & Gomez, 2012), because they are not actively in control of their own body and emotions. Indeed, traumatized individuals are at more risk of becoming disconnected from their body, and somatic symptoms are common in this population, such as asthma, fibromyalgia, chronic fatigue, and irritable bowel syndrome (van der Kolk, 2014).

## 2.4 Body Psychotherapy

In this section I give an overview of the historical development of body psychotherapy (BP), and the core pioneering theories of the discipline. Body psychotherapy has historically been viewed as an ‘alternative’ therapy, placed outside of mainstream psychotherapy (Staunton, 2002). A split emerged between traditional psychoanalysis focused on the mind, and body psychotherapy oriented around action and the body, however this split was not existent in early psychoanalysis. In Freud’s early practice he worked directly with the analysand’s body, such as massaging the body or applying direct pressure to specific bodily areas to relieve pain and tension (Totton, 2002). Such practices were later lost in contemporary psychoanalysis. Freud’s structural model of the mind was indeed based on the body, as he said “*the ego is first and foremost a bodily ego*” (Freud, 1923, p. 364), highlighting the embodied nature of consciousness. Writing to his friend Wilhelm Fliess, Freud states,

*Yesterday Mrs K again sent for me because of cramplike pains in her chest; generally it has been because of headaches. In her case I have invented a strange therapy of my own: I search for sensitive areas, press on them, and thus provoke fits of shaking that free her.*

(Masson, 1985, p. 120).

Psychoanalytic theory was intrinsically body-centered as it was based on bodily drives and the tension of expressing and satisfying these drives in a civilised society, where repression and prohibitions are required. Freud used hypnosis and touch, and the idea of the body-mind connection was a practised discipline (Ben-Shahar, 2012). Freud moved away from the use of touch after discovering transference and the re-enactment of sexual or erotic transference in the therapeutic relationship. Following on from the direct somatic interventions in the treatment of hysteria, the body largely took a place at the side line in psychoanalysis. However, Sandor Ferenczi and Wilhelm Reich continued as the two main practitioners practising body-mind psychotherapy at the time. Ferenczi experimented a great deal in his therapeutic work and, influenced by Georg Groddeck, began working actively with client’s body process, movements and expressions. This was unfavourable in the psychoanalytic community at the time, which preferred a more distant observer/surgeon position (Anderson, 2008).

Reich, a student of Freud’s and the originator of BP, developed his body-centered psychoanalytic technique which sought to reconcile mind and body within the client. Reich was chiefly interested in repression, specifically *how* children repress their desires, which he

understood as a primarily bodily phenomenon located in the rigidity of the musculature (Staunton & Samuels, 2002). He concluded, “*muscular rigidity, wherever it occurs, is not a ‘result’, and ‘expression’, or a ‘concomitant’ of the mechanism of repression. In the final analysis...somatic rigidity represents the most essential part of the process of repression*” (Reich, 1973, p. 300). One of his key ideas was that of muscular armour- a somatic defence of the musculature to protect the self. Like defence mechanisms, muscular armour develops relationally. The body comes to be organized in a way which manifests the defended against affects or drives, for example a tense jaw which withholds the expression of anger (Ben-Shahar, 2012). A primary goal of Reich’s BP was to create the environment, through the therapeutic relationship, by which these psychosomatic patterns could be dissolved (Boadella, 1985). Reich worked on clients’ muscular rigidity as a way of relieving repressions and freeing unexpressed affects. His initial form of BP was slow and un-invasive, with a strong element of using the breath (Totton, 2002). He advocated for the unity of the mind and body within the individual and therefore disagreed with Freud’s ideas that the mind should control emotional and energetic discharge, which placed the mind in a position of domination over the body (Reich, 1972). The tension of the autonomic nervous system, such as rigid musculature and holding the breath “*is the concrete form in which ‘mind’ (ego) seeks to dominate ‘body’ (id), by ‘tying up’ desiring impulses*” (Staunton & Samuels, 2002, p. 14). Reich sought to address the embodied patterns of resistance of his clients and therefore moved away from primarily verbal analytic methods (Totton, 2020). For example, he wrote:

*All our patients report that they went through periods in childhood in which, by means of certain practices in vegetative behaviour (holding the breath, tensing the abdominal muscular pressure, etc.), they learned to suppress their impulses of hate, anxiety, and love. ... It can be said that every muscular rigidity contains the history and meaning of its origin*  
(Reich, 1973, p. 300)

He later developed orgonomy, which was taken up by Alexander Lowen, a student of Reich’s who incorporated these ideas into a more publicly accessible approach called Bioenergetics (post-Reichian school). Other non-Reichian somatic therapies developed, namely Focusing, Primal therapies, Holotropic breathwork, and process-oriented psychology (Totton, 2020).

Working with traumatized and hysterical patients, Ferenczi also engaged actively with his analysand’s bodies by promoting the transition into altered states, whereby the client relived

and discharged traumatic memories (Totton, 2020). He thereby returned to Freud's core method of bodily discharge, where the rest of the psychoanalytic discipline was privileging transference, and moving further away from working with the body. Ferenczi confirmed Freud's and Breuer's earlier observation and radical theory at the time, that hysterical symptoms could be alleviated by restoring the memory of the trauma with accompanying emotional discharge (Staunton & Samuels, 2002). This idea has been echoed by trauma therapists today. Freud and Breuer stated, "*we must presume...that the psychological trauma- or more precisely the memory of the trauma- acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work*" (1895, p. 56). Reich and Ferenczi sought to release the tension of the voluntary musculature, along with the feelings and memories contained in the muscles and soma.

Since the pioneering work of Freud, Reich and Ferenczi, BP has proliferated into a number of different schools, modalities and ways of working. BP has also been strongly influenced by practices such as yoga, martial arts, dance and movement therapy, and meditation. Despite the overt suspicion of the role of the body among the psychoanalytic community, prominent psychoanalysts nonetheless held the body and its movements in high regard and focused a great deal of analytic attention to it in the therapeutic encounter. Winnicott (1949) in his analysis of a 47-year-old woman, observed her body closely, and reacted with movements of his own, such as noting changes in breathing and muscle contractions. Through his own breathing, and listening to her body he was holding her, and demonstrates the importance of joint movement (Engelhard, 2017). In another example, Ogden (2001) successfully treated a 38-year-old male attorney who was a victim of child sexual abuse. Ogden observed and witnessed the man's body communicating the memory through the body's frantic movement on the couch, and gently brought the sensations to the client's attention and created space to think about the body's movements and their meaning. Thus, movement is an essential component of therapy, but has been approached with much caution.

#### ***2.4.1 Contemporary Developments of Body Psychotherapy***

Contemporary approaches to trauma using the body include most prominently the work of traumatologists Levine, with his pioneering Somatic Therapy, and Ogden's Sensorimotor Psychotherapy. Both of these therapies attend to the way traumatic experiences and memories are stored in the body and not as a cognitive, conscious memory, and help clients access these experiences without the primary use of verbal narration and cognitive reflection (Ringel &

Brandell, 2012). Their clinical technique aims to release blocked instinctual responses to trauma that are encoded and stored somatically. This is achieved by attending to the body experience of both the client and therapist during the session, which has been described as a ‘bottom up’ trajectory in contrast to the traditional psychoanalytic approach of creating a narrative that generates more coherency (‘top down’) (Eldredge & Cole, 2012). They assert that focusing primarily on the client’s sensate experience enables the completion of this blocked response. This invites a new meaning to emerge as the client gets in touch with the various sensations and associated affects that they have been defended against (Levine, 2010). Their work has contributed to a significant change in trauma treatment towards emphasizing the felt sense of the body in treatment, rather than purely attending to cognitive or affective aspects of experience.

van der Kolk (2014), a preeminent psychiatrist at the forefront of trauma research advocates in his book ‘The Body Keeps the Score’, for physiological regulation through breath and movement. He highlights the value of action in connecting to and overcoming the powerless, frozen and trapped condition of the traumatized individual. He emphasizes the importance of the body in trauma treatment, such as through drama, dance and martial arts. He states, *“trauma robs you of the feeling that you are in charge of your life...the challenge of recovery is to re-establish ownership of your body and your mind- of your self”* (van der Kolk, 2014, p. 203). He also asserts that the learning achieved through trauma treatment is not just cognitive but bodily, for example *“for real change to take place, the body needs to learn that the danger has passed and to live in the reality of the present”* (van der Kolk, 2014, p. 21).

The branch of occupational therapy known as Sensory Integration, has shown the modulating effects on arousal of sensory motor input generated through movement (Koomar & Bundy, 2002). Preliminary clinical experience with traumatized children and adolescents using gross motor activity has shown the modulating effect of active sensory-motor play and movement on levels of arousal (Warner et al., 2013).

#### **2.4.2 Dance/Movement Therapy**

Dance/movement therapy (DMT) is defined as *“the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual, for the purpose of improving health and wellbeing”* (American Dance Therapy Association, 2020). DMT is an expressive approach where the body is central in enabling healing. It is based on the premise of holistic wellbeing and the interconnectedness between mind, body and spirit. It views



movement as the foundation of human communication (Goggin, 2018). DMT can tap into unconscious emotions and experiences, and uses the body as a vehicle through which to express and release difficult stored feelings and memories. One DM therapist states,

*Dance/movement therapy embraces a felt-sense knowledge of working. It provides us with information and methods of knowing that are body-based. As dance/movement therapists, we have created a whole body of work from this deeply felt-sense and primarily experiential way of knowing”* (Capello, 2008, p.36).

DMT enables the working through of issues located at a non-verbal or pre-verbal level, and bypasses the need for significant cognitive capacity. It utilizes a number of techniques including mirroring, ritual, body scanning and learning body-based skills and self-soothing strategies. DMT has been used since the 1940s as a treatment modality for a diverse range of mental illnesses and psychological disturbances, such as eating disorders, depression and PTSD. However, the use of dance and movement as a form of healing has existed for thousands of years (Ritter & Low, 1996).

The use of movement for the treatment of trauma is based on the theory that the body’s natural response to trauma is to shut down as a defensive mechanism (Levine & Land, 2016). The traumatic experience is unintegrated and a disconnection develops between kinaesthetic, emotional, and cognitive experiences (Pierce, 2014). The mind and body become disconnected and cut off from each other (Ogden et al., 2006). Therefore, a goal of a body-oriented approach, including DMT, is to bring trauma survivors back into their bodies and increase their awareness of their bodies’ feelings and responses. Using movement helps individuals to become aware of their body, its responses, and how the trauma has manifested in the body. Ogden, Minton & Pain (2006) suggest that involving the body in trauma treatment reduces the duration of necessary treatment as it establishes connections between thoughts, feelings, neurobiology, and the somatic responses.

There is currently no manualized DMT intervention for the treatment of trauma, which has meant evaluation of the effectiveness of this approach has been limited. A meta-synthesis of qualitative studies on DMT for trauma, conducted by Levine & Land (2016), found the re-establishment of connections between the mind, body and brain can help heal PTSD symptoms, making DMT an effective treatment for trauma. In the literature reviewed, effective DMT approaches included four essential elements:

*(a) creating awareness of the mind–body connection; (b) increasing the range of movement (for the purpose of efficacy, empowerment, and reclaiming the body); (c) creating a new and*

*healthy relationship with the self, therapist, or group through the movement process; and (d) creating a new and healthy relationship with movement* (Levine & Land, 2016, p. 343).

Much of the existing literature supporting the efficacy of DMT for trauma comes from case studies and interviews (Pierce, 2014). Parker (2018) in a literature review of DMT for PTSD, found it is an effective treatment, due to DMT's inherent connection to the body, its compatibility with other treatment modalities, its accepting nature, and for helping patients develop coping skills. Tin Hung Ho (2015) in a research study on the impact of a DMT program for adult survivors of sexual abuse, found that the participants reported increased awareness of personal boundaries, more hope and interpersonal understanding. The intervention utilized creative dance both individually and as a group, as well as group movement games. This intervention supported their development of a sense of security and their sense of connectedness to the self and others. Goggin (2018) concludes that DMT has shown to be an effective therapeutic modality for alleviating the symptoms of trauma.

#### **2.4.3 Trauma Treatment for Children**

In the past two decades more trauma research has focused on the paediatric population and appropriate treatments, and has recognized traumatic exposure as significant contributors to morbidity in children (Tareen et al., 2007). Van Westrhenen and colleagues state that *“establishing an effective treatment protocol for children after trauma is challenging and there is no consent on what is internationally recognized as evidence-based health care”* (et al., p. 134). However, common and widespread approaches for the treatment of child trauma include Cognitive Behavioural Therapy (CBT), play therapy, and creative arts therapy (Van Westrhenen & Fritz, 2014). CBT focuses on verbal disclosure and dialogue of the trauma, transforming negative thoughts and emotions. Dorsey (2017) and colleagues state that the most successful treatment for children and adolescents who have experienced trauma is individual and group CBT, however, there are currently inadequate studies on mind-body approaches. Mind-body coping skills have been considered ‘possibly efficacious’ and ‘experimental’, as there is currently an insufficient amount of research on the effects of mind-body approaches compared to CBT (Goggin, 2012). Gillies and colleagues in their critical review asserts that there is no clear evidence for the relative effectiveness of psychological interventions for childhood PTSD (et al., 2012). The majority of treatment approaches for traumatized children have been ‘top-down’- focused on changing cognition and thought patterns to relieve symptoms (Goggin, 2018). Evidence for non-verbal and embodied interventions exists from

mostly ‘practice-based evidence’ which consist of case studies by therapists (Southwell, 2016). The nature of expressive arts therapies and embodied approaches is non-directive, fluid, and generally non-linear which makes it difficult to apply to scientific experiments and randomized controlled trials. Therefore, it is not currently considered as ‘evidence-based’ practice. However, Klorer (2017) states that there has recently been “*a shift away from conscious, explicit, left-brain discourse to the non-verbal, body-based approaches utilizing all three levels of the brain*” (p. 14). Numerous professionals agree that non-verbal interventions may be more effective for certain populations, such as younger children (van Westerhenen et al., 2017). Top-down approaches, which focus on cognition and thought patterns, may overlook the somatic and biological traces of trauma that are unconscious and implicit.

Various creative and expressive arts approaches have been developed for use with traumatized children which suit their developmental needs of expressing their experience in a non-verbal, non-threatening, and playful way (Van Westrhenen et al., 2017). Expressive arts can be understood as an umbrella term for a range of play and creative arts modalities used in psychotherapy, including arts therapy, music therapy, drama therapy, DMT, poetry and bibliotherapy, play therapy, and sandplay therapy (Malchiodi, 2005). Expressive arts therapies are action-oriented, and tap into the implicit embodied experience of trauma, addressing the sensory-based aspects of the experience (Malchiodi, 2020). Due to the visual and sensational nature of the traumatic experience, recent neuroscience findings support the use of creative or expressive arts therapies for the treatment of trauma, as the memories are stored in the brain and body and often cannot be accessed with words (van der Kolk, 2002; Van Westrhenen & Fritz, 2014).

Over the last decade there has been significant development of expressive arts therapy approaches for traumatized children, informed by trauma and attachment theories and neuroscience. The field of child and adolescent PTSD is relatively young and although significant research has been developed, much of the existing knowledge base is still focused on adults (APA, 2020). A shift in interest to non-conscious processes and operations of the brain-mind body is propelling work in the area of somatic, body-based ways of working with children.

#### **2.4.4 Movement Approaches with Children**

Dennis McCarthy is a psychoanalyst who first trained in dance therapy, Jungian Analysis, and Bioenergetic Analysis, and has developed his own body-centered play therapy approach with

children. He combines the use of movement, sandplay, drama and art materials, in a child-led approach that utilizes the imagination in a body-centered format (McCarthy, 2007). He states that, “*children speak in the immediate language of the body and the imagination, their symbols being a composite of the two- body and mind*” (McCarthy, 2007, p. 29). In his book, “If You Turned Into a Monster: Transformation Through Play”, McCarthy gives a number of case illustrations of his work with children, including children with a trauma history. He suggests that the key element in therapeutic work with children is accessing the energy within the child, and he employs a variety of sensory and physical mediums, such as foam bats, clay, a mattress and a trampoline, to direct and enable the expression of the child’s feelings and energy in a way in which the child becomes more aware of their body. McCarthy’s approach is believed to be effective for traumatized children, however it was not designed specifically for this population, and has not been systematically evaluated.

Levine (2010) has applied his theory to working with children, guiding them in play to successfully discharge the emotions that accompanied their traumatic experience. For example, enabling them in play to complete an active escape or other instinctual motor impulse geared towards survival, where they had previously experienced helplessness during the trauma. This often involves active play and movement as the body mobilizes and completes a previously thwarted action. His work too has shown great promise and effectiveness for helping children heal from trauma, although there is no distinct somatic therapy training program geared towards children, limiting its accessibility.

In their book ‘Born for Love’, Szalavitz and Perry (2010) discuss the effects of trauma, and the potential of music and movement as powerfully restorative for traumatized children. The combination of music and movement, such as through rhythmic drumming, provides regulation for the stress response system, and thereby provides relief from anxiety.

Research supports the use of DMT for children who have experienced trauma, as well as for social, communication and expressive difficulties (Levy, 1995; Tortora, 2005). Support for the use of DMT for adolescents specifically is hopeful, suggesting that it can change mood states and affect quality of life (Anderson, 2014). This research also suggests it to be an effective treatment modality for trauma. Coburn (2018) in her thesis, showed that DMT was helpful for adolescent females in a residential treatment centre, in identifying their internal mood states and learning coping strategies. Jeong (et al., 2005) tested the efficacy of DMT on reducing the negative psychological symptoms of depression in adolescent females. They found reduced

concentrations of dopamine and increased concentrations of serotonin following the group DMT intervention, showing that it can provide improvement of depressive symptoms.

Demott (et al., 2017) carried out an early intervention program for asylum seeking boys between the ages of 15-18 years. This population of children often have a trauma history and reduced mental health functioning. The study used expressive arts therapy, and compared the children's levels of life satisfaction and hope with a control group who had no intervention. The study found that expressive arts was an effective modality to increase the adolescent's hope and life satisfaction. The modality included some movement-focused activities, such as gestures and mirroring, among other arts-based aspects. However, as this study used different arts interventions, the results do not point to the effectiveness of movement approaches on their own. Malchiodi (2020) also advocates for including creative arts interventions (including movement) for trauma treatment based on current evidence and emerging brain-body practices, asserting that it can restore the child's aliveness and soothe the mind and body.

## **2.5 Summary**

In this chapter I have detailed the historical developments of trauma theory and practice, the deleterious effects on the brain and body of childhood trauma, and reviewed the development of body-based ways of working with traumatized individuals. Movement approaches with children pursue a somatic sense of wholeness and integration between the mind and body, and are supported by research evidence, but remain under-utilized in comparison with evidence-based 'top-down' approaches.

## Chapter Three: Research Design

In this chapter I outline the philosophical assumptions informing the research, the semi-systematic methodology and why it was chosen for my study, and the overall design of the study following a thematic analysis method.

### 3.1 Ontological Position

My research method is a thematic analysis undertaken using an interpretive ontological position. Interpretivism is a philosophical paradigm that assumes the nature of reality is socially constructed, and there are multiple versions of reality (Ponterotto, 2005). This paradigm emerged from a critique of positivism which held that the nature of reality is objective, and a single, external truth exists which may be deduced by the scientific hypothetico-deductive method. Interpretivism assumes that “*our knowledge of reality is gained only through social constructions such as language, consciousness, shared meanings, documents, tools, and other artefacts*” (Klein & Myers, 1999, p. 69). Interpretive research sees knowledge and understanding as subjectively created, and seeks in-depth, multiple understandings of experience.

Qualitative research seeks to discover underlying meanings and processes, whereas quantitative research is concerned with measuring observable facts and data, and not in the interpretation of the human experience (Thompson & Harper, 2012). Qualitative research is rich in meaning, contextual, and subjective and the researcher is intricately involved throughout the entire research process, bringing particular understandings, perceptions, beliefs and assumptions to the research. This is integral to qualitative research and the interpretive process. This position relates to the relativist/constructivist epistemology, which is based on the idea that the researcher is active in creating a version of reality via interpretation and subjectivity, and that no ultimate external reality is discoverable through the research process (Terry et al., 2017). As a researcher, I am embedded in a Western cultural philosophy and this colours and influences my seeing and knowing, and therefore my findings. For example, the way the body is perceived and treated is influenced by sociocultural beliefs and attitudes, such as the prevailing biomedical model. Furthermore, as a child psychotherapist working in a paediatric hospital, I witnessed the impact of trauma on the body, and was curious about the relative absence of attention to the body in the psychotherapeutic treatment. I also bring my own painful experience of grappling with chronic fatigue, and my own journey of attuning to my body and coming to value it for its wisdom and mystery. This situates me in a position of wanting to

honour the role and potential of the body in psychotherapy. I hope to shed light on lesser known and recognized ‘truths’ about the potential of movement of the body to bring healing and restoration, and thereby also challenge existing culturally constructed truths, such as mind-body dualism. This project seeks to create space for competing, oppositional or diverging views, thus emphasizing the belief in truth as multiple and contextual. Though my own interpretation of the data set, I will identify and develop themes and shared meanings about the use of the body and movement in work with traumatized children.

Interpretive research is well suited to the psychotherapy discipline, which understands individuals’ experiences, such as trauma and how it impacts on them and the personal meaning they make, as unique, complex, and highly subjective, and there is no one, single truth regarding experience, embodiment, or effective psychotherapeutic treatments. As a child psychotherapist I value creating space for children’s unique meaning and felt sense of their experiences, and I bring this same value to the research. Starting this research, I bring my own preliminary understanding to the study which shapes, and is shaped by, my engagement and meaning making with the text. My prejudice and preunderstandings are necessary and vital to the research process, as they fuel my will and curiosity to understand what is unfamiliar to me and ‘other’ (Schuster, 2013). My prejudice around this topic stems from the sociocultural climate I am a part of, in which there is a long Western tradition of alienating the body and mind, and treating the body as separated from scientific thinking (Schuster, 2013). From this background of understanding I have been able to identify new questions, and areas for exploration.

### **3.2 Semi-Systematic Review**

A semi-systematic review was chosen for this research to identify and synthesize the relevant literature. Systematic literature reviews originated from the field of medicine, and are linked to evidence-based practice (Grant & Booth, 2009), although Petticrew & Roberts (2006) suggest this approach dates back to the Victorian times. For decades, systematic reviews have been used in the social sciences to develop theory and guide practice (Petticrew & Roberts, 2005). The systematic review is a scientific methodology aimed at answering a specific research question in a clear and targeted way, while minimizing bias. It has been most commonly used in the healthcare professions, however many other disciplines and professions also now employ this approach. They are useful for mapping the field of research and identifying themes. This was deemed appropriate and valuable for the current study which

seeks to identify patterns in the data. Snyder (2019) states that literature reviews create a “firm foundation for advancing knowledge and facilitating theory development” (p. 333).

There are different types of literature reviews including systematic, semi-systematic and integrative. Systematic reviews, which cover all relevant data and have strict rules, was considered unsuitable for the current project as it requires a narrow research question. In addition, a full systematic review of the topic of childhood trauma was not possible considering the vast amount of research and theory on the topic from many different social and cultural professions. Instead, a semi-systematic review was chosen which is “designed for topics that have been conceptualized differently and studied by various groups of researchers within diverse disciplines and that hinder a full systematic review process” (Snyder, 2019, p. 335). This methodology enabled collecting and synthesizing previous research, and the integration of findings and perspectives.

The systematic review uses particular methods to yield valid and reliable results. This is a strength of this approach and was considered a good fit for my research question, which necessitated a logical and linear process and approach to the data. Guided by the principle of reliability, this methodology ensured a systematized and structured way of comprehensively gathering the data and organizing it. Using extracting search strategies, the reviewer identifies and appraises all relevant research, and thereby ensures a comprehensive coverage of the topic, and helps to control for bias (O’Brien & McGuckin, 2012). The semi-systematic approach requires tailoring the process and standards to the specific project at hand (Wong et al., 2013), which will be outlined in the next chapter.

### **3.3 Method: Thematic Analysis**

I will employ thematic analysis for this study, which is a qualitative research method involving coding and the generation of themes, in order to answer my research question, *‘How can body-centered psychotherapy ameliorate the effects of childhood trauma in children?’* My goal is to study the way in which movement may be used in therapeutic work with children to ameliorate the debilitating effects of childhood trauma. TA is a method that identifies and analyses data to provide a set of themes and patterns in the data. The themes will aim to reveal patterns of shared meaning across the studies, capturing implicit ideas (Clarke et al., 2019) of body psychotherapy that may be therapeutically used with children who have a trauma history. This method fits well for the purpose of my study, as it provides a meaningful way of finding and conveying shared meanings and tenets about using the body and movement with children. Thematic analysis includes “...identifying, organizing, and



offering insight into patterns of meanings (themes) across a data set. Through focusing on meaning across a data set, TA allows the researcher to see and make sense of collective or shared meaning and experiences” (Braun & Clarke, 2012, p.57).

Thematic analysis (TA) can be understood as an ‘umbrella’ term as it entails different approaches within it, such as coding reliability, codebook, and reflexive TA (Clarke et al., 2019). Reflexive TA is characterized by the researcher taking an active role in the knowledge production process. It is conceptualized as

*meaning-based patterns, evident in explicit (semantic) or conceptual (latent) ways, and as the output of coding – themes result from considerable analytic work on the part of the researcher to explore and develop an understanding of patterned meaning across the dataset* (Clarke et al., 2019, p. 848).

As a researcher, I am not extracting themes which reside in the data as objective truths, but rather providing readers with a set of themes as filtered by my own perceptions, experiences, assumptions, and interest. Ely (1997) states that themes do not ‘reside’ in the data but rather in our heads as researchers “*from our thinking about our data and creating links as we understand them*” (et al., p. 205-6).

For the purpose of this study, reflexive TA was chosen which is a fully qualitative method, as opposed to other schools of TA, which involve a mixture of quantitative and qualitative elements, and which seek greater scientific reliability in the data. The coding process is open and iterative and emerges from the analysis of the data, not determined by a pre-established codebook. I seek to engage with the data at depth, and thereby develop themes which relate to the use of movement in therapeutic work with children. The findings from my study seek to increase awareness of the potential of the role of the body and movement specifically in psychotherapeutic work with this population.

### **3.4 Summary**

This chapter discussed the ontological position, the semi-systematic research review methodology that underpins this research. I have provided an overview of TA, which is a suitable qualitative research method for this research. Next, I describe the application of TA according to Braun and Clarke’s model (2006).

## **Chapter Four: Method**

In this chapter I provide a detailed description of the process of collecting my data, analysing it and generating codes and themes using a thematic analysis (TA) method.

Braun and Clarke (2006) identify six phases of the TA process: familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. These are intended as flexible guidelines (Patton, 1990). These will form the basic structure for the analytic process. Although I outline the process here as linear, in reality it is more recursive and circular as I went back and forth between the phases.

### **4.1. Phase 1: Familiarisation with the Data**

This is the first step in the analytic process. Below I detail the components of the process:

#### ***4.1.1. Establishing the Data Set***

To obtain my data set, a comprehensive literature search was completed using the following online databases: AUT library search, Psychoanalytic Electronic Publishing (PEP), PsycINFO, PsycARTICLES, and Google Scholar. Initially, I searched broader and wider, using terms such as “body-mind”, “expressive arts”, and “body psychotherapy” in Google and the AUT library. This helped me become familiar with the field and the amount of data relevant to children and trauma. I realized the majority of the literature within ‘body psychotherapy’ focused on the adult population. Studies which used body-oriented approaches with children sat within the ‘expressive’ therapies or ‘arts’ therapies, or within the discipline of dance movement psychotherapy specifically. ‘Body psychotherapy’ encompassed an umbrella term for a number of body-oriented ways of working, which went beyond the scope of this dissertation, for example approaches using touch, and breathwork. I also discovered numerous body-oriented treatments such as yoga, sensorimotor psychotherapy, sensory motor regulation and eye movement desensitization and reprocessing and drama therapy, all of which involved the body in some way. Through reading this literature I narrowed my topic down to focus on movement specifically, as this seemed to be a central component of the work with traumatized children and this is where my primary interest was centered. Stern (2004) explores movement in his book ‘Forms of Vitality’ and suggests that movement is our most primitive and fundamental experience, and “has a primacy in experience throughout life” (p. 19). Movement has been given a foundational role in feeling and in thinking (McNeill, 2005). One’s movement capacity

is the basis for the ability to approach and withdraw (Stern, 2004), which is a central issue for traumatized individuals.

From here, I began a more systematic search of the databases using the terms shown in Table 1. I used different combinations of these key terms (as shown in Appendix A), in all of the five databases until no new data was emerging. At this point saturation was believed to be achieved.

**Table 1.**

*Key Concepts & Search Terms*

<b>Child</b>	<b>Trauma</b>	<b>Movement</b>	<b>Body</b>
Adolescent	Abuse	Move	Soma
Teen		Dance/movement	Mind-body
Young person		Psychomotor	Body psychotherapy
Youth		Psychophysical	Somatic-based intervention
Children		Creative arts	
		Expressive Arts	

I also reviewed the reference lists of selected works to obtain further relevant data. Articles which were not available online or through the AUT library were obtained via the inter-library loan system.

**4.1.2 Inclusion Criteria:**

- I) Body-centered psychotherapy approaches used in trauma treatment for children and adolescents between the ages of 5-18 years.
- II) Studies will include both individual therapy and group therapy modalities. Body centered approaches which exist as a distinct practise not amenable to incorporation into an individual psychotherapy session, will be excluded, such as trauma sensitive yoga.
- III) Studies focusing on the use of movement in therapy.
- IV) Case studies, and journal article research studies.
- V) Situational trauma

#### ***4.1.3 Exclusion Criteria:***

- I) Studies not written in English.
- II) Body-centered or somatic interventions for the treatment of non-trauma related conditions or symptoms.
- III) Studies with children under five years, and over 18 years.
- IV) Studies using body-centered treatment modalities for adults.
- V) Studies that did not include case illustrations.
- VI) Studies published prior to 1985, for the purpose of focusing on currently practiced movement therapies, and excluding out-dated approaches not influenced by recent developments in trauma theory.
- VII) Body-centered approaches not using movement, e.g. only incorporating breath or touch.
- VIII) Other forms of literature, such as book reviews, dissertations and editorials. These were excluded to keep the focus of the dissertation on clinical research. Due to the size of the dissertation, other theses and dissertations were excluded as the sheer amount of data was beyond my capacity to analyse.
- IX) Intergenerational and historical trauma.

#### ***4.1.4 Final Data Set***

The process for selecting articles consisted of reading the titles of the entire search result and identifying which articles were relevant and met criteria. For example, some were easily excluded as they were not focused on children or on trauma. I then proceeded to read the abstracts of the identified articles and further decided whether they met criteria. In total, 3314 articles were reviewed and from this a total of 14 articles were selected (see Appendix B for a list of the data set). A final article was located through reviewing the reference lists of the selected 14 articles, bringing the total data set to 15. Most studies that were excluded was due to the absence of a case illustration, therefore the selected data set is not a reflection of the existing theory on this topic. Some studies included different treatment modalities, such as creative arts therapy alongside movement therapy. I have chosen to include these studies but will only focus on and analyse the movement/body-centered components of the intervention. The final data set contains individual (9) and group (6) cases. It includes a variety of types of trauma including physical abuse (1), sexual abuse (5), a combination of sexual and physical abuse (1), traumatic loss (1), medical trauma (1), natural disasters (1), war (1), violence (2), witnessing violence (1), and torture (1).

#### ***4.1.5 Familiarization of the Data Set***

This involved ‘immersing’ myself in the data which meant reading and re-reading the dataset to become familiar with the breadth and depth of the content. This reading was an ‘active’ reading (Braun & Clarke, 2006) of getting to know the dataset thoroughly, and making notes of ideas which stood out to me. I read and re-read the selected 15 articles, highlighting key concepts/ideas of potential interest. These notes were kept in a separate book with each article’s author at the top for easy identification. I wrote my own thoughts and impressions too, as a way of integrating what I had read and forming my own thoughts.

### **4. 2. Phase 2: Generating Initial Codes**

#### ***4.2.1 Selecting Data for Coding***

Following the selection of my data set, I assessed which sections of the articles could be meaningfully coded. I included the case illustrations and case discussions of each article, and excluded portions heavily focused on theory and literature as I wanted to focus on the client’s experience of transformation and the way in which this was achieved (to align with my ‘how’ oriented question). Boyatzis (1998) defines a codable moment as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way” (p. 63). This part of the coding process can be approached in a number of different ways. Coding can be either deductive or inductive (Braun & Clarke, 2006). Deductive (or theory driven) is led by prior knowledge of the topic and theory. Inductive (or data driven) is “constructed inductively from raw information. They appear with the words and syntax of the raw information” (Boyatzis, 1998, p. 30). According to Braun and Clarke (2006), the latter is more suited for identifying overall themes in the data set, whereas deductive coding is more suited for analysing a specific aspect of the data in detail. To answer my research question, ‘*How can body-centered psychotherapy ameliorate the effects of childhood trauma in psychotherapeutic work with children?*’, I adopted an inductive orientation, whereby I approached the analysis of the data without pre-existing codes, themes or ideas, also termed a ‘bottom-up’ approach (Clarke et al., 2019).

#### ***4.2.2 Coding***

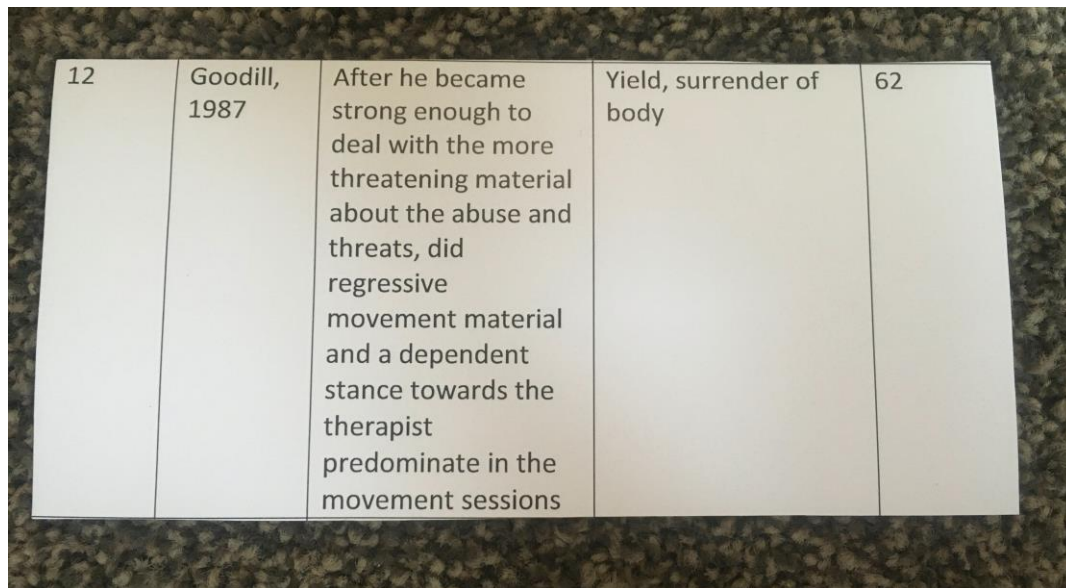
After the data was organized, I proceeded with the coding process. This involved reducing the data into manageable segments, enabling the data to be organized into meaningful groups for the analysis and identification of themes (Braun & Clarke, 2006). As I read the relevant portion

of the text, I underlined any sentence or words which stood out to me. Initially this involved me ‘feeling my way through’ the text as it was not always immediately apparent what the selected text’s associated initial code was or could be. When this occurred, I would read and re-read the selected text slowly and emphasize each word to obtain a deeper, rich understanding of what the author was communicating. This ‘pondering’ and ‘playing’ process in my mind expanded my understanding of the texts’ meanings and supported the generation of codes. In addition, I also drew upon visual imagery. As I read the text segment selected, I imagined the scene in my mind or even at times acted out the movement described, such as beating a rhythm on the floor with my hands. This gave me another entry point into the rich meaning of the text and allowed me to use my ‘bodymind’ in analysing the text, thereby bringing all of my faculties to the work.

Each segment of the text that was deemed codable was underlined and ‘tagged’ with an initial code, as I sequentially worked through the data (Lyons & Coyle, 2007). I created a separate Word document with a table for each article’s codable moments, with the author’s name as a header for easy identification. I also included the page number of each text segment and the codes in separate columns. Text segments to be coded were copied and pasted/typed into the correct table columns (see Appendix C). Text segments ranged in length from a few words, to multiple sentences, and text segments were inserted multiple times if denoting different ideas or concepts. Working directly and closely with the text, I often used the same word from the extract for the code. A total of 633 codable moments were captured and identified as initial codes.

### **4.3 Phase 3: Searching for themes**

In this stage all the data had been coded and a generous list of initial codes had been compiled from the data set. To generate the themes, I printed out and cut up each article’s data extract and code, as shown below.



12	Goodill, 1987	After he became strong enough to deal with the more threatening material about the abuse and threats, did regressive movement material and a dependent stance towards the therapist predominate in the movement sessions	Yield, surrender of body	62
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*Figure 1.* Example of the individual segments used in the theming process.

I then laid the segments out on the floor and grouped the segments together according to matching or similar codes to form coherent themes. At the top of each group, I wrote a draft title identifying the core idea of the pile. This stage was a time-consuming process but was considered the most effective way for me to visualize and organize my data. This created a total of 57 groups or piles, with varying amounts of segments in each pile. This enabled the identification of prominent ideas as evidenced by larger piles (as shown in Figure 2 below).

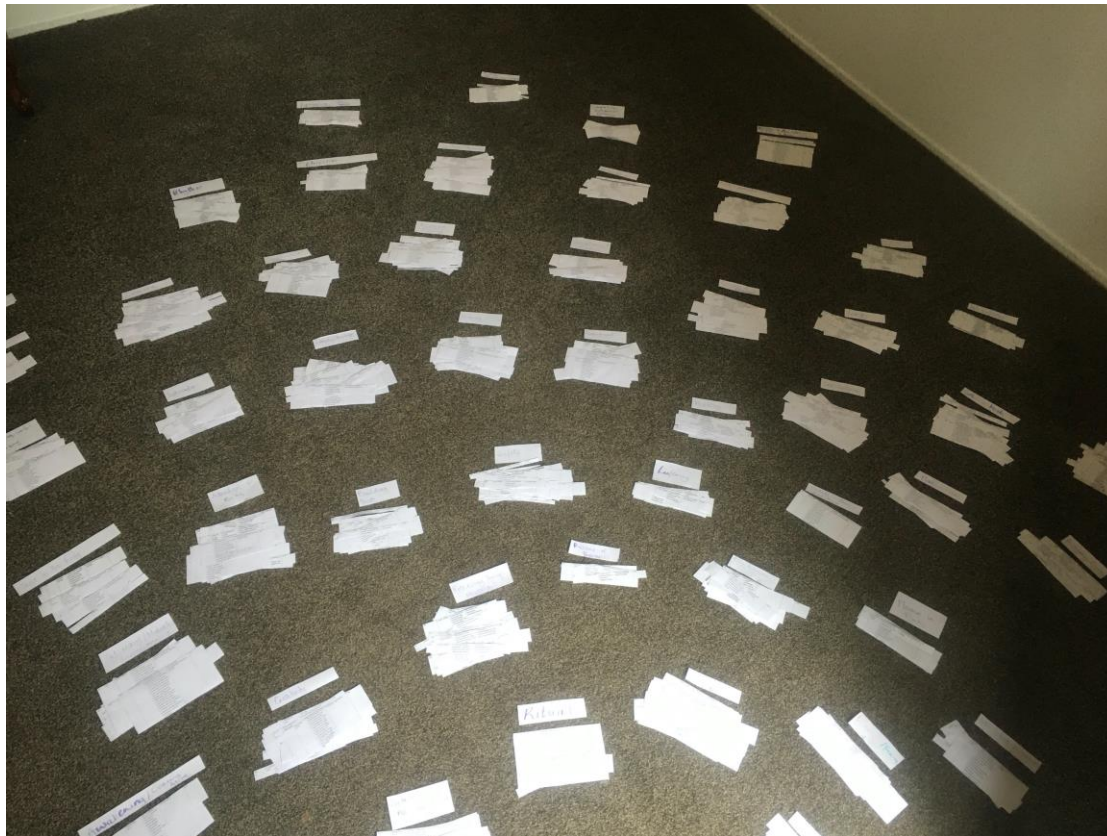
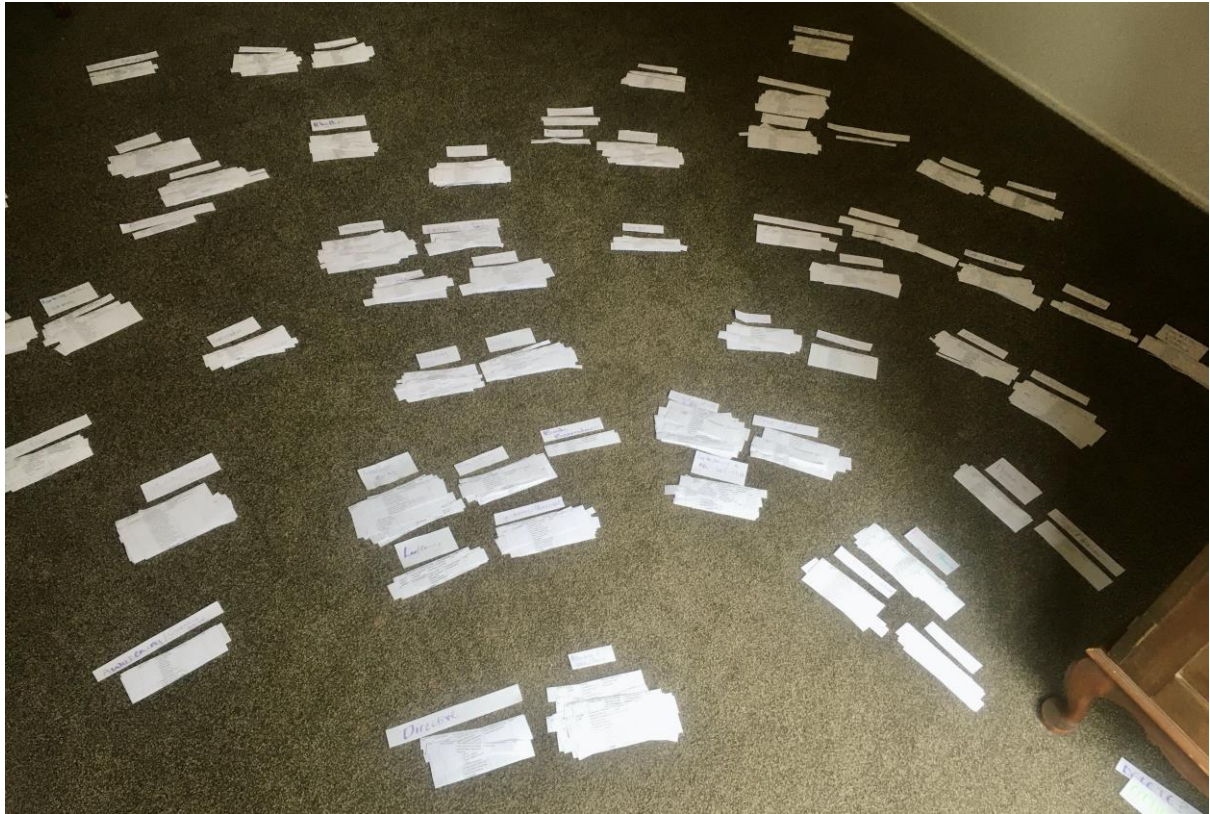


Figure 2. Organizing codes into groups.

After completing this, the code groups were analyzed and the relationship between the different code groups, to search for common overarching themes. I re-positioned groups close to each other which I perceived to be related, such as connection and sharing, and safety and trust. This formed the beginning of *organizing themes*, which represent a cluster of related codes. The 57 'basic themes' were thereby organized into organizing themes, based on the underlying meanings and the relationships among the basic themes. The attention moved away from the individual codes and re-focused the analysis 'at the broader level of themes' (Braun & Clarke, 2006). Some piles remained on their own and distanced, signifying the lack of a relationship with other code groups. Figure 3 shows the development of this thematic network showing the spatial relationship between different code groups.





*Figure 3. Re-organized piles to form thematic network*

I continued this process, with the central research question in mind, focusing on how movement can help children heal from trauma. Ultimately, this yielded four overarching global themes, each with organizing/sub-themes which support the global theme. These global themes are principal metaphors in the data as a whole (Attride-Stirling, 2001). These themes were: moving together, moving it out, moving back in, and moving forward. These four titles captured the centrality of movement and directed the attention to three directions of movement, and one quality of movement - the act of moving together.

#### **4.4 Phase 4: Reviewing themes**

The fourth stage involved a detailed review and refinement of the themes and extracts of data. Patton's (1990) criteria of internal homogeneity and external heterogeneity were used as guiding principles to ensure the chosen themes were each distinct, and that each theme held together coherently. I ensured that there is no overlap of themes, that the themes reflect shared meanings across the entire dataset not disparate ideas, that the data does in fact support each theme, and that a shared meaning in the data had not been missed. To do this, I created a table in a word document with each thematic network, the basic themes and organizing themes to visually identify any overlaps and ensure internal consistency (see Appendix D). Within

theme network one, the basic theme ‘exploration’ was merged with ‘experiencing a new self-state’ as the core ideas fitted naturally with what this theme was capturing. Similarly, the basic theme ‘body boundaries’ was absorbed into ‘body awareness’. This process was influenced by the research’s subjectivity and interpretation, and the research question (Clarke et al., 2019).

#### **4. 5 Phase 5: Defining and naming themes**

The fifth phase of Braun and Clarke’s (2006) approach involved ensuring each theme, and theme name, is built on a core organizing concept, which together captures the intended meaning of the dataset. They state that it requires “*identifying the essence of what each theme is about, and determine what aspect of the data each theme captures*” (Braun & Clarke, 2006, p. 92). To do so, all the coded data for each theme was compiled and reviewed. The naming of themes required checking that the central theme concept was accurately reflected in the name. As my dissertation was on movement, I chose theme names which focused on movement, and the different aspects of this which guided the child in a particular direction. I also ensured the theme names were in holding with the research question, therefore each theme and subtheme elucidates a particular aspect of how movement focused approaches can help heal trauma in children.

#### **4. 6. Phase 6: Producing the report**

The final phase involved final analysing and writing the dissertation in a clear, well-structured and cohesive way. This phase provided an opportunity to reflect on how well the themes work individually and overall, and included minor revisions to themes. The report aims to convey “*the most salient constellations of meanings present in the data set*” (Joffe, 2011, p. 209). The data meanings were further analysed and woven into the context of existing theory and literature around the topic.

#### **4. 7 Summary**

In this chapter I have described the details of the six methodology phases which guided the thematic analysis, according the Braun & Clarke’s model (2006). This yielded four global themes with eight subthemes. I will now describe these findings in the following chapter.

## Chapter Five: Results

The purpose of the research was to address the primary question, “how can movement ameliorate the effects of childhood trauma?” To answer this question, I completed the six phases of the thematic analysis process, and in this chapter I describe the research findings. The analysis revealed an inherent developmental process guiding the therapy with traumatized children, described by the four global themes below:

1. Moving Together: qualities of the movement therapist and the therapeutic environment which generates containment, safety, and trust which were foundational to the therapy.
2. Moving it Out: Bodily communication and expression of the trauma material.
3. Moving Back In: Reconnecting to the lived-in body and reclaiming fragmented parts of the mindbody.
4. Moving Forward: The equipping of the child to move forward empowered and with a greater sense of freedom and wholeness.

Each theme will be described in relation to the research question, with data extracts from the original articles as supporting evidence linking the data and the interpretation provided.

### **1. Moving Together**

In this section, I focus on therapists’ body-oriented techniques and movement-oriented ways of working which developed a safe, holding environment for the child. This is described in the following sub-themes:

- 1.1 The therapist’s attunement
- 1.2 Rhythm, repetition, and regulation
- 1.3 Joined in Movement

#### ***1.1 Attunement***

The research revealed that the establishment of a felt sense of safety was the first and paramount goal of intervention. Research from neuroscience has corroborated the basic Maslowian fact that learning and integration can only take place if the human system is in a state of calm, and is regulated (Cozolino, 2002). The way in which this was approached was by deep attending and attunement to the subcortical emotional memory and body memory, below the level of conscious memory. The research revealed a view of the body as containing

and reflecting unconscious psychological material. Steckler (2016) states “*movement patterns, sensations, tension patterns, posture, gaze and gestures can all represent and ‘contain’ psychological issues, patterns, and dynamics*” (p. 169). The therapist paid very close attention to the body’s non-verbal communications and identified a large range of movement qualities, such as the locus, frequency, intensity and duration of movement, where movement is fluid or broken, and areas which appear frozen or stuck. This information from the child’s body language was used to understand the child more fully and enable an implicit, non-verbal connection to them.

The following quotes are a selection of codable moments from the data which illustrate the therapist’s attention and attunement to the child’s non-verbal, unconscious bodily communications.

1. “*Her movement arose peripherally and developed with very little connection to the centre of her body. Her movements were sharp, broken, and stiff*” (Asher & Koren, 2002, p. 29).
2. “*Her movements were extremely slow, listless, and disconnected from her centre. There was little movement in her chest and pelvic area*” (Weltman, 1986, p. 58).
3. “*Daniel’s body helped me to gather information about his mood*” (Valdivia, 2010, p. 77).
4. “*As I listened to her non-verbal expression, she was able to speak the unspeakable*” (Weltman, 1986, p. 58).

The therapist’s close observations served a ‘witnessing’ function to the child; the child’s communications were seen and received. This deep attending, reading and witnessing of the body serves to acknowledge and validate by seeing all of the child. This ‘receiving’ function of the therapist may also help the child to feel seen and thereby to feel more real.

Anderson (2008) writes,

*with deference to the patient’s inner wisdom, which guides the movement toward health, I listen. My listening is most meaningful not for what it reveals to me, but because it creates a space for things to begin to shift and move, within the patient and between us*  
(p. 154).

This listening and witnessing opens the therapist to the child, and vice versa. These children wanted to be seen and heard but struggled to verbalize their feelings and experiences, yet their body was ‘speaking’ for them, providing a physical script which the finely tuned therapist

decoded and made meaning of. Skilled non-verbal attunement is used as an intervention at the start of therapy, and throughout, to help the child in developing a sense of ‘feeling felt’ (Siegel, 2012), which is the sense that someone else feels one’s feelings and is vital to attachment. Siegel (2012) states,

*when we attune with others we allow our internal state to shift, to come to resonate with the inner world of another. This resonance is at the heart of the important sense of ‘feeling felt’ that emerges in close relationships. Children need attunement to feel secure and to develop well (p. 27).*

It was crucial for the children to have someone else feel their feelings and deeply know their experience, therefore the therapist’s attunement helped the child feel safe, and seen, and to form an attachment to the therapist. The establishment of safety is especially important for this population, as traumatized children may develop distorted neuroception- which is an unconscious process of the nervous system that evaluates risk in the environment (Porges, 2011). When neuroception detects safety, learning and social engagement can proceed, if not the child will be defensive and on edge.

The therapist’s attunement to her own body’s sensations and feelings and to the child provided a vital source of information and insight into the child’s subjectivity, and this often led to implementing a joint movement intervention, such as direct mirroring or joint movement tasks. Bosnak (1996) coined the term ‘symbiotic communication’ to describe the therapist feeling in his/her own body aspects of the client’s subjectivity. The therapists describe many different sensations in working with traumatized children including feeling numb, nauseous, muscle contractions, strength, and confusion, which represented their receiving of the child’s communications and unverbalizable felt experiences. Such somatic reactions of therapists during their encounter with clients have been termed ‘body counter-transference’ by Pearl & Saakvitne (1995). More contemporary research has defined body-countertransference as “*awareness of their own body, of sensation, images, feelings and fantasies that offer a link to the client’s process and to the intersubjective field*” (Jakubowski, 2012, p. 14). Thus, the therapist’s somatic reactions are part of the therapeutic interaction (Vulcan, 2009). Such reactions may be meaningfully used to guide therapeutic interventions. For example, Engelhard (2017) states, “*from the feeling of distance and falsity, I suggest that we both sit cross-legged on the chair, and perhaps in this way I will be able to sense something she wishes to tell me*” (p. 107). Engelhard (2017) used her feelings as a valuable communication from the client’s

mind-body and then adopted the same posture as the child to further this communication and non-verbal sharing.

The listening and witnessing of the therapist required the therapist to bring all of themselves to the therapeutic endeavour. *“As a therapist one must be comfortable and surrender to whole body, mind, and heart listening in order to be receptive and engaged simultaneously”* (Margolin, 2019, p. 181). This facilitated a deeper felt understanding and resonance with the child. As Lynch (2000) states,

*it dawned on me that Gina needed me to physically feel the bumpy road of relationship breakdown that had been her life, and I said that she had been pulled along without people noticing her being knocked around or bumped into* (p. 172).

The therapist had to experience in her own body the felt experience of the child in order to then make the experience digestible for the child. Through attunement to her own sensations and feelings, the therapist received the implicit corporeal dialogue which was taking place between the two right-brain hemispheres of the therapist and child (Colace, 2020, p. 44). This mimics the early child-caregiver relationship of attunement and allows the child to have her feelings felt by a safe, organizing adult and thereby help her to start to feel her own feelings. This is consistent with how Orbach (2004) views the phenomenon of body counter-transference. She posited that the client is using the therapist's body, and that body counter-transference can be used to help clients change the way they experience their bodies (Orbach, 2004). The act of self-attunement and openness to body counter-transference is instrumental in changing the way traumatized children relate to their own bodies, as the resonance with the child's internal world that the therapist feels, helps the child feel safe and secure in their own bodies.

## ***1.2 Getting in Sync - rhythm, repetition and regulation***

Safety and trust were also formed through the deliberate use of repeated physical exercises, which established predictability, rhythm, and a sense of containment for the children. These activities were introduced in the first session and often were used at the start of every subsequent session. In this way they formed rhythms and rituals which the children came to expect and rely on to get started. Some of these movement-based activities were directive, that is orchestrated and led by the therapist, and some developed more organically, led by the child.

Gray (2001) describes the use of a recurring movement dance with a 17-year-old adolescent with a history of abuse. The child naturally developed a movement pattern characterized as a

*“push and twirl dance”* (Gray, 2001, p. 3) which he repeated in every session. In addition to this child-led pattern, the therapist supplemented a walk as a ritual for the sessions. This was an effective way of regulating him, and the consistency of this helped him to connect with the therapist. *“For children whose persisting fear state is so overwhelming due to traumatic experiences, there would be no improvement ‘until their brainstem is regulated by safe, predictable, repetitive sensory input”* (Perry & Hambrick, 2008, p.43). This predictable sequence of activity regulated his nervous system, which then helped to open him to further exploration and to seeking a relationship with the therapist. Baudino (2010) writes about the use of recurring activities and consistency for establishing safety and trust with children, which facilitates self-regulation.

Valdivia (2010) discussed how Daniel, a 9-year-old boy who had been traumatized by witnessing a shooting and by his mother’s house being burnt down, began to be organized and contained by the session’s predictable active structure. Each session started with a warm-up which involved enactment of stories and games that Daniel led. *“Gradually the simplicity, clarity, and short duration of the warm-up served as part of an organizational structure for Daniel’s chaotic body-mind”* (Valdivia, 2010, p. 80). Another example from the research is from Harris - *“we opened activities during the first session, and every session, with a simple movement ‘energizer’* (Harris, 2007, p. 208). This involved forming a circle, and one by one each member of the group says a greeting, their name, and show an action or gesture, which is repeated by the rest of the group. The warm-up created a pattern and ritual which served to ground the children in their body at the start of every session, paving the way for further bodily and emotional exploration.

A crucial aspect of these repetitive activities was providing containment and continuity for the child’s fragmented self. The use of rhythm has been extensively written about in the context of the mother-infant dyad, as daily interactions between the pair form a psychobiological regulating rhythm which the infant comes to know and depend on for a sense of “going on being” (Winnicott, 1971). The initial phase of the therapy thereby mirrors the early parent-infant attachment relationship, marked by attunement, rhythmicity, and regulation. This phase is crucial for laying a foundation for the child to develop the skills for self-regulation and emotional bonding (Pierce, 2014). Lynch (2000) writes, *“the children in therapy express at the affective body level their needs, pain and history. The therapist must learn how to come into rhythm with such expressiveness”* (p. 178). Establishing a bodily rhythm between the child and

therapist created a non-verbal dialogue and sense of synchrony between them that ‘held’ the child together. Lynch continues and says, “*there was a sense of us moving into a rhythm, having gained the correct distance for bumps and disruptions to occur*” (2000, p. 173). The active, but contained, repeated movements helped regulate the child’s arousal and emotion to within the ‘window of tolerance’ where new exploration and learning could take place (Siegel, 2012). The therapist therefore acts as an active psychobiological regulator for the child during the initial stages of the movement therapy, making a way for them to later internalize this regulating capacity for themselves. The rhythmic synchrony often took time to develop during the therapy, but once established solidified the children’s sense of safety and connection to themselves and to the therapist.

### ***1.3 Joined in Movement***

Joint movement was used by the therapist for the purpose of forming a relational connection, intimacy and openness with others and to establish a sense of safety and acceptance. Joint movement also helped the therapist to feel in her/his own body how the child is feeling, and thereby gain greater understanding of the child’s internal world and felt experiences. I use the term ‘joint movement’ to refer to acts of synchronous or mutual movement between the therapist and child. This was achieved in different ways but all served to help the therapist get in touch with the child’s felt experience, and also to act as a container and regulator of the child’s feelings.

In her work with children who have been sexually abused, Weltman (1986) describes working with a girl where the shared, joint movement enabled the girl to move through various different self-states and emotions. “*As we moved together, she shifted through rapidly fluctuating states of defiance, defensiveness, self-destructiveness, and wreckless abandon. I gently described each state and allowed her the space and time to modulate her efforts*” (Weltman, 1986, p. 60). It can be postulated that the act of joint movement in this case allowed the girl to be anchored in her body and connected to the therapist, feeling safe enough to explore different aspects of herself. This breaks the children’s sense of isolation with their feelings as someone else shares their embodied realities. The emotions associated with trauma are often too overwhelming and dysregulating for the child to feel alone, but as the therapist ‘moves through’ various feelings, both pleasurable and difficult, the child is supported to allow feeling again. Through joint movement and action, the children were guided to confront their painful realities in a manageable way because they were doing it with another. Van der Kolk (2014) writes,



*“being able to experience and tolerate deep emotions is essential for recovery from trauma”* (p. 344). By meeting the children where they were at and getting alongside them in their movement, or suggesting new movements to try out together, the therapist facilitated greater emotional experience and expression.

The act of moving together enables the sharing of affective experience, which created a sense of unity and togetherness between the therapist and child, and also between the children. Goodill (1987) states that *“synchronous moving implies a heightened sense of communication and ‘witness’ between movers”* (p. 62). Goodill (1987) describes in her work with Michael, a 10-year-old boy, how they moved together and engaged in strong rhythmic stamping patterns, and gradually Michael began to enjoy this act of moving together with the therapist and built up his trust in her. He went on to embody states of vulnerability and dependency as he moulded his torso around a padded piece of equipment and rocked in a slow, rhythmic way. Through first mutually moving with the therapist, the child was able to allow himself to move in new ways and to let go of his defences against doing so. It seems it was only through the mutuality and act of moving together which gave the child the safety to explore new experiences in his body, namely that of experience his vulnerability and dependence.

Postural mirroring was used by several therapists to establish embodied empathy and help the therapist ‘get in touch’ with the child’s embodied experience. Tortora (2009) defines mirroring as the embodiment of *“the exact shape, form, and movement qualities of a child’s actions, creating a mirror image of the mover”* (p. 166). Mirroring serves multiple therapeutic functions simultaneously, including connection, empathy, solidifying the client’s sense of self, and creating safety and ‘holding’. Mirroring offers the client a ‘secure base’ (Bowlby, 1988) and ‘holding’ (Winnicott, 1971), which then encourages further exploration of the space, room, the therapeutic relationship and the self. Engelhard (2017) mirrored her client’s sitting position and used the insight gained to connect with the child.

*The sitting position which G. favours, with the soles of her feet on the seat of the chair, is one that I generally find comfortable but this time, exposes me in an embarrassing way. I say, “perhaps you’d like to feel really comfortable here but then you feel guilt and a sense of becoming ruined somehow* (Engelhard, 2017, p. 107).

Mirroring the client’s body posture and movements communicates to the client non-verbally they are seen and accepted, and for the therapist this synchronizing act can increase their empathy and understanding of their client (Shafir, 2016). Mirroring the client’s posture allows

the therapist to feel in her own body the emotional fluctuations of the client during the session. This is predominantly governed by mirror neurons in the brain which allow us to feel another's person's emotions and get a sense of their internal world (Rothschild & Rand, 2006). In this way, postural mirroring can be utilized to establish a symbiotic connection with the child and provide them with a sense of 'feeling felt', contributing to their felt sense of safety, and the holding environment. Mirroring has been successfully used with children that have faced trauma by helping them develop a sense of attunement and empathy towards others (McGarry & Russo, 2011). By being seen in this way they also develop a more positive relationship with their body.

## **2. Moving it Out**

This theme captures the ways children used movement to process their trauma and 'move it out' of the stuck, internal place it resided. This global theme includes the sub-themes 'the body tells the story, and 'opening up', which illustrate the central therapeutic aspects of communication, and expression, which are interconnected.

### **2.1 The Body tells the story**

*"Offering the patient the possibility to improvise through movement...can help give voice and movement to archaic memories buried in the body and exiled from consciousness"* (Colace, 2020, p. 43).

This organizing theme captures various ways in which the children communicated their trauma and distress through bodily movement, whether this was consciously or unconsciously and directed or spontaneously occurring. It includes the manifestation and expression of traumatic memories and affects through symbolic play, symbolic re-enactment, posture and gestures, and specific movement activities of dance and drama. The data suggested the striking finding that where children have experienced trauma, and may attempt to hide, silence, or suppress the experience, the body will ultimately tell the story. Evan (1951) states that creative DMT emphasizes that active movement can represent the physical equivalent of the psyche in the body. Movement therapy helped expose the trauma's imprint on the child's mind-body. The following table provides a snapshot of some of the data extracts which show the non-verbal communication of traumatic residues.

**Table 2.**

*Data Extracts from 'The Body tells the Story'*

<i>"With her body, G. was able to show me what she could not in any other way" (Engelhard, 2017, p. 107).</i>
<i>"She did not give words to the experience. In fact, when I asked her to tell me what happened, she sighed saying "I already did" (Weltman, 1986, p. 63).</i>
<i>"Daniel communicated his experience of lacking support...through his own body by quickly losing balance" (Valdivia, 2010, p. 84).</i>
<i>"used the red ball, alternately lying on it, kicking it, bouncing it and attacking it with her hands and feet. I described her actions 'kick, bounce, attack, bite', and added that this was what happened when she got too close to people" (Lynch, 2000, p. 171).</i>
<i>"Nirit brought into the treatment room bodily expressions of reckless endangerment, boldly risking herself through high jumps from the ladder, attempts at dangerous balancing feats intended to hurt her body" (Asher &amp; Koren, 2002, p. 30).</i>

Jung suggested that expressive body movement is one way to give form to the unconscious, and Margolin echoes this saying, *"creative dance guides and gives form to ineffable and intangible feelings"* (Margolin, 2019, p. 186). This experience equates to an articulation of the bodyself- an expression and communication which otherwise would remain unconscious, concealed and held captive by the censoring mind.

Goodill (1987) describes how with her patient, David a seven-year-old boy who experienced physical abuse, the therapy was only able to progress once *"any expectations for David to verbalize his emotions were discarded"* (p. 62). A physical mode of therapy was needed where David could communicate his experience and distress, as he was not able to organize and symbolize his trauma to put it into words. The traumatic experience, which is implicit and procedurally encoded in the right hemisphere of the brain, is distinct from the logical, verbal left hemisphere (Fisher, 2011). Vick (2002) states that *"we all carry traumatic material in our bodies and that for a full connection to these hidden but troublesome aspects of ourselves, it is necessary to make contact at physical, emotional, mental and energy levels"* (p. 146). The movement therapy provided the children a crucial pathway to express and give form to their traumas through the language of the body.

In another example, Daniel, a 9-year-old boy who had experienced a number of disparate traumas, showed a stiff chest and torso and a blank expression. Valdivia (2010) notes that,

*“Daniel’s disorganisation was also expressed bodily. He usually moved one body part at a time, quickly jumping ‘sequentially’ between them. It was as if his body was made up of separated parts that were not linked up, as if there was no sense of internal body connectivity”* (p. 79). His body reflects chronic physical holding of unexpressed feelings, indicating the somatic impact of trauma. The therapist suggested for Daniel to move with ‘free flow’, but when he tried this he would accelerate until losing his balance and collapse on the floor. Valdivia (2010) interpreted this as Daniel expressing bodily what he had experienced in life - being knocked off balance. In this way, his body was unconsciously telling his story of what he was struggling with- frightening feelings held inside and denied, and that were unverbalizable. Daniel also communicated the body’s sense of trauma through symbolic expression in active re-enactment of stories and games. Freud (1920) stated long ago, *‘what the mind has forgotten, the body has not, thankfully’*. Daniel’s body and movements through active play continued to communicate his implicit narrative of his traumatic life experiences, even though his mind could not make sense of it. By paying careful attention to the somatic dialogue of the body, the therapist can gain significant insight into the child’s felt experiences of the trauma and how they are coping with it, or have adapted to it.

## **2.2 Opening Up**

*“Practical work freed the child within”* (Beaven & Tollinton, 1994, p. 441).

This subtheme illustrates how movement enabled a psychic opening allowing emotions to surface, which had long been buried or exiled from the self. This opening and release of affective energy was vital to the process of healing from trauma, and formed a core part of moving the trauma out of their body-mind. Often the active moving of the body, by its very nature an act of mobilizing, not only helped loosen the body from its often frozen, numb or immobilized state, but facilitated a psychic opening. By moving in a new or different way, the children accessed feelings which were contained in their muscles and stored away. Gray (2015) states that,

*muscles contain and retain emotions and memories, expansion of movement repertoire inevitably work to release repressed feelings and to increase the range of feeling, as well as thought patterns and belief systems, a person is capable of experiencing*  
(p. 181).

The following quotes illustrate the increased emotional awareness and expressiveness observed in the research:

- 1) *"Towards the end of the therapy, Sibü expressed more feelings without being prompted"* (Van Westrhenen et al., 2017, p. 133).
- 2) *"She started to deal more openly with her feelings toward her family, and was able to dance out her impression or imitation of each sibling"* (Goodill, 1987, p. 67).
- 3) *"As disturbing as it may have been to acknowledge the truth of their involvement in making people suffer, the youths found a renewed empathy for one another and for themselves"* (Harris, 2007, p. 223).
- 4) *"During the final session, he concluded, 'I'm happy because we were drawing, telling stories and talked about our feelings'"* (Van Westrhenen et al., 2017, p. 133).

There is an integral connection between movement and affect; they have a bidirectional relationship on each other so feelings may be accessed and influenced by changing the movement repertoire of the individual, which in turn will shift the way the individual carries himself. Some of these movements were directed and some developed spontaneously by the children. Therapists/facilitators incorporated variations of the circle game where children formed a circle, and each spoke their name and made a physical gesture to represent the self or represent how they were feeling. For example, *"one youth crossed his arms loosely over his chest and said the word for 'sad'. Another placed a hand on his face, covering it in part, and stated clearly 'I cry'"* (Harris, 2007, p. 218). This same format was used throughout the sessions also to 'check in' with how participants were feeling. The participants would go around the circle repeating each gesture, which enabled them to connect to their own feelings by embodying the feeling, and also connect to others' feelings as they mirrored their gestures. This was an effective way to start opening the body and emotions. This is vital for trauma recovery as *"children who are emotionally disturbed due to some trauma tend to cut themselves off in some way; they will anesthetize their senses, restrict the body, block emotions and close down their minds"* (Oaklander, 2015, p. 6).

Where the movements developed spontaneously, the children also got in touch with feelings that had been dissociated or blocked. For a girl who had been sexually abused, *"the movement of specific body parts evoked sounds and images that were sexualized"* (Weltman, 1986, p. 61). As she wiggled her toes, she had a visceral, felt experience of aspects of her trauma, thereby bringing those sensations and feelings into the open to be acknowledged and worked with. *"The somatic experience gave rise to sensation, emotion and verbal association and contributed to the therapeutic relationship and to its process"* (Engelhard, 2017, p. 107).

In numerous cases, the children engaged in verbal discussions or story-telling of their experiences only AFTER they had engaged their bodies and moved around. Tortora (2019) using movement therapy with a boy in hospital writes, *“as he becomes more limber, he also opens up about his recent experience with his illness”* (p. 13). Similarly, Lee and colleagues (2013) write *“there was a marked change in their behaviour, as it changed from tussling, wild grappling and turmoil to the children sharing their feeling with each other”* (p. 154). The movement may have facilitated a psychophysical liberation, opening the door for psychological contents to manifest and become conscious. Goodill (1987) also observed how physical activity re-kindled the child’s sense of feeling. *“Spontaneous games with a big cage ball began and allowed some of her affect to emerge”* (Goodill, 1987, p. 66). Like free association, play, and dreams, movement and physical activity may be another effective pathway through which to access hidden psychological content and shift entrenched emotions. Where at the start children were numb due to chronic emotional suppression and dissociation, towards the end of therapy the children were less inhibited in their affective expression, which corresponded to a freer body-state.

### **3. Moving Back In**

*“Knowledge is only a rumour until it lives in the muscle”*  
Papua New Guinea Proverb

#### **3.1 Awakening the Embodied Self**

Through a variety of different movement-based activities and free active play, the children were supported to become more aware of their bodily experience and felt sense in the present. The act of moving mindfully in new ways facilitated the development of body awareness among the children and young people and they re-connected with their bodies and felt experiences.

To be fully alive one has to be grounded in the body - to feel and receive its impulses, sensations, and instincts. The children were guided to notice their body through the use of movement and this helped them to start to identify with their body instead of ignoring or denying it. For example, Harris (2007) states that with his work with traumatized child soldiers *“blank stares and psychic numbing typified much of our early time together. In subsequent weeks, however, decreasing inhibition in the group led to more direct expression through*

*words and symbolic action*” (p. 212). One way in which this inhibition and freeing of the body was facilitated was by the therapist modelling or demonstrating a variety of movements and patterns to be copied by the children (Goodgame, 2007). Goodgame (2007) writes the “*leader moves around the room, and the rest of the group follow behind copying the movement*” (p. 80). The children moved in novel ways and had new somatic experiences that were inherently empowering on a physical level. Often at the start of the sessions the therapist would incorporate music and rhythm to create a physical warm up of all the parts of the body (Harris, 2007). Lee (2013) states, “*we stretched out our limbs and freed our bodies*” (et al., p. 152), which highlights how the act of mobilizing helps to unlock the frozen and imprisoned body by giving it permission to move and to feel. This freeing of the body was often associated with a noticeable release of energy and affect among the children. The use of musical instruments also supported the children’s finding their own rhythm and affective feeling. For example, Van Westrhenen (et al., 2017) write of one child, “*he responded well to physical expressive activities, particularly drumming, where he became very enthusiastic and energized*” (p. 133). The act of mobilizing and getting the body moving, activated the child on a physical and emotional level and he became more expressive and open in both gesture and affect. The movement exercises helped the children to revive their body’s vitality and childlike joy. This is discussed by Lowen (1995) as he explains without movement there can be no feeling, and how children (who have not been traumatized) tend to be free and joyful as they do not rigorously repress their affects and impulses. Such repression causes a numbing and deadening of the soma-psyche.

Reconnecting and revitalizing the body was also facilitated in one-on-one therapy by the therapist’s gentle noticing of the body’s reactions and responses, and supporting the child/young person to notice and attune to their own body. Van Westreheenen (et al., 2017) did so using the Sensory Motor Arousal Regulation Treatment with a 13-year-old boy after he was sexually abused. The following transcript describes their work.

*Gently noticing with him how his legs began to shake and his breathing quickened, the therapist began to teach Sam how his pressure to talk did not immediately make him feel better, but in fact, the opposite. Slowing him down, the therapist explored with him what would feel more regulating. Working together, they found that when he jumped on the mini-trampoline, or intensely bounced a basketball his energy and agitation gradually subsided...when Sam had urges to hurt himself, he learned “this was his body’s way of telling him” he needed to slow down and use ways to self-regulate*  
(Van Westrhenen et al., 2017, p. 239).

In this example, the therapist explored with the child how his body responded to different external stimulation, and what felt soothing and regulating. A connection was forged for the child to their vital being as they re-connected to their body and learnt to receive its signals and communications more openly, instead of unconsciously fleeing from them. This is in line with what Lanyado (2004) writes in working with traumatized children by helping them to find greater continuity and to feel more joined up internally.

Van der Kolk (2014), in his decades of experience working with traumatized individuals, states that helping individuals find words for their experience is profoundly meaningful but usually inadequate. *“The act of telling the story doesn’t necessarily alter the automatic physical and hormonal responses of bodies that remain hypervigilant, prepared to be assaulted or violated at any time”* (van der Kolk, 2014, p. 21). He asserts that real change requires the body to unlearn these responses and re-learn that the trauma is in the past and mindfully live in the reality of the present (van der Kolk, 2014, p. 21). Coming back into their bodies helps anchor the ego to reality (Lowen, 1967) and therefore to the present. Another way in which this was achieved was through drama exercises where the child visualized a time they *“felt powerless or helpless, and to think of what shapes or positions the body had”* and how it felt and moved (Van Westrhenen et al., 2017, p. 132). Attention is focused on how the body moves and feels, and how different postures are associated with certain affects.

*Then the visualisation moves to a time in which the child felt powerful and able to act as they wished. If the child cannot locate a memory of ever feeling powerful the children can act like animals, for instance a powerless animal such as a mouse, and a powerful animal such as a lion* (Van Westrhenen et al., 2017, p. 132).

This again helps the child release their body through free, spontaneous and creative movement. The act of moving in such a way as to resemble a powerful animal, activates the same powerful feeling in the child, giving them a new felt experience of a powerful body. Where the children’s movements at the beginning of therapy were often rigid, one-dimensional and constricted, they became more open, spontaneous and expansive through the process.

Tortora (2019) gives an example in a DMT session with cancer patients, how the children spontaneously created a play scene of a storm involving embodying sharks and hunting for prey. This active, symbolic play experience enabled the children to access, and cope with powerful feelings related to their medical experiences of fear, invasion, pain, bewilderment, shock, helplessness, and provides a way for them to get in touch with new feelings of strength,



and hope. Through active, creative movement they embodied their various, often conflicting, feelings in a safe way, and following on from this exercise they were able to give voice to their feelings through discussion. Beaven & Tollinton (1994) did similar body-awareness work and state, *“to move is to know, the sense of knowing in one’s bones was reached through body awareness work even when the mind had forgotten”* (p. 441). Becoming familiar with their bodily sensations and internal landscape was central to the child’s core sense of self (Levine & Kline, 2006) and through this the children developed a more harmonious sense of self.

### **3.2 Finding a Home Within**

*Our sense of agency, how much we feel in control, is defined by our relationship with our bodies and its rhythms...in order to find our voice, we have to be in our bodies- able to breathe fully and able to access our inner sensations*  
(van der Kolk, 2014, p. 331).

This organizing theme conveys the powerful re-connecting and re-integration that took place through the movement therapy approaches and which helped the children and young people reclaim fragmented parts of their minds and bodies. Once becoming more aware and conscious of their bodies and impulses, as described in the preceding theme, the children were supported to ‘move back in’ to their bodies, re-establishing the body as a safe, reliable home to live in.

David in his movement therapy, proceeded through activities like *“rolling on the floor, curling the body to an oval shape, stretching and lengthening on the vertical axis”* (Goodill, 1987, p. 63). These experiences helped David to establish a more solid sense of his corporeal self and his body boundaries. This movement, although simple and matched to a very early developmental level, helped David to unthaw from his frozen state and start to reside inside his own body. This process can be likened to coming home to the self. Many traumatized children do not feel at home in their own bodies; the body is alien and frightening. Through movement, in a safe, holding environment, David was able to gradually receive tactile feedback which fostered a sense of safety in his own being. Being able to feel their body and the feelings that arise from it, develops into a somatic resource and builds the child’s innate resilience (Buckley et al., 2018).

Lisa, an 11-year-old girl who had been sexually abused, began to explore feminine qualities of movement through improvised dancing with scarves as props. Lisa held extreme tension in her hip/pelvis and legs and had very restricted use of her kinesphere. Through her dancing she

experienced new sensations in her body, and also explored new social roles. Through this she transformed her sense of her own body as she integrated a new felt sense of her body. Goodill (1987) reflects, *“it was as though she had been set free and could let go of the violated, constricted perception of her body”* (p. 66). Lowen (1995) affirms that *“to know ourselves we have to feel our body...the loss of feeling in any part of the body is the loss of part of the self”* (p. 23). All the various parts of the body contribute to our sense of self and due to her chronic tension and holding in certain body areas, her connection to this part was disturbed, affecting also her sense of self. Her new felt experience of her body gave rise to new ways of thinking and perceiving, bringing her closer to connecting with her true self. Creative dance gave rise to experiencing her body in a new and positive way, as the therapist (like an audience to a play) observed the creation and was witness to it. Moving in a new way, brought with it a new feeling to parallel the new posture. This in turn awakened a new way of being in the world for Lisa, as she accessed a side of herself long forgotten and suppressed for survival reasons. Bessel van der Kolk (2014), talking about helping individuals with post-traumatic stress, states *“for real change to take place, the body needs to learn that the danger has passed and to live in the reality of the present”* (p. 21). Lisa was able to step into the reality of the present through doing these improvisational dances because it made a way for her to re-possess parts of herself that she had disavowed. In sufferers of trauma, there is often a part of them that has been split off and separated from consciousness as a survival mechanism (Bromberg, 2006). This dissection, whether it is of painful memories, self-states, affects or body-based affects and sensations, was part of their way of adapting and coping with a threatening environment, however in the present often causes them to feel fake and unreal, and is usually maladaptive to the current environment. This is supported by Levine (2015) and van der Kolk (2014) who describe trauma as severing the connection between psyche and soma. A fundamental reorganization occurs in the way the mind and brain manage perceptions, thus the core self’s relation to itself and the outside world becomes distorted. Traumatized individuals often find it very difficult ‘being in their bodies’ due to feeling too much (hyperarousal) or feeling too little (dissociation). For Lisa, and others in the research, they had dissociated from parts of their bodies, and creative, active movement gave them a way to reconnect with these vital parts.

Similarly, Margolin (2019) in her work observed how Shirley reclaimed her body to which she had felt disconnected, and so started to experience a newfound pleasure in her body. She came to re-inhabit the different parts of herself by getting in ‘touch’ with all her parts of her body. *“She harmonized these fragmented aspects together allowing the paradox of control and*

*abandon to exist simultaneously within her through the frame of lyrical dance”* (Margolin, 2019, p. 186). Towards the end of her therapy, *“Shirley unearthed a former contented, and integrated image of herself, which she was now relying on to think, choose, and act with her peers”* (Margolin, 2019, p. 182).

Scaer (2014), a prominent neurologist, discusses how numerous of his trauma patients present with specific neuromuscular postural patterns which are not explained by physiological findings, such as chronic pain in a specific body part. These postural abnormalities and somatic symptoms unconsciously reflect the pain of the traumatic incident, and the body’s attempt to move away from the injury or threat. This somatic dissociation serves a protective and survival function as the body tries to insulate itself from pain, however as was found in my research, this dissociation causes children to be ‘out of touch’ with their bodies and feelings. Being out of touch with the body also means one is out of touch with reality, as Lowen (1995) states *“our basic reality is our body”* (p. 23). Individuals may ‘lose their ground’ or standing. It is only by fully reclaiming those parts of themselves that healing can occur from trauma.

#### **4. Moving Forward**

*“Creative movement promotes both activity and innovation, which can take the place of conditioned habits of immobilization and passivity”* (Margolin, 2019, p. 185).

This final theme captures how through movement focused therapy the children and young people were empowered and equipped to move forward with their lives, free from the physical bondage that the trauma had over their bodies and emotional states.

##### **4.1 Being Empowered**

The very act of taking active, deliberate, effective and self-determined action is empowering on a bodily level to these children who have experienced a collapsed, frozen, or powerless body. This allows them to feel on a visceral level a sense of agency and power. Empowerment was evident as the children and young people showed greater confidence in themselves. They reclaimed the authority to take effective action. Through role-playing and dramatic, imaginative action, the children experienced a new felt sense of themselves as strong and capable. By positioning themselves fully in a new, alternate bodily position they were able to embody and feel a more empowered self-state. Margolin (2019) explains how this took place with Shirley, a young woman who had experienced dating violence. Margolin devised an exercise where Shirley was sitting inside a box and had to break out of the box, thereby helping

to affirm her body boundaries and encouraging self-directed action. By using her body in an empowering, freeing way she learnt that her body could provide positive experiences. Shirley reflects,

*Those exercises were something that was so focused on the individual and it was something that you really had to create on your own and I really enjoyed that individuality of creating and acting completely on my own during a time when I was feeling like I was not an individual (Margolin, 2019, p. 186).*

The act of taking individual effective action affirmed and strengthened Shirley's self. Her ego strength was bolstered as she felt vitally believed in and affirmed for her own actions. Through exploring bodily movement, she recognized her capacity to act. *"I observed an increase in Shirley's pushing movements, which lay a foundation to begin to reach physically and psychically for emotional support in relationships"* (Margolin, 2019, p. 181). As she recovered her physical capacity to move freely and effectively, it corresponded with her social engagement system being re-awakened. She now felt she could take authoritative action to take care of her needs. She was returning to a place of consciously inhabiting her own body-mind.

Developing innate resilience was facilitated by physical exercises which expanded the individual's movement repertoire, helping identify and reveal lost capacities (Buckley et al., 2018). For example, Beaven & Tollinton (1994) worked with girls who had been sexually abused and guided them to embody assertive action to protect their body boundaries and take up postures which increased their sense of strength and stability. They tested each other's strength by sitting back-to-back and trying to push their partner across the room. This activated a visceral sense of strength, agency and assertiveness, and directly countered their usual embodied states of helplessness and passivity. *"They gained a sense of how posture could convey purpose and how to feel less like victims through assertion of their needs"* (Beaven & Tollinton, 1994, p. 441).

Empowerment included the re-kindling of buried physical and psychosocial capacities that strengthened the child's sense of self. George was a 17-year-old child who showed a fixation in his upper body and who was highly withdrawn and isolated.

*At this point, I began to supplement our walks with range of movement exercises to gently encourage George to bridge more with his environment. As we walked, I raised my arm up, or squatted low, or opened my arms wide, inviting him to join me. As he became more comfortable with these movements, he began to increase eye contact with an occasional peek at me. He began to smile more, evidence of increasing emotional expression (Gray, 2001, p. 1).*

These newly acquired movements helped George move out of his specific physical holding pattern that reflected an adaptation to trauma that was no longer adaptive. Fixed postural patterns not only reflect certain beliefs about the self but also reinforce these beliefs, for example a rigid posture may reflect and maintain the belief ‘I need to protect myself’. Only select emotions may be possible in these postural positions and therefore changing the posture and movement of the child also opens up new feeling states and beliefs to be amended. George began to re-kindle his capacity for social connection and emotional expression. Harris (2007) also found that joining in ritualized movement-based activities “*successfully rekindled long dormant capacities for interaction and empathic connection with others*” (p. 207). The movement-based exercises helped correct the children’s somatic-psychic organization which previously drove defensive behaviour, enabling them to reach out and connect.

Langmuir (2012) suggests that helping individuals become more aware of their physical sensations is key in helping them develop the capacity to soothe themselves and regulate their emotions. For these children their body was able to become a resource, which was a drastic change from the body as a source of fear, terror, and helplessness. By grounding themselves in their body, becoming familiar with their body’s sensations and their embodied feelings, they felt more at ease in their own skin and learnt to use their body to help them cope. For example, one boy commented at the end of a DMT group intervention when facing difficult feelings, he learnt to “*go find friends from the group and if music were available would dance until ‘working up a sweat’*” (Harris, 2007, p. 219). Several of the other boys in this intervention also pointed to restored confidence to control their angry impulses and cope with difficult situations (Harris, 2007). The youths developed tools to increase their ability to cope and to manage their feelings. Homann (2010a) states that as children develop the facility to link emotions and physical sensations, the body naturally becomes a resource for emotional regulation.

## **5. Summary**

This chapter discussed the research findings, consisting of four overarching themes and eight sub-themes, showing how movement facilitated shifts in psychic, emotional and physical functioning for children and young people who have experienced some form of trauma.

## **Chapter Six: Discussion**

This dissertation followed six phases of thematic analysis to identify core themes, from a clearly defined selection of movement-focused scholarly articles, that answer the research question, “how can movement ameliorate the effects of childhood trauma?” This revealed four overarching themes as described in the previous chapter, showing a gradual pathway from establishing a felt sense of safety, trust and containment in the therapeutic environment, to communicating and expressing the traumatic material using movement, to equipping and empowering the child using the body and movement as a somatic resource. In this chapter I discuss the findings and implications for the profession and clinical practice, the strengths and limitations of the study, and potential further research based on my dissertation.

## **6. Findings in a Broader Context & Clinical Implications**

### ***6.1 The Body as a Secure Base***

As discussed, trauma can profoundly disrupt the child’s relationship to the people around them, and also to their own sense of self. The findings presented here point to a conceptualization of the empowered, resourced body as holding the potential to provide a secure base for the child. Traumatized children tend to not feel safe or at home in their own bodies, which can inhibit their exploration, learning and resilience. By using movement approaches to restore the child’s confidence in their own body’s wisdom, competency and strength, the child can use the body as a ‘secure base’, from which they can seek comfort, safety and support. By learning to become more aware of their physical sensations and feelings, and acquiring a new empowered embodied experience, they learn to see themselves, soothe themselves, and provide a felt sense of safety for themselves, which are three pillars of a secure attachment relationship (Siegel & Bryson, 2020). Although attachment theory has been traditionally theorized in relation to an external attachment figure, I am proposing attachment theory and Bowlby’s (1988) concepts of a secure base and safe haven, may also be usefully applied to clinical thinking around traumatized children’s relation to their own sense of self. Through these empowering, movement approaches discussed, a child can establish a new secure relationship to their own body and mind - one where their body is no longer a source of further terror and torment (such as through states of dissociation or hyperarousal), but may provide comfort, safety and a safe haven to peacefully reside in.

### ***6.2 The New Zealand Context***

New Zealand currently is facing high levels of domestic violence, sexual abuse (New Zealand Family Violence Clearinghouse, 2017), and suicide attempts (Phillips, 2019), all of which

constitute traumatic exposure which may also affect the next generation. Maori health advocate and researcher Dr. Mason Durie developed the Te Whare Tapa Whā model in 1984 which provides a Maori model of health (see figure below). I would like to briefly discuss my findings in relation to this model.

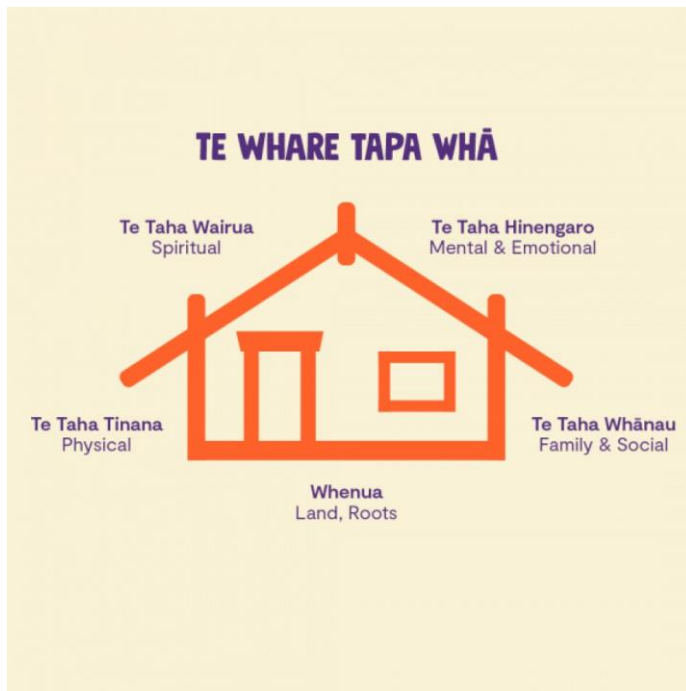


Figure 4. The Whare Tapa Whā.

Whenua can be understood as “the place where you stand”, your connection to the land and also your sense of belonging (Mental Health Foundation, 2019). This forms the foundation for wellbeing upon which the other pillars stand. All aspects of health are interrelated and cannot be separated into distinct parts. In the case of trauma, children lose their basic sense of groundedness, their sense of safety in the world, and their standing. Without this firm foundation, all the others pillars of health may be compromised. Trauma may disrupt every aspect of the child’s wellbeing (physical, spiritual, mental and emotional, and family and social). In my research, I have discussed how the body can become a resource that empowers the child. This can help strengthen their place of standing and vital connection to their ‘mauri’ (life force), and their sense of grounding. Thus, if a child, due to trauma, is disconnected from their own physical body and sense of aliveness, their spiritual sense of self, their internal thoughts and feeling states, and connection to family and friends also suffer. My findings highlight the interconnectedness between Tinana (the physical body) and Hinengaro (mental & emotional health). Such body-mind unity is exemplified in this model, which Western

psychology often struggles with (Lambrecht, 2016). Furthermore, the benefits of a somatic approach to healing trauma for children may extend to Te Taha Whānau, as children's social engagement system restores, and they reconnect with their loved ones.

Therefore, my findings bear some consistency with Maori health beliefs, and may be considered suitable for the NZ context.

### ***6.3 The Somatic Impact of Trauma***

A significant contribution of this research to child mental health clinicians working with traumatized children, is the theoretical knowledge of the somatic impact of trauma. As a child psychotherapist in New Zealand, my training was significantly influenced by the prevailing notion in Western culture that cognition is the main source of intelligence (Malchiodi, 2020), to the neglect of embodied intelligence. This dissertation has shown how body-oriented interventions may help children connect with the ancient wisdom of the body, and re-experience their body as a source of strength, self-efficacy and resilience, replacing their past embodied experiences of helplessness, weakness or incompetence. Such knowledge is much needed as the majority of the developed somatic theories for trauma are based on adults. In my research I have applied existing theories and concepts from somatic experiencing, bodyenergetics, sensorimotor psychotherapy and dance/movement therapy and shown how these ideas apply with children. My research therefore provides clinicians with numerous case examples detailing therapeutic interventions and outcomes of movement-based approaches. Such knowledge can directly inform clinical assessment and treatment planning for this vulnerable population. Having knowledge of effective non-verbal ways of working with traumatized children is essential for practitioners to create a safe, non-threatening and accessible modality for these children who struggle to verbalize their experiences. As such, movement-based approaches can expand the range of effective, available tools for the clinician. The interventions described here can be incorporated as adjuncts to traditional psychotherapy, or as interventions on their own. Clinicians thereby are better resourced to meet the needs of a larger range of clients.

### **7. Interrelationships between Themes**

As I stood back and reflected on the major themes, I became aware of a core interrelationship between the themes and the clinical implications. Within the four global themes and eight sub-themes, there is significant overlap on the issue of attunement and mindfulness of somatic experience, both for the therapist to their own body and to the child client in the room. Such



‘knowing’ is foundational to the therapeutic process and has a fundamental connection to meaning. Block & Kissell (2001) state that, “*most people do not allow their bodies to think; in fact, we are trained from childhood to repress embodied knowing*” (p. 10). What I have discussed in this thesis therefore not only provides new learning regarding body-based ways of working, but also suggests the need to unlearn the ways we may repress our own embodied knowing. As shown in the figure below, the majority of the sub-themes held an aspect of embodied awareness and being more present/connected to the self.

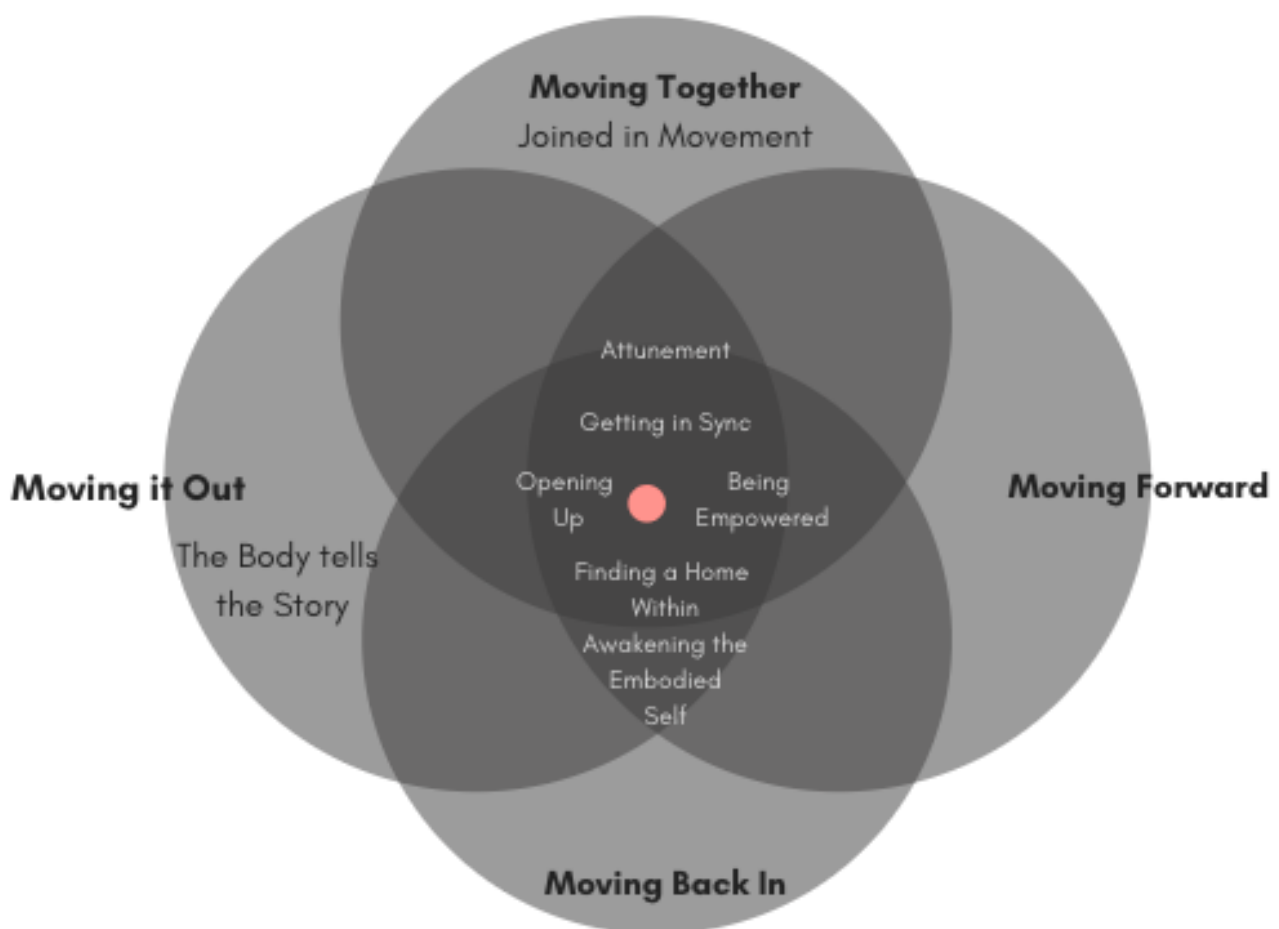


Figure 5. Thematic Interrelationships

This interrelationship between the themes can further be understood as connection- to one’s mind-body and sense of self, and to others. Ultimately, the child’s healing from trauma depends on their connection to their body, their feelings, to others, to embodied wisdom and meaning, and to their innate resources and potential.

It is my hope that the findings I have presented here go beyond the functional transmission of information and speak to our sense of being in the world, how we express this sense of being and our embodied values. This research project has profoundly affected my own awareness and understanding of the power of the body in shaping our sense of self and the way in which we carry our history with us. This will significantly inform my clinical practice with children going forward, as I am more connected and ‘joined up’ internally (Lanyado (2004), and therefore more present to myself, my own embodied story, and to others.

## **8. Research Limitations & Further Research**

As a researcher and psychotherapist, I bring my own human, embodied experience to the research, however due to the limitations of a thematic analysis method, such personal reflections were excluded in this study. Immersing myself in the body psychotherapy literature has taught me a great deal about the centrality of the body for my own clinical practice, as well as mind-body unity. In the undertaking of this research, I have undergone my own personal journey of learning to listen to my body, to receive its communications and in learning to trust and yield to it. The absence of these personal reflections are an unfortunate limitation of the methodology and scope of this dissertation. Furthermore, my subjectivity and personal understanding of the literature naturally informed my selection of data extracts, and the way in which I coded and made meaning of the data. This subjectivity is rather natural and intrinsic to a qualitative research approach where “the researcher is the instrument” (Patton, 2001, p. 14). Finlay and Ballinger (2006) argue that the subjectivity of the researcher should be acknowledged and celebrated, and not solely understood as ‘contamination’ to be eliminated. However, one way in which I have limited my subjectivity and interpretations of the accounts is by providing ample examples of direct quotes from the participants in the studies.

A strength of this study was that it included two different intervention formats - individual and group therapies, and the results showed that movement approaches were useful in both of these modalities. This is especially promising to support the use of group work for traumatized children.

Further research is needed into body-oriented approaches with traumatized children under five years old, as this was not covered in the present study. Children who have been traumatized in these early formative years may present with greater embedded somatic responses and patterns

and often later fit the diagnostic criteria for complex trauma, if the trauma was repeated over time. Approaches with this population need to be specialized and tailored to their needs and developmental level.

Furthermore, the present study looked at a number of different types of trauma, which on the one hand represents a strength of the study as it demonstrates that movement-focused approaches may be a useful intervention for children with a variety of traumatic experiences. This may be due to the fact that many traumas occur inherently on a bodily level, such as medical trauma, and physical assault (Malchiodi, 2020). However, future research may need to explore the use of body-oriented approaches focusing more in depth on one specific type of trauma and perhaps devising tailored ideas to be applied for that traumatic experience. There is indeed a great deal of variability even within the same category of trauma which affects the way a child may respond to a particular treatment approach.

This research focused on situational trauma, and did not include intergenerational and historical trauma. This is particularly important for research into the New Zealand context, as it has been well established that Maori have experienced intergenerational trauma in part due to colonization and associated oppressive practices which undermined the value of Maori culture (New Zealand Family Violence Clearinghouse, 2019). There is increasing recognition in child and adolescent mental health services of the need to draw on indigenous healing knowledge alongside Western knowledge when working with Maori clients (NiaNia et al., 2017). Although traditional Maori healing knowledge inherently believes in the interrelated nature of mind, body and spirit (Mark & Lyons, 2010), caution should be taken when generalizing the findings of this research to indigenous Maori clients, as it has been shown that Maori cultural perspectives influence their views of the body and health, and they have historically experienced the oppression of their health knowledge. This relates to the Treaty of Waitangi principle of protection, which aims to protect indigenous knowledge, values and taonga. Other considerations for working with indigenous tamariki or rangatahi under the Treaty of Waitangi include the principle of participation and partnership. The current research findings will need to be considered in view of these principles. The value of participation may entail the involvement of whanau for example in the treatment process, and the value of partnership requires considering how the therapist can partner with the client in the treatment process in a way which is empowering and which honours their mana and Maoritanga.

## **9. Conclusion**

In this dissertation I have given a detailed overview of the development of the study of trauma, and the impact of trauma on the developing child's nervous system and body, as well as different body-oriented ways of working with trauma for both adults and children. I have described the six phases of thematic analysis applied, and the philosophical underpinnings. The results of this dissertation yielded four primary themes and eight sub-themes which provided valuable knowledge and insights into how movement may be used as a therapeutic intervention for children who have experienced trauma. The results described the ways in which movement, as a primary non-verbal and physical modality, provided a way for the children and young people to communicate their traumatic experience, express the buried material, re-connect to dissociated emotional and physical parts of themselves, re-inhabit their bodies, and form a more integrated self-concept. I have shown that working with each child's unique trauma history, how it impacted on their mind-body organization, the internalized meaning, and how they coped in the aftermath, requires a psychotherapy that is holistic, dynamic, and body-oriented. The results show how the body can be an entry point into the psyche, and the somatically stored memory of the trauma may be reorganized and transformed, changing the individual's core relationship to the self. I have linked the research findings and interpretations to existing theory, and this has been woven into each theme. Finally, the implications for the profession have been discussed and the strengths, limitations and ideas for further research outlined.

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**Appendix A: Literature Search Log**

<b>Database</b>	<b>Search Terms</b>	<b>Search Result</b>	<b>Selected Articles</b>
<b>PsycARTICLES</b>	("body-cent*" or "body cent*" or bodycent* or "body psychotherapy)	790	0
	("body-oriented " or "body-cent*" or "body cent*" or bodycent* or "body psychotherap*")	1045.	0
	((child* or teen* or adolescen* or youth* or "young person*") adj8 ("body-oriented" or "body-cent*" or "body psychotherap*"))	6	0
	((child* or teen* or adolescen* or youth* or "young person*") adj8 ("expressive art*" or "dance therap*" or "dance movement"))	28	0
	((child* or teen* or adolescen* or youth* or "young person*") adj8 ("soma* intervention*" or "dance therap*" or "dance movement"))	7	0
	((child* or teen* or adolescen* or youth* or "young person*") adj8 ("soma* intervention*" or "movement"))	1163	0
	((child* or teen* or adolescen* or "youth*" or "young person*") adj8 ("soma*	3	0

	intervention*" or "dance movement"))		
	((("child* or teen* or adolescen* or youth* or "young person*") adj8 ("soma* intervention*" or "dance movement" or "body-mind") adj8 (trauma*))	2	0
	((child* or teen* or adolescen* or youth* or "young person*") adj8 ("dance movement" or "move*" or "body") adj8 "trauma*")	132	0
	Dance movement	40	0
<b>Psychoanalytic Electronic Publishing</b>	"Body psychotherapy" AND "child* trauma""	3	0
	""Body psychotherapy" AND "child*""	37	0
	"Movement" AND "child" AND "trauma"	77	0
	"Dance/movement therapy" AND "child" AND "trauma"	2	0
<b>PsycINFO</b>	((child* or teen* or adolescen* or "young person") adj8 (move* or "body-cent* or body therap*"))	10,345	0
	((child* or adolescen* or teen*) adj8 movement adj8 trauma*)	61	2



	((child* or teen* or adolescen*) adj8 ("dance movement" or "soma* intervention"))	84	1
	(child* adj8 body adj8 trauma*)	125	0
	((child* or teen* or adolescen* or "young person") adj8 (move* or "body-cent* or body therap*") adj8 (trauma))	52	0
	((("child*" adj8 (mind-body or embodiment))	154	1
	("Dance/movement therapy") adj8 (child* or adolescen* or teen*) adj8 ("abuse"))	5	0
<b>AUT Library</b>	"Movement" AND "child" (title) AND "body" AND "trauma"	1298	0
	"Movement" AND "child" (title) AND "body" AND "trauma" (title)	54	0
	"Movement" (title) AND "child" (title) AND "trauma" (title)	17	0
	"Movement therapy" (title) AND "child" AND "body" AND "trauma"	74	1
	"Dance/movement therapy" (title) AND children or adolescents or youth or child or	2	0

teenager (title) AND "body" AND "abuse" (title)		
"Dance movement therapy or dmt or dance or movement" (title) AND "children or adolescents or youth or child or teenager" (title) AND "abuse" (title)	27	0
"Dance movement" and "child or youth or adolescents or children" (title) and trauma (title)	14	1
"Dance movement" (title) AND "child or youth or adolescents or children" (title) AND "trauma"	20	0
"Therapy" (title) AND "child or youth or adolescents or children" (title) AND "trauma" AND "body" (title)	13	2
Dance movement therapy or dmt or dance or movement (title) AND child or youth or adolescents or children (title) AND trauma	371	0
Dance movement therapy or dmt or dance or movement (title) AND child or youth or	33	0

	adolescents or children (title) AND trauma (title)		
	(body-mind) AND child or youth or adolescents or children" (title) AND trauma (title)	13	0
	"body-mind" or "body psychotherapy" (title) AND child or youth or adolescents or children" (title)	11	0
	"psychomotor therapy" AND "children or adolescents or youth or child or teenager" (title)	136	0
	"psychomotor therapy" AND "children or adolescents or youth or child or teenager" (title) AND "trauma"	9	0
	"psychomotor" AND "children or adolescents or youth or child or teenager" (title) AND "trauma" (title)	18	0
	"psychophysical" AND "children or adolescents or youth or child or teenager" (title) AND "trauma" (title)	5	0
<b>Google: Scholarly Articles</b>	(("dance/movement therapy") AND ("child") AND ("abuse"))	2050	6

<b>Total</b>	<b>14</b>
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## Appendix B: Coded Articles

Beaven, D., & Tollinton, G. (1994). Healing the split: a psychophysical approach to working with sexually abused teenage girls. *Physiotherapy*, 80(7), 439-442.

Ben-Asher, S., Koren, B., Tropea, E. B., & Fraenkel, D. (2002). Case Study of a Five Year-Old Israeli Girl in Movement Therapy with Case Discussion. *American Journal of Dance Therapy*, 24, 27-43. <https://doi.org/10.1023/A:1019769631655>

Engelhard, E. S. (2017). Body and movement in dynamic psychotherapy: Reflections on talking and movement therapies. *Body, Movement and Dance in Psychotherapy*, 12(2), 98-110.

Goodgame, J. (2007). Beyond words: Dance and movement sessions with young people with social, emotional and behavioural difficulties in Estonia. *Support for learning*, 22(2), 78-83.

Goodill, S. W. (1987). Dance/movement therapy with abused children. *The Arts in Psychotherapy*, 14, 59-68. <https://doi.org/10.1016/0197-4556%2887%2990035-9>

Gray, A. E. L. (2001). Dance movement therapy with a child survivor: a case study. *Dialogues*, 6(1), 8-12.

Harris, D. A. (2007). Pathways to embodied empathy and reconciliation after atrocity: former boy soldiers in a dance/movement therapy group in Sierra Leone. *Intervention*, 5(3), 203-31.

Lee, T., Lin, Y., Chiang, C., & Wu, M. (2013). Dance/movement therapy for children suffering from earthquake trauma in Taiwan: a preliminary exploration. *The Arts in Psychotherapy*, 40, 151-157.

Lynch, M. (2000). The role of the body as the medium in child psychotherapy: snapshots of therapy with an 11-year-old, severely abused, multiply placed girl. *Journal of Child Psychotherapy*, 26(2), 159-181.

Margolin, I. (2019). Breaking free: One adolescent woman's recovery from dating violence through creative dance. *American Journal of Dance Therapy*, 41, 170-192. <https://doi.org/10.1007/s10465-019-09311-9>

Tortora, S. (2019). Children Are Born to Dance! Pediatric Medical Dance/Movement Therapy: The View from Integrative Pediatric Oncology. *Children*, 6(14), 1-27.

Valdivia, M. E. (2010). A psychoanalytic perspective of endings in therapy: A dance movement psychotherapy case study. *Body, Movement and Dance in Psychotherapy*, 5(1), 75-87.

Van Westrhenen, N., Fritz, E., Oosthuizen, H., Lemont, S., Vermeer, A., & Kleber, R. L. (2017). Creative arts in psychotherapy treatment protocol for children after trauma. *The Arts in Psychotherapy*, 54, 128-135.

Warner, E., Spinazzola, J., Westcott, A., Gunn, C., & Hodgdon, H. (2014). The Body Can Change the Score: Empirical Support for Somatic Regulation in the Treatment of Traumatized Adolescents. *Journal of Child & Adolescent Trauma*, 7(4), 237.

Weltman, M. (1986). Movement therapy with children who have been sexually abused. *American Journal of Dance Therapy*, 9, 47-66.

## Appendix C: Codable Moments Example

# Beyond words: dance and movement sessions with young people with social, emotional and behavioural difficulties in Estonia

JENNA GOODGAME

This article details an experimental project in Estonian schools, using therapeutic dance and movement as a basis to explore beyond the boundaries of language in supporting young people to develop their creative expression. The author visited three residential schools in different areas of Estonia in September 2006 to lead sessions with groups of young people who had a range of social, emotional and behavioural problems. This personal account details the aims of the project, the sessions and the experiences of those involved. It asks: can dance and movement offer a creative and dynamic form for expression, beyond the boundaries of culture and language, for those troubled and damaged young people who often struggle to communicate and express with words?

**Key words:** emotional and behavioural difficulties, Estonia, group work, therapeutic dance and movement.

## Introduction

The young people come into the hall looking nervous and uncertain. In the large space they are unsure of where to go or what to do. Some distance themselves immediately, huddling themselves together near some chairs in the far corner of the room. Three boys walk out of the room and stand outside the door creating a disturbance. The boys and girls in the far corner of the room banter self-consciously and push chairs at one another to relieve the tension.

I smile and throw a soft ball toward one of the boys and say 'Jenna!' Initially bewildered, the boy catches the ball, ponders for a second or two staring at the space

between the ball and me, then throws the ball back and says 'Andriis!' I throw the ball again to another boy and say 'Jenna!' He energetically throws the ball back to me and says 'Toomas!' And so the session begins.

We are in a residential school (sanatoorne) for secondary aged young people experiencing psychological difficulties, in southern Estonia, close to the Latvian border. It is a very large and imposing building, typical of many built in the Soviet era, with high ceilings and long corridors. Recently, the school has appointed a new head and the building has been completely renovated, the walls painted in fresh bright colours, and new resources brought in. It has a welcoming and relaxed atmosphere as one enters the school, indicating the new ethos and approach being introduced across all areas of school life and work. It has a new optimism and positive outlook regarding the pupils who are referred from the schools' psychology service across southern Estonia to receive support for the range of psychological, learning and school attendance difficulties. The school has a balance of boys and girls across the age range, most resident during term time and returning home during the holiday period.

We are following the leader around the room. She is making exaggerated movements and jumping from foot to foot. She turns one way and then the next, totally absorbed in her movements and the music. She notices the group following and dancing in her steps, laughs, and pirouettes across the hall. The group follow her.

In small groups we are constructing sculptures out of bodies. The sculptures will reflect a memory, an emotion or event that we can freeze in time. One group are standing facing each other in a small circle, their hands held together upwards and their heads thrown back. Another group are surrounding a youngster curled up in the middle of the circle as if asleep; the others are holding him gently and caring for him.

### Appendix D: Developing Themes

#### Theme Network 1

Codes	Basic Theme	Organizing theme	Global theme
<b>Theme Network One</b>			
Safety through touch	Safety	Creating a Holding Environment	Moving Together
Gentle touch			
Engaging in a non-threatening way			
Creating safety			
Forming trust	Building Trust	Creating a Holding Environment	Moving Together
Practising trust			
Vulnerability			
Collaboration			
Using props for holding	Containment	Creating a Holding Environment	Moving Together
Predictability			
Structure			
Physical containment			
Physical proximity			
Consistency			
Familiarity			
Using therapist as container			
Soothing	Nurturing	Creating a Holding Environment	Moving Together
Holding			
Comfort			
Holding of therapist			
Providing sustenance			
Nourishing			
Affectionate touch			
Intimacy			
Use of therapist's body			
Therapist bodily countertransference	Bodily Countertransference	Attunement	Moving Together



Therapist attuning to self			
Kinaesthetic empathy	Kinaesthetic empathy	Attunement	Moving Together
Getting in touch with client's somatic experience			
Joint activity	Mutual Movement Experience	Attunement	Moving Together
Shared movement activity			
Mutual experience			
Joining in			
Moving in unison			
Attunement	Synchrony	Attunement	Moving Together
Building synchrony			
Bodily empathy			
Attuning to child through the body			
Joint experience	Mutuality/connection	Getting in Sync	Moving Together
Opening up			
Vulnerability			
Sharing of genuine feeling			
Sharing the past			
Sensory regulation	Regulation	Getting in Sync	Moving Together
Supporting self-regulation			
Physiological regulation			
Soothing			
Relaxation			
Connecting through rhythmic movement	Rhythm	Getting in Sync	Moving Together
Establishing dyadic rhythm			
Entering child's rhythm			
Attunement through rhythm			

Regulation by rhythm			
Ritualized action	Ritual	Getting in Sync	Moving Together
Repetition of activities			
Group ritual			
Reading the body	Attention to Body	Creating a Holding Environment	Moving Together
witnessing			
Watching body			
Being seen			
Focusing attention on the somatic body			
Listening to bodily communication			
Tracking movements			
Therapist's trust in body and wisdom	Trust in the Body	Creating a Holding Environment	Moving Together
Trust in the body process			
Free movement	Allowing of space/freedom	Creating a Holding Environment	Moving Together
Non-directive			
Spontaneous play/movement			
Fluid leadership			
Cooperation between therapist and child			
Offering space and choice			
<b>Theme Network 2</b>			
Symbolic play	Bodily communication	The body tells the story	Moving it Out
Embodying felt experience			
Re-enactment			
Communicating experience non-verbally			
Psyche expressed through the body			

Developing self-attunement	Body Awareness	Awakening the Embodied Self	Moving It Out
Body awareness			
Exploring body's responses and sensations			
Drawing attention to body			
Learning about the body			
Establishing healthy body boundaries			
Strengthening physical boundary between therapist & client			
Mobilizing	Activating the body	Awakening the Embodied Self	Moving It Out
Warming up the body			
Active use of body			
Activating the body			
Exploring feelings	Accessing Feelings	Opening Up	Moving It Out
Accessing feelings			
Emotional awareness			
Grappling with multiple feelings			
Experiencing new emotions			
Embodied feeling			
Releasing emotions	Self-Expression	Opening Up	Moving it Out
Authenticity			
Representing the self through gesture/movement			
<b>Theme Network 3</b>			
Enjoyment in the body	Positive Bodily Experience	Finding a Home Within	Moving Back In
fun			
joy			
pleasure			

Experiencing body as powerful			
Embodying new self states	Experiencing a new self-state	Finding a Home Within	Moving Back In
New felt sense of self/body			
Exploring different roles			
New self			
Creating a new identity			
Exploration of self			
Multiplicity of self			
Development of new way of being			
New mental state developed			
Connecting with the self	True Self	Finding a Home Within	Moving Back In
Being authentic			
Finding true self			
Listening to the self			
Valuing the self			
Making space for true self			
Coming alive			
New identity			
Mobilizing the true self			
Gaining mastery over trauma	Reclaiming Body	Finding a Home Within	Moving Back In
Reclaiming ownership over body			
Gaining control of body			
Gaining control over impulses			
Feeling in control			
Integrating trauma	Integration of Self & Experience	Finding a Home Within	Moving Back In
Owning their experiencing			

Accessing forgotten embodied memory			
Linking body & mind			
Splitting of body and mind			
disconnection			
Integration of body			
Integrating thoughts & feelings			
Finding safety in body	Comfort in body	Finding a Home Within	Moving Back In
Acquired confidence in body			
<b>Theme Network Four</b>			
Accessing or building bodily resource/strength	Equipping	Being Empowered	Moving Forward
Developing coping skills			
Agency			
Strength			
Positive experience of body			
Equipping			
New learning and knowledge gained about the self or bodymind			